Enhancing Partnerships for Head Start and Oral Health
Report for Region V Forum

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# Table of Contents

Executive Summary ........................................................................................................................................ i

I. Introduction........................................................................................................................................... 1
   A. History of Regional Forums ........................................................................................................... 1
   B. Welcome and Opening Remarks .................................................................................................... 1

II. Plenary Session ................................................................................................................................... 3
   A. MCHB and HSB IntraAgency Agreement ..................................................................................... 3
   B. Region V Head Start Overview ...................................................................................................... 4
   C. Plenary Presentations: State-Based Models ................................................................................. 5
      Ohio .................................................................................................................................................. 5
      Illinois ............................................................................................................................................. 8
      Indiana ........................................................................................................................................... 10
      Wisconsin ....................................................................................................................................... 12
      Minnesota ...................................................................................................................................... 13
      Michigan ....................................................................................................................................... 14

III. Summary of Small Group Discussions ............................................................................................. 16
   A. Group 1: Prevention and Education .............................................................................................. 16
   B. Group 2: Access to Dental Care .................................................................................................... 20

IV. Response and Closing Remarks ....................................................................................................... 25

Appendix A: Participant List
Appendix B: Maps of Regional and State Oral Health Forums
Appendix C: Publications Referencing the Ohio Head Start Oral Health Special Project
Appendix D: Small Group Discussion Notes
Executive Summary

The Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) convened a Region V Forum “Enhancing Partnerships for Head Start and Oral Health” on July 12, 2005, in Chicago, IL. This was the 12th and final forum to be held under an IntraAgency Agreement between the Maternal and Child Health and Head Start Bureaus that resulted from a 1999 National Head Start and Partners Oral Health Forum convened by the Head Start Bureau (HSB); HRSA; the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services, or CMS); and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

The major aim of the Region V Forum was to determine how organizations and agencies at a regional level could work together to improve the oral health of Head Start children and their families. More specific goals of the Region V Forum were 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
- Identify promising State-based models for enhancing oral health in Early Head Start and Head Start
- Develop strategies that include assessment of current oral health issues and 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.

More than 35 participants attended the Forum representing the six Region V States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. The group was comprised of participants from Head Start and oral health programs. Speakers represented the regional offices of ACF, HRSA, Head Start, the Association of State and Territorial Dental Directors (ASTDD), MCHB, a State oral health program, State Head Start associations, a dental school, a Head Start grantee, and a nonprofit oral health program. A full list of participants can be found in Appendix A.
The speakers noted barriers to prevention and access to dental care in Region V and discussed promising approaches for improving oral health outcomes for young children and their families. During the Forum, participants also shared their unique experiences and perspectives on the oral health component of Head Start programs.

Guided by Head Start and Oral Health Partnership Project consultant, Jane E.M. Steffensen, M.P.H., Consultant with the Head Start and Oral Health Partnership Project, the participants met in small groups to discuss one of two areas: prevention and oral health education or access to dental care. During the first session, each group discussed challenges and identified priority oral health issues. In the second session, each group outlined strategies for future action and identified collaborating organizations and agencies necessary to address priority issues. The priority challenges identified by each group are described below.

The Prevention and Education group discussed the need for a comprehensive approach to oral health tailored to meet the specific needs of the Head Start population. They agreed that an effective strategy for prevention and education requires a consistent message and the collaboration of dental and health providers, Head Start staff, and parents. The group discussed several challenges related to prevention and education. After combining these issues around common themes, the group rank-ordered their top three priority areas for future efforts in this area:

- Identify clear oral health messages, and increase communication and dissemination of materials and resources that reflect these messages.
- Increase the use of evidence-based prevention strategies to improve oral health among children and pregnant women in Head Start.
- Clarify oral health performance standards with more objective guidance from the HSB at the national level.

The Access to Dental Care group recognized that issues related to access are difficult to address considering the challenge of sustaining policy and program interest in the topic of oral health in the face of competing health agendas. The group spent time addressing workforce issues such as the shortage of dental providers, disincentives associated with
the Medicaid Program, and the additional provider challenges that can be experienced in providing dental care to young children. The need for accurate data also emerged as a pressing issue in order to report accurately the barriers to accessing dental care and the oral health status of children and pregnant women in Early Head Start and Head Start. The group also noted the importance of demonstrating the economic impact of expanding access to preventive oral health care. Of the many areas discussed, the group selected three areas of priority and identified corresponding strategies for implementation to expand access to oral health care to children in Head Start. The following were selected as priorities by the group:

- Improve quality of oral health data and especially oral health data measures collected through the Head Start Program Information Report (PIR).
- Expand the size and capacity of the current dental workforce.
- Identify and secure alternative revenue streams to support the reimbursement of dental services.

Further details regarding the recommended overall strategies, action steps, and collaborating partners needed to achieve these goals are outlined in the full report. 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.
I. Introduction

A. History of Regional Forums

In 1999, the Head Start Bureau, the Health Resources and Services Administration (HRSA); the Centers for Medicare and Medicaid Services (CMS, then known as the Health Care Financing Administration); and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) convened a National Head Start Partners Oral Health Forum to focus attention on early childhood oral health. The purpose of the Forum was to discuss strategies for improving oral health status among young children and for increasing collaboration at the Federal, State, and local levels to enhance access to oral health services.

One outcome of this national Forum was the development of an IntraAgency Agreement between HSB of the Administration for Children and Families (ACF) and HRSA’s Maternal and Child Health Bureau (MCHB) to support efforts to improve the oral health of children in Head Start and Early Head Start. As part of this agreement, the two Bureaus decided to sponsor a series of regional, special-population, and professional-organization forums to determine how organizations and agencies could work together at the regional level to enhance oral health efforts in Head Start and Early Head Start programs.

B. Welcome and Opening Remarks

Kay Willmoth, Director, Office of Family and Child Development, ACF Regional Office, began by welcoming the group to Chicago, IL. She stressed the connection between oral health and overall health, stating that oral disease in children can be particularly devastating, affecting energy, concentration, eating, and speaking. She noted that access to oral health care is a primary concern among Head Start staff, technical assistance (TA) providers, and parents. She cited the 2004 Head Start Program Information Report (PIR) indicating that 80 percent of the children in Head Start received
the dental care they required at the national level. However, in Region V, only 66 percent of the children in Head Start received the dental care they required according to PIR data. Ms. Willmoth suggested that this discrepancy is due in part to the large number rural Head Start grantees in the region.

Ms. Willmoth noted that since 1999 Head Start programs have taken steps to improve oral health among children. She noted that the Forum was an opportunity to examine the progress of current efforts and evaluate the potential for future programs.

