

# Enhancing Partnerships for Head Start and Oral Health Report for Region IV Forum

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Prepared for:

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# Table of Contents

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Executive Summary.....	1
I. Background and Introduction: Region IV Forum on Head Start and Oral Health .....	8
II. National and Regional Perspective: History and Vision for Head Start Oral Health ....	11
III. Panel Discussion: Enhancing Oral Health in Region IV—Opportunities and Challenges .....	14
IV. Road Map for the Forum: Goals and Process .....	18
V. Summary of Small Group Discussions to Identify Challenges, Promising Approaches, Strategies, and Action Steps .....	18
VI. Closing Remarks and Next Steps.....	32
Appendix A: Map	
Appendix B: Agenda	
Appendix C: Part List	
Appendix D: Group Discussion	

## Executive Summary

The Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) hosted the Region IV Forum: Enhancing Partnerships for Head Start and Oral Health on May 13-14, 2004 in Atlanta, Georgia to determine how organizations and agencies can collaborate at a regional level to improve the oral health of Head Start children and families. This was the seventh in a series of regional forums held as a follow-up to the National Head Start Partners Head Start Forum convened in 1999 by Head Start, 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).

Sixty-nine participants attended the Forum representing all the States in the region and a variety of organizations, agencies, and professional groups from the public, private, and non-profit sectors. During the forum the attendees shared their unique experiences and perspectives regarding Head Start and oral health.

Speakers at the Forum represented the regional offices of HRSA, ACF, CMS, and USDA, as well as several states in the region, and included Jim Simpson, Galo Torres, Beverly Taylor, Lorraine Bizzell, Donna Cross, W. Kenneth Jackson, Dr. Harry Bickel, Dr. Mary McIntyre, Dr. Gary Rozier, Dr. Nicholas Mosca, and Linda Hampton. Dr. John Rossetti, Dental Consultant for the Maternal and Child Health Bureau, HRSA served as a plenary speaker and noted the long history of oral health and early childhood activities and stressed the importance of partnerships to improve oral health outcomes in the Head Start program. The speakers highlighted some of the regional barriers to oral health care, including a limited provider pool, especially providers who are able and willing to provide dental care to young children in Head Start, and a lack of understanding regarding the importance of oral health on the part of Head Start parents and families. The speakers addressed the growing concern around access to oral health services for both children and their families. The speakers also highlighted promising practices that address enhancing education, expanding prevention and reducing barriers to oral

health services, including Smile Alabama! Healthy Smiles, Health Children – Medicaid Dental Outreach Initiative, the North Carolina early intervention program for children birth to two through the North Carolina Smart Smiles and Into the Mouth of Babes, and the Kentucky Oral Health Education Program with Kentucky Invests in Developing Success (KIDS NOW), and other oral health collaborations with Early Head Start and Head Start programs.

Guided by instructions from Jane Steffensen, Head Start and Oral Health Partnership Project Consultant, the participants met in small groups to prioritize key issues and describe promising practices. On the second day the groups outlined strategies and action steps, identified roles and discussed resource needs for the four focus areas: access to dental care; prevention; oral health promotion and education external to Head Start; and oral health promotion and education within Head Start. The recommendations from the are summarized in the next section.

### **Prevention**

Participants identified three main priorities under the topic of prevention: lack of trained providers of oral health education; inadequate funding for prevention services; and limited availability of timely interventions, materials, and program support.

Among the strategies and action steps participants identified were efforts to:

- v Work with the Commission on Dental Accreditation (CODA) to develop curriculum to support work with young children.
- v Approach State and regional licensure groups to develop a pediatric examination to assess competence.
- v Develop “Lunch and Learn” sessions that cover infant/toddler/preschool growth and development topics.
- v Target residency programs for primary health care providers, including medical and nursing students, because they often see young children under the age of five more than dentists.
- v Place stronger emphasis on prevention education.

- √ Develop demonstration programs in the region focused on prevention in Head Start.
- √ Investigate forgiveness of loans for new dental providers practicing in rural areas.
- √ Obtain funding from EPSDT and Medicaid to cover the application of fluoride varnish.
- √ Collaborate with non-traditional partners working in the community on school readiness and child development like the Zero to Three and Success by Six programs.

Participants identified a number of potential collaborators in health related fields, including the American Academy of Pediatrics and the pediatric dental community, nursing associations, OB/GYN practitioners, pediatricians, family practitioners, the National Association of Community Health Centers, the American Dental Association, the American Dental Student Association, the American Medical Student Association, the Association of State and Territorial Dental Directors, Academy of General Dentistry, the Maternal and Child Health Bureau, Head Start, Healthy Start, Medicaid/SCHIP, family planning directors, special needs organizations, the March of Dimes, the American College of Obstetrics and Gynecology, Zero to Three program, Success by Six program, etc.

### **Access to Dental Care**

This group identified a number of issues, which they were able to group into three overarching priorities: inadequate numbers of practitioners able and willing to provide dental care to the Head Start population; coordination and communication between Head Start and the provider community; and limited financial resources and inadequate reimbursement.

Among the strategies and action steps identified by participants to increase access to care were efforts to:

- √ Conduct county/community level needs assessment of practitioners (e.g., dentists, hygienists, etc). Work with the American Dental Association (ADA) and the

American Dental Hygienist's Association (ADHA) to conduct State level assessments of provider capacity as well.

- v Communicate with State Associations related to the dental profession as well as dental schools and dental hygiene education programs about the need to expand access to dental care for Head Start children. Support service learning opportunities for dental and dental hygiene students working with Head Start programs in the region.
- v Develop an expanded network of providers.
- v Investigate whether State dental and medical practice acts hamper or support access to dental care and explore the feasibility of expanded scopes of practice to increase access to dental care for children in Head Start.
- v Use mobile vans to conduct screenings at schools and Head Start programs, provide case management and referrals for additional care if needed.
- v Have all Head Start Health Advisory Committees recruit dental professionals.
- v Cross-train Head Start and dental community on what each other does, and identify common issues (e.g., insurance) for both Head Start and dental care providers.
- v Create and distribute Head Start and dental provider "101" information that covers such topics as low reimbursement rates, and how "no shows" hurt overall relationship between Head Start and dentists and be sure to include parents and families in these informational meetings.
- v Educate and involve legislators and other policymakers on the importance and impact of oral health.
- v Maximize current resources (e.g., make sure there is not duplicate payments for the same services across agencies including Head Start, Medicaid, and MCHB).

Potential collaborators include local businesses, churches, families, retired volunteers, the HRSA Regional Office, State Head Start Collaboration Offices, as well as Head Start health coordinators, State Head Start Associations, State dental and dental hygiene associations, Medicaid providers, child advocacy groups, community health centers and local public health departments. Resources include a number of grant opportunities such as collaboration with the MCHB's Early Child Care Systems grants, Ronald McDonald grants, conversion foundations, and state or national dental association foundations.

## **Oral Health Promotion and Education External to Head Start**

Participants identified and prioritized a number of challenges with regard to oral health promotion and education focused on individuals, programs and partnering organizations within the larger community. The priority needs included: increase oral health awareness of non-dental providers and health professionals; educate legislators on the importance of early screening and prevention, as well as appropriate reimbursement for preventive services; and educate and market the idea of prevention for the 0-5 population to businesses and the public at large.

Among the strategies and action steps identified by participants were efforts to:

- v Utilize Head Start Health Advisory Committee meetings to educate non-traditional groups about oral health.
- v Work to establish partnerships between State oral health providers and traditional health care providers.
- v Create an oral health coalition to draft position papers.
- v Create a national slogan that could increase the visibility of the issue such as "Toddler and Preschool Kids Smile" or "You are Never Too Young to Smile".
- v Establish a Head Start community service award to dentists with a documented commitment to caring for young children.
- v Encourage policymakers to participate in oral health events, and develop a presentation and display that can be made available for policymaker meetings.
- v Create an oral health marketing position at the Head Start Regional Office
- v Have the regional office identify a well-known personality or celebrity to serve as a spokesperson on this topic.
- v Identify major oral health industries and other commercial sponsors to increase their marketing efforts relevant to Head Start children and families.
- v Provide oral health messages through family entertainment and leisure outlets. Utilize State Head Start Collaboration office staff to create a unified message explaining early childhood caries using mass marketing and public broadcasting spots.

- v Provide oral health education in parenting classes at health departments and hospitals, as well as to school nurses and others who interact with Head Start, young children, and their families.

Participants identified many collaborators, including State Head Start Collaboration Offices, State Head Start Associations, professional associations, State Dental Directors, schools of dentistry, child advocacy organizations, health departments, physicians, WIC, maternal and child health representatives, and state and governmental offices that provide services to the target population.

### **Oral Health Promotion and Education within Head Start**

Participants were able to prioritize many of the issues regarding the oral health promotion and education needs of Head Start staff and children and families by identifying three overarching needs. First, participants identified the need to obtain a regional dental consultant to oversee the oral health activities of Head Start. Next they noted the need to develop and share Head Start oral health materials to promote best practices and evidence-based science for parents, staff, children, pregnant women, and providers, and ensure all materials are culturally appropriate and linguistically competent. Finally, they wanted to empower parents by providing education that prepares parents to be advocates for their family's oral health.

Among the strategies and action steps identified by participants were efforts to:

- v Obtain a full-time oral health coordinator in the region to provide guidance on oral health activities of Head Start, including Early Head Start, Migrant and Seasonal Head Start Programs, and American Indian/Alaska Native Head Start Programs. This person would:
  - Gather and distribute successful programs and best practices within the region and the Nation;
  - Provide oral health training and technical assistance to regional, State, and local Early Head Start and Head Start programs about applying model oral health promotion and education activities in Head Start;



- Work in collaboration with MCHB programs and other stakeholders;
  - Encourage Tennessee, Georgia, North Carolina, and Florida to hold statewide Head Start Oral Health Forums to gather State-specific information and develop plans; and
  - Provide technical assistance to States to implement Forum action plans in coordination with State Oral Health Programs, Head Start Collaboration Offices and State Head Start Associations and other stakeholders.
- v Ensure that the educational component in Head Start contains developmentally appropriate practices and anticipatory guidance, identification of oral health providers, and strategies for parents and families to access and use the network of oral health providers.
  - v Convene a regional Task Force that would include parents, Head Start program staff, oral health care providers, and corporate sponsors to identify, review, develop, and share educational materials to expand the application of best practices.

Participants identified HRSA/MCHB and the Head Start Bureau/ACF, as well as regional representatives of Federal partners within Head Start, MCHB, and USDA, Regional Technical Assistance Network, State Head Start Collaboration Offices, state associations and state MCH related programs and others as potential collaborators.

The Regional forum accomplished its aim of bringing people together and building linkages to make Head Start stronger and more effective in promoting oral health. The participants recommended strategies to expand oral health education, enhance prevention, and increase access to dental care. The groups identified specific areas where the regional office could facilitate efforts to work together more effectively in the future.

To access the full report, please visit the National Maternal and Child Oral Health Resource Center Web site at [www.mchoralhealth.org/HeadStart/hsforums.html](http://www.mchoralhealth.org/HeadStart/hsforums.html).

# I. Background and Introduction: Region IV 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), Centers for Medicare and Medicaid Services (CMS, then 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 formulation 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 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 a map of regions for the Head Start Bureau designated by the U.S. Department of Health and Human Services).

The Region IV Forum: Enhancing Partnerships for Head Start and Oral Health was held May 13-14, 2004 in Atlanta, Georgia and sponsored by the Regional Office of ACF and the MCHB. (An agenda for the Forum can be found in Appendix B.) The goals of the Region IV Head Start Oral Health Forum were to:

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

- v 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.

Participants at the Forum included a broad range of representatives from the Regional Offices of ACF, CMS, HRSA, and USDA Food and Nutrition Service, State Oral Health, Maternal and Child Health (Title V) Programs, WIC, Medicaid, State Head Start Collaboration Offices and State Head Start Associations, State Dental Associations, Community Health Centers, Local Health Departments, Head Start Grantee Directors and Health Managers with Early Head Start and Head Start Programs, Dental School Faculty, Local Dentists working with Head Start Programs, and a Statewide Early Childhood Oral Health Program. A full list of attendees is available in Appendix C.

## B. Introduction to Region IV Forum

**Jim Simpson, Head Start Branch Manager, Division of Community Programs, Administration for Children and Families, Region IV**, welcomed participants on behalf of the regional office and stated that he is looking forward to working with the participants to develop recommendations that will inform strategic efforts in the regional office.

