

Migrant and Seasonal Head Start XII Oral Health Forum: Enhancing Partnerships for Migrant and Seasonal Head Start and Oral Health

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Executive Summary

The Migrant and Seasonal Head Start Region XII Forum, "Enhancing Partnerships for Migrant and Seasonal Head Start and Oral Health" was held on February 6, 2003 in Washington, DC. This Regional Forum was held as a follow-up conference to the national Head Start Partners Oral Health Forum convened in 1999 to focus attention on early childhood oral health. This was the fifth in a series of regional forums hosted by the Health Resources and Services Administration (HRSA) and Administration for Children and Families (ACF). The Region XII Forum was held in conjunction with the Maternal and Child Health Bureau (MCHB), HRSA, Migrant and Seasonal Program Branch, Head Start Bureau (HSB), ACF and Region XII Migrant and Seasonal Head Start (MSHS), Quality Improvement Center (QIC).

Participants at the Forum had expertise in a broad range of disciplines and were working at the national, state, and local levels. They represented diverse organizations, agencies, and professional groups in the public, private, and nonprofit sectors. Attendees had interests in Head Start, migrant and seasonal health, and oral health. The forum included plenary sessions with presentations and small group discussion sessions.

Participants assessed and prioritized current oral health issues and challenges faced by Migrant and Seasonal Head Start programs. They identified promising practices and developed strategies for regional action to enhance the oral health component in MSHS. They also outlined specific activities to support MSHS programs in increasing access to dental care, enhancing prevention, and expanding effective oral health education. Forum participants recommended collaborations among organizations and agencies to improve oral health status in Migrant and Seasonal Head Start children. The strategy plan delineated ways that Region XII can collaborate with HRSA's Maternal and Child Health Bureau (MCHB), and the Centers for Medicare and Medicaid Services (CMS) as well as other entities to combine efforts and improve oral health outcomes in MSHS programs. The collaborations included actions within agencies, across disciplines, and among organizations at the national, regional, state, and local levels.

The work groups focused on oral health education, prevention, and access to dental care and prioritized the following issues:

Oral Health Education

- Lack of a comprehensive approach to oral health education
- Lack of available oral health resources to grantees
- Oral health education of parents is currently not a "high" priority for grantees

- Lack of consistency among physicians in delivering oral health and a gap between dentists and physicians
- Lack of a system to track “real” data on oral health disparities, what sources for care are used, etc.

Prevention

- Lack of prevention programs that specifically address oral health care needs of migrant and seasonal farmworker children
- Programs do not specifically address migrant and seasonal farmworker lifestyle issues (e.g., culture, housing, socioeconomic factors) related to oral health
- Lack of a focus on outreach delivery efforts that reach migrant and seasonal farmworkers in a variety of settings
- Need for training and technical assistance (T/TA) about prevention to outreach and other MSHS staff
- Lack of providers for preventive care

Access to Dental Care

- Disconnect of the delivery system
- Workforce issues
- Financing challenges
- Families' values, knowledge and reality
- Policy challenges

I. Introduction

A. National Forum

In 1999 the national Head Start Partners Oral Health Forum was convened by Head Start, WIC, HRSA, and CMS (then the Health Care Financing Administration) to focus attention on early childhood oral health. The purpose of the Forum was to discuss strategies for improving oral health status among young children. Several papers were presented that reviewed current evidence related to oral health and nutrition, dental caries risk assessment and prevention, and access to oral health services. Also, this National Forum outlined strategies to increase collaboration at the Federal, state, and local levels to improve oral health status and enhance access to oral health care services. Participants at the Early Childhood Oral Health Forum expressed support for replication of this type of activity at the regional, state, and local levels across the country.

One outcome of this National Forum was the formulation of an Inter-Agency Agreement between the Head Start Bureau, Administration for Children and Families and Maternal and Child Health Bureau, Health Resources and Services Administration to develop linkages to support oral health in Head Start. As part of this agreement ACF, HSB and MCHB are sponsoring a series of the Regional Forums in 2001-2003. Ten regions are designated by the U.S. Department of Health and Human Services. Also, two additional regions are under the auspices of the Head Start Bureau; they include Region XI – American Indian-Alaska Native Program Branch and Region XII – Migrant and Seasonal Program Branch.

The regional forums were developed to build on the hard work and accomplishments of Head Start and all those that serve infants, toddlers, and young children. Planning was also informed by the successes of oral health services in states and communities. The overall aim was to determine how organizations and agencies could work together at a regional level to improve the oral health of participants in Head Start.

B. Region XII Forum

A Migrant and Seasonal Head Start (MSHS) Region XII Forum, “Enhancing Partnerships for Migrant and Seasonal Head Start and Oral Health” was held on February 6, 2003 in Washington, D.C. The Region XII Forum was held in conjunction with MCHB, HSRA, the Migrant and Seasonal Program Branch, HSB, ACF and Region XII Migrant and Seasonal Head Start (MSHS), Quality Improvement Center (QIC). This Forum was the fifth in a series of regional forums hosted across the U.S. by HRSA and ACF. This report summarizes the proceedings of the Region XII Forum.