Steven P. Geiermann, D.D.S., Captain, U.S. Public Health Service, Regional Dental Consultant, DHHS/HRSA Chicago Regional Division, compared Head Start's oral health efforts over the years to a phoenix, noting that these efforts flourish for a time, eventually collapse and then arise again. He stated that approximately 15 years ago, Region V had over 100 Head Start consultants coordinated by Dr. Bill Hall, the regional dental consultant at that time, but these positions were eliminated due to funding decisions made at the Headquarters level. Though the State Oral Health Forums showed great promise for promoting oral health, especially with sharing of information across state lines, he regretted that some of the activity generated was not sustainable over time. Captain Geiermann sees the Head Start Regional Oral Health forums as the latest incarnation of Head Start's effort to improve oral health. He expressed his hope that the regional meetings would be a catalyst for an improved and sustained commitment to oral health and urged the group not to let the momentum generated by these meetings fade away.

Lewis Lampiris, D.D.S., M.P.H., President of the Association of State and Territorial Dental Directors (ASTDD) and Chief of the Division of Oral Health, Illinois Department of Public Health, informed the audience that the ASTDD plays a key role in the IntraAgency agreement between Head Start and MCHB. ASTDD created a Head Start Oral Health Advisory Committee, worked with the National Maternal and Child Health Resource Center to review and develop material, and has funded 48 State and Territorial Oral Health Forums. He expressed a desire to see stronger linkages between State oral health programs and Head Start, noting that state programs can
provide valuable TA to Head Start programs. He envisioned that every state oral health program should ideally have a dedicated staff member to work with Head Start programs, one with expertise in public health and the knowledge to perform needs assessments and engage community resources. He also stated that Head Start programs should explore linkages with academic institutions such as dental schools and dental hygiene programs to maximize resources and engage dental professionals in Early Head Start and Head Start.

II. Plenary Session

A. MCHB and HSB IntraAgency Agreement

John Rossetti, D.D.S., M.P.H., Consultant to MCHB, began his remarks by noting that there is often a lack of cooperation among Federal departments but suggested that the IntraAgency partnership between Head Start and MCHB is an exception. Next, he described the Head Start and Oral Health Collaborative Projects supported by the MCHB and HSB Interagency Agreement and discussed the results of the Regional Forums conducted to date. Maps indicating the Regional and State Forums can be found in Appendix B. Despite the progress that has been made by the State and regional forums, Dr. Rossetti stated that there is still room for further increasing collaboration between Head Start and the dental community. He stressed that Head Start can be a strong partner in ensuring the oral health of children.

Based on his experience working with government programs, Dr. Rossetti offered three pieces of advice to the attendees:

- People make programs work.
- Never take no for an answer.
- Follow up persistently.

Dr. Rossetti acknowledged the recent release of an RFP for the first Head Start Oral Health Initiative, which offers selected grantees up to $75,000 annually for 4 years to
plan, implement, and evaluate oral health efforts in Early Head Start and Head Start programs. Dr. Rossetti presented this oral health initiative as one positive outcome of the relationship between Head Start and the MCHB at the national level but stressed that implementation must be strong at the local level for programs to have a long term impact.

B. Region V Head Start Overview

James Dagger, Head Start Program Officer, Office of Family & Child Development, ACF Regional Office, described the characteristics of children and families receiving Head Start services in Region V. He began his presentation by explaining the criteria that children must meet to participate in Head Start programs. He noted that children from birth to 3 years of age are eligible to enroll in Early Head Start and children between 3 and 5 years of age can enroll in Head Start. Federal regulations require that 90 percent of families with children enrolled in either of these programs must have incomes below the Federal poverty level.

Mr. Dagger noted that the Region V enrollment in Head Start ranged from 10,241 in Minnesota to 39,178 in Illinois. Mr. Dagger compared the number of children living in poverty in each of the Region V States to the number of children enrolled in Head Start or Early Head Start in those States. In each State, the number of children enrolled in Head Start or Early Head Start was less than the number living in poverty – meaning there are many Head Start eligibly children who are not being accommodated. He noted that the region’s largest unmet need for Head Start programs was highest in Illinois, followed by Ohio and Michigan.

Mr. Dagger spoke about the characteristics of children from low-income families in Region V. He noted that these families often have low educational attainment and are more likely to be single-parent households. He noted that children from families with low incomes live in both rural and urban settings and they tend to be highly mobile as they move often. Also, Mr. Dagger stated that children from families with low incomes are often persons of color in Region V. He showed statistics that compared the number of poor Black, Latino, and white children living in the States across Region V. In addition,
Mr. Dagger described how parental nativity, employment status, and mobility influence low-income families in Region V.

After describing the characteristics of children from families with low incomes, Mr. Dagger reported on statistics from the Head Start Program Information Reports in Region V. He described health insurance coverage for children in Head Start during 2002, 2003, and 2004. Mr. Dagger noted that one of Head Start’s goals is to ensure that every child has an oral health screening within 90 days of enrolling in the program and receives necessary follow up dental care.

Next, Mr. Dagger discussed the dental services received by children attending Head Start in Region V. He showed the number of children in Region V Head Start who had received a dental examination compared to the number of children who received followup treatment. Both the number of children examined and the number of children receiving required treatment had increased since 2002 according to Region V PIR data. In 2004, nearly 90 percent of Head Start children in Region V received a dental examination. Approximately 25 percent were in need of dental care, and about 20 percent received the follow up care. Lastly, Mr. Dagger noted that about three percent of Early Head Start children had received a dental screening during a well-baby examination, while about one percent of these children had received professional dental examinations.

C. Plenary Presentations: State-Based Models

Ohio

Shannon Cole, R.D.H., B.S., Project Co-Director, Bureau of Oral Health Services, Ohio Department of Health, presented on oral health and Head Start in Ohio. She explained that her presentation was adapted from a presentation given at Ohio’s State Oral Health Forum held in April 2004. She noted that the materials were based on the Ohio Head Start Oral Health Special Project and noted the leadership of Mark Siegal, D.D.S., M.P.H., Chief of the Bureau of Oral Health Services. Information was collected from a statewide Head Start oral health (open-mouth) screening survey, dentists’ mail
survey, telephone interviews of Early Head Start and Head Start parents about barriers, and a telephone interview of Early Head Start and Head Start staff about barriers and innovative approaches that work.

Ms. Cole began her discussion of oral health among the Ohio Head Start population by acknowledging assumptions about barriers to oral health care. She introduced a logic model that was used in the Ohio Special Project. She noted that there are multiple barriers to accessing dental care, presenting a complex problem with no simple solution. She identified certain assumptions about what is required to overcome barriers to accessing oral health, stating that the problem can be addressed through various means, including education for Head Start staff and families, collaboration between Head Start and other public organizations, early intervention supported by statewide and professional dental programs, and increased parent involvement.

