

# EFFECTIVE PARTNERSHIPS GUIDE:

*Improving Oral Health for Migrant and  
Seasonal Head Start Children and  
Their Families*

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ADMINISTRATION FOR  
**CHILDREN & FAMILIES**



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# How to Use this Guide

The “Effective Partnerships Guide: Improving Oral Health for Migrant and Seasonal Head Start Children and their Families” has been developed for the following groups:

- Migrant and Seasonal Head Start (MSHS) grantee administrators and staff;
- Federally Qualified Health Center (FQHC) administrators and staff; and
- Migrant Health Center administrators and staff.

The purpose of this Guide is to help MSHS grantees and FQHCs establish an effective partnership that increases access to oral health preventive and treatment services for MSHS children and their families. Information provided will help MSHS grantees and FQHCs gain a better understanding of each other and the complimentary roles they can take to improve access to dental care. Furthermore, this Guide provides the steps and considerations for effective partnering. There are also website links to useful resources for MSHS grantees and FQHCs throughout the document.



# Introduction

The Migrant Clinicians Network describes migrant and seasonal farmworkers as a mobile population. Most families move in pursuit of work and their patterns and length of migration can vary significantly. The number of migrant and seasonal farmworkers may vary during any given season. This community is often extremely isolated from social networks as well as from social service and health care providers.<sup>1</sup>

Migrant and Seasonal Head Start (MSHS) children and their families suffer disproportionate levels of disease and disability due to the nature of their living and workplace environments. Children from migrant and seasonal families, in particular, are vulnerable to dental caries (or tooth decay) and demonstrate significant risk for dental disease when compared to their peers from non-agricultural working families.

MSHS grantees and Federally Qualified Health Centers (FQHCs), in some places called Community Health Centers, are mandated under federal law to serve this population. Through a Memorandum of Understanding (MOU) between Office of Head Start, Migrant and Seasonal Head Start Program Administration for Children and Families and Migrant Health Center Program



Health Resources and Service Administration Bureau of Primary Health Care there is a commitment to work together and serve the Migrant and Seasonal population.

MSHS grantees and FQHCs co-exist in many of the same communities. However, only a few have established collaborative partnerships to coordinate oral health services to MSHS children and their families. Joining together to serve this population enables both MSHS grantees and FQHCs to advance their respective missions and achieve improved programmatic as well as population-based health outcomes.

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<sup>1</sup> Migrant Clinicians Network. Migration Patterns  
<http://www.migrantclinician.org/issues/migrant-info/migration-patterns.html>

## MIGRANT AND SEASONAL HEAD START PROGRAM

The MSHS program is a comprehensive early childhood program that aims to prepare every migrant and seasonal child for school. The program, established in 1969, provides comprehensive health and child development services to infants and toddlers, preschoolers, pregnant women of low-income, and migratory and seasonal farmworkers. There are 60 MSHS grantees located in 36 states currently providing an array of services to approximately 35,000 children of migrant and seasonal farmworker families. While these grantees have the same goal as other Head Start grantees, there are additional goals unique to migrant populations—ensure that children continue to receive health services while migrating with their families).<sup>2</sup>

### Key to Success

#### Responsiveness to Needs of

**MSHS Children:** The primary goal of any MSHS initiative is to design and implement a program that effectively and efficiently addresses needs of the family.

MSHS children and families have unique characteristics and circumstances that differentiate their program service needs from traditional Head Start children and families.<sup>3</sup>

These differences can create barriers within healthcare systems and add a layer of complexity to MSHS grantees' responsibilities and service capacity.

Studies over the past 30 years have demonstrated that children of farmworkers experience greater frequency of malnutrition, infectious disease and dental caries than

other, non-farmworker children.<sup>4</sup> An early study found that nearly half of the children from farmworker families experienced significant decay in four or more teeth.<sup>5</sup> Recent Office of Head Start (OHS) Program Information Report (PIR) data reveals that problems continue to exist in access and utilization of dental care services among MSHS children and families. However, slight improvements have been observed. In the 2009-2010 Region XII PIR, data showed that 86 percent of MSHS children had a continuous source of dental care at the end of the enrollment period.<sup>6</sup> While this demonstrates a child's ability to access oral health services, issues associated with treatment completion prior to migration to a new worksite were readily noted.<sup>7</sup>

<sup>2</sup> 2009-2010 Head Start Program Information Report (PIR); Health Services Multi-Year Report. Region 12 April 2011

<sup>3</sup> MSHS Design Project; Final Design Report May 2011

[http://www.acf.hhs.gov/programs/opre/hs/migrant\\_mshs/reports/migrant\\_design.pdf](http://www.acf.hhs.gov/programs/opre/hs/migrant_mshs/reports/migrant_design.pdf)

<sup>4</sup> *ibid*

<sup>5</sup> Chase et al., 1971; as cited in Koch, 1988; National Center for Farm Worker Health

<sup>6</sup> 2009-2010 Head Start Program Information Report (PIR); Health Services Multi-Year Report. Region 12 April 28, 2011

<sup>7</sup> Anecdotal Parent Report, MSHA Advisory Committee, March 2011



## RECENT HISTORY

OHS established two initiatives in response to: the national trend depicting a steady increase in dental caries, the need for dental treatment among Head Start children, and a notable inability of Head Start families to access oral health care services. The aim of the Oral Health Initiative (OHI) and the Dental Home Initiative (DHI) was to ensure that all Head Start children had access to a dental home. These OHS initiatives launched a national campaign to educate Head Start children, staff, and families on the importance of good oral health and access to routine dental care services. Both initiatives sought to increase the number of dental health providers willing to serve Head Start children.

Since the DHI, many Head Start grantees have seen success in their ability to attain dental care and sustain dental homes. However, MSHS grantees have not been as fortunate. This is due to the variety of unique characteristics and circumstances that affect MSHS grantees, children and their families, such as: access to a continuous source of oral health care, completion of oral health treatment services, and determination as to whether a child is up-to-date on a schedule of age-appropriate preventive and primary health care.

Coordinating dental care continues to remain a significant challenge for MSHS grantees and a major concern for MSHS families.

The DHI was grounded in the Head Start Performance Standard § 1304.20 stating that grantees must work in collaboration with parents to determine whether a child has an ongoing source of continuous, accessible health care; and, to obtain from a health care professional whether a child is up-to-date on a schedule of age-appropriate preventive and primary health care including dental based on a schedule that incorporates the state Medicaid agency's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

## FEDERALLY QUALIFIED HEALTH CENTERS

For more than four decades, the Health Resources and Services Administration (HRSA) has supported a national network of health centers that provide primary health care services, including dental care, through the Health Center Program (HCP). The HCP serves millions of

individuals who would otherwise have little or no access to care.<sup>8</sup> FQHCs are a part of the HCP and are locally-based health centers that commonly serve: low-income populations, the uninsured, and those with limited English proficiency.

