

HEAD START® BULLETIN

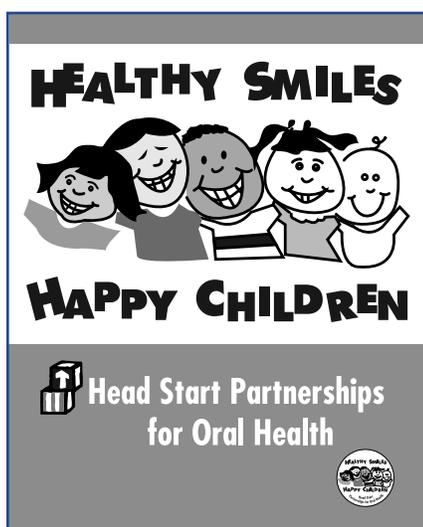
enhancing head start communication



U.S. Department of Health and Human Services ★ Administration for Children and Families ★ Administration on Children, Youth and Families

Head Start and Partners Forum on Oral Health

By Robin Brocato, Head Start Bureau



During much of the 1990s, Head Start directors, staff and parents, as well as the Administration on Children, Youth and Families (ACYF) program specialists, reported that the number one health issue affecting Head Start programs nationwide was access to oral health services. Programs and parents alike told us about children suffering in pain, children who could not eat, or children who had speech and language delays because they were unable to get needed dental treatment. Even if parents were able to find a dentist who would accept Medicaid patients, they would have to wait months for an appointment, or travel over thirty miles to keep the appointment.

In March 1999, representatives from the Head Start Bureau, Health Resources and Services Administration (HRSA), Health Care Financing Administration (HCFA), and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) met to discuss an oral health initiative that was being

developed by HCFA and HRSA. The Head Start Bureau shared its concerns about the lack of Medicaid providers and listened to HRSA express its concern that low-income children experience a disproportionate share of dental disease. After much discussion, it was decided that while the most pressing need was to get children necessary dental treatment, a long-term strategy would be to prevent dental disease from occurring in the first place. This would require that all the federal partners, as well as Head Start staff and parents, work together to improve the oral health of young children.

On September 16 and 17, 1999, the "Head Start and Partners Forum on Oral Health" was held in Washington, D.C. Head Start staff and parents, training and technical assistance providers, pediatric dentists, representatives from local and state WIC programs, Medicaid, Maternal and Child Health and Child Care, and regional ACYF, HRSA, and HCFA staff met to learn about oral health. The purpose of the Forum was to convene a group of representatives from Head Start and other federal agencies, researchers, scientists, practitioners, parents, and advocates to discuss the latest research and evidence-based oral health practices, and to develop strategies to implement these practices.

The Forum was unique to Head Start for two reasons. First, three scientific papers specifically written for the

continued on page 3

Inside this Issue...

Surgeon General's Report on Oral Health	4
Causes of Dental Caries and the Role of Good Nutrition .	10
Oral Health Assessment and Dental Prevention	12
Access to Dental Care for Preschool Children	14

Contents

Head Start and Partners Forum on Oral Health	1
Surgeon General's Report on Oral Health	4
Oral Health in the WIC Program	5
HRSA-HCFA Oral Health Initiative	7
Oral Health Forum Keynote Address: Dr. Therman Evans.....	8
Causes of Dental Cavities and the Role of Good Nutrition	10
Oral Health Assessment and Dental Prevention.....	12
Access to Dental Care for Preschool Children	14
At the Forum: Participant Comments	15
Feedback on the Forum	16
An Interview with Dr. John Rossetti	17
Comments from Parents Participating in the Oral Health Forum	19
You've Been to the Forum (or Read about It): Now What?	20
Oral Health: Integrating New Science into Daily Practice.....	21
Oral Health Update: Region IIa QIC.....	22
Feedback on the Forum: Region I.....	22
Region VII Activities in Oral Health.....	23
Oral Health Initiative Activities in Region VIII.....	24
New Mexico's Dental Health Summit 2000: Region VI-b.....	25
Toothbrushing and Head Start: What's It All About?.....	27
Why Bother? They're Baby Teeth.....	29
Fluoride Supplements: By Prescription Only!.....	30
Something to Smile About	31
The Implications of Culture on Oral Health Practices in Migrant Head Start Programs	32
Oral Health Care Access Issues for Head Start's Indian Programs.....	34
Dental Coverage Under Medicaid	35
Bright Smiles, Bright Futures: New Oral Health Kit for Early Head Start ..	37
HRSA Field Office Dental Consultants and Pediatric Dental Consultants..	38
Resources	39
Oral Health Virtual Resource Guide.....	40
Bureau Update: 2000-2001 National Head Start Fellows	41

The Head Start Bulletin is published six times a year by the Head Start Bureau, Administration on Children, Youth and Families, Department of Health and Human Services. The Bulletin is a service of the Head Start Bureau's Training and Technical Assistance Branch. Its purpose is to enhance communication among the Head Start Bureau, Head Start programs, and interested national, regional, and state organizations and agencies.

Tommy G. Thompson
Secretary

Diann Dawson
*Acting Principle Deputy
Assistant Secretary*
Administration for Children
and Families

Pamela Carter
Acting Director
Office of Public Affairs

James A. Harrell
Acting Commissioner
Administration on Children, Youth
and Families

Douglas Klafehn
Acting Associate Commissioner
Head Start Bureau

JoAn Knight Herren
Chief, T/TA Branch
Head Start Bureau

Traci Hefner
Managing Editor
Head Start Bulletin

The Head Start Bulletin is prepared under Contract No. 105-96-2010 with PaL-Tech, Inc.

Jean Swift
Co-Editor

Deborah Hamilton Kremer
Writer/Editor

Head Start Bulletin
Oral Health
Issue No. 71

Robin Brocato, Head Start Health Specialist, was the guest editor for this issue.



Robin Brocato, Head Start Bureau

Forum were sent to participants prior to the Forum. At the Forum, each paper was presented and participants were given an opportunity to comment on the papers during breakout sessions. Second, researchers, practitioners, and parents met face to face to discuss the feasibility of integrating the research findings into daily practice. (Summaries of these papers can be found on pp. 10–15.)

For each paper, Forum participants were asked the following questions—

- What did you learn that was new and different?
- Are the recommendations feasible?
- What will you do with this information?
- What partnerships will you form to address these issues?
- What other comments do you have for the authors?

Participants also had an opportunity to address concerns related to special populations such as infants, toddlers, pregnant women, and children with disabilities. They also addressed the cultural implications of the recommendations. On the second day, they met in regional groups to develop action plans to implement after they returned home.

Partnerships with other federal programs serving children and families are not new to Head Start. However, the partnership between Head Start, HRSA, HCFA, and WIC is unique because it supports the larger DHHS Oral Health Initiative and efforts to address oral health issues with constituencies at a regional, state, and local level. Furthermore, each partner made a financial contribution to the development of one of the scientific papers, and committed to disseminating consistent messages from the papers to their respective communities.

The Forum had three objectives—

1. To develop strategies to increase collaboration at the federal, state, and local levels and to develop and implement strategies to improve oral health services to children and families
2. To present three scientific papers to participants about—
 - current evidence-based oral health practices and recommended guidelines related to nutrition
 - access to preventive and treatment services
 - the prevention, management, and suppression of caries
3. To assess participant's reactions to the scientific papers and the feasibility and cultural appropriateness of implementing recommendations on local, state, and national levels

After the Forum, comments on each paper were compiled and sent back to the authors for revision. The final papers were published in the summer edition of *The American Journal of Public Health Dentistry*. (See back page on how to get copies of the journal or of individual papers).

In this issue of the *Bulletin*, you will find general information that was presented at the Forum, summaries of each of the three papers, participants' reactions to the experience, descriptions of follow-up activities that have taken place throughout the country since the Forum, and oral health resources. Enjoy reading about this unique and exciting effort to improve the oral health status of children and families throughout the country.

Robin Brocato is a Head Start Health Specialist, Head Start Bureau, T: 202-205-9903; E: rbrocato@acf.dhhs.gov.



Patti Mitchell, WIC; Burton Edelstein, HRSA; Donald Schneider, HCFA; Betty DeBerry-Summer, HRSA.

Surgeon General's Report on Oral Health

Oral Health in America: A Report of the Surgeon General—Executive Summary

United States Department of Health and Human Services



“We have gone from a nation plagued by the pains of toothache and tooth loss to a nation where most people can smile about their oral health.”

The recent report of the Surgeon General discusses major findings in the area of oral health, which

the report stresses is essential to general health and well-being. It also provides a framework for action to enable us all to make more progress in this field.

Most of us know that oral health involves our teeth and gums. The report emphasizes, however, that oral health means much more than healthy teeth. Oral health also includes being free from chronic oral and facial pain, oral and throat cancers, oral soft tissue lesions, birth defects such as cleft lip, and other diseases that affect the oral, dental, and craniofacial tissues. These tissues are the ones that allow us to speak, smile, sigh, kiss, smell, taste, chew, cry out, and convey many feelings through facial expressions.

In addition to the theme expressed above—that oral health includes more than healthy teeth—other themes form the foundation for the rest of the report, including—

- Oral health is integral to general health
- Safe and effective disease prevention measures exist that everyone can adopt to improve oral health and prevent disease
- General health risk factors, such as tobacco use and poor dietary practices, also affect oral and craniofacial health

The Secretary of Health and Human Services asked that the report, commissioned by the Surgeon General, “define, describe and evaluate the interaction between oral health and [quality of life] through the life span in the context of changes in society.” The report covers the following topics—

- Part one outlines the meaning of oral health and provides an overview of the craniofacial complex in development and aging
- Part two describes the major diseases and disorders that affect the craniofacial complex and gives an oral health status report card to the United States
- Part three focuses on the relationship between oral health and general health and well-being
- Part four reviews how oral health is promoted and maintained and how oral diseases are prevented
- Part five focuses on what we need to do to enhance oral health

One of the major findings of the report is that oral diseases and disorders affect health and well-being throughout life. These conditions and some of the treatments used to address them sometimes undermine self-esteem, discourage normal social interaction, lead to depression, and can possibly interfere with work, school, and family interactions.

Another important finding, especially relevant to the Head Start community, is that there are profound oral health disparities within the U.S. population. These disparities relate to income, age, sex, race or ethnicity, and medical status. Not everyone is informed of or can take advantage of appropriate health-promoting measures. Furthermore, social, economic, and cultural factors affect how health services are delivered and used. One approach to improving access to care involves making dental insurance more available. Currently, public coverage for dental care is minimal for adults, and programs for children have not been able to reach all of the eligible beneficiaries.

Though we have made significant strides in oral health, steps still need to be taken to improve quality of life and eliminate health disparities. The report describes a National Oral Health Plan which provides a framework for action to—

1. Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health
2. Apply scientific research to effectively improve oral health
3. Build an effective health infrastructure that meets the needs of everyone and integrates oral health into overall health
4. Remove barriers to care related to access, utilization, financing, and reimbursement of services
5. Use public-private partnerships to improve the oral health of those who suffer disproportionately from oral diseases

As is evident from other articles in the *Bulletin*, creating partnerships is an especially important component for Head Start. The report states that the collective and complementary talents of public health agencies, private industry, social services organizations, educators, health care providers, researchers, the media, community leaders, voluntary health organizations, community groups, and concerned citizens are vital if America wants to eliminate health disparities.

For more information and to read a full version of the executive summary of the report, please go to www.nidcr.nih.gov/sgr/execsumm.htm.

Oral Health in the WIC Program

By Patti Mitchell



Dr. Peter Domoto, Dept. of Pediatric Dentistry, University of Washington School of Dentistry, conducts a lap-to-lap examination to assess and prevent early childhood caries in a toddler.

The WIC Program can play an important role in preventing oral health problems in women, infants, and children through its education and referral programs. The identification of oral health problems is part of the nutrition risk assessment used by local agency WIC staff to establish eligibility for participation in the Program. Depending on local priorities, WIC local agencies

may provide nutrition counseling as well as classes to parents and guardians of infants and children on proper care of the gums and teeth at home and feeding practices that reduce the risk of developing nursing bottle caries and other tooth decay. Many WIC local agencies have improved the links between participants and the local oral health community through referral and networking.

USDA's Food and Nutrition Service (FNS), which administers the WIC Program, and WIC state and local agency staff participated in the Head Start and Partners Oral Health Forum held September 1999. Several follow-up activities are planned to disseminate information regarding the Forum and the recommendations made in the scientific papers. For example, a working group of representatives from FNS regional offices and WIC state and local agencies around the country has been formed to provide guidance in developing materials for parents and WIC staff. These materials will be based on recommendations from the Head Start and Partners Oral Health

Forum and the scientific papers on nutrition and oral health.

At the federal level, USDA has joined with other departments and agencies to participate in several initiatives in an effort to further improve the oral health of children, including participation in and support of the Surgeon General's Conference on Children and Oral Health that took place June 12-13, 2000.

WIC and Head Start: Opportunities to Work Together on Oral Health

Head Start programs can contact and partner with state and local WIC agencies to obtain oral health educational materials. Many WIC agencies have training modules, protocols for oral health screening and referral, assessment tools, and other oral health resources. For example, the Washington state WIC agency has an excellent oral health program. The Washington WIC Baby Bottle Tooth Decay Prevention Project started at a local WIC clinic and, in 1992, was expanded statewide. Many other organizations and agencies in the state collaborated with WIC to develop the project, including the Department of Pediatric Dentistry at the University of Washington.

The project has three goals: (1) to promote nutrition and oral health education to improve infant feeding practices and reduce the risk of baby bottle and early childhood tooth decay; (2) to encourage caregivers to value their child's baby teeth; and (3) to provide oral health referrals when needed. Washington state has numerous materials on oral health, including two publications—"Healthy Snack Tips" and "Super Smart Snacks"—that provide information on snacks that minimize tooth decay. These materials can be ordered via their Web site:

www.doh.wa.gov/publicat/pubsdata.html. To search, enter “dental/oral” as the subject.

Not all WIC agencies have specific oral health materials or projects, but FNS encourages Head Start programs to inquire and, if needed, to collaborate with WIC to obtain oral health resources for use in Head Start programs. By coming together to identify needs and leverage resources, WIC and Head Start may be able to find creative ways to bring good oral health components to their programs and into the lives of the families they serve.

One of the biggest problems facing local communities is finding dentists and oral health care programs willing to serve low-income participants. Head Start and WIC can work together to publicize this concern in their local areas, identify oral health care services and referrals, and share this information with each other. Working together, the two programs have more power to raise awareness that oral health and access to oral health care are priorities in their communities.

Patti Mitchell is a Nutritionist, Supplemental Food Program Division, Food and Nutrition Service, U.S. Department of Agriculture, T: 703-305-2741; E: patti.mitchell@fns.usda.gov.

Possible Areas of Collaboration between WIC and Head Start

- Invite representatives from WIC to attend your local, state, regional, and national meetings
- Develop joint staff training opportunities
- Coordinate health and nutrition screening/assessment
- Share staff
- Exchange education approaches and share educational materials
- Cosponsor community resource fairs and community information sessions
- Encourage contributions to WIC and Head Start Bulletins and newsletters

A Success Story

A survey of Head Start children in nine villages of the Yukon-Kuskokwim Delta Region of Alaska found that an average of 67 percent of children had baby bottle tooth decay. Both WIC and Head Start staff found that children in Alaskan Native cultures are more often and more consistently given sweets and soft drinks compared to non-native children. This emphasized the need for educating parents and caregivers regarding nutrition and its relationship to maintaining good oral health.

The Yukon Kuskokwim Health Corporation (YKHC) WIC program initiated a demonstration project to address this issue. WIC and Head Start staff conducted home visits to provide training that placed special emphasis on nutrition education to parents and caregivers, tooth brushing and flossing, and referral information on oral health and nutrition. Tooth brushes, posters, pamphlets, and a video were distributed.