Ms. Cole discussed assumptions about the “players” involved in Head Start’s efforts to promote oral health, a group that includes children, parents, Head Start staff, and dentists. She noted that since Head Start children have high rates of tooth decay combined with poor access to dental health care parents play a vital role in promoting oral health. Ms. Cole suggested that Head Start staff also can contribute positively to children’s oral health by educating families about oral health practices, but she acknowledged that Head Start staff members’ ability to help is hampered by time limitations. Due to numerous demands on their time, this becomes a constraint on their ability to take on multiple roles in health promotion.

After discussing the assumptions related to dental care and the Head Start population, Ms. Cole identified certain facts about the oral health problems experienced by Head Start children. She presented statistics derived from 2001–2002 PIR data indicating that 20 percent of Head Start children needed dental care. Findings from the statewide Head Start oral health (open-mouth) screening survey showed 38 percent of Head Start children had experienced tooth decay (had fillings or untreated tooth decay), 28 percent had untreated tooth decay, and 9 percent had experienced a toothache in the past 6 months. Also, she noted that 73 percent of children who had ever experienced tooth decay (e.g.,
had a filling or untreated tooth decay) still had untreated tooth decay that needed treatment. The statewide survey of Head Start children in Ohio showed that a large number of children in Head Start were finding it difficult or impossible to get their need for dental care met.

Ms. Cole then discussed parental responsibility in children’s oral health, beginning by noting negative biases held by some Head Start staff and dentists. She indicated that two-thirds of Head Start staff surveyed felt that parents with children in Head Start did not take their children’s oral health seriously enough, while three-fourths of dentists surveyed felt that parents of young children receiving Medicaid did not value oral health.

Ms. Cole compared these opinions to feedback from parents with children in Head Start. Parents noted that dentists are not readily available, particularly dentists who accept patients with Medicaid and indicated long waiting times to get appointments. Parents with uninsured children could not afford the cost of dental care. Also, these parents expressed difficulty in getting their children to dental appointments, which often required them to take time away from work, find child care for their other children, and obtain transportation. Head Start staff stated that they had more difficulties to find a dentist compared with a physician and that the most prominent access barriers included; locating a dentist that accepts new patients, accepts Medicaid, will see young children, and will provide followup dental care beyond examinations.

Ms. Cole argued that Head Start staff can help parents by teaching them how to care for their children’s teeth, helping them apply for Medicaid, and, when funds are available, arranging for Head Start to pay for dental care. Ms. Cole also suggested that Head Start staff can help children access professional dental care in a variety of ways, including setting up dentist visits at Head Start sites, transporting children to dental offices and clinics, and facilitating the dental appointment process for parents.

Ms. Cole closed by discussing oral health activities undertaken by the Ohio Department of Health since the state’s oral health forum. Ohio now recognizes outstanding local dental providers with the Dental Heroes’ Award. The State has held one ceremony and
now plans to make the award an event at the annual meeting of the Ohio Head Start Association. The Department of Health has developed requests for proposals to pilot-test innovative ideas. The Department is also developing a Head Start fact sheet on oral health in Ohio, which will be used to educate legislators and the public, and is working with Ohio State University to develop a strategic plan to encourage more dentists to see young children.

Also, Ms. Cole noted that survey instruments and findings from the Ohio Head Start Oral Health Special Project were reported in a number of publications. This list of publications can be found in Appendix C.

**Illinois**

Marge Stillwell, Executive Director, Illinois Head Start Association, began her comments by noting that Head Start is in a unique position to address the health needs of children, but she stressed that Head Start should collaborate with the public and private health sectors for technical expertise. She indicated that before the Illinois State Oral Health Forum in 2002, Illinois Head Start developed a draft vision statement for improving the oral health delivery systems available to children enrolled in Head Start and Early Head Start. In addition to drafting a vision statement, Illinois developed an action plan for improving oral health. The action plan had four elements with specific action steps. The elements included education and changing perceptions about oral health among the Head Start population, assisting the State in using existing dental infrastructure to benefit Head Start, identification and removal of barriers to oral health care, and conducting a statewide needs assessment. The action plan was developed through feedback from five regional planning sessions, the work of a planning committee, and discussions at the Illinois Head Start Association Training Conference.

After the State action plan was finalized, it was circulated to Illinois Head Start and Early Head Start programs, and to oral health professionals around the State. A survey of programs receiving the action plan found that seventy percent of Head Start programs reported using the action plan, and 82 percent became involved in local oral health
groups. The groups ranged from formal health affiliated organizations to civic groups, such as the Rotary. Eighty-eight percent of programs noted that they had added policies and procedures to support the Head Start oral health performance standards. A recommendation from the survey resulted in the development of an oral healthcare curriculum for adults and children by the Illinois Department of Public Health. Head Start teachers assisted with information to incorporate in the oral health curriculum. There was an increase in onsite oral health screenings for infants and toddlers, which was attributed to a need identified in the survey. Another important recommendation, still in the discussion stage, was to establish a “Tooth Fairy” fund for low income families whose children needed extensive, costly treatment.

Ms. Stilwell presented PIR data demonstrating improvements in the establishment of dental homes, diagnosis for treatment, and follow-up treatment since the inception of the State action plan. She noted several other positive oral health changes, including increased Medicaid reimbursement for dental services and expansion in the scope of practice for dental hygienists in Illinois. Also, she indicated that more onsite dental screenings are being performed for children 0 to 5 years old and that there is an increased number of programs with grants to support oral health, including toothbrushes, toothpaste, and an oral health education train-the-trainer program. The Illinois Head Start Association works in partnership with IFLOSS, a statewide oral health coalition in Illinois and the Illinois Department of Public Health, Oral Health Division. In addition, the Illinois Early/Head Start Managers Network integrates oral health efforts into its work through grant initiatives, conferences, networking, assessments, instructional materials, and cooperative agreements with dentists and other activities.

Despite the success of the Illinois State Oral Health Action Plan, Ms. Stilwell indicated that there are still oral health needs in the State. She closed stressing challenges regarding a lack of dentists in rural areas, a shortage of dental clinics, pediatric dentists, lack of access to oral surgery, too few children 0 to 3 years of age receiving oral health examinations, and a need for more prevention and education programs.
Karen Yoder, R.D.H., M.S.D., Ph.D., Director, Division of Community Dentistry, Indiana University School of Dentistry, explained that the Seal Indiana Program provides a model for partnerships among universities, social service programs, and Head Start. She listed the program goals to:

- Locate Indiana children who are not receiving dental care
- Provide oral examinations and, when indicated, apply dental sealants and fluoride varnish for prevention of dental caries
- Help to find a local dental home to insure restorative services and continuity of care
- Provide service-learning experiences for dental and dental hygiene students to foster greater providers’ understanding of issues related to community oral health and access to dental care
- Engage in research that will promote optimal oral health and more equitable access to care.

