Enhancing Partnerships: A Regional Forum on Head Start and Oral Health

Report for Region II Forum

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Executive Summary

The Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) hosted the Region II Forum, “Enhancing Partnerships for Head Start and Oral Health” on October 18–19, 2004 in New York City, New York. The major aim of the forum was to determine how organizations and agencies at a regional level can work together to improve the oral health of Head Start children and their families. This was the tenth in a series of regional forums held as a follow-up to the 1999 National Head Start and Partners Oral Health Forum convened by the Head Start Bureau (HSB), HRSA, the Health Care Financing Administration (now known as CMS, or the Centers for Medicare and Medicaid Services) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Over sixty-five participants attended the forum representing all the States and territories in the Region and a variety of organizations, agencies, and professional groups from the public, private, and non-profit sectors. During the forum, they shared their unique experiences and perspectives of Head Start and oral health.

Speakers represented the regional offices of ACF, HRSA, Head Start and children’s oral health programs, and included Ms. Mary Ann Higgins, Dr. Mercedes Franklin, Dr. Meryl Hersh, Ms. Amanda Lehrer, Dr. Marsha Butler, and Dr. John Rossetti. The speakers noted growing oral health disparities, barriers to dental care, and the pivotal role that collaboration and partnerships with Head Start can play in improving oral health outcomes for young children and their families.

Guided by Head Start and Oral Health Partnership Project consultant, Jane Steffensen, the participants met in small groups to discuss three areas—prevention, oral health education, and access to dental care. During the first session, each group discussed promising practices and identified priority issues. In the second session each group outlined strategies and action steps, as well as identified collaborators and resources necessary to address priority issues.

What was unique about the discussions of the three breakout sessions in this Region was the fact that many of the same priorities were identified independently. Each group focused some of its
discussion on the importance of early intervention, and defined this intervention as needing to occur before the child is born with his or her parents and caregivers. More than one group identified the development of a uniform standard of care with specific guidance and reporting requirements as a priority. Acknowledging that the economic burden of dental education, both the access and education groups endorsed the idea of loan forgiveness or financial incentives to encourage dentists to serve children in Head Start. Throughout the deliberations, each group also recognized that consistent, clear, culturally competent communication would be critical for this partnership.

Meeting participants’ discussions echoed some of the findings from other Regional Forums. For example, they discussed that for this partnership to work, Head Start programs at the local, State and Regional levels must not only work with professional dental educational institutions and associations, but also with public health agencies and private foundations and organizations committed to the health and well-being of children. The Supplemental Food Program for Woman, Infants and Children (WIC) was identified by all three groups as a partnership that Head Start should foster at the national level to improve oral health.

This Executive Summary provides an overview of the priorities identified by each breakout group. The full Report of the forum includes more in-depth analysis of the discussion of each group and details the process by which the group came to their conclusions. The full report can be downloaded from the Maternal and Child Oral Health Resource Center Web site at www.mchoralhealth.org/HeadStart hsforums.html.

For the group discussing Prevention, the most significant goals identified were to maximize early prevention opportunities, promote appropriate use of fluorides including community water fluoridation, fluoride varnishes, and dietary fluoride supplements, explore holistic approaches to oral health, and increase funding for prevention efforts. Similarly, the Oral Health Education Group identified education efforts that would support earlier intervention as well as provide a basis for a more active collaboration between Head Start, WIC and the young families they serve. In addition, the Oral Health Education Group outlined education for dental students, nondental providers, and practicing dental professionals, as well as the opportunity for Head Start to contribute to research studies as their top priorities. The Access to Dental Care Group
thought that addressing reimbursement issues, eliminating barriers to oral health services, and increasing workforce capacity were priority activities that would improve the oral health of Head Start children and their families. More detailed descriptions of the priorities, action steps, collaborators and resources identified by the groups are outlined in the full Forum Report.
I. Background and Introduction: Region II Forum on Head Start and Oral Health

A. History of Regional Forums

In 1999, the Head Start Bureau (HSB), the Health Resources and Services Administration (HRSA), the Centers for Medicare and Medicaid Services (CMS, then known as the Health Care Financing Administration), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) convened a National Head Start Partners Oral Health Forum 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 and for increasing collaboration at the Federal, State, and local levels to enhance access to oral health services.

One outcome of this National Forum was the development of an Intra-Agency Agreement between the Head Start Bureau of the Administration for Children and Families (ACF) and HRSA’s Maternal and Child Health Bureau (MCHB) to develop linkages to support oral health in the Head Start Bureau (HSB). As part of this agreement, the two Bureaus decided to sponsor a series of regional forums to determine how organizations and agencies could work together at a regional level to improve the oral health of participants in Head Start (see Appendix A for a map of the Head Start Bureau regions as designated by the U.S. Department of Health and Human Services).

B. Region II Forum on Head Start and Oral Health

The Region II Head Start Oral Health Forum was held October 18–19, 2004 at the Ted Weiss Federal Building in New York City. The meeting space was provided by the New York-based Regional Office of the Administration for Children and Families. The planning process was supported by the Regional Office of the ACF and a planning committee representing all areas of the region. (An agenda for the Forum can be found in Appendix B.) The goals of the Region II Oral Health Forum were to:

- Assess access to care and other issues that may improve or detract from oral health education and clinical services available to the Head Start and Early Head Start populations.
Develop a strategic plan for the region that includes an assessment of current regional oral health issues and the identification of promising practices to address challenges throughout the region.

Identify strategies and the key roles of regional agencies and other entities for future action.

Contribute to the development of a national strategic plan to improve the oral health of children in Head Start and Early Head Start.

Participants at the Forum included a broad range of representatives from the Regional Offices of ACF, HRSA, and WIC Program in USDA, State Oral Health Programs, Maternal and Child Health (Title V) Programs, Medicaid and State Children’s Health Insurance Programs, Local Health and Child Care Departments, Community Health Centers, Hospital Dentistry Programs, State Dental Societies, Dental Hygiene and Dental School Faculty, Head Start Training and Technical Assistance Specialists, State Head Start Associations and State Head Start Collaboration Offices, Health Managers with Early Head Start and Head Start Programs, Child Care Health Educators and Consultants, Advocates, and Local Dentists working with Head Start Programs. Sixty-eight participants from New York, New Jersey, Puerto Rico, and the Virgin Islands attended the Regional Forum. A full list of attendees is available in Appendix C.

C. Introduction to Region II Forum

Welcome and Opening Remarks

Mary Anne Higgins, Regional Administrator, Administration for Children and Families, Region II, welcomed participants on behalf of Deborah Konopko, the ACF Regional Director. She highlighted the importance of the wide representation of participants and the group’s unique opportunity to address young children in need, particularly with regard to their oral health care. After acknowledging the solid foundation of work that has been supported by various entities, she shared three goals for the forum: to assess access to care, to identify key players, and to develop a strategic plan. She thanked participants for their willingness to work on the important issue of oral health for Head Start Families.
II. National Perspective: History and Vision for Head Start Oral Health

_**Jane Steffensen, MPH, CHES, Consultant, Head Start and Oral Health Partnership Project,***
introduced Dr. John Rossetti, who before his current role as Oral Health Consultant to the Head Start Oral Health Partnership served as the Maternal and Child Health Bureau’s (MCHB) Chief Dental Officer. Ms. Steffensen shared that Dr. Rossetti would provide a national perspective of the history and vision of the Head Start and MCHB’s collaborative oral health initiatives.

_**John Rossetti, DDS, MPH, Dental Consultant for the Maternal and Child Health Bureau, HRSA,**_ began by sharing three lessons from his experiences working to improve oral health of children: 1) never take no for an answer; 2) follow-up on all work; and 3) people make programs work. He stressed that these three lessons were critical to the success of the MCHB and Head Start Bureau’s (HSB) collaborative oral health efforts that began with the 1999 National Head Start Partners Oral Health Forum. This event revived the formal relationship between the HSB and MCHB and culminated in an Intra-Agency Agreement (IAA) whose purpose was to create a formal relationship between the two Bureaus that would specifically address oral health needs of Head Start children. The IAA created a framework to address specific issues of access, the disconnect between some dental and Head Start communities, and new and established oral health interventions. A copy of the handout illustrating the various activities comprising the IAA can be found in Appendix D.

Dr. Rossetti noted that this Regional Forum is one of the ways the IAA intends to address oral health needs of pregnant women and children in Early Head Start and Head Start at the local, State, and regional levels. Oral Health Forums are being conducted at the State and regional levels as well as with professional organizations. The specific goal of the regional forums has been to identify the issues, barriers, and strategies needed to expand access to dental care and enhance prevention practices for Head Start children and their families. In many instances, the forums have emphasized the importance of considering the partnerships, linkages, and common goals between Head Start, dental communities, and Medicaid, among others.
Since the inception of the IAA, Dr Rossetti noted that these planning efforts have resulted in positive change as a growing number of general dentists, who never before provided dental care to patients in Head Start, are finding the work rewarding and subsequently are serving an increased number of children. In addition, as a direct result of past Regional Forums, HRSA recently began to fund Regional Dental Consultant positions. These part-time consultants are available to support the Head Start Regional Offices in their efforts to promote and implement the recommendations that emerged from their forums. Dr. Rossetti noted that by convening this meeting, Region II would soon be in a position to strategically use the resources of a Dental Consultant who is familiar with the oral health needs of underserved children and their families. He also underscored that the results that emerge from Region II’s work during this time represent one of the final pieces needed to create a national plan to improve the oral health of young children. In conclusion, Dr. Rossetti charged the group to approach its work keeping in mind that change is often incremental and that persistence and effective collaborations can have a long-term positive impact.

III. Best Practices in Oral Health Partnerships: A Community-Based Approach

Following Dr. Rossetti’s presentation, Mercedes Franklin, DMD, MPH, Director of the Bureau of Oral Health, Programs and Policy for the New York City Department of Health and Mental Hygiene, gave an overview of the oral health services provided throughout New York City. She spoke of the evolving role of dental hygienists, from educators who provided broad-based community health screenings in schools and clinics, to critical oral health service providers. The availability of staff to meet the city’s oral health program needs peaked in 1975 when the city’s fiscal crisis affected the services provided by the Department. More recently, the city’s oral health services have expanded and improved once again due to the development of novel programs, new technologies, a commitment by city government to provide support to for this critical dental public health services.