The project resulted in improved access to WIC, dental programs, Head Start, and other health programs in the region. It enhanced nutrition services and nutrition education and improved coordination among health providers of these programs by giving them experience in a new approach to collaboration efforts. The project also raised awareness in the community of the prevalent, painful, yet preventable problem of baby bottle tooth decay.

HRSA-HCFA Oral Health Initiative

By Candace M. Jones

The HRSA-HCFA Oral Health Initiative was inspired by the recognition that dental access is a problem for families enrolled in Medicaid and SCHIP. According to a 1996 Office of Inspector General report, only 18 percent of Medicaid children visited the dentist. A meeting in Lake Tahoe in June 1998 was the genesis of this initiative. It has resulted in an interagency agreement between the Health Resources and Services Administration (HRSA), the “access agency”, and the Health Care Financing Administration (HCFA), the agency responsible for the public financing of Medicaid, Medicare, and the State Children’s Health Insurance Program. The Interagency Oral Health Initiative aspires to eliminate access disparities and to advance the oral health of all Americans, particularly those most vulnerable due to age, income, race, or special needs. A three-part strategy was developed to—

- maximize the federal role in access to care,
- partner with the private sector and states, and
- maximize prevention through science transfer.

A team of Medicaid dental consultants at the central and regional levels, public health dentists, dental hygienists, and pediatric dentists has been instrumental in the activities of the initiative. Since its inception in 1998, the initiative has made a number of valuable contributions to oral health promotion, including—

- convening or encouraging 24 state coalitions or “oral health summits” that focus on access to care and the elimination of oral health disparities
- developing a home page (address located at the end of this article) that contains a Web based “tool box” for

states and advocates to use in reforming dental programs. The tool box includes—

- actuarial models
- workforce models
- geographic mapping
- model contract language
- policy briefs
- participation in various aspects of the Surgeon General’s work-shop and conference on oral health
- assisting with the development of the first Surgeon General’s Report on the Oral Health of America
- raising the issues of oral health disparities and lack of access to care with the Secretary of Health and Human Services, resulting in a departmental oral health initiative

Through the various bureaus within the HRSA and through the operating divisions within HCFA, a new emphasis on oral health has been achieved:

- The Bureau of Primary Health Care has increased the number of providers and the number of community and migrant health care centers providing dental services.
- The Maternal and Child Health Bureau (MCHB) has actively focused on children and families through school-based sealant and fluoridation programs and increased training for dental and medical providers offering critical health services to young children and their families.
- HCFA has created a special technical advisory group to explore ways to improve the quality and quantity of services for low-income families in partnership with states. They have also initiated a research program on the cost-benefits of early prevention, and provided assistance to states on reforming Medicaid and implementing SCHIP dental programs.

The HRSA-HCFA Oral Health Initiative is eager to help promote regional and state activities that address the oral health of America’s youngest children. A list of regional HRSA field consultants and pediatric dental consultants to the HCFA regional offices has been sent to each ACF Regional Office health liaison and QIC health specialist. Contact your Regional Office or QIC for more information on assistance available for your program.

For more information on the HRSA-HCFA Oral Health Initiative, go to the web at: www.hrsa.gov/oralhealth.

Candace M. Jones is Deputy Director Program Operations, Division of Oral Health, Office of Health Programs, Dental Program, Indian Health Service, T: 301-443-1106; E: jonesc@hqe.ihs.gov.

“This unique gathering of Head Start staff and parents, dentists and other health care providers, representatives from Medicaid and WIC, researchers, and others is an opportunity to explore new ways of working with partners to tackle issues of access to health services.”

*Tom Schultz
Director of Program Operations
Head Start Bureau*

Oral Health Forum Keynote Address Dr. Therman Evans



After battling severe weather and employing multiple modes of transportation—an airplane, a train, a bus and a taxi—Dr. Evans arrived in Washington 17 hours later. For the Forum participants, Dr. Evans' efforts were truly appreciated. He delivered an inspiring and thought provoking keynote address to an audience of 120 participants, each of whom had also braved the elements to attend. His central theme was that to truly address the problems of how health care is delivered today—including oral health care—we must take a holistic approach to creating health and wellness in human beings. We also must be willing to change.

Dr. Evans reminded the audience of the role that humor plays in keeping our perspective through challenging times and in developing creative solutions to difficult problems. He told us of how Einstein valued humor and imagination. In fact, imagination requires humor: humor leads to laughter, which promotes relaxation, which enhances imagination, which leads to creativity, which stimulates productivity, which strengthens security, which

Therman Evans, M.D.

Dr. Therman Evans, founder and CEO of WholeLife Associates, Inc., is the former Vice-president and Corporate Medical Director of the CIGNA Corporation, one of the world's largest health care companies. He has served as Chairman of the Mayor's CityWide Commission on the Prevention of Teenage Pregnancy in Philadelphia; as a member of the Board of Directors for The Wellness Council of America as well as on other boards; as a member of the Advisory Panel of the National Association of Health Service Executives; and as President of the Washington, D.C. Board of Education. He has published over 24 articles in various health journals and newspapers, including the *Journal of the American Medical Association*, the *Los Angeles Times*, *Ebony* and *Collegiate* magazines. Dr. Evans is the author of five booklets called "Prescriptions", the host of a radio show called "Lifeline" in Philadelphia, Pennsylvania, and a pastor.

Dr. Evans, known as "Mr. Inspiration," is one of the most exciting and dynamic motivational presenters in this country and abroad. He addresses wellness (inclusive of fitness and nutrition), diversity, and stress and change management.

makes one more able to laugh. The more humor in one's life, the more creative one can be. And as Dr. Evans pointed out, being uptight and defensive has not solved our health care problems yet, so we might as well relax—it just may help us develop the creative solutions we need to address the intractable problems facing our health care system!

If Forum participants remembered one thing from Dr. Evans address, it was likely to be the concept that “all things are related.” To address oral health, we must look at the overall health of a person. Similarly, to address the problems of our health care system, we must look at the whole system of delivery—not just the medical solutions. In many cases, we have had the medical solutions to health problems, yet we have not been successful in bringing the solutions to the people because we have not been looking at the whole system—or the whole person. While we have continued to advance in technologies, we still do not understand the basics of dealing with human beings. To do this in any meaningful way, we are going to have to change the way health care is taught and the way it is delivered.

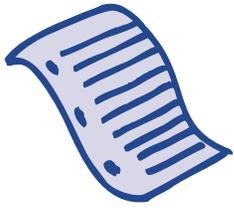
Dr. Evans talked about how we must begin to look at health care, including oral health care, from a positive frame of reference. We need to move away from the traditional medical school training of seeing patients as only the diseased organ or set of symptoms they present, and toward seeing each person as a whole human being. The human condition is one of spirit, mind, and body. If we do not learn to address all three aspects of a person, we will never have an effective and efficient health care system.

Dr. Evans emphasized in his address that access to health care is not just a function of available expertise and close geographic proximity. If that was the case, those in lower income neighborhoods surrounding urban medical centers should be some of the healthiest people in the community. Access is also affected by human factors such as whether people feel welcome or valued. People do not need to be highly educated to have an innate ability to read body language, and they can clearly read the signs of not being welcome or valued. We must teach our health care professionals to set aside their discomfort and learn to connect with people. They must learn to be comfortable with feeling uncomfortable as they work with people who do not look like them,

act like them, or speak like them. Until we learn to do that, all the medical solutions or medical credentials in the world will not do what they are created to do. Ultimately, Dr. Evans contended, degrees do not mean much if you cannot connect to another human being.

Just as we need to look at the individual holistically, we must also look at the system of health and wellness care holistically. Each part is unique and critical to the functioning of the whole. Oral health, for example, is critical to and dependent upon general health. Dentistry is critical to and dependent upon general medicine, nutrition, and cultural norms. We must learn to understand and value each component of the whole. We must learn to partner, collaborate, and connect as individuals and organizations to create a truly effective, efficient system for health, healing, and wellness.

We also must learn to become more comfortable with change. Human beings, Dr. Evans reminded us, do not like change—especially when they have a vested interest in the status quo, as do many health professionals. However, if we want to address the problems in the health care system, we all must be willing to change. We must expect that change will bring pain, yet once we get past the pain and effort, we will have the kind of health care system and, more importantly, health outcomes, that we can now only imagine. Like delivering a baby, the pain is necessary and the new life it brings is its own reward.



Head Start and Partners Forum on Oral Health: Paper # 1: Causes of Dental Cavities and the Role of Good Nutrition

We all know that sugar causes cavities, but most of us do not really know why. We also have heard that it is harmful for infants and children to be put to bed with a bottle containing sweetened drinks. A paper by dentist Norman Tinanoff and nutritionist Carol Palmer entitled “Dietary Determinants of Dental Caries and Dietary Recommendations for Preschool Children” (published in the *American Journal of Public Health Dentistry*, Volume 60, No. 3, Summer 2000) explains how frequently eaten foods containing a lot of sugar promote tooth decay and how a child’s diet can be improved so that teeth are protected.

Here is the way it works. Bacteria, or dental plaque, can attach to our teeth, feed on the sugars we eat, and produce acid. A specific bacteria, called *Streptococcus mutans*, can be transmitted from mothers to their children, and this bacteria is able to produce great quantities of acid from sugar. This acid can erode away the enamel on teeth. If sugar is frequently consumed, acid is formed over and over again and can readily lead to cavities.

Therefore, if children suck on candies, lollipops, or throat lozenges for long periods of time, their risk of tooth decay increases—the sugar is staying in the children’s mouths longer, giving the bacteria a longer time to produce acid. Equally harmful to children’s teeth is frequently drinking juice from a sippy cup or bottle, especially at nighttime. Of course, many parents frequently give their children juice throughout the day because children like it, it is cheap, and juice is thought to be nutritious. However, these juice drinks, and even “natural juices,” have sugar, and just like candies and lollipops, consuming them over a period of time can cause cavities.

The Prenatal Period

Pregnant mothers need to understand that even before their child is born, they are having an effect on their child’s future



tooth decay. Because children’s baby teeth begin forming before birth, pregnant mothers can help prevent future tooth decay in several ways. First, mothers should ensure they are getting adequate nutrition. Developmental defects in children’s teeth due to poor prenatal

nutrition are strongly related to the development of tooth decay later in life. Second, mothers need to pay special attention to their own oral health. Studies have shown that mothers with tooth decay increase the risk of passing cavity-causing bacteria to their children. For these reasons, pregnant mothers should make sure to follow the balanced eating guidelines of the Food Guide Pyramid and maintain proper dental health.

From Birth to One Year

Good nutrition is especially important for oral health during the first year of life. Breast-feeding is good, not only because it is good for the baby’s health, but also because it decreases the chance of tooth decay.

As already stated, an important factor for early childhood tooth decay is the prolonged use of baby bottles containing sweet drinks, such as fruit juice or other sweetened drinks. Children on a bottle should be weaned to a cup by age one. As infants make the transition from breast or bottle to cup, it is important that they not be allowed to suck on a sippy cup for long periods of time, and drinks other than milk or water should be limited to meal times. Additionally, pacifiers dipped in sugar, honey, syrups, or other sweets are also a problem.

Children like sweet foods, but parents and caregivers need to have influence over children’s food preferences. For example, infants are more likely to accept nutritious food if it is offered several times. Also, children who eat a lot of sugar as infants are more likely to prefer sweet foods when they are toddlers.

From One to Two Years

During the toddler period, children are forming eating habits and are more able to eat on their own. We need to pay attention to food choices that are good for a child’s oral health. For example, parents should give their child nutritious finger foods, such as cheese and fruit, as snacks. Studies have shown that children may reject a new food many times before they accept it. Consequently, it is important to continue exposing children to healthy foods by keeping them available. And while parents and caregivers should provide children with healthy foods, let children decide for themselves when and how much to eat. By doing this, you are helping children sense when they are hungry or full.

Also, one should *avoid* offering children sweet foods as rewards for an action or good behavior, which only reinforces a positive feeling about eating sweets.

From Two to Five Years

In the preschool years, try to reinforce good eating habits, including eating at regular meal times and avoiding snacking throughout the day. As children grow to be more independent, the patterns they were taught earlier in life should help them make healthy food choices. Parents and caregivers can also help children make healthy choices by limiting the availability of sweet and unhealthy foods in the home.

Children with Special Needs

Children with special needs can be at increased risk of tooth decay due to feeding difficulties and the use of sugar-based medications. Such problems can lead to longer feeding times with foods staying in children's mouths for longer periods of time, increasing the risk of tooth decay. Therefore, parents and caregivers need to pay special attention to the oral health concerns of children with special needs. Nutritional counseling can be very helpful in reducing the risk of tooth decay for these children.

Summary

Good eating patterns play a major role in children's oral health, and parents and caregivers have an important role in developing these patterns. They need to understand how frequently consumed sugar-containing food can harm teeth.



This article is a summary of "Dietary Determinants of Dental Caries and Dietary Recommendations for Preschool Children" by Dr. Norman Tinanoff and Carol Palmer. The full text of this article is available in the Summer 2000 edition of the American Journal of Public Health Dentistry as well as on the Web site: www.hskids-tmsc.org.

Oral Health Dietary Guidelines for Expectant Mothers and Preschool Children	
Dental Period	Nutrition
Pregnant Women	<ul style="list-style-type: none"> Follow the Food Guide Pyramid, taking into account increased needs for pregnancy Take prenatal vitamin/mineral supplement as prescribed Limit intake of cariogenic foods, especially as between-meal snacks
Birth to One Year	<ul style="list-style-type: none"> Avoid allowing infants to sleep or nap with a bottle Avoid excessive consumption of juice Eliminate dipping pacifiers in sweetened foods
One to Two Years	<ul style="list-style-type: none"> Avoid frequent consumption of juice or other sweet drinks in a bottle or sippy cup Encourage weaning from a bottle to a cup Continue avoidance of taking the bottle to bed Promote "tooth-safe" foods for snacks Foster routine eating patterns and following the Food Guide Pyramid
Two to Five Years	<ul style="list-style-type: none"> Discourage slowly eaten, sweet foods, such as candy, lollipops, or suckers. Promote "tooth-safe" foods for snacks Encourage eating at meals following the Food Guide Pyramid



Head Start and Partners Forum on Oral Health: Paper # 2: Oral Health Assessment and Dental Prevention

Tooth decay remains one of the most common diseases of childhood. Even more troubling is the fact that low-income children are affected by tooth decay much more than are the rest of the population. Therefore, Head Start, and WIC need to take particular interest in the oral health of their families and children. Dr. Michael Kanellis, in his paper, "Caries Risk Assessment and Prevention" (published in the *American Journal of Public Health Dentistry*, Volume 60, No. 3, Summer 2000), suggests that to lower the rate of tooth decay in these preschool children, it is important to have oral health as part of the structure of the Head Start and WIC programs.

Screening

Oral screening exams for infants, toddlers, and preschoolers are an important first step in determining a child's oral health care needs. These exams can provide important information on the rate of current tooth decay and the risk of future decay.

Head Start Program Performance Standards require that Head Start programs provide dental exams for their children within 90 days of enrollment. Additionally, for those children in Head Start, Early Head Start, and WIC, a

referral to a dentist should take place so that "dental homes" can be established for each child.

Risk Assessment

Screening exams provide an important first step in determining which children are at high risk for dental decay. They help establish different preventive strategies for each child. Children of

low-income status should generally be considered at a higher risk of tooth decay. However, it is still important to conduct risk assessments at the individual level.

