Access to Dental Care for Head Start Enrollees

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Abstract

Objectives: The objectives of this review are to characterize the oral health and dental access of Head Start children, describe barriers to their care, advance strategies to address those barriers, and consider how Head Start Performance Standards can be utilized to maximize oral health and access to dental care. Methods: Published, programmatic and solicited data describing the oral health status and dental service utilization are reviewed together with reports of conferences exploring access barriers. Head Start Performance Measures for child health and development services, child health and safety, family partnerships, and community partnerships are individually evaluated for their potential to improve oral health. Results: Head Start children, like all low-income children, enjoy the highest rates of dental coverage (because of Medicaid and the State Child Health Insurance Program), yet these children also experience the highest rates of tooth decay, the most unmet dental care needs, the highest rates of dental pain and the fewest dental visits. Getting children the dental care they need is problematic because of: multiple barriers associated with public and private dental delivery systems, Medicaid program funding and administration, dental workforce sufficiency and distribution, and issues of culture and communication that stand between parents, children, and caregivers. Conclusions: To move beyond screening and to access necessary dental care requires integration between medical and dental care, recognition and elimination of barriers to care, an understanding of dental provider types and their capacities, a formally structured referral process, and regular monitoring to assure that complete care is obtained. Action steps are suggested that can maximize the effectiveness of Head Start Performance Standards. Head Start holds tremendous potential to actively develop and implement policies that can markedly improve both access to needed dental services and the oral health status of young disadvantaged children.
Introduction

Odd as it may seem, young low-income children have the highest rates of dental insurance, yet the lowest frequency of dental visits. Head Start holds tremendous promise to resolve this longstanding access and utilization challenge. Solving this problem is important because low-income preschoolers experience more dental disease and suffer more from it than their affluent peers. Significant consequences of dental disease include diminished growth, dental and facial pain and infection, damage to the forming permanent teeth, and behavioral problems that come from an inability to eat, sleep and play normally. Head Start’s central office reports that access to dental services is the single most problematic health issue confronting program staff, center directors and Head Start parents.

This paper documents disparities in dental health and dental care of low-income preschoolers, discusses many of the barriers limiting Head Start children’s access to comprehensive dental care, and reviews existing Head Start Performance Standards for their usefulness in assuring appropriate dental care for enrolled children.

Oral Health Disparities of Preschoolers

While US children today enjoy the best dental health (fewest cavities) of any generation, the dramatic improvements gained during the 1970’s and 80’s did not continue into the 90’s. Reductions in disease burden have either leveled off, or are beginning to rebound. The Healthy People program of the Department of Health and Human Services reports that 6-8 year olds today have about the same decay experience as 6-8 year olds in 1986, and the percentage of children who need dental treatment for cavities has not declined. Healthy People also reports no improvement in the number of preschoolers who access dental care today than 10 years ago despite programs like Head Start and WIC and a growing consensus that children should have their first dental visit at age one (1). A child health promotion project representing the consensus of over a dozen child health authorities including the American Academy of Pediatrics and the American Academy of Pediatric Dentistry, endorses the “age one dental visit” in order to assure timely health promotion and disease prevention (2).

Disparities in Disease

Tooth decay in the US is not distributed evenly among young children. The third National Health and Nutrition Examination Survey reported that about a third of preschoolers from families with incomes under 133% of poverty had cavities that could be seen on visual examination using no special
instruments. By contrast, only 12% of children from higher income families had such cavities (3). Furthermore, decay rates continue to climb as children age and more teeth become at risk.

Not only do more low-income children have decay, but also affected low-income children have more cavities than affected affluent children. For every cavity in groups of children over 300% of poverty, there are almost 5 (4.8) cavities in groups of children under 100% of poverty. Surprisingly, this same national study showed that low-income children have about the same number of fillings as higher income children even though they have more cavities (3). Today Black children still have more cavities than White children, Hispanic children more than Black children and Native American and Pacific Islanders have the highest rates of all children (1).

Looking at Medicaid-eligible children of all ages, nearly 80% require only minimal dental repair, 15% require more substantial dental repair, and 5% require very extensive dental repair (4). Many preschoolers, who do not have visible cavities, may in fact have decay that is too small to see on visual examination. These children and many others who take more time to manifest disease will go on to develop obvious cavities. A much smaller subset will remain cavity-free to adulthood.

**Disparities in Healthy Feeding Behaviors**

The percentage of parents who say they employ preventive feeding practices to avoid early childhood caries (ECC), also know as baby bottle tooth decay and nursing caries, varies considerably by race and education. The federal survey used to measure preventive feeding practices defined these practices as no use of a baby bottle, or if a bottle is used at bedtime, that the bottle contains only plain water. While 55% of all parents assure “preventive feeding practices” for their infants and toddlers, only 39% of Hispanic and 48% of Black parents and caregivers do so. Parents and caregivers with less than high school education assure appropriate feeding practices least often (36%) (5). Since this measure was developed, ECC has become better understood. Any feeding practice that provides a young child with frequent sugar exposures, day or night, is now known to be capable of promoting tooth decay. For example, allowing toddlers unlimited access to a bottle containing sweetened or flavored milk likely contributes significantly to high levels of ECC in some ethnic sub-populations.