FQHCs (similar to other health centers in the HCP) are generally:

- located in high-need and underserved communities;
- governed by a representative community board;
- provide comprehensive primary health care services; and,
- offer an array of supplemental family support services.

FQHCs receive federal grants for operational costs and maximize their resources through reimbursement from individuals, families and third parties. FQHCs also use a corresponding schedule of discounts on the basis of the patient's ability to pay.

FQHCs offer a unique partnership opportunity with MSHS grantees, as they provide culturally competent comprehensive primary health care and enabling services, such as interpretation, translation and transportation for medically underserved communities.<sup>9</sup>

Some of HRSA-supported health centers receive specific funding to focus on certain special populations. These include:

- **Health Care for the Homeless Program** a major source of care for homeless persons in the United States, serving patients that live on the street, in shelters, or in transitional housing. Health Care for the Homeless grantees recognize the complex needs of homeless persons and strive to provide a coordinated, comprehensive approach to health care including substance abuse and mental health services.
- **Public Housing Primary Care Program** provides residents of public housing with increased access to comprehensive primary health care services through the direct provision of health promotion, disease prevention, and primary health care services. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents

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<sup>8</sup> <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>

<sup>9</sup> <http://www.hrsa.gov/ourstories/factsheets/healthcenter.shtm>

- **Native Hawaiian Health Care Systems** improves the health status of Native Hawaiians by making health education, health promotion, and disease prevention services
- **Migrant Health Center (MHC) Program** provides support to health centers to deliver comprehensive, high quality, culturally-competent preventive and primary health services to migrant and seasonal farmworkers and their families with a particular focus on the occupational health and safety needs of this population. Principal employment for both migrant and seasonal farmworkers must be in agriculture.<sup>10</sup>

There are currently 156 MHCs across the United States. In 2010, MHCs served just more than 800,000 patients. Of those, 22.7 percent were children under age twelve. In addition, one out of four MSHS children received services from MHCs that year.<sup>11</sup>

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<sup>10</sup> <http://bphc.hrsa.gov/about/specialpopulations/index.html>

<sup>11</sup> 2009-2010 National Head Start PIR Data

# Office Head Start

## COMPREHENSIVE SERVICES MODEL

Since 1965, Head Start has helped more than 30 million children from low-income families receive a quality PreK education and comprehensive services to support their development. The Office of Head Start (OHS) continues to promote school readiness by enhancing a child’s physical, social and emotional, and cognitive development through the provision of educational, health, nutritional, social and other services. OHS allocates grants to local public and private non-profit and for-profit agencies to provide these services to economically disadvantaged children and families. In 1995, the Early Head Start program was established to serve pregnant women and children from birth to three years-old in recognition of the mounting evidence that the earliest years matter a great deal to children's growth and development.

Significant emphasis is placed on the involvement of families in the administration of local Head Start and Early Head Start grantees. Head Start engages parents in their children's learning. Head Start also helps parents make progress toward their own educational, literacy and employment goals.

OHS has special focus on helping preschoolers develop the early reading and math skills they need to be successful in school.

## HEAD START PROGRAM PERFORMANCE STANDARDS

Head Start Program Performance Standards (HSPPS) are specific, federally mandated requirements that govern program systems and services. They are established under federal law as part of Title 45 CFR Part 1304 of the Head Start Act. All MSHS grantees are responsible for complying with the Head Start Program Performance Standards to ensure quality services to children and their families.

The Head Start Program Performance Standard: §1304.20 Child Health and Developmental Services states, “For each child enrolled in a MSHS program, grantees must obtain:

- An ongoing source of continuous, accessible health care (for the purposes of this document an ongoing source of continuous, accessible health care will be referred to as "dental home") within 90 days (within 30 days if program is in operation for 90 days or less) of the child's enrollment in the program; and
- A determination (from a health care professional) as to whether a child is up-to-date on a schedule of age appropriate preventive and primary health care, including dental care, under the state Medicaid Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program.<sup>12</sup>

Each year, an estimated 35,000 MSHS children across America will require oral health care services as outlined under the Head Start Program Performance Standard § 1304.20 Child health and developmental services.

## THE DENTAL HOME

Head Start Program Performance Standard: §1304.20 Child Health and Developmental Services refers to the "dental home." A dental home is an ongoing source of continuous accessible oral health care.<sup>13</sup> For MSHS children, a dental home should be established as early as possible and in close proximity to where the family designates as their "home base." Efforts to begin and complete all annual dental care as early as possible in the program year should be made. When treatment completion in the designated dental home is impossible due to the family's migratory work schedule, a specific FQHC referral site for treatment completion should be identified and an appointment scheduled. It is recommended that MSHS grantee assist families and providers to transfer dental records to assure continuity of care for the MSHS child.

## EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) REQUIREMENTS

Head Start Program Performance Standard: §1304.20 Child Health and Developmental

<sup>12</sup> Early Childhood Knowledge and Learning Center

<http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/Program%20Design%20and%20Management/Head%20Start%20Requirements/Head%20Start%20Requirements/1304/1304.20%20Child%20health%20and%20developmental%20services.htm>

<sup>13</sup> Early Childhood Knowledge and Learning Center

<http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/Program%20Design%20and%20Management/Head%20Start%20Requirements/Head%20Start%20Requirements/1304/1304.21%20Education%20and%20early%20childhood%20development.htm>

Services refers to "Early and Periodic Screening, Diagnosis, and Treatment" (EPSDT) program. The EPSDT program is a comprehensive and preventive health program for children enrolled in the Medicaid. EPSDT was first defined by legislation in 1989 (OBRA '89) and includes requirements for periodic primary health care screening; including vision, dental, behavior health, and hearing services. It requires state Medicaid agencies to pay for services that are deemed medically necessary. Under each state Medicaid EPSDT program, states must:

- Ensure the availability and accessibility of required health care resources; and
- Assist Medicaid recipients and their parents or guardians in the effective use of these resources.

### **What MSHS Grantees Should Know**

MSHS grantee administrators should be aware that each state has the ability to define "medically necessary." What may be deemed "medically necessary" in one state may not be in another. Under all state Medicaid EPSDT programs, comprehensive oral examinations, x-rays, dental prophylaxis (cleanings), fluoride and sealants and restorative treatment are covered benefits. However, these benefits differ in each state by: 1) age of beneficiary; 2) provider (dentist, dental hygienist, dental assistant; physician); 3) frequency of services per visit and per year and in some cases by the materials used. Understanding these specifications will assist budget conscious administrators when developing budgets and agreements that include payment for dental services.

### What FQHCs Should Know

FQHC administrators, medical and dental directors should be aware that MSHS grantees are required under federal law to provide EPSDT services as outlined in state Medicaid law. These specific dental care services include:

1. Enrollment in Medicaid or CHIP
2. Oral Examination
3. Treatment Plan
4. Prophylaxis (dental cleaning)
5. Fluoride Treatment
6. X-rays if indicated
7. Therapeutic (restorative) services if indicated
8. Referral to specialty care if indicated
9. Transition Plan: Referral to other providers
10. Provision for emergency care
11. Provision for after-hour care
12. Linkage to primary care provider

Although this responsibility is placed in the hands of the MSHS grantees, FQHCs may assist by collaborating and planning with MSHS grantees to address this federal mandate.