Risk assessment strategies that are most effective are ones that are easily performed, are low cost, require no special equipment, and provide reliable results. Strategies that meet these guidelines include—

- **Review history** — One of the best indicators of future tooth decay is past tooth decay.
- **Look for cavities and white spot lesions** — Look for brown or black spots that cannot be removed with a tooth brush; white spot lesions (pre-cavities) often follow the gum line.
- **Look for plaque** — The presence of visible plaque on a child's teeth indicates risk for tooth decay.
- **Get a dental professional's opinion** — Dentists, hygienists, and other health professionals can accurately predict a child's risk for tooth decay.
- **Screen for bacteria** — *Streptococcus mutans* is the bacteria in plaque that is necessary for tooth decay to begin. Tests that look for these bacteria are good risk indicators.
- **Ask about dietary habits**— Sleeping with a bottle containing sweet liquids or letting a child suck on a bottle or sippy cup throughout the day are risk factors for tooth decay.

Prevention

After a child has been screened and his or her risk of tooth decay has been assessed, preventive strategies should be planned. The following list of preventive measures are appropriate for nearly every child in Head Start, Early Head Start, and WIC.



- **Education** — Education has long been an important part of preventive dentistry programs. However, studies have shown that although education increases the knowledge levels about oral health issues, it is often ineffective in making people change their unhealthy oral health behaviors.
- **Tooth brushing** — It has long been understood that tooth brushing is an important means for reducing the risk of tooth decay. Yet, what is even more important is making sure that the toothpaste used with brushing contains fluoride. Preschool children should use less than a pea-size amount of toothpaste. It is best for children not to rinse or to minimally rinse after brushing to maximize the effects of the fluoride.
- **Fluoride varnish** — Fluoride varnish is suitable for young children at high risk for dental cavities. In some states, dental hygienists can apply the varnish without direct supervision. No special equipment is needed for the application, and children can eat and drink right after a

varnish application. Fluoride varnish applications can be performed two times a year for all children, and more often for children who are at a higher risk of tooth decay.

- **Sealants** — Sealants protect the pits and fissures of teeth and are the single most effective means for preventing tooth decay, especially for permanent molars in children over the age of six.

Early screening, risk assessment, and preventive programs in WIC, Head Start, and Early Head Start children are important because children in these programs are generally at high risk for tooth decay and are sometimes unable to access preventive dental care through more traditional means.

This article is a summary of "Caries Risk Assessment and Prevention" by Dr. Michael Kanellis. The full text of this article is available in the Summer 2000 edition of the [American Journal of Public Health Dentistry](#) as well as on the Web site: www.hskids-tmsc.org.

Oral Health Prevention for Head Start and WIC Children

- Emphasize the importance of screening preschool children for tooth decay to dentists, hygienists, nurses, physicians, and parents.
- Consider all children enrolled in Head Start, Early Head Start, and WIC at high risk for tooth decay.
- Help find a dental home for each child.
- Do not rely solely on education to help prevent tooth decay.
- Incorporate daily brushing with fluoride toothpaste into daily routines.
- Incorporate twice yearly fluoride varnish applications into preventive dental programs.



Head Start and Partners Forum on Oral Health: Paper # 3: Access To Dental Care For Preschool Children

Children's access to dental care is closely related to age and income. Young children and low-income children obtain far less care than others. Children involved in Head Start and WIC programs often do not receive dental services beyond screening and nutritional counseling. When they do see a dental professional, they frequently obtain less care than they need to resolve all of their dental problems. This problem persists even though most qualify for dental coverage through Medicaid or the State Child Health Insurance Program.

A paper written by Dr. Burton Edelstein entitled "Access to Dental Care for Head Start Enrollees" (published in the summer edition of the *American Journal of Public Health Dentistry*, Volume 60, No. 3, Summer 2000) discusses the problems that limit Head Start and WIC eligible children from getting good dental care. These include problems stemming from Medicaid and SCHIP (burdensome administration, low fees, contracting issues, and some limited benefits in SCHIP plans); problems stemming from dental delivery systems (few safety net dental facilities, dentists' unfamiliarity with treating very young children, cultural barriers, and lack of dentists located close to children's homes); and problems stemming from parents and families (lack of awareness about oral health and dental care needs, problems using the private dental care system, and competition from other daily living activities). Because of these barriers, low-income children with dental problems often do not receive adequate care. As a result, these young children frequently have high levels of disease and experience dental pain and oral infections.



Dr. Burton Edelstein, Director, Children's Health Dental Project, Health Services and Resources Administration.

One of the first steps in solving the problems of dental care for Head Start and WIC children is screening to identify obvious dental problems and children at high risk of dental disease.

Head Start and WIC could also develop training materials to advance and refine the approaches used by dentists and other health professionals to screen children and assess them for risk. By working with dental schools, WIC and Head Start could develop

evaluation tools that measure the effectiveness of screenings and assessments. By linking efforts with safety net providers, particularly community health centers, programs serving young children could help integrate oral health services into overall primary health care.

Head Start and WIC should also work with local dental associations to encourage dentists to support their oral health programs. With the local associations, Head Start and WIC can arrange for training programs that teach dentists and hygienists how to deal with young children and can provide social rewards for those engaged in seeing the children they serve. Furthermore, Head Start and WIC can involve parents in raising their awareness about oral health and in preparing them and their children for dental visits. For example, dental visits should never be used as a threat or punishment. Parents also need to be advised of expectations about their use of dental services, from appointment making and appointment keeping to office decorum and compliance with oral health promoting recommendations. Additionally, staff in these programs can help tremendously to engage families in essential dental care by—

- helping make dental appointments,
- assisting with transportation to dental offices,
- assuring child care for siblings during dental visits,
- accompanying concerned parents to the dental office, and
- providing translation services.

Modern dental care offers children tremendous and unprecedented opportunities to obtain and maintain excellent oral health. Head Start and WIC programs can go a long way toward reducing access disparities for young, low-income children by understanding barriers and removing them in supportive and thoughtful ways.

This article is a summary of "Access to Dental Care for Head Start Enrollees" by Dr. Burton Edelstein. The full text of this article is available in the Summer 2000 edition of the American Journal of Public Health Dentistry as well as on the Web site: www.hskids-tmsc.org.

At the Forum: Participant Comments

<p>Topic 1: Nutrition and Oral Health</p>	<ul style="list-style-type: none"> • More research is needed on the cultural habits of families, so that the approach for implementing the nutrition recommendations can be tailored to each culture. • There may be challenges in implementing the recommendations; however there are many important steps programs can take. Some strategies include— <ul style="list-style-type: none"> • disseminating information to staff and parents, (i.e., educating pregnant 	<p>women about good nutrition and its effect on their own and their child's oral health),</p> <ul style="list-style-type: none"> • establishing or strengthening community partnerships with WIC, Title V programs, and dental associations, and • revising policies and procedures that reflect the recommendations are important steps programs can take.
<p>Topic 2: Prevention, Suppression, and Management of Caries</p>	<ul style="list-style-type: none"> • Education about preventing caries is still a viable option in Head Start. • Educational approaches for both staff and parent education include use of— <ul style="list-style-type: none"> • non-print media such as videos or CD-ROMs, • educational kiosk programs, 	<ul style="list-style-type: none"> • parent delivered education, and • community access cable channels. • Adults should be helped to overcome their own fear of dentists. • The feasibility of the recommendations is affected by culture and special family circumstances.
<p>Topic 3: Access to Dental Care for Head Start Enrollees</p>	<ul style="list-style-type: none"> • Working with the local dental community to obtain direct services and access for families is a winning strategy. Programs can involve medical professionals in observing dental health needs, and can develop a tip sheet of key points that staff can discuss when making contact with medical and dental providers. • Parents are key players in ensuring dental care for their children. Programs should work with employers to allow personal leave for parents when taking their children to the dentist. Encouraging parents to take children to the dentist by age one is a strong message about the importance of dental care. 	<ul style="list-style-type: none"> • Head Start staff should be given the tools to promote oral health. Programs should ensure that staff understands and implements the Performance Standards for dental services, including payment and follow through. • Oral health needs a higher profile. Programs should prepare and deliver frequent, consistent messages to parents about oral health. • The Head Start community can influence system and policy changes, such as incentives to work in rural areas, allowing dental hygienists to perform some procedures, and changing Medicaid claims forms to make them less cumbersome.



Feedback on the Forum

By Judy Pulice

They say you are never too old to learn. Although some days it seems I am, that was not the case when I attended the Oral Health Forum last September. In fact, I learned a lot about oral health during that day and a half.

First I had to throw out some of my misconceptions, developed nearly 25 years ago, of how Head Start programs operate and how local programs fit with state and federal activities and oversight. Second, and most importantly, I had to learn what is not working when it comes to oral health and treatment for Head Start children.

Head Start is not unique in its attempts to deliver dental care to poor children, especially those between the ages of two and five. The basic problem encountered is the inadequate Medicaid dental programs in most states. Funding is often inadequate, the forms are cumbersome, and the policies do not make sense to most dentists. Additionally, in a majority of programs, the reimbursement rates do not come close to covering the costs of providing the services. We can see why a great many dentists have discontinued participation.

During the Forum, Head Start program staff expressed their frustration and even anger at dentists in their communities who are unwilling to treat these vulnerable children. I understand and empathize with Head Start staff. I also, however, understand and

empathize with the dentists who are no longer able to participate in a program that is, it seems to them, beyond repair. Members of the American Dental Association often express their frustration and anger at state legislators and officials who consistently underfund their dental programs, either because they do not believe dental care is essential to a child's well being, or because they feel other services have priority.

At the end of the Oral Health Forum, after meeting and talking with so many program staff and federal coordinators, I knew that not only had I learned something, but so had the other participants. Though they still seemed frustrated and angry, they promised to return home and contact the local or state dental society to see if they could work together to make a change in the attitude of policymakers. I hope they followed through. The theme at several "access" conferences lately has been community collaboration; it will take contributions from all stakeholders to make the significant changes needed. I am hopeful, in the case of oral health, we can work together to make the necessary changes.

Judy Pulice is Director, Department of State, Government Affairs, American Dental Association, T: 312-440-3520.

"This was the first time that these federal agencies (Head Start, USDA, HCFA, and HRSA) got together to try to eliminate the barriers to oral health care for low-income families. The development of the papers and the real world response from parents and program staff will help us deliver coherent messages to families and programs that can be effective."

"I was very impressed by the knowledge of the Head Start community about oral health."

"The partnership has a lot of potential. Certainly some work is going on at the regional as well as national level. Materials are being produced for use by local programs. We are working hard on improving the access to dental care through Medicaid. The personal connections among the partners should not be underestimated. We value the expertise and commitment of all the partners and continue to review each other's work and ask for advice. Head Start has a lot to offer the dental community."

Donald Schneider, DDS, Chief Dental Officer for Health Care Financing Administration.

Interview with Dr. John Rossetti

Chief Dental Officer, Maternal and Child Health Bureau
Chief Dental Officer, Health Resources and Services Administration

1. Overall, what was your impression of the Forum? Did you find anything particularly exciting, unique, or innovative? If so, what?

I was very excited about the Forum. We need more of this type of activity. I still find it refreshing to see the enthusiasm that Head Start programs and staff have for addressing critical issues. It brought back fond memories of the annual training meetings and workshops that Head Start and HRSA's Maternal and Child Health Bureau (MCHB) held for several years where training, data, and other information were shared between Head Start grantees and dental experts. But, based on comments from participants, I am not sure if appropriate oral health information is getting down to the grantee level as well as it did in the past when Head Start and MCHB worked together more closely. I think the understanding and dialog generated at the Forum—cavities as an infectious transmissible disease, innovative ways to prevent dental disease, and the critical role that diet and feeding practices play in dental disease—were very eye opening to many participants.

Today, many Head Start programs are having greater difficulty accessing dental services and finding dentists to treat their children than in the past. The Forum provided participants a great overview of why this has happened. It's obvious there is a maldistribution of dental providers, and there may not be enough trained dentists to treat young children.

Access to dental services for Head Start children is a problem confronted by grantees all over the country, and it seems to be getting worse in some communities. Dental disease among many Head Start children is not any better either. For example, a study done in Maryland found that 50 percent of Head Start children had decayed teeth and 90 percent of these children required fillings; 16 percent of these children were in pain. In a similar study conducted in California, 37 percent of Head Start children were found to have urgent dental needs. How can children learn, be well-behaved, and feel good about themselves when they are in constant pain?

2. While Head Start and Health Resources and Services Administration (HRSA) have worked together for many years on oral health (through the interagency agreement), this is the first time the partnership has been expanded to include Women, Infants and Children (WIC) and Health Care Financing Administration (HCFA). Do you have any thoughts on this expanded partnership? What do you think made it work?

None of us can do it alone. I think the partnership worked because we recognized that oral health must be addressed comprehensively; each agency must be involved—each plays an essential role. It is critical to have WIC participate in prevention and early intervention efforts, not only for children but for pregnant women as well. Many children are seen by WIC before entering a Head Start classroom or being seen by a dentist. WIC has an important role to play in reinforcing dental health concepts taught and practiced in Head Start programs, but we need a mechanism to let WIC staff know



what is happening in Head Start. By working with families, WIC is in a unique position. If a pregnant mother has active tooth decay and her children have decay, chances are pretty good that the next child born will also have tooth decay. Knowing this, WIC staff can be trained in prevention and early intervention that would have enormous benefit to both the mother and the child. HCFA's involvement is critical because of its role in financing dental services—services that can be provided by Head Start and WIC staff. HRSA also offers valuable expertise in providing information and training on oral health education, prevention, early intervention, and treatment.

There are HCFA staff at the national and regional levels who are working very hard to overcome the access to care barriers and their efforts seem to be paying off. After several years of inertia, we are beginning to see some movement by states to increase dental fees and remove some of the paper work and administrative barriers that have kept dentists out of the program. But, we have only begun the process and have a long way to go to make Medicaid a program that the dental providers will readily accept. I strongly recommend that grantees and state level Head Start organizations work much more closely with Medicaid and SCHIP staff. If a state level Head Start organization has an advisory committee, Medicaid or SCHIP representatives should be asked to be members. If they say no, ask again.

3. You have worked with Head Start programs for over 25 years. Have the training and technical assistance issues related to oral health remained the same, or have they changed? If they have changed, what are the emerging issues?

As I mentioned, for many years MCHB administered an agreement with Head Start to provide technical assistance to grantees on prevention, early intervention, and access to oral health care. We maintained over 200 dental consultants and experts to work with grantees on all aspects of oral health. The agreement no longer exists, but the issues are basically the same—with a few noteworthy changes. We have always had higher disease rates in Head Start

than in the general population, and the need for prevention, early intervention, education, and access has been with us for a long time. But for some programs, the situation may have worsened.

Today it is more difficult to access providers and there are fewer dentists willing to treat Head Start children than in the past. This may not be the case everywhere but the feedback that I get from many states reinforces this point. Nationally, we are seeing about 6,000 dentists retiring every year and only 4,000 graduating from dental school, and we also see fewer and fewer dentists practicing in underserved areas where our Head Start programs may be located. There is also a problem with the low numbers of pediatric dentists. Low Medicaid fees also have been a problem for some time. Until recently, there were very few states that raised their Medicaid rates to attract dentists to treat Head Start children.

The distribution of oral health disease has also changed. Oral health problems are more concentrated in a smaller proportion of children than in the past. Currently, 80 percent of the dental decay is concentrated in 25 percent of the children. These children are usually from low-income families, families with low parental education, and recent immigrants—the same 25 percent that are Head Start children. The general public, many providers, and policy makers do not think oral health is a problem. They do not see it in their children so they think it no longer exists. But we all know they are wrong. We see it every day.

Some people may not see or experience it, but dental decay is the most prevalent chronic disease in children in America today. The fact that the organisms that cause dental decay are transmitted from caregiver to child (and are also affected by nutrition and hygiene) is a new concept to many. This goes back to what I said about the need for greater involvement of WIC in prevention and early intervention programs. We know how to prevent it and intervene early in the disease process, but we have not been using the tools that we have. The right people have to be made aware of these tools and be trained to use them if we are to gain control of the problem.