Dr. Yoder noted that Seal Indiana received startup funding from a number of sources, including the Indiana State Department of Health, Indiana University – Purdue University Indianapolis. The program receives ongoing funding through fees for services (e.g., Medicaid and sliding fees) and grants from the Indiana State Department of Health through MCHB and the State Oral Health Collaborative Systems (SOHCS) Grant. She referenced the Healthy People 2010 goals that Seal Indiana strives to meet, which include increasing the proportion of children who have dental sealants while decreasing the proportion of children with untreated tooth decay compared to children who have ever experienced tooth decay.

Ms. Yoder described the Seal Indiana mobile unit and showed photographs of the vehicle. Seal Indiana provides services at Title 1 Schools, Community Health Centers, Homeless Shelters, Special Olympics Sites, and Head Start Programs. She explained that since the program’s inception in March of 2003, dental and dental hygiene students and faculty participating in the program have examined 6,469 children and visited 327 sites.
Thirty-seven percent of the children 6 to 18 years old examined by Seal Indiana had few to moderate caries and 18 percent had severe caries. Dr. Yoder indicated that these statistics were proof that Seal Indiana was meeting its goal of locating children not receiving dental care. She noted that, to date, Seal Indiana has provided over 11,000 dental sealants. She also stated that Seal Indiana enjoys positive media coverage, including a spot on a PBS service learning program and has been well-received by the local dental community.

After explaining the efforts of Seal Indiana, Dr. Yoder discussed the history of Head Start in Indiana. From 1968 to 1989, the Indiana State Department of Health provided a dental consultant for each Head Start grantee. The consultants were intended to provide technical assistance to Head Start programs, evaluate programs based on Federal performance standards, and serve as liaisons with local dentists. However, the Indiana State Department of Health was unable to sustain the large number of dental consultants as focus on oral health issues waned from Region V and National Head Start and MCHB.

Dr. Yoder concluded her remarks by discussing the role of Seal Indiana in improving oral health among the Head Start population. She stated that Seal Indiana helps Head Start programs meet Federal performance standards by providing onsite dental services including examinations, x-rays when indicated, fluoride varnish, and education. The program frees up Head Start health managers to coordinate the follow up care needed by about 25% of the children and assists Head Start staff in finding dental homes for children. She stated that Seal Indiana does not provide restorative services but rather refers children to dentists in order to encourage the concept of dental homes. She stated that dental homes encourage sustained relationships between families and providers, which are necessary for comprehensive and continuous dental care. Dr. Yoder acknowledged that in addition to benefiting the children it serves, Seal Indiana benefits the dental and dental hygiene students who participate in the program. She noted that Seal Indiana teaches students about public health and health disparities across diverse communities.
Kiyoko Fiedler, M.P.A., Director of Planning and Development, Western Dairyland Economic Opportunity Council, Inc., discussed the *Shining Smiles Project*, a model for providing and maintaining dental health care for low-income families including Head Start children in rural areas developed by the Western Dairyland Economic Opportunity Council. Ms. Fiedler noted that implementation of this model is pending funding but that development of the model itself was a positive product of Head Start’s funding of the Innovations Grant Program.

Goals of the project include linking children with dental homes and creating a sustainable program for improving oral health. In particular, the *Shining Smiles Project* is intended to explore methods for the delivery of dental care in rural areas, noting that the project, if funded, will serve a four-county service area in western Wisconsin. Ms. Fiedler indicated that in the process of developing the current service delivery model, several methods were studied and given initial consideration but never fully explored after being deemed inappropriate. For instance, the diffuse population and extreme cold made mobile units a nonviable option. The planners explored partnerships with dental schools in universities, including Marquette University, but were unable to identify a dental program with the capability to take on the number of families and children in Head Start that the program would channel to them.

As part of planning the delivery model, Western Dairyland Economic Opportunity Council surveyed low-income parents to assess their needs. Parents responded that in spite of logistical difficulties, if more dental services were available, they would ensure that their children obtained dental care. Dentists were surveyed as well in order to determine why many of them refused to accept patients with Medicaid. Ms. Fielder stated that dentists often felt that patients with Medicaid were unaware of dental office etiquette and that many parents of children enrolled in Medicaid already had existing dental problems. Existing dental problems indicated two challenges: 1) parents were not ensuring that their children were using good oral health practices and 2) earlier
intervention was needed before the children developed dental problems. Ms. Fiedler argued that these assumptions demonstrate the need to intervene with pregnant women enrolled in Medicaid early in order to start infants on a positive path towards long-term oral health.

Ms. Fielder showed flowcharts describing the major components of the *Shining Smiles Project* model, including restorative treatment services, a train-the-trainer education program, and a comprehensive plan for oral health education. All program components demonstrated the linkages between Head Start staff, Head Start children, Head Start parents, public health, WIC, local physicians and nurses, community organizations, and the dental community. Ms. Fiedler explained that the model sought to create a culture of oral health by promoting a consistent message and connecting children and families to the appropriate services. She noted that the *Shining Smiles Project* model is not rigid and could be adapted to suit the varied needs of other States and localities. She closed by stressing that the program has great potential for long-term results and sustainability.

Also, it was noted that the Oral Health Program, Division of Public Health, Wisconsin Department of Health and Family Services has been involved in several Head Start oral health initiatives in Wisconsin. The oral health program conducted a statewide oral health assessment of Head Start children and developed a State Head Start oral health action plan. Several publications have been produced, including the Healthy Smiles for a Head Start Survey Report and the Wisconsin Early Head Start/Head Start Oral Health Forum Report. The report from the Head Start Survey is available at [http://www.dhfs.state.wi.us/health/Oral_Health/pdf_files/headstartreportPPH0003.pdf](http://www.dhfs.state.wi.us/health/Oral_Health/pdf_files/headstartreportPPH0003.pdf).

**Minnesota**

Jayne Cernohous, D.D.S., Twin Cities Dental Director, Apple Tree Dental, began her presentation by identifying the extent of the oral health problems among American children, noting that over 5 million school hours per year are lost to oral health problems. She also stated that low-income, minority, immigrant, disabled, and other special-needs children suffer disproportionately high rates of dental disease.
Dr. Cernohous acknowledged barriers to accessing oral health care in Minnesota. She stated that a primary barrier in Minnesota is lack of providers, noting that Minnesota leads the nation in decline of dentists-to-population ratio. Additionally, few of the dentists practicing in Minnesota see children enrolled in public programs and many refuse to see children under the age of 3. Transportation issues and language barriers also affect access to dental care in Minnesota.

