



Head Start Oral Health State Activities

The National Center on Health (NCH) prepared the following to provide a brief description of Head Start oral health activities in the areas of oral health education, disease prevention, and treatment programs from a few states. Contact information for each activity is provided so that Head Start staff can request additional information. We hope that sharing information about activities will lead to increased efforts to improve the oral health services for children and pregnant women enrolled in Head Start and their families. For detailed information about each state activity, see the state submission forms following the summary.

Building Successful Collaborative State Oral Health Consortiums

A two-state initiative funded by the DentaQuest Foundation this builds upon a previous DentaQuest grant to the Massachusetts Head Start Association (MHSA) to address oral health disparities and promote access to care for children enrolled in Head Start in Massachusetts. As part of its current initiative, MHSA has shared strategies and lessons learned with the Pennsylvania Head Start Associations related to building community awareness and promoting the importance of oral health through state-level community engagement, community network building, strengthening of key partnerships, and targeted education to improve the delivery of primary preventive oral health care for young children, especially those at high risk for oral disease such as children enrolled in Head Start.

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Pennsylvania	<u>7</u>

National Center on Health Dental Hygienist Liaison Project

In response to the need to locate dental homes for children enrolled in Head Start, NCH and the American Dental Hygienists’ Association work collaboratively to recruit a volunteer in each state to act as a dental hygienist liaison (DHL) to Head Start programs. The DHL provides a communication link between NCH and state Head Start oral activities and programs. Michigan and Kansas DHLs serve as examples of the services provided through this project and illustrate the project’s impact on children’s access to care.

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Rural Teledentistry Pilot Program in Kindercamps

An affiliated practice dental hygienist provides oral health assessments; preventive oral health services, including fluoride varnish application; and triage at local Head Start Kindercamps (health fair events). Using teledentistry equipment, a pediatric dentist provides diagnosis and treatment planning. Parents are contacted to set up treatment appointments in the dental office.

Arizona	<u>17</u>
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San Antonio Head Start Oral Health Program

Metro Health partners with Head Start agencies in Bexar County to provide oral health services, including onsite oral health screenings, fluoride varnish application, referrals, individualized case management, oral health education to Head Start teachers and other staff, implementation of the *Cavity Free Kids* oral health curriculum, training and technical assistance, data management, and leveraging of funding for clinical services for underinsured children. Additionally, Metro Health collaborates with the University of Texas Health Science Center Dental School, allowing dental and dental hygiene students to gain experience working in the Head Start community.

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Head Start Oral Health State Activities Submission Form

Building Successful Collaborative State Oral Health Consortia A grant from the DentaQuest Foundation to the Massachusetts Head Start Association, in partnership the Pennsylvania Head Start Association

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Below is a summary of a successful Head Start oral health state activity (e.g., practice, program, service, event, policy).

State/Territory: Massachusetts

Activity

Note: MA and PA state activities and results are reported separately. What follows is a summary of the activities and impacts in MA, as well as some lessons learned from the two-state initiative. For additional information on activities and impacts in PA, see *Building Successful Collaborative State Oral Health Consortia* PA narrative.

With a grant from the DentaQuest Foundation, the MA and PA Head Start Associations (MHSA and PHSA) are engaged in the final year of a three-year effort, *Building Successful Collaborative State Oral Health Consortia*. This two-state initiative builds upon the success of a previous DentaQuest grant to MHSA to address oral health disparities and promote access to care for MA Head Start children. In our current initiative MHSA has shared strategies and lessons learned with PHSA regarding how to build community awareness of the importance of oral health through state-level community engagement, community network-building, strengthening of key partnerships, and targeted education to improve the delivery of primary preventive oral health care for young children, especially at risk populations such as Head Start. Specifically, we have focused on: 1) developing effective state oral health coalitions by developing a consortium model to connect key stakeholders to Head Start; 2) promoting oral health education and consistent oral health messaging across children's medical, dental and educational homes; and 3)

increasing access to oral health care by connecting Head Start children to dental homes beginning with the age 1 visit. We recently broadcast a webinar on our project for the Association of State and Territorial Dental Directors (ASTDD), and we are currently working on a toolkit of resources for groups that may be interested in replicating the consortium model in their state.

Note: MA and PA state activities and results are reported separately. What follows is a summary of the activities and impacts in MA, as well as some lessons learned from our two-state initiative. For additional information on activities and impacts in PA, see *Building Successful Collaborative State Oral Health Consortia* PA narrative.

1) *Developing effective state oral health coalitions.* In our first grant, we established the MA Early Childhood Oral Health Consortium, convening key stakeholders to partner with the State Head Start Association. While MHSA is the fiduciary agent for the grant, the Consortium guides all of our activities. Members of the Consortium include representatives from: MHSA, MA Dental Society (MDS), MA Chapter of the American Academy of Pediatric Dentistry, MA Chapter of the American Academy of Pediatrics (MCAAP Oral Health Chapter Advocate), MA Academy of Family Physicians (MassAFP), MA League of Community Health Centers, MassHealth Dental Program (the only MA MCO), MA Department of Public Health, MA Office of Oral Health (OOH), MA WIC, Boston Children's Hospital Dental Clinic, Boston University Goldman School of Dental Medicine, Tufts University Public Health and Community Services Program, Commonwealth Mobile Oral Health Services Program, and the NCH Dental Hygienist Liaisons. Meetings are held three times a year. Membership is voluntary, and members receive no compensation for their participation.

