Charting A Future Course: A Regional Forum on Head Start and Oral Health Region III

Philadelphia, PA
June 9 and 10, 2003

Prepared for:
Health Resources and Services Administration and Administration for Children and Families
Region III, Philadelphia, PA

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I. Background and Introduction: Region III Forum on Head Start and Oral Health

A. History of the Regional Forums

In 1999, the Head Start Bureau (HSB), the Health Resources and Services Administration (HRSA), Centers for Medicare and Medicaid Services (CMS, then the Health Care Financing Administration), and 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 care services.

One outcome of this National Forum was the formulation of an Interagency Agreement between the Head Start Bureau, Administration for Children and Families (ACF) and HRSA’s Maternal and Child Health Bureau (MCHB) to develop linkages to support oral health in Head Start. As part of this agreement, the 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 list of regions designated by the U.S. Department of Health and Human Services).

The sixth in the series of these regional forums was held on June 9-10, 2003 in Philadelphia, Pennsylvania, and sponsored by the regional field offices of ACF and MCHB. (An agenda for the forum appears in Appendix B.) The goals of the Region III 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;

- Assess current regional issues, challenges, and promising practices related to improving the oral health of children in Head Start and Early Head Start;

- Identify strategies and the key roles of regional agencies and other entities for further action; and
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 HRSA, ACF, and USDA Food and Nutrition Service, State oral health, primary care, Medicaid/State Children’s Health Insurance, and WIC programs, State Head Start Collaboration Offices, Head Start Associations, Head Start grantees, academic institutions, and community-based organizations. A full list of attendees is available in Appendix C.

B. Introduction to Region III Forum

Victor Alos, D.M.D., M.P.H., HRSA Regional Dental Consultant in the HRSA Philadelphia Field Office, welcomed participants and stressed that the forum offered a great opportunity to provide recommendations for oral health services for Head Start at the regional and national levels.

On behalf of Department of Health and Human Services Secretary Tommy Thompson, Robert Zimmerman, DHHS Regional Director, offered a formal welcome, stating that one of the Secretary’s priorities is to get programs to collaborate with one another to effect change, an idea that is being played out through the conduct of these regional forums. Mr. Zimmerman reflected on his own experiences as a public health graduate student, and observing rural patients with severe tooth decay. He stated that it is the personal experiences related to dental health that bring the forum participants together.

Oral health is central to health and well-being, and Mr. Zimmerman highlighted some of the problems associated with oral diseases. Dental caries is the single most common chronic childhood disease, and dental illness contributes to more than 51 million school hours lost each year. The most vulnerable populations are children from low-income families, and minorities, as well as children with special health care needs (CSHCN). Moreover, dental diseases affect activities of daily living; children with dental pain may be unable to concentrate on learning in
Mr. Zimmerman urged a greater integration of oral health into general health as a way to promote holistic health among children and their families in Head Start.

Gwen DeVeaux-Way, ACF Region III Head Start Branch Chief, highlighted promising practices and challenges facing the Head Start community in accomplishing the goals outlined by Mr. Zimmerman. Oral health status must be determined within 90 days for all children in Head Start. Some programs have used this requirement to develop innovative partnerships, such as one program’s contract with a dentist from the University of Pittsburgh to help create an oral health plan. This same Head Start program works with the dental school to help train Head Start staff on dental issues, and to set up a home visitation schedule to screen children and families. In addition, pediatric dentists attend Head Start socialization groups to reinforce the importance of oral health and proper dental care.

But despite these successes, Ms. DeVeaux-Way stressed that programs continue to encounter difficulties. While the data indicate that Head Start served 78,000 families in the region, still more than a quarter of children lacked a continuous source of care, and roughly 17% were diagnosed as needing dental treatment. Ms. DeVeaux-Way emphasized the importance of serving these children, and how the strategies arising from this forum could contribute to improvement of services for this population, but that any great early childhood program depends on collaboration.

Allen Conan Davis, Chief Dental Officer at CMS, offered the perspective on CMS’s priorities in oral health. One of these is enhancing Medicaid to improve the provision of dental care services and serve vulnerable populations. Secretary Thompson also has met with dental groups and continues to stress the need for continuation of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Dr. Davis noted that the graduate medical education program that has supported dental residencies is currently under review and consideration by CMS.

Finally, Jane E.M. Steffensen, M.P.H., CHES, Consultant for the Head Start and Oral Health Partnership Project, reviewed the goals for the forum and emphasized the need for participants
to develop a regional strategy plan and outline challenges. Participants were encouraged to find ways oral health and Head Start efforts can be combined in Region III. Forums have already taken place in the Kansas City, Dallas, Denver, San Francisco regions, and with representatives from Migrant and Seasonal Head Start programs in Washington, DC. She added that the regional forums are running parallel to a series of state and territorial forums via the Association of State and Territorial Dental Directors, which also aim to build on the accomplishments of Head Start and successful oral health programs already present in communities. Through these venues, HRSA and ACF hope to allow participants time to develop a shared vision to increase communication, deepen understanding of oral health issues, and improve collaboration and integration across the region.

II. The National Perspective

Following introductions of forum participants, representatives from HRSA and ACF provided an overview of how these regional meetings fit within the broader landscape of initiatives focused on improving access to dental care and enhancing prevention. Robin Brocato, M.H.A., Senior Health Program Specialist with the Head Start Bureau, offered further information on the 1999 National Forum and the vision the Bureau has for the future of oral health in Head Start.

The 1999 National Oral Health Forum recognized that access to oral health services is the number one health issue facing children in Head Start across the country. Data collected at that time showed a steady decline in children actually receiving needed dental care. Thus, participants representing Head Start and other Federal agencies discussed the latest research and evidence-based oral health practices. Three papers were commissioned for the forum and reviewed nutrition, dental caries prevention, and access issues. These papers were later published in the Journal of Public Health Dentistry.