The Region XII Forum goals were to:

- Discuss critical oral health issues that impact Migrant and Seasonal Head Start children;
- Assess access to care and other issues that may improve or detract from oral health education and clinical services available to the Migrant and Seasonal Head Start population;
- Develop a strategy plan for the Migrant and Seasonal Head Start community that includes assessment of current regional issues, priority gaps, promising practices, and problem areas;

- Allow for dialogue about strategies to address the oral health needs of Migrant and Seasonal Head Start children; and
- Contribute to the development of a national strategic plan to improve the oral health of children in Head Start and Early Head Start.

Forum participants assessed current issues, identified promising practices, and developed strategies to enhance the oral health component in Migrant and Seasonal Head Start. (See the Forum Agenda in Appendix A.) At the end of the Forum a plan was drafted that outlined recommended strategies and activities for Region XII action to support MSHS programs in increasing access to dental care, enhancing prevention, and expanding effective oral health education. The plan delineated ways that Region XII can collaborate with HRSA, CMS, and other entities to combine efforts and improve oral health outcomes in MSHS.

The recommendations were developed by a broad-based group of representatives with interests in Head Start, migrant and seasonal health, and oral health. The Forum involved representatives of diverse organizations, agencies, and professional groups from the public, private, and nonprofit sectors working at the national, state, and local level. (See Forum Participant List in Appendix B.) Forum participants included representatives from MCHB, HSRA, the Migrant and Seasonal Program Branch, HSB, ACF and Region XII MSHS QIC, and Health Coordinators and Family Service Specialists with Migrant and Seasonal Head Start programs. Also, participants included a state dental director, representatives from national pediatric dentistry and dental professional associations, national maternal and child oral health resource and policy centers, academic institutions, a foundation, and nonprofit organizations working with migrant and seasonal farmworker families and migrant health centers.

II. Plenary Session

Ms. Sharon Yandian, Project Director, Migrant and Seasonal Head Start Quality Improvement Center. Ms. Yandian opened the Region XII Forum and noted the importance of the oral health forum as a part of the National Migrant and Seasonal Head Start Conference. She pointed out that it is a crucial time for MSHS families and children. Ms. Yandian encouraged participants to recommend ways to support and provide better oral health services to migrant and seasonal families in Head Start programs across the country. She reiterated that the MSHS Quality Improvement Center is the national entity that covers training for the full spectrum of services in MSHS programs.

Mr. Marco Beltran, Training and Technical Assistance Health Program Specialist, Migrant and Seasonal Head Start Quality Improvement Center. Mr. Beltran presented an update on Region XII MSHS and compared MSHS programs with the other regional Head Start programs. He noted that regional Head Start programs primarily serve children ages 3 to 5 years of age, while MSHS programs serve children from birth to the compulsory school age in the state. In 1994, the Head Start reauthorization allowed for services to be provided to infants and toddlers through Early Head Start programs. Although they also serve children from birth, MSHS does not receive Early Head Start funds, and they do not serve pregnant women but instead provide referrals for pregnant women. MSHS is not allowed to use funds to serve pregnant women. He remarked that infants and toddlers have been served in MSHS since the inception of the program. Currently, 44% of 30,539 children are infants and toddlers in MSHS and this influences costs related to staffing ratios and health care services in MSHS programs.

Mr. Beltran discussed that regional Head Start programs are open primarily during the school year, while the majority of MSHS programs are open during extended summer months or even year-round if agricultural work is available in the area. MSHS programs are based on growing

seasons (e.g., the cherry crop in Oregon only lasts 4-6 weeks—when the crop is over, the MSHS program closes). Whereas MSHS programs are designed to be flexible based on the growing season, most regional Head Start programs run primarily on a set schedule. Furthermore, the majority of regional programs run 3 or 4 hours a day, 4 days a week, whereas during peak season, MSHS programs run 12-14 hours a day, 6 to 7 days a week. Mr. Beltran noted that in some states, peak season lasts 6 weeks, and in other states, 6 months.

Mr. Beltran explained that several education and health programs that provide services to migrant and seasonal families use different definitions for “migrant families” and “seasonal families.” He outlined the definitions used by MSHS based on Head Start Program Performance Standards and the Head Start Act and other regulations. For the purposes of Head Start eligibility, a migrant family is defined as “a family with children under the age of compulsory school attendance who changed their residence by moving from one geographic location to another, either intrastate or interstate, within the preceding two years for the purpose of engaging in agricultural work that involves the production and harvesting of tree and field crops and whose family income comes primarily from this activity.” A seasonal family includes “families who are engaged primarily in seasonal agricultural labor and who have not changed their residence to another geographic location in the preceding two-year period.”

