

**Oral Health for Ohio Head Start Children
Compendium of Promising Approaches**

Prepared for:
Bureau of Oral Health Services
Ohio Department of Health

Evaluation Services Center
University of Cincinnati

May, 2003

Oral Health for Ohio Head Start Children Compendium of Promising Approaches

Evaluation Services Center

Debbie Zorn, Director

Mary L. Marx, Evaluation Associate

With the assistance of:
Deborah Smith, Consultant
Lisabeth Bauer, Editor

In collaboration with Ohio Department of Health, Bureau of Oral Health Services:
Mark D. Siegal, DDS, MPH
Shannon L. Cole, RDH, BS

Acknowledgement

UCESC project staff wish to acknowledge Health Coordinators from Ohio Head Start and Early Head Start programs who participated in study interviews so that the successes and challenges of their work could come to life in this report.

Oral Health for Ohio Head Start Children Compendium of Promising Approaches

Table of Contents

Results.....	2
Structure of Collaboration.....	2
Systematic Coordination in (Rural) HS/EHS programs	2
Community Oral Health Planning in Urban HS/EHS Programs	4
Mass Screenings.....	6
Working With Universities and Training Programs	7
Promotion and Incentive Strategies	7
Comprehensive Approaches for EHS Programs.....	8
Mobile Services	9
Education and Prevention	9
Operational Challenges.....	10
Summary Comments: Elements Worthy of Replication.....	14

Oral Health for Ohio Head Start Children Compendium of Promising Approaches

The Evaluation Services Center (ESC) of the University of Cincinnati College of Education was contracted by the Ohio Department of Health, Bureau of Oral Health Services, to prepare a compendium of promising approaches for use by Head Start programs in addressing oral health needs of the children they serve. The compendium is to serve the purpose of highlighting the structure of oral health partnerships and collaborations, operational challenges, and elements worthy of replication within Head Start programs. Information in this compendium is pulled largely from a targeted interview study of health coordinator staff from 60 Ohio Head Start (HS) and Early Head Start (EHS) programs. Interview respondents represented approximately 75% of HS and EHS programs in the state of Ohio. Participant programs had a similar distribution to all HS and EHS programs in Ohio with respect to urban, rural, and suburban location. Detailed information on the study may be found in the January 2003 report entitled, “Oral Health for Ohio Head Start Children: *Approaches That Work* Interview Results.” Companion reports¹, a mail survey of Ohio dentists and an interview study of health coordinator staff and parents from a sample of Head Start programs in the state, offer multiple perspectives on the status of oral health care and access to care for children in Ohio Head Start programs.

¹ Oral Health for Ohio Head Start Children: Dentist Survey Results, May, 2003; Oral Health for Ohio Head Start Children: Parent and Staff Attitudes and Practices Interview Results, May, 2003.

Results

Results of interviews of Head Start (HS) and Early Head Start (EHS) health coordinator staff showed that there was no single model that comprehensively addressed children's oral health needs. Head Start staff used a combination of approaches to chip away at the problem. Some strategies indicated by health coordinator staff as being successful were reported by multiple respondents across program types and geographic settings. Other strategies were mentioned less frequently, but were thought to hold promise in tackling a specific aspect of access or education. The compendium features a combination of the best elements that emerged from Head Start and Early Head Start health coordinator staff working in the field.

Single and composite case examples have been assembled to illustrate critical elements of the structure of collaboration and operational challenges experienced by those interviewed. Based on these case examples, the report will conclude by summarizing promising approaches that may be worthy of replication to serve the oral health needs of children in Ohio's Head Start and Early Head Start programs.

Structure of Collaboration

The Partners. Oral health partners and collaborators identified most frequently by Head Start health coordinator staff were the following: local dentists; hospitals, clinics, and health departments; universities and training institutions; and mobile dental services. Identified less frequently as partners were funding entities, community agencies/collaboratives, state partners (Ohio Department of Job and Family Services); and other partners, including pediatricians and pediatric dentists serving infants and toddlers.

Partnership Characteristics. Most health coordinator respondents reported they had multiple partnerships or collaborations in place in their programs. More than half of the partnerships described (54.1%) had been in effect for two to five years.