Dr. Franklin explained that the major goal of New York City’s integrated oral health system is to focus on high-risk geographic areas that have limited access to dental care. To meet this need the city supports forty-five community-based clinics and a broad range of programs utilizing
portable equipment. The city also uses mobile dental programs to bring comprehensive prevention, treatment, and referral services directly into high-risk communities. Dr. Franklin then outlined the specific goals of the Preschool Oral Health Program as she highlighted the need to make the program flexible, fun, and educational. She noted that Head Start has been a significant partner in the identification of high-risk children. Direct phone contact or outreach to Head Start programs has enabled the city to gather information on oral health issues in specific communities and leverage resources from numerous community players.

After providing a few examples of how she initiated work with Head Start programs, Dr. Franklin introduced Meryl Hersh, DDS, Regional Dental Director for the Bureau of Oral Health, Programs and Policy in the New York City Department of Health and Mental Hygiene, Region IV Office. Dr. Hersh’s presentation answered the question: “What do we do once we are invited into a Head Start program?” Dr. Hersh reviewed the approaches used successfully in each of the oral health regions in the city. She stressed the importance of on-site education in which Head Start parents receive an information packet with an explanation of Head Start’s commitment to optimal oral health for its children. The parents are asked to send back a consent form and to make an appointment for their child. The children received on site education with a no touch, visual screening at East Tremont Head Start, Educational Alliance, Annunciation Head Start and Graham Wyndham Head Start. Fliers are also widely distributed, and with the support of the Head Start staff, the response is often extraordinary. She explained that New York City’s ability to provide borough-wide screening and education also has been enhanced by its partnership with Colgate-Palmolive’s Bright Smiles, Bright Futures (BSBF) Mobile Dental Program and with the New York Police Department. This summer’s picnics, where approximately 5,000 children were screened, highlighted the challenge of securing signed consent forms, as many children were unable to receive services due to incomplete paperwork.

Despite these challenges, Dr. Hersh noted that partnerships with Head Start Programs throughout the city provide access to care for many children and their families. She mentioned three sites where there is a hygienist providing on-site preventive services during the summer months and referral to nearby OHPP clinics for the year. They are the Vincent Caristo Head Start, Glenwood Family Head Start, and the Sunset Park Head Start. The Hudson Guild Settlement House in Manhattan, which houses seven Head Start programs, provides off-site referrals for dental
treatment to nearby health centers. In the Bronx, children are bussed from other Sharon Baptist Head Start programs, as well as from the community, to Sharon Baptist Head Start #4 for full on-site dental treatment. This partnership has been so successful that Sharon Baptist Head Start is opening a new center and has already committed to include space for another OHPP dental clinic. Dr. Hersh’s final example was an on-site dental clinic at a Head Start center that had opened recently on Staten Island. After treating over 90% of the Head Start children, as well as their siblings, the clinic was opened to the greater community with the result that many additional children and families received services. Dr. Hersh also shared two letters expressing appreciation for the program, which depended upon the support of Head Start and local communities.

Dr. Hersh concluded her remarks by emphasizing the importance of the behavioral changes regarding dental care, diet and prevention that this oral health program has had on very young children. This comprehensive approach makes a positive impact on the oral health of Head Start children and their families that lasts a lifetime. During the question and answer period, Dr. Hersh discussed the sources of funding for the Preschool Oral Health Program and ways to successfully replicate this successful program in other localities.

IV. Region II Head Start Program Information Report (PIR) Data: A Regional Overview

_Amanda Lehrer, M.S.W., Health Content Area Specialist, Region II Head Start_, presented PIR data from New York, New Jersey, Puerto Rico, and the Virgin Islands. Ms. Lehrer began by noting that the Head Start Program Information Report (PIR) is an Office of Management and Budget approved report that collects comprehensive data on the services, staff, children and families served by Early Head Start and Head Start programs nationwide. She explained that all grantees are mandated by Federal regulations to submit a Program Information Report for each year in which they provide services to children and families.

For each State and Territory, she presented information that summarized 2002-2003 enrollment data, the percentage of Early Head Start and Head Start children with health insurance, the number of completed dental examinations, and the number of children diagnosed as needing
dental treatment and receiving dental care. Ms. Lehrer concluded her remarks by stating that the condition of the mouth reflects the condition of the body and is an important indicator for overall health and well being. She stated how health plays an important role in a child’s growth and development. She noted that oral health has been an integral part of Head Start since its inception. Finally, she encouraged participants to use PIR data and other information to transform oral health challenges into opportunities.

Several participants inquired regarding the source and accuracy of the PIR data. Ms. Lehrer reiterated that the data is self-reported and may not accurately reflect an individual participant’s experiences working with local programs. She advised that PIR data can be used in conjunction with other sources of information available in States, Territories and local jurisdictions to make determinations about oral health issues affecting pregnant women and children in Early Head Start and Head Start.

V. A National and Corporate Approach to Collaboration

_Marsha Butler, DDS, Vice President, Global Professional Relations and Marketing Colgate-Palmolive_, focused on her company’s mission to improve oral health through the development of coalitions and oral health education. Dr. Butler provided a brief background of the company’s evolution from a producer of soap and toothpaste to its current role as a company striving to positively affect global oral health. She noted that Colgate-Palmolive’s mission in the United States is to “demonstrate that coalitions of organizations can work together to improve the oral health of our children” including educators, dental professionals, communities, and parents. Since 1991, Colgate-Palmolive’s most extensive programs have been school-based prevention programs. Dr. Butler explained that, based on a comprehensive evaluation of the Bright Smiles, Bright Futures initiative, Colgate-Palmolive began working with Head Start programs using classroom, home, and dental profession components. The company also funds a grass-roots approach by supporting access to oral health care through a mobile van program. Throughout her remarks, Dr. Butler emphasized the need for partnerships and collaboration to improve oral health.
VI. Road Map for the Forum: Process and Goals

Next, Ms. Steffensen reviewed the Region II Forum goals and provided directions for the assigned breakout groups. The discussions during the two days focused on challenges and promising practices as well as the identification of priorities and development of specific action steps for prevention, oral health education, and access to dental care. She encouraged participants to build upon promising practices that currently exist within the Region, and elsewhere, as well as to consider new partners and additional resources. The recommendations that emerged from this Forum will be integrated with the outcomes of previous Forums and will ultimately result in National recommendations.

VII. Summary of Small Group Discussions to Identify Challenges, Promising Approaches, Strategies, and Action Steps

Following the plenary sessions, participants met in three groups to identify Region II challenges and obstacles, as well as promising practices and resources related to three areas: prevention, oral health education, and access to dental care. The results of the discussion on the first day were compiled and distributed to participants prior to their deliberations on day two of the Forum when the groups reconvened to develop specific regional strategies to address the priority issues identified the previous day.

Due to both the diversity of the needs of a region consisting of two States and two Territories with different resources and infrastructures and the high degree of interest by all participants, the discussions that emerged from each group were complex. Often strategies and best practices emerged during the discussion of challenges, and the breakout session participants revised some of their assumptions from day to day. Complete notes from each breakout group are included in Appendix E. However, for purposes of this report, the discussion is summarized in a linear fashion that captures the major themes and recommendations of each group. Although time was allotted for the States and Territories to meet among themselves during an extended lunch so they could discuss development of grant applications for upcoming State and Territorial Forums, those discussions are not included in this Report.
Group 1: Prevention

According to findings from national surveys reported by the National Center for Health Statistics, Centers for Disease Control and Prevention, close to 20 percent of preschool children (2-4 years of age) have tooth decay, with 50 percent developing tooth decay by the third grade, and nearly 75 percent by age 15. As these statistics refer to the general population it is safe to assume that the at-risk children in Head Start have an even greater need for early intervention and prevention. The breakout group assigned to this topic was well aware that with proper prevention, such as regular check-ups, brushing, use of fluorides, and application of dental sealants, the risks of dental disease would be greatly reduced among children. Their goal was to prioritize preventive strategies that would have the most significant impact on Head Start children and their families.

This group considered numerous challenges and obstacles related to prevention for Head Start children. After some discussion on the importance of establishing dental homes, the participants concluded by identifying four priority areas that Head Start programs could focus on:

- Maximizing early prevention opportunities.
- Utilizing appropriate fluorides.
- Exploring holistic approaches.
- Increasing funding for prevention.

These priorities were a distillation of the discussion that touched on a number of aspects of prevention for Head Start children. Some of which are summarized in the next section.

Promising Approaches

The group reviewed a handful of existing promising approaches. Participants easily identified alliances and relationships with local dental societies that have provided assistance on advisory committees and coalitions to increase community awareness of Head Start and its challenges in meeting the oral health needs of enrollees. Participants also discussed the successes of a number
of school-based programs that include oral health education, fluorides, and dental sealants. One promising program mentioned was “Healthy Mouths/Healthy Babies” through New York University and Clinton County, New York Health Department. Lastly, the group discussed the need to disseminate national guidelines on oral health standards of care more efficiently, and to maximize opportunities for more comprehensive data collection.

**Priority One: Maximizing Early Prevention Opportunities**

Since the group agreed that prevention needs to begin prenatally or during early infancy, they decided that a priority would be to develop strategies for linking and collaborating with other service providers such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), prenatal care providers, Medicaid, TANF, hospitals, and health care providers in order to identify pregnant women and infants and to provide them with one consistent oral health message that promotes evidence-based practices. The group discussed the need to create an environment in which prevention of oral disease is valued throughout the Head Start program. In addition, they supported the goal of providing each child with a dental home. The group identified numerous steps to maximize early prevention opportunities: including networking and collaboration, emphasis on performance standards, and the development of improved oral health data and information.

The **Action Steps** for each of these categories include the following strategies:

- **Networking/Collaboration**
  1. Participants first discussed the need to establish better referral networks across programs serving the same population (e.g. child care programs and pre-kindergarten programs that feed into Head Start programs).
  2. They considered ways to build upon linkages with local health departments (linkages already exist for immunization, lead poisoning, early intervention, etc.), resource centers, and other agencies and organizations to distribute and cross-reference their respective materials.
  3. Finally, participants decided that Head Start programs could do more to foster the connection between providers and families.
Networking ideas included mobilizing Head Start Health Services Advisory Committees, offering continuing education programs on proven prevention strategies, and promoting promising practices such as “Adopt a Center” and “Lift the Lip”.

- **Strengthening Performance Standards and other Oral Health Guidelines**
  Group members felt that proactive action regarding performance standards would be an excellent way to address prevention. They noted that if oral health messages and education was specifically included in performance standards or other guidance, programs would prioritize oral health care early on in their work. Furthermore, many group members suggested that national standards for EPSDT guidelines become part of the standard package. Two recommendations that emerged from the discussion were for the Head Start Bureau to:

  1. Issue a Head Start Information Memorandum (IM) on Oral Health.
  2. Encourage programs to integrate oral health into their general health assessments as soon as possible. For example, investigate the feasibility of putting oral health and health screenings on the same cycle as the required developmental assessments, i.e., 45 days rather than 90.