**Disparities in Visiting a Dentist**

According to their parents, only one-in-five children under the age of six years (21.5%) had a dental visit in a year, while over half of school age and adolescent children had a visit (6). Even among preschoolers, there are sharp disparities in dental care by race, income and parental education. Females had slightly more visits than males – a trend that holds throughout life. More significantly, White children had 1.5 times greater chance of visits than children of color; higher income
children had 2.4 times greater chance of a visit than low income and working-poor children; and children whose parent completed at least high school education had about twice the chance of a visit as compared to children whose parent did not complete high school (Table 1).

If a preschooler did get to the dentist, that child received about the same number of dental visits as any other preschooler, regardless of sex, race, income or parental education. All preschoolers who got to the dentist had an average of 1.5 dental visits. However, because low income and minority children have more dental disease, they should have more visits in order to complete their repair needs. Other national data look at whether children under the age of five ever had any oral health screening, referral, or follow up. In 1991, 63% of White children under five experienced such a service, but only 51% of Black and Hispanic children did so (1). It should be recognized, however, that such data do not identify whether the disparities in visits and dental care are because dentists are not available to the children or because parents do not seek care for their children.

Disparities in Unmet Dental Needs

Among parents who report that their children have an unmet health care need, dental care is cited more often than the need for prescriptions and eye glasses, and similar to medical care that is delayed because of cost. In fact, 38.7% of all unmet health care needs experienced by children under the age of four are for dental care. Slightly over 6% of all parents report that their toddlers and preschoolers had an unmet health care need. About 30% of that unmet need was for care that parents sought but could not obtain. Almost 40% was for care they wanted but could not afford (7).

For children of all ages, unmet dental needs are higher for children living only with their mothers compared to children living with both parents, for children living in rural and central cities compared with children in suburban areas, for children in poverty compared to children from more affluent families, and for children in “fair or poor health” compared to children in “excellent, very good or good health”.

Disparities in Suffering.

Parents also reported whether or not their child had a dental visit in the past year because of “pain or because something was bothering them”. Again, children of color were over 1.5 times more likely to have a dental visit for pain than White children. Poor children and children of parents with less than high school education were twice as likely to have an “emergency” dental visit compared with non-poor children and those whose parents had more than a high school education (Table 2).

The same trends are evident when evaluating children who need dental procedures that relieve pain. A study conducted by a large dental group practice in Minneapolis compared Medicaid
eligible children with non-Medicaid eligible children for their use of these emergency dental services. Children with incomes low enough to qualify for Medicaid had 1.4 times more dental emergency services than higher income children (9).

Directors of Pediatric Dentistry training programs around the country were interviewed in June 1999 regarding their experience with children presenting for dental pain (10). They report that the overwhelming number of children with severe disease are preschoolers with advanced cases of early childhood caries. One director described the situation with these words, “Dental pain in low income preschool kids exists and comes at you like a tidal wave.” Another, reflecting on the impact on the child stated:

“Many children grow up with dental pain and consider it a normal part of life. It is only when facial swelling occurs that the parent brings the child to the ER where they may wait up to 12 hours to be seen and given a prescription and referral. This is tragic for the development of the child. How can a child learn, grow and mature when they are in constant pain and have draining pus flowing into their mouth and system? It is a shame that when we see them, often the only immediate answer to relieve the infection is removal of several teeth, sometimes without the benefit of sedation or general anesthesia.”

Disparities in Coverage

Unlike disparities in disease, visits, unmet need and suffering, low-income children enjoy much better dental insurance coverage than their higher income peers. Because of Medicaid and the State Child Health Insurance Program (CHIP), children from low income and working-poor families have the highest rates of dental coverage of all children. There are about 2.5-2.6 children who lack dental insurance for every child who lacks medical insurance (11,12). Most children enrolled in Head Start are eligible for dental care either through Medicaid or CHIP. If Medicaid and CHIP were as effective in delivering dental services as they are in delivering medical services, Head Start and other low income children would enjoy far better access to dental services.

Oral Health of Children in Head Start

An overview of ten studies of Head Start enrollees in the last decade provides a snapshot of these children. Head Start studies frequently show that 60% or more of enrolled children have cavities and that the average number of teeth affected (across both children with and without decay) exceeds five tooth surfaces (13). As children get older, they accumulate additional cavities. Head Start
children frequently show very high progression rates – Connecticut Head Start children were found to have a 2.2 increase in “decayed, missing and filled surfaces” over 2 years (14). As expected, Head Start children experience decay like other low-income young children in the nation; however, studies from such populations provide additional information beyond what can be learned from large national studies.