Systematic Coordination in (Rural) HS/EHS programs

The following case examples highlight comprehensive coordination of children's oral health care through a case management approach and relationship building with providers. The coordination begins with helping families apply for Medicaid. Head Start programs educate and prepare the children and the parents for what to expect at a dental visit. Programs track and assist with the treatment progress in terms of making referrals, setting up appointments, reminding parents, tracking follow-up, and documenting treatment. Head Start programs support families with child care, transportation, and costs, if there is no other source of funds. Building a relationship with the provider includes recruitment of dentist partners and entails ensuring that

children and parents, if they are able, be present for appointments; that consent forms are completed if the parent is unable to be present; and that HS staff act as an extension of the dental office with any scheduling and paperwork, if necessary.

Building Relationships with Providers

I am a health coordinator in a rural Head Start program in Ohio. Being part of a small town has benefited our partnerships with dentists. People know me here because I worked for many years with a well known doctor in our town. They see me at football games, in church, and at the grocery.

One dentist holds two or three clinics for me in the fall. He blocks out his day. I schedule the kids and go to his office to help with the paperwork. I got a letter of recommendation from this dentist stating that he had worked with me for years and that I was organized. You have to be organized and keep accurate records. If you schedule someone during the blocked time and they have moved away, it will create problems.

I contacted a new pediatric dentist. He was leery, and didn't know me from Adam. It began with him agreeing to see two children in our program. The dentist told us how many visits the treatment would take. The office staff saw that I kept my appointment times, and that the parents and the kids were there. Then they agreed to take two more kids. In the following year, that blossomed into that office blocking out some time for me—a whole afternoon per month! I now know how they schedule, how much time they need for a new patient, and how much time they need for an operative. They even call me if they have cancellations—especially in the month of December when people cancel because they don't want to spend the money. I have a reservoir of 20 kids on a waiting list. Instead of them staying on the phone and calling family after family to keep their schedule full, they can count on me to fill last minute cancellations.

Recruiting Providers

I developed a written contract with private dentists to provide services for our children. The contract gets renewed annually. I have a spreadsheet in Excel with each dentist in our service area, whether they accept Medicaid, whether they are willing to contract with us, and the number of children they will serve. I go door to door to get them to participate. If a dentist is not a Medicaid provider, I ask him if he will serve a number of our children by donating services for those children. I am also working to get dentists to give us one day a month when they are normally closed. As part of this arrangement, I volunteered to do the paperwork for them and we arrange for transportation. I had one dentist do that and we got 30 dentals that day.

Oral Health Case Management

Our social service staff help families make appointments (check up and follow-up). We track progress and appointments. The most effective course has been a postcard reminder system—a tickler system. Our secretary sends out postcard reminders to remind families to make it to the appointments.

The program has an arrangement with the dental clinic in town to set a side a day for children to be seen, and some dentists in town volunteer for several hours. We pull files, obtain consents, and the health assistant goes along to help fill out the forms. We arrange for follow-up care.

We try to see that the children get a dental home. If they don't have a medical card, Head Start pays, so if a child has a dental problem, we get it fixed somehow. (Sometimes dentists will slip one or two children in if it is a bad case.) We also try to educate parents about what to expect at the dentist's office and try to address any fears. We take field trips to the dental office, and a local hygienist comes in to do role playing with the children. Parents are always invited.

If our families have their own transportation and need help, we give them gasoline allowances. Otherwise the drivers of our van are available to get the families and transport them for dental visits. This includes travel to the hospital clinic, which is pretty far away. We encourage parents to go with their children to the appointments because we want them to be actively involved in health care for their child and establish an oral health home. We offer child care, if needed. We also have an ESL (English as a Second Language) liaison who accompanies families to the dentist if no other bilingual speaker is available.

Family service workers call families regarding follow-up, what the families have done, and what they need help with. We provide families with information as to what dentists take medical cards. We give them magnet reminders to put on their fridge. Our family services representatives bend over backwards to assist in getting the dentals completed.

Community Oral Health Planning in Urban HS/EHS Programs

The case examples illustrating community oral health planning highlight local and regional collaborative initiatives, grant funding, sharing of information, dental homes for children, and the role of dentists in providing services and in encouraging participation of their colleagues. The urban and rural case examples share many common themes.