Since the national forum, more science has emerged, especially related to oral health considerations for pregnant women. The Head Start Bureau and other agencies are working to rebuild an infrastructure for oral health activities. While the 2002 Head Start Program
Information Report (PIR) data appear promising—roughly 74% of children have a dental home—Ms. Brocato warned that because these data are self-reported, they do not always create the most accurate picture. Moreover, the same data revealed that only 4% of children in Head Start received a dental screening during a well baby examination, indicating that additional education among pediatricians, family practitioners, and nurses is necessary. Ms. Brocato added that the Head Start Bureau is working on revising the Interagency Agreement with specific national objectives for oral health education, prevention, and access to dental care. It is hoped that strategy plans developed in conjunction with the state and regional forums will support this national vision.

John Rossetti, D.D.S., M.P.H., Oral Health Program Consultant, MCHB, HRSA, discussed the National Head Start Partners Oral Health Forum and noted his involvement as the former Chief Dental Officer, MCHB, HRSA. He stressed the importance of past and future collaboration among CMS, HRSA, Head Start and WIC to assure oral health improvements for young children.

Dr. Rossetti added that the goal of the Interagency Agreement between Head Start and HRSA was to rekindle partnerships and expertise at the regional levels, and to build partnerships with state oral health programs, WIC, Medicaid/SCHIP, as well as professional dental and dental hygiene associations. The agreement was designed to be flexible, and to increase the focus on oral health within Head Start and the community.

Dr. Rossetti noted that the state and territorial forums have shown initial success in several areas. First, many state policymakers have attended the forums to learn about opportunities and innovative practices. Also, states are following up on the issues they have identified during the forums. In addition, representatives from HRSA are meeting with representatives from national dental and dental hygiene associations to develop partnerships that can enhance information sharing and better address the oral health needs of Head Start eligible children and their families.
III. Enhancing Oral Health in Region III: Opportunities and Challenges

A. Perspectives from Head Start and Oral Health Advocates

Deborah Gillan-Shaw, a Head Start Program Specialist in Region III ACF, introduced the next two presenters. The presenters discussed oral health and Head Start in Region III from their viewpoints. Mary Gunning, M.S.W., President of the Region III Head Start Association and Harry Goodman, D.D.S., M.P.H., Associate Professor of Pediatric Dentistry at the University of Maryland Dental School were selected due to their expertise and unique experiences in Region III. The speakers emphasized the crucial oral health issues outlined by the Report of the Surgeon General: Oral Health in America. The Report stressed the significant disparities in oral health status and access to dental care among low-income and minority children. Both presenters discussed their perspectives on this national report, and presented the opportunities and challenges of meeting the oral health needs of children in Head Start in Region III.

Ms. Gunning noted that regional Head Start data reveal that more needs to be done to ensure the children in Region III receive needed dental care. Only 75% of Region III children in Head Start have had a dental visit. Ms. Gunning identified three major barriers that contribute to this lack of dental care: 1) a lack of dentists, particularly pediatric dentists and dentists working in rural areas; 2) families not being properly insured for dental care; and 3) general awareness of oral health and concerns about dental visits. A shortfall in the number of people choosing dental careers, the rising cost of deductibles and co-payments, and cuts in the State Children’s Health Insurance Program budget in many states contribute equally to the first and second of these barriers. But the third barrier, Ms. Gunning felt Head Start was in a position to play a key role in implementing change.

She noted that Head Start has traditionally done a good job of integrating oral health with other activities. One way to build on this practice, she suggested, is to host another regional forum that showcases promising practices, such as local programs that provide a field trip experience for children to visit a dental office prior to their first examination. An event such as this would
actualize one of the recommendations from the Surgeon General’s Report to build on existing initiatives and continue to facilitate collaborations at all levels. Ms. Gunning observed that this forum is a great start, and urged the participants to keep the momentum moving forward.

Next, Dr. Harry Goodman from the University of Maryland Dental School highlighted dramatic disparities in dental caries rates and access to dental care at a national level and in the state of Maryland. Also, he described promising approaches implemented in Maryland to improve oral health status and dental services.

Dr. Goodman stressed the substantial impact of dental caries on young children. Oral health problems in young children impede nutrition and physical development, cause pain and suffering, and affect overall health. Dental caries in young children can lead to impaired speech development, inability to concentrate on early learning experiences, and absences from child development programs like Head Start. These infections from primary teeth can cause permanent damage in adult teeth. The youngest children, under age five, face the most barriers and are least likely to access dental care.

He noted that the most severe tooth decay appears in low-income children. A statewide oral health survey of Maryland children in Head Start found 52% with untreated tooth decay. And of these children, 17% of their parents were aware of the condition. Fifty-five percent of the children in Head Start had experienced dental caries (e.g., had current restoration or tooth decay), and of these children, 17% complained of pain. The most common reason reported by parents for children in Head Start not having a dental visit was that they were too young.

Dr. Goodman noted that an insufficient dental workforce and inadequate oral health infrastructure contributes to these problems. The majority of children enrolled in Medicaid do not receive needed dental care. Moreover, many dentists are dissatisfied with managed care arrangements, low reimbursement rates, and bureaucratic structures in Medicaid. For these reasons, dentists are less likely to provide dental care to patients with Medicaid. Only 10% of dentists in Maryland currently participate in Medicaid.
Dr. Goodman emphasized the need for more public-private partnerships to improve oral health outcomes and increase access to needed dental care. Some of the strategies Maryland has been working on to address these problems include:

- **Developing a cadre of providers willing to provide dental care to patients with Medicaid.** Strategies have included implementing pilot dental access projects with several local health departments and establishing the Maryland Dental Care Loan Assistance Repayment Program.

