Proceedings from the:

HEAD START ORAL HEALTH FORUM
JUNE 3, 2005







Sponsored by

Delaware Health and Social Services
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Acknowledgements

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Executive Summary

The Head Start Oral Health Forum was held on June 3, 2005. The all-day event brought together 71 individuals representing a myriad of organizations from the public and private sectors with interest in improving oral health for Delaware's Head Start enrolled children. Please refer to Appendix A for a list of Forum attendees. The purpose of the Forum was **to improve the oral health of Head Start Children in Delaware.**

To achieve its goals, Delaware's *Head Start Oral Health Forum* was intended to meet four primary learning objectives:

- To gain an understanding of how Delaware's Head Start program measures against the national Head Start Performance Standard requirements on oral health.
- To learn about national strategies to improve oral health access, prevention and practitioner availability for Head Start enrolled children.
- To develop an action plan for putting six critical oral health strategies into practice for the benefit of Delaware children enrolled in Head Start.
- To gain an understanding of the impact of oral health on school readiness and public policy implications in reaching Delaware's school readiness goals

The Head Start Oral Health Forum built upon the work done at the Delaware Oral Health Summit 2004 held on December 8, 2004. Six critical oral health strategies were identified and Forum participants were asked to define action steps for putting these strategies into practice for the benefit of Delaware children enrolled in Head Start. Concurrent Sessions focusing on access, prevention and provider education strategies (described below) were repeated three times throughout the day and all Forum participants rotated through each concurrent session.

Access Strategies

- Improve Head Start access to pediatric dentists, especially in Kent and Sussex Counties**.**
- Create financing opportunities for under-insured, un-insured and undocumented Head Start children and families.

Prevention Strategies

- Prevent decay when Head Start children and families live in un-fluoridated communities
- Infuse dental education and prevention strategies in Head Start programming for children and families.

Provider Education Strategies

- Improve the comfort level of general dentists in serving Head Start eligible children.
- Enhance the role of medical community (obstetricians, hospitals, pediatricians, and family practitioners) in oral health education, prevention, and treatment of Head Start children and families.

Action Steps derived from the concurrent sessions centered on several key themes:

- Pregnant women need access to dental screening and treatment to prevent poor birth outcomes and transmission of dental disease to their infants.

- Parents need to be made aware, informed and educated about the importance of oral health as a part of overall health for themselves and their children.
- Head Start and the Division of Public Health need to collaborate with other organizations and dental providers to ensure enrolled children receive early screening, prevention and treatment services.
- Dentists and dental hygienists need to provide more community-based prevention and treatment services with coordination by state agencies such as the Department of Education and the Division of Public Health
- Disparities that prevent access to dental services need to be addressed, including insurance status, income, race and ethnicity.
- Better coordination and communication among the dental community and with the public is needed.

The Concurrent Session Section on page 13 of these proceedings provides a comprehensive listing of the recommended action steps derived from these sessions.

An evaluation form (see Appendix B) was distributed to conference participants to assess the value of the information presented, the Forum outcome, and the overall effectiveness in meeting the objectives. Forty-five participants (63%) submitted an evaluation form. The evaluation results were good to excellent, with an average overall score of 3.55 on a four-point scale where excellent equates to 4.0 and poor equates to 1.0. A Summary of evaluation results are presented in the Evaluations Section on page 17 of these proceedings.

Forum participants also were asked to complete a questionnaire, pledging their ongoing participation and support in Delaware's oral health agenda (See Appendix C). Thirty-one of the Forum participants responded to the questionnaire and of those, 26 stated an interest in participating in an oral health coalition; 28 wanted to participate in developing an oral health plan; and all respondents wished to receive additional information. Of those, 87 percent of respondents stated "yes" to participating in all three activities.

This report provides an overview of the data and information offered at the Forum; the ideas generated and the recommendations to be further explored and potentially implemented in Delaware. A copy of these Forum proceedings will be distributed to all Forum registrants.

The next section provides an agenda from the Delaware Head Start Oral Health Forum.

Delaware Head Start Oral Health Forum

Friday, June 3, 2005

Delaware Technical and Community College, Terry Campus

Dover, Delaware

Agenda

8:00 a.m. Lobby	**Registration & Continental Breakfast**
8:30 a.m. Room 400	**Welcome and Opening Remarks** Gregory McClure, DMD, MPH — *Delaware State Dental Director* Suzanne S. Burnette — *Delaware Head Start Association President*
9:00 a.m. Room 400	**Overview of Head Start** ***Nurturing the Promise Video***
9:15 a.m. Room 400	**Plenary Session: Strategies to Improve the Oral Health of Delaware's Most Vulnerable Children** James J. Crall, DDS, ScD *Chair, Pediatric Dentistry, UCLA School of Dentistry*
10:00 a.m. Room 400 & Lobby	**Break**
10:15 a.m. Room 400	**Overview of Dental Health Requirements and the Status of Delaware Head Start Dental Services** Harry S. Goodman, DMD, MPH *Professor, Department of Health Promotion and Policy, Program of Pediatric Dentistry, University of Maryland Dental School*
10:45 a.m. Room 400	**Setting the Stage for Action Planning** Gregory B. McClure, DMD, MPH
11:00 a.m.	**Concurrent Discussion Sessions: Putting the Strategies into Action** *Participants will rotate among session during each of three concurrent discussion sessions (morning and afternoon)*
Session 1 Room 407A	**Access Strategies** Subject Matter Expert: Gregory B. McClure, DMD, MPH Facilitators: Kimberly A. Hickman- Bowen, RDH, BSDH, MA
Session 2 Room 407B	**Prevention Strategies** Subject Matter Expert: Harry S. Goodman, DMD, MPH Facilitators: Amy R. Requa MSN, CRNP
Session 3 Room 411	**Provider Education Strategies** Subject Matter Expert: James J. Crall, DDS, ScD Facilitators: Helen Arthur, RDH, BSDH
12:00 p.m. Room 400	**Lunch**
12:30 p.m. Room 400	**A Vision for School Readiness** Valerie Woodruff, Secretary, DE Dept. of Education
1:15 p.m. Rooms 407 & 411	**Concurrent Discussion Sessions: Putting the Strategies into Action**
2:15 p.m. Rooms 407 & 411	**Concurrent Discussion Sessions: Putting the Strategies into Action**
3:15 p.m. Room 400	**Closing Session: Wrap-up and Summary** Gregory B McClure, DMD, MPH & Suzanne S. Burnette
3:30 p.m.	**Adjourn**

General Session Presentations

This section provides an overview of the central issues, topics and themes addressed by each of the general session speakers. Biographies for each of the Forum presenters may be viewed in Appendix D. Appendix E provides the presentations delivered by Drs. Crall and Goodman.

Welcoming and Opening Remarks

Gregory B. McClure, DMD, MPH, *Delaware State Dental Director; Chief, Health Systems Management Section, Division of Public Health*
Suzanne S. Burnette, MA,
President, Delaware Head Start Association

Dr. Gregory McClure opened the Forum by thanking the audience for participating in Delaware's first Forum to discuss oral health issues. He spoke of the silent epidemic of oral diseases that are affecting our most vulnerable citizens, including low-income children. He reviewed the program goal and learning objectives and encouraged the audience to participate fully in the concurrent session discussions so that a strong oral health plan can be developed for the State of Delaware.

Suzanne Burnette encouraged the audience to be part of the solution for improving oral health for Delaware's most vulnerable children, by establishing partnerships and working together to improve access to care and oral health education for children and families.

Ms. Burnette introduced the *Nurturing the Promise* video, which featured children, staff, and families in Head Start and Early Head Start programs at several locations across the country illustrating Head Start's comprehensive approach and key principles of encouraging:

- a nurturing environment that supports the healthy growth and development of each child in the context of the child's family, culture, and community:
- parents as partners in the shared decision-making process and as active participants in policy groups; and
- recognition of the importance of strengthening linkages within communities.

The *Nurturing the Promise* video is available for purchase at the Head Start Information and Publication Center at: http://www.headstartinfo.org/

Plenary Session: Strategies to Improve the Oral Health of Delaware's Most Vulnerable Children

James J. Crall, DDS, ScD

Chair, Pediatric Dentistry, UCLA School of Dentistry

Dr. James J. Crall presented the plenary address entitled *Head Start and Early Head Start: Establishing a Foundation for a Lifetime of Oral Health.* The presentation focused on five major areas of discussion:

- Magnitude and significance of oral health problems in preschool children and contributing factors
- Emerging science and opportunities for improving oral & general health in Head Start
- Current systems gaps
- Challenges getting Head Start children connected to dental care + 3 successful models
- Key elements & strategies for creating effective Head Start oral health program

The presentation is provided in Appendix E. The following is an overview of the key points made in the presentation:

Magnitude and significance of oral health problems in preschool children and contributing factors

- Many children are not getting care early enough and their decay remains untreated due to access barriers.
- Dental decay may be decreasing in prevalence, but we cannot be complacent. Tooth decay is a chronic disease.
- Only two to three percent of all dentists are trained in pediatrics
- Access will continue to be a challenge: the workforce is busy; there is a decline in dentists coming out of school and the workforce is aging; conversely, the population is growing, especially among those more likely to have dental problems.
- Eighty percent of dental disease is experienced by 20 percent of the population and the lower the poverty level, the higher the chance of untreated decay.
- Educating parents and children early can prevent decay.
- Race and ethnicity also matter: African Americans and Hispanic children are more likely to have tooth decay and untreated decay; many of these children are enrolled in Head Start.
- Emphasis needs to be on getting education, screening and treatment to high-risk populations earlier.
- The progressive nature of disease is exemplified in the 20 percent difference between dental needs in three year olds versus four year olds.
- Keys to good oral health include: good eating & snacking practices; regular "self-care" practices, including daily brushing with fluoride toothpaste; and access to "dental homes"—a regular, ongoing source of dental care
- We take for granted everyone is practicing these habits, but they are not. Brushing programs in schools are making a big difference
- Language, attitudes and behaviors (LAB) are important considerations. The words we use are important. For example, the words, "baby teeth" to many means that the teeth will fall out anyway so oral hygiene is not important; however, children keep these teeth until age 9. Children can have both baby teeth and permanent teeth from age five to nine. Good habits at an early age are important.

- "Prevention" is another LAB problem. People hear the word prevention and think one visit to the dentist will take care of their decay. Ongoing prevention is needed—85 percent of the population is still getting tooth decay by 18 years old.
- The healthcare system needs to connect the resources and provide continuity over time. Fluoride and sealants need to be part of an overall prevention and treatment program. They cannot stand alone.
- Children with untreated decay have the potential for breathing and sight problems.
- Blood flows through the mouth and the decayed tooth. Those bacteria then flow through other organs in the body, causing other health problems and learning delays.
- The rate of those uninsured for dental is almost three times that of medically uninsured
- Nationally, health care expenditures attributed to dental care is about 30 percent; Medicaid expenditures for dental services are about two percent.
- Dental Education needs to stress the importance of taking care of children (and understanding Head Start). General dentists are not trained to take care of children and should not be expected to do so; however, general dentist can provide screening and prevention for young children, referring restorative work to pediatric dentists.

Emerging science and opportunities for improving oral & general health in Head Start

- Bacteria from dental disease can be transmitted from mother to baby after teeth appear.
- Pregnant women with periodontal disease are more likely to have poor birth outcomes. Clinical trials are currently underway to see if prevention and treatment can have an impact on birth outcomes.

Current systems gaps

- Most Head Start parents report that their children have a dental home, have had a dental exam, and have received preventive care when needed; however, epidemiological data shows that 52 percent of these children have untreated decay in over 5 teeth.
- Our current dental care system includes a relatively high rate of oral disease; a disjointed system; and an outdated, one-size-fits-all approach to delivery. What is needed is: continuous, coordinated approach to controlling disease and promoting oral health; and strategic, data-driven approaches that respect diversity.

Challenges getting Head Start children connected to dental care + 3 successful models

- The American Academy of Pediatrics (AAP) published a policy statement promoting an early caries risk assessment for children under 12 years old; referring those at high risk to a dental home.
- Visual screening for plaque and white spots should be done on all children because these problems are likely to become decay. These children are prime candidates for early prevention and treatment.
- Dental disease is a chronic disease; the risk for dental disease is never at zero and must be managed over a lifetime.

Key elements & strategies for creating effective Head Start oral health program

- An efficient system for treating Head Start children is needed. Bringing dental care to Head Start center should be considered, rather than busing children to the dental office.

Vision for Head Start Oral Health:

- Head Start families, communities and learning environments actively engaged in effective oral health promotion

- Community-based systems that provide comprehensive care making efficient use of local providers
- Local dental groups linked to Head Start programs and providing "dental homes" for all Head Start children
- Other community service providers educated and linked to Head Start

Strategies:

- Getting people to talk to each other is key: families and communities working together
- Engaging dental community on Head Start advisory committee
- Money can be spent on prevention and treatment, yet still save money by focusing resources on at-risk children.

Overview of Dental Health Requirements and the Status of Delaware Head Start Dental Services

Harry S. Goodman, DMD, MPH
Professor, Department of Health Promotion and Policy, Program of Pediatric Dentistry, University of Maryland Dental School

Dr. Goodman presented a foundation for Head Start oral health requirements and strategies to improve oral health. He also provided data showing how Delaware compares to other states in the region as well as the nation with respect to these standards.

Factors Affecting Oral Health:

- Poor children are much more likely to have more severe tooth decay than affluent children and are less likely to have access to dental care.
- Head Start enrolled children are three times more likely to have a dental screening than are other low-income children.
- Early childhood caries is a term that describes rampant dental caries in infants and toddlers; commonly referred to as nursing caries, nursing bottle caries and baby bottle caries.
- Early childhood caries occurs in children under age three; is an infectious disease transmitted from mother to baby; and is associated with inappropriate use of sugar.

Program Information Report (PIR)

All Head Start Programs must complete an annual PIR. The following provides an overview of how Delaware fares in comparison to the nation and other states in the region (Maryland, New Jersey, Pennsylvania, Virginia and Washington, DC)

- Delaware ranks better than the region and nation in:
  - Children having completed a dental exam.
  - Children in need of treatment.
- Delaware ranks lower in:
  - Children 0-3 years receiving a well-child exam
  - Pregnant women receiving a dental exam
- The likelihood a Delaware child will receive a follow up to the initial dental exam equates is better than the nation; which equates to ongoing and continuous access to care, once the child is in the system
- Delaware also is doing very well getting migrant and undocumented children into dental care through its Migrant Head Start programs in Georgetown and Smyrna.
- Family and provider education is an important key in improving access to care and improved oral health, especially for pregnant women.