- **Information/Data**
  Increasing access to timely and accurate scientific information on preventive measures was determined to be an important action step. The group discussed how the production and dissemination of this information was also important. Some of the data the group thought should be collected and analyzed were:

  1. Community water fluoridation
  2. Family health practices (use of fluoride toothpaste and dietary fluoride supplements)
  3. The application of sealants and fluoride varnishes
  4. Treatment of early childhood caries

Finally, participants suggested examining the results from Head Start Program Information Report (PIR) to determine how and when data are collected and whether the data accurately represent the issues faced by Early Head Start and Head Start programs.

- **Providers/Provider Training**
  Action steps on ways in which providers could contribute to preventive care included:
1. Expanding the scope of practice by Registered Dental Hygienists (RDH) to assure access to preventive services by pregnant women and children in Early Head Start and Head Start (a strategy not allowed under current practice acts in many States).

2. Encouraging dental and dental hygiene students to provide preventive services to pregnant women and children in Early Head Start and Head Start programs as a part of their opportunities for service learning and community-based education.

Another priority that was mentioned was the importance of fostering an environment where prevention of oral disease is valued by the population. Ideas for achieving this include communicating the importance of oral health via the media and seeking grant funding for information dissemination.

**Resources and Collaboration**

Participants identified numerous potential collaborators to assist Head Start with action steps related to prevention these included other health-related disciplines, other service and support programs, OB/GYNS, pediatricians, nurse midwives, nurse practitioners, general dentists, and dental hygienists, and dental hygiene and dental schools, and other training programs. A host of opportunities for emphasizing the prevention of oral disease already exists within Head Start programs including utilization of its nutrition, health, and education components; Health Services Advisory Committees; parents; and families. Other collaborators mentioned were State Maternal and Child Health Title V programs, HRSA grantees, Title XIX Medicaid programs, Head Start Associations, Head Start Publication Center, National Maternal and Child Health Oral Health Resource Center, WIC, Family Planning, TANF, departments of social services, prenatal programs and clinics, nutritionists, other child care providers, and local health departments. These collaborators could provide funding or other support to the prevention activities outlined previously.

For example, existing channels of communication (i.e., the Head Start Information and Publication Center) should be used as a mechanism to distribute or link consumers to pertinent Head Start oral health literature (e.g., Oral Health Tip Sheets for Head Start Staff) that is available through HRSA’s Maternal and Child Health Information Center.
Priority Two: Use of Fluorides

The second priority for the prevention group was promoting community water fluoridation and appropriate use of fluoride toothpaste, dietary fluoride supplements, and application of fluoride varnish. The group identified action steps to achieve the overall strategy of providing communities and families with scientific information and education regarding fluorides.

Action steps can be categorized as programs, information, and other opportunities.

- Programs
  Due to the success of many school-based fluoride programs, participants suggested expanding fluoride programs to all of the Region’s Head Start programs by promoting the appropriate use of fluoride toothpaste, dietary fluoride supplements including fluoride drops and tablets, and application of fluoride varnish. Participants also determined a need for funding to support the expansion of fluoride varnish programs for high-risk preschool children.

- Information
  Similar to the group’s early prevention discussion, group members felt it imperative to give parents and communities more timely, scientific, and accurate information regarding community water fluoridation, fluoride varnishes and family health practices—including toothpaste, bottled water, dietary fluoride supplements and fluorosis. They also identified the need to monitor promising research (e.g. FDA approval for fluoride varnish products).

Collaborators and Resources

Participants identified numerous potential collaborators including State and local health departments, water companies, local governments, media, Consumer Affairs, EPA, Medicaid, WIC, and the Head Start Publication Center. The group also discussed leveraging resources from the media, the Centers for Disease Control and Prevention, the Food and Drug Administration, the National Institutes of Health, and the National Maternal and Child Health Oral Health Resource Center at Georgetown University.

Priority Three: Holistic Approaches

The discussion of early prevention and fluoride inspired the group to focus next on holistic approaches to prevention. The group defined this overarching strategy as focusing on building
greater connections between medical and oral health providers, emphasizing the relationship between oral health and general health, and acknowledging and respecting the influence of culture and religion on oral health. The theory is that building better collaborations between medical and oral health providers and strengthening the relationship between oral health and general health will yield better oral health outcomes for Head Start children.

**Action Steps** revolved around collaborative activities including:

- Incorporating oral health as an element of interagency agreements with State/Territorial child care agencies, Department of Education, Department of Health, and WIC.
- Involving Head Start in oral health planning processes and coalitions at the Regional, State, Territorial, and local levels.

Participants also suggested educating dental, pediatric, and family practice residents on oral health issues, perhaps by having Head Start programs serve as a community practice site and by researching other funding sources to support this holistic approach, possibly through the CDC and other entities. In addition, the Prevention Group acknowledged the influence of cultural and religious factors on prevention. With this in mind, an important step will be to develop information regarding the impact of culture and religion on oral health practices.

**Collaborators and Resources**

Participants identified the following as potential collaborators: New York State Education Department, New York State Dental Association, New Jersey Board of Dentistry, New Jersey Dental Association, American Dental Education Association (and affiliated training programs for dental professionals), accreditation bodies, child care, and WIC. They also identified resources including the National Center for Cultural Competency at Georgetown University, Head Start Associations, and the Association for State and Territorial Dental Directors.

**Priority Four: Funding**

The group did not have sufficient time to adequately discuss funding issues as they relate to prevention, but felt it imperative that funding be listed as a priority. They suggested that the Head Start Regional office and local Head Start programs be made aware of funding
opportunities for prevention activities as well as funding streams that could assist providers who struggle to receive reimbursement for prevention activities.

Other *Action Steps* included:

1. Enlisting assistance from the Head Start State Collaboration Offices to disseminate information to the Early Head Start and Head Start Programs.
2. Requesting that Head Start be included in solicitations.
3. Locating support for dentists who need assistance with processing reimbursement for preventive services.
4. Helping providers gain access to managed care networks.

*Collaborators and Resources*

Due to limited time, the group simply mentioned potential collaborators including Head Start State Collaboration Offices, State Oral Health Programs, MCH Title V, Medicaid, State Children’s Health Insurance Programs (SCHIP), and managed care directors.

**Group 2: Oral Health Education**

The breakout group assigned to discuss strategies on oral health education represented all States and Territories. Their deliberations were thoughtful and complex and reflected their individual experiences in providing services to pregnant women and their children enrolled in Early Head Start and Head Start. The group came to an early consensus that defining the audience for oral education was a key challenge. Another important challenge was the variety of levels of oral health information needed, including educational materials for the child and his or her family; the Head Start caregivers, teachers, and program staff; other health professionals; the larger community; relevant legislators; and health policy makers. In light of this extensive list of audiences, the challenges and issues related to education were broad in scope and were discussed at length by the group. The consensus of the group was that by brainstorming all the issues related to oral health education they could generate a list from which to cull their priorities. For purposes of this summary, these issues are divided into broad categories related to the content of oral health education and information; various delivery methods; and the unique characteristics
of different audiences. Some of the many issues discussed on Day One are summarized in the next sections and outlined in detail in Appendix E.

**Challenges and Issues Related to Oral Health Education**

Group discussion on the content of oral health educational needs was engaged and detailed. Participants noted that even among health and dental professionals, conflicting oral health messages are being communicated to patients and the public. For instance, the American Academy of Pediatrics and the American Dental Association promote different standards of care for children. The group noted that recent reports including *Oral Health in America: A Report of the Surgeon General* and *National Call to Action to Promote Oral Health* should guide the development of a consistent oral health message. In addition, the group discussed the need for culturally-appropriate oral health materials. Considering the diversity of languages, literacy levels, and cultures present throughout the region and the need to find innovative culturally-appropriate ways to engage families is critically important. Overall, the need for consistent, culturally-appropriate oral health messages was a common theme throughout each of the educational priorities.

Due to the different educational, linguistic, and literacy levels of the different audiences for oral health educational materials, the group discussed numerous ways in which information could be disseminated. Some of the suggestions included greater use of photographs and posters in multiple languages including English, greater use of posters in nontraditional settings, and a national multimedia campaign. The group also recognized that incorporating oral health content into the curriculums for health professionals including medical schools would be an effective model. In addition, partners such as school advocates, nurses, and social workers could be trained to deliver consistent oral health messages.

The group agreed that cultural competency is needed in order to recognize the unique needs of specific populations and target educational messages appropriately. For example, the health decision-maker in some cultures and traditions is the father or grandmother, and targeting health messages to resonate with these different audiences is important. In addition, those who develop educational materials must be sensitive to different cultural backgrounds involving diet and food groups. Some families need more information on child development or strategies to soothe a
child without using a bottle. However, if the audience is composed of legislators, it is important to know what motivates them and to frame the oral health materials in a way that is relevant to them. For example, legislative information should stress the value of oral health and data demonstrating that prevention saves money. In essence, educational materials must take into account the needs of the audience in order to be effective.

**Identifying Priorities**

In light of the many aspects of oral health education, the group determined that it was best to develop educational priorities that would increase the capacity of the health care system to improve the oral health of Head Start children. Initially, the breakout group sorted all the issues discussed into four main categories. These four broad categories were: infrastructure (which was described as being comprised of both workforce and resources); communication, education, and research. (Ultimately the group agreed to combine the communication and education topic areas.) Next, the group discussed what was meant by each of the categories. Infrastructure was defined as the people or personnel involved in educating the public on oral health issues. Communication and education methods were defined as strategies that impart culturally- and age-appropriate information about the importance of oral health to positively influence individual oral health behaviors and attitudes among those associated with Early Head Start and Head Start. Finally, oral health research was defined as the exploration and development of new knowledge regarding oral health. Using these categories attendees then participated in a nominal group process to identify the top priority in each area for further discussion on Day Two. The priorities that emerged were as follows:

- The top priority under infrastructure was to build the capacity of those working with Head Start programs to provide earlier intervention.

- Two priorities emerged from the combined communication and education area: first, the importance of developing a partnership between WIC and Head Start; and second, the need to address the dental workforce shortage through a) educational incentives for dental students, b) the education of non-dental providers on importance of oral health, and c) continuing education for practicing dental professionals.

- With regard to research, the group said the priority activity should be to create, evaluate, support and promote innovative models that lead to improved oral health outcomes.
Strategies and Action Steps

On Day Two, the group discussed the appropriate strategies and action steps for each of these priorities. They were reminded to focus on activities that Head Start could address, especially at the Regional level. In addition, when time permitted specific collaborators and resources were identified by the group.