Dr. Cernohous described the *Apple Tree Head Start Teledentistry Project* supported in part through a Head Start innovations project grant. The objectives of the Project are to develop a Head Start mobile teledentistry project in 64 sites in three rural regions and one urban area in Minnesota, create partnerships between Head Start programs and dental education programs, develop dental care models, and expand the oral health care workforce. She also noted several partners involved in the creation and implementation of the teledentistry program. The Minnesota Head Start Association conducted statewide focus groups to identify barriers to accessing oral health. Dental hygiene programs provided the dental workforce necessary to staff the teledentistry program through new roles via collaborative agreements. Head Start-based dental experts provided follow up treatment services and professional evaluators have been used to assess the effectiveness of the program.

Dr. Cernohous then described the mechanics of the teledentistry program. One hygienist visits a Head Start site, and using photographic equipment to collect oral images from the children, stores the information on a laptop computer. From their own offices, dentists perform examinations on the children via the recorded information. Dr. Cernohous noted that in Minnesota dentists are allowed to bill Medicaid for this type of examination. After completing the examination, dentists prepare a treatment plan and return to the Head Start site with mobile equipment to perform the necessary follow up dental services.

**Michigan**

Christine Farrell, R.D.H., Medicaid Program Specialist, Michigan Department of Community Health, *substituted for Michelle Cyper, Training and Outreach*
Specialist, Michigan Head Start Association, who was unable to attend the forum. Ms. Farrell presented an overview of activities related to the Michigan Head Start Forum, Statewide Oral Health Forums, and the Michigan Oral Health Coalition. She stated that the Michigan Head Start Oral Health Forum, held in May 2004, influenced current oral health activities in the State. Plenary sessions at the forum included panel discussions of best practices for prevention, education, and access to dental care. Four work groups met during the forum and focused on behavior and education; pediatric care and the medical/dental connection, prevention, and access. The work groups developed several recommendations and actions steps for improving oral health among the Head Start population. These recommendations included:

- Disseminating public service announcements on the importance of oral health
- Conducting sensitivity training with dental professionals regarding positive attitudes toward families with children in Head Start
- Integrating oral health education for parents, beginning with their child’s birth
- Reinstating Adult Dental Medicaid coverage equitable to the children’s dental program reimbursement
- Utilizing more mobile dental units with a referral mechanism in place for those needing additional dental treatment options.

In additions, a series of five Michigan Oral Health Coalition Statewide Forums were hosted across the State in Spring 2005. Head Start programs were represented at these forums along with the Michigan Department of Community Health and various health care providers. Because of the Forums, Michigan has produced an oral health action plan that integrates Head Start oral health issues into the topics of prevention, education, awareness, funding, workforce, and advocacy. In addition, the Michigan Head Start Association and the Michigan Head Start Collaboration Office participate in the Michigan Oral Health Coalition Steering Committee and serve on the Education/Awareness Work Group.
III. Summary of Small Group Discussions

In the afternoon following the morning plenary sessions, the participants were assigned to discussion groups. In preparing for these sessions, Jane E.M. Steffensen provided participants with a roadmap for the breakout discussions, charging each group to focus their deliberations on actions at the regional levels. She also encouraged discussion regarding how successful strategies could be implemented or expanded, including ideas on which organizations and agencies can partner together to achieve the overarching goals of improved oral health status for children and their families in Region V Head Start programs.

These groups were given the task of identifying and prioritizing challenges and specifying overall strategies, actions steps, and collaborating partners related to two topic areas. Group 1 discussed prevention and education while Group 2 covered access to dental care. Following these group discussions, a representative from each group shared highlights with the group at large.

The discussions that emerged were complex and did not necessarily follow a linear format. The following summary synthesizes these discussions by presenting the major topics, issues, and strategies identified by the groups. To avoid duplication, topics that emerged in both discussions were included in the most appropriate group. The groups maximized their time by first identifying the challenges and issues and then narrowing this list to the top three priority areas. Because groups met only for a limited number of hours, there was not sufficient time to develop strategies, action steps, and collaborating partners fully for all of the priority areas. The complete notes from the small group discussions can be found in Appendix D. The deliberations of each group are summarized in the next section.

A. Group 1: Prevention and Education

Group 1 focused its discussion on the topics of prevention and education of oral disease in Head Start programs. The group began their discussion by reiterating the importance of
oral health and its connection to overall health. The group also agreed that prevention is a lifelong process and that any plan to address prevention should be comprehensive in its scope and encompass education of many target audiences, including parents, providers, legislators, and policymakers as well as Head Start program staff that serve children.

Challenges and Issues

The group acknowledged that although prevention and education resources exist, including training materials and evidence-based prevention strategies, these resources are not readily available or applicable to Head Start staff and families. The group spoke to the need for a comprehensive prevention and education plan tailored to meet the needs of the Head Start population. In addition, the group agreed that the HSB should refine and clarify its national oral health performance standards. The group also noted that the system for evaluating the quality of dental care provided to the Head Start population should be improved. This seemed to be a concern reiterated in several States. The group pointed out the growing need for Head Start staff and parents to receive guidance from oral health programs about the factors that should be assessed to assure that children receive the highest-quality dental care.

Identifying Priorities

After discussing a variety of challenges and issues related to prevention and oral health education, the group identified three main priority areas. The priority areas were as follows:

1. Identify clear oral health messages and increase communication and dissemination of materials and resources that reflect these messages.
2. Increase the use of evidence-based prevention strategies to improve oral health among children and pregnant women in Head Start.
3. Clarify performance standards with more objective guidance from the HSB at the national level.
Priority One:

Identify clear oral health messages and increase health communications that reflect these messages. As part of a health communications strategy, the group suggested the dissemination of educational materials and resources, such as best practices, culturally competent toolkits tailored to distinct audiences, and anticipatory guidance for parents.

Strategies and Action Steps

The group identified the lack of a consistent message for prevention and education as a primary barrier to improving oral health and how as a result, oral health is ineffectively integrated into overall health across practice areas. They agreed that in addition to a consistent message, Head Start programs needed a common framework that is comprehensive in nature for implementing prevention and education activities. They suggested that Head Start develop a culturally competent toolkit that encompasses consistent messages for improving oral health. The toolkit should include components tailored towards such audiences as Head Start staff, health and dental providers, parents, children, and legislators. This toolkit should be flexible enough to adapt to local needs for effective use across a variety of populations while addressing Federal performance standards and goals.