**Galo Torres, DDS, HRSA Regional Dental Consultant, Atlanta Regional Division**, also welcomed participants to Atlanta on behalf of HRSA, and noted that planning for this forum had been underway for a many months and he was gratified to see so many people in attendance from throughout the region. He acknowledged ACF for their support in the financing and convening of this event.

**Lorraine Bizzell, R.D., M.S., M.B.A., Regional Nutritionist, Special Supplemental Food Program for Women, Infants, and Children, USDA**, reviewed some of the regional collaborative efforts between WIC and Head Start. She noted that WIC and Head Start both serve pregnant women and young children and that identification of oral health problems is part of the risk assessment conducted by WIC. The two programs have worked collaboratively in the past, planning the National Head Start Oral Health Partners Forum in 1999 and the Surgeon General's Oral Health Forum in 2000. In addition the two programs have co-authored

articles related to oral health and preschoolers. Ms. Bizzell stated that in the Spring of 2004, a mailing was sent to two thousand WIC agencies outlining oral health resources that are available for use at WIC sites. The WIC program also includes assessment and nutrition education that can focus on the importance of oral health, behaviors that can improve oral health, and ways to prevent dental caries. Ms. Bizzell noted that the Alabama WIC program has an exemplary nutrition education model to prevent early childhood caries that is culturally appropriate and linguistically competent for the population served by WIC.

**Donna Cross, Technical Director, Division of Medicaid and Children’s Services, Centers for Medicare and Medicaid Services,** welcomed participants to Atlanta on behalf of Dr. Conan Davis, Chief Dental Officer at CMS. Dr. Davis asked her to convey the message that CMS places a high value on partnerships. One example of this commitment to partnering at the Federal level is the Memorandum of Understanding, that was entered into last year by HRSA and CMS that outlined how partnerships can be formed between HRSA, CMS, and other Federal agencies. Ms. Cross also mentioned that CMS and Head Start are exploring ways the two organizations can collaborate and partner through the development a Memorandum of Understanding. Ms. Cross conveyed Dr. Davis’s support of these regional forums, and thanked the organizers for giving her the chance to participate in the forum. She noted that the Division of Medicaid and Children’s Health EPSDT/Oral Health Coordinator for the region is Catherine Cartwright. Ms. Cross indicated an interest in taking participants’ questions or concerns back to CMS.

**W. Kenneth Jackson, Deputy Regional Administrator, Administration for Children and Families, Region IV,** welcomed all participants to Atlanta and extended his thanks to Beverly Taylor, Galo Torres, John Kehoe, Barbara Jackson and all others who planned this forum. He noted that those in attendance today are the heroes of America’s Head Start community, and that the collective mission to remove barriers for the most vulnerable children is something Head Start programs and staff continue to do with distinction. He urged Forum participants to work toward achieving the overarching goal of the forum—to enhance partnerships. Mr. Jackson stated that some reviews of the Head Start program show a failure to provide needed oral health care, and that all Forum participants should work to ensure that all children, including Head Start participants, receive the same considerations and prompt dental care. He

noted that it is the responsibility of each Head Start program to ensure that any child diagnosed with an oral health condition receives needed dental care. Mr. Jackson emphasized that Forum participants should take into account regional issues when developing a strategic plan. He stressed that these goals can be accomplished by working together and with other stakeholder groups that may not be present at the forum. He concluded by urging Forum participants to meet the challenge of establishing the partnerships necessary to provide children in Head Start needed dental and other health care services.

## II. National and Regional Perspective: History and Vision for Head Start Oral Health

Jane E. M. Steffensen, MPH, CHES, Consultant, Head Start and Oral Health Partnership Project introduced **John Rossetti, DDS, MPH, Dental Consultant for the Maternal and Child Health Bureau** who presented the national perspective of the history and vision of the relationship between Head Start and the MCHB's oral health initiatives. Although Robin Brocato, M.H.A., Senior Health Program Specialist with the Head Start Bureau, was unable to attend the Forum, Dr. Rossetti's presentation reflected the fruit of their collaborative efforts. He reviewed past oral health and early childhood collaborations and stressed the continuing importance of oral health and access to dental health services to Head Start, MCHB, CMS, WIC, and other Federal agencies. He noted that the 1999 National Head Start Partners Oral Health Forum revived the formal relationship between HSB and MCHB and resulted in an Intra-Agency Agreement between the two Bureaus to address oral health issues for pregnant women and children in Early Head Start and Head Start at the local, State, regional, and national levels. As part of the Intra-Agency Agreement, oral health forums are being held at the State and regional levels, as well as with professional organizations such as the American Association of Pediatric Dentistry, the American Dental Hygienists' Association, and the American Dental Association. He provided an overview on how these Head Start Oral Health Forums fit into the broader landscape of national initiatives focused on increasing access to dental care, expanding prevention, enhancing oral health education, and improving oral health. Specifically, these forums are designed to identify the issues, barriers and strategies needed to improve services and enhance prevention practices for

Head Start children and families. Dr. Rossetti noted that the next challenge will be to compile the results of these forums into a national plan to improve the oral health of young children.

In conclusion, Dr. Rossetti emphasized the importance of partnerships, as well as the need for follow-up. He stated that persistence pays off and the value of “not taking no for an answer.” Especially in the context of government programs, he suggested that with sufficient follow-up “no’s can become yes’s.” Dr. Rossetti also asked participants to keep in mind that “it is people who make these programs work.” As an example of the importance of persistence, Dr. Rossetti noted that several years passed between the 1999 Oral Health Forum and the subsequent Intra-Agency Agreement, illustrating that “things take time,” and that participants should remain optimistic and expect to see results from this forum “down the road.” Dr. Rossetti encouraged Forum participants to become involved in Head Start oral health initiatives at the state and local levels.

After Dr. Rossetti finished explaining the outcomes of the regional and professional organization forums conducted to date, Ms. Steffensen introduced **Harry Bickel, DMD, MPH, Health Specialist, Training and Technical Assistance Services, Western Kentucky University.** Dr. Bickel has a long history of working on oral health issues throughout Region IV and was able to present regional data on the prevalence of oral disease among Head Start and other low-income children. He also provided insight into how the relationship between Head Start programs and the families of vulnerable children can work together to improve the oral health of children in Early Head Start and Head Start.

Dr. Bickel used dental performance indicators to illustrate changes in oral health over time. He noted that the US Public Health Service used to be involved in every aspect of oral health. He stated that while visiting oral health programs during his time in the Public Health Service, he found many inconsistencies in the messages being conveyed to programs. Before the contract ended, he spent some time in the region writing manuals for health coordinators, dental consultants, and dentists.

Dr. Bickel emphasized the importance of numbers and quantitative data when making a case before State government. Using Program Information Report data for the region, he demonstrated that children receiving treatment dropped from 99% to 84% between 1993-2003. To illustrate the magnitude of the problem, he also noted that 18,000 children in the region have unmet dental needs.

To add to the quantitative data presented, Dr. Bickel gathered qualitative data from oral health and Head Start professionals across the region by posing several questions to the 1300 people registered for a regional listserv dedicated to oral health and other health needs. The informal survey yielded stories about innovative children's oral health programs in the region. Some best practices he described included a lending library established in Alabama with a grant from the Samuel Harris Fund of the American Dental Association Foundation; a Regional Dental Health Preventive Team in Tennessee that comes into the Head Start centers and provides examinations and dental cleanings for all children; a program in Florida that partners with a local dental hygiene program; a program in North Carolina that utilizes Healthy Smiles (sponsored by Smart Start) in which dentists donate their time and office space; and a program in Kentucky that utilizes a dentist who was formerly a Head Start child to provide free annual examinations.

When asked what their State does for Head Start programs related to oral health, a representative from Kentucky noted that their State has a community-wide multi-agency group called Well Child that recently chose dental health as their number one issue. This action allowed access to grant funding and other resources dedicated to oral health. North Carolina highlighted its "Into the Mouths of Babes" program. Their State representatives are striving to make their programs and resources known to the groups they effect, rather than waiting for them to come asking the State for help.

Dr. Bickel also noted respondents identified two pressing issues in their States related to oral health and Head Start. First, there are not enough dentists able or willing to provide dental care to young children, especially children in Head Start and Medicaid and secondly there is a lack of understanding on the part of parents regarding the importance

of their child’s oral health. One North Carolina program also noted that finding and paying for dental services for children who are not U.S. citizens is a major problem for their program.

### III. Panel Discussion: Enhancing Oral Health in Region IV—Opportunities and Challenges

Following the plenary speakers, panelists representing two states in the region talked about the challenges and opportunities of enhancing oral health in Head Start. Panel moderator **Barbara Jackson, Consultant, Phoenix Management Group, Inc.,** introduced the panel participants.

**Mary McIntyre, M.D., Medicaid Director, Alabama Medicaid Office,** shared “The Alabama Story: Enhancing Partnerships for Head Start and Oral Health.” She reviewed Alabama’s Medicaid program, noting that it has no “bells and whistles,” but instead is very basic, covering 19% of Alabama’s total population, 46% of all deliveries in Alabama, and 37.1% of Alabama’s children. Medicaid’s covered population in Alabama is 48% White, 50% Black or African-American, and 2% Hispanic or Latino.

Dr. McIntyre then highlighted Alabama’s Medicaid Dental Program, “Smile Alabama—Healthy Smiles, Healthy Children.” She noted that the idea for the program grew out of the realization that oral health was a pressing issue throughout the State. The program was the result of a private-public partnership funded by the Robert Wood Johnson Foundation and matched with Federal dollars. Dr. McIntyre noted that when trying to develop the program they specifically targeted funding sources from outside the State.

The target populations of the program are children in Medicaid and their caregivers, practicing dentists, and stakeholder or partner associations and groups. The program is composed of several “interventions” including claims processing simplification, an increase in reimbursement rates for dental care, provider outreach and education, and consumer and patient education. The goals of the program are to increase the number of



participating dental providers by 15% in three years, and to increase the number of children receiving dental care by 5%.

Dr. McIntyre reviewed some of the materials and information developed as part of the “Smile Alabama” program. These included educational tools and radio announcements targeted to Head Start programs, primary care physicians, and pregnant women, and a dental fact sheet for advocacy and legislative groups. Dr. McIntyre noted that it is important to tailor the message to specific groups.

Dr. McIntyre highlighted some of the results of the program, including an increase in both enrolled and active dentists in Medicaid, and an increase in utilization of dental care. She also noted several challenges, including State and Federal budgetary shortfalls, unfunded Federal mandates, an increase in the Medicaid-eligible population, and increasing pharmacy costs. Dr. McIntyre noted that the current Medicaid reform calls for an adjustment to the matching rate formula and changes to current policies and procedures regarding the transfer of assets and considerations of annuities. These changes will impact how Medicaid is implemented at the State level.

Finally, Dr. McIntyre offered several activities that meeting participants can do to improve the oral health of the Head Start population. They include assisting in the distribution of information to increase knowledge of the importance of oral health to overall health, encouraging the use of oral health lesson plans and education in Head Start and kindergarten programs, and supporting funding for Medicaid.

**Gary Rozier, D.D.S., M.P.H., Professor, School of Public Health, University of North Carolina at Chapel Hill**, then presented “Prevention of Early Childhood Caries in Medical Practices: The North Carolina Experience.” Dr. Rozier reviewed North Carolina’s oral health statistics, stating that the state ranks 47<sup>th</sup> in the number of all dentists, 45<sup>th</sup> in the number of pediatric dentists, and 44<sup>th</sup> in dentists’ participation in Medicaid. Only 9% of North Carolina dentists accept Head Start children.

Given these statistics, the issue of oral health rose to the governor's attention. This increased Statewide focus on access to dental care, and later moved to include an emphasis on prevention. North Carolina initiatives include the training of medical primary care clinicians through the "Smart Smiles" and "Into the Mouths of Babes" projects. North Carolina also linked Early Head Start programs to local medical primary care providers. The goals of these initiatives include increased access to preventive dental care for low-income children, reduced prevalence of early childhood caries in low-income children, and a lessening of the burden of treatment on a dental care system already stretched beyond its capacity to serve young children. The assumptions underlying these goals are based on an understanding that early childhood caries is a serious public health problem, and that this burden can be reduced through prevention targeted to young children. In addition, it was assumed that virtually all young infants and toddlers obtain care at medical offices so it is a logical place to provide preventive services. Once physicians and their staff know that early childhood caries is a problem they are willing to help prevent it, although they may need help in learning procedures and implementing them in their practices.