Mr. Beltran presented summary information for MSHS according to the Head Start Program Information Report (PIR) for 2001-2002. A total of 30,539 children were enrolled in MSHS under 24 different grantees. MSHS programs are in 35 of 50 states. He noted that although 24 grantees look small, in reality this covers over 66 different agencies, which include delegate agencies. For example, the East Coast grantee includes the entire coastal geographic area.

He outlined the distribution of ages served; the total number of children with and without health insurance (at enrollment and at end of enrollment); the numbers with an ongoing source of continuous, accessible medical care (at enrollment and at end of enrollment); and the numbers of those receiving medical services through a migrant community health center (at enrollment and at end of enrollment). He explained that an ongoing source of continuous care involves having a “medical home,” and also said that the majority of grantees defined “medical home” as being a place where a family receives their primary and continuous care, whether this is one physician or a migrant or county health clinic. He added that a holistic definition of “medical home” is “accessible, family-centered, continuous, coordinated, culturally competent primary health care.” Mr. Beltran discussed a comparison of National Head Start and MSHS PIR data. He described the number of children with an ongoing source of continuous, accessible dental care, dental treatment and preventive services for younger and older groups of children in Head Start programs, as well as health and dental comparisons.

Next, Mr. Beltran discussed the responses he has received from grantees when asked about the health issues reported by families served by MSHS. According to Mr. Beltran, grantees reported the most urgent health concern for families involves access to medical and dental services, including paying for services and insurance concerns, lack of preventive care, continuity of care, and lack of culturally sensitive providers. Grantees reported oral health issues included lack of access to dental care, lack of dental providers providing care to children in remote areas, difficulty of accessible services, reluctance of general dental providers to treat young children, and geographical challenges in remote areas.

Discussions ensued about the health-related PIR data, systems, standards, definitions, and criteria used when obtaining PIR data, comparisons with national and state surveys, improvements needed to accurately represent the health and oral health needs, and barriers among migrant and seasonal children families.

Ms. Jane E. M. Steffensen, Associate Professor in the Department of Community Dentistry at the University of Texas Health Science Center at San Antonio. Ms. Steffensen works with the Head Start and Oral Health Partnership Project. She provided background information about past forums held by DHHS regions in Kansas City, MO; Dallas, TX; Denver CO; and San Francisco, CA. She discussed that the regional forums are working in parallel with state forums funded by the Association of State and Territorial Dental Directors.

Ms. Steffensen reviewed the Region XII Forum goals and described the instructions for the small group discussions. She encouraged participants to learn from promising practices and model programs that are working in local communities. Ms. Steffensen urged participants to develop creative and innovative strategies for the long-term and short-term actions. She discussed that participants should consider the unique issues, situations, and circumstances of migrant and seasonal families and MSHS programs when identifying solutions.

She encouraged participants to outline practical ways that regional efforts can be combined among Region XII ACF, Region XII MSHS QIC, HRSA, CMS, and other entities. Ms. Steffensen asked participants to look at collaborations and leadership within Head Start and outside of Head Start so that organizations and agencies can work together to benefit MSHS children and their families. She noted that the Forum provided opportunities for participants to share expertise, unique perspectives, and experiences from several disciplines and organizations.

Ms. Sandra Carton, Chief of the Migrant and Seasonal Programs Branch, Head Start Bureau. Ms. Carton introduced herself to the Forum participants. She noted frustration with many unmet needs and challenges. Also, Ms. Carton remarked that people in the Head Start Bureau are interested in working on these issues. This gives her hope that the Bureau will be able to move forward on these important concerns. She emphasized the need to create an accessible health care and a service delivery system that overcomes barriers. Ms. Carton encouraged participants to discuss approaches that facilitate reciprocity and portability in health care to meet the health needs of children in MSHS.

Dr. John Rossetti, Maternal and Child Health Bureau, HRSA. Dr. Rossetti emphasized three points: (a) people make programs work; (b) there needs to be follow-up action; and (c) do not take no for an answer at first and remain persistent. He stressed that the Forum provided an opportunity for people to share ideas about future strategies for MSHS programs. Dr. Rossetti indicated that it was important for the participants at the Forum to identify key issues and strategies unique for MSHS programs.

Dr. Rossetti discussed the common oral health goals of MCHB and HSB and described their activities that have provided a foundation for oral health and early childhood development over many years. Dr. Rossetti emphasized that oral health issues affecting young children cut across many agencies and organizations. He highlighted the importance of prevention and oral health education as well as access to dental care in Head Start.

Dr. Rossetti described how oral health had always been an important component of Head Start since its inception. He noted that from the mid-1960s to the mid-1990s MCHB and its predecessor dental programs had an Inter-Agency Agreement (IAA) with Head Start. Through the IAA MCHB dentists provided dental training and technical assistance (T/TA) to Head Start programs across the country, and also assisted Head Start in developing dental program policies and standards. Head Start revised its T/TA system and the IAA between Head Start and MCHB was discontinued in the mid-1990s.