State Head Start Forums

- Oral health is a top priority for Head Start with 10 Regional Head Start Oral Health Consultants and regional and state forums in all but one region and six states.
- All but five states in the nation have been funded to conduct a Head Start Oral Health Forum.
- Forum goals include developing a state action plan to address oral health access, prevention and education.
- Funding sources are available for shared initiatives moving forward from the state plan.

Setting the Stage for Action Planning

Gregory B. McClure, DMD, MPH

Dr. McClure provided an overview of the concurrent session as a means to have all audience members participate and provide guidance and input on action items that will make each of the identified Head Start Oral Health strategies a practice in Delaware.

He explained how the Head Start Oral Health Forum ties into the Delaware Oral Health Summit held in December 2004 and the findings and outcomes of both conferences will be the basis for Delaware's Oral Health Plan.

Dr. McClure further remarked that while disparities among race, ethnicity and income are tremendous factors in oral health; little attention has been paid to this issue. At a recent health disparities conference, there were no dentists present and oral health was not seen as part of overall health.

The audience was urged to work together to create awareness for oral health disparities.

A Vision for School Readiness

Valerie Woodruff, Secretary, DE Dept. of Education

Secretary Woodruff presented an overview of the challenges that lie before us in improving oral health and ensuring school readiness for Delaware's children, as follows:

- Dental care is not a way of life for many children
- Dental decay has an effect on learning, overall health and success
- Head Start goals must be married with the Department of Education's goals
- The information and education children receive in Head Start (i.e., brushing teeth after every meal) does not always follow through life
- Many low income families do not know how to access the healthcare system. They do not know who to call, especially when they do not have health insurance.
- Children with severe tooth decay often have failure to thrive issues—they do not eat good food—these factors impact their ability to learn and speak. Once the dental disease is cared for, these children show significant and rapid improvements in learning and development.

Secretary Woodruff established several opportunities for addressing these issues:

- All dentists should accept Medicaid
- Recruit more pediatric dentists to Delaware
- Impress upon healthcare providers to stop talking and start doing—this is imperative—a duty as citizens and professionals to care for all.
- Establish a safety net for children that do not have dental homes
- Everyone involved in this Forum must be an advocate for children's oral health—and each one must bring one to support and further the cause

In closing, Secretary Woodruff noted that good oral health and hygiene is not all about learning, but it is also about self-esteem, confidences, and being a whole person.

Concurrent Discussion Sessions: Putting the Strategies into Action

Forum participants rotated among each of three concurrent discussion sessions on access, prevention and provider education strategies. The purpose of the sessions was to develop action steps for putting the identified strategies into practice. The following provides a summary of the action steps established in the concurrent sessions.

General Recommendations:

1. Develop a committee representative of all constituencies to coordinate education, programs and services for Head Start families. Schedule dates for school-based services a year in advance. The committee should meet quarterly and include no more than two representatives from each of the following organizations: Christiana Care Dental Residency Program, Delaware State Dental Society, Delaware Dental Hygienists' Association, Department of Education, Division of Public Health, Head Start, Federally Qualified Health Centers (FQHC) and School Nurses' Association.
2. The Division of Public Health should schedule a follow up meeting to review action steps and develop an implementation plan.
3. Send a copy of the Forum proceedings to everyone in attendance.

Access Strategies

Subject Matter Experts: Gregory B. McClure, DMD, MPH & David Michalik
Facilitator: Kimberly A. Hickman- Bowen, RDH, BSDH, MA
Scribes: Rebecca Ruiz and Thowana Weeks

Improve Head Start access to pediatric dentists, especially in Kent and Sussex Counties.

1. Promote non-traditional office hours for dental providers to see Head Start children.
2. Consider removing or changing licensing regulations to remove recruitment barriers
3. Promote dental case management programs for high-risk children
4. Promote private industry partnerships, corporate sponsorships, insurance companies, and other funding options (private grants, DE lottery, taxes, etc.) for dental education support for students who will later practice dentistry in Kent or Sussex County.
5. Establish partnerships with dental pediatric residency programs in other states in the region to rotate through Delaware's underserved areas and provide treatment to Head Start children.
6. Schedule Head Start children in existing dental clinics/offices that have underutilized chair time.
7. Appropriate parental consent forms are needed to treat Head Start children—Head Start should review consent forms before appointment; educate the child about what to expect; and promote the value of seeing the dentist and good oral health.
8. Develop a public awareness campaign with specific links to organizations that can coordinate access to dental care.

Create financing opportunities for under-insured, un-insured and undocumented Head Start children and families.

1. Provide financial incentives to recruit dentists to practice in underserved areas—DIDER, State Loan Repayment Program.
2. Provide dental coverage through Delaware Healthy Children Program for eligible children of undocumented parents.
3. Develop partnerships with dental schools, dental hygienists, community health clinics, hospitals, and Nemours to provide services to uninsured and underinsured children.
4. Develop a dental assistance program with co-pays, similar to the Delaware Prescription Assistance Program, to provide financial assistance and/or discounted services to low-income families.
5. Increase Medicaid coverage to include dental screening and treatment for pregnant women as part of the Smart Start program.

Prevention Strategies

Subject Matter Expert: Harry S. Goodman, DMD, MPH
Facilitators: Amy R. Requa, MSN, CRNP
Scribe: Douglas Trader

Prevent decay when Head Start children and families live in un-fluoridated communities

1. Topical applications of fluoride should be promoted, including rinses and varnishes. Where there is no fluoride at home and at school, prescriptions for fluoride tablets may be warranted.
2. Encourage families to have well water tested for fluoridation. Based on test results, families are provided information on oral health and prevention of tooth decay. If no fluoridation, refer family/children to a healthcare provider for prescription, further evaluation and education.
3. Publish water supply fluoridation levels to ensure that there is an optimal level of fluoridation based on state law.
4. Implement the Infant Mortality Task Force recommendation to promote oral health care, particularly the prevention and treatment of periodontal disease, as a component of comprehensive perinatal programs.

Infuse dental education and prevention strategies in Head Start programming for children and families.

1. Develop an education campaign (public service announcement) on the importance of oral health and prevention of tooth decay. Promote value of good teeth or oral health in overall health and well-being.
2. Educate Head Start parents about prevention and their role in helping children brush their teeth; using fluoride toothpaste and brushing at least twice a day. For early head start parents, encourage them to brush with water (or wipe the gums) early on and then add a "smear" of toothpaste as the child reaches two years of age. Inform parents about the duration of brushing and to set a timer to ensure the child brushes long enough. Teach parents how to floss their child's teeth.
3. Utilize Head Start parent policy councils and parent committees to increase value of oral health care and promote the role of parents.
4. Include information on low sugar foods and drinks in nutrition education programs for healthy teeth and weight control.
5. Utilize dentists, dental hygienists, and nursing students to conduct outreach programs to educate Head Start families and staff about oral health and prevention.
6. Educate pregnant women enrolled in Early Head Start should on the importance to oral hygiene for themselves and their baby as well as any older children.
7. Head Start and community organizations partners to distribute dental education and prevention information to pregnant women and parents of young children. Community organizations/programs should include: Medicaid, Healthy Start, Smart Start, Parents as Teachers, Home Visiting Program, March of Dimes, and Even Start.
8. Head Start collaborate with the Delaware Dental Hygienists' Association, dental hygiene programs, Division of Public Health and the ADA to identify the parent's role in oral health and use positive feedback to reinforce.
9. Teach children how to brush their teeth in Head Start and school. Encourage them to talk to their parents about what they learned about the importance of oral health.
10. Mentor parents to advocate for oral health assessments during well-child visits.
11. Promote community-wide oral health education and oral hygiene (e.g., Operation Smile)
12. Catalog, organize and coordinate the oral health information and education resources available. One site of interest is: www.mchoralhealth.org
13. Identify a champion for Head Start oral health advocacy efforts.
14. Promote the use of Medicaid/Delaware Healthy Children Program outreach services to help Spanish-speaking families access dental services (1-800-996-9969)
15. Enhance oral health education for Head Start and Early Head Start program enrollees through the American Dental Association (ADA), Delaware State Dental Society (Delaware State Dental Society) and Head Start Collaborative.
16. Make available multi-cultural education materials for patients from other cultures, such as Latino and Asian.

Provider Education Strategies

Subject Matter Expert: James J. Crall, DDS, ScD
Facilitators: Helen Arthur, RDH, BSDH
Scribe: Erika Sherman

Enhance the role of medical community (obstetricians, hospitals, pediatricians, and family practitioners) in oral health education, prevention, and treatment of Head Start children and families

1. Integrate oral health into well-child visits for children under three years.
2. Utilize nursing schools, dental hygiene programs, FQHCs and Dental Residency Program to promote oral health in the community—to Head Start and all children.
3. Create a collaborative among the Division of Public Health and Delaware State Dental Society should work with Daycare Licensing and Family and Workplace Connection to develop a training process on oral health education and prevention for daycare providers and encourage a change in the day care regulations to incorporate oral health.
4. Improve communication among all organizations and agencies targeting oral health improvement, especially Division of Public Health, Delaware State Dental Society, Delaware Dental Hygienists' Association, the Medical Society of Delaware and the Delaware Chapter of the American Academy of Pediatrics.

Improve the comfort level of general dentists in serving Head Start eligible children.

1. Division of Public Health, the Delaware State Dental Society and the Delaware Dental Hygienists' Association (Delaware Dental Hygienists' Association) should develop or adopt a dental education training module for healthcare providers and parents. A planning group should be gathered to devise a process, identify trainers and ensure multi-cultural focus. The target audience should be part of the planning process and should include Head Start/Early Head Start parents.
2. Dental providers should attend monthly Head Start meetings.
3. Division of Public Health, Head Start (Head Start) and the Delaware State Dental Society should work together to organize field trips to dental offices so young children will know what to expect when they go to the dentist.
4. Promote a Community Healthcare Access Program pilot for dental services in Kent and Sussex Counties.

Evaluations

The Forum evaluation form was scored using a scale from excellent to poor. Participants were asked to rank the Forum on several criteria using this scale. The scoring associated with this scale is as follows:

Excellent = 4 points Good = 3 points Fair = 2 points Poor = 1 point

The evaluation form is provided below with an average participant evaluation score provided in the right column. Forty-four evaluation forms were completed.

OVERALL QUALITY?	**Average Score**
1. The presentations were:	3.61
2. The illustrative materials were:	3.49
3. The audiovisual quality was:	2.52
4. The meeting facilities were:	3.64
5. The registration process was:	3.67
HOW WELL WERE THE SUMMUT OBJECTIVES MET?	
6. To gain an understanding of how Delaware's Head Start program measures against the national Head Start Performance Standard requirements on oral health.	3.30
7. To learn about national strategies to improve oral health access, prevention and practitioner availability for Head Start enrolled children.	3.23
8. To develop an action plan for putting six critical oral health strategies into practice for the benefit of Delaware children enrolled in Head Start.	3.16
9. To gain an understanding of the impact of oral health on school readiness and public policy implications in reaching Delaware's school readiness goals	3.14
GENERAL SESSION CONTENT/QUALITY?	
Plenary Session: Strategies to Improve the Oral Health of Delaware's Most Vulnerable Children – James J. Crall, DDS, ScD	
Overall Session Value	3.64
Content Usefulness	3.65
Ideas/Information Presented	3.87
Conference Materials Presented	3.93
Overview of Dental Health Requirements and the Status of Delaware Head Start Dental Services – Harry S. Goodman, DMD, MPH	
Overall Session Value	3.59
Content Usefulness	3.57
Ideas/Information Presented	3.55
Conference Materials Presented	3.52
Setting the Stage for Action Planning – Gregory B. McClure, DMD, MPH	
Overall Session Value	3.45
Content Usefulness	3.41
Ideas/Information Presented	3.41
Overall Session format	3.40
A Vision of School Readiness – Valerie Woodruff	
Overall Session Value	3.52
Content Usefulness	3.50
Ideas/Information Presented	3.52
Overall Session format	3.45

CONCURRENT SESSION CONTENT/QUALITY?

Access Strategies

Overall Session Value	3.44
Overall Session Format	3.39
Opportunity for Audience Participation and Input	3.45
Facilitator Effectiveness	3.38
Subject Matter Expert Effectiveness	3.49
Potential for Putting Session Outcomes into Practice	3.28
Likelihood that you will participate in ongoing activities to put the Head Start Oral Health Plan into practice.	3.46

Prevention Strategies

Overall Session Value	3.38
Overall Session Format	3.43
Opportunity for Audience Participation and Input	3.51
Facilitator Effectiveness	3.51
Subject Matter Expert Effectiveness	3.41
Potential for Putting Session Outcomes into Practice	3.41
Likelihood that you will participate in ongoing activities to put the Head Start Oral Health Plan into practice.	3.51

Provider Education Strategies

Overall Session Value	3.36
Overall Session Format	3.36
Opportunity for Audience Participation and Input	3.46
Facilitator Effectiveness	3.46
Subject Matter Expert Effectiveness	3.38
Potential for Putting Session Outcomes into Practice	3.28
Likelihood that you will participate in ongoing activities to put the Head Start Oral Health Plan into practice.	3.46

Appendix A

Head Start Oral Health Forum Attendees

Zita Aquino
Division of Public Health

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Nancy Brohawn
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Alecea Bryant
Delaware Psychiatric Center

Suzanne Burnette
DE Early Childhood Center

Charles Calhoon
Delaware State Dental Society

Paul Christian
Delaware Dental Society

Brenda Coakley
Migrant & Seasonal Head Start Collaboration

Valerie Covington
Telamon Kent County Head Start

Cherrell Davids
New Castle County Head Start

Gloria Dunsmore
DECC/ECAP

Norma Everett
Division of Public Health

Juanita Farrington
New Directions Early Head Start

Carmelita Franco
Division of Public Health

Judith Gaston*Eastern Shore*
Oral Health Outreach Project

Doris Gonzalez
Telamon Corporation Head Start

Esther Graham
Telamon Kent County Head Start

Lindy Green-Hack
New Castle County Head Start

Cynthia Hall
Telamon Kent County Head Start

Amy Harter
New Directions Early Head Start

Kimberly Hickman-Bowen
Delaware Dental Hygienists' Association

Jennifer Hudson
Delaware Dental Hygienists' Association

Phyllice Jackson
Telamon Kent County Head Start

Melissa Jones
Delaware Dental Hygienists' Association

Susan Kerwin
Indian River Project VILLAGE

Samantha Kiley
Wilmington Head Start

Maria Lopez
Telamon Corporation Head Start

Becky Luis
Division of Public Health

Debbie MacGregor
Telamon Kent County Head Start

Clara Martinez
Telamon Kent County Head Start

Gregory McClure
Division of Public Health

Tawana Medlin
Dentist

Dave Michalik
Division of Social Services

John Moore
Bear-Glasgow Dental, LLC

M. Lorraine Morris
Southern Delaware Center

Sharon Mossman
Delaware Dental Hygienists' Association

Brian Murphy
Oral-B

Gilda Nieves-Knight
Indian River Project VILLAGE

Charita Okorafor
Southern Delaware Center

Margarita Olivencia
Telamon Corporation Head Start

Gina Perez
Advances in Management, Inc.