Dr. Rozier reviewed the elements of preventive services, oral screening, caregiver education, and the use of topical fluoride. He emphasized that Medicaid is a key partner in this endeavor since they set policy, and provide reimbursement to the providers. However in order for Medicaid to provide reimbursement to medical providers for screening, risk assessment, referral, caregiver counseling, and fluoride application, all providers must first receive training. Medical professional societies currently offer continuing medical education courses covering such topics as the cause and outcomes of early childhood caries, how to conduct an oral health risk assessment, how to perform a dental screening for abnormalities, and how to counsel caregivers on oral health practices. Courses also cover the role of fluoride in the prevention of early childhood caries as well as methods for applying fluoride to primary teeth.

Dr. Rozier noted that in North Carolina since 2000, more than 2,000 providers have been trained to provide these services and they cover a wide geographic area, including 135 pediatric offices, 108 offices of family practice physicians and 84 (out of 87) health

departments. Since the initiative began, there has been an eight-fold increase in the number of infants and toddlers with preventive dental visits. Since 2003, there has been a 9.6% increase in the number of dentists who regularly provide dental care to patients enrolled in Medicaid, resulting in an increase of 12,000 patients per month. Among the services that primary care physicians and nurses report providing to young children and their families are: risk assessment, oral health counseling, the application of fluoride varnish, prescriptions for fluoride supplements, and referral to dentists. These services focus on risk assessment, primary prevention, and intervention of early dental caries (non-cavitated lesions) with fluorides.

In addition, Dr. Rozier described the North Carolina initiative to link Early Head Start Centers with medical practices participating in the Into the Mouth of Babes Project. The Early Head Start initiative includes educational materials for Head Start staff. Also, a brochure and video for parents have been developed and distributed to Early Head Start centers to increase awareness of the importance of oral health and medical practices providing preventive dental services.

Dr. Rozier noted that throughout the State there has been an increase in access to prevention and that studies on systems integration and long-term dental outcomes are underway. He explained that while tooth decay is a preventable problem, there are several challenges to improving the oral health of children, including the need for partnerships to provide effective services and to meet the oral health needs of the increasing number of uninsured children and their families. He closed by discussing that evaluation is important to demonstrate the effect of initiatives on dental care and costs, the oral health of children, and the oral health-related quality of life for children and their families.

#### **IV. Road Map for the Forum: Goals and Process**

Next Jane E.M. Steffensen, MPH, CHES, who works with the Head Start and Oral Health Partnership Project, provided an overview of the group discussions. She

highlighted the success of past Regional Forums and discussed parallel State and Territorial Forums funded by MCHB through the Association of State and Territorial Dental Directors (ASTDD). She noted that ASTDD had issued the 5<sup>th</sup> Cycle of Request for Proposals (RFP) for State Head Start Oral Health Forums due at the end of June 2004 and several states in the Region IV were eligible to apply for the grant support. Ms. Steffensen also reviewed various resources participants' have at their disposal and noted that Katrina Holt, Director of the Maternal and Child Oral Health Resource Center, was attending the Forum representing the Resource Center and the ASTDD Head Start Oral Health Project.

Next, Ms. Steffensen reviewed the Region IV Forum goals and described the instructions for the group discussions. She encouraged participants to learn from promising practices and model programs that currently exist in local communities in their States and to think about strategies for implementing them at the regional level. She also encouraged participants to consider a variety of stakeholders, especially parents and community members when discussing action steps. She suggested that the groups focus their efforts on articulating both short- and long-term creative, practical strategies to enhance existing promising approaches and inform new ones. Notably, Ms. Steffensen asked participants to consider collaborations and leadership opportunities among organizations and agencies at the regional level that will benefit pregnant women and children in Early Head Start and Head Start.

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

Following the plenary sessions, participants met in four groups to identify Region IV challenges and obstacles, as well as promising practices and resources related to four areas: prevention, access to dental care, oral health promotion and education (external to Head Start), and oral health promotion and education (internal to Head Start). On the second day of the Forum, the groups met again to develop regional strategies to address the priority issues identified the previous day. The groups outlined strategies, action

steps, collaborators, and resources needed in Region IV. In particular, the groups were charged with identifying strategies to increase communication, deepen understanding, and improve collaboration and integration throughout the region with regard to the oral health needs of HS/EHS populations. The group discussions are summarized here, and a detailed outline of the deliberations from the discussion groups are provided in Appendices D.

## Group 1: Prevention

### *Issues*

This group considered a number of challenges and obstacles related to prevention facing Head Start children. After thorough discussion they were able to narrow these issues down to three main priorities:

- √ Lack of trained providers of oral health education;
- √ Inadequate funding for prevention services; and
- √ Limited availability of timely interventions, materials, and program support.

### **Priority One: Lack of trained providers of oral health education**

#### *Promising Approaches*

Some of the promising approaches identified by participants include: North Carolina “Smart Smiles” and “Into the Mouths of Babes” models, Alabama’s Head Start classroom materials from the “Smile Alabama—Healthy Smiles, Healthy Children”, Colgate’s Bright Smiles, Bright Futures Program (as used by local programs), and Tennessee’s use of pediatric dental residents to counsel families within twenty-four hours of a baby’s birth.

#### *Priority Issues, Overall Strategies, and Action Steps*

Participants were able to identify overall strategies and action steps for the first two priority issues. To address the issue of lack of trained providers of oral health education,

participants devised the overall strategy of providing prevention education to “primary professionals,” i.e., persons enrolled in medical, nursing, dental, dental hygiene, and related programs. They stressed that early and continuous exposure to preventive dental care information and the development of partnerships between Head Start and the dental community could be highly successful. In addition, they discussed that the region could develop the capacity to provide in-service training to practicing professionals through continuing education courses.

Action steps identified include:

- v Work with the Commission on Dental Accreditation (CODA) to develop curriculum to support work with young children.
- v Approach State and regional licensure groups to develop a pediatric examination to assess competence.
- v Develop “Lunch and Learn” sessions that cover infant/toddler/preschool growth and development topics.
- v Provide clinical experiences for students to increase exposure to young children.
- v Target residency programs for primary health care providers, including medical and nursing students, because they often see young children under the age of five more than dentists.
- v Place stronger emphasis on prevention education.
- v Investigate forgiveness of loans for new dental providers practicing in rural areas.
- v Seek foundation funding to support training activities.
- v Obtain buy-in from dental schools and State dental boards, as well as non-dental providers, State boards for other health professionals, Medicaid, and Children’s Health Insurance Programs.
- v Develop position statement to support work with young children to influence CODA, ADEA, etc. Also, target the Council of Access Prevention and Inter-Professional Relations (CAPIR) within American Dental Association (ADA).
- v Develop advocacy/group sessions and lobby legislators.
- v Create consumer-driven process.
- v Conduct faculty development courses.

- v Find a “champion” for the cause.
- v Provide continuing education courses for nurses.
- v Establish a train-the-trainer model on basic prevention and oral health messages
- v Obtain funding from EPSDT and Medicaid to cover the application of fluoride varnish.
- v Identify trainers to go into dental offices to provide infant and toddler training.
- v Identify/compile State dental and physician requirements to determine capacity limitations for involvement.
- v Obtain funding from HRSA, Head Start, and corporate sponsors for oral health promotional materials
- v Replicate the American Academy of Pediatrics (AAP) and American Academy of Pediatric Dentistry (AAPD) collaborative model at the regional level, including, which includes the use of public health practitioners, Head Start staff, nurses working with the Children with Special Health Care Needs (CSHCN) program, nurse practitioners, pediatricians, family medical providers, OB/GYN, residents, faculty, and University Centers for Excellence in Developmental Disabilities (UCEED).

### ***Resources and Collaborators***

Participants identified a number of potential collaborators in health related fields, including the American Academy of Pediatrics and the pediatric dental community nursing associations, OB/GYN practitioners, pediatricians, family practitioners, the National Association of Community Health Centers, the American Dental Association, the American Dental Student Association, the American Medical Student Association, the Association of State and Territorial Dental Directors, Academy of General Dentistry, the Maternal and Child Health Bureau, Head Start, Healthy Start, Medicaid/SCHIP, family planning directors, special needs organizations, the March of Dimes, the American College of Obstetrics and Gynecology. Other collaborative partnerships could be formed with faith-based and cultural organizations, African-American fraternities and sororities, the media, foundations such as the Robert Wood Johnson Foundation and other funding sources, such as States’ tobacco settlement dollars.

## **Priority Two: Inadequate funding for prevention services**

Next this group engaged in lively discussion on potential actions steps to increase funding for prevention activities. They identified a number of action steps that could be pursued at both the State and regional levels including:

- v Meet with Medicaid commissioner and appropriate State organizations to ask for approval of prevention expenditures.
- v Develop a summary of regional policies related to oral health and prevention.
- v Develop comprehensive demonstration programs with Federal funding.
- v Investigate alternative funding opportunities including foundation support. (This could include completing the application process for statewide and regional funding.)
- v Identify non-traditional partners with common goals to apply for funding such as school readiness groups, “Zero to Three” programs, “Success by Six” programs, and dental insurance providers.
- v Establish a regional oral health task force/work group with a focus on prevention and education.
- v Recommend that the Administration for Children and Families develop an awareness campaign for policymakers/legislators.
- v Provide education for pregnant women around the issue of linkages between oral health, the transmissibility of dental caries and other infant/toddler oral health outcomes.

### ***Resources and Collaborators***

Resources identified include the Grottos (a Masonic group providing dental care funding), CSHCN funding for children under eighteen years of age, Medicaid/SCHIP, Robert Wood Johnson Foundation funding, Kellogg Foundation funding, WIC, and dental insurance providers. Participants also named a number of potential collaborators, including school readiness groups, “Zero to Three” and “Success by Six” programs, speech therapists, nutritionists, early childhood educators, and dental insurance providers.



**Priority Three: Limited availability of timely interventions, materials, and program support.**

For the third issue, the limited availability of timely interventions, materials, and program support, participants had time only to identify an overall strategy of evaluating existing materials for best practices, and recommending standardized curricula for Head Start programs.

**Group 2: Access to Dental Care**

***Issues***

Participants in the access group covered a number of challenges in their discussion, since access is considered a major challenge throughout the region. This group identified a number of issues, which they were able to group into three overarching priorities:

- v Inadequate numbers of practitioners willing and able to provide dental care to the Head Start population;
- v Coordination and communication between Head Start and the provider community; and
- v Limited financial resources and inadequate reimbursement.

Participants in the access group identified strategies and action steps for all three priority issues.

**Priority One: Inadequate numbers of practitioners willing and able to provide dental care to the Head Start population**

To address this workforce challenge participants felt it was important to emphasize two separate aspects of this issue: the raw number of active providers (a dwindling number due to retirement) versus providers willing to provide dental care to the Head Start population. This group suggested a number of action steps:

- v Conduct county/community level needs assessment of practitioners (e.g., dentists, hygienists, etc). For example, are low-income populations being served? Are children being served?

- v Incorporate these questions into Head Start assessments—use as an annual survey tool.
- v Work with the ADA and the American Dental Hygienist’s Association (ADHA) to conduct State level assessments of provider capacity as well.
- v Identify underserved communities.
- v Develop individual strategies for each community.
- v Educate dental schools to make students aware of Head Start and oral health.
- v Develop an expanded network of providers.
- v Explore the feasibility of expanded functions of hygienists
- v Investigate whether medical and dental State Practice Acts hamper or support expanded functions of various providers.
- v Make current providers more effective (e.g., New Zealand created “dental nurses”).
- v Work with key stakeholders, especially Region IV Head Start, regarding the use of alternative providers for screenings, but be sure not to advocate for a lower standard of care.
- v Communicate with the State Associations associated with the ADA, AAPD, ADHA and dental and dental hygiene schools regarding the need to provide dental care to Head Start children. Provide opportunities rotations with Head Start programs within underserved communities (pay for room and board and stipend).
- v Work towards consensus on a standard of care and/or expanded practice acts and ensure that this agreement is reflected in regional regulations.
- v Use mobile vans to conduct screenings at schools and Head Start programs, provide case management and referrals for additional care if needed. (Special attention could be given to schools with free or reduced lunch an idea being piloted in Kentucky.)