Fluoridation is often cited as the most cost-effective and powerful public health intervention. Fluoride availability has the expected effect of decreasing decay generally, but children with extreme disease often overwhelm the expected benefits and continue to develop new cavities despite fluoridated water availability. Additionally, fluoridated water is not universally available to young children in the US. Most private and small-shared wells do not contain fluoride and not all major US cities are fluoridated. The Centers for Diseases Control and Prevention report that less than two-thirds of the population served by community water supplies have fluoride available to them (1).

With Early Head Start’s entry into services for infants and toddlers, there is growing interest in assessing very young children. An Arizona study of children in WIC, Head Start and daycare centers showed that 6% of one year olds, 20% of two year olds, 35% of three year olds, and 49% of four year olds had visible decay (15). Low-income children had four times the rate of high-income children. Children of parents with low educational attainment had three times more decay than children of parents with higher educational attainment. Few children with decay under age three showed any dental repair.

Self-reported data from Head Start’s Program Information Reports (PIR) in 1988 and 1998 have been compared to evaluate possible trends (16). The percentage of enrolled children identified as needing dental care was 59% in 1988, yet 76% a decade later. This finding may represent greater disease or greater awareness on the part of parents that their children have dental problems. Regarding receipt of care, 35% of parents reported that their children completed their dental care in 1988, while 31% reported complete dental care in 1998. Because of vagaries in data, these findings may be comparable or may belie a trend toward more need or less care completion. In any case, it is notable that only about one-third of children needing dental repair obtained that care for both reporting years.

Like all children in the US, some Head Start children are severely affected by decay while the majority are either healthy or have relatively minor dental problems. However, Head Start children, like other low-income children in the US, experience more decay, more extensive decay, and more pain and suffering from decay than higher income children. They have the best dental coverage but the fewest dental visits. When they do get dental care, it is often insufficient to meet all of their needs.
The problem confronting Head Start programs is how to assure that all children in need obtain dental care and that the care they obtain is sufficient.

**Getting Children the Dental Care They Need**

The steps in assuring that children obtain the care they need are screening, access to appropriate dental providers, full professional examination and treatment, follow up for treatment completion, and institution of regular, ongoing, supervised preventive care. Lay screening is routinely accomplished for over 90% of enrolled children (17). However, next steps, including a professional dental examination and full treatment for children with disease is much more problematic.

A recent study of 54 Head Start centers in North and South Carolina highlights some of the barriers that inhibit success in assuring complete care (18). Of the 3,375 dentists practicing in those two states, only 7% reported that they currently accept Head Start children as patients, while 23% reported accepting Medicaid patients. Over a third (35%) stated that they would not accept Head Start children explaining that the children are too young for them to treat (15%), that payments were insufficient (30%), or that they were too busy to see these young children (39%). Where care was obtained, the average wait for an initial visit in North Carolina was 3.7 weeks and in South Carolina was 2.6 weeks. Transportation was a significant barrier with children traveling an average of 32 miles to obtain care in North Carolina and 16 miles in South Carolina. This travel took children out of their county of residence 69% of the time in North Carolina and 42% of the time in South Carolina. This survey reflects widely recognized barriers to dental care for low-income children on Medicaid including issues arising from state administration, from families, and from dentists (19). For Head Start children, the additional barrier of widespread unwillingness to see young children compounds the problems of accessing care.

**Screening**

Most Head Start children receive a dental screening. In 1997, 90.2% of the 823,634 children enrolled for 45 days or more were screened. The majority of those noted to have obvious dental care treatment requirements did receive some dental care, but far fewer were noted to have care completed (20). For example, in a population of 8,008 Head Start children in a Native American program, 87% were screened and 50% were noted to require dental treatment, but over one-third of children needing dental repair did not obtain complete care (21).

These screenings, often conducted by lay persons rather than dental professionals, are useful in identifying large obvious carious lesions and other problems, such as broken teeth, missing teeth,
substantial soft tissue lesions, but do not provide a thorough and objective assessment of oral health status. Although these casual evaluations meet the EPSDT requirement for early screening, they do not meet the Medicaid requirement for a diagnostic examination. Such screening relies on noting caries already present and therefore does not identify children who have early stages of disease or are at high risk for future disease.

Risk profiles have been actively developed in a number of research sites (22,23,24) but no single, simple risk assessment protocol has been found valid and reliable. However, risk factors that can raise suspicion include: high decay experience in mothers and siblings, frequent sugar ingestion by mothers or children, pacification with a bottle, poor oral hygiene (visually evident plaque on the young child’s four upper incisors), evidence of “white spot lesions” on the incisors, and enamel surface defects. Any one or a combination of these factors should be considered signs of high caries risk and should lead to a timely comprehensive dental evaluation.