Ray Rafetto
Delaware State Dental Society

Irene Rees
Delaware Early Childhood Center

Betty Richardson
Department of Education

Vivian Rizzo
Delaware Dental Hygienists' Association

Karen Rose
Delaware Psychiatric Center

Gwendolyn W. Sanders
G & G Enterprise

Milagros Santiago
ECAP-Latin American Community Center

Erika Sherman
Division of Public Health

Zachary Smith
Southern Delaware Center

Wendy Strauss
GACEC

Lacie Strauss
Dental Hygiene Student/Del. Tech

Kathy Taylor
Kreative Kids Head Start

Merith Taylor
Delaware Dental Hygienists' Association

Deborah Thomas
Wilmington Head Start

Robbin Thompson
Southern Delaware Center

Douglas Trader
Division of Public Health

Edith Villasenor
Division of Public Health

Gail Wade
New Directions Early Head Start

Mary Watson
ECAP Consultant

Bridget Wheatley
Delaware Early Childhood Center

Sydney White
New Directions Early Head Start

Angela Williams
Telamon Kent County Head Start

Leonard Young
Standford Children Delaware

Rossana Zambrano
Telamon Corporation Head Start

Alan Zimble
Private Dentist

Appendix B

Evaluation Form

Please rate the overall quality of this program.

	Excellent	Good	Fair	Poor
10. The presentations were:	☐	☐	☐	☐
11. The illustrative materials were:	☐	☐	☐	☐
12. The audiovisual quality was:	☐	☐	☐	☐
13. The meeting facilities were:	☐	☐	☐	☐
14. The registration process was:	☐	☐	☐	☐

How well was each overall conference objective met?

	Excellent	Good	Fair	Poor
15. To gain an understanding of how Delaware's Head Start program measures against the national Head Start Performance Standard requirements on oral health.	☐	☐	☐	☐
16. To learn about national strategies to improve oral health access, prevention and practitioner availability for Head Start enrolled children.	☐	☐	☐	☐
17. To develop an action plan for putting six critical oral health strategies into practice for the benefit of Delaware children enrolled in Head Start.	☐	☐	☐	☐
9. To gain an understanding of the impact of oral health on school readiness and public policy implications in reaching Delaware's school readiness goals	☐	☐	☐	☐

18. Overall comments and/or suggestions for future topics? _____

_____

_____

_____

_____

Please rate each general session presentation for quality and content.

Plenary Session: Strategies to Improve the Oral Health of Delaware's Most Vulnerable Children - Dr. James J. Crall, DDS, ScD

	Excellent	Good	Fair	Poor
Overall Session Value	☐	☐	☐	☐
Content Usefulness	☐	☐	☐	☐
Ideas/Information Presented	☐	☐	☐	☐
Conference Materials Presented	☐	☐	☐	☐

Overview of Dental Health Requirements and the Status of Delaware Head Start Dental Services - Harry S. Goodman, DMD, MPH

	Excellent	Good	Fair	Poor
Overall Session Value	☐	☐	☐	☐
Content Usefulness	☐	☐	☐	☐
Ideas/Information Presented	☐	☐	☐	☐
Conference Materials Presented	☐	☐	☐	☐

Setting the Stage for Action Planning - Gregory B. McClure, DMD, MPH

	Excellent	Good	Fair	Poor
Overall Session Value	☐	☐	☐	☐
Content Usefulness	☐	☐	☐	☐
Ideas/Information Presented	☐	☐	☐	☐
Conference Materials Presented	☐	☐	☐	☐

A Vision for School Readiness – Valerie Woodruff

	Excellent	Good	Fair	Poor
Overall Session Value	☐	☐	☐	☐
Content Usefulness	☐	☐	☐	☐
Ideas/Information Presented	☐	☐	☐	☐
Overall Session Format	☐	☐	☐	☐

General Session Comments_____

_____

_____

_____

Please rate each concurrent session for overall quality and content.

Access Strategies	Excellent	Good	Fair	Poor
Overall Session Value	☐	☐	☐	☐
Overall Session Format	☐	☐	☐	☐
Opportunity for Audience Participation and Input	☐	☐	☐	☐
Facilitator Effectiveness	☐	☐	☐	☐
Subject Matter Expert Effectiveness	☐	☐	☐	☐
Potential for Putting Session Outcomes into Practice	☐	☐	☐	☐
Likelihood that you will participate in ongoing activities to put the Head Start Oral Health Plan into practice.	☐	☐	☐	☐

Prevention Strategies	Excellent	Good	Fair	Poor
Overall Session Value	☐	☐	☐	☐
Overall Session Format	☐	☐	☐	☐
Opportunity for Audience Participation and Input	☐	☐	☐	☐
Facilitator Effectiveness	☐	☐	☐	☐
Subject Matter Expert Effectiveness	☐	☐	☐	☐
Potential for Putting Session Outcomes into Practice	☐	☐	☐	☐
Likelihood that you will participate in ongoing activities to put the Head Start Oral Health Plan into practice.	☐	☐	☐	☐

Provider Education Strategies	Excellent	Good	Fair	Poor
Overall Session Value	☐	☐	☐	☐
Overall Session Format	☐	☐	☐	☐
Opportunity for Audience Participation and Input	☐	☐	☐	☐
Facilitator Effectiveness	☐	☐	☐	☐
Subject Matter Expert Effectiveness	☐	☐	☐	☐
Potential for Putting Session Outcomes into Practice	☐	☐	☐	☐
Likelihood that you will participate in ongoing activities to put the Head Start Oral Health Plan into practice.	☐	☐	☐	☐

Concurrent Session Comments_____

_____

_____

Thank you for your time.

Appendix C

Oral Health Action Plan Participation Questionnaire

1. I would like to continue to participate in the development of Delaware's oral health planning process

   _____ yes _____ no

2. I would like to receive information about Delaware's Head Start Oral Health Plan and about the development of a Delaware Oral Health Coalition

   _____ yes _____ no

3. I would like to participate in a Delaware Oral Health Coalition

   _____ yes _____ no

   a. If yes, please indicate your area(s) of interest (check all that apply)

   _____Access Strategies _____ Population Oral Health Issues
   _____Prevention Strategies _____ Children's Oral Health Issues
   _____Provider Education Strategies _____ Head Start Oral Health Issues

If you answered "yes" to any or all of these statements, please provide your contact information so that we may include you in future activities and/or information dissemination:

□ Mr. □ Ms.
□ Mrs. □ Dr. First Name _____

Last Name _____Suffix_____

Title_____

Organization_____

Address_____

City_____ State_____ Zip code _____

Phone_____Fax_____Email_____

Thank you for your time and interest!

Appendix D

Speakers' Biographies

Suzanne Burnette is the ECAP supervisor for the Delaware Early Childhood Center and is President of both the Delaware Head Start Association and the Sussex Health Advisory Council. Suzanne also is an early childhood trainer for the Family and Workplace Connection as well as a master trainer for Partners in Excellence. Previously, she was the deputy director for the Hilltop Lutheran Neighborhood Center. Suzanne has a Bachelors degree in Special Education and a Masters degree in curriculum and instruction.

James J. Crall, DDS, ScD is Director of the HRSA/Maternal and Child Health Bureau's National Oral Health Policy Center and Professor and Chair of Pediatric Dentistry at UCLA. Prior to moving to UCLA in 2004, he held faculty appointments at Columbia University (2000-2004), the University of Connecticut (1986-2000) and the University of Iowa (1979-1986). Dr. Crall has been actively involved in national, state and professional policy development concerning oral health over the past 15 years, and has served as an advisor for numerous organizations including the:

- American Academy of Pediatric Dentistry,
- American Academy of Pediatrics,
- American Dental Association,
- Joint Commission on Accreditation of Health Care Organizations,
- Pew Health Professions Commission,
- Milbank Memorial Fund,
- National Committee on Quality Assurance,
- National Governors Association,
- Robert Wood Johnson Foundation,
- U.S. Department of Health and Human Services, and
- U.S. General Accounting Office.

Dr. James J. Crall received a D.D.S., master's degree and certificate in pediatric dentistry from the University of Iowa, and is a (board-certified) Diplomate of the American Board of Pediatric Dentistry. He was selected to be a Robert Wood Johnson Foundation Dental Health Services Research Scholar at Harvard from 1984-86, and subsequently obtained masters and doctoral degrees in Health Policy and Management from the Harvard School of Public Health. In 1997, Jim was appointed as the first Dental Scholar-in-Residence at the Agency for Health Care Policy and Research (AHCPR), now the Agency for Healthcare Research and Quality (AHRQ).

Harold S. Goodman, DMD, MPH is Professor in the Department of Health Promotion and Policy, Pediatric Dentistry Program, University of Maryland Dental School. Dr. Goodman directs the Pediatric Dental Fellowship program, which provides care to underserved children throughout Maryland. He also serves as the Region 3 Head Start Oral Health Consultant responsible for oral health training and technical assistance for programs in DE, MD, PA, VA, WV, & DC. Dr. Goodman previously served as the Maryland State Dental Director. Prior to that, he was the Dental Public Health Residency Director for the VA Maryland Healthcare System and was Clinical Director of a community health center dental program for indigent children in New Mexico. Dr. Goodman has given numerous presentations at national and local meetings and has published many articles with his primary interests in oral cancer and health services utilization. He rreceived his dental degree from the University of Medicine and Dentistry of New Jersey in 1975 and obtained a Masters in Public Health (MPH) degree from the Johns Hopkins School of Hygiene and Public Health in 1986. He also completed a one-year Dental Public Health residency program at the University of Michigan School of Public Health in 1989.

Gregory B. McClure, DMD, MPH is the dental director for the Delaware Division of Public Health. He is responsible for the dental public health program, which includes managing the Division's dental clinic system. Dr. McClure serves as dental consultant for the dental Medicaid program and is a Delaware Institute of Dental Education and Research Board member representing the Division of Public Health. He also is the clinical director for the Special Smiles program of Special Olympics. Prior to joining the Division of Public Health, Dr. McClure was in general practice in Binghamton, NY where he also completed his residency in Dental Public Health with the New York State Department of Health. His residency research focused on county and state dental public health programs to improve access to dental care, prevention, and coalition development.

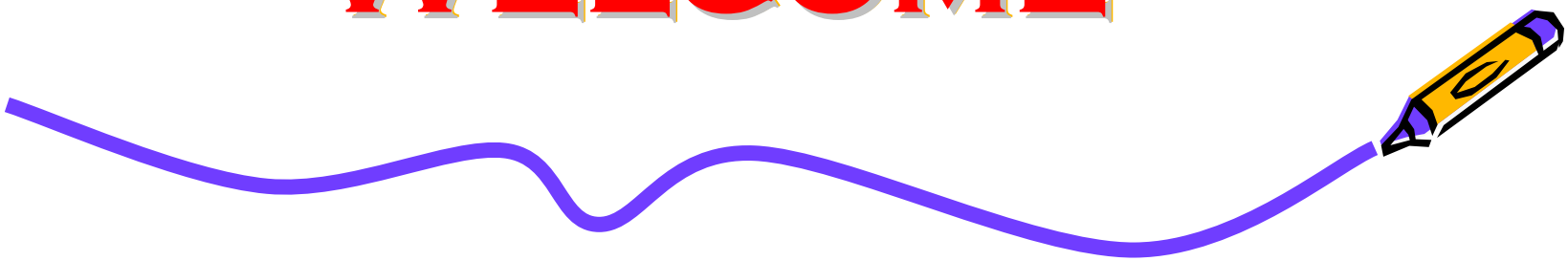
Valerie Woodruff, M.Ed. has served as Secretary of Education since July 1999. Prior to being appointed Secretary of Education, Mrs. Woodruff served as the Associate Secretary for Curriculum and Instructional Improvement for the Delaware Department of Education. She has been a teacher, counselor, assistant principal and principal in high schools in both Maryland and Delaware. Secretary Woodruff led the development of the first School Based Wellness Center in Delaware, has served as a Thomson Fellow for the Coalition of Essential Schools, and was selected as Delaware's Principal of the Year in 1990. She currently serves as a member of several boards including the Delaware Workforce Investment Board and its Youth Council, Delaware Region National Council for Community and Justice and the State Chamber of Commerce Partnership. She is also a Delaware representative on the Southern Regional Education Board and serves on the Executive Committee of SREB. She has served on the Board of the Council of Chief State School Officers and was recently chosen as President-elect of CCSSO.