Local and Regional Health Planning Efforts in an Urban Setting

Our county has made [oral health] a community issue rather than a dental issue. We sit on the county strategic planning committee to address our county's health needs. It brings the dental issue right to the forefront—a huge benefit. We also participate in a regional dental collaborative. We were able to screen 1,500 children in 15 school districts through the collaborative. Our local children's hospital is assisting us in recruiting dental offices that are willing to adopt Head Start classrooms and act as a dental home for children in that classroom. We also have a local foundation that is developing cultural competence training. This will help health professionals be better prepared to serve Latino families in our county and other culture groups.

We obtained funding from a major medical insurer and from a state grant to establish a dental clinic in an already established health and social services clinic. The health department is partnering with us to hire a dentist and support staff, and to raise additional money.

Our Self-Sufficiency Coalition focuses on health, education, and social services, and strongly encourages those who have something to offer to step up to the [plate]. We are fortunate to have a semi-retired dentist who champions our efforts. He is able to build support within the dental community because he talks their language.

Collaborative Oral Health Initiative in a Rural Setting

At the community level, we have dentists on our steering committee that help us evaluate our county for oral health needs of the community, young and old. Area safety net clinics are utilized for all ages. We are thinking through a strategic plan for oral health. Working through a task force, we were able to open a dental clinic and start a dental sealant program.

The collaborative community group was the driving force behind the clinic. The clinic has a couple of dentists, one with expertise in children, and one serving patients with disabilities. Local dentists do screening, and half accept Medicaid. Some dentists accept Head Start children with medical cards even if they are not taking new Medicaid patients. While some dentists seemed to oppose the idea of the clinic, others have contributed dollars, equipment, or supplies—in lieu of volunteering.

The clinic does full service treatment, but refers more complicated cases to the university clinic. We have established a relationship with that clinic. Head Start staff help them track down families who have moved or changed their phone numbers. If they have a cancellation, they call us and we transport our children to appointments on short notice.

One county's Job & Family Services has an excellent oral health grant that provides education and assistance in finding dentists and providers for families. They work with children through ninth grade, so we'll be able to get dental care for siblings and other children in the

community. Through another grant effort, we'll be able to dedicate two staff members to provide oral health case management for our families.

At the program level, a local dentist sought out other dentists to participate and advocate for the program. Most serve children. Some dentists donate their time at our center and provide exams. Others do exams, cleaning, and fluoride at reduced prices. We have dentists that open up their facilities for evening events and invite parents to learn more about dental care. We also have dentists that serve on our advisory board.

Mass Screenings

Mass screenings can provide a critical first step in evaluating the oral health status of a large group of children, meeting Head Start Program Performance Standards, and identifying children in need of follow-up treatment. The case examples below illustrate promising approaches to mass screening that are used by Head Start programs.

- *In our community, the dental clinic is funded through the government. I schedule mass clinics for screening, then we send flyers home with the children. The parent can contact the dental clinic or I can do it. It helps that the clinics see both adults and children.*
- *We organize and run a health fair in August with help from staff at the health department. This is done in a location in each of our two counties. We get all of our physicals, dental, vision, hearing, and speech screenings done—everything except developmental. Professionals donate their time and it is free for families; one dentist sees children in the morning and another one in the afternoon. After the dentist does the screening, we know which children are having problems with their teeth. He gives an approximate amount of treatment. If there is a barrier in getting follow-up treatment, we help parents set up appointments with their dental home providers. If there is no dental home, I schedule a group of 5 children with a dentist willing to take them.*
- *The dentist schedules days he will come into the schools. I send a letter to the center manager, and center staff take care of parent permission. We did two centers in one day. If the child doesn't need treatment at the screening, we do a follow-up letter to recheck in 6 months. If the child does need treatment, we send a letter to the parent telling them what is needed and that we will assist them in finding a dentist and in providing transportation.*
- *Once a year, we use a mobile dentist group that provides dentists and hygienists to do a mass screening. They do Xrays and prevention. Time is blocked out for about 130 screenings. We do our health screenings—vision and hearing—at the same time.*

Working With Universities and Training Programs

Partnering with universities and dental training programs is another avenue Head Start programs have pursued to get children's oral health care needs met. The case examples below illustrate several of those partnerships.