- **Sponsoring dental fellows.** The University of Maryland operates a Pediatric Dental Fellowship Program where U.S. trained pediatric dentists provide comprehensive clinical dental care to underserved children in Maryland public health clinics. This program focuses on young children, birth to age 5, and children with special health care needs. Also, these oral health activities are linked with Head Start programs.

- **Engaging advocates and changing legislation.** Legislation in 1999 provided funds for the Medicaid dental program, setting utilization targets, mandating dental coverage for pregnant women, supporting demonstration access projects, establishing in statute the state Office of Oral Health, requiring an Oral Health Advisory Committee and oral health needs assessments.

Dr. Goodman noted that while these measures have improved access for some children, still 71% of children in Maryland with Medicaid (224,000 children) did not receive dental services in 2001. Language in a current budget bill directs the Maryland Department of Health and Mental Hygiene to restrict $7.5 million of 2004 managed care payments to increase fees for restorative dental procedures and develop an action plan for increased utilization of dental care. He added that coordinated planning which is credible and collegial is the only way to foster change.

### B. Summary of Breakout Sessions

Following the plenary session, participants met in small groups representing different geographical areas within Region III, and identified challenges and obstacles, as well as promising practices, related to three areas: prevention, oral health education, and access to dental care. A detailed outline of their comments appears in Appendix D. The next section summarizes these topics from the breakout sessions on day one.
1. Challenges and Obstacles to Prevention

Challenges and obstacles related to prevention of dental caries and other oral diseases centered on a number of issues, including:

- **Insurance issues.** A lack of dental insurance and affordable dental care, high cost of co-payments, lack of coverage for dental services by some employers, and problems in getting insurance to pay for dental care for very young children (under age 5) were all cited as challenges.

- **Lack of knowledge.** A significant lack of education about oral health, both for parents, caregivers, and primary care providers, indicated a need for greater prevention campaigns. Also noted as challenges were the need to:
  - Educate broader about dentists being their “friends” and to assuage fears of dentistry;
  - Have broader dissemination about the importance of diet and nutrition, and that the bacteria that cause cavities are transmissible (as studies have shown mothers pass them on to their young children);
  - Lack of opportunities to promote prevention in rural communities;
  - Find culturally appropriate education materials about prevention;
  - Identify a prevention message that is easy to understand (e.g., something akin to the “Got milk?” or food pyramid campaigns) to promote oral health and dental care; and
  - Need to get media outlets to do public service announcements using these messages.

- **Prioritizing oral health.** Many participants noted that oral health is seen as separate from general health and as a cosmetic measure, therefore it is not high on families’ and communities’ priorities. Any prevention message should promote the association of oral health with general health and overall well-being.

- **Provider issues.** Obstacles related to providers of care regarding prevention included:
  - A lack of dental providers and specialists, especially those serving the youngest children;
  - Decreasing attraction to dentistry as a health career;
  - Pediatricians, family physicians, and nurses not providing thorough and complete oral health screenings;
• The need for more training of personnel on how to screen children; and
• State legislation and regulations that impede the ability of dental hygienists and other auxiliary personnel to perform oral health screenings unsupervised.

Inconsistent standards for pediatric dentistry. Participants also noted that there is inconsistency about the age for children to have a first dental visit and in the definition of an oral health screening. The Head Start community and Medicaid EPSDT need to decay coordinate and ensure their messages are consistent, and public insurance programs cover that dental care for young children.

Need to consider alternative prevention measures. Locations in the U.S. without community water fluoridation have not examined alternatives (e.g., adding fluoride to salt and sugar as is done abroad). Likewise, some dentists do not use fluoride varnish and sealants on primary teeth.

Case management and continuity of care. Prevention works best when consistent messages are delivered multiple times, and continuity of care facilitates this, yet many families still lack a consistent provider. Providers, likewise, also face a challenge in handling “no shows” to appointments.

Political battles and bureaucratic issues may impede the creation of partnerships and campaigns that can spread prevention messages.

Funding and lack of resources to promote prevention strategies.

2. Promising Practices: Prevention

Some of the promising practices cited by the groups as currently underway in the area of prevention included:

- Community water fluoridation;

- Establishing school-based dental clinics;

- Educating families about nutrition and caries prevention in WIC settings;

- Having representation of dentists and dental hygienists on health advisory committees, especially those within Head Start;
■ Making dental care a political priority, as some states have done;

■ Having trained Head Start personnel do initial screenings;

■ Engaging primary care physicians in oral health screenings;

■ Providing transportation to appointments;

■ Advertising and educating the public about oral health through campaigns such as the awareness campaign for policymakers “Watch Your Mouth” in Washington state;

■ Maximizing parent involvement through educational workshops and representation on policy councils; and

■ Providing continuing education for dentists and dental hygienists on how best to serve young children.

3. Challenges and Obstacles to Oral Health Education

Many of the challenges associated with delivering oral health education were similar to those identified under prevention, such as lack of funding, making oral health a priority, and the need to improve knowledge about all aspects of oral health. The participants also noted the need to address:

■ Lack of time on the part of both providers and clients;

■ Mixed messages on how to prevent oral diseases;

■ Barriers, both cultural and linguistic, that impede the exchange of oral health information and increase oral health knowledge for families and communities;

■ Best practices for prevention and oral health education—what are they, and how best to disseminate them;

■ How to get parents involved and serve as role models for their children, as well as being proactive in preventing caries;
Strengthening the oral health component in EPSDT;

How to connect oral health to general health;

Communicating the difference between advocacy and lobbying around oral health issues;

Marketing dentistry as a profession;

How to provide the public with oral health messages (in multiple venues) through effective oral health education and promotion; and

Engaging dental and dental hygiene students in understanding the dental problems occurring in their communities.


Oral health education strategies that participants deemed successful have been working at multiple levels:

In the classroom. Participants noted success when oral health education curricula have been introduced in the classroom setting, especially when it includes complementary parent components. School nurses, class field trips to the dentist, and bringing dentists into schools to alleviate fears were also referenced as promising practices.