During my 25-year involvement with Head Start, I have provided direct dental care to Head Start children, taught in the Head Start classroom, conducted teacher training, managed regional technical consultants and been a national advisor/consultant to the Head Start Bureau. These have been very enjoyable and rewarding years for me. During this period I have observed much about the Head Start program, its children and families, and I have also developed several opinions and philosophies. Today Head Start puts greater emphasis on parents or caregivers getting the child to the dentist for needed care instead of having Head Start programs access care for the children. Unfortunately, we're finding that many children aren't always getting to the dentist. As we discussed earlier, it's much more difficult to get an appointment today for a Head Start child on Medicaid than it was 15 to 20 years ago. It's great to get parents involved, but if they fail to follow through or just can't get a dentist to see their child, it is the child that suffers—the child falls through the cracks. In the past, programs made the appointment and ensured that children received care. We can't have kids falling through the cracks. We may need to go back to having programs take a more active role in getting children to the dentist.

Most of us tend to think of parents as the teachers of their children, but I have found that children can be teachers of their parents and siblings as well. When Head Start children learn proper and regular oral health habits in the Head Start classroom, they bring this information and healthy habits home to their families. I have had many Head Start parents come into my dental clinic after years of dental neglect because their child came home from Head Start and told them how important it was to take care of their teeth and that they shouldn't be afraid of going to the dentist.

With respect to the emerging issues, we are now much more aware that children with a high level of decay in their baby teeth are probably going to have a lot of decayed adult teeth. We also recognize that the bacteria that cause tooth decay are transmissible—most likely from the mother or caregiver to the child. We also know that we can stop or slow down the decay process once it begins. This lends strong support for training and utilizing Head Start and WIC in dental screening and early intervention techniques. We are exploring the use of fluoride varnish application as one of the things that Head Start and WIC staff can do to address the problem.

4. In your opinion, what are the challenges that Head Start and Early Head Start programs face in implementing some of the preventive practices presented at the forum? What steps can programs take to overcome these challenges?

Just getting things started will be tough. The challenge is to put more emphasis on early intervention. We need more training and technical assistance for local programs. We need more dental providers on health advisory boards to provide training and technical assistance to programs, and hopefully become providers of dental care for Head Start children.

We need to get parents involved in getting their children to dentists, or if parents can't do it, find ways to get care for children through the Head Start programs (by taking groups of children to the dentist, for example). The challenge is to get kids to leave Head Start with good oral health habits and attitudes toward oral health and ensure they continue healthy habits and routine dental care once they leave Head Start.

We need to get WIC, the dental community, and the pediatric medical community involved. The pediatric community could help enormously. For example, they could provide oral health guidance to Head Start parents, they could better screen children for dental disease, and apply fluoride varnishes. In general, we need better utilization of the private sector medical and dental community.

5. Do you have any final thoughts on the Forum, the partnership, or the recommendations?

We need more Forum-type meetings around the country. Over a decade ago, we routinely held regional workshops similar to this one. We should do that again. I'd also like to see a rejuvenation of the collaboration between HRSA and Head Start on a formal basis, maybe including WIC and HFCA.

Most of us tend to think of parents as the teachers of their children, but I have found that children can be teachers of their parents and siblings as well.



Comments from Parents Participating in the Oral Health Forum

The Oral Health Forum benefited from the participation of several parents who offered valuable input to the discussion. As one of the parents said, she was able to bring daily “real life” health information, concerns, and problems to the discussion. The parents also were an important conduit back to their programs and communities.

Tracy Kennedy, chair of the Head Start Parent Policy Council in Litchfield, Connecticut, said she took what she learned at the Forum and applied it that night with her family. Tracy enjoyed sitting and sharing her thoughts with educators who worked in the field of oral health. She found it gratifying that her opinions, as well as the opinions of other parents, were listened to by the experts.

Tracy also found it exciting to be on the cutting edge of oral health information. She was particularly interested in the research on cavities as a disease—a concept unfamiliar to her before the Forum and important to her as a parent. She was excited to learn that oral health actually begins before birth and that a woman taking care of her teeth while pregnant has a positive effect on her unborn child. Although some of the information presented was scientific, the sessions helped her understand the concepts and provided an opportunity for her to speak with experts “on the same level.” She knew that her input was valued since she was able to discuss the daily concerns and problems that average parents face—a critical aspect to any oral health practice.

Melissa Scott, a parent representative who works with the Olympic Education Service Department in Bremerton, Washington, attended the Forum with the hope of learning how to get dental services to small communities and remote areas like Alaska—she had lived in remote areas where dental care was hard, if not impossible, to find. Melissa found the experts at the Forum to be very open. While following the medical jargon used by some of the presenters was difficult at first, they did a good job of explaining the terms and why it was important for people to be familiar with the terms. By the end of the presentations, Melissa was comfortable with the new jargon and information she had learned. Melissa was honored to have been asked to participate in the Forum, and felt that her interest and work in trying to get oral health services to young children in remote areas was valued by people at the Forum.

“Excellent idea to include Head Start parents—it is rare for agencies to include those persons who actually receive the services. People don’t realize they can learn a great deal from them.”

-Agency Participant

“ I learned a great deal of information from people other than my usual colleagues—from parents and people who work with children on a daily basis.”

-Dentist Participant

You've Been to the Forum (or Read About It): Now What?

By Robin Brocato

As the planning committee for the Head Start and Partners Forum on Oral Health met, one topic of discussion was what follow-up activities would take place after the Forum. Planning committee members envisioned the Forum being replicated on a regional, state, and local level, and in fact, this has taken place in several regions and states (see articles on pages 22 through 26 about some of these

events). While we know that no community or state is exactly alike, and no forum will replicate the September 99 Forum, here are some steps that you can take to get your community or state more involved in oral health—

- **Contact your Administration on Children and Families Regional Office.** They may already be working in partnership with the regional HCFA or HRSA office. They may be able to assist you in identifying regional, state, and local resources, or may be able to share what other Head Start programs in your region are doing to improve access to oral health services.

- **Contact your Regional Quality Improvement Center Health Specialist.** The QIC health specialists have been working on this issue for many years. They can identify state and local resources and contact persons, and can provide technical assistance as needed. They also have a limited supply of oral health buttons and posters they can send you in support of local and state oral health activities.

- **Contact your State Collaboration Office.** Many of the state collaboration offices are working on health issues such as improving access to care or Medicaid/SCHIP outreach. Ask them if they have information about state interest in or activity on oral health. They may also have names of state or local contact persons from HCFA, HRSA, or WIC.

- **Take this opportunity to revisit formal and informal community partnerships.** If you have an existing interagency agreement (state or local) with either WIC or HCFA (Medicaid), look over the agreement to see if it is broad enough to cover oral health, or think about how it could be revised to do so. If you rely on informal partnerships with your local health department or other community health

providers (such as a managed care organization), think about the pros and cons of formalizing the partnership.

- **Involve your Health Services Advisory Committee.** Recruit a dentist or dentists to serve on your HSAC! Provide copies of the papers presented at the Forum to your HSAC (for information on how to get copies of the papers, see page 44) and ask them to help develop a plan to implement some or all of the recommendations. They may also be helpful in contacting state dental schools to ask them to get more involved with Head Start.

- **Let technology work for you.** In this issue of the Bulletin, several resources are presented. Visit the Head Start Oral Health Virtual Resource Guide at: www.hs-kids.tmsc.org (see page 40 for a description of the guide). Ask your HSAC for assistance in deciphering the vast information available on the Internet, keeping in mind that the source and quality of the information is very important. Download pamphlets, fact sheets, and articles from reputable sites; copy them and give them to parents.

- **Speaking of parents, do not forget the Policy Council!** Copy some of the articles in this issue of the Bulletin, provide parents with copies of the papers, or view the actual videos from the Oral Health Forum. Have a parent meeting dedicated to the topic of oral health. Invite health staff, HSAC members, and community providers to watch the videos or discuss the Forum papers and this issue of the Bulletin.

Robin Brocato is a Head Start Health Specialist, Head Start Bureau, T: 202-205-9903; E: rbrocato@acf.dhhs.

Visit the ACF Head Start Website at: www.acf.dhhs.gov/programs/hsb for information on how to reach your Regional Office, QIC, or State Collaboration Office.

By Sue Wilson

Head Start Fellow, Class of 2000

Forum participants gave useful suggestions for how to make the most of your Health Services Advisory Committees (HSAC)—

HSAC members can be important resources for programs—

- Include a dentist on the Health Services Advisory Committee
- Involve Medicaid consultants on the HSAC

Finding dentists to serve on your HSAC can be challenging—

- Look for retired dentists and pediatric dentists
- Approach dental societies, Kiwanis or Rotary Clubs, American Academy of Pediatrics, Healthy Child Care America, and health consultants for suggestions

The HSAC can play an important role in implementing the recommendations in the Forum's papers—

- Use the HSAC to sort through the research and information received from experts before implementation
- Ask the HSAC for advice and assistance on incorporating realistic activities
- Ask the HSAC for technical advice such as—
 - Whether chlorhexidine is useful for children,
 - If Head Starts can request the dental history of mothers, and
 - If programs should encourage applying varnishes twice each year.

Oral Health: Integrating New Science into Daily Practice: Perspectives from the Field

By Dorothy Allbritten

How do we integrate new scientific findings into what we do and how we do things at our Head Start centers? This is a common question for participants at research conferences as they return to their Head Start programs armed with new knowledge as well as the desire, hope, and enthusiasm to share the information they know will be helpful to children and families.

Many participants left the September 1999 Oral Health Forum with that very question in mind. The Head Start Bureau and its partners had provided summary recommendations in three areas of research—nutrition and oral health, prevention, and access to dental care (summary papers can be found on pages 10 to 14 of this Bulletin). The far-reaching recommendations outlined strategies for incorporating the new science discussed at the Forum into daily practice.

The Challenges

When Head Start staff returned to their centers, some common challenges were echoed from Maine to California: What are these new findings? How can we get the word out? People will not understand why they should change the way they do things. How can we show people how these activities can benefit expectant parents, children, and ultimately families? Folks will not want to change what they do, since their parents did it the same way. Medicaid will never increase reimbursement so providers can cover their costs. Is it really possible to integrate medical and dental systems to provide continuity of care?

Addressing the Challenges

At a minimum, it will take four steps to address the challenges of integrating new science into the daily

practice of oral health at Head Start centers—

1. Identify the challenges to implementing the new science as a priority for your center.
2. Plan two or three approaches to addressing the specific challenges. Prioritize them.
3. Implement your priority plan of action using all appropriate strategies.
4. Evaluate the outcome of your implemented plan. Determine if the new science is being practiced as intended.

Implementing the Change

The details of a sound plan are what make it successful. Therefore, it is important to consider the following when implementing the plan—

- Assess the audience for whom the new science is intended. Is it Head Start staff, expectant women, children, parents, or oral health providers you want to inform about the new science? Clearly articulate how the new science will benefit the audience.
- Plan the approach based on where the audience “is.” Include representatives of the audience in the planning process. Consider the following questions—
 - What practices do the audience currently use?
 - What change will be necessary to incorporate the new science into daily practice?
 - How will the audience receive and integrate the proposed change today, tomorrow, and from now on?

- Deliver only one change in practice at a time. For example, introduce only one new food to a toddler at a time. Be sure to provide the change in an acceptable—or “bite size”—dose.
- Assist people in replacing old ways with new ones by providing strategies for incorporating the change into the way daily practices have been conducted in the past.
- As change is implemented, provide positive feedback and encouragement to those who have begun to use a piece of the new science on a routine basis.

The Outcomes

When implemented, the recommendations from all three scientific sections of the 1999 Oral Health Forum will fuel a high quality, comprehensive, coordinated, culturally competent American system of oral health care. The only challenge remaining in this future utopia will be where to find a carious tooth as an example for dentists in training!

Dorothy Allbritten is a Pediatric Nurse Practitioner and Health Services Manager, Fairfax County Head Start, T: 703-324-8124.

Oral Health Update: Region IIa QIC

By Jeanne Zozobrado

Region IIa is working hard and testing a variety of different activities to improve oral health care for Head Start children.

Representatives from the Region II Administration for Children and Families, Regional Office, Head Start Quality Improvement Center IIa, New York Dental Society, New York State Head Start Collaboration Office, and Head Start programs met to discuss ways in which they would collaborate on oral health issues. They agreed to pursue the following—

- Inviting health managers to local meetings of the New York Dental Society (NYDS) to discuss the oral health problems of Head Start children
- Encouraging health managers to invite a dentist from the NYDS to attend Health Services Advisory Committee meetings
- Sharing information about Head Start at NYDS annual meetings and information about NYDS at Head Start meetings

- Exploring ways to establish training for staff and parents on the best ways to access local dental communities

Additionally, two New Jersey programs will be chosen to participate in a pilot project on oral health. Each program will work with a dental consultant to train staff in oral health issues and to work on developing a dental health plan. The dental plan will include creative ways to ensure that each child has a dental exam, dental treatment, and a dental home.

The QIC is also planning a dental screening initiative for programs in New Jersey. This program, headed by a QIC dental consultant, will teach Head Start staff how to perform initial dental screenings on children. The purpose of this program is to ensure that children with advanced dental problems are referred to a dentist as soon as possible.

Jeanne Zozobrado is a Health Specialist, Head Start Quality Improvement Center, New York University, T: 800-336-4848; E: jzozobrado@aol.com.

From Research to Practice

By Stuart Reynolds
Child Inc., Austin, Texas

According to Stuart Reynolds of Child Inc., folks in Austin, Texas are putting research to practice. "One of the most immediate changes that we will initiate will be to develop a procedure to screen and examine all children beginning at one year of age. This will affect nearly 50 infants currently enrolled in our Early Head Start program. As a result of what we learned at the Oral Health Forum, we will add several key messages to our annual in-service training for teachers and to our parent workshops on dental health. Specifically, we will highlight that dental caries can be considered an infectious disease and that mothers can expose children to the infectious *streptococcus mutan* bacteria inadvertently through kissing or the exchange of saliva. The training will also look at ways to prevent dental caries as described in the research articles."

Feedback on Forum

By Larissa Zoot

For me, the highlight of the Head Start and Partners Oral Health Forum was meeting service providers who had previously been involved with the Head Start program as children. In the midst of discussing the challenges of accessing quality oral health care, it was such an inspiration to meet terrific, dynamic, professional adults who fondly remember how Head Start positively affected their lives, and who are now dedicated to giving something back by serving current Head Start families. Perhaps together we can address the challenge of finding pediatric dentists and other providers with the training and willingness to work with our most underserved populations.

The image of "climbing a ladder with one hand reaching up to new accomplishments, and the other hand reaching back down to help others in their climb" reinforces for me the spirit behind all our efforts in oral health. The strongest message I carried with me from the Forum's Region I breakout session was that it is just such leadership at the local level which will be instrumental in reaching our goals.

On August 23, 2000, there was a meeting of the regional T/TA health specialist, the regional health and disabilities liaison, and health services managers from Head Start and Early Head Start programs in the region. The meeting served as a brainstorming and planning session for initiatives targeting oral health.

Larissa Zoot is a EHS Specialist/Health & Disabilities Liaison, Region 1, New England, T: 617-565-1153; E: lzoot@acf.dhhs.gov.

Region VII Activities in Oral Health

By Marcia Manter

In July, 1999, Region VII Head Start began expanding its capacity to ensure quality oral health services for children and families in each state. This growth was sparked by exceptional collaboration among organizations and individuals, all committed to the same goal. The information and excitement generated at the National Oral Health Forum, held in Washington, D.C., in September 1999, served as a catalyst for our work.

Many strategies are being used to accomplish our goal. Each state Head Start Association and Community Development Institute (Region VII OIC) conducted a survey to document the access to dental care in each county. The survey results have been used to communicate information pertaining to the barriers to oral health care to legislators, Medicaid staff, and dental associations. Iowa Head Start Association incorporated the data in a resolution for state political leaders and the Iowa Dental Association signed the resolution.