The MA project leadership team includes the project director (formerly 8 hours/week; now 4), the state Head Start oral health coordinator (formerly 12 hours/week; now 4), and a pediatric dentist consultant.

Members of the leadership team represent the interests of Head Start children on various state level workgroups such as (partial list):

- MCAAP Oral Health Committee.
- MA Better Oral Health Coalition.
- Massachusetts Perinatal Oral Health Guidelines Project (DPH workgroup currently developing state oral health guidelines for children and pregnant women).

2) *Promoting oral health education and consistent oral health messaging.* To raise awareness of the importance of oral health and encourage Head Start teachers to incorporate oral health into their lesson plans, in our first grant we trained all MA HS programs (100% of programs) in *Cavity Free Kids*, an evidence-based oral health curriculum. We developed the *Head Start Family Oral Health Guide* to educate Head Start families, which we translated into 10 languages. It is available for download free at <http://www.massheadstart.org/oral-health.php>. We also wrote a children's oral health book, *Happy, Healthy Teeth*, that includes the importance of going to the dentist starting at age one. To promote consistent oral health messages across children's medical, dental and educational homes in our current grant, we developed the *Doctor's Guide to Oral*

Health Communication that has been disseminated by the MDS and MCAAP to its members, and shared with Head Start programs; we also worked with the MA OOH and MDS to add consistent oral health messages to a map of fluoridated communities in MA that the MDS and MCAAP disseminated to all of its members. We also developed additional oral health messages for families.

3) *Connecting Head Start children to dental homes beginning with the age 1 visit.* While we achieved progress in connecting preschool Head Start children to dental homes, we encountered difficulty in finding providers willing to treat children at the eruption of the first tooth and no later than 12 months of age, as required by our state EPSDT dental periodicity schedule. In 2011 the Consortium helped the MDS survey its members about dental practice. While 95% of MassHealth (Medicaid) members have at least 2 providers, either a general or a pediatric dentist, within 5 miles of their home, only 19% of MDS members reported that they accepted children at age one (vs. age three). Accordingly, we developed and branded an age one initiative, called *Connect the Dots*. The MDS Director of Dental Practice, grant project director, our pediatric dental consultant, and MCAAP Chapter Advocate developed a presentation for general dentists and physicians about the importance of establishing a dental home by age one, a description of the first visit including how to do a knee-to-knee exam and apply fluoride varnish, suggestions about how to incorporate very young children into a dental practice, and an explanation of how to bill for dental exams. We have held trainings at MDS and three district meetings, as well as at an annual meeting of Community Health Center medical and dental directors. In addition, our pediatric dental consultant has conducted trainings at the Yankee Dental Congress. To date we have reached approximately 200 dentists. We developed a *Connect the Dots* handbook with the *Doctor's Guide*, information on caries risk assessments to share with physicians, and information on Head Start programs. Our Oral Health Coordinator has followed up with dentists who attended *Connect the Dots* events, has helped to link them to local pediatricians and Head Start programs, and has responded to requests to identify dental practices that will accept children at age one. Consortium members submitted oral health articles for MCAAP newsletters, and journal articles for a special MDS Age One journal that received a national award. MDS also instituted an age one public relations campaign, set up a special age one section of its website, and encouraged members to modify their profile and add age one practice when applicable. In 2013 we surveyed MDS members again, and in only two years, the number of dentists reporting that they treat children at age one increased from 19% to almost 40%.

Lessons Learned

- The most important lesson that we learned from our collaboration with PA was the need to balance our desire to share our experiences and lessons learned with the recognition that each state has a unique set of strengths and challenges, and will need to adapt the strategies shared to meet the unique characteristics of their own state.
- Successful collaboration and engagement require transparency, open communication and clear, written expectations regarding roles and responsibilities, as well as a willingness to embrace new ideas and share ownership of the project. We struggled a bit initially, but ultimately were able to work through this. When this is accomplished, both states can learn from each other.

- It is helpful to conduct a gap analysis early on to determine if there are any key stakeholders missing.
- Regarding the promotion of the age one visit, practice change takes time. It requires repeated and coordinated efforts to raise awareness, shift attitudes, and provide new knowledge. Branding is an effective strategy. It is also important to use a data driven approach. Our surveys of MDS members included questions about barriers and challenges to age one care that helped to inform our strategies.
- Consistent messaging is important as families report that they are confused when they don't hear the same oral health message from their medical and dental and educational providers.
- It is difficult for many families to prioritize and follow up on oral health treatment. Families need continuous, simple, and easy to understand oral health educational messages.

The most important lesson that we learned overall is that a consortium is a highly effective approach to state coalition building to improve the delivery of primary preventive oral health care for young children. Many of our partners have worked together for more than 7 years, and are highly committed after the grant ends to sustaining the progress we have made in our state to improve access to oral health care for vulnerable populations like Head Start.



Head Start Oral Health State Activities: Submission Form

Building Successful Collaborative State Oral Health Consortiums A grant from the DentaQuest Foundation to the Massachusetts Head Start Association, in partnership the Pennsylvania Head Start Association

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Below is a summary of a successful Head Start oral health state activity (e.g., practice, program, service, event, policy).

State/Territory: Pennsylvania

Activity

Note: MA and PA state activities and results are reported separately. What follows is a summary of the activities and impacts in PA, as well as some lessons learned from the two-state initiative. For additional information on activities and impacts in MA, see *Building Successful Collaborative State Oral Health Consortiums* MA narrative.