The effectiveness of screening could be improved by teaching lay-screeners exactly what to look for and how to examine the oral cavity. Specifically, lay screeners need to know how to best position a child for a dental examination, how to recognize the first stages of dental caries and how to consistently and reliably record findings. Local program policies to implement these changes might include a requirement that all screeners receive formal training from the dentist consultant including both didactic and hands-on experience. A specific protocol should be developed for recording and maintaining findings of these screenings. A local center could develop a feedback process so that the screener’s findings can be compared with subsequent findings from a dentists’ complete examination or screeners could accompany children for their dental examination to observe the dentist’s findings. Such feedback could markedly improve a screener’s capacity to properly identify children with disease.

Nationally, Head Start can facilitate these policies by developing training videotapes and programmed learning materials, perhaps by adapting the Association of State and Territorial Dental Directors dental screening materials. Head Start centers should be encouraged to liaison with dental schools, hygiene programs, and dental assisting programs to engage faculty from these institutions in training screeners and engage students in performing the screenings.

**Accessing Appropriate Providers**

Because the medical and dental health care delivery systems developed independently in the United States, they are distinctly different in character. It is often difficult to assure that both medical and dental services are provided consistently. Dental is frequently treated as a second tier concern and therefore, may be forgotten or ignored. Nonetheless, there are opportunities to link primary pediatric care and health promotion to dental concerns. For example, promotion of personal hygiene
and proper nutrition should be explained in both systemic and dental contexts. Physicians should be encouraged to comment on the condition of teeth when completing a physical examination. One promising screening modality that could be readily integrated with children’s physical examinations by physicians or nurses is microbiologic screening for the bacteria that initiate cavities. Children with high levels of mutans streptococci should be targeted for immediate follow up care. Because early and severe tooth decay has been implicated in children’s failure to meet growth expectations, Head Start children who are noted to be underweight or under height should be evaluated for dental disease. Similarly, children who present difficulties eating or distractible behavior should be evaluated for the possibility that dental pain contributes to their dysfunction. A simple screening method that may indicate high risk for tooth decay in toddlers and young preschoolers is to determine the presence of plaque on the front four teeth (25). Very young children with discernable plaque may be considered at higher risk for caries than their peers without recoverable plaque.

Medicaid funds the majority of Head Start children’s health care. Because dental Medicaid programs generally function so much less effectively than medical programs, it is often difficult to assure dental care. A number of specific access barriers have been identified and summarized by the American Dental Association as issues of funding, program policies and administration, workforce sufficiency and distribution, and culture and communication (26).

Some of these barriers may be beyond Head Start direct influence or control. These include inadequate funding of dental services, administrative burdens imposed by Medicaid on providers, unfavorable geographic distribution of dentists, a declining dentist-to-population ratio, a paucity of minority dentists and minimal experience with young low-income children during dental training. Other barriers can be directly influenced by Head Start, perhaps in conjunction with State Title V Maternal and Child Health Programs or Medicaid EPSDT administrative and enabling services. These include parental information and training in how to use the dental delivery system, such as specific assistance with appointment making and appointment keeping, transportation, translation, and establishing behavioral expectations for visits to a dental office. A model program for preschoolers in Washington State, the “Access for Baby and Children’s Dentistry (ABCD) Program” showed that access for toddlers and preschool children could be markedly improved through such family assistance and social case management. Still other barriers require thoughtful one-on-one relationship building. These relate to negative attitudes that many dentists and their staffs may harbor about treating low-income children on Medicaid. A recent study documented that dental office receptionists may contribute to access difficulties even when the dentist is positively inclined to provide care (27).

Local approaches that hold potential to reduce dentists’ reluctance to work with Head Start children include active liaison between Head Start Centers and local dental societies (e.g. Head Start
presentations to dental society meetings, an open house for community dentists, Center directors’ visits to dental offices, involvement of active dentists in peer contacts, such as visiting Head Start centers together, doing a screening together, and involvement with dental society “share-the-care” programs and “donated dental services” programs). Many dentists welcome groups of young children to the office for “field trips.” Head Start can provide social rewards for dentists including certificates of appreciation, favorable press releases and photographs suitable for dental office display. Educational rewards could include free or subsidized formal training programs in care for young children. Dentists may particularly appreciate subsidized courses that meet requirements for continuing dental education in states that have a mandatory continuing education requirement. Head Start Programs also may liaison with local Area Health Education Centers (“AHECs”), federally supported professional education resources that deliver education and training related to public health needs.