Appendix E

Speaker's Presentations

Head Start Oral Health Forum
June 3, 2005

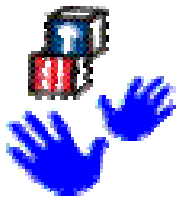
Welcome



Gregory B. McClure, DMD, MPH
Suzanne S. Burnette

Forum Sponsors

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health



Delaware
Head Start Association

Delaware
Department of Education

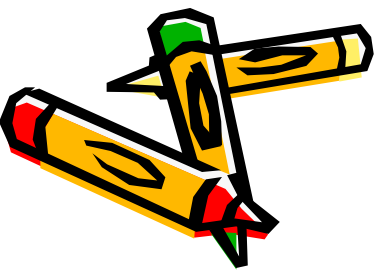
Delaware Head Start
State Collaboration project
Early Childhood Assistance Program

Purpose of the Forum

To Improve the Oral Health
of Head Start Children in Delaware

Forum Learning Objectives

- To gain an understanding of how DE's Head Start program measures against the national Head Start Performance Standard requirements on oral health.
- To learn about national strategies to improve oral health access, prevention and practitioner availability for Head Start enrolled children.
- To develop an action plan for putting six critical oral health strategies into practice for the benefit of Delaware children enrolled in Head Start.
- To gain an understanding of the impact of oral health on school readiness and public policy implications in reaching Delaware's school readiness goals



Head Start and Early Head Start: Establishing a Foundation for a Lifetime of Oral Health

Jim Crall, DDS, ScD

Director, MCHB National Oral Health Policy Center
UCLA Center for Healthier Children, Families & Communities

Delaware Head Start Forum
June 3, 2005

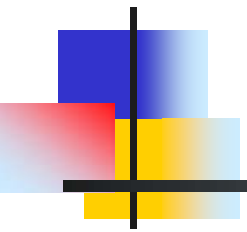
Presentation Overview

- Magnitude & significance of oral health problems in preschool children and contributing factors
- Emerging science and opportunities for improving oral & general health in HS
- Current systems gaps
- Challenges getting HS children connected to dental care + 3 successful models
- Key elements & strategies for creating effective Head Start oral health programs

Background and Environment

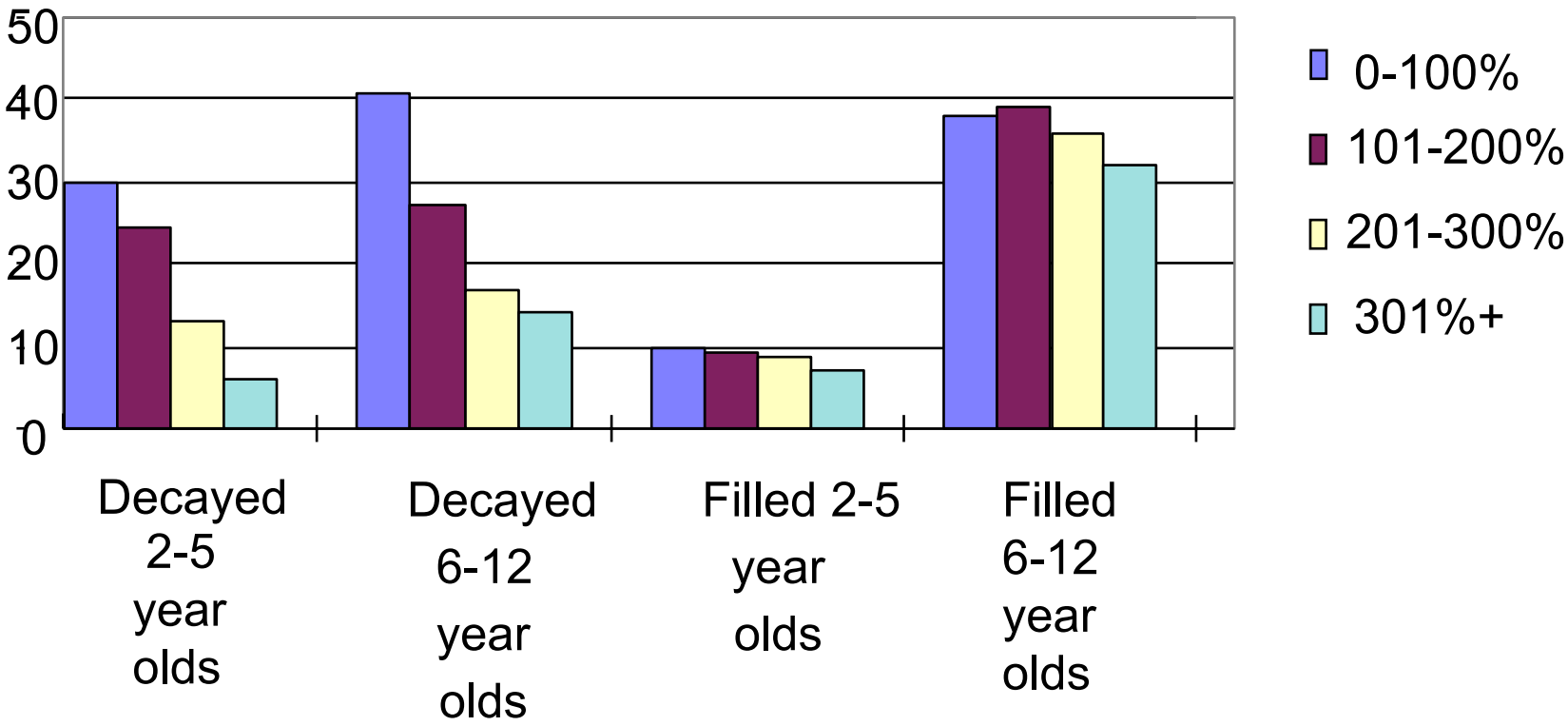
- Children eligible for Medicaid and SCHIP are 3-5x more likely to have untreated decay (NHANES III)
- Access to dental services for children covered by Medicaid has been a chronic problem (OIG, 1996; GAO, 2000)
  - funding is not the only issue, but it IS a major issue
- Dental decay is highly preventable, but not simply or uniformly preventable (SGROH, 2000)
- EPSDT requires prevention AND treatment
- Dental workforce is busy, diminishing and "unorganized". . . but the population is growing, especially groups at higher risk for dental disease.

Tooth Decay and Oral Health Problems in EHS/Head Start & Preschool Children



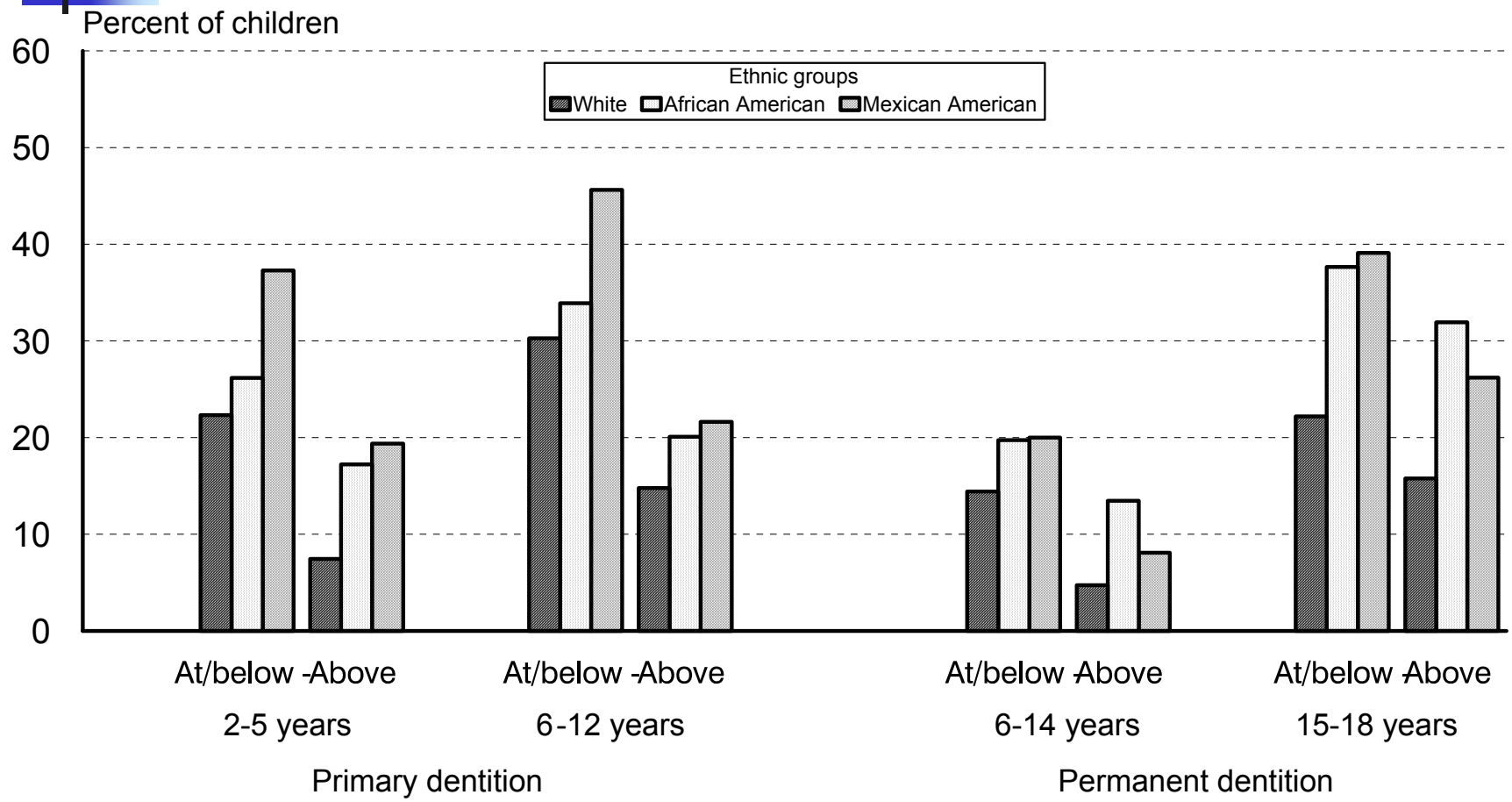
Percent of Children with Decayed and Filled Primary Teeth by Household Income Level

(by % of Federal Poverty Level)



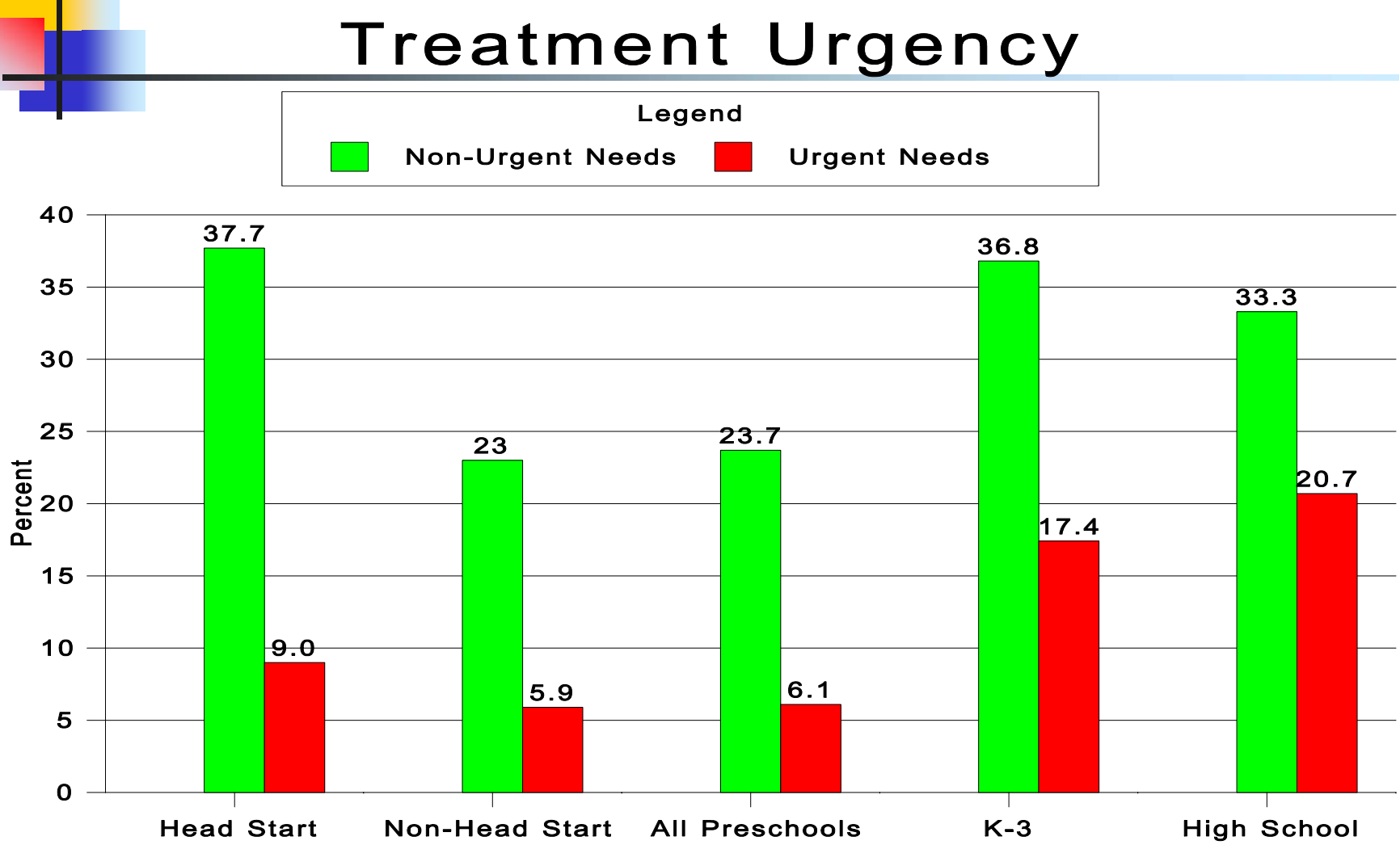
Vargas, Crall, Schneider. Analysis of NHANES III data. JADA, 1998.

Percent of Children with Caries by Income Level and Ethnicity



Vargas, Crall, Schneider: JADA 1998;129:1229-1238.

Treatment Urgency Data
California Needs Assessment - 1993-94



Results of a MD State-wide Survey

- 52% of children in Head Start centers had untreated tooth decay
  - 43% of 3 year-olds
  - 62% of 4 year-olds
- Over 5 decayed tooth surfaces per child with decay

Vargas CM, Monajemy N, Khurana P, Tinanoff N. Oral health status of preschool children attending Head Start in Maryland, 2000.Pediatr Dent 2002 May-Jun;24(3):257-63.