Dr. Rossetti outlined national collaborations that have involved several Federal agencies, including HRSA, ACF, and CMS. Also, he noted that HRSA had supported important policy development efforts and specific strategies regionally and within states during the last decade.

He underscored several reports and activities that highlighted the critical oral health needs of young children:

- Office of Inspector General Report HRSA/HCFA Partnership Initiative (1996);
- Joint Oral Health Initiative and National Conference to focus attention on the oral health needs of children enrolled in Medicaid and the State Child Health Insurance Program (SCHIP) (1998);
- American Dental Association (ADA) Improving Access in Medicaid (AIM) Conference (1999);
- National Head Start Oral Health Forum (1999);
- U.S. Surgeon General's Report on Oral Health, Workshop and Conference on Children Oral Health (2000); and
- 2010 Healthy People Objectives (2000).

Dr. Rossetti cited the Head Start and Partners Forum on Oral Health held in 1999 and funded by the HSB, HRSA, CMS, and WIC. This national forum emphasized the need for strategic planning to implement evidence-based practices that build on models that work. A key outcome of the National Forum was the formulation of an Inter-Agency Agreement (IAA) between ACF-HRSA to develop supportive linkages in oral health and Head Start. Goals of the partnership are to:

- Implement recommendations of the National Forum;
- Rebuild public and private partnerships;
- Increase access to clinical preventive and early intervention services;
- Provide oral health expertise to HSB, grantees and the TA network; and
- Link Head Start to oral health programs in HRSA, states, communities, and with public and private providers.

Dr. Rossetti noted that the series of regional forums was one of the activities being held under the auspices of the IAA. Through the forums the roles of HRSA field office staff and expectations of regional offices would be identified in collaboration with Head Start, Medicaid/SCHIP, and WIC. Also, state and territorial forums are being held to examine issues and identify strategies, and outline roles. Also, materials, resources and best practice models are being collected and disseminated as a part of the project. In addition, the Maternal and Child Health Bureau is collaborating with professional organizations to explore linkages that would enhance the oral health component in Head Start and increase awareness among providers. He described an ideal oral health component in Head Start that would include risk assessment, screening, early intervention, prevention, nutrition, oral health education and promotion, and clinical oral health services.

III. Small Group Sessions

A. Oral Health Education

Oral Health Education Issues and Promising Practices

Several oral health education issues and promising practices were identified in the small groups. These included:

- The agency needs to support a comprehensive curriculum (need to see integration of oral health with health specialists and educators). It is important to integrate component areas to provide a comprehensive oral health curriculum and education.
- Health and oral health are not top priorities in the Head Start Bureau anymore.
- Grantee “buy-in” is important for specific oral health, health and nutrition curricula that will encompass domain areas to enhance on-going assessments and outcomes.
- There is a need for training that includes all people involved in the training process (primary training).
- There is a need for a curriculum and a dissemination process.
- Oral health information is not uniform and there are mixed oral health messages. There is a need for consistent and culturally appropriate oral health information and messages. There is a need for culturally sensitive parent education materials (linguistically, idea of novellas, etc.).

[Promising Practice: Association of State and Territorial Dental Directors Head Start Oral Health and Head Committee plans to develop an Oral Health Head Start Resource Guide and the National Maternal and Child Oral Health Resource Center has an oral health and Head Start web page.]

- For many MSHS programs it is hard to implement an oral health education program for a short period of time (e.g., children and families entering and leaving). It is difficult to reach parents with parent education, as parents can work 14 hours a day.
- There is tremendous staff turnover for MSHS programs.
- There is no consistent structure for MSHS programs.
- There are no supportive resources to implement oral health in the classroom or with families. There is a need to increase available resources (funding and partnerships) to provide oral health activities for the classroom and through family outreach and education.
- There is a need for a system to track outcomes by tracking “real” data on oral health disparities, what sources of care are used, etc.
- It is important to disseminate oral health information to every component of MSHS, every level of staff, from the top to the bottom, so that everyone has all the information—there is a need for distribution of all information (i.e., Memorandums of Understanding (MOUs), Agreements, etc.) regarding Federal partnerships, available

resources to all levels of grantee staff (i.e., across component areas). Information should not stop at the director's desk.

- The agency needs to prioritize what is most important to them. Oral health education is one of many health education curriculum topics that programs are mandated to implement. It is difficult to prioritize the various curriculums and topics.
- Oral health education needs to start with parents (e.g., ways to provide education to parents about early prevention). It is important that oral health is a higher priority at the “start” of the program year (specifically targeting the families & education about prevention).
- Early Periodic Screening Diagnosis and Treatment (EPSDT) issues - dental screenings are not being done (many physicians are not screening children)—physicians are not performing oral examinations.

[Promising Practices: North Carolina provides joint training of physicians, nurses, dentists, and dental hygienists on screenings, assessments, referral, parent counseling, fluoride varnish; Washington State dentists train physicians to provide dental screenings.]