**Priority Two: Coordination and Communication between Head Start and the Provider Community**

This group had a number of ideas on how to address the issue of coordination and communication between Head Start and the provider community. They were able to devise an overall communication strategy using the following action steps:

- v Have all Head Start Advisory Committees recruit local dental professionals
- v Distribute information on State Collaboration Offices
- v Have State Collaboration Offices contact state and local dental associations and dental hygienists
- v Cross-train Head Start and dental community on what each other does, and identify common issues (e.g., insurance) for both Head Start and dental care providers.
- v Create and distribute Head Start and dental provider “101” information that covers such topics as low reimbursement rates, and how “no shows” hurt overall relationship between Head Start and dentists and be sure to include parents and families in these informational meetings.
- v Facilitate Head Start site visits and open houses for dentists as an educational tool.

### **Priority Three: Limited financial resources and inadequate reimbursement**

Although time was limited for the discussion of this important issue the group was able to identify a number of ways to address these challenges. Specifically, participants discussed the following action steps:

- v Educate and involve legislators and other policymakers on the importance and impact of oral health. Be clear when advocating with policymakers that a crisis is coming if they don’t take action immediately.
- v Maximize current resources (e.g., make sure there is not duplicate payments for the same services across agencies including Head Start, Medicaid, and MCHB) and avoid over-utilization by using MCHB funding for CSHCN for case management and review of services for appropriateness.
- v Look for outside grants and funding at the local, State, and national level.
- v Coordinate assistance for children of migrant and seasonal farmworkers—ensure that Migrant and Seasonal Head Start programs such as the East Coast Migrant Association and other Head Start migrant service providers in the State are involved in these discussions, especially if the outcomes will have an impact on them.
- v Have Head Start representatives become involved in other partners’ meetings so that partners can develop an understanding of Head Start’s mission and activities.

- v Develop a central collection point for the name and contact information of all health coordinators in the region.

### ***Promising Approaches and Strategies***

Participants cited a program in Mississippi that used Robert Wood Johnson funds to purchase a dental van. Six States have demonstration projects under the State Action for Oral Health Access grant program. In addition, a rural health initiative currently supports a new dental van that provides sealants in five counties in Western Florida. In Kentucky, the State Head Start Association has a Health Services Committee, which elects its own officers and meets regularly during the Association's meetings. In South Carolina, an independent Health Network maintains a list of all the health coordinators in South Carolina and meets with all their partners annually. Some of these models could be replicated on a regional level.

### ***Resources and Collaborators***

Participants identified a number of collaborators, including local businesses, churches, families, retired volunteers, the HRSA Regional Office, State Head Start Collaboration Offices, as well as Head Start health coordinators, rural and migrant programs, and State Head Start Associations; dental professionals including dental schools, State dental and dental hygiene associations, other oral health care providers, Medicaid providers, child advocacy groups, community health centers and local public health departments. Among the resources identified were Head Start and other technical assistance providers, possible part time staff funded by the Head Start region to assume leadership and perhaps an MCHB funded regional oral health consultant. A number of grant opportunities were discussed including collaboration with the MCHB's Early Child Care Systems grants, Ronald McDonald grants, the Grottos (a Masonic group that provides funding for dental care for children with disabilities), conversion foundations, and Delta Dental Foundations (where applicable) or other state or national dental association foundations. Other resources the group considered were dental school subsidies for practitioners who could provide care for children, and county health departments/commissions funding for indigent care. To help educate legislators,

participants suggested established advocacy groups such as Healthy Mothers, Healthy Babies, and Action Alliances for Children and Youth and universities.

### Group 3: Oral Health Promotion and Education External to Head Start

#### *Issues*

Early discussion by this group included defining the external audiences to Head Start. These included any informational activities that occurred outside of the Head Start classroom and included local communities, policymakers, the dental community, extended families and the general public. With this definition in mind, participants identified and prioritized a number of issues including:

- √ Increase oral health awareness of non-dental providers and health professionals (utilizing the Standard and Guidelines by the American Academy of Pediatric Dentistry and American Academy of Pediatrics).
- √ Educate legislators on the importance of early screening and prevention, as well as appropriate reimbursement for preventive services.
- √ Educate and market the idea of prevention for the 0-5 population to businesses and the public at large.

Details concerning increased public awareness, advocacy and marketing are described below.

#### **Priority One: Public Awareness**

##### *Promising Approaches and Strategies*

Participants identified several promising approaches, including the ABCDE curriculum used in Washington State, and public relations activities conducted by other oral health coalitions. Specific strategies to address the lack of oral health awareness on the part of non-traditional providers were outlined by participants using the following action steps:

- √ Involve more people in Head Start Oral Health Forums.
- √ Coordinate Forums through the State Dental Director's Office.

- v Recommend that a Head Start grantee contact their State Oral Dental Director.
- v Utilize Head Start Health Advisory Committee meetings to educate non-traditional groups about oral health.
- v Work to establish partnerships between State oral health providers and traditional health care providers.

### **Priority Two: Advocacy**

To address inadequate knowledge of policymakers, participants discussed an overall strategy of educating State Political Action Committees, lobbyists, advocates, and policymakers on a range of oral health issues including access to oral health care for the Head Start population. To achieve this goal, the following action steps were delineated:

- v Create an oral health coalition to draft position papers.
- v Target State Political Action Committee lobbyists.
- v Create a national slogan that could increase the visibility of the issue such as "Toddler and Preschool Kids Smile" or "You are Never Too Young to Smile".
- v Establish a Head Start community service award to dentists with a documented commitment to caring for young children.
- v Invite policymakers to local Head Start and oral health programs.
- v Encourage policymakers to participate in oral health events.
- v Develop a presentation and display that can be made available for policymaker meetings.

### **Priority Three: Marketing**

Participants felt that to develop a successful marketing strategy that addresses the importance of oral health for children ages 0-5, designated staff were needed and the group recommended that the Head Start Regional Office create an oral health marketing position to implement these activities. Additional action steps identified include:

- v Have the regional office identify a well-known personality or celebrity to serve as a spokesperson on this topic.
- v Identify a former Head Start child that completed the Head Start program and benefited from the oral health component it provided to share their story at meetings, etc.
- v Identify major oral health industries and other commercial sponsors to increase their marketing efforts relevant to Head Start children and families.
- v Provide oral health messages through family entertainment and leisure outlets. Advertise in parenting magazines, style magazines, and TV channels such as MTV and Lifetime, as well as events such as NASCAR races.
- v Utilize State Head Start Collaboration office staff to create a unified message explaining early childhood caries using mass marketing and public broadcasting spots.
- v Provide oral health education, guidance and disclaimers for nursing bottles and “sippy” cups at annual Head Start fairs.
- v Provide oral health education in parenting classes at health departments and hospitals, as well as to school nurses and others who interact with Head Start, young children, and their families.

### ***Resources and Collaborators***

Participants identified many collaborators, including State Head Start Collaboration Offices, State Head Start Associations, the American Public Health Association, other professional associations, State Dental Directors, schools of dentistry, child advocacy organizations, health departments, physicians, WIC, maternal and child health representatives, and state and governmental offices that provide services to the target population. Collaborators related to marketing goals include community health centers, media outlets, marketing agencies for dental products, cosmetology associations, beauty supply business associations, Chambers of Commerce, Rotary clubs, and children’s hospitals. The participants suggested additional resources including in-kind services, State foundations, philanthropy and donations from local businesses, donated space (from business, faith-based agencies, civic organizations), local newspapers and media coverage, and direct appeals to dentists for financial support.

## Group 4: Oral Health Promotion and Education Within Head Start

### *Issues*

Participants first delineated how their task differed from Group 3's efforts regarding external promotion and education. Therefore, they limited their discussion to educational efforts that occur within Head Start classrooms and programs. They identified a range of issues related to oral health promotion and education within Head Start, primarily concerning the lack of knowledge of and competing demands on both parents and Head Start staff. The group was able to prioritize the myriad issues into three overarching needs:

- v Obtain a regional dental consultant to oversee the oral health activities of Head Start;
- v Develop and share Head Start oral health materials to promote best practices and evidence-based science for parents, staff, children, pregnant women, and providers, and ensure all materials are culturally appropriate and linguistically competent; and
- v Empower parents by providing education that prepares parents to be advocates for their family's oral health.

### *Strategies and Action Steps*

Participants felt that it was crucial for the region to obtain an oral health coordinator to provide guidance on oral health activities of Head Start, including Early Head Start, Migrant and Seasonal Head Start Programs, and American Indian/Alaska Native Head Start Programs. Participants felt that this coordinator could provide consistency in oral health activities in Head Start programs and act as a conduit of information to the States within Region IV and network with other regions across the country.

Participants developed a number of activities for this full time permanent coordinator, including:

- v Gather and distribute successful programs and best practices within the region and the Nation;



- v Provide oral health training and technical assistance to regional, State, and local Early Head Start and Head Start programs;
- v Work in collaboration with MCHB programs and other stakeholders;
- v Encourage Tennessee, Georgia, North Carolina, and Florida to hold statewide Head Start Oral Health Forums to gather State-specific information and develop plans; and
- v Provide technical assistance to States to implement Forum action plans in coordination with State Oral Health Programs, Head Start Collaboration Offices and State Head Start Associations and other stakeholders.

Participants felt that to achieve the goal of developing and sharing materials to promote best practices, a regional Task Force will be necessary. Such a Task Force would include parents, Head Start program staff, oral health care providers, and corporate sponsors to identify, review, develop, and share educational materials.

To provide educational efforts that prepare parents to be advocates for their family's oral health, participants suggested strengthening the educational component of current Head Start program performance standards related to oral health. To do this, participants felt it was important to ensure that:

- v Any Technical Assistance (TA) network is knowledgeable of the Head Start program performance standards;
- v The on-site review with the Program Review Instrument for Systems Monitoring (PRISM) is utilized to identify best practices to serve as models in oral health promotion and education and to identify programs in need of assistance to strengthen the oral health promotion and education component;
- v The educational component contains developmentally appropriate practices and anticipatory guidance, identification of oral health providers, and strategies to access and use a network of oral health providers.

### ***Resources and Collaborators***

Participants identified HRSA/MCHB and the Head Start Bureau/ACF, as well as regional representatives of Federal partners within Head Start, MCHB, and USDA as potential collaborators. Other collaborators identified are the regional TA network,

including Head Start Regional Offices and their oral health projects, the State Head Start Collaboration Offices and State Head Start Associations; State CSHCN programs; State oral health programs; dental and dental hygiene schools; medical/health educational programs; programs of public health; early childhood educational programs; professional organizations; parents; faith-based organizations; organizations representing minority groups; and infant and child advocacy groups.

To obtain a regional oral health coordinator and carry out the activities listed, participants recognized the need for funding. Potential funding resources discussed were the MCHB and the Head Start Bureau. Other resources that could promote internal educational materials mentioned were the Head Start and Oral Health Collaboration Projects associated with the HSB and MCHB Intra-Agency Agreement, Region IV Websites (e.g., Region IV Website), and Region IV listservs (e.g., Oral Health listserv). The participants noted that Internet access is not yet available for all Head Start programs and should be made a priority. Participants also suggested that it was important to make States aware of the technical assistance available for State Head Start and oral health forum funding from Kathy Geurink (ASTDD Head Start Oral Health Coordinator) and the Maternal and Child Oral Health Resource Center Director, Katrina Holt.

To provide parents with the information they need to be advocates for their children's oral health, participants identified a number of resources, including the latest PRISM reviews for Head Start programs in Region IV, existing developmentally appropriate oral health materials, such as "Smile Alabama" and "Bright Futures" and the National Maternal and Child Oral Health Resource Center.

## VI. Closing Remarks and Next Steps

Before closing remarks were provided, representatives from Mississippi and Alabama shared their experiences with regard to conducting a State Head Start Oral Forums. **Nicholas Mosca, D.D.S, Dental Director for the Mississippi State Department of Health**, stated that he learned about the grant process at last year's national oral health

conference, and in retrospect, felt it was well worth the time to apply. There were 97 participants at the one-day Mississippi forum, representing a wide range of oral health and Head Start stakeholders, similar to this regional forum. Two outcomes of the meeting were the creation of an oral health advisory committee, which has met twice since the forum last November. This advisory committee and is currently working on a manual for Head Start and dental providers summarizing the issues discussed at the forum. In addition it is devising strategies to spark of discussion in communities about how to solve the oral health issues brought up during the forum.