With a grant from the DentaQuest Foundation, the MA and PA Head Start Associations (MHSA and PHSA) are engaged in the final year of a three-year effort, *Building Successful Collaborative State Oral Health Consortiums*. This two-state initiative builds upon the success of a previous DentaQuest grant to MHSA to address oral health disparities and promote access to care for MA Head Start children. In our current initiative MHSA has shared strategies and lessons learned with PHSA regarding how to build community awareness of the importance of oral health through state-level community engagement, community network-building, strengthening of key partnerships, and targeted education to improve the delivery of primary preventive oral health care for young children, especially at risk populations such as Head Start. Specifically, we have focused on: 1) developing effective state oral health coalitions by developing a consortium

model to connect key stakeholders to Head Start; 2) promoting oral health education & consistent oral health messaging across children’s medical, dental & educational homes; and 3) increasing access to oral health care by connecting Head Start children to dental homes beginning with the age 1 visit. We recently broadcast a webinar on our project for the Association of State and Territorial Dental Directors (ASTDD), and we are currently working on a toolkit of resources for groups that may be interested in replicating the consortium model in their state.

Note: MA and PA state activities and results are reported separately. What follows is a summary of the activities and impacts in PA, as well as some lessons learned from our two-state initiative. For additional information on activities and impacts in MA, see *Building Successful Collaborative State Oral Health Consortia* MA narrative.

1) *Developing effective state oral health coalitions.* In December 2009, a PA leadership team with key state partners came together to launch the “Healthy Smiles, Happy Children: A Dentist for Every Child Initiative.” Members included then Region III ACF/OHS Oral Health Consultant (Dr. Harry Goodman, DMD, MPH) and then Region III Head Start Health Specialist (Amy Requa), the PHSA Executive Director (Blair Hyatt), the PA Head Start State Collaboration Office Director (Tracey Campanini), and our State Medicaid Agency partner (Dr. Paul Westerberg, DDS, MBA, Chief Dental Officer at the PA Department of Public Welfare’s Office of Medical Assistance Programs). The Leadership team planned the launch of our “Healthy Smiles” initiative through 3 regional oral health forums, bringing together key stakeholders, including Head Start/Early Head Start programs and Dental Providers representing the Eastern, Northern Tier, and Western regions of PA, each with its own unique access to care gaps and barriers, challenges to communication and collaboration, as well as geographical considerations. Combined, the forums reached over 175 participants. Summaries of issues, barriers, and recommendations were compiled from all 3 forums, along with a unanimous call to action for the formation of a state-level Oral Health Task Force for Head Start.

The “PA Healthy Smiles Task Force” was convened by PHSA in January 2011 to implement the forum recommendations. The purpose of our Task Force is to address the oral health status and educational needs of our most vulnerable children and families, and to implement strategies and recommendations for improving access to, and utilization of, comprehensive oral health services. Our Task Force goals are to: 1) Establish dental homes for children; 2) Educate everyone to prevent oral diseases by fostering health promotion practices early in life; 3) Forge collaborations to improve access for our Head Start children, engaging the providers who would serve our children; and 4) Build lasting relationships with the dental community as a foundation for sustainable work together.

Our Task Force work dovetailed with the Office of Head Start’s Dental Home Initiative, launched in PA in May of 2011, and over the past 3 years, we’ve been providing ongoing networking and relationship-building opportunities with dental providers, such as through collaboration with the PA Dental Association and PA Dental Hygienists Association, to address the needs of Head Start children, including infants and toddlers, and to provide necessary follow up treatment, as well as to understand the unique needs of families on Medical Assistance. Our Healthy Smiles Task Force is committed to developing an ongoing plan and process to improve

access to comprehensive oral health services in local communities and to provide oral health education to empower families to utilize these services. Through this work together, we are raising the bar and closing the gaps, and we feel that we are moving oral health policy forward to improve the oral health and well being outcomes of at-risk families.

The PA Healthy Smiles Task Force is charged with:

- Engaging in ongoing networking and professional support for dental providers to serve Head Start.
- Implementing oral health promotion education that effectively communicates the importance of oral health and evidence-based disease prevention approaches for parents, families, staff, and community.
- Developing an ongoing state-level plan and process to sustain concrete improvements for Head Start.
- Supporting the movement of state policy to improve oral health status and well-being for vulnerable families and children, through better service access, utilization, and education.

Healthy Smiles Task Force Goals and Objectives:

1. *Improving Access to Care* by building and sustaining a network of providers who serve Head Start children and families through continuously accessible Dental Homes affiliated with the 9 Managed Care Organizations (MCOs) across the state.
2. *Promoting Education of Parents, Families, Staff, and Community* by applying best practices in adult learning and oral health promotion for all audiences through professional development opportunities, such as *Cavity Free Kids* training.
3. *Fostering Dental Provider Collaboration* by continuing to build a network of dental providers to serve Head Start children, starting in the first year of life, and to understand the unique needs of the Head Start Community, and to promote successful collaborations between dental providers and Head Start programs in local communities through professional education.
4. *Mobilizing Institutions, Organizations, and Individuals* in developing community outreach opportunities for Head Start and engaging the dental provider community by strengthening collaboration with key stakeholders, including dental schools, dental associations, state agencies, public/private organizations, community partners, and child advocates.

Healthy Smiles Task Force Membership Commitment:

1. At least 2 face-to-face meetings every year (usually Spring and Fall).
2. Quarterly updates by conference call or webinar.
3. Self-organized subcommittee calls throughout the year as needed to meet goals and objectives.