In the community. The creation of low literacy oral health materials, mobile dental vans that work in low-income areas, and the support of private donations and partnerships with industry also were cited as potential successes.

In Head Start. Finally, the participants saw promise in the idea of incorporating oral health messages into Head Start meetings with parents.
5. Challenges and Obstacles in Access to Dental Care

The breakout sessions identified a number of factors that impede access to dental care, ranging from logistical issues, lack of knowledge about oral health, location of dentists, and reimbursement.

- Logistical problems. These challenges included: lack of transportation to dentists, access problems encountered by children with special health care needs (e.g., disability accessible facilities, dentists experienced with this population), handling long waiting periods in the dentist’s office, and combating bureaucratic problems that impede access to dental care.

- Lack of oral health knowledge. In addition to parents not understanding the importance of oral health, there is the need for more culturally relevant materials for non-English readers and speakers to facilitate access to dental care. This lack of understanding was also thought to contribute to missed appointments. Finally, providers of services need more education on national best practices to reach those families not accessing oral health services.

- Location of dentists. Many participants cited the maldistribution and/or limited availability of dentists in areas, especially rural areas. They felt more needed to be done to encourage graduating dental students to serve in needy communities.

- Reimbursement. Financial assistance and better insurance coverage were considered critical to improving access to dental care. Parents without insurance are less likely to take children for dental visits even if their children are insured. Likewise, Medicaid reimbursement rates should be increased to encourage more dentists to accept patients with Medicaid.

6. Promising Practices: Access to Dental Care

Participants cited promising practices occurring at all levels, from within communities and schools to legislation at the state level.

- In communities and schools:
  - School-based dental clinics;
  - Mobile vans;
• Health fairs; and
• Dentists participating in “Give a Kid a Smile” (opening practice for free services one day a year) and “Take Five Program” (providing dental care for five underserved families).

■ In Head Start:

• Having health assistants/family workers case manage oral health;
• Collaboration projects;
• Partnering with dental providers to set up group visits with children;
• Conducting oral health screenings prior to entry into Head Start; and
• Integrating oral health education with medical/prenatal visits.

■ At the state level:

• Developing dental fellowships (e.g., Maryland) and loan repayment programs;
• Creating health advisory committees with dental representation;
• Studying oral health outcomes (e.g., Pennsylvania);
• Increasing reimbursement rates in Medicaid for dental care;
• Linking state Maternal and Child Health (MCH) Title V programs to Head Start; and
• Reducing barriers and requirements for dental licensure to increase access to dental care (e.g., reciprocity).

IV. Prioritizing the Issues and Developing Strategies

During the second day of the forum, participants reconvened in small group sessions to prioritize the top challenges and obstacles identified the day before, and to develop strategies to overcome these challenges in improving oral health in Head Start in the region. Participants were quick to point out, however, that strategies within each area would only work if they are seamlessly integrated with one another. Only a holistic approach to oral health—working on issues from prevention through receipt of treatment and follow-up care—will mitigate the challenges listed in the Surgeon General’s Report and evidenced throughout the region. Because of the natural connection between prevention and oral health education, these two categories were combined into one overarching session. The second breakout session focused on access to dental care.
A. Recommendations for Prevention and Oral Health Education

Participants in the prevention and oral health education breakout session cited a wide range of issues as being top priorities in the field, ranging from affordability of dental care to incomplete oral health screenings, to getting parents involved more in dental care. Following a nominal group exercise, however, the group pared down the list to five priorities:

- The need for improved education in dental schools;
- Bridging the disconnect between oral health and general health;
- Funding;
- Getting parents more involved and acting as role models; and
- Lack of community education about oral health.

Upon further reflection, the group connected the last two recommendations into a broader priority about social marketing and creating consistent messages about oral health.

Priority Challenge #1: Improving the knowledge of dental and dental hygiene students about oral health in their communities. Participants felt that this challenge encompassed more than just oral health education, and included cultivating more “socially responsible” dentists and dental hygienists who understand the nuances and challenges in underserved communities, and view it as their professional duty to improve oral health and dental care for everyone.

Overall Strategy: Link dental schools and dental hygiene programs with regional offices (ACF, HRSA, MCH) to promote knowledge and education in public health dentistry and the importance of working with Head Start eligible children and their families.
Specific Activities:

- Conduct an assessment of the seven dental schools and dental hygiene programs in Region III to evaluate what is being done to educate dental and dental hygiene students about community dentistry.

- Convene a meeting between representatives of dental schools and dental hygiene programs, regional offices, and community organizations with a stake in oral health to discuss these issues.

- Have regional offices disseminate best practices and models of community dentistry.

- Provide dental schools and dental hygiene programs with opportunities to have “externships” in Head Start programs.

Resources: Most of the resources for these activities are assumed to come from collaborative efforts between regional offices, dental schools, and dental hygiene programs. It was recommended that regional office Web sites might be a tool for disseminating the best practices.

Roles of Partnering Organizations & Agencies: ACF, HRSA, state MCH programs, state oral health offices and dental associations, community dentists, dental schools and dental hygiene programs, and community leaders could all partner to collect best practices and models.

Priority Challenge #2: Bridging the disconnect between oral health and general health. The participants felt that much more needed to be done to market the message that oral health is intricately tied to general health and well-being, and that oral diseases can cause or exacerbate other chronic conditions. Participants wanted to see greater message development around dental care as more than a cosmetic procedure, as well as messages of the possibility of transmission of dental caries from parent to child by transmitting caries causing bacteria.

Overall Strategy: Develop social marketing messages on the importance of oral health’s connection to general health, and its connection to child development.
Specific Activities:

- Have regional offices establish oral health as a priority; include a theme such as “zero percent cavities.”