**Linda Hampton, M.A., Director, Alabama Head Start Collaboration Office and Acting Commissioner, Alabama Department of Children's Affairs** stated that their forum looked at oral health as a school readiness issue, and had a wide range of participants, including parents and providers, and a format similar to this regional forum. Thank you certificates and continuing education units were offered to participants. She stated that Alabama has developed a resource book and is in the process of finishing the forum report. The State report is being written from the perspective of collaboration, as a natural progression from what was already started with their Robert Wood Johnson Foundation grant. Since the forum came in under budget, they are considering holding another oral health forum in another part of the state or reproducing some materials for distribution throughout the state.

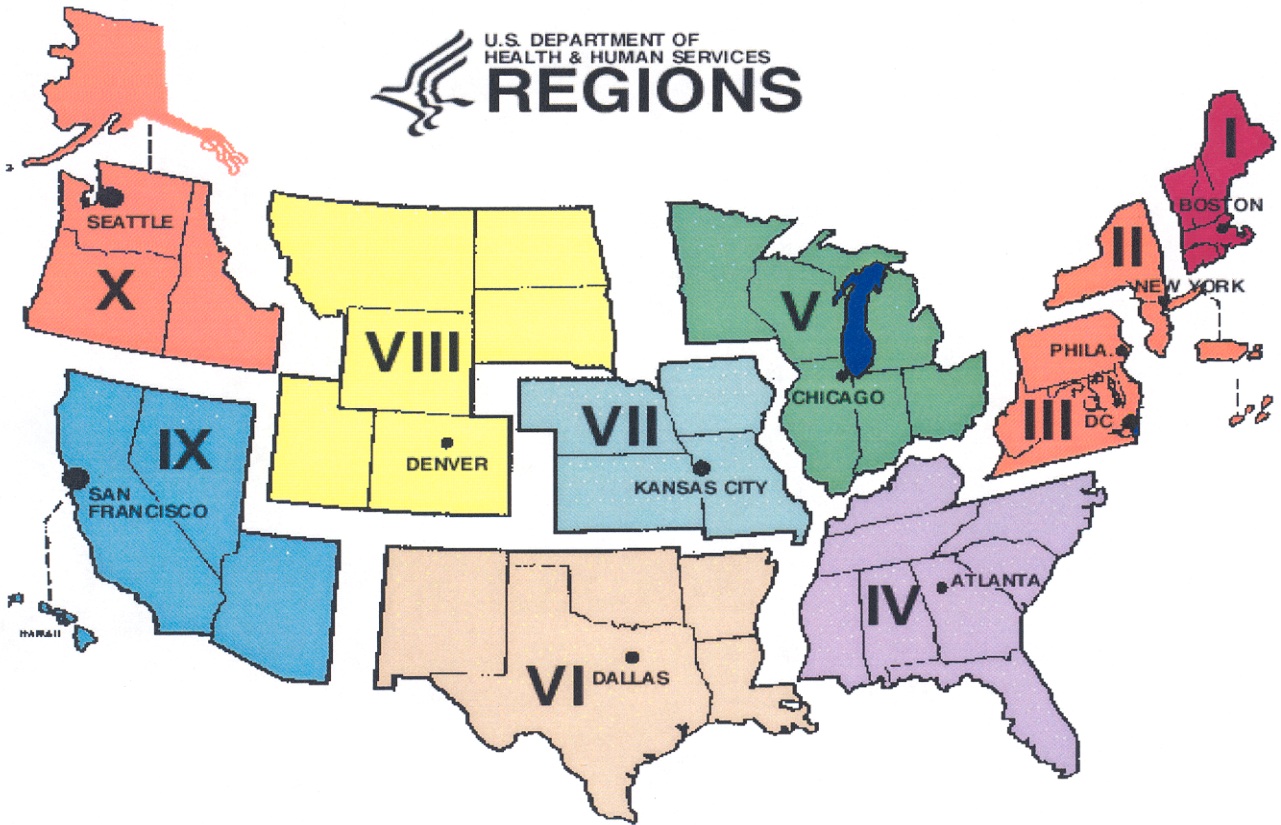
Beverly Taylor, Health and Disability Specialist, Administration for Children and Families, Region IV then thanked everyone for participating in the forum. John Rossetti, DDS, MPH, Dental Consultant for the Maternal and Child Health Bureau commented on the “phenomenal” energy in each of the groups. He briefly outlined next steps, including the development of a report summarizing the forum, and a meeting with the Head Start Regional Office to prioritize action steps and try to identify resources to make them happen. Once there are regional recommendations, staff will then present their ideas to the Head Start Bureau. He also asked States that have not yet held a State forum to consider doing so. He concluded the forum by emphasizing again the importance of follow-up, not taking no for an answer, and keeping in contact with the attendees at today’s meeting. By nurturing these new regional relationships, he suggested that we

can make these Head Start Oral Health partnerships work to improve the oral health of pregnant women, young children and their families.

## Attachment A: Map

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U.S. DEPARTMENT OF  
HEALTH & HUMAN SERVICES  
**REGIONS**



**DHHS Regional Offices**

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

**Head Start Bureau (Additional Regional Offices)**

<b>Region XI</b>	<b>American Indian-Alaska Native Head Start Program Branch Washington, DC</b>
<b>Region XII</b>	<b>Migrant Seasonal Head Start Program Branch Washington, DC</b>

## Attachment B: Agenda

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## Goals and Agenda

**Region IV 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**

May 13-14, 2004  
Sheraton Buckhead  
3405 Lenox Road NE  
Atlanta, Georgia

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.



## Agenda

### Day One - Thursday, May 13, 2004

12:30 - 1:00 pm	<b>Registration</b>	<b>Terrace Foyer</b>
1:00 - 2:00 pm	<b>Opening Plenary Session</b>	<b>Terrace Ballroom</b>

#### **Welcome and Opening Remarks**

Jim Simpson	Head Start Branch Manager, Division of Community Programs, Administration for Children and Families, Region IV
W. Kenneth Jackson	Deputy Regional Administrator, Administration for Children and Families, Region IV

#### **History & Vision for Head Start Oral Health**

##### **National Perspective**

###### Moderator

Jane E. M. Steffensen, MPH, CHES	Consultant, Head Start and Oral Health Partnership Project
Robin Brocato, MHA	Senior Head Start Health Program Specialist Health and Disabilities Branch, Head Start Bureau

John Rossetti, DDS, MPH	Dental Consultant for the Maternal and Child Health Bureau, HRSA
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##### **Regional Perspective**

Harry Bickel, DMD, MPH	Health Specialist, Training and Technical Assistance Services, Western Kentucky University
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2:00 - 3:00 pm	<b>Panel Discussion</b> <b>Enhancing Oral Health in Region IV: Opportunities &amp; Challenges</b>
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###### Moderator

Barbara Jackson	Consultant, Phoenix Management Group, Inc.
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##### **The Alabama Story**

Mary McIntyre, MD	Medical Director, Alabama Medicaid Office
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##### **The North Carolina Story**

Gary Rozier, DDS, MPH	Professor, Health Policy and Administration School of Public Health, University of North Carolina at Chapel Hill
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3:00 - 3:15 pm	<b>Road Map for the Forum: Goals and Process</b>
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Jane E. M. Steffensen, MPH, CHES	Consultant, Head Start and Oral Health Partnership Project
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3:15 - 3:30 pm                      **Break (with Refreshments)**                      **Terrace Foyer**

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

Focus Topic	Invited Facilitators	Room
Prevention	Stuart Lockwood, DMD, MPH Dental Director, Oral Health Branch, Alabama	<b>Camellia Room</b>
Access to Dental Care	Harry Bickel, DMD, MPH, Health Specialist, Training and Technical Assistance Services, Western Kentucky University	<b>Dogwood Room</b>
Head Start Oral Health Education & Promotion (e.g., external to Head Start)	Thomas Duval, DDS, MPH Director, Oral Health Section, Georgia	<b>Terrace Ballroom</b>
Head Start Oral Health Education & Promotion (within in Head Start - e.g., staff, children & families)	Christine Veschusio, RDH, MA, School Dental Program Coordinator, Division of Oral Health, South Carolina	<b>Magnolia Room</b>
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**                      **Terrace Ballroom**  
Moderator  
Jane E .M. Steffensen, MPH, CHES  
Consultant, Head Start and Oral Health Partnership Project

6:00 - 7:00 pm                      **Reception**                      **Cascades Lobby**  
Sponsored by Head Start

Evening                      **Dinner on Your Own**

**Day Two - Friday, May 14, 2004**

7:30 - 8:30 am                      **Continental Breakfast**                      **Terrace Ballroom**

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

9:00 - 10:30 pm

**Session II - Small Group Discussions: Strategies, Action Steps, Resources, Collaboration and Leadership**

Focus Topic	Invited Facilitators	Room
Prevention	Stuart Lockwood, DMD, MPH Dental Director, Oral Health Branch, Alabama	<b>Camellia Room</b>
Access to Dental Care	Harry Bickel, DMD, MPH, Health Specialist, Training and Technical Assistance Services, Western Kentucky University	<b>Dogwood Room</b>
Head Start Oral Health Education & Promotion (e.g., external to Head Start)	Thomas Duval, DDS, MPH Director, Oral Health Section, Georgia	<b>Terrace Ballroom</b>
Head Start Oral Health Education & Promotion (within in Head Start - e.g., staff, children & families)	Christine Veschusio, RDH, MA, School Dental Program Coordinator, Division of Oral Health, South Carolina	<b>Magnolia Room</b>
Each group will: <ul style="list-style-type: none"> <li>♣ Identify an overall strategy for each priority issue</li> <li>♣ Outline specific action steps, resources needed and roles of regional agencies and other entities required to implement strategies</li> </ul>		

10:30 - 10:45am

**Break** (with Refreshments)

**Terrace Ballroom**

10:45 - 12:00 pm

**Small Group Discussion (Continued)**

12:00 - 1:30 pm

**Lunch**

**Atrium Courtyard**

1:45 - 2:45 pm

**Small Group Discussion (Continued)**

2:45 - 3:30 pm

**Closing Plenary Session**

**Terrace Ballroom**

**Reports from Small Groups**

Moderator

Beverly Taylor

Health and Disability Program Specialist, ACF, Region IV

**Closing Remarks and Next Steps**

John Rossetti, DDS, MPH

Dental Consultant for the Maternal and Child Health Bureau, HRSA

3:30 pm

**Forum Evaluation and Adjournment**

## Attachment C: Participant List

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U.S. Department of Health and Human Services  
Health Resources and Services Administration  
Maternal and Child Health Bureau  
Administration for Children and Families

Presents

## **Region IV Oral Health Forum: “Enhancing Partnerships for Head Start and Oral Health”**

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*Sheraton Buckhead  
Atlanta, Georgia  
May 13-14, 2004*

### **Participant List**

#### **Alabama**

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## Attachment D: Group Discussion

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# PREVENTION

## Issues

### **Lack of Values and Knowledge Regarding Oral Health**

Lack of education of mother during early prenatal period  
Lack of importance of oral health in pregnancy and family planning (e.g., Title X)  
Need for nutritional counseling  
Need to prevent and delay transmission of bacteria resulting in dental problems (e.g., related to mother's dental education)

### **Lack of Education for Community at Large, Including Parents, Head Start Staff, Child Care and Health Care Providers, Funders, and Other Stakeholders**

Need for partnerships with pediatricians and other health providers  
Need to increase oral health education for middle and high school students  
Need Oral Health Fact Sheet-Care for Infants and Children with Disabilities and Special Needs  
Need to communicate & implement Oral Health "Best Practices" for EHS & HS staff & parents  
Need to initiate public awareness campaign  
Failure to use technology effectively

### **Lack of and Limited Funding**

Paperwork required for Medicaid  
State funding limitations on preventive care (need to educate policymakers)

### **Lack of Timely intervention**

Office Hours and Days of Operation  
Infant Oral Health (Pregnancy)  
Appropriate use of fluorides and sealants on primary molars  
Need to develop a packet of information about effective interventions

### **Lack of Parental Involvement**

Lack of and limited contact with family caregivers (e.g., these are the persons making decisions regarding children's eating habits, etc.)  
Lack of parental involvement and shared responsibility in dental visits and dental care (e.g., prevention and treatment)