Healthy Smiles Task Force Leadership

From January of 2011 to March of 2012, leadership for the Task Force included Blair Hyatt, E.D. of PHSA, and Amy Requa, then a Health Consultant working under an independent

contractor agreement for the PA Head Start State Collaboration Office (PA HSSCO). In April of 2012, Amy Requa was hired by PHSA and accepted a full-time salaried position (35 hours per week) as the State Oral Health Coordinator under the DentaQuest Foundation Grant with Massachusetts Head Start Association. The PA core leadership team for the DentaQuest Foundation Grant with MA includes Blair Hyatt, E.D. of PHSA, Amy Requa, Dr. Harry Goodman (dentist consultant), and Lisa Schildhorn, Executive Director of the Pennsylvania Coalition for Oral Health (PCOH). In her role as State Oral Health Coordinator, Amy Requa manages the operations and is responsible for all PA specific deliverables of the DentaQuest Foundation Grant with Massachusetts, as well as representing the interests of Head Start children and families on the Leadership Team for “Healthy Teeth, Healthy Children”, an oral health initiative of the PA Chapter, American Academy of Pediatrics (currently funded through an Oral Health 2014 Grant from the DentaQuest Foundation), and the Steering Committee for the PA Coalition for Oral Health (PCOH). In addition to her role as the State Oral Health Coordinator for the DentaQuest Foundation Grant, Amy provides ongoing leadership support for the Task Force as an independent consultant, due to the continued funding commitment from the PA HSSCO.

2) *Promoting oral health education and consistent oral health messaging.* Starting in June 2012, we began our educational outreach initiative to address the importance of oral health and to encourage Head Start teachers to incorporate oral health into their lesson plans, by following the lead of Massachusetts in adopting the *Cavity Free Kids* curriculum, an evidence-based oral health curriculum, delivered through multiple train-the-trainer courses across Pennsylvania. At each Cavity Free Kids Train-the-Trainer course, we distributed the Massachusetts’ *Head Start Family Oral Health Guide* to educate Head Start families, and the oral health book, *Happy, Healthy Teeth*, depicting the importance of seeing a dentist starting at age one. To promote consistent oral health messages across children’s medical, dental and educational homes, we adapted MHSA’s *Doctor’s Guide to Oral Health Communication* for our professional development offerings to medical and dental providers, in collaboration with the PA Chapter, American Academy of Pediatrics. Thus far, after conducting 5 train-the-trainer sessions, we have reached approximately 85% of our Head Start grantees across 67 counties (note that PA has three times the number of Head Start programs as Massachusetts), and to date, we have trained over 210 trainers of Cavity Free Kids, to include staff from Early Head Start and Head Start; the Maternal, Infant & Early Childhood Home Visitor (MIECHV) grantees; child care health consultants; infant/toddler specialists; health coordinators; teachers; family advocates; family support personnel; home visitors who work directly with families; center/site managers; health/nutrition coordinators; education managers/specialists who support curriculum implementation and who have the capacity to train others; community outreach professionals, such as dental hygienists, public health dental hygiene practitioners, health educators, and public health dentists and those who are committed to promoting oral health in infants, toddlers, pregnant women, young children, and families. For more information about *Cavity Free Kids*, go to: <http://www.cavityfreekids.org/>

3) *Connecting Head Start children to dental homes beginning with the age 1 visit.* As an outcome of the our DentaQuest Foundation Grant funding in collaboration with Massachusetts Head Start Association, in early 2012, we began to experience significant traction in our work with our key partners leading to the implementation of some promising practices and strategies.

In July 2012, an internal Operations Memorandum from the PA Department of Public Welfare, Office of Medical Assistance Programs, was directed to the state's contracted Medicaid Managed Care Organizations, or MCOs, of which there are currently 9, supporting the collaborative partnership between the Department and the Head Start Healthy Smiles Task Force. This Operations Memo described how the Office of Medical Assistance Programs (OMAP), the HealthChoices Managed Care Organizations and their participating dental networks, would collaborate to develop a process of coordinated dental care for the children enrolled in the local Head Start programs across the state. The Memo indicated there was a great need for better care coordination between the MCOs and the local Head Start Programs in each county and zone served by the MCOs. Also, the MCOs were encouraged to address issues pertaining to other EPSDT-related services beyond oral health services through this effort. The resulting "MCO-Head Start Liaison Project" was initially piloted in 2012 in selected Head Start programs from the Southwest HealthChoices Region of Pennsylvania, which were experiencing significant barriers to obtaining follow-up services for children with oral health treatment needs. Over the course of the pilot project, improvements in gaining access to appropriate follow up treatment services were reported by the Head Start pilot sites as a result of the increased communication and collaboration with the MCO Head Start Liaisons. This is an innovative partnership whereby each MCO assigns 1 MCO-HS Liaison, who is housed in their Special Needs Unit, to work directly with each Head Start program located within their service areas. Likewise, each Head Start program assigns a point person to work with the MCO-HS Liaison. Many of the internal Head Start point of contacts are Health Coordinators or Family Services Coordinators. Both the MCO-HS Liaison and the internal Head Start point persons are called upon to reach out to each other, shake hands, and to build their relationships, being responsible to communicate unique needs to each other, to describe the barriers and challenges, and to do real problem-solving together, working together to bring children into dental homes and to obtain the appropriate level of care through follow-up treatment. Because of the success of the initial pilot project in 2012, the Office of Medical Assistance Programs expanded the MCO-HS Liaison Project in 2013 to all of the HealthChoices Regions, and all 9 of the MCOs, thereby reaching every HS program in all 67 counties of Pennsylvania. As a result of this partnership building initiative, 100% of the Medicaid Managed Care Plans participated in our October 2012 Healthy Smiles Task Force meeting – a marker of excellent progress. Since 2012, the MCOs continue to send representatives to Head Start Task Force meetings, PHSA conference sessions, health coordinator roundtable sessions, and Head Start Administrators Meetings on a quarterly basis.