Priority One: Build the capacity of those working with Head Start programs to provide earlier intervention

Independent of the prevention breakout group, the education group reached consensus that Early Head Start programs should begin intervention education prenatally with parents and caregivers. They agreed that oral disease is well established among many young children by the time they reach Head Start. They identified two specific concurrent action steps to achieve this goal:

1. Work with the infrastructure of Early Head Start programs to identify and educate pregnant women and their partners.
2. Establish programs where pregnant women meet with a health coordinator, who could introduce oral health concepts in an appropriate way and inform the parent about how oral health affects the child throughout his or her life.

Collaborators and Resources

In order for this outreach to be effective, the participants suggested that Head Start collaborate with dental consultants or other dental education or research organizations to evaluate current materials and develop a contemporary curriculum regarding early intervention that can be used specifically by Early Head Start staff. Other collaborators for this effort could include Head Start Health Services Advisory Committees, Departments of Health, WIC programs, academic institutions, and dental professionals.

Priority Two: Develop a formal partnership between WIC and Head Start

The group was fortunate to have a participant with extensive background with the WIC program. This participant described WIC as a Federal program supported by the U.S. Department of Agriculture to provide food vouchers to pregnant woman and mothers with children up to age five at local clinics. The clinics provide mandatory nutrition counseling and monitor the
family’s food consumption. She noted that WIC nutritionists use a standardized curriculum, however, oral health is not regarded as a priority for WIC. In light of this information, the education group decided that an overall strategy for this goal would be to create the supports for WIC and Head Start to develop an oral health education component for use in WIC clinics.

Some of the Action Steps discussed included:

1. Supporting an Interagency Agreement between WIC (Department of Agriculture) and the Head Start Bureau (Department of Health and Human Services).

2. Developing mechanisms to support community partnerships at the local level to connect WIC programs to their local Head Start Programs.

3. Inviting WIC to serve on the National Head Start Oral Health Committee in order to integrate an oral health curriculum for use by Head Start and WIC.

Priority Three: Address the shortage of dentists through financial incentives for dental students and the education of non-dental providers on the importance of oral health

The group discussed broad strategies to meet this educational priority. They suggested that efforts be made to disseminate information to educate dentists and non-dental providers on the oral health needs of Head Start children and increase the capacity of Head Start to case manage access to dental care and education regarding oral health.

Specifically, they suggested the following Action Steps:

1. Educating National Health Service Corps members regarding Head Start and Early Head Start and the needs that exist in this population for oral health services.

2. Educating policy makers to designate Head Start as a Health Profession Shortage Area population.

3. Collaborating with other organizations to provide dental school scholarships and loan repayment with a commitment to provide services to underserved Head Start areas.

4. Creating incentives for pediatric dentists already in practice to provide services to Head Start programs.

In addition to the above steps, there was further discussion on education for target audiences who were not dentists. The group discussed a need to educate the public on the importance of oral
health and suggested a long-term goal of a national media campaign to improve the health awareness of the public regarding oral health. The group recognized that components of this action step must incorporate elements of health literacy and be culturally- and age-appropriate in order to reach particular audiences. They suggested a short-term goal, for the Regional Offices to develop a unified oral health message to be disseminated in multiple ways. It was suggested that this oral health message be in the form of a resource package that is flexible enough for use in different parts of the country and with different age groups. Overall, they agreed that the Head Start Bureau must work with other national partners to make a policy decision regarding the requisite components of any oral health curriculum on early intervention.

This group also discussed ways to enhance the oral health education for allied health professionals. They discussed a long-term goal to include oral health training in all allied health professions and social work curriculum covering issues such as early intervention and prenatal care. The consensus was that this information should be in three different curricula; one for children and their parents, another for continuing education courses for practitioners, and finally training for Head Start staff.

**Collaborators and Resources**

These education strategies would require collaboration among the National Health Service Corps, the Head Start Bureau and Regional Offices, the Deans of Dental Schools, academics, the American Medical Association, the American Dental Association, the American Dental Education Association, corporations, news outlets, and others.

**Priority Four: Create, evaluate, support, and promote innovative models that lead to improved oral health outcomes.**

Unsure of the ethical ramifications of this priority, the group suggested that Head Start and Early Head Start programs be included in oral health research studies and as a mechanism to translate and apply oral health research findings. The group felt that the health requirements of the program, coupled with the capacity for case management, made Head Start programs ideal for noninvasive oral health research. The group suggested that Head Start programs could contribute to the following potential research questions:
1. Understanding oral health outcomes among Head Start cohorts.

2. Identifying successful strategies to improve parental involvement.

3. Disseminating cutting edge oral health information and prevention strategies to children and families in a culturally competent manner, including new and emerging knowledge on the transmissibility of caries causing flora within families and on the relationship between oral health and low birth weight.

Collaborators and Resources

For this research, academic institutions, universities, research institutes, hospitals, and clinics would need to collaborate and seek resources from the National Institute for Dental and Craniofacial Research (NIDCR); corporations; Federal, State and local governments; foundations such as Robert Woods Johnson Foundation; health insurers and HMOs.

Group 3: Access to Dental Care

Participants all agreed that access to care is a major obstacle throughout the Region. Their initial discussion of the challenges was far reaching and the complete notes from their deliberations are outlined in Appendix E. After reviewing their list, participants determined the need to focus their discussion by categorizing the issues into three overarching priorities:

- Adequate and timely reimbursement
- Elimination of barriers
- Increased capacity

Participants in the access group identified strategies and action steps for the first two priorities and integrated components of priority three into them.

Promising Approaches

A number of strategies to improve access to oral health care for Head Start children were discussed in the breakout sessions. Among the numerous existing promising approaches identified were: the Children’s Dental Access Program’s Parent Orientation Packet (New York 4th District Dental Society); New York City Department of Health, Oral Health Program with
Head Start; local Head Start Oral Health Programs in New Jersey; New Jersey Oral Health Coalition; and “Give Kids a Smile”. Participants also discussed opportunities to use local Head Start programs as a model for all children’s oral health programs, since Head Start is able to leverage outside resources, integrate oral health into social services, bring advocacy groups together, and develop linkages with WIC.

**Priority One: Adequate and Timely Reimbursement**

Group participants felt that this fiscal challenge affects providers’ ability to provide dental care to pregnant women and children in Early Head Start and Head Start more than any other barrier. The group discussed the need to increase overall funding for services through the following **Action Steps:**

1. Increasing provider fee schedules and reimbursement levels.
2. Targeting fees to increase incentives for providers to serve areas of critical need.
3. Advocating for Federal influence on State Medicaid and SCHIP reimbursement levels.
4. Training Head Start staff to enroll children in third party oral health reimbursement plans, such as Medicaid and SCHIP.

In addition to mechanisms for directly providing reimbursement to providers, the group identified a need for a support structure to report oral health data. Participants discussed how the current haphazard reporting system frequently hinders reimbursement. To overcome this barrier, the group considered methods to facilitate better reporting by streamlining Head Start forms and reporting mechanisms, as well as creating methods of oversight to ensure accountability and quality dental care.

Much of the group’s discussion of priorities was based on the assumption that the best way to assure increased access is through legislative change. This change will have to be based on persuasive, complete, and accurate data on the oral health needs of children; indicators showing that preventive measures save money, and evidence of how adequate reimbursement could improve the oral health of all children. The group then identified several data collection strategies that they felt were necessary. These **action steps** would ultimately result in increased payments for services and include:
- Collecting and reporting more accurate data on the oral health program in Medicaid and SCHIP.

- Collecting information in Head Start programs about the number of children and pregnant women enrolled in Medicaid and SCHIP as well as the number needing treatment and the number of children who do and do not receive needed treatment.

- Clarifying through specific guidance, the expectations related to oral health screenings and examinations in Early Head Start and Head Start and how these relate to guidelines for coverage under Medicaid.

- Developing training manuals that standardize the reporting of oral health data.

- Incorporating information into Head Start Reports about barriers faced by Head Start programs and families when trying to access dental care and include information on the completion, scheduling, waiting periods, and travel times to receive dental examinations and treatment, and the time taken to complete all treatment.

**Collaborators and Resources**

Participants identified many collaborators in various arenas. Within Head Start, the group discussed collaborating with Regional Offices, the Head Start Training and Technical Assistance Network, and State Head Start Collaboration Offices. The group also suggested HRSA; State Dental Associations; Maternal and Child Health Consortium; State Medicaid/SCHIP programs; WIC; Federally Qualified Health Centers; State and local Health Departments; State Oral Health Coalitions; and the State Early Childhood Comprehensive Systems (SECCS) initiative. In addition, the group identified numerous resources that would facilitate much of this work, including a comprehensive data collection system, a tool or mechanism to demonstrate low-cost and no-cost options, and training and technical assistance.

**Priority Two: Elimination of Barriers**

After discussing alternatives and support systems to increase reimbursement, the group discussed strategies for eliminating barriers to care for both patients and providers. While brainstorming on barriers, the group concurred that use of best practices could help eliminate many barriers. For example, the group advocated combining medical and dental examinations to ensure that more children receive adequate care to meet the oral health Performance Standard. Next, the
group discussed eliminating barriers through better communication, coordination, accountability, and provider capacity. The **Action Steps** are defined as follows:

The group felt that clear and consistent communication to all parties would assure access to care by decreasing confusion and increasing utilization. Those parties include patients and their families, providers, and Head Start staff. The group discussed ways to increase communication between groups by:

- Encouraging attendance at meetings of associated groups.
- Using online “Find the Head Start Program” resources.
- Compiling and cross-listing a centralized directory of oral health providers accepting Head Start clients on Web sites.
- Recommending that State Primary Care Associations link with their State Head Start Associations and Collaboration Offices.

Another strategy discussed was increased coordination and case management services. The group felt that Head Start staff could increase efficiency within the program by coordinating the following activities:

- Scheduling appointments and transportation
- Bringing children together to the provider’s office so that more children could be provided dental care
- Standardizing all pertinent forms and administrative processes
- Supporting linkages between HMO Care Coordinators, Head Start staff, and oral health providers
- Ensuring that the managed care and HMO system has a Head Start contact.

The group recognized that in order for Head Start Family Advocates and Family Workers to assume these additional responsibilities, they must receive adequate compensation, requiring additional program funds.