## DENTAL PERIODICITY SCHEDULES

Head Start Program Performance Standard: §1304.20 Child Health and Developmental Services refers to "a schedule of age-appropriate preventive and primary health care including dental care"—or a dental periodicity schedule. The American Academy of Pediatrics (AAP)<sup>14</sup> and the American Academy of Pediatric Dentistry (AAPD)<sup>15</sup> have developed recommendations for the routine provision of professional pediatric health and oral health care services, respectively. These recommendations, also called periodicity schedules, represent a consensus by both organizations and have been designed to emphasize the importance of continuity of care.<sup>16,17</sup>

<sup>14</sup> American Academy of Pediatrics, <http://practice.aap.org/popup.aspx?aid=1625&language=>

<sup>15</sup> American Academy of Pediatric Dentistry, [http://www.aapd.org/media/Policies\\_Guidelines/G\\_Periodicity.pdf](http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf)

<sup>16</sup> American Academy of Pediatrics; Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) <http://practice.aap.org/content.aspx?aid=1599>

<sup>17</sup> [http://www.aapd.org/advocacy/state\\_periodicity\\_schedules/](http://www.aapd.org/advocacy/state_periodicity_schedules/)

### **What MSHS Grantees and FQHCs Should Know**

Many state Medicaid agencies have adopted the AAPD dental periodicity schedule, however, some have not. It is important for MSHS grantee administrators to be aware of each state Medicaid agency's periodicity schedule for dental services. **If a state Medicaid periodicity schedule does not specifically list a designated dental service, or if the state does not have an available periodicity schedule, it may not cover the dental provider's fee for that service.**<sup>18</sup> This may impact the budget and planning processes for dental care services for the respective age group.

## **PROGRAM INFORMATION REPORT (PIR)**

The PIR provides comprehensive data about the children, pregnant women and families enrolled, as well as services provided by Head Start, Early Head Start, MSHS and American Indian and Alaska Native (AIAN) grantees. All grantees are required by federal law to submit annual PIRs to the Office of Head Start (OHS).<sup>19</sup>

OHS has established five oral health related PIR performance indicators.<sup>20</sup> These indicators (or measures) align with Head Start Program Performance Standard §1304.20. All Head Start grantees, including MSHS, are expected to comply with the standard and document their program performance annually on their PIR.<sup>21</sup>

### **PIR Performance Indicators**

**Head Start and MSHS Grantees** are required to report information on:

- Number of children with a source of continuous, accessible dental care provided by a dentist
- Number of children who received preventive care since last year's PIR was reported
- Number of children, including those enrolled in Medicaid or CHIP, who have completed

<sup>18</sup> [http://www.aapd.org/advocacy/state\\_periodicity\\_schedules/](http://www.aapd.org/advocacy/state_periodicity_schedules/)

<sup>19</sup> Early Childhood Learning and Knowledge Center, <http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/pi>

<sup>20</sup> [http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/pir/2010-2011\\_PIR\\_Performance\\_Indicators.pdf](http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/pir/2010-2011_PIR_Performance_Indicators.pdf)

<sup>21</sup> <http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/pir/faq.html>



a professional dental examination since last year's PIR was reported

**EHS and MSHS Grantees** are required to report information on:

- Number of all children who are up-to-date on a schedule of age-appropriate preventive and primary oral health care [according to the relevant state's EPSDT schedule](#)
- Number of all pregnant women served who received a professional dental examination(s) and/or treatment since last year's PIR was reported

### **What MSHS Grantees Should Know**

MSHS grantee administrators should consider the transitory nature and limited residential period of the migrant family when planning for primary health care and oral health services of MSHS children. MSHS children should receive comprehensive oral examinations as early as possible following enrollment to allow adequate time for the scheduling and completion of any needed restorative treatment.

### **What FQHCs Should Know**

FQHC administrators should consider the transitory nature and limited residential period of the migrant family when planning for primary health care and oral health services of MSHS children. MSHS children should receive comprehensive oral examinations as early as possible to allow adequate time for the scheduling and completion of any needed restorative treatment. When the completion of a treatment plan is not possible, the FQHC should refer the migrant family to the FQHC nearest their future work site.

# Importance of Oral Health

Pediatric developmental experts agree that oral health is a fundamental component to the sound development of children. Good oral health is particularly important for those in the earliest developmental period of life -- birth through five years of age. Oral health is that condition which is necessary to maintain optimum orofacial (oral and facial) structure and

Many MSHS children and their families experience disproportionate levels of dental disease.

function. It allows individuals to speak, smile, taste, chew, swallow; and, communicate an array of feelings and emotions verbally and non-verbally. Oral health contributes to the normal development of children and one's ability to thrive and succeed.

Oral health among MSHS children is variable. Due to a variety of environmental, socio-cultural and access considerations, many MSHS children and their families experience disproportionate levels of dental disease (dental caries).<sup>22</sup> These disproportionate levels of dental disease may result in pain, suffering, and an inability to excel in school or in the workplace. Helping MSHS children and their families' access dental care services is an important step in helping them to attain and sustain good oral health.

## DENTAL CARIES

Dental caries, also known as "cavities" or "tooth decay" is the most prevalent chronic childhood disease.<sup>23</sup> It is an infectious, progressive and destructive disease of the teeth that continues to be one of the major health problems in the United States, especially among low-income and minority children.<sup>24</sup> This disease, which is wholly preventable, when left undiagnosed and untreated, imparts chronic pain and suffering.

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<sup>22</sup> Assuring Comprehensive Dental Services in Medicaid and Head Start Programs: Planning and Implementation Considerations. Schnieder, Rossetti, Crall NOHPC Technical Issue Brief 2008

<sup>23</sup> Oral Health in America: A Report of the Surgeon General. May 2000 <http://www.surgeongeneral.gov/library/oralhealth/>

<sup>24</sup> Oral Health in America: A Report of the Surgeon General. May 2000 <http://www.surgeongeneral.gov/library/oralhealth/>

## What MSHS Grantees Should Share with Families

- *“Baby teeth” are important.* The best way to protect your child from dental caries (tooth decay) in his/her permanent (adult) teeth is to prevent it in the baby teeth.
- *Dental caries is infectious.* Bacteria that cause dental caries can be transmitted from mother to child through saliva-sharing activities (e.g., sharing utensils, cleaning pacifiers and bottle nipples by mouth). Once the bacteria is transmitted, cavities can still be prevented.
- *Dental disease is manageable.* Daily exposure to fluoridated toothpaste and fluoridated drinking water combined with healthy nutrition and regularly scheduled meals and snacks is the most effective way to prevent cavities.
- *A dental home is important.* Regular visits to your child’s dental provider allow for early identification, prevention, and treatment of oral health issues. Children should have a dental home by age 1.
- *Good oral health during pregnancy is safe and important.* Women of childbearing age should receive routine dental care even during pregnancy to ensure optimum oral health.