Priority Oral Health Education Issues and Promising Practices

The priorities to target:

1. Issue: There is a lack of a comprehensive approach to oral health education. The approach should include:
 - Define framework for a comprehensive delivery mechanism for oral health
 - Parent education
 - 0-5 curriculum plan
 - Incorporate component areas (i.e., Education, Health, Nutrition, Mental Health, Disabilities, Family Partnership) into oral health training
 - Include community involvement as part of the approach

Promising Practice: Washington State Curriculum Model

2. Issue: There is a lack of available oral health resources to grantees.
 - Make an oral health curriculum available as a resource for children, families and teachers
 - Include culturally sensitive parent education materials (linguistically, novellas, etc.)
 - Develop a system to distribute all information (i.e., MOUs, Agreements) to all applicable staff, as well as sharing component specific resources and information

Promising Practice: Federal and State Health and Human Services and Resource Centers

3. Issue: Oral health education of parents is currently not a “high” priority for grantees. Oral health education for parents needs to be on-going.
4. Issue: Physicians should be consistent in delivering oral health prevention services. There is a gap between dentists and physicians. This should include:
 - Risk assessment
 - Family oral health education
 - Application of fluoride varnish
 - Referral

Promising Practices: North Carolina - provides joint training of physicians, nurses, dentists, and dental hygienists on screenings, assessments, referral, parent counseling, fluoride varnish; Washington State - dentists train physicians to provide dental screenings; Medicaid in both North Carolina and Washington reimburses physicians for application of fluoride varnish

5. Issue: There is a lack of a system to track “real” data on oral health disparities, what sources for care are used, etc.

Oral Health Education Strategies

Issue: There is a lack of a comprehensive approach to oral health education.

Promising Practice: Washington State Curriculum Model

Overall Strategy for Region XII ACF, MSHS QIC & HRSA

Develop a framework to deliver comprehensive oral health education and curriculum. The approach should include:

- Define framework for a comprehensive delivery mechanism for oral health
- Parent education
- 0-5 curriculum plan
- Incorporate component areas (i.e., Education, Health, Nutrition, Mental Health, Disabilities, Family Partnership) into oral health training
- Include community involvement as part of the approach

Specific Activities

- Form a committee to plan the model and the implementation (invite oral health professionals, MSHS grantee representatives [inter-disciplinary], community representatives, HSB, MCHB, and MSHS QIC.
- Review existing models of integrative curriculum geared towards MSHS; determine which contains a continuum to parent education.
- Plan the implementation and evaluation of the model.

Partnering Organizations and Agencies for Collaboration

American Dental Association (ADA), American Dental Hygienists' Association (ADHA), MSHS, MCHB, Migrant Health Centers, Bureau of Primary Health Care (HRSA), American Academy of Pediatrics, American Academy of Pediatric Dentistry, Migrant Education/Department of Education, Medical & Dental Educators, Promotoras, American Dental Education Association (ADEA), ASTDD, etc.

Issue: There is a lack of available oral health resources to grantees.

Overall Strategy for Region XII ACF, MSHS QIC & HRSA

Designate a “Clearinghouse” of all available oral health resources and develop a Head Start Oral Health Resource Guide.

Specific Activities

- Form a committee to review guide for cultural sensitivity and appropriateness, to include dissemination of the material.
- Have the committee identify funding sources to create the guide and the replication of the model (non-Federal funds).

Partnering Organizations and Agencies for Collaboration

Maternal and Child Oral Health Resource Center, WIC, ADA, ADHA, MSHS, MCHB, Migrant Health Centers, Bureau of Primary Health Care (HRSA), American Academy of Pediatrics, American Academy of Pediatric Dentistry, Migrant Education/Department of Education, Medical & Dental Educators, Promotoras, ADEA, ASTDD, etc.

Issue: Oral health education of parents is currently not a “high” priority for grantees.

Overall Strategy for Region XII ACF, MSHS QIC & HRSA

Link oral health education to on-going assessment and outcome measures (literacy and domain areas).

Specific Activities

- Create activities in the domain areas (e.g., toothbrushing—Fine Motor).
- Define and communicate a consistent language for both the educational curriculum and the oral health curriculum.

Partnering Organizations and Agencies for Collaboration:

Maternal and Child Oral Health Resource Center, WIC, ADA, ADHA, MSHS, MCHB, Migrant Health Centers, Bureau of Primary Health Care (HRSA), American Academy of Pediatrics, American Academy of Pediatric Dentistry, Migrant Education/Department of Education, Medical & Dental Educators, Promotoras, ADEA, ASTDD, National Association for Education for Young Children (NAEYC), etc.

Issue: Physicians should be consistent in delivering oral health prevention services. There is a gap between dentists and physicians.

Promising Practices

North Carolina - provides joint training of physicians, nurses, dentists, and dental hygienists on screenings, assessments, referral, parent counseling, fluoride varnish; Washington State - dentists train physicians to provide dental screenings; Medicaid in both North Carolina and Washington reimburses physicians for application of fluoride varnish.