Nationally, Head Start parents’ groups can play an active role in supporting and promoting access initiatives. Currently these initiatives include the Federal HRSA-HCFA Oral Health Initiative, the Surgeon General’s Workshop and Conference on Children and Oral Health, and federal legislation that targets increased access to children’s dental services. For example, the 106th Congress saw the introduction of the Children’s Dental Health Improvement Act (S. 901) by Senator Bingaman and the “Dental Health Access Expansion Act” by Senator Feingold (S.1035) and Congressman Barrett (HR 1920). Active involvement with advocacy and professional groups already addressing dental access would add a focus for Head Start children in the national debate on dental care. Head Start parent groups and early childhood advocates can join those currently active including the National Parents Consortium (of which the Head Start parents group is a member), the March of Dimes, Families USA, Children’s Defense Fund, the American Academy of Pediatrics, the American Academy of Pediatric Dentistry, the American Association of Dental Schools, the Association of Maternal and Child Health Programs, the National Conference of State Legislatures, the American Public Human Services Association, the American Dental Association, the American Dental Hygienists Association and many foundations. Other leading groups might be favorably influenced by Head Start parents taking the lead in activism. These include the National Association of Community Health Centers, the National Governors Association, the Association of State and Territorial Health Officials, and the National Association of Children’s Hospitals. Generating public will often requires anecdotes of children who cannot access dental services. Head Start groups could readily provide examples of children who typify this national problem.

Dental Providers for Children

About 80% of the roughly 185,000 dentists in the US are generalists rather than specialists, most of whom see some children. However, a far smaller but undetermined number are comfortable with or professionally prepared to see preschoolers. Young children can be some of the most
charming and engaging of all dental patients, but they can also offer dentists tremendous challenges in securing their cooperation and acceptance of treatment. Very young children with dental pain, those who need lengthy or uncomfortable treatments, those whose communication is impaired by language development or lack of English facility, or those who are fearful of the dental experience may present such a challenge that the dentist may be unable to manage their care. Many young children with extreme dental disease require treatment under general anesthesia, usually in a hospital operating room or outpatient surgical facility where care can be delivered with the least risk. Because most dentists are not educationally qualified or credentialed to provide such care, children’s access to essential dental services can be restricted even further.

In order to provide timely and early preventive care, the American Academy of Pediatric Dentistry, American Dental Association and the Bright Futures coalition, including the American Academy of Pediatrics, suggest that children first see a dentist at age one or when their first tooth erupts. Because dentists and hygienists-in-training have only recently been taught how to examine infants and counsel parents of very young children, many practitioners may not be comfortable providing this service. The resultant difficulty finding a dentist willing to see infants may add to confusion regarding the best age for a child’s first visit. Nonetheless, because tooth decay is well established as a disease process before age two, early visits are important in providing primary decay prevention advice as well as in counseling parents about growth and development, accident prevention, positive feeding practices, common soft tissue conditions of young children, and oral habits.

About 3,600 dentists in the US are Pediatric Dentists who specialize in children’s dental care, which is roughly one Pediatric Dentist for fourteen Pediatricians. With this minimal specialist availability, the majority of children’s dental care must be provided by generalists. Where available, Pediatric Dentists and generalists who have identified an interest in treating children (e.g. member of the American Society of Dentistry for Children) are often particularly interested in working closely with Head Start programs because they are comfortable with young children and with the special dental needs of children who have complex clinical problems. With social case management assistance from Head Start, MCH and Medicaid to assure that children keep their appointments, these dentists are often particularly efficient at providing dental services.

Dental hygienists can contribute significantly to Head Start programs by conducting professional level screenings, triaging children according to acuity of need, providing classroom, staff and parental education and guidance, helping implement oral hygiene programs, reviewing dietary components of programs for their cariogenicity and counseling individual children and their families regarding oral health maintenance. They can, within applicable regulations, provide direct patient
services including application of preventive agents. As the science and practice of “medical management of dental caries” advances, i.e. the behavioral and topical medication approach to reducing the disease process that causes cavities, the hygienist may play an expanded professional role in clinical case management that prepares children for dental repair that can only be provided by dentists.

The dental safety net in the US, comprised of community and migrant health center dental clinics, hospital dental clinics, dental schools, hygiene programs, and school-based clinics are extremely modest in number and availability. Only 58% of all federally supported health center grantees provide dental care (28) and the 55 dental schools in the US are not well distributed geographically. Many publicly supported providers confront the same barriers to providing Medicaid dental services as private sector providers. For children already accessing medical care in safety net facilities that have dental clinics, care coordination can be facilitated by encouraging parents to obtain dental care in the same facility. It is important for local Head Start programs to do a complete inventory of local dental treatment resources in order to maximize liaison with both private and public sources of care.

The Referral Process

The critical elements of a successful referral include specificity and follow through. Specificity requires that the parent know exactly where the child is to be seen, by whom, exactly when, by what means of transportation, who and what to bring to the visit and how to prepare the child. The dentist needs similar specific information including who is responsible for arranging the visit, who to contact if there is a problem with the appointment and any special information about the child that should be known before the visit (e.g. medical condition, social or family condition, behavioral condition).