Each state Head Start association has addressed prevention and access issues for children at risk. Two state associations have held oral health caucuses with state government leaders, politicians, dental professors, dental association executive directors, and dental hygienist association board members. In each state, the Head Start collaboration director has played an active leadership role in building and sustaining the partnerships with these individuals and groups.

In July 1999, the Community Development Institute responded to the issue of oral health by creating an Early Head Start Oral Health Demonstration Project. The goal is to determine what strategies community health partners and EHS staff can use to ensure that each EHS child reaches his or her third birthday without experiencing oral health problems. The study will generate useful information about building community partnerships and designing an effective curriculum to address the oral health needs faced by EHS families. Three EHS grantees in Nebraska are now implementing the project: Lincoln Action Program (Lincoln), Central Nebraska Community Services (Loup City and Columbus), and Salvation Army (Omaha). Dr. Kim McFarland, Nebraska state dental director, has given her support, and two pediatric dental professors have stepped forward with guidance and direct services to families.

Dr. Michael Kanellis, professor of pediatric dentistry, University of Iowa School of Dentistry, has inspired his Masters in Public Health dental students to address Head Start's need to better teach children to care for their teeth. For instance, in May 2000, the UI faculty offered the workshop "Oral Health Risk Assessment and Prevention for the Head Start and Child Care Health Community."



The Kansas Medicaid office gained a waiver from HCFA so that Head Start can be Medicaid providers. This gives programs greater access to a wide range of dentists and saves the program money. Even if they have to pay the full amount for dental services from a non-Medicaid dentist, they can collect a percentage by filing the Medicaid claims.

Missouri Head Start has accepted the lead in the state to convene and facilitate the oral health education committee, which is part of the statewide consortium to address access to dental care. Chris Groccia, Head Start collaboration director, and several Head Start managers are active participants in this group.

At the Surgeon General's Conference on Oral Health, Dr. Diane Gastmann presented the Iowa Head Start Dental Access Survey results. Thirty-six state government, political, dental, and early childhood leaders from Kansas also attended this conference. The group, sponsored by United Methodist Health Ministries Fund, intends to hold a strategic planning session based on their learning at the conference. Head Start is represented in this group and will offer strategies for grantees to play a significant part in improving access to oral health in the state.

As a result of the regional and state activities, Region VII Head Start anticipates improved access to quality oral health care for high-risk children. In addition, all of our grantees are committed to increasing their roles in prevention, oral hygiene for children and families, and parent and community education.

Marcia Manter is a Professional Development and Health Coordinator, Community Development Institute, Region VII Head Start Quality Improvement Center, T: 816-356-5373, ext.13; E: mmanter@aol.com.

Oral Health Initiative Activities in Region VIII

By John Thomas

HCFA and HRSA staffs have been very active in developing oral health initiatives. Our three most significant activities to date have been—

- Participating in Comprehensive Systems of Quality Care meetings in two states, followed by dental specific summits in Montana in November 1999 and North Dakota in April 2000. We have found these meetings to be extremely successful in raising state and public awareness of the barriers to accessing dental care, as well as for developing cooperative relationships to promote change. We believe they are the most appropriate method for this activity in this region.
- Providing technical assistance in developing Geographical Information System (GIS) mapping data in three states (Colorado, North Dakota, and South Dakota) under a special one percent HRSA grant. This data will help our partners identify their primary areas of need by geographic area and will serve as a basis to design strategies to improve access.
- Representing all ten HCFA regional offices (ROs) on the Maternal and Child Health/Oral Health Technical Advisory Group and as the consultant for the HRSA cluster representatives, as well as examining federal policies that affect access to provider enrollment and access to care.

While our focus has been on these three key activities, regional team activity has not been limited to these areas. Examples from other significant activities, classified by state, region, and nation, follow.

John Thomas is a Health Resource Specialist, Head Start Quality Improvement Center, Community Development Institute, Denver, Colorado, T: 800-488-2348, ext. 14; E: John_Thomas@ceo.cudenver.edu.

Colorado

- Participated in two meetings initiated by the Rose Foundation to coordinate efforts between the state dental association, department of health, and other key partners to obtain a comprehensive dental benefit package for their SCHIP
- Provided a dental initiative presentation at a rural health coalition meeting to align their support and identify areas where we can work together
- Participated in the evaluation of Anthem Blue Cross/Blue Shield Foundation's Miles for Smiles mobile dental van program
- Assisted in a local community effort to develop an outreach campaign by identifying existing models of public service announcements and informational materials, as well as funding and development opportunities

North Dakota

- Participated in a second forum addressing access to care for the state's American Indians

Montana

- Provided a summary of the HCFA/HRSA Oral Health Initiative and the state dental summit to the legislature's health committee to encourage infrastructure support
- Monitored ongoing activities to develop the state's infrastructure and generate specific strategies for the resolution of particular barriers by providing technical assistance and data support
- Notified the state of additional funding opportunities for support of infrastructure development. Subsequently assisted state in writing Community Infrastructure Support System (CISS) grant application. HCFA provided letter of support for project

South Dakota

- Developed information and reported on access to dental care as part of the SCHIP implementation review August 1999
- Met with the president of the South Dakota Dental Association to discuss opportunities to work together to address barriers to access
- Worked closely with the state partners to amend the dental practice act to allow dental programs to operate in community health centers, and along with HRSA Central Office staff to assign a USPHS Commissioned Corps officer to the program

Utah

- Initiated and facilitated a Medicaid EPSDT and dental staff conference call to discuss current state initiatives on dental care access, including a discussion of tentative plans to hold a dental summit

Wyoming

- Initiated discussions with the state dental director to identify opportunities for a dental summit

Regional Initiatives

- Partnered with the Head Start Quality Improvement Center to provide Medicaid and SCHIP eligibility and benefit package presentations at five regional conferences for new Head Start staff, identifying ways we can work together to get more children served
- Instigated regional state dental directors conference calls on a quarterly basis to discuss the oral health initiative and current state activities. We also included Nebraska from Region VII at their request
- Provided presentations on the oral health initiative to Primary Care Association meetings

National

- Participated in the RO/Central Office meeting of the Oral Health Initiative teams and the National Oral Health Conference in Chicago
- Represented HCFA at the Head Start/Women, Infants, and Children Dental Initiative rollout conference
- Provided input in the development of the national GIS mapping project, participating in training of state staff and evaluating data collection methodologies and mapping strategies

New Mexico's Dental Health Summit 2000: Region VI-b QIC

By Marilyn Smith

In January 2000, New Mexico's Primary Care Association (NMPCA) coordinated a statewide forum sponsored by HRSA, HCFA, and the New Mexico Department of Health's Primary Care Bureau which brought together key decision makers, state agencies, advocacy groups and other stakeholders. The purpose of the summit was to identify barriers, discuss solutions, and build broad-based support for the implementation of strategies to improve dental health care access in New Mexico.

Over 110 participants attended the summit, including representatives from various dental associations, the New Mexico public schools, HCFA, and HRSA. Two legislators, several advocacy groups who represent children with disabilities, Native American tribes and pueblos, and grassroots dental providers attended as well.

The issue of dental health access for all New Mexicans regardless of income is complex and challenging. Many dental health access issues had been addressed prior to the summit through Senate Joint Memorial 21, which amended the Dental Health Care Act by—

- allowing dental hygienists to work in "collaborative practices" with dentists
- explicitly requiring licensure by credential for dentists and dental hygienists without practical or clinical examination for those applicants who are duly licensed by clinical examination as a dentist or hygienist under the laws of another state, who are in good standing, and who otherwise meet the requirements of the Dental Health Care Act

The Dental Health Summit was viewed as an opportunity to continue the momentum in New Mexico and provide another source of input to the legislative process in assuring access to dental health services for all New Mexicans.

The first afternoon's large group discussion proposed an intensive review of five major areas—

- 1) Health promotion/disease prevention
- 2) Supply/demand
- 3) Access/infrastructure
- 4) Education/training
- 5) Finance/Medicaid/insurance issues

Topic groups were charged with evaluating these issues and proposing recommended strategies. The strategies were presented the following afternoon and approved by the general assembly.

Recommendations under the *health promotion/health prevention* category included—

- Promoting an early childhood caries program that addresses prenatal women and children age birth–3
- Encouraging innovative technology for prevention and treatment
- Promoting educational media campaigns

Under the *supply and demand* category, recommendations included—

- Encouraging the legislature to pass legislation that encourages a dental scholarship program
- Supporting a tax credit or exemption as an incentive to dentists in rural areas
- Reinstating New Mexico's National Health Service Act to promote a greater distribution of providers
- Encouraging states to publicize and promote "loan for service" programs
- Initiating a "Dental Career Ladder" supported through community colleges
- Establishing dental auxiliary programs through the dental board and the community
- Expanding the roles of dental assistants and hygienists
- Expanding Medicaid's scope of practice to include participation in recruitment of dental personnel

The *access/infrastructure* category recommended—

- Encouraging partnerships between the private and public sector
- Educating the legislature to address oral health access and funding issues
- Promoting the use of alternative services such as mobile dental services
- Employing capital funds for school-based clinics, Medicaid outreach workers pay, and cost reimbursement for licensed social workers
- Assessing current models and improving or duplicating where feasible
- Promoting media participation to educate people about the disparities in access

The *education and training* category developed the following recommendations—

- Integrating a dental educator into Welfare to Work efforts
- Expanding dental training programs including those for dental hygienist
- Educating the general population about the need for preventive and primary dental care
- Encouraging collaboration among private and public sectors to support linkages between education, supply, access, finance, and health promotion and disease prevention strategies

Recommendations from the *financial* category included—

- Looking into ways in which Medicaid could have independent dental contracts as opposed to contracting solely with HMOs
- Encouraging the reduction of barriers within the payment system
- Advocating for pre-authorization to reduce the potential problem of dental denial
- Creating a current state administered database for dental providers, services, participants, and expenses

• Mandating the fluoridation of community water
These recommendations are viewed as necessary steps in the elimination of inadequate dental health care for many New Mexicans. A dental health coalition was created to further promote Senate Joint Memorial 21 and to work to address the recommendations of the workgroups. The goals and recommendations identified by summit participants, if acted upon by the coalition, would go a great

distance toward assuring preventive and curative dental health care for those in New Mexico who presently suffer the consequences of inadequate dental health care.

Marilyn Smith is a Health Specialist, West Texas Cluster Manager, Head Start QIC, Texas Tech University – Institute for Child and Family Services, T: 800-527-2802; E: msmithrn@worldnet.att.net.

Toothbrushing and Head Start: What's It All About?

By Dr. Harry W. Bickel, Jr.

Since three- and four-year-old children have trouble tying their shoes, how can we expect them to brush their teeth in the classroom?

Actually I have asked myself this question many times. As a dentist, I think all people should brush their teeth as often as possible. I realize this is impossible in the fast-paced, modern world. As a person who has spent a lot of time in Head Start classrooms, I cannot ignore the fact that classroom toothbrushing is a difficult and time-consuming activity. It is also a messy one.

Consequently, the question arises, "Is it worth it?" I guess that is a matter of personal opinion. If you value teeth, health, and personal hygiene, then your answer will be "yes". In my opinion classroom toothbrushing is worth it, but then again, I am a dentist. Some of my reasons may be different from yours.

For at least a century, dentists have been telling their patients that if they brush their teeth, they will not have tooth decay. Parents and teachers, of course, have been imparting these same pearls of wisdom to their children. The problem is, people still get decay, even if they brush all of the time. Why is this?

The reality is that decay is the result of several factors, toothbrushing or oral hygiene being only one of them. Other major factors are exposure to fluoride, diet (particularly sugar intake), and tooth morphology or structure. If you do not have control of these factors, then the best toothbrushing in the world may not prevent decay. It can, however, help.

Looking at the larger picture illustrates that reducing tooth decay is only one of the possible benefits of good oral hygiene. Without question, there is also a direct relationship between good oral hygiene and healthy gums. Though most people do not

realize it, teeth are lost because of gum disease as much as they are lost because of tooth decay. Since gum disease does not affect children, we do not usually think about it in Head Start. However, the people who lose their teeth to gum disease are usually the ones who didn't learn to take care of them as children.

Now, we are finally down to the heart of the matter: It is most important to realize that we can do things for children that will affect them for the rest of their lives. This is what Head Start is all about. This is what we are trying to do by teaching them to brush their teeth. Like so many of the things we do in Head Start, this is simply part of the process of giving children the tools they will need in the future to be happy, healthy, and productive adults.

One goal of classroom tooth brushing in Head Start is to create a desire in the children to have a clean and healthy mouth. We do this by making toothbrushing a part of our daily routine. In other words, we are trying to develop a positive health habit. This is no different than teaching children to wash their hands or flush the toilet or a number of other things that we teach in Head Start. It is simply a different behavior and a different result.

My advice to teachers, then, is to focus on the experience and not the technique. Technique will come later as motor skills improve. For now, make it a positive experience for the children. Make them understand that this is also something they should do at home and continue doing after they leave Head Start.

Now for some questions—

What about the mess?

Do not worry about it. It is certainly not as messy as finger-painting.

Will toothbrushing spread disease?

Not if it is done properly. There should be no more potential for spreading disease from toothbrushing than from many other things we do in Head Start, such as handling dishes or helping children use the bathroom or blow their noses. The key here is to use your head and realize that the bristles of the brushes contain microorganisms, some of which are capable of causing disease. When you place the toothpaste on the brush, make sure that the mouth of the tube does not drag across the brush. Better yet, put the toothpaste on a small square of wax paper and then on the brush.

What kind of toothpaste should I use?

This really does not matter too much. I would suggest using a toothpaste that is approved by the American Dental Association (ADA) since these have been tested and approved. If it does not have the ADA seal of approval, then you really don't know its quality.



Should I use a fluoride toothpaste?

Yes. Recent research has demonstrated that the topical effect of fluoride (directly on the surface of the teeth) may be as great as the systemic effect (via the bloodstream, as in community water fluoridation). Many also recommend that the child not rinse after brushing so that the fluoride will remain on the teeth longer.

What kind of toothbrushes should I use?

Use a children's toothbrush (one with a small head) that has soft bristles. If you do not already have a ready source of toothbrushes, check with one of your local program dentists. He or she should have a number of dental supply catalogs from which you can order. If you really want to get fancy, you can have your program's name printed on the handles.



What toothbrushing method should I use?

I would recommend that you have the children use what is often referred to as the "scrub brush method". This simply means that you place the brush against the teeth and move it in a circular motion. Make sure that the brush goes up near the gum line where much of the plaque is located. Also, do not

forget to brush the tops and the insides (tongue side) of the teeth and not just the front surfaces.

Should I use floss?

Though some people may disagree, I think three- and four-year-old children should not attempt flossing, at least not in a group setting. They simply do not have the manual dexterity to do it.

How should I store the toothbrushes?

This is probably the most frequently asked question about toothbrushing. Toothbrushes should be stored in the most hygienic way possible. There are many good ways to do so and people need to decide what works best for their particular situation. I do, however, think that any toothbrush storage should meet certain criteria. Here are the ones that I would suggest:

1. Toothbrushes should be stored in a manner that prevents cross-contamination. This is the basic principle that determines whether or not our storage method is adequate. We do not want to transmit one child's germs to another via the toothbrush. Consequently, toothbrushes must not be allowed to touch one another and must be returned to a proper storage site each time they are used. Finally, toothbrushes must be clearly labeled with the child's name so that each brush returns to the same mouth each time.
2. Toothbrushes should be stored in a manner that allows them to dry properly. It is important, from a microbiological standpoint, that toothbrushes not be allowed to remain moist during storage. The optimum conditions for bacterial growth are dark, warm and moist. Most, but not all, bacteria do not survive well without a source of

moisture. This means that wrapping toothbrushes in plastic wrap, or placing them in a container that has no ventilation, is not advisable.