# Oral Health Care

## The Dental Home

Maintaining a good relationship with an oral health provider is important and can help to prevent tooth decay (cavities) and sustain oral health. The first dental visit is critical for children and families to establish a good relationship with a dental office. A child's first visit should take place around six months following the eruption of the first tooth, no later than a child's first birthday.

### **What MSHS Grantees Should Know**

For MSHS children and their families, the dental home is that dental office or clinic where the comprehensive oral examination takes place. For MSHS children, FQHCs along the family's migratory route can serve as "extenders" of the dental home.

### **What FQHCs Should Know**

A FQHC located in the community that a MSHS family considers "home base" may serve as the dental home for the MSHS child and his/her family. When a MSHS child and his or her family initiate dental care in a FQHC, all efforts to complete treatment should be taken. Because MSHS families reside for such brief periods in each location along the migratory route, FQHC administrators should be keenly aware of the narrow window of time available for the completion of treatment services. If treatment plans cannot be completed as planned an FQHC near the family's future work site should be found. [Find a Health Center](#).

A dental home should provide children and their parents/caretakers with:

1. Comprehensive oral examination that includes an oral health history, dental risk assessment, diagnostic assessment, such as X-rays (as needed), and clinical assessment.
2. Preventive plan based on findings gathered during the comprehensive oral examination.
3. Treatment plan to establish and maintain oral health based on findings gathered during the comprehensive oral examination.

4. Anticipatory guidance
  - Age- and developmentally-appropriate oral health promotion and disease prevention instructions (e.g., brushing with fluoridated toothpaste, teething, weaning).
  - Oral injury prevention recommendations and strategies.
  - Information on nutrition and feeding and eating practices.
5. An ongoing relationship with an oral health professional that provides preventive, restorative and surgical care as appropriate.
6. Interceptive orthodontic care to address future malocclusion issues.
7. Referrals to specialty care (e.g., oral surgeon, orthodontist, pediatric dentist), when appropriate.
8. A coordinated plan of care with the child's primary care medical provider and other appropriate health and social service professionals.

## **COMPREHENSIVE ORAL HEALTH CARE**

All children should receive routine, comprehensive oral health care services. This includes an oral examination, as well as preventive and treatment services. When FQHCs and MSHS grantees assess a child's health and oral health record, certain oral health services should show completion and documentation. See Table 1 on page 24 for more information.

## **ORAL ASSESSMENT**

### **Oral Examination**

Dental examinations are provided by licensed dentists. A dental examination is a type of oral evaluation that includes the comprehensive assessment of the teeth and all of the orofacial structures. The components of a dental examination include the assessment of:

- General health/growth
- Pain
- Extra-oral soft tissue
- Temporomandibular joint (TMJ)
- Intraoral soft and periodontal tissues
- Oral hygiene

- Teeth
- Occlusion
- Caries risk
- Behavior

### **What MSHS Grantees Should Know**

All MSHS children are required under Head Start Program Performance Standard §1304.20 Child Health and Developmental Services to have a comprehensive primary health care and dental examination within 90 days of enrollment in a Head Start grantee (within 30 days if program is in operation for 90 days or less). The outcome of the examination must include a determination of health—a diagnosis of the presence of disease; and it must recommend an appropriate course of treatment including the need for preventive services, disease management and/or restorative services.

### **Oral Health Screening**

Oral health screenings are a type of oral assessment that makes limited observations of the teeth and other oral structures. Screenings are provided by dental auxiliary personnel (e.g., dental hygienists and assistants) and non-dental healthcare providers (e.g., physicians, nurse practitioners and physician assistants). Referrals are made to a dentist if a condition warrants an examination. Oral health screenings do not provide a diagnosis. A child with any suspicious looking condition should be referred to a dentist for a definitive examination and diagnosis.

### **What MSHS Grantees Should Know**

Oral health screenings do not take the place of an oral examination and are not considered a service which meets the Head Start Program Performance Standard requirement. For more information [Dental Screening and Examination: Well-Child Health Care Fact Sheet](#).

**Table 1:**

Oral Health Services	Frequency of Services (Best Practice)
<p><b>Examination</b></p> <ul style="list-style-type: none"> <li>– Oral health history</li> <li>– Dental risk-assessment</li> <li>– Diagnostic assessment (X-rays)</li> <li>– Clinical assessment of teeth and mouth</li> <li>– Identification of oral disease and any abnormal oral conditions (diagnosis)</li> <li>– Development of a prevention and/or treatment plan</li> <li>– Assessment and placement of dental sealants</li> </ul>	<ul style="list-style-type: none"> <li>• First examination should take at the eruption of the first tooth or no later than 12 months of age.</li> <li>• Repeat as indicated by child’s risk status/susceptibility to disease.</li> <li>• Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.</li> <li>• For high risk primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; sealants should be placed as soon as possible after eruption.</li> </ul>
<p><b>Prophylaxis (cleaning)</b></p>	<ul style="list-style-type: none"> <li>• Repeat as indicated by child’s risk status/susceptibility to disease.</li> </ul>
<p><b>Fluoride Treatment (Fluoride varnish)</b></p>	<ul style="list-style-type: none"> <li>• Repeat as indicated by child’s risk status/susceptibility to disease.</li> </ul>
<p><b>Assessment of Malocclusion</b></p>	<ul style="list-style-type: none"> <li>• Annually.</li> </ul>
<p><b>Anticipatory Guidance (Parent counseling)</b></p> <ul style="list-style-type: none"> <li>• Dietary guidance</li> <li>• Oral hygiene</li> <li>• Injury Prevention</li> <li>• Speech and language development</li> </ul>	<ul style="list-style-type: none"> <li>• Appropriate discussion and counseling should be a part of each dental visit.</li> </ul>
<p><b>Treatment</b></p> <ul style="list-style-type: none"> <li>• Tooth restoration (fillings or crowns)</li> <li>• Extractions</li> <li>• Space maintainers and other interceptive orthodontics</li> </ul>	<ul style="list-style-type: none"> <li>• Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.</li> </ul>

<b>Oral Health Services</b>	<b>Frequency of Services (Best Practice)</b>
	<ul style="list-style-type: none"><li>• All treatment planned should be completed within six months of dental examination.</li></ul>



## EXAMINATION VERSUS SCREENING

It is important that MSHS grantee administrators understand the difference between an "oral examination" and an "oral health screening." Table 2 lists the key differences.