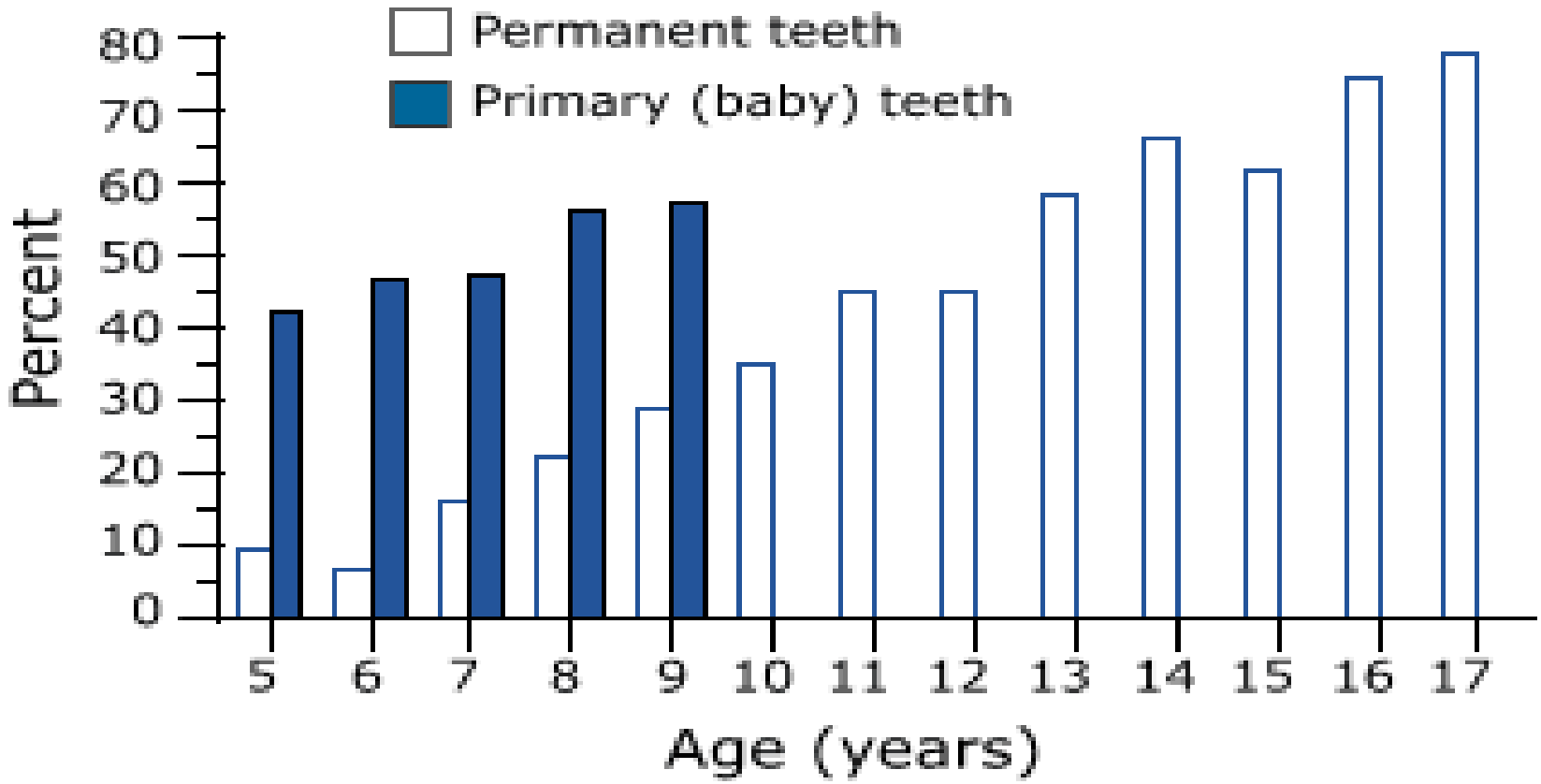
Keys to Good Oral Health

- Good eating & snacking practices
- Regular "self-care" practices
  - Daily brushing with F toothpaste

"While health is a blessing, it doesn't work until it becomes a habit" – *Dr. Ernest Smith*

- Access to "dental homes"
  - Regular, ongoing source of dental care
  - Diagnostic, preventive, disease management & treatment services, ideally risk-based

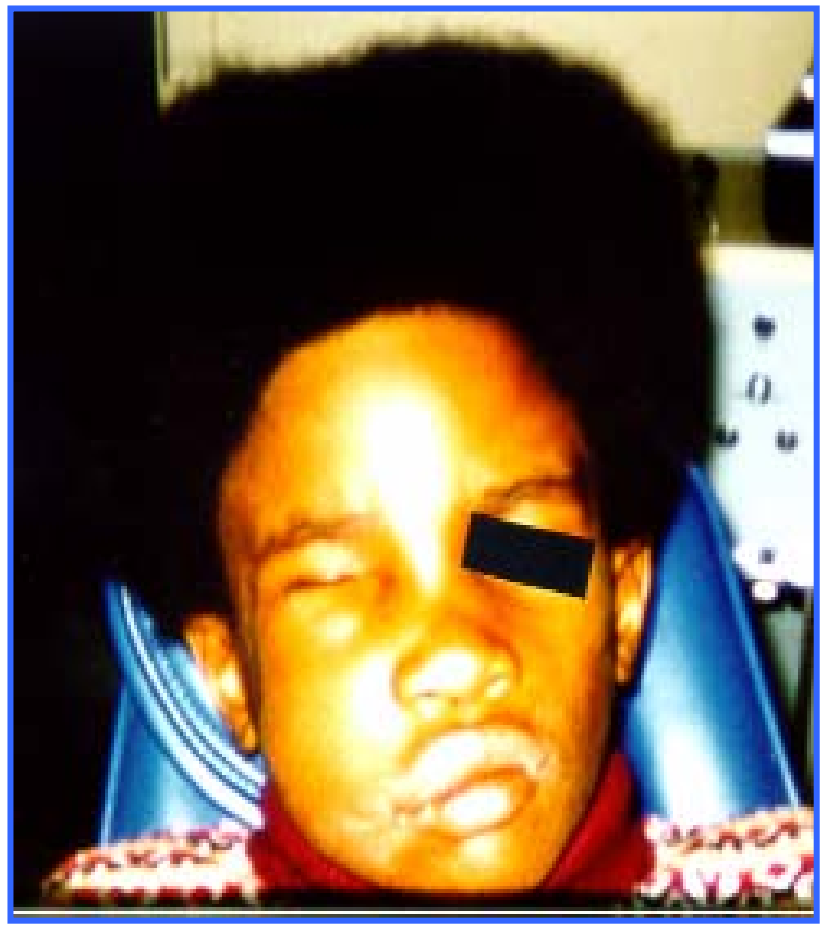
"Baby Teeth": A LAB Problem for Parents & Professionals



Source: National Center for Health Statistics, CDC. Third National Health and Nutrition Examination Survey, 1988-1994

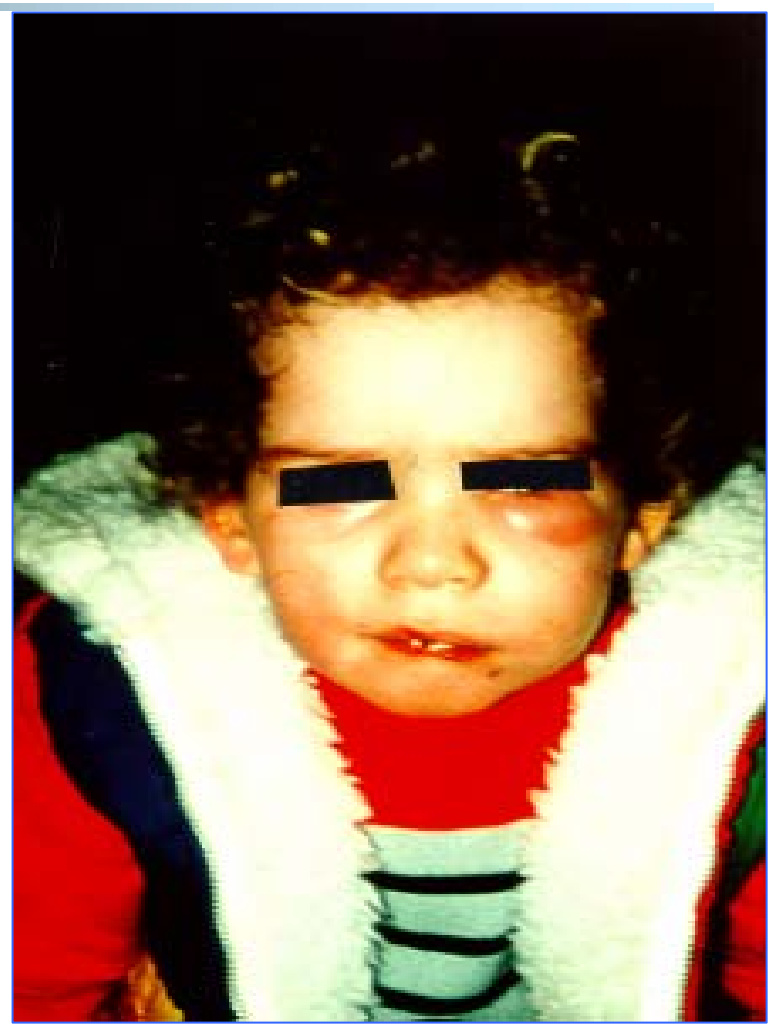
Its about much more than "baby teeth"

What do you suppose the PET scan of this child's brain looks like?



It's about much more than "baby teeth"

This facial cellulitis resulted from a cavity in tooth. This child is in pain, can't eat and is suffering. If she is not treated, her ability to breathe could be compromised and she may lose her sight.



Effective Coverage Is Important

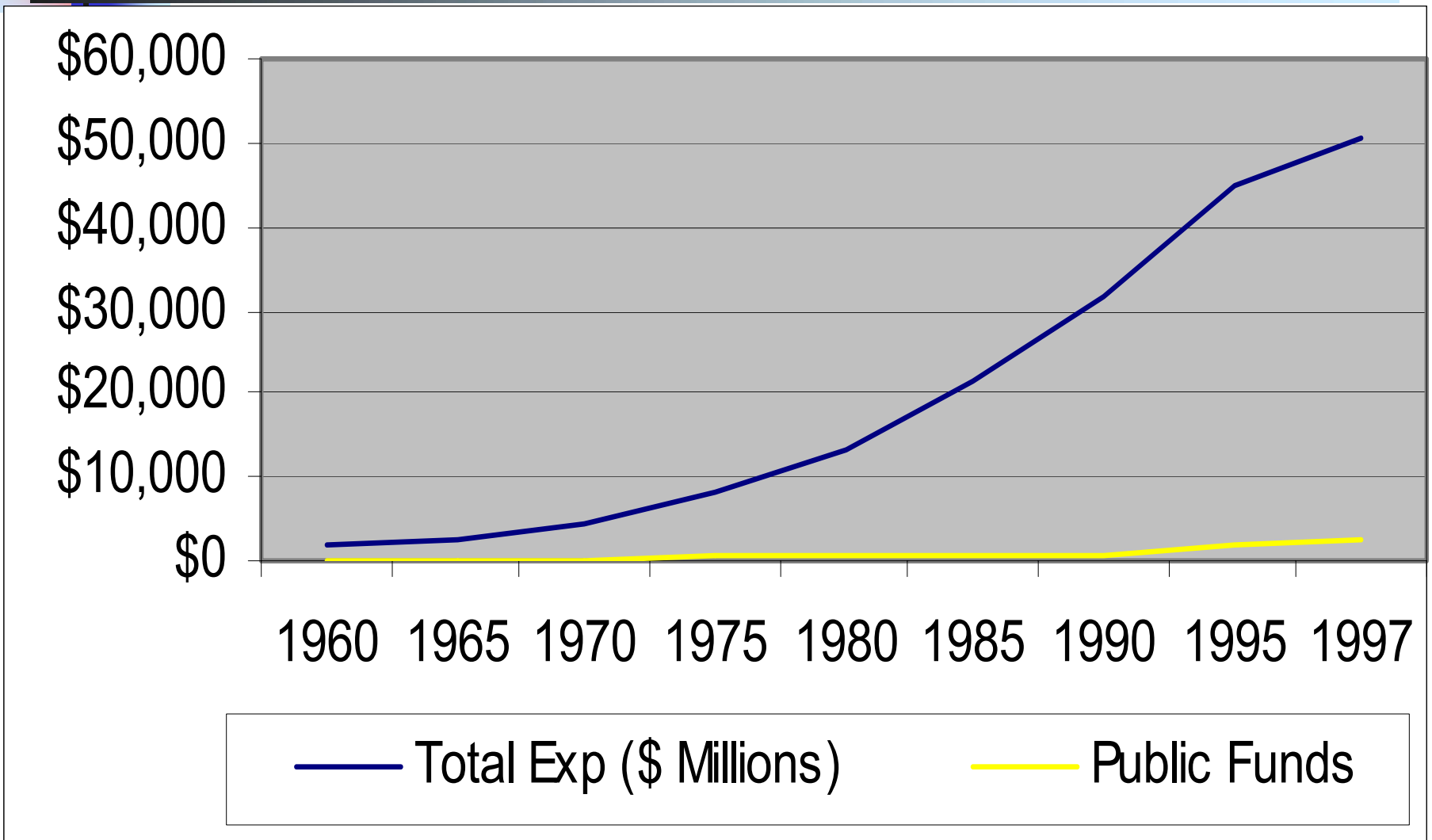
- For every child who lacks “health insurance” there are 2.6 kids who lack dental insurance

- Coverage

that doesn’t provide access

is of little value.

U.S. Dental Care Financing Trends: Total and Public Funding ($M)



Medicaid Expenditures for Pediatric Dental Services

- Dental care expenditures account for over 20% of all pediatric health care expenditures and approximately 30% of all health care expenditures for children ages 6 to 18.
- Medicaid expenditures for pediatric dental services are estimated to be 2.3% of Medicaid expenditures for child health care (0.5% of overall program spending)

State Medicaid Innovations: Delaware

- State-administered program
- Access report (1997) → Dental Care Access Improvement Committee (1998) → NGA Policy Academy → Vision and Program Changes
- Electronic eligibility and claims submission; DE Dental Society Medicaid recruitment program; New provider office manual developed
- 1/1/98: Medicaid pays 85% of dentist's usual charges
- Medicaid participation: 1 → 108 (of 302) dentists

	1998	1999	2000	2001
Number with any Visit (Form 416-12A)	8,428	9,699	13,403	15,430
Number Enrolled (Form 416 – line 1)	60,577	61,028	64,814	67,836

Improving Medicaid Is Essential, but . . .