Attributes of primary care that Head Start grantees should seek to assure for their children include comprehensiveness, continuity, competency, coordination, cultural sensitivity, quality and ready accessibility. When primary care meeting all of these requirements is unavailable, Head Start should seek to compensate for the missing attributes. For example, many States and volunteer groups maintain mobile dental vans that provide dental care for a short period of time when in a locality. Head Start Centers may arrange to have children noted on to have acute dental needs to be seen by the van (e.g. Washington Dental Service’s Smilemobile) and may then arrange a secondary source of care in an adjacent community for emergent situations that may arise when the van is unavailable. In this way, the Center can assure care continuity where the dentist cannot.

Head Start’s most important role in the referral process is to assure that children are actually seen by a dentist. It is appropriate for Head Start centers, in their role as educators, to work with
parents and dentists so that all parties understand the importance for care and how to obtain it. As parental value for dental care is assured, problems of missed appointments and incomplete treatment can be expected to decline.

**Treatment**

Children ages three to five present a wide range of behaviors in the dental office. Many, if not most, are excited about the visit and behave very well. A minority may find the visit threatening and overwhelming and may act out through crying, yelling and kicking. Since a primary goal of early dental care is to develop positive attitudes that support positive life-long oral health behaviors and since it is important to provide an experience acceptable to parents as well as children, it is important to minimize negative experiences. Centers can play a number of roles in assuring a positive experience including teaching children about appropriate expectations of a dental visit, not lying about the visit by characterizing it as exclusively “fun” or claiming that “nothing ever hurts” or “it will be real quick” when treatment may be time consuming and avoiding any negative mention of dentistry. On the positive side, Head Start teachers and staff can help children understand exactly why it is important to have healthy teeth and mouths, what the dentist and office staff are doing for them, and what the children can expect about being safe, cared for, liked and helped. Head Start staff can be encouraging, setting expectations for the children about how to act and talk to the dentist the same way they talk to their Center teachers and staff. Since most Head Start staff would not be expected to know the intricacies of dental treatment, it is better to focus on the reason and outcome of the visit than the content. For example, children respond well to understanding that the dentist will “make a dirty spot on your tooth clean” or “put tooth vitamins on your teeth to make them stronger and prettier and healthier” than they do to an explanation of how a filling is accomplished or how a fluoride preparation is applied.

Center staff can also assist parents and dentists with assuring a successful dental visit. Parents should be specifically instructed to not use “going to the dentist” as any type of threat or punishment and to downplay any negative attitudes they may harbor about dental care. They can offer guidance to the dentist about a child’s personality and concerns. If children have suffered physical or sexual abuse or demonstrate any particular fear, it is very useful to inform the dentist so that care can be tailored to the individual child’s perceptions and experiences.

Early Head Start children present dental providers with the unique challenges of dealing with infants and toddlers. Engaging parents, children and dentists in a positive way about the dental visit by setting appropriate expectations can help make the dental interaction successful. In particular, parents of these very young children and their dentists need to understand the utility of crying and when it should be interpreted as signaling pain, threat, imposition or a request for attention so that crying by itself is not regarded as a negative event.
Nonetheless, children may tire of dental treatment before it is complete, either during a single visit or in the face of additional visits. This problem may disrupt care and lead to incomplete treatment. Again, setting appropriate expectations, providing parents and children with a frame of reference so they understand when care will be complete and encouraging follow up so that all a child’s needs are met, are important roles for individual Head Start personnel. Parents and even their young children can subscribe to goal setting – the determination to complete a task – particularly when all are informed about how close they are to the desired outcome.

Although dental treatment is often complex and demanding, modern dental care can be surprisingly pleasant and non-threatening. Dentists have a variety of treatment modes available that can be individualized to meet each child’s unique characteristics and comfort needs. Behavioral interventions range from explanation, to demonstration, modeling, distraction and even sedation or general anesthesia. Linking each child to the most appropriate provider can be an important first step in assuring that a child’s complete needs are met.

Follow Up Care

Once care is completed, it is critical to continue regular professional oral health supervision in a way that reflects a given child’s risk of ongoing disease. Traditional one-size-fits-all semiannual dental visits may provide sufficient supervision for the majority of children. However, children with early or extensive dental disease and special needs children should be followed more closely for preventive supervision and disease process management. Here too, Head Start personnel can play important roles in teaching parents how to utilize and maintain regular dental care and can provide the essential follow up by assuring that parents maintain their children’s care. Local policy to support this essential component of care would include a formalized process to check with parents regarding ongoing dental care. Nationally, Head Start could refine a performance measure collecting information on this aspect of care.

**Head Start Policies On Oral Health Services and Access**

Many Head Start Performance Standards apply directly to oral health services or relate to dental access. These standards clearly describe program requirements and can serve as a useful basis for engaging the local dental community in a discussion of program needs and responsibilities. Following is a listing of performance standards that apply to dental services and access to care.
Child Health and Development Services

Requirement to assure appropriate care frequency: 1304.20(a)(1)(ii); Requirement to assure that care is individualized: 1304.20(f)(1)

These performance standards tie appropriate preventive and primary health care (explicitly including dental) to EPSDT schedules as well as “additional recommendations from the local Health Advisory Committee (HAC). Head Start and especially Early Head Start should adopt the professionally promoted standard that dental care be initiated at age one. Health Advisory Committees should consider modifying the semiannual standard for dental care supervision to a more individualized protocol that reflects the variability in disease activity between children. Under a separate requirement, care must be provided within 30-45 days of enrollment.