### **Cultural Differences and Language Barriers**

### **Availability of Data**

Lack of Head Start data available to states  
No comprehensive tracking systems

### **Need to Maximize Educational Moments and Opportunities**

First point of contact- (prior to pregnancy)  
Second point of contact-beginning of pregnancy  
Third point of contact-delivery  
Fourth point of contact-six to twelve months of age

## **Prioritization of Issues**

1. Lack of education of stakeholders, providers, Head Start staff, parents and other members of the community
2. Inadequate funding for prevention services
3. Availability of timely interventions, materials, and providers
4. Cultural diversity and language barriers
5. Data tracking system

<b>Existing Promising Approaches</b>
North Carolina Models – Smart Smiles Project and Into the Mouth of Babes Project Smile Alabama! Healthy Smiles, Healthy Children - Alabama Head Start Classroom Materials Colgate Bright Smiles, Bright Futures Program-used by local programs Tennessee - Counseling with Pediatric Dental Residents within twenty-four hours of baby's birth

<b>Priority Issue #1 (PI#1)</b>	<b>Lack of Education for Providers</b>
<b>Overall Strategy (for PI#1)</b>	<p><b>Provide Prevention Education to Providers</b></p> <p>(A) Primary Professionals, i.e., persons enrolled in medical/dental/hygiene and related programs:</p> <ol style="list-style-type: none"> <li>1. Early and continuous exposure to preventive dental care (prenatal counseling, sealants, fluoride varnish, infant care)</li> <li>2. Work with Head Start programs to provide exposure to prevention opportunities</li> <li>3. Develop partnerships between Head Start and the Dental community</li> <li>4. Form partnership with American Dental Education Association (ADEA)</li> <li>5. Change prevention intent statement provided by Commission on Dental Accreditation (CODA)</li> </ol> <p>(B) In-service Training for practicing professionals</p> <ol style="list-style-type: none"> <li>1. Establish region wide continuing preventive dental education courses for non-dental health providers and have each state implement</li> </ol>
<b>Action Steps (for PI#1)</b>	<p><b>Group A</b></p> <p><b>Provide Prevention Education to Providers - Primary Professionals (i.e., persons enrolled in medical/dental/hygiene and related programs)</b></p> <p>Work with CODA to develop curriculum to support work with young children</p> <p>Approach state and regional licensure groups to develop pediatric examination and assess competence</p> <p>Follow the same procedure for medical education</p> <p>Lunch &amp; Learn Sessions-cover infant, toddler, and preschool growth and development topics</p> <p>Provide clinical experiences for students to increase exposure to young children</p> <p>Target residence programs for primary health providers, including medical and nursing students, because they see young children eleven times more often than a dentist before age five</p> <p>Place stronger emphasis on prevention education</p> <p>In rural areas, investigate forgiveness of loans for new dental providers</p> <p>Establish and require dental residence experience</p> <p>Seek grant and foundation funding to support training activities (e.g., dental schools and states)</p> <p>Obtain buy-in from dental schools</p> <p>Develop position statement to influence CODA, ADEA, etc.</p> <p>Target Council of Access Prevention and Inter-Professional Relations (CAPIR) within American Dental Association (ADA)</p> <p>Develop advocacy groups and sessions</p> <p>Lobby legislators</p> <p>Create consumer-driven process (e.g., top-down and bottom-up)</p> <p>Conduct faculty development courses</p> <p>Provide education and residency Courses</p> <p>Obtain buy-in from state boards</p> <p>Find a "champion" for the cause</p>



	<p><b>Group B</b>  <b>Provide Prevention Education to Providers - In-Service Training for Practicing Professionals</b></p> <p>Continuing Education Courses for Nurses  Establish a Train-the-Trainer Model  Three Hour On-line Continuing Education Course - University of Minnesota  Find a “champion” for the cause.  Obtain buy-in from non-dental providers, state boards, Medicaid, and Children’s Health Insurance Programs  Robert Woods Johnson sponsored continuing education training for general dentists  Obtain funding from EPSDT and Medicaid to cover fluoride varnish  Identify trainers to go into dental offices to provide infant and toddler training  Identify and compile state dental and physician requirements to determine capacity and limitations for involvement  Obtain funding from HRSA, Head Start, Corporate Sponsors  Replicate the American Academy of Pediatric (AAP) and American Academy of Pediatric Dentistry (AAPD) Collaborative Model at the regional level  including:  a. Public Health, Head Start, School-Based, CSHCN Nurses, Nurse Practitioners, etc.  b. Pediatricians, Family Medicine, OB/GYN  c. Residents (Family Medicine, OB/GYN, Pediatrics, etc.)  d. Faculty  e. University Centers for Excellence in Developmental Disabilities (UCEED)</p>
<p><b>Collaborators (for PI#1)</b></p>	<p>Head Start  American Academy of Pediatrics (AAP)  Nurses, OB/GYN, Pediatrics, Family Practitioners, and other Health-Related Associations  National Association of Community Health Centers  Area Health Education Centers (AHECs)  American Dental Association (ADA)  Association of State &amp; Territorial Dental Directors (ASTDD)  Academy of General Dentistry (AGD)  Title V - Maternal &amp; Child Health Bureau  Children’s Rehabilitative Services  Title X - Family Planning Directors  Special Needs Organizations  Medicaid  March of Dimes  American College of Obstetricians and Gynecologists (ACOG)  State, Regional and National Organizations Faith-Based Organizations And Cultural Organizations  African-American Fraternities and Sororities  American Student Dental Association  American Medical Student Association  Health-Related Associations and Related Service Providers  Media</p>
<p><b>Resources (for PI#1)</b></p>	<p>Head Start  Medicaid  Robert Woods Johnson Foundation and other funding sources  Healthy Start  Tobacco Settlement Money  Pediatric Dental Community</p>

<b>Priority Issue #2 (PI#2)</b>	<b>Inadequate Funding</b>
<b>Overall Strategy (for PI #2)</b>	<b>Obtain/ and Increase Access to Funding</b>
<b>Action Steps (for PI#2)</b>	<p>Meet with Medicaid Commissioner and appropriate state organizations</p> <p>Ask for approval for prevention expenditures</p> <p>Develop summary of regional policies</p> <p>Develop comprehensive demonstration programs, using federal dollars</p> <p>Identify foundation support</p> <p>Investigate funding opportunities/priorities.</p> <p>Complete application process for statewide/regional funding.</p> <p>Identify potential partners, with common goals.</p> <p>Establish regional oral health task force / work group. (Focus: prevention and education)</p> <p>Recommend that Administration for Children and Families develop awareness campaign for policy makers/ legislators (reimbursement/paperwork)</p> <p>Develop and implement data tracking system.</p> <p>“Data is the magic key to taking us where we want to be.”</p> <p>Provide services for pregnant women (re: linkage to infant concerns/ transmission of germs)</p> <p>Develop relationships with non-traditional Partners, including:  School Readiness, Zero to Three, Success by Six, and Dental Insurance</p>
<b>Collaborators (for PI#2)</b>	<p>School Readiness, Zero to Three, Success by Six</p> <p>Speech Therapists, Nutritionists</p> <p>Early Childhood Educators</p> <p>Dental Insurance Providers</p>
<b>Resources (for PI#2)</b>	<p>GROTOS: Masonic Group providing dental care funding (Website: scgrottos.org)</p> <p>CSHCN Funding for children under eighteen</p> <p>Medicaid</p> <p>Robert Woods Johnson Foundation</p> <p>Kellogg</p> <p>WIC</p> <p>Dental Insurance Providers</p>

<b>Priority Issue #3 (PI#3)</b>	<b>Limited Availability of Timely Interventions, Materials, and Providers</b>
<b>Overall Strategy (for PI#3)</b>	<b>Increase Availability of Timely Interventions, Materials, and Providers</b>
<b>Action Steps (for PI#3)</b>	<p>Evaluate existing materials for best practices</p> <p>Recommend standardized curricula for Head Start programs</p>

## ACCESS TO DENTAL CARE

### Definitions Related to Topic

**Access**—a lack of barriers to care (whatever prohibits patients from utilizing services)  
**Availability**—related to supply, number of providers, whether they accept Medicaid and Head Start patients and actually participate in the program, distribution of providers  
**Accessibility**—whether patients can actually get there  
**Utilization**—actually receiving dental care (e.g., dental care may not be a high priority for some families)  
**Barriers**—anything that prevents access to care. Barriers—poverty, insurance status, unemployment, limited transportation, shortage of providers, language, lack of childcare for children who aren't being seen by the dentist, hours of service, fear, lack of education of importance to oral health  
**Providers**—not just dentists. To create innovative programs, we need to consider nurses, primary care physicians, etc.  
**Recipients**  
**Target population**  
**Resources**  
**Shortage**  
"Culturally appropriate"  
**Screenings**—are we referring to EPSDT? Other more generic terms were used in earlier presentations. What does Head Start consider a screening vs. examination? Definition of screening is a cursory assessment of the oral cavity by a non-dentist; examination is by licensed dentist. The gray area is when physicians do screenings. Performance standards for Head Start written in early 90's did not address these issues. Frequency is not specified.  
**Continuity of care**—promoted in Head Start (related to dental home)

### Issues

#### **Financial resources.**

80% of children in Head Start program are SCHIP/Medicaid eligible. Resources often need to come out of the program funds for the other 20%.

#### **Coordination between Head Start and providers.**

Head Start and Medicaid/SCHIP agencies need to communicate with providers re: Medicaid eligibility/insurance status of children they are seeing.

#### **Lack of providers/ Maldistribution of providers.**

Dental schools closing.

Cost of dental education increasing.

Lack of pediatric dentists too—dentists do not want to treat children under five—unwilling, fearful, uncomfortable, young children often require sedations - sedation in office causes insurance to go up.

#### **Lack of training/education in treating pediatric patients**

#### **State licensing requirements may prevent dentists from moving to states with shortages.**

#### **Problems recruiting dentists to participate in Head Start.**

Late shows, no shows, etc. are barriers to provider participation.

#### **Difficulty in working with Head Start staff**

Lack of coordination, communication between providers and Head Start staff.

There needs to be mutual understanding/training between head start and dental providers of how their systems work.

Young dentists use Head Start to build their practice and then stop seeing those patients.

#### **Obtaining consent (paper vs. face-to-face)**

Getting parents face to face for consent to perform sedation, etc. is difficult.

#### **Cultural issues/language barriers.**

#### **Reimbursement**

#### **Transportation**

New regulations have made transporting kids more expensive.

Some programs have sold their buses.

**Stigma with treating the Head Start population.**

**Dental practice acts/dental licensure.**

Need the backing of the state dental association to make changes.

Have to develop a protocol for other medical personnel to encourage prevention.

Need to have a plan that works for dentists and other providers—“needs to work for everybody.”

**Lack coordination and communication.**

No central collection of Head Start health coordinator’s contact information

**Existing Promising Approaches**

KY model—part of State Head Start Association - Health Services Committee-elect own officers.

Meet every time the association meets.

South Carolina—have Health Network (not really tied to Head Start Association—Mary Williams is chairperson)—have list of all health coordinators in south Carolina. Meet with all their partners once a year. Formalizing the relationship gives more clout—point person. Head Start needs to go to other partners’ meetings. Need to have them know and understand what Head Start does.

**Prioritization of Issues**

1. Inadequate numbers of practitioners willing and able to treat the Head Start children (for various reasons).
2. Coordination and communication between Head Start and provider community
3. Financial resources/reimbursement

**Summary Points from Group Discussion**

Issue seems more acute in rural areas. What will it take to expand practices into rural areas like the Public Health Service education paid if years of service in manpower shortage area. (Different idea than forgiving loans.) Need to understand the needs of the specific areas. Urban areas have the same access problems. Loan forgiveness may not help - Outreach to future providers and building in moral responsibility into curricula. Some mobile vans cream the services / reimbursements but do not provide treatment. Vans may eliminate the idea of a dental home unless mobile vans linked to a referral network. Contact Medicaid agencies on Strategies for Health Care (e.g., Strategies Report from 2000). See how their activities changed access. Head Start Collaborations could take the lead on this although they have the capacity. Could it be a top down HSB priority? KY made optometric exams mandatory for admission to school.