- Additional education for dentists and dental professionals may be needed
  - About Head Start
  - About providing care for young children
- Need to create programs that identify and share promising approaches for getting Head Start kids, families & programs connected to services in their communities

New Science & Opportunities for Early Head Start

- Bacteria (germs) that cause tooth decay generally are passed from mothers to infants after teeth appear → opportunity to delay infection or change the mix of bacteria
- Mothers with periodontal disease are more likely to have babies that are born early (pre-term) and at low birth weight → potential to have healthier babies and improve mothers' oral health in pregnancy

Current Systems Gaps

Data & Performance Standards:

What PIR Data Show for Head Start Children

- About 74% have a "dental home"
- 78% completed a dental examination
- 60% received preventive care
- 22% were diagnosed as needing treatment
  - Of those, 76% received treatment

But Epidemiologic Surveys Suggest a Different Picture:

Results of a MD State-wide Survey

- 52% of children in Head Start centers had untreated tooth decay
  - 43% of 3 year-olds
  - 62% of 4 year-olds
- Over 5 decayed tooth surfaces per child with decay

Vargas CM, Monajemy N, Khurana P, Tinanoff N. Oral health status of preschool children attending Head Start in Maryland, 2000. Pediatr Dent 2002 May-Jun;24(3):257-63.

Gaps In Oral Health & Oral Health Care

What we have --------

- Relatively high rates of oral diseases
  - Those with the greatest needs & highest risk have least access to services
- Disjointed / fragmented delivery system
  - Public Sector / Private Sector
  - Dental Care / Primary Care
  - 'Preventers' / 'Treaters'
  - Clinicians / Communities
- 'Blind' / one-size-fits-all / dated approaches to service delivery

Gaps In Oral Health & Oral Health Care

What we have --------What we need

- Relatively high rates of oral diseases
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- 'Blind' / one-size-fits-all / dated approaches to service delivery

- Continuous, coordinated, risk-based use of effective measures that promote oral health, control oral diseases and restore damaged oral structures

Gaps In Oral Health & Oral Health Care

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- Relatively high rates of oral diseases
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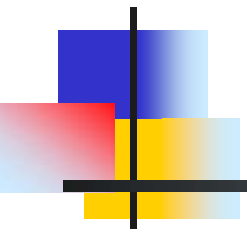
  - Public Sector / Private Sector
  - Dental Care / Primary Care
  - 'Preventers' / 'Treaters'
  - Clinicians / Communities
- 'Blind' / one-size-fits-all / dated approaches to service delivery

- Continuous, coordinated, risk-based use of effective measures that promote oral health, control oral diseases and restore damaged oral structures
- Strategic, data-driven approaches that recognize and respect diversity among people and communities, and engage a broad group of stakeholders to address local needs

Dental Homes and Systems Integration:

Concepts & Implementation Challenges



AAP Policy Statement

Oral Health Risk Assessment Timing and Establishment of the Dental Home

AMERICAN ACADEMY OF PEDIATRICS

Policy Statement

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Section on Pediatric Dentistry

ABSTRACT. . . . To prevent caries in children, high-risk individuals must be identified at an early age (preferably high-risk mothers during prenatal care), and aggressive strategies should be adopted, including anticipatory guidance, behavior modifications (oral hygiene and feeding practices), and establishment of a dental home by 1 year of age for children deemed at risk.

Pediatrics 2003; 111 (5) :1113-1116.

Oral Health Risk Assessment Timing and Establishment of the Dental Home
AMERICAN ACADEMY OF PEDIATRICS

RISK GROUPS FOR DENTAL CARIES

If an infant is assessed to be within 1 of the following risk groups, the care requirements would be significant and surgically invasive; therefore, these infants should be referred to a dentist as early as 6 months of age and no later than 6 months after the first tooth erupts or 12 months of age (whichever comes first) for establishment of a dental home:

- Children with special health care needs
- Children of mothers with a high caries rate
- Children with demonstrable caries, plaque, demineralization, and/or staining
- Children who sleep with a bottle or breastfeed throughout the night
- Later-order offspring
- Children in families of low socioeconomic status

Oral Health Risk Assessment Timing and Establishment of the Dental Home

AMERICAN ACADEMY OF PEDIATRICS

ESTABLISHING THE DENTAL HOME

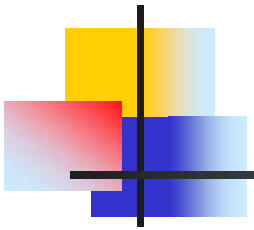
The concept of the "dental home" is derived from the American Academy of Pediatrics concept of the "medical home." . . . Pediatric primary dental care needs to be delivered in a similar manner. The dental home is a specialized primary dental care provider within the philosophical complex of the medical home. Referring a child for an oral health examination by a dentist who provides care for infants and young children 6 months after the first tooth erupts or by 12 months of age establishes the child's dental home and provides an opportunity to implement preventive dental health habits that meet each child's unique needs and keep the child free from dental or oral disease.

Caries Risk Assessment Tools

Source: American Academy of Pediatric Dentistry Reference Manual. Available at: www.aapd.org

AAPD Caries-Risk Assessment Tool (CAT)

Caries Risk Indicators		Low Risk	Moderate Risk	High Risk
	Clinical Conditions	• No decayed teeth in past 24 months • No enamel demineralization (enamel caries "white-spot lesions") • No visible plaque; no gingivitis	• Decayed teeth in the past 24 months • 1 area of enamel demineralization (enamel caries "white-spot lesions") • Gingivitis[A]	• Decayed teeth in the past 12 months • More than 1 area of enamel demineralization (enamel caries "white-spot lesions") • Radiographic enamel caries • Visible plaque on anterior (front) teeth • High titers of mutans streptococci • Wearing dental or orthodontic appliances[B] • Enamel hypoplasia[C]
	Environmental Characteristics	• Optimal systemic and topical fluoride exposure[D] • Consumption of simple sugars or foods strongly associated with caries initiation[E] primarily at mealtimes • High caregiver socioeconomic status[F] • Regular use of dental care in an established Dental Home	• Suboptimal systemic fluoride exposure with optimal topical exposure[D] • Occasional (e.g., 1-2) between-meal exposures to simple sugars or foods strongly associated with caries • Mid-level caregiver socioeconomic status (e.g., eligible for school lunch program or SCHIP) • Irregular use of dental services	• Suboptimal topical fluoride exposure[D] • Frequent (e.g., 3 or more) between-meal exposures to simple sugars or foods strongly associated with caries • Low-level caregiver socioeconomic status (e.g., eligible for Medicaid) • No usual source of dental care • Active decay present in the mother of a preschool child
	General Health Conditions			• Children with special health care needs[G] • Conditions impairing saliva composition/flow[H]



PERIODIC ASSESSMENTS

- **RISK LEVEL** (low, high)
- **DISEASE STATUS** (none, initial, advanced)
- **NEED FOR TREATMENT** (urgent, basic, advanced)

No Disease Low Risk	No Disease High Risk	Initial Disease Only	Advanced Disease
Recommend dental exam within 12 mos. Counseling to maintain low risk Anticipatory Guidance Recommend primary prevention (e.g., fluoride, sealants) Data Entry	Refer to dental home for dental examination & prevention within 6 mos. Risk mgt. program to reduce risk Anticipatory Guidance Reassess compliance in 6 months Data Entry	Refer to dental home for diagnosis to verify initial disease status Initial disease mgt. program to control disease and reduce risk Anticipatory Guidance Reassess in 3-6 months based on risk level Data Entry	Refer to dental home to develop and implement reparative treatment plan Advanced disease mgt. program to control disease and reduce risk Anticipatory Guidance Reassess in 3-6 months based on risk level Data Entry

Adapted from:
Crall JJ,
Edelstein BL.
Appendix II
Systems Capacity
and Integration.
Available at:
www.cthealth.org.

Caries = An Infectious, transmissible disease; but also a chronic, complex disease.

By appreciating that dental caries belongs to the group of common diseases considered as 'complex' or 'mulifactorial' such as cancer, heart diseases, diabetes, and certain psychiatric illnesses, we have to realise that there is no simple causation pathway. It is not a simplistic problem such as 'elimination of one type of microorganism', or a matter of improving 'tooth resistance'. Complex diseases cannot be ascribed to mutations in a single gene or to a single environmental factor. Rather they arise from the concerted action of many genes, environmental factors, and risk-conferring behaviours. As stressed recently by

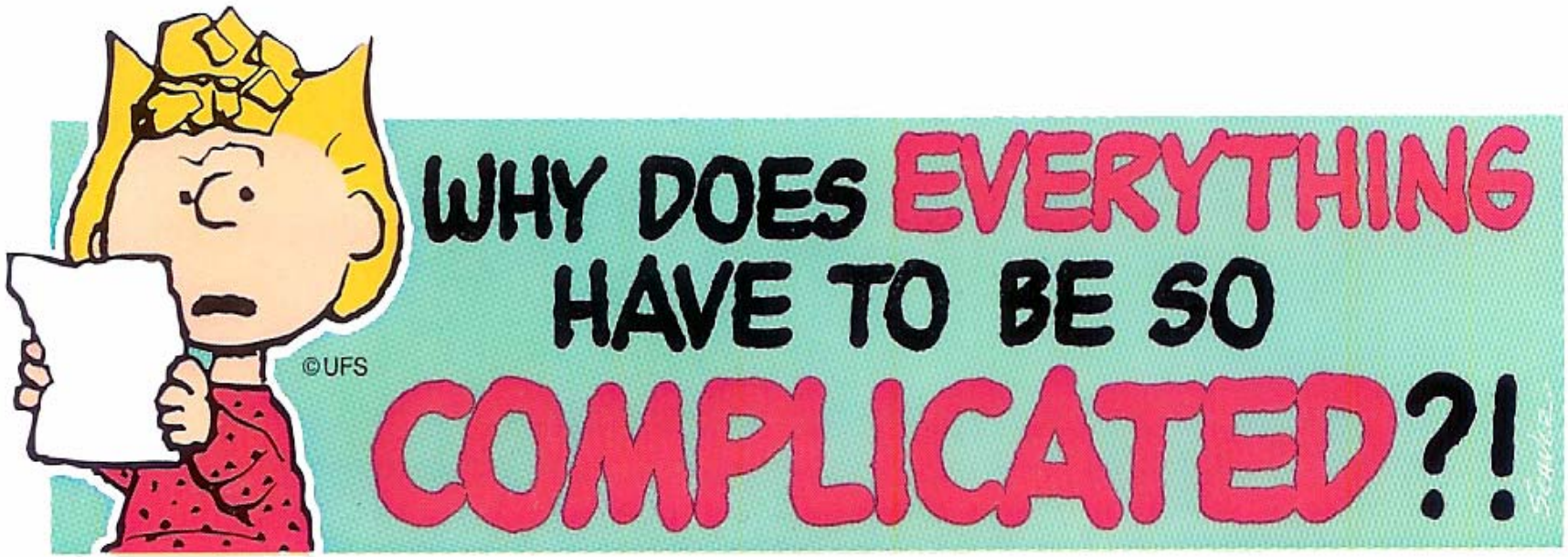
Fejerskov O. Changing paradigms in concepts on dental caries: consequences for oral health care. *Caries Res* 2004; 38:182-91.

Let us keep in mind that dental caries is ubiquitous in all populations [Fejerskov and Baelum, 1998], but the incidence rate varies greatly within and between populations. It is important to appreciate that the caries incidence rate in a group of individuals appears fairly constant throughout life if no special efforts to control lesion progression are made [Hand et al., 1988; Luan et al., 2000]. These new paradigms help to explain the nature of lesion initiation and progression and accordingly why dental caries cannot truly be 'prevented', but rather 'controlled' by a multitude of interventions.

At the individual patient level we have successfully 'controlled' the physiologic balance of the intra-oral environment with topical fluorides, dietary monitoring, 'plaque control', etc., but the well-trained clinician knows that some patients require much more and 'closer' monitoring than others to avoid new lesions. The consequence of the paradigms is to appreciate that the risk of developing new lesions is never zero. Therefore dental caries can never be 100% preventable at the individual and much less at the societal level because of its complex nature. Dental caries is as old as mankind.

Challenges & Models for Connecting Kids to Dental Care

- Arranging for dental homes for HS children with a local pediatric dentist (MS)
- Distributing care across local and remote resources (PA)
  - General dentists
  - Pediatric dentists
- Efficient method for conducting exams and prevention backed up by a system committed to providing treatment and "dental homes" for HS children (CT)


©UFS
WHY DOES EVERYTHING
HAVE TO BE SO
COMPLICATED?!

Why Head Start?