In light of the complexity of the reimbursement process, the group felt strongly that accountability of third party payers was a significant barrier for both patients and providers.
Participants discussed numerous strategies to create a system of accountability for third party payers. The basis of these strategies is that accessibility must be a contract requirement. The group then proposed two mechanisms to ensure that this requirement is met:

- Identifying an ombudsman outside of the third party payer to facilitate resolving problems. (The group stated that HMOs should be the entity to fund this ombudsman).
- Implementing or reactivating a State and Federal agency to mandate compliance to their contracts by third party payers through fines, revocation, and the like.

Due to a lack of time, the participants decided to integrate their fourth priority area (increased capacity) into their discussion. Because lack of provider capacity is often a barrier to dental care, this discussion appropriately fit into the group’s deliberations. Though this group viewed reimbursement difficulties as the primary barrier for providers, they recognized that provider capacity also limited access to dental care for pregnant women and children in Early Head Start and Head Start.

**Priority Three: Increased Capacity**

The group discussed a variety of financial incentives and continuing education opportunities that would increase the number of providers willing to provide dental care to pregnant women and children enrolled in Early Head Start and Head Start. These *Action Steps* included:

1. Providing tax credits to providers of dental care for pregnant women and children enrolled in Head Start
2. Offering loan forgiveness to practitioners working in underserved areas
3. Informing local leaders on need and support
4. Educating dental societies regarding the need for services and encouraging them to provide appropriate incentives such as continuing education courses
5. Encouraging institutes and funding organizations to provide grants for continuing education in pediatric dentistry (e.g., New York State Dental Foundation)
6. Increasing corporate support (e.g. creative technology such as continuing education courses via teleconference).
Participants felt that these strategies would create a better system and encourage providers to expand access to dental care for participants in Head Start.

**Collaborators and Resources**

The group identified a number of collaborators including SCHIP, Medicaid, CMS, and the New York State Dental Foundation. Participants reiterated the need to increase communication between the various interest groups and offered a few ways to facilitate interaction, such as cross-listing State Dental Associations and Head Start programs on Web sites; linking State Head Start Associations and Head Start Collaboration Offices; and linking with Federally Qualified Health Centers and “Look-Alike” Health Centers and Dental Clinics (health centers with dental clinics that are funded by local, State, or nonprofit organizations but to do not meet the criteria to be a Federally Qualified Health Center.)

Mindful of the interrelatedness and overlap of these issues, the group concluded its work with a general summary:

- Simplify and streamline the oral health care system to assure that more children and pregnant women receive needed dental care.
- Provide incentives for providers of dental care for children and pregnant women in underserved communities.
- Bolster enrollment, case management, outreach and education.
- Help families understand how to use the oral health system.
- Provide training and technical assistance for oral health providers and health care systems working with Head Start.
- Provide training and technical assistance for Head Start parents and staff regarding oral health care.
- Advocate for improvements in the oral health care system to make it more accessible for children and families.
VIII. Closing Remarks and Next Steps

*Jane Steffensen, MPH, CHES, Consultant, Head Start and Oral Health Partnership Project,* asked all forum participants to feel free to share and reflect on their deliberations. After representatives from the three small groups presented brief summaries of their discussions, Ms. Steffensen thanked them for their work and invited Dr. Rossetti to speak.

*John Rossetti, DDS, MPH, Dental Consultant for the Maternal and Child Health Bureau,* commented that the fruitful dialogue of the past two days was only possible by convening attendees from throughout the region. He briefly outlined next steps, which included the development of a report summarizing the forum and a meeting with the Head Start Regional Office to review the forum’s recommendations and identify priorities for implementation. He also encouraged States and Territories to consider holding a State forum, if they have not already done so. He stressed the need to work at the local level, “connecting the dots,” and re-emphasized the importance of follow-up and working toward incremental change. He concluded with the following charge to participants, “It’s you who will make these Head Start Oral Health partnerships work to improve the oral health of pregnant women, young children, and their families.”
Appendix A: DHHS Region Map
Regional Forums on Enhancing Partnerships for Head Start and Oral Health

State and Territorial Head Start Oral Health Forums

*Not Funded by ASTDD

**Cycle 6 Proposals Due October 29, 2004

Forum Funded (Cycles 1-4)
No Forum Planned**
Appendix B: Agenda
Goals and Agenda

Region II Administration for Children and Families and
Maternal and Child Health Bureau, HRSA
U.S. Department of Health and Human Services

“Enhancing Partnerships for Head Start and Oral Health”
Regional Forum on Head Start and Oral Health

Ted Weiss Federal Building
290 Broadway at Dwayne
30th Floor
New York, New York 10278

The goals of the Regional Forum are to:

- Assess access to care and other issues that may improve or detract from oral health education, prevention, and clinical services available to the Head Start and Early Head Start populations.

- Develop a strategic plan for the region that includes assessment of current regional oral health issues, and identification of promising practices to address challenges throughout the region.

- Identify strategies and the key roles of regional agencies and other entities for future action.

- Contribute to the development of a national strategic plan to improve the oral health of children and pregnant women in Early Head Start and Head Start.

October 18 and 19, 2004
New York City, NY
Agenda

Day One – Monday, October 18, 2004

12:30 - 1:00 pm  Registration  Thirtieth Floor – Prefunction Area

1:00 - 1:15 pm  Opening Plenary Session  Conference Room 1 & 2

Welcome and Opening Remarks
Mary Ann Higgins  Administrator, Administration for Children and Families, Region II

1:15 – 1:45  History & Vision for Head Start Oral Health

National Perspective
Moderator
Jane E. M. Steffensen,  Consultant, Head Start and Oral Health Partnership Project
John Rossetti, DDS,  Dental Consultant for the Maternal and Child Health Bureau, HRSA

1:45 – 2:15  Best Practices in Oral Health Partnerships: A Community Based Approach
Dr. Mercedes Franklin  Director of Medical Affairs, Bureau of Oral Health
Dr. Meryl Hersh  Regional Dental Director, Bureau of Oral Health

2:15 - 2:30 pm  Region II Head Start PIR Data: A Regional Overview
Amanda Lehrer, M.S.W  Health Content Area Specialist, Region II Head Start

2:30 – 3:00 pm  A National and Corporate Approach to Collaboration
Dr. Marsha Butler  Colgate Bright Smiles Bright Future Project

3:00 - 3:15 pm  Road Map for the Forum: Goals and Process
Jane E. M. Steffensen,  Consultant, Head Start and Oral Health Partnership Project

3:15 - 3:30 pm  Break (with Refreshments)

3:30 - 5:30 pm  Session I–Small Group Discussions: Challenges & Promising Approaches

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Each group will:
- Identify Issues (e.g., Challenges or Obstacles)
- Prioritize 3-5 Issues
- Identify Promising Approaches
5:30 - 6:00 pm  Reports from Small Group Discussions  Conference Room
Moderator
Jane E. M. Steffensen, MPH, CHES
Consultant, Head Start and Oral Health Partnership Project

Evening  Dinner on Your Own

Day Two – Tuesday, October 19, 2004

8:00 - 8:30 am  Continental Breakfast  Prefunction Area

8:30 - 9:00 am  Plenary Session - Day One Review  Conference Room
Moderator
Jane E. M. Steffensen, MPH, CHES
Consultant, Head Start and Oral Health Partnership Project

9:00 - 10:15 pm  Session II - Small Group Discussions: Strategies, Action Steps, Resources, Collaboration and Leadership

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Each group will:
- Identify an overall strategy for each priority issue
- Outline specific action steps, resources needed and roles of regional agencies and other entities required to implement strategies

10:15 – 10:30 am  Break (with Refreshments)

10:30 – 11:45am  Small Group Discussion (Continued)

11:45 – 1:00 pm  Lunch - State/Territorial Working Sessions  Prefunction Area

1:00 - 2:00 pm  Small Group Discussion (Continued)

2:00 – 3:15 pm  Closing Plenary Session  Conference Room
Reports from Small Groups
Moderator: Jane Steffensen

Closing Remarks and Next Steps
John Rossetti, DDS, MPH

3:15 – 3:30 pm  Forum Evaluation and Adjournment  Dental Consultant for the Maternal and Child Health Bureau, HRSA
Appendix C: Participant List
Enhancing Partnerships for Head Start and Oral Health

A Region II Forum on Head Start and Oral Health

Ted Weiss Federal Building
New York, NY
October 18-19, 2004

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Appendix D: Intra-Agency Agreement Activities
Head Start / Oral Health Collaborative Projects

- ASTDD/State - Forums
  - Models
  - Advisory Comm
    - Ohio
    - Expertise

- MCHB - Expertise to HSB
  - Regional Experts

- MCHB - Resource Center
  - Policy Center
  - Pediatric Dent Training

- Head Start integrated into MCHB Grants
  - Current
  - Future

- Professional Organization Forums on Head Start and Oral Health

- Regional Forums on Enhancing Partnerships for Head Start and Oral Health
Appendix E: Group Discussions
**Topic Assigned to the Group: Prevention**