It is important to note that developing collaborative relationships between the 9 MCO-Liaisons and the Head Start programs across PA is a process. PHSA is nurturing this relationship through frequent face-to-face networking opportunities at Task Force meetings, state conferences, MCO Directors Meetings, and Head Start roundtables, which provides the glue to bind us together more and more. Beginning in April 2014, we started having monthly conference calls with Head Start staff and the MCO-HS Liaisons. With support from the PA Department of Public Welfare, PHSA has been invited at least once per year since 2012 to present to the MCO Medical and Dental Directors to get their buy-in as well.

Over time, we have learned that these personal relationships are the true foundation, enabling us to pave the way for new discussions and efforts at promising practices, which include having signed Business Associate Agreements and Service Coordination Agreements between each of

the Head Start programs and each of the MCOs. Through these relationships, we are taking concrete steps to share information about individual children and what these children need to be up-to-date on the Medicaid EPSDT schedule for medical and dental services, so it's not limited to only the dental periodicity schedule. We each have a role and we try to avoid redundancy in this collaborative care coordination system. The Head Start program first works diligently with each family to identify and secure a dental and a medical home when families enroll in the program, as we are required to do in the HS Performance Standards. But as programs identify those children needing follow up, and they begin to encounter multiple barriers and challenges to getting these treatment services, this is the point at which we ask our Head Start programs to reach out to the designated MCO-Head Start Liaisons. This is similar to a pyramid model. Head Start staff work in an ongoing way at the bottom of the pyramid on the day to day collaboration with families to connect them to dental services, and as challenges to accessing services emerge and persist, these specific needs rise to the top of the pyramid, requiring MCO Liaison involvement in problem-solving and care coordination.

Most recently, Amy Requa was invited by Laurie Norris, JD, the Senior Policy Advisor and Coordinator for the CMS Oral Health Initiative at the Center for Medicaid and CHIP Services, to serve as Guest Faculty, with Marco Beltran (Office of Head Start) and Dr. Paul Westerberg (PA Department of Public Welfare), for the September 16, 2014 CMS Learning Lab: Building a Partnership Between Medicaid and Head Start, as part of their regular webinar series titled *CMS Learning Lab: Improving Oral Health Through Access*.

Another promising strategy, designed to improve access to comprehensive oral health services starting at age one, is to address the professional development needs of the general dentist workforce to implement the age one dental visit as the standard of care, especially in our rural areas. To meet this need, we are actively disseminating our adaptation of the branded age one initiative called "Connect the Dots" from Massachusetts. Our "PA Age One Connect The Dots" program is leveraged with the support of a \$25,000 grant awarded through the Dental Trade Alliance Foundation (DTAF). The grant period is from October 2013 to December 2014. Our goal is to educate 150 general dentists and dental hygienists to serve young children by performing the knee-to-knee exams according to national standards by Age One. As a result of educating our general dentists, we are improving access to comprehensive services and helping them to put this into practice using hands-on demonstrations, materials, and supplies. To date, we've reached over 140 dental professionals in the southeastern region of our state and we're collaborating with the PA Dental Association and PA Dental Hygienists Association, as well as UPMC (Managed Care Organization) and the University of Pittsburgh School of Dental Medicine to reach the western region of our state in November 2014. We are providing ongoing follow-up technical assistance to everyone who is trained via email and telephone support, and we are connecting interested dental providers to the Medicaid agency to enroll as Medical Assistance Providers, in hopes that they will serve Head Start children and families, if they aren't already. Due to our work with "PA Age One Connect the Dots" in PA, we have motivated the state to revise its Medical Assistance Fee Schedule, currently in process and approved by state policy leaders, to include code D0145 on the MA Fee Schedule for an initial comprehensive dental visit as well as ongoing dental visits for children under age 3.

Lessons Learned

- The most important lesson that we learned from our collaboration with MA was the need to balance our desire to share our experiences and lessons learned with the recognition that each state has a unique set of strengths and challenges, and will need to adapt the strategies shared to meet the unique characteristics of their own state.
- Successful collaboration and engagement require transparency, open communication and clear, written expectations regarding roles and responsibilities, as well as a willingness to embrace new ideas and share ownership of the project. We struggled a bit initially, but ultimately were able to work through this. When this is accomplished, both states can learn from each other.
- It is helpful to conduct a gap analysis early on to determine if there are any key stakeholders missing.
- Regarding the promotion of the age one visit, practice change takes time. It requires repeated and coordinated efforts to raise awareness, shift attitudes, and provide new knowledge. Branding is an effective strategy.
- Consistent messaging is important as families report that they are confused when they don't hear the same oral health message from medical and dental providers.
- It is difficult for many families to prioritize and follow up on oral health treatment. Families need continuous, simple, and easy to understand oral health educational messages.