The group identified the following action steps for creating a toolkit:

- Inventory pertinent materials.
- Implement and modify these materials as necessary.
- Establish a clearinghouse for education materials.
- Strengthen and expand communication channels between national, regional and local levels to ensure effective implementation of programs and materials.
- Train locally based Head Start staff at the regional level to use materials effectively, possibly through a regional training forum.
- Ensure that Federal funds are allocated for the development of a toolkit and follow up trainings.
The group also agreed that oral health components should be more effectively integrated into health education curricula for children in Head Start as well as continuing education programs for health professionals, including physicians and nurses. This strategy requires examining existing education models, sharing best practices, and supporting the implementation of programs.

**Collaborating Partners**


**Priority Two:**

**Head Start programs need to increase the use of evidence-based prevention strategies to improve oral health among children and pregnant women in Early Head Start and Head Start.**

**Strategies and Action Steps**

The group specifically mentioned fluoride varnish and group brushing programs as examples of evidence-based prevention practices for improving oral health among children. They suggested that the HSB should collect best practices for prevention and make the consolidated findings available to Head Start programs. The group noted that the evidence must be presented to Head Start staff in a usable format.

The group identified the following action steps for sharing evidence-based prevention strategies:
• Rank prevention strategies by effectiveness, creating a list tailored to Head Start staff and programs.
• Create an information memorandum for effective integration of these practices into Head Start programs.
• Undertake strategic planning process in Head Start to create oral health policies and guidance for dissemination throughout the HSB.
• Allocate financial resources for development of oral health training and TA.
• Develop State, regional, and local training forums.

B. Group 2: Access to Dental Care

Group 2 discussed topics related to access to dental care. The group recognized that issues related to access are difficult to address considering the challenge of sustaining interest on the topic of oral health, especially in the face of competing health agendas and priorities. To help sustain interest and promote the importance of oral health, the group mentioned the potential benefit of developing relationships across regional and State offices and with other public sector agencies that serve a population similar to that of Head Start, such as the WIC program. This could be include formalizing relationships could be formalized through a Memorandum of Understanding (MOU) that is meaningful and specifies initiatives that can be implemented at the regional and State levels.

Beyond this, the group spent much time addressing workforce issues such as the shortage of dental providers, disincentives associated with the Medicaid program, and the additional challenges providers experience when providing dental care to young children. The need for accurate data also emerged as a pressing issue in order to report accurately the barriers to accessing dental care and the oral health status of children and pregnant women in Early Head Start and Head Start. The group also noted the importance of demonstrating the economic impact of expanding access to preventive oral health care.

Challenges and Issues

Although many important issues related to access were noted during the group discussion, much of it was centered on the capacity of the oral health workforce. The
most critical aspect raised included the shortage of dental providers and the geographic maldistribution of providers, especially in rural areas. Also raised were issues related to the training and education of the current workforce. For those currently providing dental services, concerns were raised about their ability to provide dental care effectively to the Head Start population, due to the added challenges that can be experienced providing care for young children. The administrative and financial burdens associated with the Medicaid program were mentioned as additional barriers to ensuring access to dental care for children in Head Start, since a majority rely on Medicaid for their insurance coverage. The low Medicaid reimbursement rates and high administrative burdens act as disincentives for dentists to provide dental care to children enrolled in Medicaid. The financial burden is even higher when dental care is provided to low-income uninsured children, such as undocumented children that are ineligible for Medicaid but families are unable to pay for services. Underlying the challenges already presented is the issue of data and information. The group stressed that it is difficult to address issues of access adequately when data to document the scope of the problem accurately is unavailable.

**Identifying Priorities**

Based on the issues identified in the early portion of the discussion the group was assigned the task of identifying three priorities and corresponding strategies that can be implemented to expand access to oral health care for children and their families in Head Start. Emerging from the group as priorities were the following areas:

1. Improve quality of oral health data and especially oral health data measures collected through the Head Start PIR.
2. Expand the size and capacity of the current dental workforce.
3. Identify and secure alternative revenue streams to support the reimbursement of oral health services.

**Priority One:**

Data currently available for use, such as PIR data, do not report accurately the oral health status of children and their families in Head Start.
Strategies and Action Steps

The group questioned the quality of PIR data, which is widely reported and referenced. Some questioned the self reporting method of the data collection. Others expressed that the measures collected and reported on are unclear and require further clarification. One example cited was that the term “patients treated,” is not well-defined and could be interpreted in several ways therefore not reflecting the true number of patients that are completing treatment. Additionally, the group felt that the use of PIR data would be most powerful if analyzed and reported at the county level and combined with other data sources. The overarching strategy was to improve data to report accurately the assets and oral health challenges faced by children and families in Head Start, so as to make a case for appropriate allocation of resources. This is important especially when creating messages to legislators and policymakers and being able to justify why preventive care is more cost effective than waiting to treat oral disease.

Based on this discussion, the following action steps were identified:

- Identify oral health goals and objectives for families.
- Identify measurable outcomes and benchmarks.
- Define terms and data collection elements (i.e., oral health screening and assessment).
- Improve systems to ensure accuracy and reliability of data.
- Involve the regional office in monitoring data collection processes to enhance data quality.
- Have the regional office provide training to local agencies to ensure consistency in data collection.

Collaborating Partners

It was recognized that an effort as broad as improving data would require the participation and funding from a number of partners, including legislators, local agencies, the State Head Start Collaboration Offices, State Departments of Health, and State Medicaid agencies to include EPSDT representation.
Priority Two:

The size and capacity of the current workforce must be expanded to adequately meet the oral health needs of children and their families in Head Start.

Strategies and Action Steps

Due to numerous workforce challenges, the group felt that a two-pronged strategy must be undertaken to maximize overall capacity. This strategy would involve (1) identifying additional and alternate providers as sources for dental care and (2) improving the ability of the available workforce to provide oral health services to this population. Some promising strategies mentioned by participants included developing incentive programs to attract providers to shortage areas and maximizing the utilization of the expanded function dental assistants (EFDAs), registered dental hygienists (RDHs), and dental assistants (DAs). This strategy seems especially promising in rural communities, where there are even greater issues of access due to geographic isolation and lack of medical linkages. The group recommended that existing health clinics and Federally Qualified Health Centers (FQHCs) expand their capacity to provide oral health services.

Another workforce strategy is to capitalize on the potential to train Head Start staff and parents to be dental providers, such as by providing targeted training or the opportunity to enroll in a paraprofessional dental training program. The expectation is that they would be able to perform basic oral health screenings and be able to assess conditions that would require a referral or further care from a dental provider. Nurses and pediatric residents also were identified as alternate sources of dental care.