**Table 2:**

<b>Oral Examination Comprehensive Assessment</b>	<b>Oral Health Screening (Limited Assessment)</b>
Clinical oral assessment, caries risk assessment, radiographs, medical and dental history are used to: <ul style="list-style-type: none"> <li>• Identify healthy and normal oral conditions</li> <li>• Diagnose oral disease and abnormal conditions</li> </ul>	Clinical oral assessment is used to: <ul style="list-style-type: none"> <li>• Identify normal and abnormal oral conditions.</li> <li>• Triage treatment urgency and referrals to dentists and dental specialists</li> </ul>
Performed by: <ul style="list-style-type: none"> <li>• Dentist</li> </ul>	Performed by: <ul style="list-style-type: none"> <li>• Dentist</li> <li>• Dental hygienist</li> <li>• Physician</li> <li>• Nurse</li> <li>• Other trained health care professional</li> </ul>
Results in a: <ul style="list-style-type: none"> <li>• Preventive treatment plan</li> <li>• Restorative treatment plan</li> <li>• Referral for specialty services</li> </ul>	Results in a referral for: <ul style="list-style-type: none"> <li>• Urgent care</li> <li>• Dental home</li> <li>• Oral examination</li> <li>• Diagnosis</li> <li>• Treatment plan</li> </ul>

## DENTAL CARIES RISK ASSESSMENT

Dental caries risk assessments are used by dentists to quantify a child's susceptibility to dental caries. They are used to identify and minimize factors that contribute to dental disease. Dental caries risk assessments take into account lifestyle behaviors and other observations made during dental exams to help determine the best course of treatment. The determination of high, moderate, or low risk is based on the balance (or imbalance) of known risk and protective factors. The major risk and protective factors for dental caries are listed in the following Table 3.<sup>25</sup>

**Table 3:**

<b>Major Risk Factors</b>	<b>Major Protective Factors</b>
<ul style="list-style-type: none"><li>• <b>Mother has untreated dental caries</b></li><li>• <b>Family is low income</b></li><li>• <b>Child has more than three snacks or beverages a in between meals each day</b></li><li>• <b>Child is put in bed with a bottle containing a beverage with natural or added sugar</b></li><li>• <b>Child has special health care needs</b></li><li>• <b>Child is a recent immigrant</b></li><li>• <b>Child has white spot lesions or enamel defects</b></li><li>• <b>Child has visible cavities or fillings</b></li><li>• <b>Child has plaque on teeth</b></li></ul>	<ul style="list-style-type: none"><li>• Child received optimally-fluoridated drinking water or fluoride supplements</li><li>• Child has teeth brushed daily with fluoridated toothpaste</li><li>• Child receives topical fluoride from health professional</li><li>• Child has dental home/regular dental care</li></ul>

<sup>25</sup> Council on Clinical Affairs, American Academy of Pediatric Dentistry. 2011. Guideline on Caries-Risk Assessment Management for Infants, Children, and Adolescents. Pediatric Dentistry Reference Manual 34(6):118-125. [http://www.aapd.org/media/Policies\\_Guidelines/G\\_CariesRiskAssessment.pdf](http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf)

## TREATMENT PLANNING

Every time a child receives an oral examination, the dentist performing the examination will make a determination of health. This includes a diagnosis when disease is present, and an appropriate course of treatment or "a treatment plan."

**No Disease Present:** When a child presents with a healthy mouth and no cavities, or other disease/condition, the "treatment plan" is called a "maintenance plan," which aims to maintain or sustain oral health. Depending upon the risk assessment of the child, the maintenance plan may include preventive fluoride and or dental sealant services.

**Early Stage Dental Caries:** When the child presents with early stage dental caries, (no visible cavities, but evidence of disease) the dentist may recommend fluoride and/or dental sealants.

These services are important because they can remineralize tooth enamel to prevent dental caries from progressing and cavities from forming. These services are often completed at the same time as the dental examination with possible follow up appointments, if recommended.



**Late Stage Dental Caries:** When the child presents with cavities, this is a later stage of dental disease which cannot be reversed. This stage requires treatment to remove the decay and replace the tooth structure with a restorative material such as fillings. A restorative treatment plan should include the full scope of services that are being recommended. A detail record of which teeth need restoration, the nature of the restoration and the number of visits needed to complete care should be prepared.

## PREVENTING AND MANAGING DENTAL DISEASE

All children should experience good oral health. Beginning in early childhood, prevention strategies should be used to keep children healthy and free of dental disease. The combination of: regular exposure to fluoride, daily oral hygiene under the supervision of an adult, regularly scheduled meals and snacks, and routine oral health care services delivered in a dental home, all help to ensure optimal oral health. Professional oral health care services that aid to prevent and manage dental caries include: dental prophylaxis or cleanings; professional fluoride treatments or fluoride varnish; and dental sealants.

### **What MSHS Grantees Should Know**

Dental cleanings, fluoride varnish and treatments and dental sealants help prevent and manage dental caries. MSHS administrators should assist parents in understanding the preventive benefits of these services. Children that have been determined to be at a high or moderate risk for dental caries should be monitored and receive preventive services more frequently than those designated as low risk.

## COMPLETING TREATMENT PLANS FOR MSHS CHILDREN

All dental treatment prescribed by a dentist and outlined in a treatment plan should be completed within the time the MSHS children and their families are in the community. Planning ahead will help FQHCs complete treatment within a reasonable time period considering the scope of the required services. For children requiring extensive restorative care, a plan should be established that will ensure all prescribed treatment will be completed. Ideally, this means before the child and his or her family move to their next location. If there is a need for continued care, the family should be referred to a local FQHC in their new location. Patient care records should be made available to families so that services are not duplicated and existing treatment plans can be coordinated with the next provider.

## **ANTICIPATORY GUIDANCE FOR PARENTS AND CARETAKERS**

Anticipatory guidance (i.e. health advice, recommendations) helps families understand what to expect during their infant's or child's current and approaching stage of development. FQHCs and MSHS grantees provide oral health guidance on how to promote good oral health in MSHS children and families. By informing parents and caregivers of: the conditions that create dental caries, the progression of the disease, and its prevention, MSHS and FQHC personnel may help families understand their child's risk of disease as well as ways to prevent and or manage it.

## Key Points to Remember

### *A dental home:*

- Goal is to reduce the risk of dental disease.
- An ongoing source of comprehensive and coordinated dental care
- Established during child's first visit to a dentist
- Opportunity for oral health assessment and preventive services
- Provides individual child risk assessment; tailored counseling; anticipatory guidance; emergency plan

MSHS children have significant dental needs due to the at-risk nature of their families' living environments. Annual oral assessment and rigorous efforts to complete treatment as soon as possible are essential for MSHS children. MSHS grantees and FQHCs should work with families to plan for continuity of care and secure providers in the family's next work site, in case of future health care needs.

### *Importance of an Age 1 dental visit:*

- Supports primary prevention
- Helps to establish a dental home
- Source for ongoing anticipatory guidance

### *What to expect during an early childhood dental visit:*

- Dialogue between dentist and parent/caregiver regarding the child's health and dental history
- Dental caries risk assessment
- Dental examination
- Anticipatory guidance (advice about the child's health)
- Fluoride varnish
- Identifies other treatment needs

Head Start supports educational and classroom activities that inform and help children, parents and caregivers gain knowledge and build skills aimed at promoting the growth and healthy development of Head Start children. The *Choose and Use: Head Start Oral Health Curricula* guide provides information about oral-health-related curricula appropriate for use in Early Head Start and Head Start grantees.