The most important lesson that we learned overall is that committing to the Task Force model is a highly effective approach to state coalition building to improve the delivery of primary preventive oral health care for young children. Since coming together in 2009, we've been able to build enough trust and momentum to reach a "tipping point" for systems change in collaboration with our state partners, which is needed to sustain the progress we have made in our state to improve access to oral health care for vulnerable populations like Head Start.



Head Start Oral Health State Activities Submission Form

National Center on Health Dental Hygienist Liaison Project

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Below is a summary of a successful Head Start oral health state activity (e.g., practice, program, service, event, policy).

State/Territory: Michigan and Kansas

Activity

Description

In response to the need to find dental homes for children enrolled in Head Start, the Head Start National Center on Health (NCH) and the American Dental Hygienists' Association worked collaboratively to recruit a volunteer in each state to act as a dental hygienist liaison (DHL) to Head Start programs. The DHLs provide the following services:

- Provide a communication link between NCH and Head Start oral health activities and programs.
- Collaborate with state organizations and ongoing networks (e.g., Dental Home Initiatives), including state dental directors and Head Start state collaboration directors, to address prevention and access-to-care issues.

- Assist in promoting evidence-based preventive and educational services to Head Start statewide.
- Share links to resources with each other and with Head Start and other state partners to improve consistent messaging on oral health.
- Present at state or regional meetings at the request of NCH (time and funds permitting) or recommend qualified professionals from their list of contacts.

Examples of DHL activities in Michigan:

- Joined the Michigan Head Start Association to support the network needed for future collaborations.
- Participates in Head Start parent and staff educational sessions on oral health. Information and activities at these events provide opportunities for parents to ask questions and learn about oral health actions they could take to help their families stay cavity free.
- Serving on Head Start Health Advisory Councils to increase oral health literacy and address Head Start oral health concerns.
- Shares resources such as the NCH monthly oral health newsletter, *Brush Up on Oral Health*, and other NCH publications, with all Head Start program and dental contacts.
- Coordinates requests for finding dental homes for Head Start children throughout the state.
- Collaborated with a local Head Start program and local dental hygienists' society that provide children with fluoride varnish applications and oral health screenings with follow up and referrals as needed.

Examples of DHL activities in Kansas:

- Maintaining monthly communication with Head Start Directors, Health Managers, and Education Coordinators. Some examples include sharing local, state or national information regarding emerging oral health issues. The DHL disseminated an electronic copy of the *Oral Health Care During Pregnancy: A National Consensus Statement* and encouraged programs to emphasize the importance and safety of dental services during pregnancy with their local dentists and health care providers.
- Providing professional development to Head Start staff. Using curricula and oral health support materials, the DHL brought oral health awareness and evidence-based information to Head Start staff that could be used both in the classroom and with pregnant women and families of young children.
- Identifying and linking families to area dental services. The DHL has assisted in several “access to care” situations where she was able to link families to area dental services, and in two cases, provide place-based dental services utilizing her extended care permit. One example:

A Head Start program is located in an urban community with a number of private dental offices that provide services for low-income children. The program has a new health specialist who requested assistance with a small percentage of students each year that seem to fall through the cracks and are not

able to access dental services. Initially, the DHL provided a workshop for the entire staff to increase their awareness of the importance of oral health as well as providing ideas for integrating oral health educational activities into the preschool curriculum. The staff's increased knowledge and confidence will help them to influence parents to engage in making and keeping dental appointments. The DHL then connected with a safety net clinic in the region that has outreach preventive services. They were willing to provide dental services for those who have not been able to access them. A retiring local dentist was contacted and agreed to provide oral exams at the Head Start program. The outreach program at the safety net clinic provided equipment and supplies for the exams as well as preventive services provided by the DHL. The DHL and safety net clinic assisted the nurse with case management to connect families of children identified with untreated decay to a dental clinic.

Lessons Learned

The DHL Project demonstrates the positive impact dental hygienists can have in the Head Start community. With future financial support, the prospects for continuing and enhancing the DHL relationship and its influence on access to dental services and further integration of oral health into Head Start programs across the country is great.



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Health

Head Start Oral Health State Activities Submission Form

Rural Teledentistry Pilot Program in Kindercamps with Northern Arizona Council of Governments Head Start

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Below is a summary of a successful Head Start oral health state activity (e.g., practice, program, service, event, policy).

State/Territory: Arizona

Activity

Background

In 2006, the Arizona Department of Health Services, Office of Oral Health (OOH) was awarded a Health Resources and Service Administration (HRSA) grant to increase access to dental care for underserved and at-risk populations through implementation of teledentistry. A portion of these grant activities were implemented through a partnership with the Northern Arizona Council of Governments (NACOG) Head Start Program in Flagstaff, Arizona. The goal of the project was to address Healthy People 2020 objectives related to oral health, to include: 1) Reduce the proportion of children who have dental caries experience and untreated tooth decay in their primary teeth; 2) Increase the proportion of children who used the oral health care system in the past year; and, 3) Increase the proportion of low-income children who received any preventive dental service during the past year.

The NACOG Head Start program is a non-profit organization providing comprehensive programming to low-income children birth to age five, and families throughout northern Arizona counties (Apache, Navajo, Coconino and Yavapai). NACOG Head Start provides services to more than 1,585 preschool age children and 124 pregnant women, infants and toddlers at twenty-

six local centers in the four county area. The program is centrally managed from Flagstaff, AZ. NACOG Head Start's service area covers 27,000 square miles of rural northern Arizona not including the Navajo Nation. While eight of the centers are located within a thirty-minute drive from Flagstaff, many centers are located one hour to more than three hours from Flagstaff (one-way travel). Currently, children living in Navajo or Apache counties who require specialized services from a pediatric dentist must travel to either Flagstaff or Phoenix for care. The following model is NACOG Head Start's first initiative to integrate teledentistry into its program to address pediatric dental care.