- *At the community college's dental hygiene clinic, dental hygiene students do screenings and cleaning under the [supervision] of the director. We transport about 10 kids each quarter or the parents take them. The college also does dental education with our children on site.*
- *The community college has a dental program with people working for a degree giving clinical hours to do our screenings assisted by a dentist.*
- *The Dean of [an area school of dentistry] has seen it necessary to give back to the community. Students do the initial exam and then next steps are broken down into three categories—immediate care needed, follow-up, and what follow-up will entail. [We also collaborate] with a community college in the city. They have dental hygienists in training, and they do some of the teeth cleaning at a minimal cost.*
- *[Our area children's hospital] did a mass dental screening last year and we will repeat again this year. It is for all of the Head Start population, including partnerships, and it is open to children in the community. The [hospital dental department] comes to us and serves 300 children at once...they bring dental students to us for field practice.*
- *I am trying to set up a partnership with a dental school that will serve HS kids as a part of the dental training. We would take 15 kids for a 30 minute bus trip and they would have 10 chairs to use at once, so kids wouldn't have to wait. Dental students would see the kids for cleaning and fluoride. There would be education videos and dental related gifts for the kids. They would also see a dentist.*

Promotion and Incentive Strategies

Many instances of effective collaboration are being utilized in HS and EHS programs in Ohio. These efforts have been promoted explicitly (e.g., a dentist promoting collaboration among her/his colleagues) and implicitly (e.g., information sharing in community oral health initiatives). One case example below highlights media coverage of a successful collaboration. Head Start programs could publicize their collaboration *success stories* and promote results of the collaborations to market their programs to potential partners. Another case example highlights

incentives to recruit newly graduated dentists to rural areas.

- *This is just beginning. For families who don't meet the federal guidelines to get a dental exam within 90 days, the dentist at the local health department comes to our main site in early December (two mornings and two afternoons). He does a dental exam only. Children are transported from their sites to the main office. Parents give permission and are invited to be there. The local paper will be there so other dentists can see [and be encouraged to participate.]*
- *State of Ohio tuition remission program for dentists that would agree to take a certain percentage of Medicaid children or locate to an area of high need and low socio-economic [conditions]. The dentist may buy into helping these families by recognizing needs.*
- *Yes, they could try to work with dentists in providing incentives to them to serve us. Maybe help them pay for college costs if they would partner with Head Start.*

Comprehensive Approaches for EHS Programs

This case example illustrates early contact with pregnant mothers as an important way to educate families about the importance of involvement in their children's health care. It emphasizes early dental care for children and partnering with the medical community to ensure a comprehensive, integrated approach to oral health care for children aged zero to five years.

We need to address the educational component so that families understand the importance of dental care for children zero to three. We work with pregnant women and accept their children at about 6 weeks. We take advantage of access to the [mothers] and begin talking about health and oral health early. Presenters come in and speak to them as a group. We discuss baby bottle tooth decay before the baby is born. We train on wiping gums after each meal. Once the infant is born, there is a regular oral health routine, wiping gums off after each bottle. Oral health is included in the curriculum for programming in Early Head Start and Head Start.

A local dentist agreed to see patients at age one. Parents can contact her directly, and she takes Medicaid, which most of our parents have. The arrangement is beneficial to her since Medicaid has agreed to reimburse for visits of children at age one. We also work with area pediatricians. We adapted the EPSDT (Early Periodic Screening Diagnostic Treatment) guidelines for infants and toddlers. Two local pediatricians have agreed to do oral health exams for our infants and toddlers, and they use our form. For a child under one, they check the child's gums when he or she is there for a check up or an illness. I was invited to do an inservice with the program director at the free clinic. It was important to clarify what needed to be done at the early medical screening. She agreed to use the forms, and has made them available at the clinic in case a parent forgets to take one.

Mobile Services

Mobile services are useful in attending to needs for dental exams and mass screenings, and they have been used in various ways to serve unmet dental needs. However, mobile units are not necessarily considered by families or Head Start staff to substitute for a dental home physically located in the community. Head Start continues to emphasize the importance of dental homes for accessible, comprehensive, and ongoing oral health care. The case examples listed below illustrate ways in which mobile services are being used.