- Study the best ways to educate doctors, nurses, dental officers, WIC, Early Start and Head Start personnel on oral health issues—if possible, include continuing education credits for those pursuing strategies to improve oral health.

- Convene focus groups with health coordinators to determine which messages work best for specific audiences.

- Include the oral health connection to general health and child development on the agendas of state, regional, and local meetings to educate professionals about the importance of oral health.

- Have the regional office maintain downloadable presentations and materials with consistent messages for program staff, parents, and professional schools.

- Identify champions in the field who can share messages within the community, and private partners to help spread the messages.

- Train doctors and nurses on how to disseminate messages to parents.

- Educate funders about the need to prioritize oral health.

- Have regional ACF offices ensure that Head Start Policy Councils are actively involved in the planning, design, and implementation of all health services, including oral health.

Resources: No specific resources were noted for this priority area.

Roles of Partnering Organizations & Agencies: No specific agency/organizational roles were outlined for this priority area.

Priority Challenge #3: Funding for oral health. This challenge incorporated a broad array of funding and reimbursement concerns, from funding for oral health education and prevention
activities, to helping people pay for better dental care. The overall strategy developed by the group reflected the belief that until money is set aside for these activities, oral health will continue to be less of a health priority for both state programs and consumers.

Overall Strategy: Propose a 5% solution; that is, have 5% of all state-appropriated early education monies set aside for oral health.

Specific Activities:

- Have regional offices propose the 5% set-aside of funds when specifying guidance in grant applications or RFPs.
- Have regional offices encourage grants to improve oral health by giving additional weight to proposals with oral health initiatives or best practice models.
- Have regional offices recommend to the Bureau that reauthorization of Head Start include specific funds and plans for oral health.
- Create a Region III foundation workgroup to research foundations, so that the Head Start community can approach private foundations to fund unique oral health initiatives.
- Find funds to help families with co-payments.
- Have the regional offices develop a directory of resources that community programs can consult to help fund oral health projects (e.g., that include securing donations, Web sites, help with grant writing).
- Develop an oral health consortium and listserv at the regional level to discuss these issues and help form this directory.
- Create a national oral health Head Start listserv.

Resources: No specific resources were noted for this priority area.
Roles of Partnering Organizations & Agencies: In addition to the Federal and community partners outlined in Priority #1, the group recommended approaching the foundation community to educate them about oral health priorities and to partner with them in funding creative new oral health programs.

B. Recommendations for Access to Dental Care

The individuals participating in the access breakout session reviewed the challenges and obstacles discussed on day one and consolidated duplicate issues. The final list of five top priorities were as follows:

- Availability and capacity of dentists: including dental education;
- Dental insurance availability for families and Medicaid reimbursement rates;
- Medicaid administrative barriers;
- Transportation: lack of public transit, distance; and
- Family issues and barriers to seeking dental care.

The group was unanimous in the identification of the availability of dentists and all the complexities a lack of dentists creates in addressing access issues as the top priority for Region III. Consensus was reached that insurance was the region’s second priority. The workgroup did not rank the other priorities and time did not permit the development of strategies to address them.

Priority Challenge #1: Availability and capacity of dentists. The group discussed two components of the challenge of capacity of dentists. First, they identified that overall, there are an insufficient number of dentists in the region capable of serving young children and children with special health care needs. Secondly, the distribution and diversity of the dentists in the
region is insufficient to meet the needs of a culturally diverse and geographically dispersed population.

Overall Strategy: To take a variety of action steps to increase the number and skills of dentists needed to serve Head Start eligible children in the region.

Specific Activities:

- Identify one oral health advocate at the regional level to conduct activities to increase the capacity of dentists to meet the needs in the region.

- Increase funding available for dental education by increasing fellowship programs, and streamlining loan repayment options.

- Make greater use of HRSA’s National Health Service Corps scholarship program to train dentists to work with underserved low-income populations. Advocate for the supplementation of this HRSA program with ACF funds in order to have influence on where the dental graduates meet their service requirements.

- Work at the state and national level to earmark early education (for children 0 – 5 years of age) funding to support efforts to increase oral health access and education.

- Work with Federal and state loan repayment programs to create incentives for new dentists to serve Head Start eligible populations, especially in underserved areas.

- HRSA should visit dental schools and dental hygiene programs to present and discuss the needs of Head Start eligible children and public health programs.

- Work with the American Dental Hygienists’ Association (ADHA) (and existing regulations) to increase their ability to provide oral health assessments and other dental care services to increase access to dental care for Head Start eligible children.

- Find innovative ways to educate parents and increase prevention in order to reduce demand for dental treatments (e.g., urgent and complex surgical treatment for young children).
For dentists already in the field, develop ways such as “Give Kids a Smile Day” to make serving Head Start children “fashionable.” One strategy could include a national public relations campaign in conjunction with the American Dental Association.

Target recruitment, scholarship and loan repayment strategies for culturally diverse dental students who would be more likely to return to underserved communities.

Advocate for additional oral health funding at the state and Federal levels.

Advocate for tax incentives for donated care, since Head Start already calculates that as an in-kind donation, it could be a simple transfer of paperwork.

Resources:

A regional advisory committee to coordinate regional Head Start oral health activities.

An advocate associated with the committee would serve as a focal point for solving oral health issues.

Communication: listservs, Web sites, a regional leader in oral health.

Support for a Training and Technical Assistance (T/TA) person with a focus on oral health in Head Start.

Increased funding for loan repayment programs and scholarships.

Support for innovative projects: e.g., dental van, portable dental equipment to increase access to dental care for Head Start eligible children.