Overall Strategy for Region XII ACF, MSHS QIC & HRSA

Develop a joint collaboration effort between the medical and dental professionals.

Specific Activities

- Form a committee to review existing models that are proven and determine which would best fit the MSHS programs.
- Have a committee endorse recommendations to the educational institutions.

Partnering Organizations and Agencies for Collaboration

American Dental Association (ADA), American Dental Hygienists' Association (ADHA), MSHS, MCHB, Migrant Health Centers, Bureau of Primary Health Care (HRSA), American Academy of Pediatrics, American Academy of Pediatric Dentistry, Migrant Education/Department of Education, Medical & Dental Educators, Promotoras, ADEA, ASTDD, Educational Institution Representatives

Issue: There is a lack of a system to track “real” data on oral health disparities, what sources for care are used, etc.

Overall Strategy for Region XII ACF / MSHS QIC & HRSA

Develop a tool to track oral health issues (types of disparities, resources, etc.).

Specific Activities

- Form a committee to review existing tracking tools/data and make recommendations for a new, improved model for the purpose of identifying gaps, resources and the allocation of resources, policy and Head Start Bureau-level decision-making.
- Implement pilot project (MSHS) and make revisions and then determine use (Head Start versus MSHS only).

Partnering Organizations and Agencies for Collaboration

American Dental Association (ADA), American Dental Hygienists' Association (ADHA), MSHS, MCHB, Migrant Health Centers, Bureau of Primary Health Care (HRSA), American Academy of Pediatrics, American Academy of Pediatric Dentistry, Migrant Education/Department of Education, Medical & Dental Educators, Promotoras, American Dental Education Association (ADEA), ASTDD, etc.

B. Prevention

Prevention Issues

The specific oral health prevention issues identified include:

- Difficulty involving everyone in the families and bringing them together;
- Baby bottle tooth decay - very expensive to treat, yet preventable;
- Medicaid requirements different in each state (problematic for MSHS super-grantees);
- Lack of dental providers willing to treat children;
- Transfer of Head Start dental records (could reduce multiple screenings, but treatment issue often remains);
- Addressing cultural and social issues when it comes to prevention (different concept of families, socio-economic factors);
- Disconnect between National Guidelines and applicability to farmworker families;
- Housing issues make it difficult to address prevention (lack of running water, sharing of toothbrushes, lack of sanitary facilities, etc.);
- Competing health priorities for families;
- Competing health issues related to funding;
- Oral health status of parents and caregivers – lack of MSHS funds for providing services to pregnant women is problematic; and
- Delivery of preventive services and oral health education to families.

Priority Prevention Issues

- Lack of prevention programs that specifically address oral health care needs of migrant and seasonal farmworker children;
- Specifically address migrant and seasonal farmworker lifestyle issues (e.g., culture, housing, socioeconomic factors) related to oral health;
- Focus on outreach delivery efforts that reach migrant and seasonal farmworkers in a variety of settings;
- Provide training and technical assistance about prevention to outreach and other MSHS staff; and
- Lack of providers for preventive care.

Promising Practices

The specific oral health prevention promising practices identified included:

- Fluoride varnish programs;
- Training MSHS staff to conduct dental screenings;
- Basic screening survey through Association of State and Territorial Dental Directors (ASTDD);
- Cleaning the gums of infants after feedings (beginning preventive practices early) in MSHS programs;
- Contacting dental companies for donations of supplies;
- Utilize and link to community social services;
- Development of health education materials and curricula specifically designed for farmworkers and farmworker children;
- Utilize national immunization campaign as a model for a preventive dental campaign;
- Mobile dental vans;
- Linking up with community health centers, dental schools, dental hygiene programs;
- Recruiting retired dentists; and
- Using the “one day event” concept (e.g., American Dental Association “Give a Kid a Smile” Day).

Prevention Strategies

Issue: Specifically address migrant and seasonal farmworker lifestyle issues (e.g., culture, housing, socioeconomic factors) related to oral health.

Specific Activities

- Develop program profile with input from key stakeholders, including migrant and seasonal farmworker parents.
- Assess existing prevention models, curriculum, resources, policies, procedures, etc. for both families and children models and resources that may be applicable to MSHS.
- Modify or develop MSHS oral health prevention models, curriculum, resources, policies, procedures, etc. for both families and children.

Issue: Focus on outreach delivery efforts that reach migrant and seasonal farmworkers in a variety of settings.

Specific Activities

- Integrate oral health into family partnership agreements.
- Develop and strengthen collaboration efforts that address oral health.
- Utilize health advisory committees to include oral health programs and providers.

- Develop a multi-media campaign that includes Spanish radio, newspapers and other migrant and seasonal farmworker advocacy groups.
- Formalize an agreement between HSB, BPHC, MCHB and U.S. Department of Agriculture (USDA) to promote partnerships focusing on oral health and prevention.

Partnering Organizations and Agencies for Collaboration

HSB, BPHC, MCHB, USDA, ASTDD

Issue: Provide training and technical assistance (T/TA) about prevention to outreach and other MSHS staff.