- Kids need services → low-income families
- Young kids → chance to intervene early
- Manageable numbers → ¼ of eligibles
- Program support → scheduling, transportation, follow-up, payments
- Efficient use of personnel
- Opportunity for daily "self care"
- Opportunity to educate parents & teachers
- Potential "halo effect" for families
- Potential for meaningful and sustainable improvements in a relatively short time

Vision for Head Start Oral Health

- Head Start families, communities and learning environments actively engaged in effective oral health promotion
  - Sound nutrition and feeding practices
  - Daily oral health "self-care" activities
    - Brushing with fluoride toothpaste
  - Oral health education for kids & parents
  - Professional oral health screening, exams, risk assessment and individualized follow-up services for all needed services
  - Oral health leadership, technical expertise & support services to connect kids to care
  - "Dental Homes" for all children

Vision for Head Start Oral Health

- Community-based systems that provide comprehensive care making efficient use of local providers
  - On-site assessment and individualized prevention and disease managment
  - In-office/clinic diagnosis, preventive services, risk mgt., disease mgt. and treatment services as needed
- Local dental groups linked to Head Start programs and providing "dental homes" for all Head Start children
- Other community service providers educated and linked to Head Start

Broad Strategies / Goals

- Reduce the burden of disease
  - Health promotion
  - Preventive services
  - Disease management
  - Treatment services
- Expand access to ongoing diagnostic, preventive and treatment services in “dental homes”
- Application of risk assessment and targeted interventions

Evidence of the Value of Early Childhood Oral Health Care

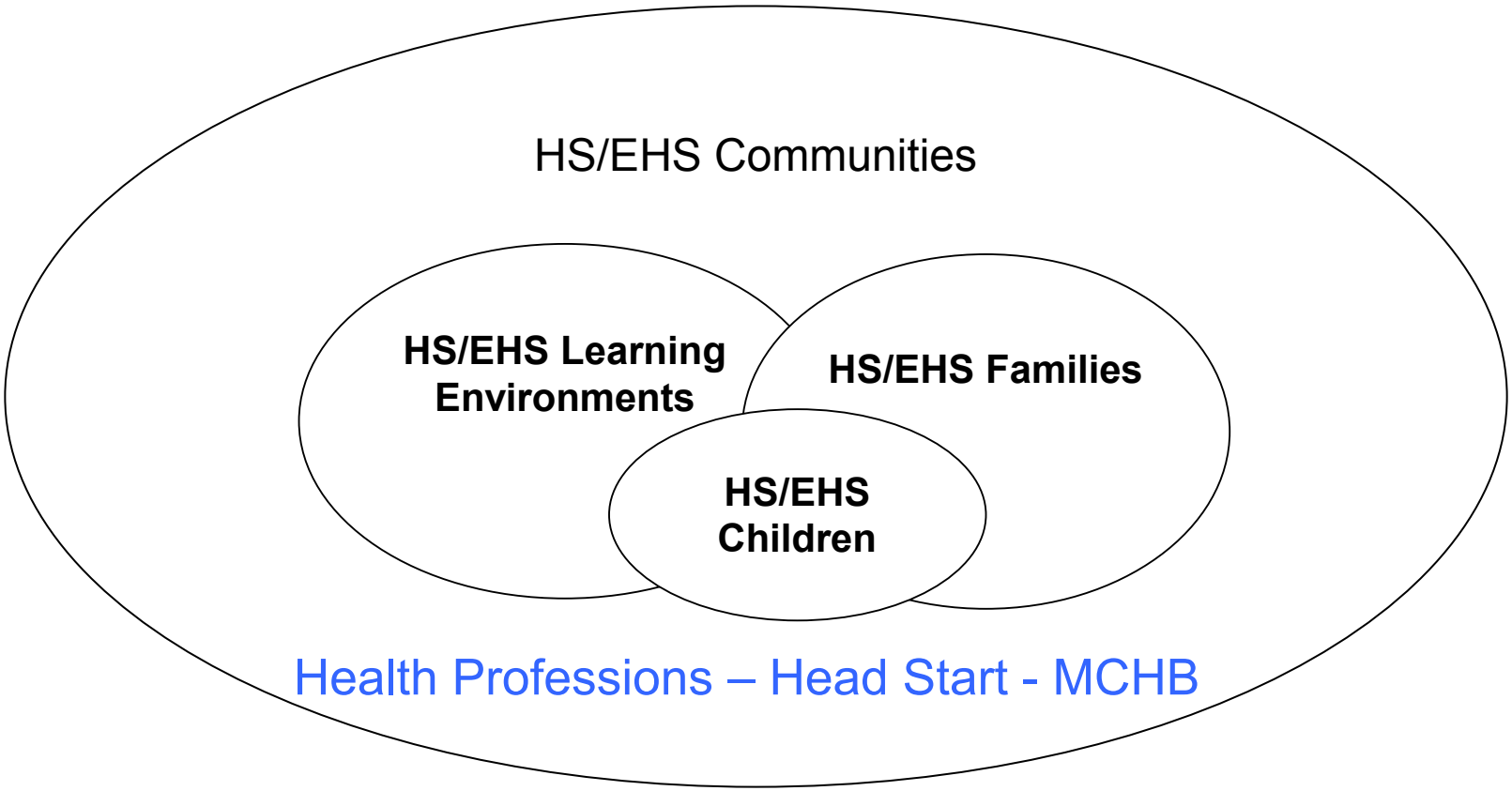
- Savage MF, Lee JY, Kotch JB, Vann WF Jr. Early preventive dental visits: effects on subsequent utilization and costs. *Pediatrics* 2004;114:418-23.

- Jokela J, Pienihakkinen K. Economic evaluation of a risk-based caries prevention program in preschool children. *Acta Odontol Scand* 2003;61(2):110-4.

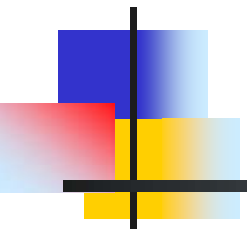
Keys to Good Oral Health

- Good eating & snacking practices
- Regular "self-care" practices
  - daily brushing with F toothpaste
  - "While health is a blessing, it doesn't work until it becomes a habit" – *Dr. Ernest Smith*
- Access to "dental homes"
  - regular, ongoing source of dental care
  - diagnostic, preventive & treatment services

Key Elements & Strategies: Building Effective Partnerships "Up and Down the Line"



Thank you
for all that you do
for Head Start!!!



Overview of Head Start Oral Health Requirements and Status of Delaware Head Start Dental Services

Delaware Head Start Oral Health Forum
June 3, 2005

Harry Goodman, DMD, MPH
Region III Head Start Oral Health Consultant
Professor, University of Maryland Dental School

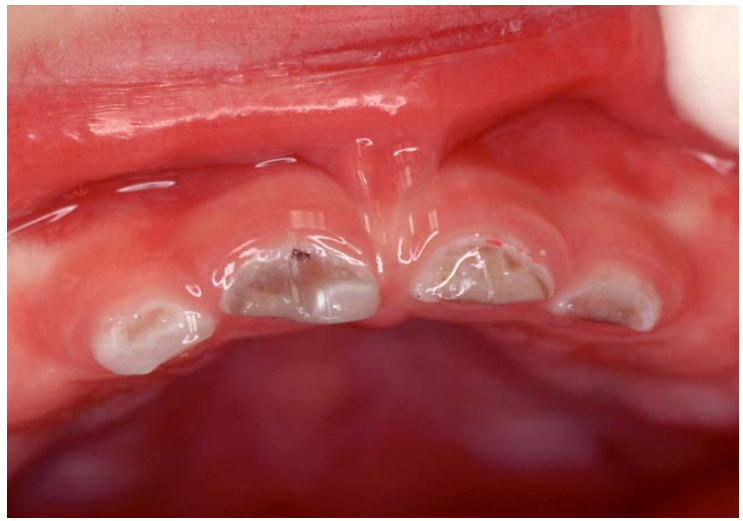
Dental Factoids

- Tooth decay is the single most common chronic childhood disease
- Poor preschoolers (ages 2-5) have 5 times the rate of tooth decay and 2 times the rate of dental pain than their affluent peers
  - More extensive tooth decay
  - Only half as likely to access a dentist
- 1 in 5 two-to-four year olds have visible cavities
- Low income Head Start preschoolers nearly 3 times as likely to obtain a dental screening than other low income children.

National Health and Nutrition Examination Survey (1988-1994)
Head Start Program Information Reports
Surgeon's General Report on Oral Health, 2000

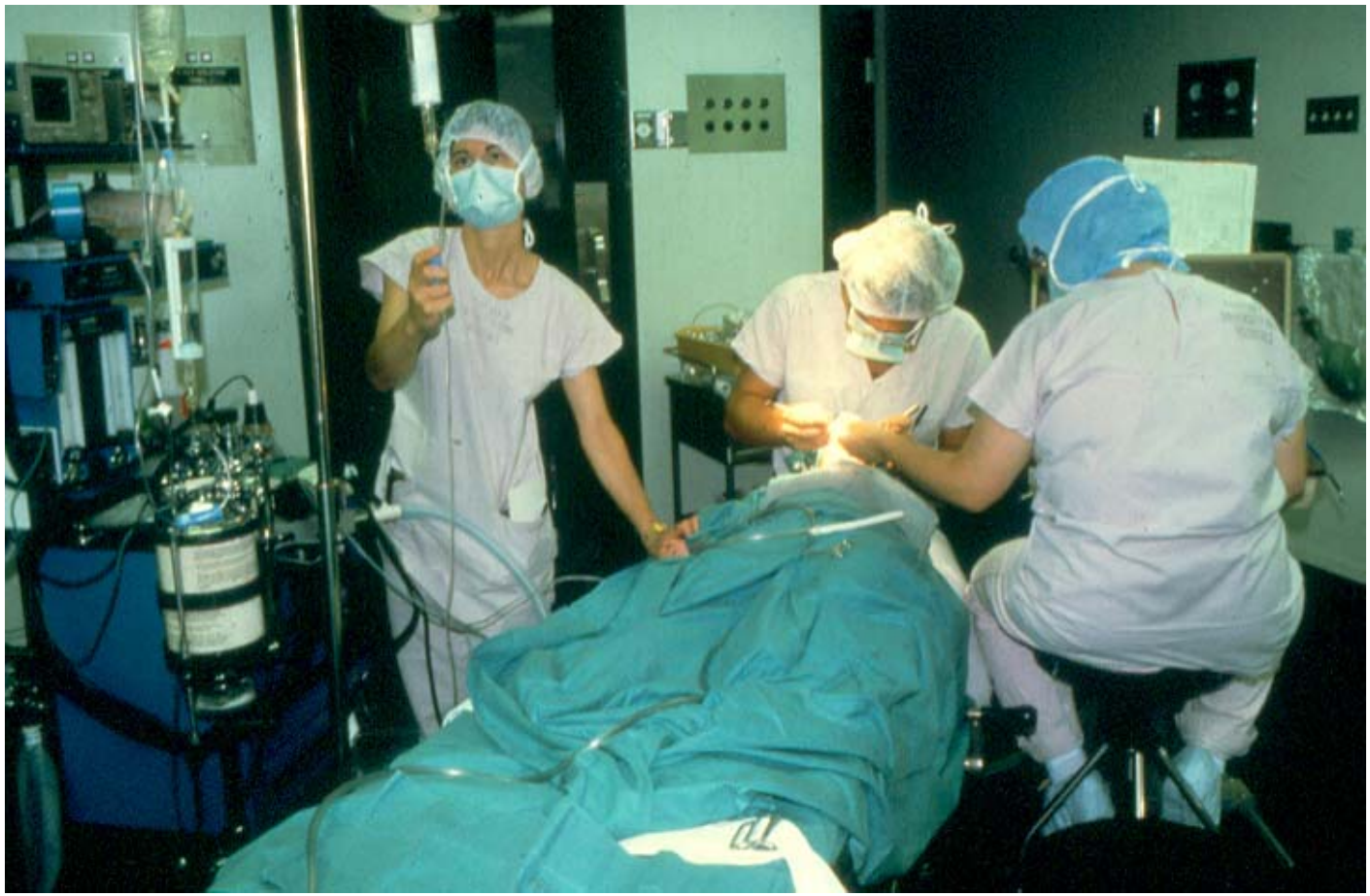
Early Childhood Caries (E.C.C.)

- Infectious disease
- Initially affecting primary incisors
- Initiated prior to 36 months of age
- Associated with inappropriate use of sugar
- Significant public health issue