- *A mobile group came to our program last year and will come again in November. They do exams, fluoride, and prophylaxis. They don't do treatment (e.g., fillings), but it is very beneficial to get the exams done.*
- *[Prior to the funding and facility for the clinic], the center set up a mobile clinic to see HS children in our area about 2-4 times per month. They had already been doing visits to nursing home residents.*
- *For the MASH unit, they need to schedule enough appointments at a given site so that it is cost effective for him to set up. He brings an exam chair and equipment. All the site needs is an electrical outlet and a water source. It's an opportunity for parents who have not gotten dental exams for their children to do that, but I'm not sure if it is a satisfactory connection for follow-up care. The dentist would like for people to establish that relationship with him, but parents tend to want to establish a relationship with a local dentist.*

Education and Prevention

Head Start and Early Head Start programs have tried and true methods for educating children and parents about oral health. Here is a sampling of practices that health coordinators thought *really worked* to help them attend to the oral health of children in their HS and EHS programs.

- *Teachers model tooth brushing. We do tooth brushing at tables and children brush longer. They sit at a table and use a timer and the teacher brushes with them and guides them through the process...it increased teacher awareness [related to] oral health. Some classrooms don't have a sink in the room, so it allows a way to get a dental component.*
- *Staff understand the importance of modeling brushing, we even have volunteer "foster grandparents" in the classroom and they're brushing too. The children have learned to have this as a part of routine. It is common practice and they*

know after meals they are going to brush their teeth. I think they take this home with them and the discussion is there too.

- *We provide children with brushes and encourage them to brush after meals. In the curriculum, one concept is expanded for the month. We stress the importance of teachers being role models. They brush teeth with the children. Most teachers buy into it. Teachers incorporate healthy practices about oral health in the daily curriculum. [We have] newsletters about oral health—including good nutritional practices...we get dentists, hygienists, and dental instructors to come in and talk to the children.*
- *In Early Head Start, education is our main focus: prevention of baby bottle tooth decay (BBTD); prenatal and nutrition during pregnancy. We have pamphlets, videos, model of BBTD and what that looks like. We provide families with infant-toddler dental kits. We have samples of baby toothpaste (no fluoride) and gum gel. We expand that into the family and provide adult size toothbrushes and toothpaste.*
- *We do little things like contests. For example, [how to get] the greatest amount of parents that go to the dentist. The contest starts in the program beginning and goes through the month of February—Dental Health Month. The classroom with the most parents' dental forms gets to go to McDonalds for a happy meal...families really like this contest.*
- *[We] provide PACT (Parent and Child Together literacy-based) activities to parents (e.g., disclosing tablet, toothbrush, how to brush).*
- *There is a health educator in the health center. She is good about going around to the classrooms, especially around February—Dental Health Month. She is also available to parent groups.*
- *A model that we used to have worked wonderfully at a small program where I used to work. We invited a local dentist to come in and make a presentation at parent meetings. The follow-up by parents was astonishing. Students from the dental school presented a video/slide presentation on dental health. It was followed by questions and answers on any dental health issue. The students liked the experience, and the families responded very positively.*

Operational Challenges

Operational challenges in meeting children's oral health needs have an impact on forging partnerships and collaborations as well as on Head Start and Early Head Start education and prevention efforts. Interviews with HS/EHS health coordinator staff surfaced the following

themes: (1) lack of availability of dentists, especially in rural areas; (2) dentists reluctance to see young children and to accept patients on Medicaid; (3) financial and administrative barriers related to Medicaid, managed care, and instability of grant funding; (4) secondary barriers (e.g., waiting lists, distance to care, lack of continuity of dental home) resulting from the gap in needs and available services; (5) family constraints due to work and school demands (i.e., Welfare to Work), and transportation and child care issues; and (6) issues related to family education and culture that are perceived as families' lack of valuing of oral health. Case examples illustrate various operational barriers and challenges across Head Start program types and geographic settings. Many of these barriers were triangulated by data from the staff-parent interview study dentist survey companion reports.

Services for young children:

- *Dentists' willingness to see children 0-3 is a barrier. Dentists are unwilling to see children under age 2. Children under age 3 are not always cooperative.*
- *Early Head Start recommends a child have a dental exam by age 1, and pediatric dentists don't recognize this as a need.*

Waiting lists, distance issues, simple services requiring multiple visits, refusal of patients on Medicaid, lack of current information on which providers accept Medicaid (most responses were from rural programs):