<table>
<thead>
<tr>
<th>Issues [List Issues]</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Goal is for a “Dental Home” – similar to a “Medical Home” for Head Start Children</td>
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<tr>
<td>- Change EPSDT guidelines if they do not require early screening</td>
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<tr>
<td>- Begin earlier with prevention. EHS is the perfect opportunity to begin with pregnant women to begin prevention prenatally (Ex: NYU and Clinton County programs in NY)</td>
</tr>
<tr>
<td>- Lack of information on fluoridation, especially in rural areas.</td>
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<tr>
<td>- Fluoridation and fluoride supplements.</td>
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<tr>
<td>- Drops, tablets and rinses – new approach is varnishes</td>
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<tr>
<td>- Lack of information available to communities that want to maintain fluoridation or begin fluoridation</td>
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<tr>
<td>- Almost had to stop giving fluoride supplements in HS due to the medication training requirements</td>
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<tr>
<td>- Information for parents</td>
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<tr>
<td>- Community by community approach is not effective – need a statewide approach</td>
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<tr>
<td>- Fluoride in bottled water – uncertainty because not labeled</td>
</tr>
<tr>
<td>- Issues about using too much toothpaste</td>
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<tr>
<td>- Payment of the dentist when child is uninsured.</td>
</tr>
<tr>
<td>- Pregnant women and liability issues for doctors and dentists –</td>
</tr>
<tr>
<td>- Lack of guidelines</td>
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<tr>
<td>- Not sure what should be done for pregnant women</td>
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<tr>
<td>- Parents need to know and be involved in dental health education</td>
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<tr>
<td>- How to identify caries</td>
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<tr>
<td>- ECC – nursing bottle syndrome</td>
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<tr>
<td>- Discouraging thumbsucking</td>
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<tr>
<td>- Discourage tongue-thrusting</td>
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<tr>
<td>- Lack of understanding of the relationship between oral health and general health.</td>
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<td>- Varnishes and sealants – insurance will not pay for earlier age groups.</td>
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<td>- Exceptions can be made only in special circumstances.</td>
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<tr>
<td>- Only permanent molars can be covered</td>
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<tr>
<td>- More cost effective</td>
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<tr>
<td>- School-based services (strategy – advocate for more $$ for programs.)</td>
</tr>
<tr>
<td>- NC study uses pediatricians and NPs to apply varnish from preschool children</td>
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<tr>
<td>- Transmission issues of common parenting practices that spread oral bacteria</td>
</tr>
<tr>
<td>- Issues about what crosses placental barriers and what is harmful to young, developing teeth.</td>
</tr>
<tr>
<td>- Dialog between pediatricians and dentists/between medical and dental homes. Failure to look in the mouth when the pediatricians do a physical exam. (Strategy: Hold people accountable for their practice. Include oral health topics in pediatrician training. Look at teeth before tonsils. Most children see a pediatrician before a dentist.)</td>
</tr>
<tr>
<td>- Holistic approaches to child’s health.</td>
</tr>
<tr>
<td>- Cultural and religious issues</td>
</tr>
<tr>
<td>- Children with special needs – health care needs, developmental delays</td>
</tr>
<tr>
<td>- Need to be especially tailored to their special need</td>
</tr>
<tr>
<td>- Their needs may not be so obvious</td>
</tr>
<tr>
<td>- Managed care as it affects medical and dental home</td>
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<tr>
<td>- Funding for preventive care as it is negotiated presently is inadequate</td>
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<tr>
<td>- Unhealthy eating habits – adding sweets to bottles.</td>
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<tr>
<td>- Issue for VI: MA recertification</td>
</tr>
<tr>
<td>- Reimbursement issues – forms are too complicated, kicked back several times, fees no longer an issue in some places, electronic and web-based billing helps.</td>
</tr>
<tr>
<td>- Make sure people have access to information on grants</td>
</tr>
</tbody>
</table>
### Prioritization of Issues [List Priority Issues]

(Note: List includes some strategies so they are not lost for tomorrow’s conversation.)

**Fluoridation and fluoride supplements** –
- distribution of drops, tablets, rinses and varnishes
- communities and families need more information/data
  - community fluoridation
  - family health practices – toothpastes, bottled water, supplements

We need to begin earlier on all prevention practices
- Relationships between oral and general health
- Pregnant women and maternal flora/periodontal disease may have implications for LBW/Preterm labor
- Early childhood caries – “nursing bottle mouth”
- More prevention for children with special needs
- Teach moms effective parenting practices early
- Parent education
- Funding issues
- People need data on what is available and effective

**Dental Home** – every child should have a dental home
- Mouth is not separate from the rest of the body
- Relationship between oral health and general health
- Risk factors not able to be identified
- Sharing information with medical home – better communication needed
- Holistic with more focus on prevention
- In managed care/funding issues
- Special Needs children

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### Existing Promising Approaches [List Promising Approaches]

**Alliances and relationships with local dental societies**
- Help on health services advisory councils
- Help build coalitions and make more people in the community aware of HS issues
- Ocean, Inc.

**Informatics/Communication** – data to inform services
- Community assessments should include information
- Better planning
- Identify all issues and barriers for HS children and families
- Make oral health more of a priority in the program
- Change way PIR data is collected to make sure the information comes directly from the dental assessment done by the dentist
- More assistance for local HS on how to file the PIR

**Models of work with pregnant women:** Healthy Mouths/Healthy Babies at NYU and Clinton County Health Dept.

**School-based (HS based) services**
- Fluoride supplementation;
- Education;
- Parent involvement;
- Seals

**Community-based**

**Published National Guidelines as are available** –
Getting research out to practice faster; we need accurate, scientific information so that we can speak with authority.
### Topic Assigned to Group: Prevention

#### Priority Issue #1 (PI #1)

- Prevention needs to begin earlier
  - prenatally
  - early infancy
  - early childhood

#### Overall Strategy (for PI #1)

- Find pregnant women and infants early and provide a consistent, scientific oral health message across service systems through linkage and collaboration with other service providers (WIC, prenatal care services, MA, TANF/DSS, managed care, hospitals, providers, residencies).

- Create an environment where prevention is valued throughout the Head Start program

- Every child should have a comprehensive “Dental Home”

#### Action Steps (for PI #1)

- Establish better referral networks across programs serving the same population.

- Examine performance standards for where they can be improved to include the oral health message/oral health education and referral mechanisms. Advocate to make the performance standards and guidance more specific on oral health issues. Issue an Informational Memorandum on Oral Health. Encourage programs in the region to begin working with families on health/oral health issues early in their contact with the HS program. Encourage programs to perform health assessments be done ASAP. (Is there a way to encourage that it should be done in conjunction with the developmental assessment? E.g. Look at the feasibility of putting oral health and health screenings on the same time frame as the required developmental assessments – 45 days, not 90)

- Give parents and communities more, timely, accurate, scientific information
  - community fluoridation
  - family health practices
    - toothpastes,
    - bottled water
    - supplements
    - sealants
    - varnishes
    - brushing for plaque control
    - parenting practices that control transmission of bacteria that cause ECC

- Advocate for allowing RDHs a scope of practice that includes counseling for improving oral health in states where it is not allowed.
Advocate to have oral health and prevention activities in HMO standards in each state.

Link with dental schools, schools of dental hygiene as a part of their community service.

Advocate for development of national oral health education materials and activities for communities, programs, families and children that stresses the connection of oral health to general health. Use the media.

Make sure ob/gyns, pediatricians, all MCH providers have access to the latest scientific information and practice guidelines on oral health. Consider web-based approaches; “incentive-ize” with continuing education credits for professional. Make offerings short, focused and scientific.

Inreach and outreach. Outreach to other day care providers/preKs that feed into HS programs.

Build on other linkages with local health departments. (Already link for immunization, lead poisoning, early intervention, etc. Now link on oral health.)

Create an environment where prevention is valued throughout the agency. Top down.

Create an environment where prevention is valued throughout the agency. Top down.
- foster staff health
- communicate importance of oral health
- seek grant funds – educate HS directors about availability of other funds.
- create a culture of fun around oral health
- use social occasions to help spread the prevention message – ie tea parties around oral health

Further examine the National Reporting System results. How and when are data collected? Does it really represent the real issues in HS?

Get the Head Start Resource Center to distribute or cross reference the MCHB materials

Advocate for national standards for EPSDT guidelines/a standard package
Create an environment where prevention is valued throughout the agency. Top down.
- foster staff health
- communicate importance of oral health
- seek grant funds – educate HS directors about availability of other funds.
- create a culture of fun around oral health
- use social occasions to help spread the prevention message – ie tea parties around oral health

Foster connections between providers and families
- Start with HSAC
- HS directors contact practitioners on their area.
- “Adopt a Center” concept. Ex: Health Friends in Utica. HS
| Collaborators (for PI#1) | Parents, families, HS programs (nutrition, health, health services advisory council members, education)  
Local health departments.  
Ob/gyns, pediatricians, nurse midwives, NPs, dentists, dental hygienists, dental schools, dental hygiene schools, hospitals and other service providers.  
State Title V programs  
Title XIX/MA programs  
HS Associations  
WIC, Family Planning, DSS/TANF, prenatal programs and clinics. Nutritionists.  
Other day care providers. |
|---|---|
| Resources (for PI#1) | HS  
The community  
Title V and the HRSA grantees  
Head Start Publication Center  
National MCH Oral Health Resource Center |
<table>
<thead>
<tr>
<th>Priority Issue #2 (PI#2)</th>
<th>Fluoride</th>
</tr>
</thead>
</table>
| Overall Strategy (for PI #2) | Communities and families need more scientific information about fluoridation  
Encourage supplementation in non-fluoridated areas |
| Action Steps (for PI#2) | Expand fluoride supplementation programs – drops, tablets, varnishes – to all HS in the region.  
Give parents and communities more, timely, accurate, scientific information  
- community fluoridation  
- family health practices  
  - toothpastes,  
  - bottled water  
  - supplements  
  - varnish  
  - fluorosis issue  
Seek funding to increase varnish programs in high risk children –  
National advocacy to support longitudinal studies in promising practices.  
Pursue MA coverage for effective practices.  
Watch promising research – ie fluoride varnish/ FDA approval? |
| Collaborators (for PI#2) | Practitioners  
State and Local Health Depts  
Water companies  
Local governments  
Media  
Consumer Affairs  
EPA  
MA  
WIC  
Head Start Publication Center |
| Resources (for PI#2) | Media  
CDC  
FDA  
NIH  
National MCH Oral Health Resource Center at Georgetown |
<table>
<thead>
<tr>
<th>Priority Issue #3 (PI#3)</th>
<th>Holistic Approaches</th>
</tr>
</thead>
</table>
| **Overall Strategy (for PI #3)** | Build greater connections medical providers and oral health providers.  
Emphasize the relationship between oral health and general health.  
Acknowledge and respect the influence of culture and religion. |
| **Action Steps (for PI#3)** | Educate dental, pediatric and family practice residents on oral health issues using Head Start as a collaborative community practice site. Head Start should reach out to residency directors to suggest this. Work with the appropriate state licensing bodies.  
Include oral health as an element of interagency agreements with state/territorial Child Care Agency, DOE, DOH, WIC.  
Head Start Programs should be involved in their state/territorial Oral Health planning process and pursue involvement in the state/territorial oral health coalition. If there are not state/territorial coalitions, HS could be instrumental in establishment of coalitions.  
Look into whether the territories have access to money from CDC for oral health plans.  
As a part of the HS community assessment, include information on impact of culture and religion on oral health practices. |
| **Collaborators (for PI#3)** | NY State Education Dept and NYSDA  
NJ State Board of Dentistry in Consumer Affairs (Dept of Higher Ed?) and NJDA  
Puerto Rico? USVI?  
American Dental Education Association of America and affiliated state bodies.  
State collaboration office  
Accrediting bodies  
Child Care  
WIC |
| **Resources (for PI#3)** | Websites  
National Center for Cultural Competency at Georgetown University  
HS Associations  
State/Territorial Dental Directors |
<table>
<thead>
<tr>
<th>Priority Issue #4 (PI#4)</th>
<th>Funding – Group did not have time to adequately address the funding issues.</th>
</tr>
</thead>
</table>
| Overall Strategy (for PI #4) | Make sure HS knows about funding opportunities for prevention activities.  
                              | Assist providers who are having problems getting reimbursed for prevention activities. |
| Action Steps (for PI#4) | Enlist assistance from the Collab Offices to get information down to the program levels.  
                             | Request that Head Starts be included in solicitations.  
                             | Get assistance for dentists who need assistance with processing reimbursement for preventive services, and help providers get involved in managed care networks. |
| Collaborators (for PI#4) | Collab offices  
                              | State Dental Directors/Title V directors  
                              | State MA directors/SCHIP Programs/Managed Care |
| Resources (for PI#4) | Collab offices |
Topic Assigned to Group: ACCESS to CARE