Roles of Partnering Organizations and Agencies: The group specified a number of potential partners, without defining specific roles they would play in these activities:

Regional ACF, HRSA, CMS
Regional Director for HHS
State and local dental societies
Dental schools: residency programs
Dental hygiene programs
- State health department dental directors and state oral health programs
- Head Start Associations: state, local and regional
- State Head Start Collaboration Offices
- State Medicaid/SCHIP programs
- State WIC, USDA Food and Nutrition Services, National WIC Association
- State Offices of Rural Health, Primary Care
- State Primary Care Associations
- American Academy of Pediatrics: state chapters
- Policymakers/legislators

Priority Challenge #2: Access to dental insurance for Head Start eligible children and low reimbursement rates. The participants felt that issues surrounding eligibility and enrollment in Medicaid and SCHIP, coupled with low reimbursement rates for dentists accepting this insurance, created the next greatest obstacle to children in need of oral health services. The economic strains on state government is exacerbating this issue, with many states in the region reducing or eliminating oral health from their public health insurance plans.

Overall Strategy: Enhance the oral health policies and procedures governing access to public oral health insurance.

Specific Activities:

- SCHIP should cover dental care in all states. For example, SCHIP does not cover dental services in Delaware.

- Increase reimbursement rates to make it profitable to serve Medicaid/SCHIP clients; currently reimbursement is lower than the Usual Customary Rate, so dentists are operating at a loss serving these children.

- Hold focus groups with dentists to gain insight into their issues regarding providing care to Medicaid/SCHIP patients, including ways to lower their discomfort in serving this population.
■ Regional offices should link Community Access Program (CAP) grantees in the region to Head Start to assure collaboration on systems development approaches to increase access to dental care.

■ Assure dental care continues in child Medicaid EPSDT program.

■ Make sure oral health is included in Medicaid physical health benefits for adults.

■ Increase staff training in linking families to sources of coverage (e.g., oral health integrated into case management in Head Start).

■ Maintain HRSA-CMS in the state SCHIP review process, perhaps including ACF and WIC as partners in this process.

■ Educate parents about the importance of care for primary teeth.

■ Identify innovative ways to utilize non-profit organizations to obtain services for uninsured children.

■ Increase utilization of Community Volunteers in Medicine to work with uninsured children.

Resources: Other than regional oral health experts to conduct these activities and case management staff to facilitate enrollment in insurance programs, no other resources were listed.

Roles of Partnering Organizations and Agencies: Cited as possible partners were:

■ State Head Start Collaboration Offices
■ State dental directors and oral health programs
■ State SCHIP/Medicaid
■ Community Access Program (CAP)
■ Regional HRSA, ACF, CMS
■ Community Volunteers in Medicine
■ Nonprofit organizations providing oral health services
V. Conclusion

Victor Alos, D.M.D., M.P.H., HRSA Regional Dental Consultant in the HRSA Philadelphia Field Office, concluded the forum by thanking the Federal sponsors, presenters, and all of the participants for the dedicated time and interest in the discussions. Dr. Alos noted that the groups worked diligently together and outlined many challenges in Region III related to oral health education, prevention, and access to dental care. Moreover, the groups identified several promising practices that can be applied in the future. He was impressed with the deliberations of the groups, as they recommended innovative strategies to address priority issues. Also, the groups identified several partners to collaborate in the implementation of the action plan.

Dr. Alos commented that the groups worked independently but common themes emerged regarding recommendations to the Regional Offices. He pointed out similar recommendations for a regional consortium of representatives of partnering organizations and agencies to meet regularly and collaborate on oral health issues in Head Start. Dr. Alos noted that several strategies called for the identification of a lead individual to focus on oral health and Head Start at the regional level. This individual could serve as a liaison among partners within Region III by enhancing communication and supporting the application of best oral health practices in Head Start programs.

In closing, Dr. Alos stated that he looks forward to collaborating with the central offices of the Maternal and Child Health Bureau and Head Start Bureau as he seeks future opportunities in Region III to move the recommended actions forward. Also, he urged participants to continue the collaborations started at the forum and take advantage of all opportunities within their states and communities to improve the oral health component in Head Start.
Appendix A: U.S. Department of Health and Human Services Regions
DHHS Regional Offices

<table>
<thead>
<tr>
<th>Region</th>
<th>City</th>
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<tbody>
<tr>
<td>I</td>
<td>Boston, MA</td>
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<tr>
<td>II</td>
<td>New York, NY</td>
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<tr>
<td>III</td>
<td>Philadelphia, PA</td>
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<tr>
<td>IV</td>
<td>Atlanta, GA</td>
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<td>V</td>
<td>Chicago, IL</td>
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<tr>
<td>VI</td>
<td>Dallas, TX</td>
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<tr>
<td>VII</td>
<td>Kansas City, MO</td>
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<tr>
<td>VIII</td>
<td>Denver, CO</td>
</tr>
<tr>
<td>IX</td>
<td>San Francisco, CA</td>
</tr>
<tr>
<td>X</td>
<td>Seattle, WA</td>
</tr>
</tbody>
</table>

Head Start Bureau (Additional Regional Offices)

<table>
<thead>
<tr>
<th>Region</th>
<th>Branch</th>
<th>City</th>
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</thead>
<tbody>
<tr>
<td>XI</td>
<td>American Indian-Alaska Native Head Start Program Branch</td>
<td>Washington, DC</td>
</tr>
<tr>
<td>XII</td>
<td>Migrant Seasonal Head Start Program Branch</td>
<td>Washington, DC</td>
</tr>
</tbody>
</table>
Appendix B: Forum Goals and Agenda
Forum Goals

- 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.

- Assess current regional issues, challenges, and promising practices related to improving the oral health of children in Head Start and Early Head Start.