Because concerns were raised about the ability of dental providers to provide dental care adequately to children in Head Start, strategies related to education and training were mentioned to address this barrier. Educational outreach and sensitivity training could better inform dentists about the Head Start program and the needs of this population, especially the crucial need for dental care. For dentists who may be uncomfortable or lack the needed skills to provide dental care to such a young population, it was suggested
that a training component could be incorporated into requirements for licensure. Continuing education credits also could be provided as an incentive for volunteering at a Head Start program or other program that serves low-income children. Generally, the group felt that dentists should assume greater responsibility for providing dental care to children in need, similar to the care associated with other physicians.

**Collaborating Partners**

The ADA was mentioned as an organization that could take the lead on such initiatives and promote Head Start as a priority issue among its members. Beyond this, the group did not have sufficient time to identify additional collaborating partners for this priority.

**Priority Three:**

**Identify and secure alternative revenue streams to support the reimbursement of oral health services to ensure the provision of care.**

**Strategies and Action Steps**

Many barriers were associated with the economic cost of providing services. Some of the strategies were specific to Medicaid and included increasing the reimbursement rates for dental services and to streamline the reimbursement process, reducing the paperwork that must be completed by providers. A dental practice in Minnesota in which a case manager completes all necessary paperwork for dentists, therefore allowing them more time for treatment, was cited as a model.

The financial burden placed on programs and providers is even higher for children that are uninsured, such as immigrant children without legal residency status and ineligible for Medicaid coverage. The group recommendation was to request that States set aside funds, such as through Block Grant funding (TANF or Title V), to supplement the provision of these services.
IV. Response and Closing Remarks

Dr. Rossetti informed the group that many issues raised at the Region V forum had been raised at previous Head Start Oral Health Forums. He noted that the commonality of concerns across regions revealed a shared vision for improving oral health. He mentioned that HSB currently is recruiting part-time regional dental consultants for each of the Head Start Regions and noted that Region V is still without a consultant. He stated that the consultants share information and resources among regions and make recommendations to HSB. He closed by reminding the audience that progress is always incremental and stressed the need for persistence to make changes in the future.
Appendix A: Participant List
Enhancing Partnerships for Head Start and Oral Health

Region V Forum on Enhancing Partnerships for Head Start and Oral Health

Doubletree Guest Suites
Chicago, IL
July 12, 2005

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Appendix B: Maps of Regional and State Oral Health Forums
Regional Forums on Enhancing Partnerships for Head Start and Oral Health

Region XI - American Indian-Alaska Native Head Start Program Branch

Region XII - Migrant and Seasonal Head Start Program Branch

July 2005

Prepared by Department of Community Dentistry, University of Texas Health Science Center at San Antonio

www.theodora.com/maps
State and Territorial Head Start Oral Health Forums
Funded by the Association of State and Territorial Dental Directors (ASTDD)

Region IX
American Samoa
Federated States of Micronesia, Pohnpei and Kosrae
Republic of Palau*
Republic of Marshall Islands*
Commonwealth of the Northern Mariana Islands
Federated States of Micronesia, Yap and Chuuk
Guam

Forum Funded (Cycles 1-6)
No Forum Planned

*Follow-up funding by ASTDD
**Not Funded by ASTDD

July 2005
Prepared by Department of Community Dentistry, University of Texas Health Science Center at San Antonio

www.theodora.maps.com
Appendix C: Publications Referencing the Ohio Head Start Oral Health Special Project
Publications Reporting Survey Instruments and Findings from the Ohio Head Start Oral Health Special Project


## Oral Health and Head Start Regional Forum
### Group Discussions
### Worksheet #1

**Topic Assigned to the Group: Prevention and Oral Health Education**

<table>
<thead>
<tr>
<th>Issues [List Issues]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of communication about current education measures standards and resources. Best practices.</td>
</tr>
<tr>
<td>2. Increasing use of evidence based prevention strategies targeting HS kids and Pregnant mothers. (educating people to HS role in community water fluoridation.)</td>
</tr>
<tr>
<td>4. Evaluation for the quality of dental care provided to HS population. Also an issue of efficient use of funds. Who performs these evaluations.</td>
</tr>
<tr>
<td>5. Parents need to be prepared what they should ask dentists. How they can make more informed decisions? Development of parent tool for anticipatory guidance</td>
</tr>
<tr>
<td>7. Need for a regional consultant(point person, or a state person who works between HS and OH. Or increase access to existing resource people. --used to be a network of HS OH consultants to concentrate on and oversee HS oral health piece.</td>
</tr>
<tr>
<td>8. Need to educate physicians to the importance of oral health and specifically the importance of baby teeth. Get dentists and physicians on the same page. --Medical community not only provides screenings but becomes and advocate and collaborator. --Support HS active involvement in state collaborative projects. --How does government ensure HS compliance with performance standards. What are the implications of failure. Typically HS uses monitoring visit to find non-compliance</td>
</tr>
<tr>
<td>9. Need for continuum and prevention and education/comprehensive. Perhaps a toolkit, broken down by child/staff/parent/provider components. --addresses high turnover, which affect the quality of HS care.</td>
</tr>
</tbody>
</table>
## Prioritization of Issues [List Priority Issues]

1. Need to increase communication about current education measures and resources, the sharing of best practices. Includes the development of a toolkit with culturally competent materials and anticipatory guidelines for parents. Need education components for HS staff, children, and parents, and legislatures. Foster MD/DDS linkages.


<table>
<thead>
<tr>
<th>Priority Issue #1 (PI #1)</th>
<th>Overall Strategy (for PI #1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>---Increase communication about current education measures and resources, the sharing of best practices. Includes the development of a toolkit with culturally competent materials and anticipatory guidelines for parents. Need education components for HS staff, children, and parents, and legislatures. Foster MD/DDS linkages.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>• Oral health is undervalued and ineffectively integrated into an overall health across practice areas. No comprehensive and culturally competent framework for HS staff to use when implementing oral health programs.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>• Develop a culturally competent toolkit that encompasses consistent messages for improving oral health. The toolkit should include target specific components tailored towards such audiences as HS staff, medical/dental providers, parents and legislators. This toolkit should be flexible enough to adapt to local needs for effective use across a variety of populations while abiding by federal performance standards and goals.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>• Ensure federal money is allocated for the development of a toolkit ad follow up trainings</strong></td>
<td></td>
</tr>
<tr>
<td><strong>• Integrate oral health components and</strong></td>
<td></td>
</tr>
</tbody>
</table>
specifically oral health among low income families, into health education curriculums and health the continuing healthcare workforce.