Specific Activities

- Develop training guides (train the trainer for implementation with outreach staff and teachers).
- Conduct training programs at national conferences, pre-service trainings, in-service days, etc.
- Develop listserves with T/TA updates to communicate among MSHS grantees.

Partnering Organizations and Agencies for Collaboration

HSB, MCHB, ASTDD

Issue: There is a lack of providers for preventive care.

Specific Activities

- Work with dental community at state and local level to increase involvement in preventive efforts (e.g., water fluoridation, fluoride varnish, screenings, etc.).
- Recruit dental community for consulting and training staff (e.g., screening).

Partnering Organizations and Agencies for Collaboration

HSB, CMS, BPHC, MCHB, ASTDD, ADA, AAPD, ADHA

Issue: There is a lack of prevention programs that specifically address oral health care needs of migrant and seasonal farmworker children.

Specific Activities and Partnering Organization and Agencies for Collaboration

These need to be outlined.

C. Access to Dental Care

Access to Dental Care Issues

The key issues identified were:

- Parents understanding the value that good oral health has and their personal access;
- Children might have Medicaid, etc. but many of the parents do not;
- Children having restorative care, parents need to be there – lost wages, etc.;
- Anything that is coming out of the Forum – has or will not be reality tested;
- Disconnect of the delivery system;
- Value system of parents regarding previous oral health access, until then (understand) we cannot design a complete system;
- Explore the positive aspects – what we do for the children – can “translate” to the parents;
- Components of the system – what would the ideal system look like?;
- Head Start more powerful if it shows that it impacts the family as a whole;
- Portability of Medicaid between states;
- Migrant Health, MSHS and Migrant Education all have different definitions of eligibility;
- Relationship between MSHS & Migrant Health Centers;
- No formalized mechanism to bring migrant population in need to existing facilities (i.e., Migrant Health Centers);
- Creating a coordinated program for migrants across the nation (carried from state to state);
- Money and financing is an issue;
- Looking at a group of children and their situation in which they can receive services;
- Level of coordination at the local level – county health, dental provider, etc.;
- Fluid population – we are imposing on a “structured schedule”—we are overlapping services between MSHS and Regional Head Start;
- Dentist who will not see children ages 0-3 years;
- Need to increase providers who will see children from 0-3 years;
- Coordination among MSHS programs;
- Head Start Bureau definitions of medical and dental care;
- Sharing information – there is a need for a system in place of tracking children - identifying a source and creating a network;
- Resources across state or counties;

- Lack of providers; and
- Need to identify and increase capacity.

Access to Dental Care Priority Issues

The priority issues identified:

- Disconnect of the delivery system;
- Workforce;
- Financing;
- Families' values, knowledge and reality; and
- Policy challenges.

Access to Dental Care Promising Practices

The promising practices identified:

- Dental community in Migrant Health Centers and Migrant Oral Health Programs are part of a network called National Network for Oral Health Access (NNOHA);
- Dental school without walls - distance learning, e.g., new Arizona Dental School targeting populations such as serving migrants through public health and community-based programs;
- Migrants Clinicians Network has a fellowship that includes dental hygienist - cost is in the stipend (\$1500 stipend);
- Use of varnish and application by non-dental providers in primary care settings – limitation can be the state dental practices;
- Taking fluoride varnish application and dental sealants to the migrant camps;
- Bring school-based health center model into Head Start;
- Head Start Bureau can offer its own school-based health/dental services; and
- Maternal and Child Health (MCH) Title V – private practitioner fee off-set and encourages the private sector to participate – between a private practitioner and community center, for example, a Head Start Program.

Access to Dental Care Strategies

Issue: Disconnect of the delivery system

Specific Activities

Track:

- Screening information;

- Found to have needs (oral health needs?);
- Has the family been educated?;
- Have they received a varnish application (when, where)?; and
- Tracking system.

Partnering Organizations and Agencies for Collaboration

BPHC, Disparities Collaborative, Maternal and Child Health, HSB, Office of Oral Health

Issue: Workforce

Specific Activities

- Partner with and look at models to incorporate the current workforce (look at alternative models);
- Catalog the best practice and most appropriate within the geographical area;
- Figure out how to efficiently use the current workforce in the local communities;
- First help people understand and then have training available to upgrade the skills of local practice; and
- Shift in value - primary care as a specialty.

Issue: Financing

Specific Activities

- Maximize enrollment of MSHS migrant children into existing programs;
- Implement efforts to make the health insurance programs work;
- Maximize other people's funds (e.g., other programs). There is a marketing piece to this effort;
- Partnership and collaboration is essential. Need clarification in regards to what a medical home model means in the Head Start community. Promote training efforts on how to use HS money better and partner with others and maximizing funding. What is the responsibility of migrant clinics in regards to children?;
- Some of the cost will have to be taken by parents. This may be more than just the co-pay and will be hard to pass with Head Start. Parents currently have a hard time paying for antibiotics let alone services; and
- Get families in the position of prevention.