- 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.
Agenda

Day One

1:00 – 1:15  Registration  Washington Room

1:15 – 1:45  Welcome to the Region III Head Start Oral Health Forum  Washington Room

Moderator
Victor Alos DMD, MPH
HRSA Regional Dental Consultant
HRSA Philadelphia Field Office

Mr. Robert Zimmerman
Office of the Secretary’s Regional Representative
Department of Health and Human Services

Gwen DeVeaux-Way
Head Start Branch Chief
ACF Region III

Allen Conan Davis DMD, MPH
Chief Dental Officer
Centers for Medicare and Medicaid Services

1:45 – 2:00  Roadmap for the Forum: Goals and Instructions  Jane E. M. Steffensen, BS, MPH, CHES
Consultant, Head Start and Oral Health Partnership Projects

2:00 – 2:30  National Perspective: ACF / Head Start Oral Health Collaboration

National Update: Oral Health and Head Start
John Rossetti, DDS, MPH & Mark Nehring, DMD, MPH
Oral Health Program
Maternal and Child Health Bureau, HRSA

Oral Health Component in Head Start and Early Head Start: National Perspective
Robin Brocato, MHA
Senior Health Program Specialist
Health and Disabilities Branch
Head Start Bureau
2:30 – 3:00  Enhancing Oral Health in Region III: Opportunities and Challenges

Moderator
Ms. Deborah Gillan-Shaw
Head Start ACF
Philadelphia Regional Office

Panel Presentation

The Head Start Regional Perspective
Mary Gunning, MSW
President
Region III Head Start Association

The Dental Advocacy Perspective
Harry Goodman, DDS, MPH
Associate Professor
Department of Pediatric Dentistry
University of Maryland Dental School

Open Discussion

3:00 – 3:15  Break

3:15 – 4:30  1st Small Group Discussion
Washington Room
Curtis Room
Wedgewood Room

Each group will answer the following questions:

1. What are the Challenges / Obstacles related to:
   ▪ Prevention?
   ▪ Oral Health Education?
   ▪ Access to Dental Care?

2. What are the Promising Practices related to:
   ▪ Prevention?
   ▪ Oral Health Education?
   ▪ Access to Dental Care?

4:30 – 5:00  Plenary Session: Report from Each Group
Washington Room

Moderator:
Jane E. M. Steffensen, BS, MPH, CHES
Consultant, Head Start and Oral Health Partnership Project

Evening  Dinner on Your Own
Day Two

7:30 – 8:00  **Continental Breakfast**

8:00 – 8:30  **Plenary Session:** Washington Room

Nominal Group Process
Moderators:
Jane E. M. Steffensen &
Anne Hopewell, MSW, Senior Associate, HSR

Prioritize Top 3 Issues for Each Focus Area:
- Prevention
- Oral Health Education
- Access to Dental Care

8:30 – 10:00  **2nd Small Group Discussion** Washington Room

Curtis Room
Wedgewood Room

For Each Priority Issue the Following Questions Will Be Answered:

1. What is the Overall Strategy for this Issue
2. What are the Specific Actions Steps?
   (What activities should be accomplished at the Regional level?)
3. What are the Roles of Regional Agencies and Other Entities to Accomplish each Strategy and what Resources will be Needed?

10:00 – 10:15  **Break**

10:15 – Noon  **2nd Small Group Discussion** (Continued)

Noon – 1:30  **Working Lunch and Closing Plenary Session** Washington Room

Moderator
Ms. Deborah Gillan-Shaw
Administration for Children and Families
Region III

**Report From Small Groups**

*Forum Wrap Up and Closing Remarks on Charting a Future Course*
Victor Alos DMD, MPH
HRSA Regional Dental Consultant
HRSA Philadelphia Field Office
Appendix C: Forum Participants List
Region III Oral Health Forum:
Enhancing Partnerships for Migrant and Seasonal Head Start and Oral Health

The Downtown Club
Philadelphia, PA
June 9 and 10th, 2003

Participant List

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Appendix D: Listing of Challenges / Obstacles and Promising Practices Identified in Small Group Discussions on Day 1
## Breakout Session Day One Notes

### Prevention

<table>
<thead>
<tr>
<th>Challenges / Obstacles</th>
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<tbody>
<tr>
<td>• Affordable care</td>
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<tr>
<td>• Lack of providers (and specialists)</td>
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<tr>
<td>• Funding for public health education programs</td>
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<tr>
<td>• Access to the community (rural health)</td>
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<tr>
<td>• Lack of knowledge on part of parents: crosses all income levels</td>
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<tr>
<td>• Lack of community education about oral health: only info out there is around toothpaste</td>
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<tr>
<td>• Educating people to get over their fears</td>
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<tr>
<td>• Need for media outlets to do community service about messages</td>
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<td>• Nutrition (e.g., babies drinking juice from bottles, consistency of foods)</td>
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<td>• Cultural issues: going to the dentist being for a good cause, need for preventive care</td>
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<tr>
<td>• Putting dental health on people’s priorities</td>
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<tr>
<td>• Conflicting messages about standards for when to bring kids to dentists for first time: changing EPSDT recommendations to be consistent with other messages</td>
</tr>
<tr>
<td>• Getting insurance companies to cover youngest children</td>
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<tr>
<td>• Caries being “contagious” and the risk of sharing spoons, kissing children</td>
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<tr>
<td>• Practitioner reluctant to see children under 5</td>
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<tr>
<td>• Physicians not doing thorough and complete preventive screening</td>
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<td>• Defining requirements for the Head Start community about what constitutes a screening</td>
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<tr>
<td>• Missing provider’s perspective</td>
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<tr>
<td>• Attraction to dentistry as a field has decreased in ratio to population</td>
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<tr>
<td>• Legislation won’t allow dental hygienists to offer preventive services</td>
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<tr>
<td>• Case management/continuity of care</td>
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<tr>
<td>• Not showing up for appointments</td>
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<tr>
<td>• Oral health not high priority – families, communities, HS programs (economic choices, life choices, other more pressing issues)</td>
</tr>
<tr>
<td>• Turf wars, bureaucracy, political battles</td>
</tr>
<tr>
<td>• Scope of practice of dental hygienists</td>
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<tr>
<td>• Changing perceptions regarding adult oral health</td>
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<tr>
<td>• Lack of Resources</td>
</tr>
<tr>
<td>• Connecting families w/community resources</td>
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<tr>
<td>• More training of personnel</td>
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<tr>
<td>• Lack of fluoride in the water</td>
</tr>
<tr>
<td>• Outside of North America, some countries add fluoride to salt and sugar. This is a less expensive alternative we haven’t explored.</td>
</tr>
<tr>
<td>• Some dentists don’t want to use sealants on primary teeth.</td>
</tr>
<tr>
<td>• Classroom Practice: Want to use enough toothpaste. Want to prevent bacteria from remaining on teeth too long.</td>
</tr>
<tr>
<td>• We need a message for people to take with them. In nutrition, people learn about the food pyramid. Dentistry needs an easy message to give to the public.</td>
</tr>
<tr>
<td>Prevention</td>
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**Promising Practices**