<b>Priority Issue #1 (PI #1)</b>	<b>Inadequate Number of Practitioners Willing and Able to Treat Head Start Children (For various reasons including number of providers, age/retirees and willingness)</b>
<b>Overall Strategy (for PI #1)</b>	<b>Increase The Capacity Of Dental Profession And Build Capacity Of Alternate Providers (To Meet the Needs of the Underserved Communities)</b>
<b>Action Steps (for PI#1)</b>	<p>1. <u>Conduct needs assessment</u>          Compile or conduct county/community level assessment of practitioners (dentists, hygienists) (are persons with low incomes receiving services? What about children?)</p> <ul style="list-style-type: none"> <li>• Incorporate these questions into Head Start assessments - annual survey tool.</li> <li>• Work with ADA and ADHA to do State level information assessment as well. (There are sub-steps to all these) meeting with ADA, children’s commission, see where coordination of efforts with other organizations.)</li> </ul> <p>Identify underserved communities          Develop individual strategies for each community. (Assistance to get a practice started.)          Educate dental schools to make students aware of HS and oral health.          Make a direct appeal to their humanity.</p>

	<p>Consider: Rural scholars program loan forgiveness; Search program Link students with rural dentists; Recruit from rural areas; Contact Medicaid agencies on Strategies for Health Care (e.g., Strategies Report from 2000) See how their activities changed access. Reimbursement rates helps. Scholarships from businesses to go to school and return to the community – of the truly underserved</p> <p><u>2. Develop (expanded) provider network</u> If the Regional office makes it a HS Collaboration priority, they can take the lead on this.</p> <p>Explore the feasibility of expanded functions of hygienists. Change the practice acts. Consider Expanded Function Dental Assistants (EFDAs). If the and pediatricians can do effective assessments that frees up capacity of dentists to do treatment.</p> <ul style="list-style-type: none"> <li>• Investigate, learn about medical and dental practice acts to determine what needs to be changed.</li> <li>• Make current provider # more effective. Create a new field “dental nurses” like they did in New Zealand</li> </ul> <p><u>3. Work with key stakeholders regarding use of alternative providers</u></p> <p>Communicate with state ADA and AAPD and schools regarding the need to treat HS children Rotates the senior dental students through underserved communities. Pay for room and board and stipend.</p> <p>Mobile vans do screenings at school. Mobile equipment to basic treatment with referral for additional care. Provide case management and vans to get kids to dentists to treatment. This creates continuity of care. Go to schools with free or reduced lunch every two years (e.g., KY program). Vans tied to University – set up a referral network.</p> <p>State dental associations, health dept and Head Start association get them together to review need. Get them to agree on standard care or expanded practice acts take that agreement to Region to change their regulations. They must agree or there can be law suits like in SC.</p> <p><u>3. Look at HS regulations</u> Work with Region IV Head Start to accept screenings by alternate providers. (Currently it needs to be a dentist.) Difficult for the current environment. Be sure that you are not advocating for lower standard of care.</p> <p>Pediatricians may not be reimbursed for oral screenings but add steps to EPSDT on oral health and they can for HS enrollment criteria.</p>
<p><b>Collaborators (for PI#1)</b></p>	<p>Businesses Regional offices Dental schools (e.g., departments of community dentistry) State dental associations, state health departments, state Head Start associations, Medicaid, hygienists, etc. Rural, migrant and community health centers Local public health departments</p>

<b>Resources (for PI#1)</b>	Technical assistance to help get these efforts off the ground Part time staff funded by the HS region to take the lead on this. Regional oral health head start consultant AHEC – Area Health Education Centers
<b>Priority Issue #2 (PI#2)</b>	<b>Coordination and Communication Between Head Start and Provider Community</b>
<b>Overall Strategy (for PI #2)</b>	<b>Develop a Communication Strategy</b>
<b>Action Steps (for PI#2)</b>	All Head Start Health Service Advisory Committee recruit local dentists. Distribute information on State Head Start Collaboration Offices (make sure they know that they have no authority over local HS programs) Have State Head Start Collaboration Offices contact state/local dental associations and dental hygienists (attend monthly meetings, get on program) Train HS and dental community on what each do - and identify issues for both providers and HS. On insurance, forms, used in practice etc. <ul style="list-style-type: none"> <li>♣ Create/distribute HS 101 information and HS need dental provider 101, i.e., low reimbursement rates, no show hurts overall relationship btw HS and docs. Include parents and families in these educational meetings.</li> </ul> Facilitate site visits/open house for dentists to HS programs as an educational tool.
<b>Collaborators (for PI#2)</b>	Retirees State Head Start Collaboration Offices State/ local dental associations or dental hygienist associations Parents families Local Health Service Advisory Committees and local HS directors and local HS health coordinators Child advocacy groups Local businesses/employers Churches (HIPPA regulations - consideration families must make the contact with children) Memorandums of Understanding (MOUs) with Medicaid, departments of health and other agencies
<b>Resources (for PI#2)</b>	Local health departments Faith communities (financial and other resources) Create and distribute materials - professional associations Early childhood systems integration grants

<b>Priority Issue #3 (PI#3)</b>	<b>Financial Resource and Reimbursement</b>
<b>Overall Strategy (for PI #3)</b>	<b>Lack of Financial Resources and Need Increased Reimbursement</b>
<b>Action Steps (for PI#3)</b>	<p>Have to educate and involve legislators and other policymakers– re: oral health awareness, importance and impact. Need to know what you want to ask (more money?) — they do not want to learn just for sake of learning. Let them know crisis is coming—people will not react until there is a crisis. Start conversations with lawmakers before they become state legislator (especially with term limits). Build relationship. Tap into local politicians. Identify child advocacy organizations who can lobby</p> <p>Maximize current resources (assure there is no duplicate payments for the same services across agencies HS, Medicaid, MCH)—avoid over utilization</p> <p>Use Maternal and Child Health Block Grant funds for Children with Special Health Care Needs (CSHCN), case management etc. for review of services, appropriateness</p> <p>Look for outside grants and funding—local, state, national</p> <p>Coordinate assistance for migrant workers and children—ensure that Migrant and Seasonal Head Start programs in states are involved in all these discussions, especially if what we are doing will have an effect on them—East Coast Migrant Association and other Head Start migrant service providers - Migrant and Seasonal Head Start is its own region</p> <p>Program in Mississippi—used Robert Wood Johnson Foundation funds to buy dental van</p> <p>State Action for Oral Health Access grant—6 states with demonstration projects</p> <p>Western Florida—rural health initiative grant—new dental van—for five counties—mostly sealants</p> <p>Business and philanthropic organizations have grants for access-Ronald McDonald</p> <p>Grotto part of the Masons - pay for dental care for children with disabilities. National piece of the masons. Not sure how to access it—maybe go through local Masonic organization.</p> <p>Conversion foundations—California, Florida, and Texas</p> <p>Delta Dental—some states have a foundation, some state dental associations have foundations, American Dental Association (ADA) has foundation</p> <p>Local dental school—some have funds to pay practitioners to care for kids</p> <p>Adopt a Head Start center –maybe have dental society do this?</p> <p>Identify, through county health departments and commission for indigent care funds</p>
<b>Collaborators (for PI#3)</b>	<p>Head Start Health coordinators</p> <p>State Head Start Collaboration Office directors</p> <p>Medicaid, Maternal and Child Health, Public Health Departments</p> <p>Parents</p>
<b>Resources (for PI#3)</b>	<p>Child advocacy groups, e.g., Healthy Mothers, Healthy Babies—these groups are effective at educating legislators</p> <p>State dental associations</p> <p>State dental programs, dental directors, departments of health</p> <p>Private organizations and charity organizations (e.g., Grotto, etc.)</p> <p>Universities—often have lots of data, have contracts to deal with these issues</p>

## **ORAL HEALTH EDUCATION & PROMOTION EXTERNAL TO HEAD START**

### **Issues**

**Increase oral health awareness with non-dental providers and or health professionals. (Utilize the Standard and Guidelines by American Academy of Pediatric Dentistry and American Academy of Pediatrics).** Promotion of age related Anticipatory Guidance

- Physicians & Physician Assistants
- Nurses (Nurse Practitioners)
- Nutrition Professionals (Importance of Diet)
- Day Care Workers
- School Nurses
- Public Health Educators
- WIC Programs
- Legislators
- Medicaid Personnel

### **Establishing a Dental Home.**

Educate Head Start workers on reimbursed services.

### **Marketing Prevention for 0-5-age population. Educating Business, Public Settings**

- Educate Head Start workers on the Dental Practice Act in individual States or Regions.
- Head Start contact for Oral Health Director or Designee in your state (i.e. Single Point of Contact for that state or HUB)
- Head Start Health Fairs with Community Civic Groups and Service Groups to collaborate events.
- Describe current dental requirements for public school enrollment on the state level (i.e. Screening for Vision, Hearing and Dental with documentation)

### **Legislator Policy**

- Educate state legislators to start early screening.
- Promote prevention policy
- Encourage reimbursement for preventive services (topical fluoride & fluoride varnish)

### **Prioritization of Issues**

1. Increase oral health awareness with non-dental providers and or health professionals. (Utilize the Standard and Guidelines by American Academy of Pediatric Dentistry and American Academy of Pediatrics)
2. Legislative Policy
3. Marketing Prevention for 0-5-age population. Educating Business, Public Settings

### **Existing Promising Approaches**

1. Anticipatory Guidance – (i.e., ABCDE Curriculum, Washington State)
2. Partnership stake holders (i.e., Family Practice, OBGYN)
3. Oral Health Coalitions
4. Develop Oral Health Strategic Plan and use it
5. Eliminate Risk Behaviors (i.e., Tobacco use)
6. Targeting middle grades and high schools students on the importance of prevention of early childhood caries by developing a curriculum to guide the learning process.



<b>Priority Issue #1 (PI #1)</b>	<b>Lack of Oral Health Awareness and Non-Traditional Providers</b>
<b>Overall Strategy (for PI #1)</b>	<b>Increase Oral Health Awareness Among Non-Traditional Providers</b>
<b>Action Steps (for PI#1)</b>	<ol style="list-style-type: none"> <li>1. Participate in State Head Start Oral Health Forum if you are not currently involved with forums.</li> <li>2. Coordinate forum through state Oral Health Directors Office or link lead group and agency.</li> <li>3. Recommend that a Head Start designee contact their State Oral Health Director.</li> <li>4. Utilize Health Advisory Committee meetings to educate non-traditional groups about good oral health.</li> <li>5. State Oral Health providers in partnership with traditional providers.</li> </ol>
<b>Collaborators (for PI#1)</b>	<p>State Forum Will Determine Appropriate Collaborators.</p> <ol style="list-style-type: none"> <li>1. State Head Start Collaboration offices</li> <li>2. Professional Associations</li> <li>3. State Dental Directors</li> <li>4. Schools of Dentistry</li> <li>5. Child Advocacy Groups</li> <li>6. Health Departments</li> <li>7. Physicians</li> <li>8. WIC</li> <li>9. Maternal Child Health – Oral Health Representatives</li> <li>10. State and Governmental Office that provide services to target populations</li> </ol>
<b>Resources (for PI#1)</b>	<ol style="list-style-type: none"> <li>1. In-Kind Services</li> <li>2. State Foundations</li> <li>3. Collaborations with other state agencies that may have an interest in oral health</li> <li>5. Public Services Announcements (PSA)</li> <li>8. Philanthropy &amp; Donations from local businesses</li> <li>9. Donated space (e.g., business, faith based agency, civic organization)</li> <li>10. Local News Papers &amp; Media Coverage</li> <li>11. Public Information Officers</li> <li>12. Health Care Organizations</li> <li>13. Direct appeal to Dentists to provide financial support</li> <li>14. Provide training and intern opportunities to future providers in the Universities, Schools of Dentistry, and Medical Schools, etc.</li> </ol>

<b>Priority Issue #2 (PI#2)</b>	<b>Inadequate Knowledge of Legislative Policymakers</b>
<b>Overall Strategy (for PI #2)</b>	<b>Educate Policymakers on Access to Oral Health Care Issues with a Focus on Head Start Population (Target State PACS &amp; Lobbyists)</b>
<b>Action Steps (for PI#2)</b>	<p>Recommendations to Regions to encourage these activities:</p> <ol style="list-style-type: none"> <li>1. Oral Health Coalition create position papers</li> <li>2. Target state PACs and Lobbyists</li> <li>3. Create a slogan for possible DC Capitol presence (e.g., possible slogans - Toddler and Pre-School Kids Smile - You are never too young to smile</li> <li>4. Head Start Community Service Awards to Dentists with documented commitment to children</li> <li>5. Invite policymakers to local Head Start Oral Health Programs</li> <li>6. Encourage policymakers to participate in Oral Health Events</li> <li>7. Have a presentation or display available for policymakers meetings</li> </ol>