# Financing Oral Health Care Services

Oral health care is an essential component of pediatric primary health care. Routine oral health assessment and preventive services help to attain and sustain oral health. The costs of these services are generally minimal once oral health is achieved. Often, however, comprehensive dental care requires treatment services that exceed routine assessments and prevention. These treatment services, which include restorations or fillings, crowns, extractions and sometimes interceptive orthodontic can be costly. Although preventing dental disease is the ideal way to minimize dental care costs, MSHS grantees should consider the costs of comprehensive treatment for each child when developing overall plans and budgets.

FQHCs provide a federal reimbursement mechanism fostered by Social Security. FQHCs are not limited to serving beneficiaries of Medicaid and Medicare.

There are several payment models to consider when financing dental care services. It is important for MSHS grantees and the FQHCs to have a mutual understanding of how their relationship will handle the financial aspects of their collaboration -- this includes funding mechanisms for both programs. The following provides a basic description of the different financial considerations.

## HEALTH INSURANCE, MEDICAID, AND CHIP

Health insurance generally refers to a type of insurance that pays for medical, dental, and hospital bills, and prescription costs. Health insurance benefits, both medical and dental, are generally administered by a central organization such as a government agency, private business, or not-for-profit entity. MSHS families, due to their income status, generally are eligible for health insurance benefits under the federal-state Medicaid or Children's Health Insurance Programs (CHIP). For Medicaid and CHIP eligible children dental benefits are included in this coverage.

The **Medicaid Program** is the federal entitlement program enacted in 1965 under Title XIX of the Social Security Act. It is jointly administrated by federal and state governments and charged with implementing the EPSDT program. It pays for "medically necessary" services, including dental care for enrollees (those individuals who meet specific age, health and income

eligibility requirements). All states participate in the Medicaid program; however, wide variability exists in coverage across the states. There are core eligibility requirements set by the federal government, but states may increase these limits to cover additional low-income beneficiaries. This is why eligibility, benefits and payment for services vary depending upon specific criteria set by each state Medicaid agency.

State Medicaid programs provide coverage for dental care for children and families who are income eligible. Often EPSDT examinations are the portals through which dental problems or the need for dental care is identified. Many state Medicaid programs also cover oral health care services for pregnant women with low incomes. At a minimum, these state Medicaid programs include dental services to relieve pain and infection, restore teeth, and maintain dental health.

Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.<sup>26</sup> States are required by the Centers for Medicare & Medicaid Services (CMS) to establish, update and publish a fee schedule of all allowable dental services covered under the pediatric Medicaid dental benefit. This schedule is most often accessible online via each state Medicaid program's website.<sup>27</sup> MSHS grantees should help facilitate the enrollment of children in Medicaid and explore Medicaid reimbursement for dental care services for each child eligible for the program.

The *Children's Health Insurance Program* (CHIP) is the federal-state medical assistance program that was enacted in 1997. This medical assistance program pays for health care

### **Key to Success**

#### **Programmatic and Financial**

**Resources:** Establishing a solid business plan which incorporates the costs for dental care services for MSHS children is essential. The plan should consider the availability of all resources, including third-party payment programs, such as Medicaid and CHIP. It should also incorporate early childhood evidence-based preventive care and quality dental health care assessment.

<sup>26</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html> and

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html>

<sup>27</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html>



services, including dental care, for children whose family's income is slightly higher than those eligible for Medicaid. The CHIP eligibility income scale, similar to Medicaid, differs by state; with the lower level threshold defined by the federal government. CHIP defines the dental benefit as those services "necessary to prevent disease and promote health, restore oral structures to health and function, and treat emergency conditions." MSHS grantees may consider the state CHIP program as a reimbursement source to dental providers for children whose family income exceeds the state Medicaid benefit and falls within the CHIP upper threshold limit.

**PAYMENT MODELS**

***Fee-for-Service*** (FFS) or Traditional Health Insurance is a payment model where fees are designated for individual services. Under this model, an individual goes to a dentist of their choice, receives dental care and pays a total amount based on the sum of the individual costs associated with each of the services provided. If the individual has private dental insurance, he/she may submit the claim to his/her insurance company for reimbursement of services

MSHS grantee administrators should be aware of the payment models used in their state and by local dental providers. This can help to budget resources, enroll children and families in Medicaid and CHIP programs; negotiate contracts; and, plan for dental services.

"covered." These insurance plans often require a copayment, impose annual deductibles and apply benefit limitations. FFS is the dominant payment method for dental care in the United States. It is the model traditionally used by state Medicaid agencies to pay dental providers that accept Medicaid. This model is also widely used by non-Medicaid participating dental providers and by some FQHCs.

***Managed Care*** is a payment model that uses a variety of strategies to reduce health care costs and improve the quality of services. Many state Medicaid agencies have contracted with managed care organizations (MCOs) to manage all or part of their dental benefits program. Under a state Medicaid-managed care contract, the state pays the MCO a capitated set amount per member per month for the services outlined in the contract. Although these contracts vary widely, a contracted MCO may: wholly or in-part administer the dental program for the state, establish a network of providers, coordinate care, and/or manage the payment for services

rendered. This is important for MSHS grantee administrators to be aware of as oftentimes MCOs appoint case managers to assist Medicaid families in accessing dental services. MSHS staff may establish a relationship with the MCO assigned to a MSHS family and serve as a liaison.

Often an individual state Medicaid agency will contract with multiple MCOs to administer the state dental program. This is important for MSHS administrators to be aware of as plan benefits differ among the various MCO vendors. These differences

often create complexity and confusion for MSHS families. In addition, in some states, families may be allowed to select a "plan," while in other states, they may be assigned. It is often difficult for families to make these choices when knowledge and understanding of health care and health insurance is limited. For example, in 2011, Arizona contracted with twelve managed care organizations (MCOs) to manage their dental benefits program and Texas contracted with three. As a result, multiple benefit plans were administered within the same state.

Multiple MCO vendors may be contracted by a state Medicaid agency. Each vendor may administer a different dental benefit package with a different fee structure. MSHS grantee administrators who understand each MCO vendor can provide guidance to families when selecting a plan.

***Prospective Payment System (PPS)*** is the primary method of payment for services provided by FQHCs. It is a reimbursement method where Medicaid payments for healthcare services, including dental care, are made based on a predetermined fixed amount. The fixed amount is established and updated as necessary based on a formula and the actual costs of services. The FQHC will generally know the method and amount paid by Medicaid in their state. In the event services are not covered by a third party, such as Medicaid, CHIP, or private insurance, the MSHS grantee will seek other methods for the payment—including being the payer of last resort.

# Planning Ahead

Contracting with FQHCs is an ideal strategy for accessing health care, including oral health care, services for MSHS children and their families. As noted earlier, FQHCs offer a wide array of primary health care, social and supplemental family support services. This section provides the steps for planning and successful partnering between a MSHS grantee, local FQHC, and other social and support services providers.