3. Toothbrushes should be kept in individual containers or in a cabinet that can be closed. Many of our Head Start classrooms are in old buildings, where insect control is either impossible or less than optimal. We do not want to hear from Head Start staff who go into their classrooms after hours and find bugs crawling over the toothbrushes!
4. Where possible, toothbrushes should be stored with the bristle end up. This keeps the bacteria that are on the handle from running back onto the bristles during storage. Several different hands may have touched the handle of the brush while it was being used and the brush was probably wet when returned to the holder.
5. Storage containers should be either washed in a dishwasher or sterilized periodically. Over time, as individual containers are used on a daily basis, they tend to build up a lot of material from the toothbrush. While most of this is dried toothpaste, some of it may not be.

One of the things I enjoy most when I walk into a Head Start classroom is for the children to run up to me and tell me that they brush their teeth. They are proud of it. They want to tell me that they are doing it. This, in itself, should illustrate why a commitment to brushing teeth is important.

Harry W. Bickel, Jr. D.M.D. is a Health Specialist, Region IV Quality Improvement Center, Western Kentucky University, T: 270-745-4041; E: hbickel@home.com.

Why Bother? They're Just Baby Teeth!

By Dr. Harry W. Bickel, Jr.

"Why bother? They're just baby teeth!" I cannot tell you how many times I have heard that statement over the past 30 years. I do not usually hear it from the parent of a child, because I have limited contact with parents. Most likely, I hear it secondhand, from a health coordinator or family service worker. They, however, have heard it repeatedly from parents. "Why bother? They're just baby teeth. The child is gonna lose them anyway."

My usual response to this question involves a detailed explanation of the development of the teeth, accompanied by a series of poorly drawn sketches (I am a dentist, not an artist). My idea here is to provide people with all the ammunition they will ever need to counter these statements. This is a dentist's approach: use knowledge to prove your point. While I feel that teaching the consequences of untreated disease is important, that is not what I plan to do here. Instead, I will start at a much more basic level and will begin with a story.

Many years ago, when I was a Head Start dental consultant for the U.S. Public Health Service, I worked with a program in the mountains of Eastern Kentucky. Part of my work involved visiting the centers and examining the children for evidence of dental treatment. I will never forget my visit to one very rural center. As I walked into the classroom and began talking with the staff, one of the staff members pointed to a little boy who was sitting at a table playing quietly. The staff member said that this child had been their number one behavior

problem from the very first day of school. In fact, they had completed six mental health referrals on the child, all to no avail. Nothing worked until they fixed the child's severely decayed teeth. From that point on, the child behaved like all the other children.

That small incident made an indelible impression upon me. It caused me to realize how much pain some of these children experienced. Even though I have had children come to me, crying from the pain of a toothache, I never understood until then how much it affects their entire life, particularly if it is allowed to drag on. I can not imagine children that small having to face that much pain every day of their life.

I could continue describing all the problems that might occur if we fail to deal with a child's dental problems. The child can not eat properly. The child has trouble speaking. The child has infections that are draining into the mouth. The child's permanent teeth may come in crooked or jumbled-up, because we have lost the baby teeth too early. All of these are valid reasons why we should deal with dental problems. They are overshadowed, however, by one very important reason: the child may be in pain or, at the very least, susceptible to pain.

Dentists may not know everything, but we do know one thing: decayed teeth do not get better. What looks like a small hole today could become an extraction three months from now. If teeth simply decayed and disappeared, the consequences of non-treatment might be far less. Unfortunately, however, this is not the case. As decay worsens, the likelihood of developing an abscess increases dramatically. An abscess is a serious infection that can spread throughout the jaw and cause extreme pain.



Dr. Harry Bickel, Jr.

If a child came to us with open sores, or visible injuries, we would do something about it immediately. Because it is in the mouth, however, we often allow much more serious conditions to persist. Maybe it is because they are "baby teeth" and they are going to be lost anyway. Maybe it is because they are in the mouth, and we do not have to look at them as often. Whatever the reason, ignoring the problem is not the right thing to do. Pain is pain, regardless of where it occurs in the body. If we in Head Start are truly child health advocates, we need to make sure this pain is dealt with properly and quickly.

Harry W. Bickel, Jr. D.M.D. is a Health Specialist, Region IV Quality Improvement Center, Western Kentucky University, T: 270-745-4041; E: hbickel@home.com.

Fluoride Supplements: By Prescription Only!

By Dr. Harry W. Bickel, Jr.

Over the past several years, I have encountered a number of classrooms where children were given fluoride tablets or were brushing with a fluoride gel. In most of the cases, this was being done either improperly or illegally or both.

Fluoride is placed in many public water supplies for the sole purpose of preventing tooth decay. The amount is so small (1 part per million) that it causes no health problems, but it does reduce the amount of decay. If you put more fluoride in the water, you would prevent even more decay. However, you would also run the risk of causing a very mild form of teeth staining called fluorosis or mottling.

In many areas of the county, particularly in rural ones, fluoride is not found in the water supply (although fluoride may be found naturally in well water). In these areas, it is possible to provide fluoride to individuals in other ways, namely through fluoride supplements. Supplements which are ingested are called systemic fluorides and usually take the form of tablets and drops. Those that are applied directly to the teeth are called topical fluorides and take the form of rinses, gels, varnishes, toothpastes, and so forth. Some of these are available over-the-counter and some are available by prescription only.

Other than using a fluoride toothpaste, fluoride supplements should not be administered in a Head Start classroom unless it is recommended and supervised by a licensed dentist.

While the chances of causing a problem with fluoride supplements are minimal, it is far too complex a process to be undertaken by a non-professional. Before fluoride tablets or drops are

given, it is necessary to test the child's home water supply for fluoride and interview the parents to determine if there are any other possible sources of fluoride. Dosage of fluoride tablets and drops varies according to the age of the child and the amount of other fluorides available. Fluoride rinses are not intended for young children because children tend to swallow them. Additionally, many of the fluoride gels are not recommended for children under the age of six. As I said, this is a complex issue.



Another serious problem is the wide availability of fluoride supplements without a prescription. Most of the fluoride supplements listed above are legally available by prescription only. Unfortunately, there are companies that will sell them directly to schools and Head Start programs, without the involvement of a dentist.

I recently talked with a health coordinator who was having the children brush once a week with a fluoride gel. She had never talked to a dentist about this, nor was one overseeing the program. This was simply something that they did when she got there. She

was not even sure if there was fluoride in the local water supply. She was buying the gel directly from the catalog of a nationally known distributor that sells to most Head Start programs. I had her send me a bottle of it and it clearly states in large letters: CAUTION: FEDERAL U.S. LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION. If there was a prescription involved, it was certainly issued without the knowledge of the program.

The most important issue in this article is that fluoride supplements require the expertise and input of a dentist before they are administered by a Head Start program. The type of supplement and the dosage must be individualized to each child and must be administered according to strict protocols. Many state health departments have supplemental fluoride programs in rural areas and it is fine for Head Start programs to participate in them. They are overseen by dentists, adhere to state and federal laws, and use appropriate scientific principles. In all other cases, a Head Start program should enlist the help of a local dentist (preferably one who is on the Health Service Advisory Committee) and make sure that what she or he is doing is both proper and legal.

Harry W. Bickel, Jr. D.M.D. is a Health Specialist, Region IV Quality Improvement Center, Western Kentucky University, T: 270-745-4041; E: hbickel@home.com.

Something to Smile About

By Mary Skatberg

When Michael was very young, he had health problems for which a lot of antibiotics were prescribed. The antibiotics contributed to severe tooth decay and when Michael entered Head Start, he had still not received the necessary treatment because his family was uninsured and not eligible for Medicaid.

Because each child receives medical, vision, and dental screenings upon entering the Community Partnership for Child Development's (CPCD) programs, Michael's dental concerns were identified and he was immediately referred for treatment. CPCD partners with numerous dentists in our community to provide services at reduced fees for children in our programs. Small Smiles Dental Clinic provided Michael with the necessary dental treatment and CPCD paid for the bill out of funds raised in the community. Thanks to the support of organizations such as Pacificare Foundation, the Colorado Springs Dental Society, Nutrition Camp School Foundation, and Peterson Air Force Base Officers' Wives Club, CPCD is able to ensure that all of the children in our

programs receive the treatment they need, without regard to their ability to pay.

As a result of prevention and early intervention health programs, children are healthier and more successful in school and life. When Michael looked in the mirror the first time after receiving treatment, he said, "Now the other children won't laugh at me anymore."

Michael's mom is very pleased with the results. "Michael can't stop smiling now!" she said. "And his speech is a lot clearer."

CPCD would like to thank Small Smiles Dental Clinic and the numerous other dentists for their support of our programs.

This article was reprinted with permission from the CPCD Community Connection, a quarterly publication of Community Partnership for Child Development, Colorado Springs, Colorado, T: 719-635-1536; Web page: www.cpcdheadstart.org.



The Implication of Culture on Oral Health Practices in Migrant Head Start Programs

By Tracy Finlayson



Paul Blatt, Donald Wyatt, Sandra Carton, Migrant Programs Branch, Head Start Bureau

Migrant Head Start families face many of the same challenges that other low-income families living in isolated, rural areas face when seeking health and oral care services. These challenges include a lack of health care providers who accept Medicaid, long waiting times for appointments, and having to travel in excess of 30 miles to obtain health and oral health care services. However, Migrant Head Start families face other challenges unique to their population, such as lack of health insurance, mobility factors, language barriers, and varying cultural beliefs.

Sandra Carton, Migrant Programs Acting Branch Chief for the Head Start Bureau, cites access to health services and communication issues as primary concerns among migrant families. Most migrant families do not have Medicaid coverage, primarily due to the lengthy eligibility process and the mobility of migrant families. Also, families coming from a country where medicine is socialized may not understand the need to obtain health care insurance while they are residing in this country. Lack of insurance inhibits a family's ability to obtain health and oral health services when they are needed.

If a health care provider does not speak the same language as the family, then the trust and responsiveness that is crucial to building a strong relationship between the family and health care provider cannot take place. In many cases, translators are needed. This further complicates building a trusting relationship. Even if interpreters are not needed, there is still no guarantee that the provider and patient understand each other and have the same ideas or beliefs about the course of treatment. Other cultural differences in child-rearing practices may also come into play and affect treatment.

Cultural beliefs govern people's values and daily practices, and there are several areas in oral health where cultural practices seem

to conflict with the traditionally recommended courses of action promoted by American health providers. An example of this would be timing of weaning.

Oral Health Forum authors Norman Tinanoff and Carol Palmer include several nutritional recommendations to help decrease the risk of dental caries in young children. One of the practices they encourage is weaning at the appropriate time, which most pediatricians agree to be around one year of age. However, this practice is not universally accepted by all cultures. For instance, Hispanic communities have a cultural value of dependence on family and would not be eager to practice a pediatrician's recommendation for early weaning or toilet training, as this would promote independence of the baby from the family.

For recommendations to become integrated into daily routines, the medical evidence and reasoning must be clearly expressed to the family. Telling a parent to do something contrary to their cultural beliefs without explanation is not an effective way to get someone to change health behaviors. Often, there is no way of knowing what recommendations health providers in other countries may have made to a family. According to Sandra Carton, "Health providers should be bicultural, not just bilingual."

Migrant Head Start Programs are the bridge between the family and health care providers, and depend on the trust and rapport they have developed with the family. As Sandra Carton points out, "They don't do just what is required, they do what is needed to work with families—with less time than most Head Start programs." Often this translates into meetings with families during evenings or weekends, or more home visits. Migrant Head Start

programs serve as advocates for children by establishing collaborative relationships with health care providers to increase their sensitivity to cultural differences and other barriers migrant families often face.

During the regional breakout session of the Oral Health Forum, these and other issues affecting Migrant Head Start families were discussed. Several action steps were identified, including educating staff and parents in their own languages about current trends and changes to Medicaid and SCHIP; building relationships with dentists so they will accept children referred from Migrant Head Start programs; developing a list of key points that staff can discuss when making contact with health care providers; and building and expanding contacts with local community and migrant health centers to obtain information about available services.

Participants in the breakout session summarized their approach with this tag line: "Champions in partnerships: challenging the dental and medical professionals and Head Start in meeting the needs of infants, toddlers, and preschool children, especially migrants, homeless, and other populations."

Tracy Finlayson was an Intern, Head Start Bureau.



*Tracy Finlayson,
Head Start Bureau Intern*

Oral Health Care Access Issues for Head Start's Indian Programs

By Tracy Finlayson

Access to oral health care is a major issue that continues to challenge staff in Indian Head Start Programs nationwide. At the Oral Health Forum, participants from different areas of the United States and different perspectives came together to identify barriers to access and develop action plans to fix the problem. Participants "spoke from the heart and echoed each other," according to W. J. Strickland, Head Start Bureau's Indian Branch Program Specialist. Although there were no identified cultural barriers, participants saw many universal problems affecting all Indian families.

A large problem is a lack of training and consistent information available to staff, dental care providers, and parents. Overall, programs reported feeling isolated, and unable to provide access to oral health care or preventive practice training and education. There is a lack of knowledge available to individual American Indian Head Start programs about the level of water fluoridation in their communities. This impairs their ability to assess whether children need fluoride supplements. The need to gain support for screening and follow-up efforts was also discussed and participants suggested that one way to address the issues of isolation would be for

American Indian Programs Branch (AIPB) grantees to form coalitions. The coalition could start a dialogue with local dental hygiene schools, since they exist in almost all the states and can become involved with the Indian Head Start programs. Participants also felt that the needed information and support could come from the T/TA networks. T/TA providers could increase the training and up-to-date information sessions they offer to educate parents and staff.

"Beautiful smiles for wholeness and wellness in the new millennium."

For some families that are able to access care and schedule an appointment, there remains the issue of following through and keeping their appointments. Lack of transportation sometimes arises as another barrier to accessing care. Also, while Head Start children have Medicaid to cover the cost of dental treatments, too few dentists accept this form of payment. The dentists who do accept Medicaid and work with Head Start children need to be better recognized and appreciated by programs.

Indian Head Start programs are the link to continuing strong relationships between Head Start children and dental providers in their communities. At the Oral Health Forum, the following strategies for action to increase oral health care access were also discussed—

- Encourage oral health care providers and dentists to become members of the Health Services Advisory Committee (HSAC)
- Encourage parents to take children to dentists by age one
- Obtain information about foundations that might support improved dental health

- Obtain information about Title V services and support for dental health
- Ask for federal support to encourage people to become involved in pediatric dentistry
- Offer more frequent screenings of children, and screen mothers
- Offer updated training materials to WIC, nutritionists, parents, and AIPB staff
- Include all key players in discussions, work holistically, and get together with partners to develop timelines and plans
- Identify and implement prevention strategies such as gum swabbing, good nutrition, and tooth brushing
- Ask the Quality Improvement Centers (QICs) to develop tip sheets and other educational information

These action plan ideas were generated from the participants representing the Indian Head Start programs. Participants had a positive experience and left the Forum with a "glimmer of hope that there would be action on the horizon," says W. J. Strickland. He expressed the importance of their input and emphasized that the "next time the Head Start Bureau has a forum, people [should] be encouraged to attend and have their voices heard. We have a commitment to the programs to work in partnership." The Oral Health Forum provided an occasion to share ideas and experiences. It created a great deal of enthusiasm for addressing oral health issues and making positive changes in Indian Head Start Programs. The message is clear in their slogan: "Beautiful smiles for wholeness and wellness in the new millennium."

Tracy Finlayson was an Intern, Head Start Bureau



Munel Richardson and W.J. Strickland, American Indian Programs Branch, Head Start Bureau

Dental Coverage Under Medicaid

Medicaid—the largest program providing medical and health-related services to eligible needy persons in the U.S.—is a means-tested entitlement program jointly financed by federal and state governments and administered by the states. Medicaid provides health and long-term coverage, including dental, for eligible individuals and families with low incomes and resources. In 1998, 41.3 million people received Medicaid services. Of those:

- 21.3 million were children;
- 9.2 million were adults;
- 4.1 million were elderly persons; and
- 6.7 million were blind and disabled persons.