<b>Collaborators (for PI#2)</b>	State Forum Will Determine Appropriate Collaborators. <ol style="list-style-type: none"> <li>1. State Head Start Collaboration offices</li> <li>2. Professional Associations</li> <li>3. State Dental Directors</li> <li>4. Schools of Dentistry</li> <li>5. Child Advocacy Groups</li> <li>6. Health Departments</li> <li>7. Physicians</li> <li>8. WIC</li> <li>9. Maternal Child Health – Oral Health Representatives</li> <li>10. State and Governmental Office that provide services to target populations</li> </ol>
<b>Resources (for PI#2)</b>	<ol style="list-style-type: none"> <li>1. Head Start Associations</li> <li>2. Political Association Committees (PACs)</li> <li>3. American Public Health Association - Oral Health Group</li> </ol>

<b>Priority Issue #3 (PI#3)</b>	<b>Lack of Marketing Presentation for Promoting Oral Health and 0-5 Population</b>
<b>Overall Strategy (for PI #3)</b>	<b>Develop Marketing Presentation for Promoting Oral Health and 0-5 Population to Educate Business &amp; Public (Recommend Oral Health Project Director at the Regional Office to Implement Marketing Program)</b>
<b>Action Steps (for PI#3)</b>	<ol style="list-style-type: none"> <li>1. Work with partners to get a well-known personality or celebrity at the Regional Office</li> <li>2. Identify a former Head Start enrollee that completed the Head Start Program; Invite to Forum as a guest to share their success story</li> <li>3. Commercial Marketing Sponsors relevant to population</li> <li>4. Commercial Sponsors relevant to dentistry</li> <li>5. Encourage major oral health industries (e.g., Colgate (e.g., Dental Van, Crest - Proctor &amp; Gamble, Sullivan Schein, and Patterson)</li> <li>6. Target outlets for entertainment and leisure that families spend time to provide direct education to tailor good oral health messages (e.g., Supermarkets, Hair Salons, Malls)</li> <li>7. Case Managers at state office educate (market) explain the dental office. Explain prevention of Early Childhood Caries in mass marketing &amp; PBS TV</li> <li>8. Provide product guidance and disclaimers for nursing bottles and sippy cups</li> <li>9. Advertisement - OBGYN Parenting Magazine, Style, MTV, Lifetime, NASCAR, Motorcycle Clubs, Teen, etc.</li> <li>10. Provide marketing and educational opportunities at annual Head Start Recruitment Fairs for Oral Health Education (Banners, Posters, Invite Community Providers to Answer Questions, Fact Sheets, Free Screenings)</li> <li>11. Case Managers at site office educate &amp; explain the dental office process</li> <li>12. Market Oral Health Education -Tailor the message to parenting classes at the Health Departments, School Nurses, Hospitals and AHECS, etc.</li> </ol>

<p><b>Collaborators (for PI#3)</b></p>	<p><u>Collaborators from PL# 1</u></p> <ol style="list-style-type: none"> <li>1. State Head Start Collaboration offices</li> <li>2. Professional Associations</li> <li>3. State Dental Directors</li> <li>4. Schools of Dentistry</li> <li>5. Child Advocacy Groups</li> <li>6. Health Departments</li> <li>7. Physicians</li> <li>8. WIC</li> <li>9. Maternal Child Health – Oral Health Representatives</li> <li>10. State and Governmental Office that provide services to target populations</li> </ol> <p><u>Additional Collaborators</u></p> <ol style="list-style-type: none"> <li>1. Community Health Centers</li> <li>2. Media Outlets - TV &amp; Radio Stations</li> <li>3. Marketing Agencies for Dental Product Organizations (e.g., Focus on Early Development Oral Health Concerns) – Messages regarding Low Birth Weight, Focus on Prevention of Early Childhood Caries, Fluoride Varnish</li> <li>4. Advocate for CDC to urge manufactures to include real oral health messages in Ad Campaigns</li> <li>5. Cosmetology Associations and Beauty Supply Business Associations</li> <li>6. Utilize Chamber of Commerce to Contact Business</li> <li>7. Rotary Clubs, Shriners</li> <li>8. Children’s Hospitals</li> </ol>
<p><b>Resources (for PI#3)</b></p>	<ol style="list-style-type: none"> <li>1. <b>Expertise</b> - Marketing Professionals (University Graduate Students, Junior League ) with masters level training and education in the field. Contact United Fund/Way, Dental Insurance Companies, and Pharmaceutical Companies</li> <li>2. <b>Information:</b> University – Masters Programs at Universities, National Civic Groups for Special Projects, Dental Office Brochures, Place Videos in the Waiting Room Areas, WIC Dietitians</li> </ol>

# ORAL HEALTH PROMOTION AND EDUCATION WITHIN HEAD START

## Issues

1. Lack of knowledge of importance of oral health
2. Competing demands
3. Parents can make a difference in child's health
4. Break myth of "soft teeth"(e.g., baby teeth will fall out)
5. Culturally competent low literacy materials, non English materials appropriate to the target children
6. Parents:
  - Intimidated by the system
  - Knowledge and understanding of the private dental care system
  - Education packet – Alabama
  - Pregnant mothers
7. Staff:
  - Turnover
  - Simplify staff oral health training (Web Base)
  - One page check off list
  - Age appropriate anticipatory guidance
  - Best practice guidelines for early childhood providers
  - Ensure that a dentist or dental hygienist on Head Start Health Services Advisory Committee
8. Children:
  - Oral health curriculum is dated
  - Review existing oral health curriculum (address EHS)
  - Establish consistent oral health messages for all groups- children, parents, caregivers
  - Pregnant women

## Prioritization of Issues

1. Obtain a regional dental consultant to oversee the oral health activities of Head Start.
2. Develop and share Head Start oral health materials to promote best practices and evidence-based science for parents, staff, children, and pregnant women. Ensure all materials are culturally sensitive and language appropriate.
3. Provide educational efforts that prepare parents to be advocates for their children's and family's oral health.

<b>Priority Issue #1 (PI #1)</b>	<b>Obtain a Regional Head Start Oral Health Coordinator to Monitor and Provide Guidance on Oral Health Activities of Head Start to Include HS, EHS, Migrant and Seasonal Head Start Programs, and American Indian/Alaskan Native Head Start Programs</b>
<b>Overall Strategy (for PI #1)</b>	<b>To Achieve Consistency in Oral Health Activities in Head Start Programs and Act as a Conduit of Information to the States within Region IV and Network With Other Regions and the Nation</b>
<b>Action Steps (for PI#1)</b>	<ol style="list-style-type: none"> <li>1. Establish &amp; hire a full time permanent Regional Head Start Oral Health Coordinator</li> <li>2. Gather and distribute successful programs and best practices within the region and the nation</li> <li>3. The Regional Head Start Oral Health Coordinator will provide training and technical assistance to regional, state and local EHS and HS programs</li> <li>4. Work in collaboration with MCHB programs and other stake holders</li> <li>5. Encourage TN, GA, NC, and FL to hold HS Oral Health Forums to provide state specific information.</li> <li>6. Region IV Oral Health Coordinator will provide technical assistance to states to implement Forum actions plans in coordination with State HS association and other stake holders</li> </ol>

<b>Collaborators (for PI#1)</b>	Action Steps #1 1. MCHB, HRSA and Head Start Bureau, HHS Action Steps #2-6 2. Regional Federal Partners, i.e., HS, MCH, CMS, USDA 3. Regional Technical Assistance (T/A) Network <ul style="list-style-type: none"> <li>• Head Start Oral Health Collaborative Projects</li> <li>• HS State Collaboration Offices</li> <li>• State Head Start Associations</li> <li>• State MCH Children Health Care Needs Program</li> <li>• State Oral Health Programs</li> <li>• Dental Schools</li> <li>• Dental Hygiene Schools</li> <li>• Medical and Health Educational Programs</li> <li>• Schools Programs of Public Health</li> <li>• Early Childhood Educational Programs</li> <li>• Professional Organizations</li> <li>• Parents</li> <li>• Faith Based Organizations</li> <li>• Organizations Representing Minority Groups</li> <li>• Infant and Child Advocacy Groups</li> </ul>
<b>Resources (for PI#1)</b>	1. Funding <ul style="list-style-type: none"> <li>• Regional Oral Health Coordinator Position (MCH &amp; Head Start Bureau)</li> <li>• Budget for implementation of activities (Federal, State, Local funds, Private, Non-Profit) Oral Health Coordinator and Partnership</li> </ul> 2. Head Start and Oral Health Collaborative Projects 3. Regional Web Sight (e.g., Technical Assistance Network) 4. Region IV Oral Health Listserve 5. Internet Access at all HS Programs 6. Awareness of Technical Assistance available to States for Forum funding Kathy Geurink, ASTDD HS OH Project Coordinator and MCH Oral Health Resource Center - Katrina Holt, Director (includes Head Start Oral Health Information)
<b>Priority Issue #2 (PI#2)</b>	<b>Develop and Share Head Start Oral Health Materials to Promote Best Practices and Evidence-Based Science for Parents, Head Start Staff, Children, and Pregnant Women (Ensure All Materials are Culturally and Language Appropriate)</b>
<b>Overall Strategy (for PI #2)</b>	<b>Convene a Regional Task Force to Include Parents, Head Start, Oral Health, Providers, Corporate Sponsors to Identify, Review, Develop and Share Educational Materials</b>
<b>Action Steps (for PI#2)</b>	1. Gather and distribute successful programs and best practices within the region and the nation 2. The Regional Oral Health Coordinator will provide training and technical assistance to regional, state and local EHS and HS programs 3. Work in collaboration with MCHB programs and other stake holders

<b>Priority Issue #3 (PI#3)</b>	<b>Provide Educational Efforts that Prepare Parents to be Advocates for Their Children’s and Family’s Oral Health</b>
<b>Overall Strategy (for PI #3)</b>	<b>Strengthen the Educational Component to Emphasize Head Start Program Performance Standards Related Oral Health</b>
<b>Action Steps (for PI#3)</b>	<p>Ensure that:</p> <ol style="list-style-type: none"> <li>1. Technical Assistance (TA) Network is knowledgeable of HS program performance standards related to oral health</li> <li>2. Utilize on-site review with the Program Review Instrument for Systems Monitoring (PRISM) to identify best practices to serve as models in oral health promotion and education.</li> <li>3. Utilize PRISM review to identify programs in need of assistance to strengthen oral health promotion and education component.</li> <li>4. Ensure that educational component contains: <ol style="list-style-type: none"> <li>a. Developmentally Appropriate Oral Health Practices and Anticipatory Guidance</li> <li>b. Identify Oral Health Providers</li> <li>c. Access and Utilization Network of the Oral Health Providers</li> </ol> </li> <li>5. Identification sharing of developmentally appropriate materials</li> </ol>
<b>Collaborators (for PI#3)</b>	<ol style="list-style-type: none"> <li>1. Regional Federal Partners, i.e., MCHB, HRSA, Head Start Bureau, CMS, and USDA</li> <li>2. Regional Technical Assistance (T/A) Network <ul style="list-style-type: none"> <li>• Head Start Oral Health Collaborative Projects</li> <li>• HS State Collaboration Offices</li> <li>• State Head Start Associations</li> <li>• State MCH Children Health Care Needs Program</li> <li>• State Oral Health Programs</li> <li>• Dental Schools</li> <li>• Dental Hygiene Schools</li> <li>• Medical and Health Educational Programs</li> <li>• Schools Programs of Public Health</li> <li>• Early Childhood Educational Programs</li> <li>• Professional Organizations</li> <li>• Parents</li> <li>• Faith Based Organizations</li> <li>• Organizations Representing Minority Groups</li> <li>• Infant and Child Advocacy Groups</li> </ul> </li> </ol>
<b>Resources (for PI#3)</b>	<ol style="list-style-type: none"> <li>1. Latest PRISM reviews for HS programs in Region IV</li> <li>2. Regional Head Start Oral Health Coordinator and Support Staff</li> <li>3. Budget for Review</li> <li>4. Developmentally Appropriate Oral Health Materials e.g., Smile Alabama, Bright Futures</li> <li>5. National Maternal and Child Oral Health Resource Center</li> </ol>