## GETTING STARTED

The key to effective partnering is planning. The first step in the planning process is for MSHS grantees and FQHCs to gain an understanding of the others' needs and service capacity. The best way to accomplish this is by planning and participating in specific meetings (i.e. Initial

### Key to Success

**Early Planning:** Early and thoughtful planning is essential. Planning ahead will provide ample time to address the details associated with the comprehensive provision of care.

Contact Meeting, Collaborative Planning Meeting, Planning Meetings Prior to Service Delivery, and Post Service Delivery Meeting/End of Year Meeting). These meetings include key management staff and decision makers from the FQHC and MSHS grantee, as well as other stakeholders. The purpose of the meetings is to develop a joint strategy for ongoing planning, service delivery and evaluation.

## INITIAL CONTACT MEETING

An initial contact meeting aims to introduce key individuals from each program that serve as the decision makers. This face-to-face meeting is important as it will help to build trust between the potential partners. During this meeting, administrators from the FQHC and MSHS grantee share key information on the need for services and benefits of collaboration. In addition, the two groups begin to identify resources, acknowledge existing services, and discuss the potential for a coordinated and collaborative plan.

*What are the goals of the initial contact meeting?*

- Establish a collaborative opportunity between the local FQHC and MSHS grantee to provide primary health care and dental services to MSHS children and their families.

- Explore additional opportunities to provide a home-base for health care, as well as other social and support services to MSHS children and their families.

After the initial contact meeting, input may be included from other staff, community representatives, such as local school administrators, social services, and employers.

*When should this meeting take place?*

The initial contact meeting should take place

approximately **six to nine months** before anticipated need for primary health care and dental services. The MSHS Executive Director or grantee appointee should send a letter of invitation to the Executive Director of the FQHC. The letter should include a brief summary of the MSHS grantee, along with the following information:

- Mission of the MSHS grantee
- Statement of recognition that the FQHC provides community-based primary care/dental care services
- Statement of alignment of services between the two programs
- Statement of need for medical, dental, behavior and other health services
- Invitation to partner
- Invitation to attend an initial contact meeting

No later than two weeks, the MSHS Executive Director should follow up with FQHC Executive Director to arrange a face-to-face meeting.

*Who should attend?*

Key strategic partners and decision makers should be present. This includes:

- MSHS Executive Director
- MSHS Health Manager
- MSHS Chief Financial Officer
- FQHC Executive Director
- FQHC Medical and Dental Director
- FQHC Chief Financial Officer

*What information should be shared and discussed?*

Each agency should bring information to share that provides an overview of the program and

its services. These items will help to facilitate discussion on whether the FQHC and MSHS administrators decide if a partnership is feasible. For more information on what should be included, see Box 1 and 2.

As a result of the initial contact meeting, the two parties should decide on a date when a decision will be made whether to partner. If the FQHC and MSHS grantee decide to partner, future meetings dates should be scheduled to continue the discussion to coordinate a plan.

**Figure 1: Example Timeframe**



### **Box 1: MSHS Grantee Overview**

- Grantee name
- Contact person(s): name, title (responsibility), telephone, number(s), email
- MSHS eligibility criteria
- Background data:
  - # and location of grantee sites; # of classrooms
  - # of current MSHS families; # of enrolled children; # of non-enrolled siblings
  - # of children eligible for Medicaid and/or Children's Health Insurance Program (CHIP)
  - # of children not eligible for Medicaid, CHIP, or any other third-party insurance
  - Enrollment and service needs justification (review last two years assessment data)
  - Timeline for anticipated services (review trends from last two years )
  - When did families arrive and depart?
  - How long did families stay in the community?
- If treatment needs are not completed or a future referral is needed, the FQHC should refer the child and family to an FQHC near the family's future work site. [HRSA's Find a Health Center.](#)
- Service needs for each child:
  - Enrollment in Medicaid or CHIP if eligible
  - Dental and primary healthcare examination
  - Treatment plan
  - Prophylaxis
  - Fluoride treatment
  - X-rays if indicated
  - Therapeutic (restorative) services if indicated
  - Referral to specialty care if indicated
  - Transition plan: Referral list of FQHCs along the route the MSHS family will follow
  - Provision for emergency care
  - Provision for after-hour care
  - Linkage to primary care provider: medical care; any special health or dental needs anticipated
  - Additional primary healthcare social and support service needs of the MSHS grantee, children and their families
  - An estimated timeline for each child that includes the anticipated arrival and departure date, if known, and the maximum amount of time to schedule services.

**Box 2: Federally Qualified Health Center**

- Name of the FQHC
- Contact information:
  - Contact name
  - Address
  - Telephone number
  - Email
- Number and location of site(s) and outreach service locations
- Hours of operation
- Services provided by the FQHC by site/location:
  - Dental
  - Primary Care
  - Social
  - Other Support
  - Linkages to services not provided by FQHC
  - After-hour coverage
  - Provisions for emergency care
  - Specialized dental care; i.e. Transitional care; pediatric specialty on site, etc.
- Current and anticipated service capacity: FQHCs should share information about the number of dental providers in their center, and their ability to augment service capacity by hiring additional temporary providers to meet the needs of the MSHS grantees
- Any unique or special information
- Other items for discussion

## COLLABORATIVE PLANNING MEETING

The purpose of the collaborative planning meeting is for MSHS and FQHC administrators to meet face-to-face to devise a mutual plan that will address the needs of the:

- Children and their families
- MSHS grantee
- FQHC

*What are the goals of the Collaborative Planning Meeting?*

- Identify, detail and document scope of services and responsibilities of each party.
- Create a joint service agreement signed by both parties, such as a Memorandum of Understanding, Memorandum of Agreement or service contract.

*When should this meeting take place?*

The Collaborative Planning meeting should take place no more than 30 days after the initial contact meeting.

*Who should attend?*

Decision makers, managers and key personnel should be present at the planning meeting. These individuals may include:

- MSHS Executive Director
- MSHS Health Manager
- FQHC Executive Director
- FQHC Medical and Dental Director
- Key FQHC dental clinic staff
- Other staff, as appropriate

### **Key to Success**

**Accountability:** An MOU, MOA, or service contract will formalize the partnership and detail the roles and responsibilities of each partner. It will help to reduce any confusion or uncertainty down the road and ensure that needs of both groups are adequately be addressed.

*What information should be shared and discussed.*



1. Child and family services that will be provided: dental; primary care; social; other support services (including HIPAA requirements)
  - Who will be responsible for enrolling MSHS children in Medicaid and CHIP
  - Provision for continuity of care
  - Logistical issues
  - Timeline for planning and services
  - Fees and/or negotiated rate for services
  - Roles and responsibilities of both programs (including inter-professional referrals)
  - Patient records
  - Names of key individuals who will be responsible for the oversight, implementation and evaluation of the program
  - Specific MSHS grantee and FQHC needs and the capacity of each program to address those needs. Example: PIR data; other federal reporting requirements
2. Key individuals should develop the agreement or MOU. An administrator from either the MSHS or FQHC may write up the agreement. Both MSHS and FQHC administrators should review it carefully for clarity and accuracy. Executive Directors from both programs and/or their appointees should sign the agreement.
3. Tentative Schedule/plan for upcoming meetings.