Requirement to assure appropriate delivery of service, follow up, and to track provision of dental care: 1304.20(a)(1)(iii-iv) as well as to assure ongoing health supervision: 1304.20(d)

Head Start must assist parents in making necessary arrangements so that children’s dental care is current. Agencies that can assist in assuring dental care include Medicaid, Title V Maternal and Child Health Programs, local health department outreach and compliance programs, local dental societies, and miscellaneous public and private social services available in various locales. The Health Advisory Committees can play a critical role in establishing, in cooperation with the local dental community, appropriate standards, protocols and measures assuring that care is continuous and well monitored. Useful tools include written statements, memos of understanding and other formalized agreements that implement case management in ways consistent with recommendations of Parent Policy Committees.

Requirement that children noted to have a dental problem on screening receive adequate diagnosis and treatment and assure that treatment is begun: 1304.20(a)(1)(iii-iv)

This is perhaps the most challenging requirement because it involves referral, often to an inadequate referral base. Efforts to engage the local dental community are essential for Head Start to develop a sufficient referral base so that children’s needs can be met and this requirement can be satisfied.

Requirement that parents be informed and assisted in obtaining necessary treatment: 1304.20(c)(1-2)

This requirement specifically extends to informing parents about how to obtain dental care upon learning of their child’s dental treatment needs.
Requirement that children are provided appropriate fluoride supplementation and treatments and other professionally recommended preventive dental treatments: 1304.2(c)(3)(i-ii)

This provision allows extensive involvement of the Health Advisory Committee and local dental authorities in determining risk-appropriate fluoride exposures.

Requirement that children with special health care needs obtain related services addressing health concerns: 1304.20(c)(4)
Requirement that children with special health care needs receive individualized care: 1304.20(f)(2)(i)

Obtaining dental care for children with special health care needs can be particularly problematic until an appropriate provider is identified. Suitable providers are dentists enrolled in advanced training through General Practice Residencies and Advanced Education in General Dentistry Programs, Pediatric Dentists and dentists affiliated with organizations that meet the needs of children with special needs. Local dental societies are good contacts for identifying dentists who treat special needs young children.

Authority to use Head Start funds for dental care: 1304.20(c)(5)

While most Head Start children are covered by dental insurance including Medicaid, the Child Health Insurance Program (CHIP), the Indian Health Service, or the military dependent dental plan, a few will either be uncovered or need supplementation. Supplemental payments for services are generally disallowed under Medicaid, HIS, and some CHIP programs while other CHIP programs and the military plan require co-payments and have some coverage limitations. These can be covered by Head Start funds. Head Start can also use program dollars for efforts that expand availability of care including provision of continuing education for dentists, arranging field trips to dental offices and perhaps funding incentive programs for dentist participation. Head Start can also fund dental services directly when it can document that services are not otherwise available.

Requirement to involve parents when a health problem is noted, to assure parental authorization of care, to inform parents about how to discuss health services with their young children and to encourage parents to actively engage in their children’s care: 1304.20(e)(1-4)

Parental involvement is critical both to meaningfully engage parents in the prevention and management of oral diseases and to assure that care will be ongoing after the child completes Head Start. Dental care provided without the active involvement of parents is less likely to succeed.
Requirement that children suspected of having a disability receive early referral to local health intervention agency: 1304.20(f)(2)(ii)

While children with advanced dental disease have not routinely been considered children with a disability, the definition of children with special health care needs could readily be applied to children with early and rampant tooth decay that results in failure to thrive or diminished growth attainment. This requirement should be extended to include young children significantly impacted physically, behaviorally or functionally by dental disease.

Child Health and Safety

Requirement that children have ready access to emergency services: 1304.22(a)

In addition to routine dental care, Head Start centers need to assure a regular source of emergency dental care for enrollees. Dentists who do not routinely participate in Head Start children’s treatment may be willing to provide such emergency services. Local dental societies should be approached to develop and implement an emergency or urgent care program for Head Start enrollees and to assist in developing written emergency care agreements with local dentists.

Requirement that suspected child abuse and neglect be handled in compliance with applicable law: 1304.22(a)(5)

Manifestations of child abuse often occur in the area of the face and mouth and the presence of extensive untreated dental disease in children may be a sign of child neglect. Training and programs related to child abuse and neglect should incorporate consideration of oral manifestation of these conditions.

Requirements concerning administration of medications: 1304.22(c)

Head Start programs have the authority to administer medications including those that are necessary for dental care, e.g. antibiotic premedication and fluoride supplements.