<table>
<thead>
<tr>
<th>Action Steps (for PI #1)</th>
<th>Collaborators (for PI #1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inventory existing materials that could fit into developing toolkit,</td>
<td>• MCHB OH resource center, ADA, ADEA, AAPD, ASTDD, AMA, NHS, ADHA, ACF, TA contractors,</td>
</tr>
<tr>
<td>• Implement and modify as necessary.</td>
<td>HS TA networks, Regional and State HS associations, HS Collaboration Offices, Foundations</td>
</tr>
<tr>
<td>• Establish a clearinghouse for education materials.</td>
<td>(United Way Robert Wood Johnson, Etc.) Educational Vendors</td>
</tr>
<tr>
<td>• Strengthen and specify channels between national and regional levels to ensure effective</td>
<td></td>
</tr>
<tr>
<td>local implementation of federal programs and materials.</td>
<td></td>
</tr>
<tr>
<td>• Train Head Start staff at the regional level to use materials effectively, possibly</td>
<td></td>
</tr>
<tr>
<td>through a regional train forum. Train the Trainers.</td>
<td></td>
</tr>
<tr>
<td>• Ensure federal money is allocated for the development of a toolkit ad follow up</td>
<td></td>
</tr>
<tr>
<td>trainings</td>
<td></td>
</tr>
<tr>
<td>• National/regional/local-governmental/non-governmental/HS</td>
<td></td>
</tr>
<tr>
<td>• Examine existing models and share best practices for integrating oral health curricula</td>
<td></td>
</tr>
<tr>
<td>into professional schools and health care workforce.</td>
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</tbody>
</table>
# Oral Health and Head Start Regional Forum
## Group Discussions
### Worksheet #2

**Topic Assigned to Group: Access to Dental Care**

<table>
<thead>
<tr>
<th>Priority Issue #2 (PI #2)</th>
<th>Increasing use of evidence-based prevention strategies targeting EHS, HS kids and Pregnant mothers, sharing of best practices. Fluoridation specifically mentioned.</th>
</tr>
</thead>
</table>
| Overall Strategy (for PI #2) | HS fluoride varnish programs, group brushing with fluoridated toothpaste.  
- Gather best practices for prevention and make consolidated findings available. Ensure that evidence is usable for HS staffs and programs. |
| Action Steps (for PI #2) |  
- Ranking prevention strategies by effectiveness, tailored list for head start staff and programs.  
- Create an information memorandum for effective integration into HS.  
- Create policy for collaborative strategic plan.  
- Disseminate policy through HS channels at varying and appropriate levels of details.  
- Allocation of financial resources for development of T/TA  
- Develop state/regional/local training forums |
### Issues [List Issues]

1. Rural specific issues – lack of dentists, geographic isolation, lack of medical/dental linkages

2. Dental shortage and inadequate workforce – underutilization RDHs and DAs and respective training schools; Better use of expanded functions expanded function dental assistant (EFDA)

3. MOAs don’t translate in a meaningful way at the regional/state level

4. Poor data; Improving data collection such as (PIR) data; clarify definitions; present data by county; Are patients completing treatment?

5. Dentists are not adequately trained to treat children; or are uncomfortable treating very young children; patient management skills

6. Dentists lack information or awareness about HS; ADA should make HS one of their national initiatives; dentists don’t really understand the HS program; perhaps tie to licensure. HS also has a responsibility to inform dentists about their client population—cultural and sensitivity training

7. Burden related to Medicaid – dentists are burdened with paperwork and hassles for submitting Medicaid reimbursement forms

8. Lack of regulation around fluoride varnishes – Medicaid reimbursement; expand ability of dental hygienist or medical provider to provide varnishes

9. Lack of payment options for undocumented children; put pressure on states or TANF to set aside funds to pay for dental services; if oral health is a priority, then money should be set aside

10. Clarification of requirement of dental health component as condition of enrollment

The regional/national offices may have these MOU, but they may not be that meaningful—how are they implemented at the regional and state level. How about taking legislative action to expand access.

HS can help by training children and build a better early prevention system that support visits to dentists. Strategy – purchase equipment to perform

The regional office needs to work more to develop a relationship with the State health departments. Offer incentives for workforce development in shortage areas (HPSAs);

Identify Medicaid-eligible through WIC program and other programs that serve MCH population
Incorporate greater training for licensure requirements; make dentist responsible to the citizens—is licensure a right or a privilege? Provide continuing education credits to volunteering at HS or other comparable program

Dentists should sign Hippocratic Oath just as physicians

Have FQHCs and community health centers target pregnant women with xylitol program and include oral health in prenatal counseling. Clinics should expand on their oral health mandate.

Tap into HS parents to receive paraprofessional dental training programs

Expand parental involvement to improve access to care

Minnesota (Oral Health Solutions) implemented by Apple Tree Dental; involves a single point of entry; it’s a family system; it’s a comprehensive solution that uses a case manager and reduces paperwork for the dentists;

You have to make the economic case—a cost benefit analysis; justify why providing preventive care is more cost effective than waiting to treat oral disease

You have to craft an articulate message to really get across the burden of oral disease on children and families. We have to find a way to sustain interest (at the national and regional level)

<table>
<thead>
<tr>
<th>Prioritization of Issues [List Priority Issues]</th>
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<tbody>
<tr>
<td>1. Improve data - Improving data collection such as (PIR) data; clarify definitions; present data by county; Are patients completing treatment?</td>
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<tr>
<td>2. Expand workforce capacity – sensitivity training/</td>
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<td>3. Expand access to rural communities lack of dentists, geographic isolation, lack of medical/dental linkages</td>
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<tr>
<td>Priority Issue #1 (PI #1)</td>
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<tr>
<td><strong>Overall Strategy (for PI #1)</strong></td>
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</tbody>
</table>
| **Action Steps (for PI #1)** | - Identify oral health goals and objectives for families  
- Identify measurable outcomes and benchmarks  
- Define terms and data collection elements (i.e. screen assessment)  
- Improve system to assure accuracy and reliability of data  
- Regional office should monitor data collection process to maintain the accountability of data  
- Regional office should provide training to local agencies to calibrate data |
| **Collaborators (for PI #1)** | - Local agencies  
- State collaborative  
- State health department  
- EPSDT/Medicaid contact |
<table>
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<tr>
<th>Priority Issue #2 (PI #2)</th>
<th>Expand and enhance workforce capacity</th>
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</table>
| **Overall Strategy (for PI #2)** | Maximize the available workforce and increase alternate sources for oral health services.  
Assure workforce to provide care. |
| Priority Issue #1 (PI #3) | Improve the reimbursement system |
| **Overall Strategy (for PI #3)** | Identify and secure alternative revenue streams to support the reimbursement of oral health services.  
Provide adequate reimbursement to ensure care |