Who Has Dental Coverage Through Medicaid?

The EPSDT (Early Periodic Screening, Diagnosis, and Treatment) benefit requires states to provide all Medicaid-eligible children under the age of 21 with comprehensive, preventive, restorative and emergency dental services furnished according to state-defined periodicity schedules. In 1996, 22.9 million children were eligible for EPSDT. However, the percent of children receiving preventive care through EPSDT remains low.

Most states have failed to meet Medicaid's mandate that all children receive early preventive care through the EPSDT benefit.

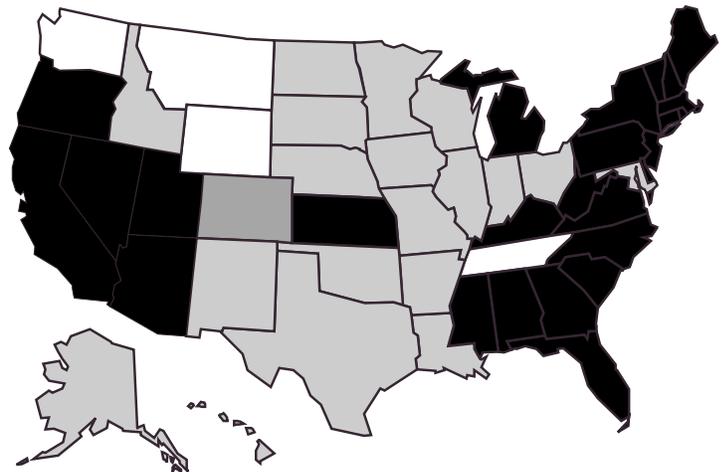
States may choose whether or not to provide adults with dental services. These states also have the flexibility to determine the number of adults they choose to cover and the type and amount of services they choose to provide. Most states cover emergency services but fewer states cover preventative, restorative or more complex services for adults.

- About 6 million, or 18%, of all Medicaid recipients receive dental services (average between 1994 and 1996).
- Children aged 14 years and younger accounted for an average of 62% of Medicaid-insured patients treated at dental practices.
- In 1996, 18% of eligible children received any EPSDT required preventative dental screening or services.

What About Medicaid and CHIP?

With the introduction of the State Children's Health Insurance Program (CHIP), states have the opportunity to expand coverage through the expansion of existing Medicaid plans, through the adoption of a non-Medicaid plan or some combination of both. States choosing to expand existing Medicaid plans must provide standard Medicaid dental benefits for children.

Inclusion of Dental Services in State CHIP or Medicaid Expansion Plans



- Dental services included through CHIP
- Dental services included through Medicaid expansion
- No dental services offered through CHIP
- To be included in pending CHIP plan

* Dental services in Florida may be covered at each county's option.

Source: National Conference of State Legislatures, August 1999

What About Medicaid and Managed Care?

Under managed care, Medicaid agencies may provide dental services through one of three options:

1. Comprehensive managed care organizations (MCOs) that deliver both medical and dental services.
2. MCOs that deliver only dental services.
3. Fee-for-service programs.

Managed care provides states an opportunity to improve access to care. By monitoring access to providers and health plans and ensuring consumer satisfaction, managed care organizations can provide useful information for improving access and utilization.

Innovative policies may also help to insure the provision and sustainability of oral health services as a component of managed care. For example, provision of sealants through school-based health clinics is one way that some managed care organizations are implementing guidelines for providing sealants and requirements for providing outreach to communities.

The majority of low-income individuals, whether covered by Medicaid or private insurance, receive dental services in the private sector. As more Medicaid enrollees receive care in the private sector through Medicaid managed care initiatives, it will be increasingly important to ensure that private health care services meet the health care needs of low-income individuals.

Enrollment and Utilization of Services by Medicaid Eligible Persons

Continued efforts to improve enrollment for Medicaid and use of dental services are important for three reasons.

First, there is poor dental provider participation in Medicaid. Insufficient dental provider participation contributes to low enrollment and utilization of dental services by Medicaid beneficiaries. The high administrative burden associated with voluminous paperwork and claims processing is another barrier to dental provider participation in Medicaid. Numerous studies have identified low dental reimbursement rates as a major reason for the lack of dental provider participation. Medicaid reimbursement varies by state.

Second, complicated enrollment processes and burdensome eligibility verification processes discourage enrollment and utilization of dental services by Medicaid beneficiaries.

Third, Medicaid beneficiaries place low prioritization on obtaining dental services, particularly preventive care. In 1993, a 50-state study of children and their use of preventive dental services by the DHHS Office of Inspector General revealed that none of the states provided preventive dental services to more than 50% of eli-

gible children. In addition, three-quarters of the states provided services to less than 30% of eligible children.

Fourth, Medicaid beneficiaries lack information concerning the benefits of dental services. Nearly a quarter of Medicaid-eligible adults do not know that dental care is provided through Medicaid.

Policy Recommendations

Increase enrollment and utilization

- Simplify enrollment processes.
- Use local public health agencies to provide care coordination.
- Educate beneficiaries about dental services.
- Broaden eligibility criteria for dental services.

Increase provider participation

- Establish competitive reimbursements for dental services.
- Insure timely payment to providers.
- Institute a loan forgiveness/repayment program for providers who participate in Medicaid.
- Provide a higher match rate for Medicaid dental services and for all children's services.
- Create tax incentives for providers of dental services to Medicaid recipients.
- Increase the number of specialists (e.g., orthodontists) eligible for reimbursement under state Medicaid programs.

Simplify administrative processes

- Make CHIP administrative processes similar or identical to Medicaid processes to streamline effectiveness.
- Use standard claim forms and eliminate inconsistencies in federal requirements so that Medicaid claims processing is similar to that of private insurance companies.
- Increase federal and state monitoring and enforcement of EPSDT.
- Clarify Medicaid rules and regulations.
- Ensure that managed care contracts specify dental provisions.
- Adapt standard American Dental Association forms and codes.
- Reduce or eliminate prior authorization.

References

1. Spisak S, Holt K, eds. 1999. *Building Partnerships to Improve Children's Access to Medicaid Oral Health Services: National Conference Proceedings*. Arlington, VA: National Center for Education in Maternal and Child Health.
2. Isman R, Isman B. 1997. *Access to Oral Health Services in the U.S. 1997 and Beyond*. Chicago, IL: Oral Health America.
3. American Dental Association. 1998. *1998 Survey of State Dental Programs in Medicaid*. Chicago, IL: American Dental Association.
4. Kaiser Commission, 1998. *The Medicaid Program at a Glance*. Washington, DC: Kaiser Commission.

Bright Smiles, Bright Futures: New Oral Health Kit for Early Head Start

At a recent health conference in Washington D.C., the U.S. Surgeon General emphasized the importance of good oral care in the overall development of children. Nowhere is this better understood than through the long-term partnership of Head Start and the Colgate-Palmolive Company. Since 1991, Colgate and Head Start have worked together to educate children and their families about the importance of good oral care through the award-winning Colgate *Bright Smiles, Bright Futures* program. Each year, this multimedia classroom kit brings developmentally appropriate, self-esteem-based materials and activities into Head Start centers nationwide.

Now, for 2001, Colgate is extending its commitment to include an all-new, free program kit for **Early Head Start**. This new addition to the *Bright Smiles, Bright Futures* family of education materials focuses on the importance of good oral health from **before birth through the age of 24 months**. Because it is a fact: good oral health practices during these first two years of a child's development are critical in helping his or her smile to last a lifetime.

Classroom kits are available to **Early Head Start** programs through their grantee on a first-come, first-served basis, and include a Teachers Guide, poster, and a set of four reproducible Parent Take-Homes. Orders will be fulfilled upon request of the grantee—so be sure to contact your grantee to obtain your copy of Colgate *Bright Smiles, Bright Futures* for **Early Head Start!**

Tufts University School of Dental Medicine is producing a video on oral health that will be available for distribution in the spring of 2001. For more information about the video, please contact—

Carole Palmer Ed.D., R.D.
Tufts University School of Dental
Medicine
1 Kneeland Street
Boston, Ma 02111.
e-mail: carole.palmer@tufts.edu.

HRSA FIELD OFFICE DENTAL CONSULTANTS

REGION I (CT, ME, MA, NH, RI, VT)

Barbara Tausey, MD, MHA
Regional Consultant for Oral Health
PHS Region I,
JFK Federal Building,
Room 1826
Boston, MA 02203
Telephone: 617-565-1426
Fax: 617-565-4027
Email: btausey@hrsa.gov

Robin Lawrence, DDS, MPH
Oral Health Consultant
Lawrence Associates
Cohasset, MA 02025-1421
Telephone: 781-383-6776
Fax: 781-383-6776
Email: rlawrence@dreamcom.net

REGION II (NJ, NY, PR, VI)

Jan Richard Goldsmith, DMD, MPH
Regional Dental Consultant
DHHS/HRSA/BPHC/DHSD, Region II
26 Federal Plaza, Suite 3337
New York, NY 10278
Telephone: 212-264-2768
Fax: 212-264-4497
Email: jgoldsmith@hrsa.gov

REGION III (DC, DE, PA, VA, WV)

Victor Alos, DMD, MPH
Regional MCH Dental Consultant
DHHS/HRSA/BPHC/MCH, Region III
Public Lender Building
150 S. Independence Mall West,
Suite 1172
Philadelphia, PA 19106-3499*
(*9 digit zip required)
Telephone: 215-861-4379
Fax: 215-861-4338
Email: valos@hrsa.gov

Melvin Lerner, DDS
Acting Director, OPMD
DHHS/HRSA/BPHC, Region III
Public Lender Building
150 S. Independence Mall West,
Suite 1172
Philadelphia, PA 19106-3499*
(*9 digit zip required)
Telephone: 215-861-4393
Fax: 215-861-4385
Email: mlerner@hrsa.gov

REGION IV (AL, GA, KY, MS, NC, SC, TN)

Jim Friday, DMD
RPC, NHSC
HRSA Southeast Field Office
Atlanta Federal Center
60 Forsyth Street, S.W., Suite 3M60
Atlanta, GA 30303-8909
Telephone: 404-562-4170
Fax: 404-562-4108
Email: jfriday@phsatl.dhhs.gov

Galo Torres, DDS
Regional Migrant Dental Consultant
HRSA Southeast Field Office
Atlanta Federal Center
60 Forsyth Street, S.W., Suite 3M60
Atlanta, GA 30303-8909
Telephone: 404-562-4121
Fax: 404-562-4108
Email: gtorres@hrsa.gov

REGION V (IL, IN, MI, MN, OH, WI)

Robert S. Enders, DDS
Regional Clinical Coordinator
Chicago Field Office
105 West Adams Street, 17th Floor
Chicago, IL 60603
Telephone: 312-353-1658
Fax: 312-353-3173
Email: senders@hrsa.gov

REGION VI (AR, LA, NM, OK, TX)

Robert A. Sappington, DMD, MPH
Regional Dental Clinical Coordinator
DHHS/HRSA 4, 10th Floor
West Central Field Office
1301 Young Street
Dallas, TX 75202
Telephone: 214-767-3719
Fax: 214-767-8049
Email: rsappington@hrsa.gov

Carol Sherman, DDS, MPH
Regional Clinical Consultant
DHHS/HRSA 4, 10th Floor
West Central Field Office
1301 Young Street
Dallas, TX 75202
Telephone: 214-767-3719
Fax: 214-767-8049
Email: csherman@hrsa.dhhs.gov

REGION VII (IA, KS, MO, NE)

Lawrence W. Walker, DDS, MPH
Regional Dental Consultant
DHHS/HRSA/BPHC/DHSD, Region VII
601 E. 12th Street, Room 501
Kansas City, MO 64106
Telephone: 816-426-5226
Fax: 816-426-3633
Email: lwalker@hrsa.gov

Steven P. Geiermann, DDS
Program Management Officer/NHSC
DHHS/HRSA/BPHC/NHSC, Region VII
601 E. 12th Street, Room 501
Kansas City, MO 64106
Telephone: 816-426-2916
Fax: 816-426-3633
Email: sgeiermann@hrsa.gov

REGION VIII (CO, MT, ND, SD, UT, WY)

James Sutherland, DDS, MPH
Regional Dental Consultant
DHHS/HRSA/BPHC/DHSD, Region VIII
1961 Stout Street, 4th Floor
Denver, CO 80294
Telephone: 303-844-3206
Fax: 303-844-0002
Email: jsutherland@hrsa.gov

REGION IX (AZ, CA, HI, NV, GU, TT)

Reginald Louie, DDS, MPH
Regional Dental Consultant
DHHS/HRSA/MCHB, Region IX
50 United Nations Plaza, Room 317
San Francisco, CA 94102
Telephone: 415-437-8101
Fax: 415-437-8105
Email: rlouie@hrsa.gov

John S. Betz, D.D.S.
Dental Director
Mariposa Community Health Center
1852 N. Mastick Way
Nogales, AZ 85621
Telephone: (520) 281-1550
Voicemail: (520) 761-2133, ext. 218
Fax: (520) 281-1112
Email: medicalstaff@theriver.com

REGION X (AK, ID, OR, WA)

Forrest Peebles, DDS
Regional Dental Consultant
DHHS/HRSA/BPHC/DHSD, Region X
2201 6th Avenue, MS RX-23
Seattle, WA 98121
Telephone: 206-615-2493
Fax: 206-615-2500
Email: fpeebles@hrsa.gov

PEDIATRIC DENTAL CONSULTANTS

Region I, Boston

Peter B. Geller
80 High Street
Medford, MA 02155
Phone: (781) 391-8300
Fax: (781) 391-0776
Email: geller_p@a1.tch.harvard.edu

Region II, New York

Martin J. Davis
Columbia University
Division of Pediatric Dentistry
630 W. 168th Street
New York, NY 10032
Phone: (212) 305-3890
Fax: (212) 305-1034
Email: mjd2@columbia.edu

Region III, Philadelphia

Ross M. Wezmar
201 Jefferson Avenue
Scranton, PA 18503

Phone: (717) 346-7760
Fax: (717) 346-9002
Email: pedormw@aol.com

Region IV, Atlanta

James C. Beall
1243 Savannah Highway
Charleston, SC 29407
Phone: (843) 571-5644
Fax: (843) 571-5647
Email: jbeall@internet.net

Region V, Chicago

Charles S. Czerepak
2536 N. Lincoln Avenue
Chicago, IL 60614
Phone: (773) 880-5455
Fax: (773) 880-5809
Email: pinedent@aol.com

Region VI, Dallas

William D. Steinhauer
706 S.W. 24th Street, #103

San Antonio, TX 78207
Phone: (210) 432-1510
Fax: (210) 431-8611
Email: necd@texas.net

Region VII, Kansas City

Paul B. Kittle, Jr.
309 S. 2nd Street
Leavenworth, KS 66048
Phone: (913) 651-9800
Fax: (913) 651-8559
Email: pedident@aol.com

Region VIII, Denver

William A. Mueller
The Children's Hospital
Department of Dentistry, B240
1056 E. 19th Avenue
Denver, CO 80218
Phone: (303) 861-6788
Fax: (303) 837-2809
Email: mueller.william@tchden.org

Region IX, San Francisco

Richard S. Sobel
2901 Lone Tree Way
Antioch, CA 94509
Phone: (925) 757-4220
Fax: (925) 757-5457
Email: sobelr@aol.com

Region X, Seattle

Bryan J. Williams
Children's Hospital & Medical Center
Department of Dental Medicine
4800 Sand Point Way, N.E.
Seattle, WA 98105
Phone: (206) 526-2243
Fax: (206) 527-3891
Email: bwilli@chmc.org

Resources

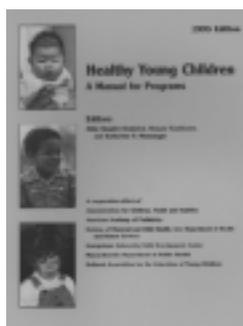


WIC and Head Start: Partners in Promoting Health and Nutrition for Young Children and Families This is a recently published handbook developed by the Food and Nutrition Service of the U.S. Department of Agriculture and the Head Start Bureau. This report provides information on how WIC and Head Start programs can work

together to enhance the quality of the health and nutrition services provided to children and families. It describes the successes, challenges, and lessons learned by state and local WIC and Head Start programs who are already collaborating, and serves as a reference for those considering building new collaborations or enhancing existing partnerships. To download this on-line publication, go to <http://www.fns.usda.gov/oane/menu/published/wic/wic.htm>.