General Summary

1. Simplify system, can see more kids, prioritize reporting, forms, etc
2. Streamlined system/simplification
3. Incentives for local community to providers to see kids
4. Enrollment and education system
5. Training and TA for OH at HS at and HS at OH (training within HS about OH to staff and parents)
6. Help families understand how to use the system

Priority Issue #1

Adequate and timely reimbursement

A. Increase overall funding
   o Increase provider fee schedule/reimbursement levels/fee for service (present fees are below overhead costs)
   o Target fees to increase to areas critical for pediatric dental
   o Federal influence on state Medicaid/SCHIP levels

B. Improve system to facilitate
   1. Reporting
      a. streamline Reports to HS
      b. insurance/Medicaid/SCHIP reimbursement forms: ADA forms, processing mechanism, enrollment and credentialing for providers to be standardized (promising practice: CAQH in NJ)
   2. Payment of submitted Medicaid/insurance
   3. Create accountability on oversight of Medicaid/SCHIP/HMOs/insurance orgs that they're actual treatment is received for meeting actual data (assure accountability and oversight of adequate dental networks for HMOs)
   4. Ensure the system is accessible for families (hours and wkd's) and providers
   5. Quality assurance
   6. Train HS staff to know how to get kids in enrolled in 3rd party reimbursement

Overall Strategy

Affect increased access to oral health care through legislative change based on complete and accurate data.
<table>
<thead>
<tr>
<th>Action Steps (for PI#1)</th>
<th>To increase access to oral health care for Head Start children and families:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* Increased reimbursement requires legislative action lobbying at both federal and state levels</td>
</tr>
<tr>
<td></td>
<td>* Accurate data</td>
</tr>
<tr>
<td></td>
<td>1. Exam must be by qualified dental professional (define criteria for exam)</td>
</tr>
<tr>
<td></td>
<td>2. # children needing treatment</td>
</tr>
<tr>
<td></td>
<td>3. # children- treated/not treated</td>
</tr>
<tr>
<td></td>
<td>4. $ for Medicaid/SCHIP/insurance for treatment</td>
</tr>
<tr>
<td></td>
<td>5. Training manuals for HS staff and dental professionals (and staff) to report accurate info from 2 &amp; 3</td>
</tr>
<tr>
<td></td>
<td>6. HS/school attendance: missed days due to dental problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Steps (ctd) (for PI#1)</th>
<th>*Go back to HS staff from top → down</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To train:</td>
</tr>
<tr>
<td></td>
<td>1. What is adequate dental exam/care?</td>
</tr>
<tr>
<td></td>
<td>2. What is consequence of inadequate care?</td>
</tr>
<tr>
<td></td>
<td>3. How does poor dental health affect children’s performance in program?</td>
</tr>
<tr>
<td></td>
<td>4. How to report info on dental care accurately?</td>
</tr>
<tr>
<td></td>
<td>5. Familiarity with various coverage plans (how to get kids enrolled)</td>
</tr>
<tr>
<td></td>
<td>*Require in HS Center Reports</td>
</tr>
<tr>
<td></td>
<td>1. Was screening done?</td>
</tr>
<tr>
<td></td>
<td>2. Was appointment scheduled for treatment?</td>
</tr>
<tr>
<td></td>
<td>3. How long was wait for appt?</td>
</tr>
<tr>
<td></td>
<td>4. How long before all treatment completed?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collaborators (PI #1)</th>
<th>HS Regional Office: Training and Technical Assistance Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In collaboration with:</td>
</tr>
<tr>
<td></td>
<td>State HS offices</td>
</tr>
<tr>
<td></td>
<td>HRSA</td>
</tr>
<tr>
<td></td>
<td>Dental Associations</td>
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<tr>
<td></td>
<td>MCH Consortium</td>
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<tr>
<td></td>
<td>State Medicaid/SCHIP programs</td>
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<td></td>
<td>WIC</td>
</tr>
<tr>
<td></td>
<td>Federally Qualified Health Centers</td>
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<tr>
<td></td>
<td>State and local Health Departments</td>
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<td></td>
<td>State OH Coalitions</td>
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<td></td>
<td>CMS</td>
</tr>
<tr>
<td></td>
<td>Early Childhood Comprehensive Systems (ECCS): planning initiative that covers all children’s (birth to 5) needs- planning grant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources (PI #1)</th>
<th>Data collection system (personnel, resources, parameters)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Identification tool/mechanism to demonstrate low cost and no cost (identify what of above can be done now with existing resources and what needs more resources)</td>
</tr>
<tr>
<td></td>
<td>Training and TA</td>
</tr>
</tbody>
</table>
## Oral Health and Head Start Regional Forum
### Group Discussions
#### Worksheet #2

### Priority Issue #2 (PI#2)

<table>
<thead>
<tr>
<th>Eliminate Barriers</th>
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<tbody>
<tr>
<td>Eliminate barriers to patients as well as providers.</td>
</tr>
<tr>
<td><em>Share “best practices”</em></td>
</tr>
<tr>
<td>1. more explicitly in Performance Standards</td>
</tr>
<tr>
<td>2. medical/dental exam combined to get more kids to have adequate exam</td>
</tr>
</tbody>
</table>

(PI#2)

### Overall Strategy (for PI #2)

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<tr>
<td>2. medical/dental exam combined to get more kids to have adequate exam</td>
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</tbody>
</table>

(not a BP, but tangent of conversation)

### Action Steps (for PI#2)

<table>
<thead>
<tr>
<th>Educate all parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. patients and families</td>
</tr>
<tr>
<td>2. providers</td>
</tr>
<tr>
<td>3. HS staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increase efficiency of system → HS care coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. scheduling/availability</td>
</tr>
<tr>
<td>2. transportation: bring served children together by HS staff</td>
</tr>
<tr>
<td>3. Standardize all forms and admin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support HS Family Advocate/Family Workers to integrate OH into care coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. adequately fund/staff/resource HS workers</td>
</tr>
<tr>
<td>2. assess training/TA needs of family advocates</td>
</tr>
<tr>
<td>3. support linkages btw HMO Care Coordinators, HS staff and OH</td>
</tr>
<tr>
<td>4. Managed care/HMO system has a HS point of contact</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>System of Accountability (for 3rd parties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. meet contract requirement for accessibility</td>
</tr>
<tr>
<td>2. must have ombudsman OUTSIDE of 3rd party to facilitate resolving problems</td>
</tr>
<tr>
<td>3. (HMOs must have money in their contracts for providing ombudsman)</td>
</tr>
<tr>
<td>4. have a resource of state/federal to require compliance of 3rd party to their contracts (fines, revocation)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increase communication btw interest groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attendance at meetings of associated groups</td>
</tr>
<tr>
<td>2. google website: “Find the HS program” by state</td>
</tr>
<tr>
<td>3. State dental association website can list providers accepting HS clients: Centralized list</td>
</tr>
<tr>
<td>4. Recommend State Primary Care Associations link w/ State HS Associations and State HS collaboration offices</td>
</tr>
</tbody>
</table>
| Collaborators (for PI#2) | CHIP/Medicaid  
CMS |
|--------------------------|-----------------|

**Increase communication btw interest groups**  
*Attendance at meetings of associated groups*  
*google website: “Find the HS program” by state*  
*State dental association website can list providers accepting HS clients*  
*Recommend State Primary Care Associations *link w/ State HS Associations and State HS collaboration offices  
*link “look-alikes” associations: state funded but doesn’t meet federal definition of underserved to meet State definition*  

NY State Dental Foundation
Oral Health and Head Start Regional Forum
Group Discussions
Worksheet #1

Topic Assigned to the Group:
Education Amanda Lehrer/Hopewell

**Issues [List Issues]**

Challenges –

Language barrier – in different centers – so many different languages.
Health literacy – too text heavy and education level.
Cultural issues some cultures don’t have the same attitudes – Educator needs to be culturally competent.
Needs to be compelling to the audience and developed for the right “voice” in the family.
Grandmothers –
Culturally sensitive to the recipients background
Each culture has a different diet and food groups. Need to know about foods of children.
Promote information for parents so they can take an active role.
More or better materials for parents.
Strategies to engage parents as partners. Need to get parents to buy in – educate the parents of these needs. Parent involvement makes outcomes more long-lasting.
Engage the parents – how do we engage the parents has different requirements and has cultural elements. This can go back to cultural.

Two parts – educate parent to educate the child
   A) for parent
   B) for child

Timing and early intervention concept is key. Teaching oral health to other oral health professionals.

Engaging other health care professionals outside of dentistry. Outside

How are HS staff communicating with the parents. If staff doesn’t buy in then it’s not communicating.
Frequency of communication. One oral health presentation won’t do it. How much is enough.

What is the environment that the child is growing up in. Grandparents may be putting juice in the bottle.

HS children have a toothbrush available and brush at least twice a day. They may not have a toothbrush at home.

Barriers to access are an obstacle to education. This has an education component. Reduce barriers to access to get to the education.

Dental care is not a priority for parents. Need to educate pregnant women about dental care.

Need some simple messages but not a media push or something else to make it more visible. Brochures aren't working. Get off the beaten track. What are the negative consequences of not paying attention of early oral health. Show pictures of the consequences to change the attitudes.

Need media and ad agencies to buy into Surgeon General’s report so that it gets national exposure.
Best practice
NJ Comprehensive Cancer Plan – getting $ from general funds. But ignored oral cancer. They get overlooked even by the professionals.

PR is only one component – get it into medical schools – let folks know about the Surgeon General’s report. Need an organized effort from this.

WIC checks on vaccines – but can’t get the same leverage on oral health. We may need legislative initiative. We may need to take a more narrow – HS focus is going to help us most right away.

AAP standards and dentists need to get them on the same page. There are conflicting messages.

Need to involve both parents including dad and other providers. Nursing doesn’t focus on oral health either. Health professionals need to get together on this.

Gear message to recipients and what they are ready to hear.

We don’t have outcome evaluations.