Requirements governing injury prevention: 1304.22(d) and first-aid: 1304.22(f)

Prevention of injuries to children’s mouth and teeth as well as their immediate management are important elements of health promotion and access to care. Programs are encouraged to develop with local dental authorities, protocols for both prevention and immediate care of injuries. This is
particularly important since damage to “baby” teeth can directly damage the development of permanent teeth.

Family Partnerships

Requirement to establish family involvement in promoting health and establishing family goals: 1304.40(b,a)

Because most common dental diseases are preventable through appropriate nutrition and eating habits, personal hygiene, and positive parenting behaviors, most dental disease may be considered as emanating from “lifestyle". True oral health promotion requires extensive parental involvement. This requirement provides the opportunity for parents to assume responsibility for their children’s oral health and for partnership building with parents to promote oral health, especially for high-risk children.

Requirement to establish with parents a dental health education program: 1304.40(f)(2)(i-iii)

This explicit requirement calls for “assisting parents in understanding how to enroll and participate in a system of ongoing family health care", “encourag(ing) parents to become active partners in their children’s dental health care process and to accompany their child to dental appointments” and “provid(ing) parents with the opportunity to learn the principles of preventive dental health.” The provision further requires that parents be provided information specific to their children’s health needs. This comprehensive standard clarifies Head Start Program’s intent to meaningfully engage parents in their children’s oral health concerns and provides the basis for a triad of program-parent-dentist to address children’s oral health. These provisions also directly address barriers to dental care that evolve from families.

Community Partnerships

Requirement that Head Start grantees develop partnerships with health care providers: 1304.41(a)(2)(i) and establish Health Services Advisory Committees: 1304.41(b)

By assuring that oral health service access is part of all partnering efforts, Head Start can meaningfully address enrollee’s access to dental care. Because access to dental care is so often problematic, it tends to be segregated as a unique problem. Solving this problem can be facilitated by “mainstreaming” the issue. This can be accomplished by linking the activities of child advocates, dental groups including hygienists, dentists and dental health foundations, WIC programs, local child advocates, early childhood development programs and others concerned either with child health or child welfare.
Conclusion

Access to dental services is a national problem, particularly impacting low-income children and young children — the very characteristics of Head Start enrollees. Because conditions vary greatly by locale and because solutions require the combined efforts of multiple stakeholders, this problem is solvable only one community at a time. While lessons can be learned and information shared between programs, it takes the special initiative of individuals concerned about children and their overall health to develop a local concept of “dental home”, a strong linkage to other local health efforts, and a meaningful engagement of the local dental community.
References


9. Amudson C., Dental Director HealthPartners, Minneapolis MN, personal communication 1999.


28. Anderson J. Bureau of Primary Health Care, Health Services and Resources Administration, Department of Health and Human Services, personal communication, 1999.
Table 1. Children under age six with a dental visit in 1996 by age, race, income and parental education (6).

<table>
<thead>
<tr>
<th>Dental Visits</th>
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<tbody>
<tr>
<td>Male</td>
<td>20.7%</td>
</tr>
<tr>
<td>Female</td>
<td>22.3%</td>
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<tr>
<td>Non White</td>
<td>15.7%</td>
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<tr>
<td>White</td>
<td>24.2%</td>
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<tr>
<td>0-200%FPL*</td>
<td>12.2%</td>
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<tr>
<td>200-400%FPL</td>
<td>28.4%</td>
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<tr>
<td>&gt;400%FPL</td>
<td>29.7%</td>
</tr>
<tr>
<td>Some or no high school</td>
<td>12.5%</td>
</tr>
<tr>
<td>HS graduate</td>
<td>20.7%</td>
</tr>
<tr>
<td>College graduate</td>
<td>27.7%</td>
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* FPL = Federal Poverty Level
Table 2. Percentage of children whose parents report dental visits for “relief of pain” or because “something is bothering the child” (8).

<table>
<thead>
<tr>
<th>Group</th>
<th>% With Visit for Pain</th>
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<tbody>
<tr>
<td>All children 2-17</td>
<td>11.2</td>
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<tr>
<td><strong>Race/Ethnicity</strong></td>
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<tr>
<td>White</td>
<td>10.0</td>
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<tr>
<td>Black</td>
<td>16.0</td>
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<tr>
<td>Hispanic</td>
<td>17.4</td>
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<tr>
<td><strong>Education of head of household</strong></td>
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<tr>
<td>Less than high school</td>
<td>19.5</td>
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<tr>
<td>High school</td>
<td>13.3</td>
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<tr>
<td>More than high school</td>
<td>8.3</td>
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<tr>
<td><strong>Poverty status</strong></td>
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<tr>
<td>At/above FPL*</td>
<td>9.7</td>
</tr>
<tr>
<td>Below FPL</td>
<td>19.4</td>
</tr>
</tbody>
</table>

* FPL = Federal Poverty Level