A Healthy Mouth for Your Baby This easy-to-read booklet is available free of charge from the National Institute of Dental and Craniofacial Research. The booklet highlights the importance of fluoride, cleaning your baby's teeth, preventing baby bottle tooth decay, and taking your child to the dentist. A Spanish version is also available. *For copies, contact the National Institute of Dental and Craniofacial Research, 45 Center Drive, MSC 6400, Building 45/Room 4AS-19, Attn: Department Head Start, Bethesda, MD 20892-6400.*



Healthy Young Children: A Manual for Programs-1995 Edition Reviewed by both health and early childhood professionals, this basic manual is used by early childhood programs to promote the health and safety of children, staff, and families. Designed in a readily usable format for ease in locating information, it is frequently used as a textbook. *To order, contact*

NAEYC at: 202-232-8777 (ext. 604), or visit their Web site at www.naeyc.org. The cost of this publication is \$16.00.

Books from the National Maternal and Child Health Clearinghouse:



Oral Disease: A Crisis Among Children of Poverty This fact sheet discusses how preventable oral diseases are still affecting a majority of the children in America, especially children of poverty.



Early Childhood Caries Resource Guide The Resource Guide gives lists of useful resources related to oral health, including journal articles and state, federal, and professional organizations.



Crisis in Care: The Facts Behind Children's Lack of Access to Medicaid Dental Care This policy brief lists the facts behind a lack of access to Medicaid dental care and actions that need to be taken.

Print copies may be ordered from the National Maternal and Child Health Clearinghouse at 888-434-4624, or visit their Web site at: www.nmchc.org.

Oral Health and Children Virtual Resource Guide

ADA ONLINE, THE AMERICAN DENTAL ASSOCIATION

<http://www.ada.org>

Offers a comprehensive resource for oral health information and education. The ADA is the professional association of dentists dedicated to serving both the public and the profession of dentistry. Go to their parents and children section for the following:

ADA Kids' Corner, Parents' Page, National Children's Dental Health Month, Preventing Baby Bottle Tooth Decay.

The teacher and students section lists classroom activities, links to free materials, and online ordering capability.

THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY

<http://www.aapd.org/>

Dedicated to improving and maintaining the oral health of infants, children, adolescents, and persons with special health care needs. In addition to a wide range of information for professionals and the public, they offer online brochures for parents' questions about children's oral health covering 24 different topic areas.

THE AMERICAN DENTAL HYGIENISTS ASSOCIATION

<http://www.adha.org/>

Includes a feature for kids, called *Kids Stuff*, with general information, a game, and a chance to win a toothbrush. Also has an E-mail address to direct questions to a hygienist.

NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH (NIDCR)

<http://www.nidcr.nih.gov>

Part of the National Institutes of Health, the mission of the NIDCR is to promote the general health of the American people by improving their oral, dental, and craniofacial health. This site includes general oral health and patient care information and resources, research activities, programs, and links to other related sources. Publishes brochures, articles, and posters you can order or download. Topics focus on children's oral health issues: tooth brushing, nutrition, sealants, and fluoride use. Offers several titles in Spanish as well.

THE NATIONAL ORAL HEALTH INFORMATION CLEARINGHOUSE (NOHIC)

<http://www.nohic.nidcr.nih.gov/welcome.html>

A service of the National Institute of Dental and Craniofacial Research. Many Americans have medical or disabling conditions that compromise oral health. NOHIC is a resource for health professionals and these special care patients that gathers and disseminates information from many sources, including voluntary health organizations, research institutions, government agencies, and industry. NOHIC produces and distributes patient and professional education materials, including fact sheets, brochures, and information packets. They also sponsor the *Oral Health Database*, which includes bibliographic citations, abstracts, and availability information for a wide variety of print and audiovisual materials. NOHIC staff provides free custom or standard searches on specific special care topics in oral health.

ORAL HEALTH AMERICA

<http://www.oralhealthamerica.com>

A fully independent, non-profit, national charity, working for more than forty years to educate the public, improve access to services, and support research and dental education. Several informative articles and reports designed to raise public awareness about oral health care disparities can be obtained online here.

INDIAN HEALTH SERVICE ORAL HEALTH INITIATIVE

<http://www.ihs.gov/publicinfo/publicaffairs/director/initiatives/oral2001jan.asp>

The catalog of materials offers several good resources relating to children's oral health. You can view their newsletter, *Baby Steps*, the IHS policy on dental sealants, and information about their Early Childhood Cavities (EEC) initiatives, including a screening form that can be used for Head Start programs.

SURGEON GENERAL'S REPORT ON ORAL HEALTH

<http://www.nidcr.nih.gov/sgr/oralhealth.htm>

Site includes the recent press release in English and Spanish and the complete report and executive summary in English.

For a more comprehensive listing of oral health Web sites, visit Head Start Information and Publication Center at: www.headstartinfo.org.

2000-2001 National Head Start Fellows

Head Start has served as a national laboratory for services to young children and their families, developing new knowledge to inform the entire early childhood field on best practices for young children. In keeping with this tradition, the National Head Start Fellows Program was created. The core of the program is an intensive work experience in Washington, D.C. The Fellows spend one year working in the administrative branch of the federal government where they learn firsthand from nationally recognized leaders and contribute their knowledge, skills, and local perspectives to the discussion of significant issues affecting children and families.

Head Start Fellows are energetic professionals who serve as apprentices in the areas of program development, research, child development, health, family development, and policy. They also participate in educational and leadership development programs, attend seminars, and explore national issues with senior government officials, policy makers, researchers, community leaders, and innovative early childhood program practitioners. We are proud to introduce the 2000-2001 Class of National Head Start Fellows:

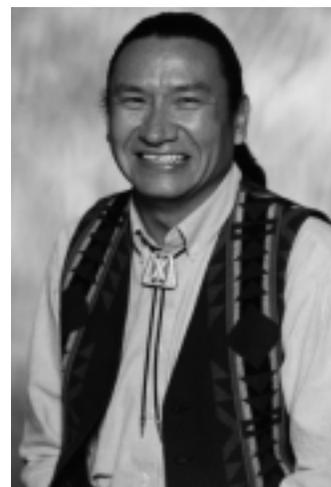


Beverly Ann Angustain is an Even Start Director at Plaza de la Raza Head Start in the city of Commerce, California. Beverly Ann's responsibilities include the management and operations of the Even Start Literacy Program. Before this appointment, Beverly Ann was Parent Educator at Plaza de la Raza, Inc. She earned a BA in American Studies from California State University, Los Angeles, and has completed

graduate coursework in the Marriage, Family and Child Counseling Program at Pacific Oaks College in Pasadena, California. Beverly Ann's voluntary activities include a variety of local grassroots initiatives. She is an advocate of family literacy and a firm supporter of "Home, School, and Community" collaborations and partnerships. Beverly Ann will work with the Program Management and Operations Branch in the Head Start Bureau, and can be reached at (202) 205-8899, or by E-mail at: bangustain@acf.dhhs.gov.

Terra Bonds is a Child/Family Development Specialist at KCMC Child Development Corporation in Kansas City, Missouri. She is responsible for working with children and families in their home environments by providing parents with education, employment, and housing resources, and assisting families with developing strategies for building strong foundations for their children. Terra earned an MS degree in Counseling Psychology from Avila College in

Kansas City, Missouri, and a BA in Psychology from Spelman College, Atlanta, Georgia. She serves as a classroom leader for elementary school-aged children at J.S. Chick African Centered School and as an instructor and public speaking trainer for adolescents at the Kansas City Media Project and Leadership Institute. Terra will work with the Family and Community Partnerships Branch in Head Start Bureau, and can be reached at (202) 205-8034, or by E-mail at: tbonds@acf.dhhs.gov.



Harold "Jess" Brien is a social worker for the Division of Child Family Service in Salt Lake City, Utah. Jess was previously employed as a child welfare worker intern for the state of Utah, a partial care worker, and director of personnel for the Crow Tribe Administration, Crow Agency, Montana. He earned a MSW degree from the University of Utah in Salt Lake City and a BS in Human Services from

Montana State University in Billings, Montana. Jess' voluntary activities include providing recreational activities for members of the Salt Lake City Track Club and service as a consultant for the Indian Walk-In Center—Health Advisory Committee. Jess will work with the American Indian Program Branch, Head Start Bureau. He can be reached at (202) 205-8696, or by E-mail at: jbrien@acf.dhhs.gov.



Beverly Gould is a doctoral candidate at the New York University School of Psychology with a focus on child and adolescent psychiatry. Prior to pursuing a Ph.D., Beverly was a clinical supervisor at an Early Head Start program in New York, a clinician, social worker, and social psychologist. Her community service includes the co-development of a summer program for neighborhood youth at the Madala Center and membership in an Interfaith

Fellowship Choir. Beverly will work with the Health and Disabilities Branch of the Head Start Bureau. She can be reached at (202) 205-8478, or by E-mail at: bgould@acf.dhhs.gov.

Traci Hefner was a Social Service Manager for the New Britain Head Start Program in New Britain, Connecticut. She was responsible for ensuring that family advocates received appropriate training and were familiar with community resources. She was also previously employed as a behavioral health care consultant for Inglewood Associates in Pittsburgh, Pennsylvania, and supervisor at Summit Center for Human Development in Clarksburg, West Virginia. Traci earned an MSW degree from West Virginia University in Morgantown, and a BA in Liberal



Arts from Fairmont State College, Fairmont, West Virginia. She served as a Court Appointed Special Advocate in Morgantown, West Virginia, and as a volunteer counselor for the Sexual Assault Crisis Service in New Britain, Connecticut. Traci will work with the Training and Technical Assistance Branch, Head Start Bureau. She can be reached at (202) 205-5931, or by E-mail at: thefner@acf.dhhs.gov.

Karen Heying is Executive Director of Child Care Choices, Inc. in St. Cloud, Minnesota, a private non-profit organization providing child care resource and referral and a child and adult care food program. She was previously employed as a statewide consultant/director in Rochester, Minnesota, for the Minnesota Child Care Resource and Referral Network and executive director and national field manager for Big Brothers/Big Sisters of America. Karen's voluntary activities include service as a CanSurmount Coordinator for the American Cancer Society and as a Big Sister for Big Brothers/Big Sisters of St. Cloud, Minnesota. Karen will work with the Program Operations Division of the Child Care Bureau. She can be reached at (202) 205-8713, or by E-mail at: kheyng@acf.dhhs.gov.



Sarah Merrill was a teacher at the John Hancock Child Care Center in Boston, Massachusetts. Her responsibilities included the implementation of care programs for seven infants, ranging in age from two months to twenty months. Sarah also has been a mentor teacher for the past few years, working with protégé teachers and assisting with their professional development. Her voluntary activities have



included serving as co-founder of the Wheelock College Policy Seminar Advocacy for Care and Education Team, founder of the John Hancock Child Care Center Sign Language Task Force Committee, and service on the St. John's Episcopal Church Nursery Program Committee. Sarah will work with the Early Head Start Team, Head Start Bureau. She can be reached at (202) 205-8654, or by E-mail at: smerrill@acf.dhhs.gov.



Dr. Guylaine L. Richard is Director/Program Services Coordinator for Family Services Agency, Inc./Early Head Start in Gaithersburg, Maryland. Her duties include the management, supervision, and monitoring of the program's staff and independent consultants. Guylaine has also been a consultant for the Commonwealth of Virginia Department of Social Services, Professor of Allied Health at Maryland's Prince George's County Community

College, and Health/Mental Health/Nutrition Coordinator for the Prince George's County Public Schools Project Head Start. She earned a Masters degree in Public Health from George Washington University, an M.D. from Universite d'Etat d'Haiti, and a Baccalaureate I and II from Institution Ste. Rose de Lima, Port-au-Prince, Haiti. Her voluntary and community involvement includes providing transportation and assistance to elderly individuals through the American Red Cross, conducting program activities for St. John's Literacy Institution at Prospect Hall in Frederick, Maryland, and teaching religious education to youths at Mother Seton Parish in Germantown, Maryland. Guylaine will work with the Health and Disabilities Branch, Head Start Bureau. She can be reached at (202) 205-8283, or by E-mail at: grichard@acf.dhhs.gov.

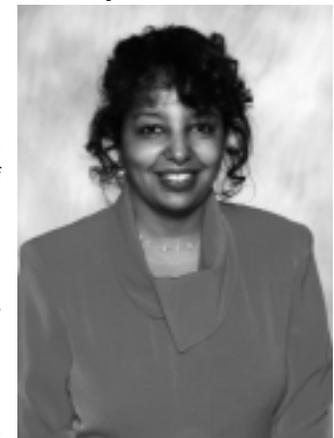
Kathleen Sullivan is a Family Support Coordinator for WSEM-CDC Head Start in Cleveland, Ohio. She is responsible for compliance, training, and management of parent involvement and social service programs. Recently promoted to this position, Kathleen was formerly a parent involvement coordinator at WSEM-CDC and an AmeriCorp member. Her

voluntary activities include service on the WSEM Youth Services Advisory Board, coordinator of an art show, and member of the American Bando Association in Cleveland, Ohio. Kathleen will work with the Program Operations Division, Head Start Bureau. She can be reached at (202) 205-8602, or by E-mail at: ksullivan@acf.dhhs.gov.



Wassy Tesfa is a Special Needs Specialist at Community Housing Service/Head Start in Pasadena, California. Her duties include the design, development, and implementation of disability services for the program; collaboration; community outreach; and grant writing. Wassy has also held positions as a speech, language, and mental health consultant, counselor for Ethiopian Community Center Outreach

Services, Inc., and as a freelance journalist for Radio Voice of Germany in Frankfurt, West Germany. Her community service includes the creation of "Tesfa in Los Angeles," an initiative designed to rehabilitate homeless families in Ethiopia, and serving as founder of the Ethiopian Human Rights Committee in Los Angeles, California. Wassy earned an MA degree from Johannes Gutenberg University in Mainz, West Germany, and a certificate from Studien Kolleg, Cologne, West Germany. She will work with the Program Support Division of the Head Start Bureau, and can be reached at (202) 401-2962, or by E-mail at: wtesfa@acf.dhhs.gov.



The fax number for all Head Start Fellows is (202) 401-5916. For more information on the National Head Start Fellows Program, contact: JoAn Herren, Training and Technical Assistance Branch Chief, Head Start Bureau T: 202-205-8566; E: jherren@acf.dhhs.gov.

Extra copies of the Forum Papers!

Extra copies of the Forum Papers can be obtained by sending a fax request to the Head Start Information and Publication Center at 202-737-1151. You can also download them from their Web site: <http://www.headstartinfo.org>.

A limited number of Healthy Smiles, Healthy Children buttons and posters will be available on a first come, first serve basis through your regional QIC. Videotaped copies of the Forum general sessions will also be available for purchase. Information on how to order videos will be sent in the mail.

Put us on your mailing list!

We'd love to keep in touch with what's happening in your programs and communities.
Head Start Bulletin • 330 C Street, S.W. • Washington, D.C. 20447



U.S. Department of
Health and Human Services
ACF/ACYF/HSB
Washington, D.C. 20201

OFFICIAL BUSINESS
Penalty for private use \$300