Photos have an impact especially on very young children. This is grant funded program. The photos are shown to a dentist and if they need treatment they are getting referred. With a three month follow-up. For early detection. Baby teeth are not taken seriously. This is done at the University of Rochester. HS case management helps on this Buddhi Shrestha may know more about this.

NYS – requires prisoners to have exam, nursing home patients have dental exam, but not kids and oral health.

Need to get public consensus on this issue. That’s what motivates legislators. Deciduous teeth have stem cells. Tooth fairy delivers – stem cells. Must show this is a public health issue. Set up a legislative education – need a national push to value oral health. Prevention saves money is a good catch.

There’s not enough information about what makes a difference. What is the education we need to give to people to make a difference? Gear message to recipients –

Need something concrete – not a big idea – how to get a parent engaged. Who is our audience for our message? Multiple directions. We don’t know how to ask for or promote oral health messages.

Parents don’t come to meetings. Need to do more to have creative ways to educate parents. Parents – need to be drawn in to this.

Tailor messages to the age of the person too. Social marketing information to enhance the message.

Photos help to educate kids – make kids brush. Educate parents and grandparents. Big photo of baby bottle mouth – good way to educate. Need to give other strategies to keep the baby quiet.

Not enough dentists willing to see parents. Maldistribution of dentists.

Need to make classrooms more dad friendly – and oral health focused. Colgate has great posters that are good in classrooms.

Needs to be earlier than head start age. New approaches are needed. Link being established between oh of mom to child – transmissibility. Evidenced based information – educate parents that they need to keep their mouth clean since that impacts the child’s teeth.

If dentists are paid on a capitated basis like in PR they call the families to come in to get treatment.

Sugar as a tooth decay element – that message hasn’t come gotten through. Kids favor sugar must come up with a better public health message. Companies don’t like the message to get out. We may never beat this –but you can get out the number of servings of sugar or sugar delivery method can be
influenced.

HS partners with WIC and that can help get the message out. And school advocates can get soda machines out of the schools.

Can we get companies to donate stuff for kids to use at home. Educate parents on their own oral health.

Coordination between WIC and HS targets the mom and the children. Develop linkages between these. Small steps programs in PR are WIC educational materials.

VI has lack of dentists and clinics and hurricane knocks things out. Federal Health center equipment did not get fixed. Dept of health –

Let’s group them first –

Here are the groups – together they create capacity.

**Infrastructure(workforce)/resources**
- #3 Lack of dentists 2
- #3 Practices acts/ restrictions 2
- #2 WIC and HS 4
- Lack of access is an educational barrier 0
- Advocacy network 0
- #1 Earlier intervention 8

**Communication (cultural)**
Environmental considerations/ baby bottles
Surgeon Generals Report
- #2 PR campaign 3
- #2 Lack of understanding State and Fed Government 3 [PR an multiple levels]
- #3 Cultural issues 2
- #1 Health Literacy 7 (cultural, issues, competency)
- Cultural competency

**Education**
Lack of role models 1
Photos as education tools
Health literacy 1
Nutrition regarding sugar and food
- #1 Teaching nondental personnel includes educational curriculum 4
  Curriculum in professional schools 1
- #2 Consequences of poor oral health 3
  HS Initiative focus on oral health 1
- #3 Education on oral health issues (parents too) 2
  More parental materials
  Parent involvement 2

**Research**
- #3 Relationship mom and child /parents 3
- #1 Innovative models 7
- #2 Outcomes 3
- Social marketing 1
# Prioritization of Issues [List Priority Issues] Tuesday AM

The group spent some time prioritizing the challenges grouped the day before under the four headings – Infrastructure, communication, education and research. See numbers above as to how this boiled down.

Need to define the broad categories –
Infrastructure/resources – the people, personnel involved in educating the public on oh issues. I.e. the professional and staff who will educate others in oh issues. Includes the organized system. Personnel and organization to educate public on oral health.

Education/Communication – The imparting of appropriate culturally and age appropriate information about the importance of oral health care to positively influence individual behavior and attitudes related to EH/Head Start.

Research – exploration and development of new knowledge regarding oral health.

## C. Existing Promising Approaches [List Promising Approaches]

<table>
<thead>
<tr>
<th>Partnerships with WIC And HS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Moms program for prenatal care</td>
</tr>
<tr>
<td>New York City Health Department focus on oral health which was built gradually over time.</td>
</tr>
</tbody>
</table>

Oral Health Consortium –
Realize that these approaches start small and grow as the opportunity arrivals.
NYU buses HS kids to the dental school for the pediatric dentists to treat.
Smile Mobile funded by McDonalds in Rochester – but they've been trying to fund a clinic for 5 years.

Colgate vans are very expensive to maintain van and driver – that’s the cost for one year + liability insurance ($20,000 – 30,000)

St. Peter’s Hospital in Reno – has an 18 wheeler truck that they've converted into a mobile clinic which is parked on the property of the supermarket chain. The supermarket funded some of the project and increased access in Reno.

Rotary Club and McDonald's contribute for five years but school based mobile vans require long term commitment. Easy to buy a van – hard to maintain.
If you park it you save on liability for driving.
## Oral Health and Head Start Regional Forum
### Group Discussions
#### Worksheet #2

### Topic Assigned to Group:

<table>
<thead>
<tr>
<th>Priority Issue #1 (PI #1)</th>
<th>Early intervention – should begin prenatally.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Strategy</strong> (for PI #1)</td>
<td>Early Head Start programs should begin early intervention education with either parents or caregivers prenatally.</td>
</tr>
</tbody>
</table>
| **Action Steps** (for PI#1) | At the Regional Level
Identify EHS personnel who will implement this early intervention. Pregnant women meeting with health coordinator could introduce oral health and how it affects the child.
Reach out to Advisory Board, dental consultant or other org to evaluate materials currently in place and develop a contemporary curriculum regarding early intervention.
[Develop a curriculum that can be used with this population. This will be moved to education.]
| **Collaborators** (for PI#1) | HS advisory board, DOH/WIC, academic institutions, dental professionals |
| **Resources** (for PI#1) | |


<table>
<thead>
<tr>
<th>Priority Issue #2 (PI#2)</th>
<th>Linkage WIC and Head Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Children up to 5, pregnant woman, nutrition counseling, at local clinics serve the people. Food vouchers, clinic is monitoring the consumption with a counseling program, nutritionist has a curriculum that is required. We could expand the oral health component. OH is not a corporate priority for WIC.]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Strategy (for PI #2)</th>
<th>Joint collaboration of both organizations WIC and Head Start at the Regional Level on an oral health education component</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Action Steps (for PI#2)</th>
<th>Support an intra agency agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Develop mechanisms to support community partnerships</td>
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<td></td>
<td>Invite WIC onto HS Advisory Boards to development of an oral health curriculum.</td>
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<table>
<thead>
<tr>
<th>Collaborators (for PI#2)</th>
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</table>

<table>
<thead>
<tr>
<th>Resources (for PI#2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority Issue #3 (PI#3)</strong></td>
</tr>
<tr>
<td>------------------------------</td>
</tr>
<tr>
<td><strong>Overall Strategy (for PI #3)</strong></td>
</tr>
</tbody>
</table>
| **Action Steps (for PI#3)** | Investigate the possibility of developing linkages joint medical and dental National Health Service Corps members regarding EHS/HS and oral health.  
(Special designation of HS and EHS as a special HIPSA population.)  
Dental School scholarships for underserved areas and loan repayment. Could create similar target incentives for pediatric dentists perhaps funded by head start.  
Also dentists need to educate patients on oral health prenatally. |
| **Collaborators (for PI#3)** | National Health Service Corps, Dean of Dental Schools |
| **Resources (for PI#3)** | }
## Worksheet #3

### Decided to combine Education/Communication

<table>
<thead>
<tr>
<th>Priority Issue #3 (PI#3)</th>
<th>Education of non-dental individuals on the importance of oral health.</th>
</tr>
</thead>
</table>
| Overall Strategy (for PI #3) | Health Literacy – (want to improve the health IQ of the public regarding oral health – tailored culturally and age appropriate to reach particular audiences)  
Public Media national advertising campaign is a long term goal.  
Short term goal – how can the Head Start Bureau/Regions promote information on oral health disseminate information through the system. |
| Action Steps (for PI#3) | Health Literacy – develop age appropriate and culturally competent materials.  
Ask the Region to develop oral health message for the Region that can be disseminated in multiple ways. This resource should be put together as a resource package that is flexible enough for different parts of the region and different ages.  
General public needs information out to create demand for change. |
| Collaborators (for PI#3) | Some collaborating partners  
Have HS coordinate with the Surgeon General on getting the message out.  
Integrate HS information into DOH advertising –  
Corporations, news outlets, |
<p>| Resources (for PI#3) | |</p>
<table>
<thead>
<tr>
<th>Priority Issue #3 (PI#3)</th>
<th>Education of other health professions</th>
</tr>
</thead>
</table>
| **Overall Strategy (for PI #3)** | Include oral health training in all allied health professions and social work curriculum including early intervention and prenatal care.  
Curriculum for students  
CE for practitioners  
Training for HS/EHS |
| **Action Steps (for PI#3)** | This Advisory Committee should review what Head Start curriculum to see if elements are appropriate.  
AMA, ADA and ADEA sit down together to make a policy decision regarding curriculum on early intervention. |
<p>| <strong>Collaborators (for PI#3)</strong> | |
| <strong>Resources (for PI#3)</strong> | |</p>
<table>
<thead>
<tr>
<th>Priority Issue #3 (PI#3)</th>
<th>Create, evaluate, support and promote innovative models that lead to improved oral health outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Strategy (for PI #3)</td>
<td>Use Head Start/EHS as a component of oral health research and oral health research dissemination.</td>
</tr>
</tbody>
</table>
| Action Steps (for PI#3) | Use HS/EHS students in research studies??!!  
Research questions -  
a) Study EHS/HS cohort for oral health data  
b) How do we improve parental involvement?  
c) Develop strategies for the HS Regional Office do to disseminate cutting edge oral health information.  
d) How can HS disseminate new oral health knowledge on transmissibility of flora to families and the relationship of oral health to low birth weight to pregnant women?  
Need to communicate the message - good oral health of moms impacts the oral health of children. |
<p>| Collaborators (for PI#3) | Academic institutions, hospitals, clinics |
| Resources (for PI#3) | NIDCR, corporations, Federal, State and local government, foundation grants, RWJ, large universities may have funding for this research, HMOs. |</p>
<table>
<thead>
<tr>
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<tr>
<td>(for PI #3)</td>
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<tr>
<td><strong>Action Steps</strong></td>
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