### **PLANNING MEETINGS PRIOR TO SERVICE DELIVERY**

Once a MOU, MOA, or service agreement has been signed by the MSHS and FQHC administrators, a schedule for ongoing meetings should be established. The purpose of meeting regularly is to ensure that all activities are occurring as planned. During these meetings, executive directors may request additional information from each other or from program staff; and program staff may report any emerging issues for consideration and/or resolution by the joint group. These meetings are essential to continuing to build trust and camaraderie among all involved.

The following topics can be used to develop an agenda:

- Transportation
- Interpretation
- Scheduling appointments; time “slots/blocks”
- Data collection, including PIR
- Sharing dental and health records
- Parental consent forms
- Referrals to other FQHCs
- Custodial supervision of children while children wait for services
- Children with special health needs
- Needs of other family members
- Policy or protocol for dental and primary healthcare services and treatment plans
- Policy or protocol for treatment plans not completed

Often EPSDT examinations are the portals through which dental problems are identified. If a dental problem is identified, MSHS grantee administrators should work with the FQHC administrators to plan and coordinate care and identify a negotiated rate for non-insured patients.

### **POST SERVICE DELIVERY MEETING/END OF THE YEAR MEETING**

The purpose of the post-service delivery meeting is to assess the process and outcomes of the MSHS-FQHC partnership. The following questions should be considered during the meeting.

- Were all program objectives accomplished? If no, what services were not completed and why?
- Were any challenges observed or encountered?
- Did all MSHS children receive their planned dental care services? If not, why?
- Was the collaborative relationship beneficial for both the MSHS and FQHCs?
- Does the infrastructure, format and fees for the delivery of program services adequately support and promote program sustainability?
- Are there any suggested program modifications that could potentially improve the processes or outcomes?
- Were patients who needed additional treatment referred to the FQHC nearest the family's future worksite? If not, where were they referred?

The measures of program data in Table 4 can be collected in a similar grid. Note any challenges in meeting the total children eligible for services.

**Table 4:**

<b>Services</b>	<b>#Children Served (ages 3-5)</b>	<b># Eligible Children Served (ages 3-5)</b>	<b># Children Served (ages 0-3)</b>
<b>Enrolled in Medicaid or CHIP</b>			
<b>Received an Oral Exam</b>			
<b>Received a treatment plan</b>			
<b>Received a dental Prophylaxis</b>			
<b>Received a fluoride treatment</b>			
<b>Received X-rays</b>			
<b>Received therapeutic (restorative) services</b>			
<b>Referred to specialty care</b>			
<b>Provided a list of FQHCs</b>			
<b>Provided instructions for emergency care</b>			
<b>Provided instructions for after hour care</b>			
<b>Provided linkage or referral to primary care provider—medical care</b>			

## **Other Considerations**

Migrant and Seasonal Head Start grantees and Federally Qualified Health Centers (referred to in some places as Community Health Centers) are dedicated to serving the health and welfare of migrant and seasonal farmworkers. Both entities receive special funding to provide access to primary health care and oral health care services. However, there may be a disconnect between local, regional, and national organizations on how these valuable community assets can collaborate to develop a system of care. There are often misunderstandings regarding roles, responsibilities and resources. Successful implementation of the oral services care plan requires understanding and cooperation among all persons involved. This includes not only the administrators, but all team members, support staff, clinicians and facilitators. Their combined input, along with other key stakeholders in planning and implementation is essential to create the buy-in to make the collaboration successful.

## **BEST PRACTICES**

Over the last decade many grantees across the states have documented successful outcomes in their oral health education, prevention and access to care efforts for early childhood groups. These best practices have detailed the design, planning, partnering and management principles associated with their success. In general, MSHS and FQHCs should consider developing and implementing best practice strategies that are evidenced-based. Evidence includes research, expert opinion, field lessons, and theoretical rationale. The following websites contain detailed information on best practices and successful strategies for early childhood oral health programs:

**Office of Head Start**—[Early Childhood Learning & Knowledge Center](#)

**Association of State and Territorial Dental Directors**—[Best Practice Approaches](#)

# Resources

Numerous additional resources have been established by the following professional organizations and agencies. Their websites may be accessed by clicking on the links below.

## Other Oral Health Resources

- [Office of Head Start's National Center on Health](#)
- [National Maternal and Child Oral Health Resource Center](#)

## Federal Agencies

- [Centers for Medicare & Medicaid Services](#)
  - [Children's Health Insurance Program \(CHIP\)](#)
  - [Medicaid](#)
  - [Medicaid/CHIP Dental](#)
- [Health Resources and Services Administration](#)
  - [Maternal and Child Health Bureau](#)
- [Medicaid and CHIP Payment and Access Commission \(MACPAC\)](#)
- [National Institute of Dental and Craniofacial Research](#)
- [Office of Head Start](#)

## Payers

- [Delta Dental](#)
- [DentaQuest](#)
- [Scion](#)

## Philanthropy

- [DentaQuest Foundation](#)
- [Kaiser Family Foundation](#)
- [W.K. Kellogg Foundation](#)

## **Policy Makers**

- [Children's Dental Health Project](#)
- [National Conference of State Legislatures](#)
- [National Governor's Association](#)

## **Professional Organizations**

- [American Association of Public Health Dentistry](#)
- [Association of Clinicians for the Underserved](#)
- [Association of State and Territorial Dental Directors](#)
- [Center for Health Care Strategies](#)
- [Children's Alliance](#)
- [International Association for Disabilities and Oral Health](#)
- [Medicaid-CHIP State Dental Association](#)
- [Migrant Clinicians Network](#)
- [National Center for Farmworker Health \(NCFH\)](#)
- [National Academy for State Health Policy](#)
- [National Association of State Medicaid Directors](#)
- [National Association of Dental Plans](#)
- [National Maternal and Child Oral Health Policy Center](#)
- [National Maternal and Child Oral Health Resource Center](#)
- [Oral Health America](#)
- [Organization for Safety, Asepsis and Prevention](#)

## **Provider Associations and Professional Organizations**

- [Academy of General Dentistry](#)
- [American Academy of Pediatric Dentistry](#)
- [American Academy of Pediatrics' Children's Oral Health](#)
- [American Academy of Periodontology](#)
- [American Association of Endodontists](#)
- [American Association of Oral & Maxillofacial Surgeons](#)
- [American Association of Orthodontists](#)

- [American Dental Assistant's Association](#)
- [American Dental Association](#)
- [American Dental Hygienists' Association](#)
- [American Society of Dentist Anesthesiologists](#)
- [Hispanic Dental Association](#)
- [National Dental Association](#)