Issue: Families' knowledge, values, and reality

No parents participating in the Forum. The participants do not know parents' knowledge and values.

V. Closing Plenary and Next Steps

Dr. John Rossetti, Maternal and Child Health Bureau, HRSA. Dr. Rossetti congratulated the Forum participants for their hard work and the recommendation to enhance oral health in Migrant and Seasonal Head Start programs. He remarked about common themes that were outlined by the groups. He discussed the need for more collaboration and coordination of oral health activities at the national, state, and local levels. He described ways to connect the links and make oral health efforts more effective for MSHS Head Start programs.

Dr. Rossetti discussed the importance of identifying and adapting models for oral health education, prevention, and access to dental care. Also, he noted that oral health efforts and materials should be developed to meet the unique needs of migrant and seasonal children served by MSHS programs and to address the special circumstances of MSHS programs. The importance of assuring cultural competence among all personnel and providers to improve programs and services was highlighted during the session.

Mr. Marco Beltran, Training and Technical Assistance. Mr. Beltran discussed next steps after the Forum. He noted that participants will receive the Forum Report. The Migrant and Seasonal Programs Branch, HSB, Migrant and Seasonal Head Start Collaboration Director, MSHS QIC, and MCHB will meet to review the recommendations and initiate dialog about integrating action steps into MSHS work plans. Mr. Beltran pointed out another next step involved MSHS grantees participating in state forums funded by the Association of State and Territorial Dental Directors (ASTDD). These Forums that focus on Head Start and oral health within states promote the opportunity for grantees to develop partnerships. Through such collaborations and networks MSHS grantees can implement initiatives to enhance oral health education, prevention, and access to dental care.

Appendix A: Region XII Forum Goals and Agenda

**Maternal and Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)**

**Administration on Children and Families (ACF)
Migrant and Seasonal Program Branch**

**Region XII Migrant and Seasonal Head Start
Quality Improvement Center**

Present

**Migrant and Seasonal Head Start
Region XII Forum on**

**Enhancing Partnerships for
Migrant and Seasonal
Head Start and Oral Health**

February 6, 2003

**Omni Shoreham Hotel
2500 Calvert Street N.W.
Washington, D.C.**

Forum Goals

The Goals of the Region XII Forum are to:

- ❖ Discuss critical oral health issues that impact Migrant and Seasonal Head Start children
- ❖ Assess access to care and other issues that may improve or detract from oral health education and clinical services available to the Migrant and Seasonal Head Start population
- ❖ Develop a strategy plan for the Migrant and Seasonal Head Start community that includes assessment of current regional issues, priority gaps, promising practices, and problem areas
- ❖ Allow for dialogue about strategies to address the oral health needs of Migrant and Seasonal Head Start children
- ❖ Contribute to the development of a national strategic plan to improve the oral health of children in Head Start and Early Head Start

Agenda

Thursday
February 6, 2003

8:30 – 9:00 am	Registration and Continental Breakfast	Capital Room
9:00 – 10:15 am	Opening Plenary Session: Enhancing Partnerships to Improve Oral Health of Children in Migrant and Seasonal Head Start	Capital Room
	Welcome and Opening Remarks Sharon Yandian, MEd, Project Director, Migrant and Seasonal Head Start Quality Improvement Center	
	Migrant and Seasonal Head Start Region XII Update Mr. Marco Beltran, MPH, Training and Technical Assistance Health Program Specialist, Migrant and Seasonal Head Start Quality Improvement Center	
	Instructions for Small Group Discussions Jane E. M. Steffensen, MPH, Head Start and Oral Health Partnership Project	
10:15 – 10:30 am	Break	
10:30 am – 12:30 pm	1 st Small Group Discussions Identifying Issues and Promising Practices	
	Group 1	Capital Room
	Group 2	Congressional Room A
	Group 3	Congressional Room B
12:30 – 12:45 pm	Break	
12:45 – 1:45 pm	Working Lunch	Capital Room
	Update from Head Start Bureau (HSB) and Maternal and Child Health Bureau (MCHB) John Rossetti, DDS, MPH, Maternal and Child Health Bureau, HRSA	
1:45 – 3:45 pm	2 nd Small Group Discussions Identifying Strategies and Action Steps	
	Group 1	Capital Room
	Group 2	Congressional Room A
	Group 3	Congressional Room B
3:45 – 4:00 pm	Break	

4:00 – 5:00 pm

**Closing Plenary Session
Looking Forward and Next Steps**

Capital Room

Moderator

Mr. Marco Beltran, MPH, Training and Technical Assistance Health Program Specialist, Region XII Migrant and Seasonal Head Start Quality Improvement Center

Small Group Reports

Oral Health Education

Prevention

Access to Dental Care

Response and Closing Remarks

John Rossetti, DDS, MPH, Maternal and Child Health Bureau, HRSA

5:00 pm

Adjourn

Appendix B: Region XII Forum Participants List

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