- Fluoridated water
- School-based dental clinics
- Education about nutrition and caries prevention occurring in WIC program
- Having children actually go to the dentist
- Representation of dentists on health advisory committees, especially those for Head Start
- States who have made dental care a political priority
- To have trained “lay people” (e.g., medically trained Head Start personnel) do initial screenings
- Engaging primary care physicians in dental screening
- Providing transportation to appointments
- Advertising: emphasis on aesthetics of good teeth
- Connecting families with community resources
- Educating the larger community about oral health
- “Watch your Mouth” campaign
- Provide continuing education for dentists in caring for young children
- Maximizing Parent Involvement (education/workshops, policy council, HSAC)
- Educating HS staff to maximize opportunities
- Problems need to be communicated on different levels in society, not just within the government and the dental profession. We need social marketing.
- Continuous education in the clinics.
- Zero days lost to tooth pain “campaign”
## Oral Health Education

### Challenges / Obstacles

- Funding
- Time: providers’, clients’, dealing with limited attention span
- Language barriers
- Getting materials translated into other languages
- Getting parents involved and serving as models to their kids
- Mixed messages on how to prevent dental diseases
- Need for examination of best practices in how to get messages to public
- Need for bombardment of messages in multiple venues
- Difference between advocacy and lobbying
- The whole community needs to get involved, not just a targeted population of the community. In community forums, oral health is rarely on the agenda.
- Tell parents they need to clean baby’s mouth. Dental issues are dealt with after the fact. We need to be pro-active, not reactive.
- We may have a problem with how dentistry works. The profession is not marketing as well as it could.
- In the dental schools, students need to learn about dental problems in the communities.
- We shouldn’t disconnect oral health from general health. People need to understand that it is a part of overall health. A good smile matters to a child’s success.
- Strengthen oral health in EPSDT

### Oral Health Education

<table>
<thead>
<tr>
<th>Promising Practices</th>
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<tbody>
<tr>
<td>Low literacy appropriate materials</td>
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<tr>
<td>Head Start incorporates oral health into parent meetings</td>
</tr>
<tr>
<td>Oral health education curriculum in the classroom, with complementary parent component (will be available from MD on web sites)</td>
</tr>
<tr>
<td>School nurses</td>
</tr>
<tr>
<td>Bringing dentists into the classroom to alleviate fears</td>
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<tr>
<td>Field trips to dentist office</td>
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<tr>
<td>Mobile dental vans (privately funded)</td>
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<td>Private partnerships and donations</td>
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</table>
Access to Dental Care

Challenges / Obstacles

• Insurance: parents without it
• Not enough dentists in an area/distribution of dentists
• Transportation
• Translation of materials
• Reimbursement
• No shows
• Parents don’t know what Head Start expects and why they expect it
• Not seeing promising practices nationally
• Access for CSHCN
• Medicaid Rates
• Availability of Pediatric Dentist (other dentists who can care for young children)
• Availability of Dentist who will see low-come families
• Cultural attitudes (parents & children - dental care not as important)
• Lack of oral health education
• Administrative barriers (bureaucracy)
• No-shows/broken appts.
• Transportation (very rural communities- no public transportation)
• Family Issues (missing school, taking off work)
• Logistical issues (getting children specialized treatment)
• Lack of Insurance (working poor don’t qualify for many programs)
• Waiting room issues (waiting, understanding between both parties)
• Dental school graduates accept jobs in the suburbs, and well-to-do communities. They don’t work in under-served communities.
• We need to encourage graduates to serve needy communities with scholarships, for example.
• Need to increase the diversity of dental students because minority students are more likely to return to the under-served communities.
## Access to Dental Care

### Promising Practices

- Maryland’s dental fellowship program
- School-based dental clinics
- Mobile dental vans (WIC has vans with coordinated services)
- Health fairs
- Give a Kid a Smile: one day dentists open practice to kids without insurance
- Head Start has health assistants/family workers offer capacity to case manage: role delineation
- Legislative advocacy (i.e., Maryland)
- Mandate of Surgeon General’s Report
- Dental access committee with local dental societies
- Head Start collaboration projects
- Health advisory committees with dental representation
- PA study of oral health outcomes
- Loan repayment to encourage new dentists
- Loosening licensing requirements
- Link with State MCH program to get access to Title V money for CSHCN
- Partnering with dental providers to set up group visits of HS children (maximizes time)
- Conducting screenings before child enters HS
- Special Incentives (coupons for toothbrushes)
- Statewide Health Advisory Committees
- Increasing rates
- Improving Case Mgmt. (dental case mgrs, reminding parents of appts.)
- Discuss strategies
- Integrating Oral Health w/child medical visits
- Integrating Oral Health w/pre-natal visits
- Loan repayment and other creative ideas
- “Take Five Program” (Every dentist take 5 families to care for)
- “Pipe line programs (Training dental students in community practices)