A parent and child having to drive to Flagstaff for a dental examination and one subsequent treatment visit with the pediatric dentist may mean 12+ travel hours, two missed work days, and transportation costs. Implementing a teledentistry model helps reduce barriers to care and brings dental services to these children.

The development of the model began with collaboration among the NACOG Health Start Health Services Manager, a private practice pediatric dentist, and an affiliated practice dental hygienist. These partners developed and piloted a Head Start community outreach model for teledentistry. The community outreach model was set up to bring teledentistry equipment to local Head Start Kindercamps (Health fair events) in Flagstaff. A teledentistry team collected oral health assessment data, delivered preventive care (applied fluoride varnish), stored and forwarded oral data to the pediatric dentist, and facilitated entry to a dental care delivery system (NACOG Head Start and the contracted pediatric dentist).

Setup and Activities

An affiliated dental hygienist travels to the Kindercamps to support service delivery and collection of "store and forward" oral health data, which is sent to the pediatric dental office. The pediatric dentist provides medical history and permission-to-treat forms to the NACOG Head Start Health Services Manager. The Health Services Manager completes all of the documents prior to the arrival of the teledentistry team.

The equipment is set up in an empty classroom, and Head Start children are brought in for an oral health assessment. Each child may also receive fluoride varnish application as part of the prevention services. Small chairs and tables from the kindergarten classroom are used to accommodate the children. Oral health related data includes a review of the medical history, chief complaint, current home care, head-and-neck assessment, chart of existing conditions, intraoral photographs, and digital radiographs. Information is transmitted via a "store and forward" mechanism (along with paper forms used to record other oral health information) to the pediatric dentist.

Outputs and Outcomes

During the piloted Kindercamps, 128 children were screened; 100% were indicated for follow-up and triaged according to need and 95% received preventive oral health services in the form of fluoride varnish. The "store and forward" oral health data (e.g., digital radiographs and intraoral films) and other dental forms (e.g., medical/dental histories and dental charts) were sent to the

pediatric dentist for diagnoses and treatment planning. Of children needing further dental treatment, parents/primary caregivers were contacted by the pediatric dental office to schedule children in his Flagstaff office.

Initial results indicate patient, parent and provider satisfaction. The children, with a few exceptions, were very cooperative with the teledentistry team. Those who were uncooperative were afraid because they had previous and extensive dental procedures. One child, who was very anxious, asked if we were going to, "give [him] a shot." The teledentistry team obtained digital diagnostic data from almost all the children and did not push procedures for those who were overly anxious.

Parents appreciate having services delivered to them thereby reducing travel time and travel expenses. Dentists have seen practice growth by making connections with public partners. Teledentistry pilot models will continue to evaluate outcomes and address barriers to implementing teledentistry outreach strategies.

Lessons Learned

Several lessons were learned from the Head Start community outreach pilot project:

1. During the first screening session, children were brought to the examination area one at a time; this was time consuming and perhaps a bit frightening for the children. An adjustment was made in the session and the children were brought in groups of three, which was less intimidating and more time efficient for the teledentistry team.
2. The NACOG contracted pediatric dentist was able to efficiently triage and diagnose from the acquired oral health data (digital data and dental forms) and has provided follow-up care in his dental office.
3. The utilization of teledentistry to bridge long distances between providers and patients opens up possibilities and considerations in how a remote (spoke) dental site should operate and connect with the primary (hub) site for maximum efficiency. For example, NACOG Head Start and its teledentistry providers will need to consider the "best" setup of a remote site in terms of staffing, facility, equipment and administrative tasks. Things to consider include:
 - What will be the ideal dental team at a remote site and how will they connect with the primary site? Will a core 3-staff team be the most efficient and which combination of dentist, dental hygienist, dental assistant, and administrative staff will work best with the primary office?
 - A preview of each remote site will provide an advantage in assuring adequate space for the dental examination/treatment area, access to electrical outlets, and appropriate furniture for setting up the teledentistry equipment.
 - In addition to teledentistry equipment, portable dental chairs and dental lights may be needed for easier and efficient delivery of dental care services. For example, taking digital radiographs with the child sitting in a portable dental chair instead of a regular office chair will improve positioning.

- Having Internet access will allow completing same-day insurance verifications. Head Start centers can provide online access via their computers but other community settings may not provide such access.
4. The teledentistry dental team (dentist, dental hygienist, dental assistant and other support staff) will have a learning curve for becoming competent in the use of the teledentistry equipment, efficient in the setup of equipment in the dental treatment area, and proficient in the scheduling and time management of patients in a remote site. For example, initially the teledentistry team took about 30-45 minutes to complete their setup to receive the first patient, but the process became easier and more efficient with each child.
 5. Implementing teledentistry in a private practice setting took longer because the pediatric dentist had time constraints and could only allot limited time for the project on clinic days. A longer timeline than expected may be needed for planning and setting up teledentistry due to other clinical demands on the dental providers and staff.
 6. Teledentistry provides additional options to introduce dental care and manage young children. For example, Head Start children are at ease in the Head Start centers, which provide more familiar surroundings. Further, more points of entry to the NACOG dental care delivery system can be created by bringing teledentistry equipment and technology into other remote settings as efforts in community outreach.