- *Parents complain that they have to come in two times—one for an exam and again for a prophylaxis. Parents don't like that.*
- *Dentists can't put children out [with anesthesia] for procedures, so they refer to two large children's hospitals, and sometimes the waiting list is up to 2 years.*
- *We need in our county a children's dentist who can do the extensive care. They are currently referred to hospital clinic two and a half hours away. There is a long waiting list for follow-up treatment, typically 6 to 9 months. Families say that the clinics don't call them back for a long time, and then down the road families are not as apt to go.*
- *Initial exams are local and then families have to drive 1.5 hours for follow-up. People here don't have cars or gas in the cars they have to do this. We use our resources and personnel to help with transportation. Funding allotted in our grant is limited and we cannot afford the high price of follow-up care.*
- *The number of dentists [is a barrier]. The one that does accept Medicaid is not a [pediatric dentist]; he does the assessment and then refers them on. Referrals are no closer than 50 miles out. We are rural and the availability of doctors is*

low, which makes transportation an issue.

- *Access to an established Medicaid dentist [is a barrier], and so is transportation to out-of-county or out-of-state dentists.*
- *Sometimes [it takes] 6 to 8 months to get in for a routine exam.*
- *We have 740 children and the majority are on Medicaid. In one county, we have no dentists accepting Medicaid. In another, there are two. In a third county, the dentists come and go—they take so many and then quit taking more.*
- *Everybody in our county as far as community agencies was aware we needed to improve dental health access in our area. It was not a barrier to want [dental health], the barrier was to get it in because we are so rural and dentists can't make high income here. Our dentists are asking for more dentists in the area. Some of the current dentists are trying to retire. Since we are limited on dentists, families need to go to other counties to get an appointment in the time frame for Head Start. Also, there are waiting lists for treatment unless it is an emergency, so follow-up takes time.*
- *Turnover of dentists [is a barrier] and getting the dentists to stay.*
- *We need updated information from doctors as to whether they take Medicaid or not to make things work better for parents.*
- *The main problem is accurate information from providers. They say they take Medicaid eligible patients, but when it comes down to it, they don't accept new patients, or appointments are 6 months out.*
- *The services aren't available when we need them. There are waiting lists (urban).*
- *Dentists are not located in the inner city, so transportation is an issue. Not enough dentists period (urban).*

Medicaid and managed care reimbursement and administration:

- *The Medicaid rate and the paperwork involved. We could get more providers if the rate was higher and the paperwork less cumbersome (urban).*

- *According to our local dental society...African American dentists are decreasingly accepting Medicaid...they cannot afford it (urban).*
- *Mandated managed care [is a barrier]. Families have to work within the system. There have been 14 HMOs in three years. Two are fully functioning, and one new one is unable to capture a viable market share. Some families have been on five or six HMOs. Dentists sign on and drop off if there are any problems with billing. It's a sand dune, shifting all the time (urban).*
- *More children are eligible for healthy start (CHIP), but the state does not reimburse dentists to make it worth their while to serve this population (rural).*
- *The reimbursement rate is not as much a barrier as years ago because it was raised (rural).*

Family constraints related to hours of operation and Welfare-to-Work; education and culture issues:

- *Dentists do not have evening hours, which would be compatible with our population.*
- *A parent who works and goes to school has very limited opportunities to make appointment times.*
- *Families move and dental providers can't find them. The providers quit taking families because of no-shows.*
- *Parents believing in oral health for this age [child is a barrier].*
- *Families think baby teeth aren't necessary to take care of because they just fall out. Also, parents need dental work and it's not a priority, so they don't go to the dentist themselves. Educating the parents is a challenge.*
- *Some cultures (e.g., Hispanic, Appalachian) are less inclined toward a preventive health focus.*
- *It's an uphill battle, convincing families that dental care is needed, and that primary teeth need to be cared for. We have fluoridated water and our dental disease is lower than in other large cities, but families don't understand that caries is a preventable disease. Lots of time is spent on dental education, but it is not so successful with only a 56% completion rate of restorative work (urban).*

Summary Comments: Elements Worthy of Replication

In summary, there was no single model offered that will address the many aspects of oral health access for Ohio children in Head Start and Early Head Start programs. However, there are several approaches that health care coordinator and other program staff in this study used to address various aspects of the problem. Some of these approaches were not new, but continued to be effective. Other approaches were more innovative. Taken together, the approaches featured in the compendium represent promising practices that Head Start and Early Head Start programs could adopt in order to accomplish the goal of improved oral health status for children they serve.