Head Start Oral Health State Activities: Submission Form

San Antonio Head Start Oral Health Program

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Below is a summary of a successful Head Start oral health state activity (e.g., practice, program, service, event, policy).

State/Territory: Texas

Activity

The San Antonio Metropolitan Health District (Metro Health) partners with Head Start (HS) agencies in Bexar County to provide onsite oral health services, education, training and technical assistance. The program, referred to as the San Antonio Head Start Oral Health Program (SA OHP), partnered with the following HS agencies in 2013-14: 1) the City of San Antonio HS Program, 2) Avance HS Program, 3) Family Services Association HS Program, and 4) Parent/Child Inc. HS Program. The combined funded enrollment in these programs was 5,902 children; however, SA OHP provided services to 6,739 HS children. The combined annual budgets provided SA OHP an operating budget of \$202,334.

The SA OHP is a comprehensive oral health program that includes the following key components: assessment (including community resources and gaps in services, oral health knowledge, attitudes and beliefs of parents and HS teachers and staff); prevention; access to a dental home; education, and program evaluation. Direct services include onsite oral health evaluations, application of fluoride varnish, referrals, case management, and oral health education. Additionally, Metro Health staff provides *Cavity Free Kids* curriculum training to HS teachers as well as training and technical assistance to HS staff regarding implementation of the

HS performance standards related to oral health. Data entry and management of oral health status and services are also provided for several of the agencies.

Two onsite oral health evaluations are provided by SA OHP dentists throughout the school year. The first evaluation is scheduled within the first 90 days of the school year, and the second evaluation (re-assessment) is scheduled in the spring semester. SA OHP utilizes the Preschool Basic Screening Survey assessment tool to determine each child's oral health status, categorized as: urgent care needed, non-urgent care needed, or no treatment needs. SA OHP also determines if a child needs a dental home based on parental responses provided during enrollment. Parents are sent an individualized referral letter based on their child's oral health status, along with a list of participating pediatric dentists who accept Medicaid and/or CHIP.

A commitment to individualized case management has been crucial to the success of the program. Providing referral letters alone is often not sufficient for HS families to understand the importance of obtaining oral care for their child and/or how to navigate barriers to oral health services. SA OHP provides direct case management for children with urgent needs and special circumstances that make access more difficult, including inadequate means to pay for services. SA OHP also provides ongoing training and technical assistance to the various HS health coordinators and family support teams who provide case management for children with no dental home or who require non-urgent follow-up care. They receive a training manual that outlines all oral health performance standards and internal policies, procedure, and forms.

Another important component to the success of the SA OHP has been leveraging financial resources through a Title V Block Grant from Texas DSHS for six years (2010-2016), which provides funding for clinical services for underinsured and non-eligible Medicaid/CHIP children (i.e., undocumented). SA OHP sub-contracts to The University of Texas Health Science Center San Antonio Dental School, Department of Pediatric Dentistry to provide clinical services to these children. During the 2013-2014 school year, Title V provided \$12,197 in clinical services for children enrolled in HS. Additionally, Metro Health has negotiated reduced rates with the Dental School for any services not covered under Title V or other funding sources, which is then paid for by the appropriate HS agency.

As part of its comprehensive oral health program, Metro Health provides two fluoride varnish applications during the school year (applied in conjunction with the fall and spring evaluations). The fluoride varnish program also involves collaboration with the Dental School, which allows both dental and dental hygiene students to gain experience working in the HS community. Students are assigned to specific HS sites throughout the year to assist with various components of the program, including the application of fluoride varnish and health education activities. This is a "win-win" situation because it reduces staffing costs and provides an experiential learning opportunity for students.

Oral health education is one of the key prevention strategies employed by SA OHP staff. They provide training on the use of the *Cavity Free Kids* curriculum to the teachers and teacher assistants. Parent education is provided at recruitment and orientation events, parent nights, as well as through the distribution of newsletters, handouts, and brochures. While they are waiting to be evaluated, children receive oral health education via DVDs, puppets, and toothbrushing

demonstrations. Children also receive “goodie bags” that contain a toothbrush, toothpaste, 2-minute timer, and brochure for the parents.

In summary, the strengths of the SA OHP includes strong community collaboration, building relationships with local pediatric dentists, ability to leverage financial resources for clinical services for children that are underinsured, promotion of dental and dental hygiene students working in HS, and a commitment to serving those most in need with compassionate and dedicated oral health professionals.

Lessons Learned

1. Case management is key to ensuring treatment is obtained; however, it requires dedicated and trained staff, adequate time and appropriate resources to be successful.
2. Parent education is critical for parent engagement.
3. HS staff must receive ongoing oral health training to ensure oral health communication to HS parents and children is accurate and understandable.
4. Ongoing communication and collaboration between all stakeholders (HS staff, parents, oral health professionals, insurance agencies) are vital to ensuring good oral health for HS children.
5. Scheduling onsite visits needs to begin at the beginning of summer to allow for unexpected delays such as inclement weather, school calendars changing, etc.
6. If possible, collaboration with dental and/or dental hygiene schools provides a “win-win” opportunity for the community.

Re-assessment in the spring provides a good opportunity for dental professionals to evaluate any changes in oral health status and/or if treatment needs diagnosed in the fall have been completed.