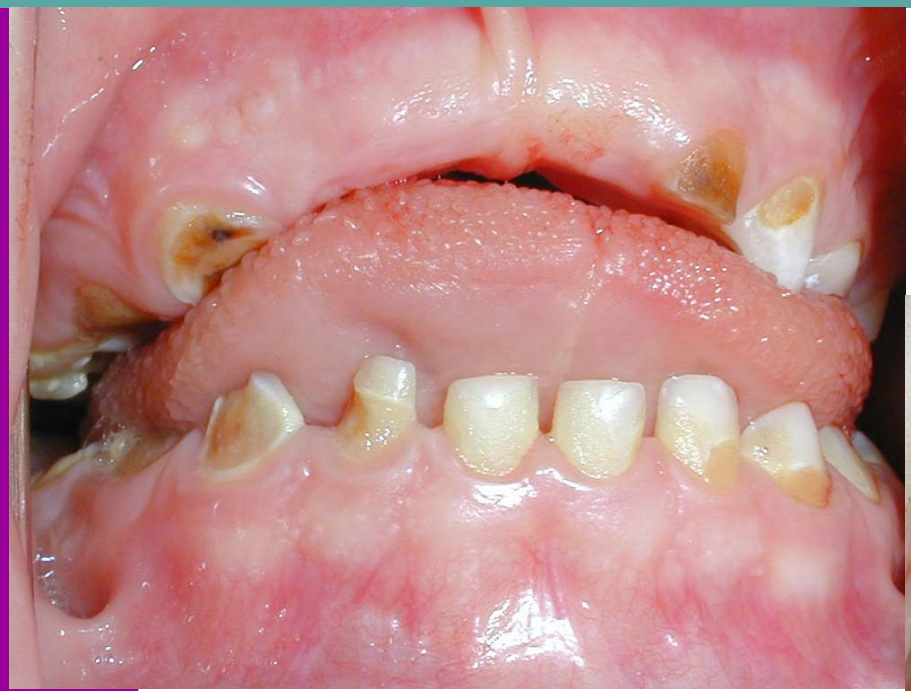


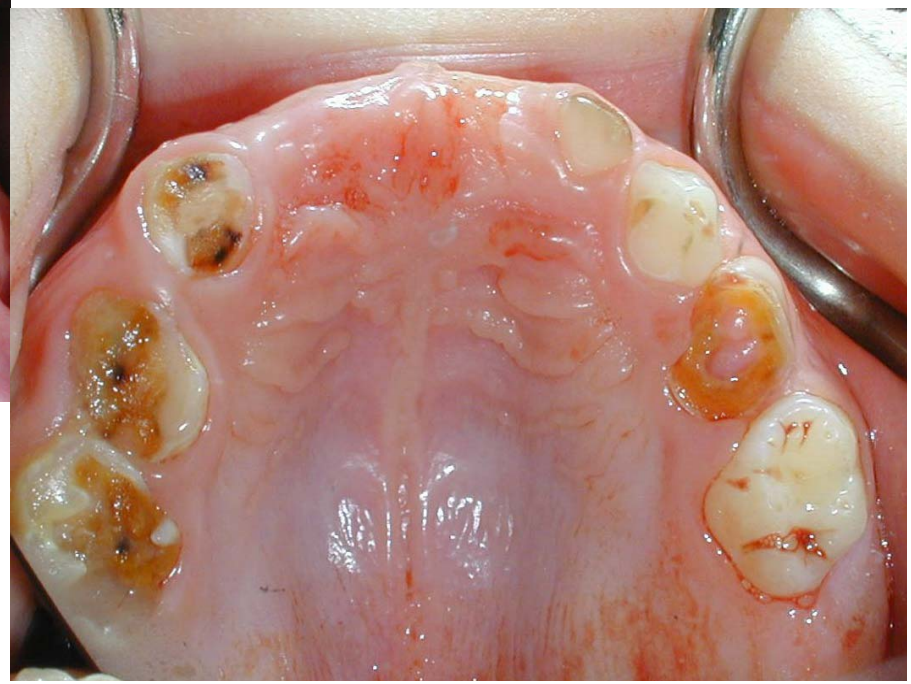
CDC Report on ECC, 1994

ECC is Costly to Treat

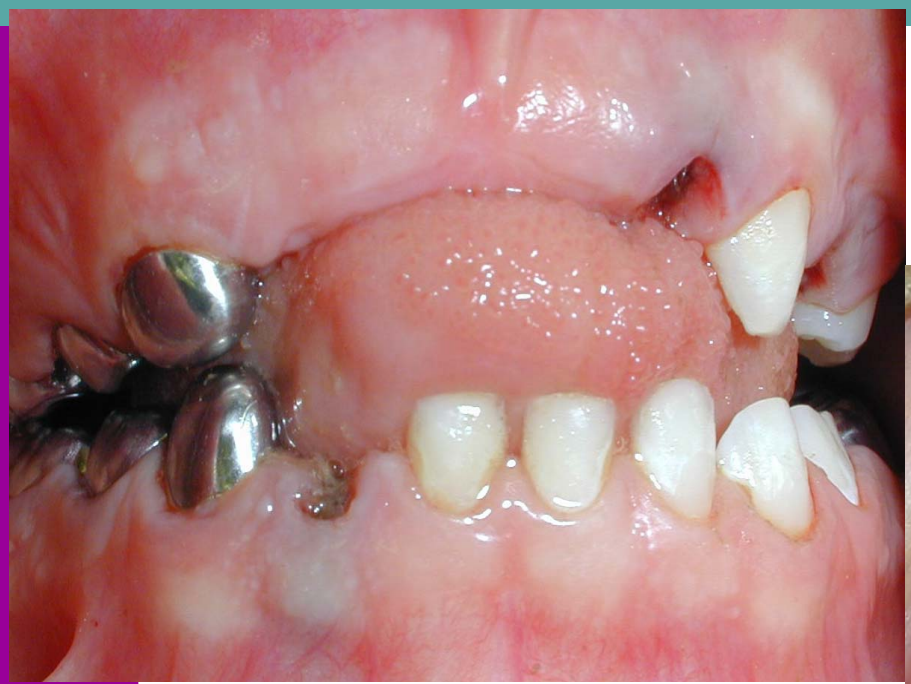


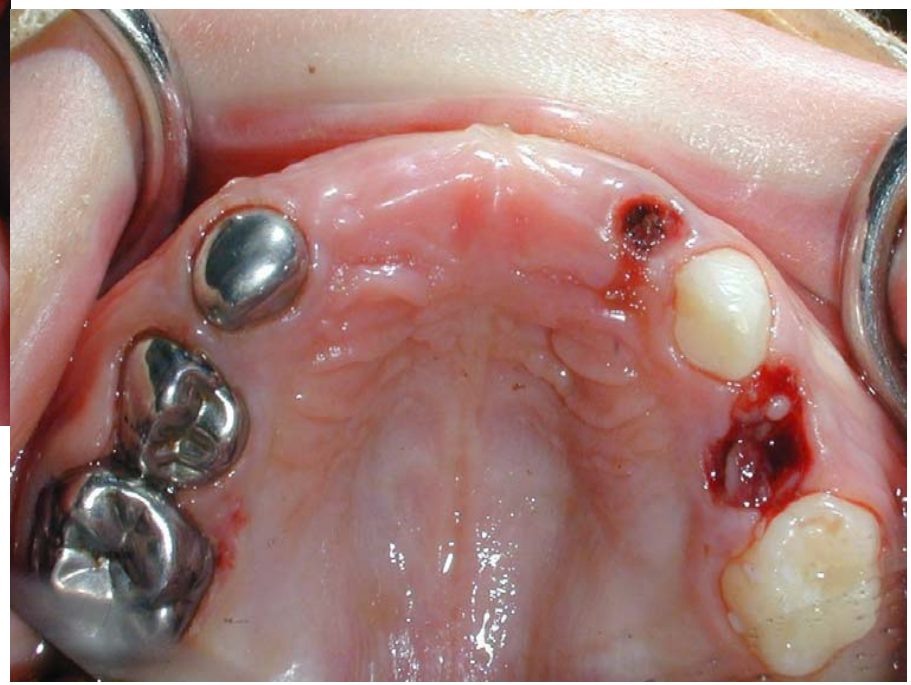
ECC is Difficult to Treat





ECC is Difficult to Treat





Oral Health and Head Start

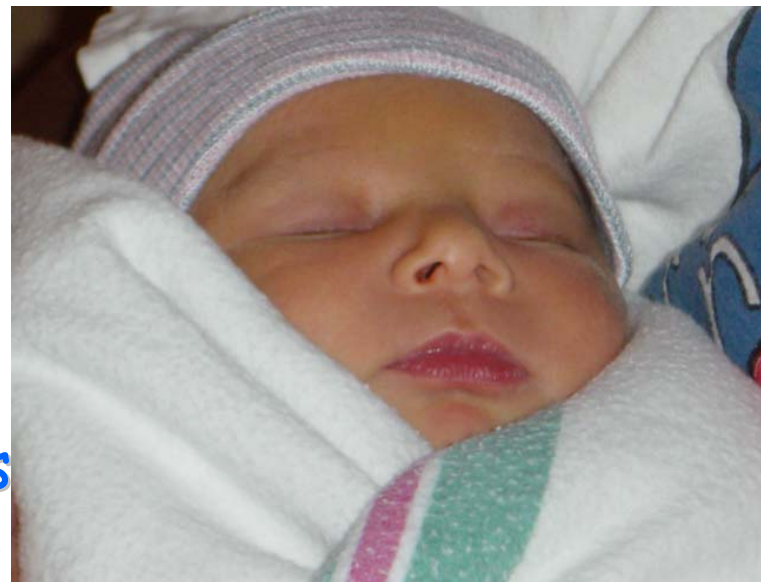
- Oral health is an integral component of Head Start
- Strategies are being developed at the national, state and local levels to integrate access to dental care, prevention and education into Head Start program activities
  - National Maternal and Child Oral Health Resource Center
    - www.mchoralhealth.org

Oral Health and Head Start

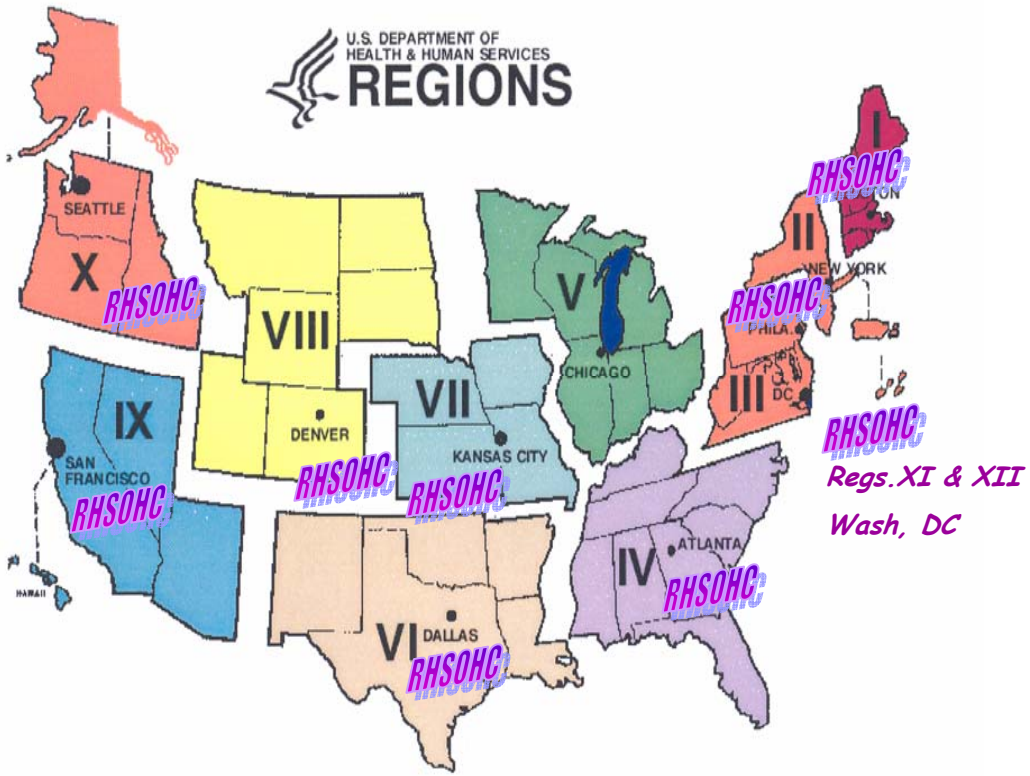
- National oral health initiatives have been included in an Interagency Agreement (IAA) between the:
  - Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA) and the
  - Administration for Children and Families (ACF)/Head Start Bureau

ACF/HRSA IAA Accomplishments

- ASTDD Head Start Committee
- Head Start included in National Oral Health Policy Center and National Oral Health Resource Center
- Oral health in Head Start Learning Center
- Funding & grant opportunities
- Oral health a top priority for Head Start
- 10 Regional Head Start Oral Health Consultants
- Regional and State Forums



Regional Head Start Oral Health Consultants



- Mary Foley, R.D.H., M.P.H (Boston, Reg. I)
- Neal Herman, D.D.S. (New York, Reg. II)
- Harry Goodman, D.M.D., M.P.H. (Philadelphia, Reg. III)
- E. Joseph Alderman,D.D.S., M.P.H. (Atlanta, Reg. IV)
- Kathy Geurink, R.D.H., M.A. (Dallas, Reg. VI)
- Lawrence Walker, D.D.S., M.P.H. (Kansas City, Reg.VII)
- Valerie Orlando, R.D.H. (Denver,Reg. VIII)
- Reginald Louie, D.D.S., M.P.H. (San Francisco, Reg. IX)
- Rebecca Slayton, D.D.S., M.P.H. (Seattle, Reg. X)
- Central Office: (Am. Indian, Alaska Native,Reg.XI; Migrant Reg XII)
  - Mark Nehring, D.D.S., M.P.H. & John Rossetti, D.D.S., M.P.H. MCHB/HRSA

Regional Head Start Oral Health Consultants

Participate in efforts that promote, advocate and improve the oral health of Head Start (HS) and Early Head Start (EHS) children and their families

Regional Head Start Oral Health Consultants: Responsibilities

- Provides oral health consultation, training and technical assistance (T/TA) to the Head Start Regional Office to:
  - Educate Head Start Regional managers and staff
  - Assist in integrating oral health T/TA into Regional T/TA system
  - Explore potential formal relationships with other agencies, organizations, and programs
- Provides T/TA to state dental programs, dental/dental hygiene schools, licensure boards, and professional organizations to increase/enhance access to care and preventive services for HS/EHS children.
- Provides planning and follow-up T/TA to regional and state HS Oral Health Forums

Regional Head Start Oral Health Consultants: Responsibilities

- Participate in consensus building for FAQ's asked by HS grantees & programs
- Provide assistance and/or participate in HS grantee site reviews (PRISM) regarding HS Performance Standards compliance
- Review and provide recommendations on PIR data

Head Start Dental Federal Requirements

- Determining whether a child has a "Dental Home" and helping to find one
- Provide oral examinations by health care professionals
- Assist families in scheduling an appointment with a dentist for treatment
- Follow-up on identified oral health care including prevention and treatment

Head Start Performance Standards

- Child Health and Development (1304.20)
  - Ongoing source of continuous, accessible care
    - Dental home
  - Recommended schedule - preventive & treatment visits
    - Follow-up services
- Education and Early Childhood Development (1304.21)
- Child Health and Safety (1304.22)
  - Dental emergencies
- Child Nutrition (1304.23)
- Family Partnerships (1304.40)
  - Pregnant women
  - Oral Health Education
- Community Partnerships (1304.41)
  - Health care practitioners

EHS/HS Performance Standards

No later than 90 calendar days from the child's first day in EHS or HS:

- Determine if a child is up-to-date on a schedule of age appropriate oral health care services as determined by the State EPSDT program
  - If not up-to-date, assist parents to bring the child up-to-date
  - If up-to-date, ensure recommended schedule is maintained
    - Dental follow-up including prevention (e.g., fluoride therapies) and treatment

Program Information Report (PIR) Data

- All programs must complete annual Program Information Report (PIR) data
- Oral health questions include:
  - Number of HS children with a dental home;
  - Number of EHS/HS children who completed dental examinations
  - Number of HS children who received preventive care
  - Number of EHS children who received well-child screenings
  - Number of EHS pregnant women who received dental exams or treatment
- The PIR also requires programs to report the number of HS children who are diagnosed as needing treatment and the number of those children who actually receive treatment

Program Information Report (PIR) Data
2003-2004

State	% Children Completing Dental Exams	Rank
REGION 3/US	83.92/84.10	x
Delaware	77.99	6
Maryland	87.86	3
Pennsylvania	78.65	5
Virginia	91.45	2
Washington, DC	97.87	1
West Virginia	81.39	4

Program Information Report (PIR) Data
2003-2004

State	% Children Needing Dental Treatment	Rank
REGION 3/US	22.93/26.83	x
Delaware	20.74	3
Maryland	17.21	2
Pennsylvania	24.31	5
Virginia	23.01	4
Washington, DC	15.17	1
West Virginia	29.98	6

Program Information Report (PIR) Data
2003-2004

State	% 0-3 Children w/ Well-Child Visit	Rank
REGION 3/US	73.15/52.40	x
Delaware	71.69	4
Maryland	62.75	5
Pennsylvania	73.71	3
Virginia	86.99	1
Washington, DC	36.47	6
West Virginia	81.23	2

Program Information Report (PIR) Data
2003-2004

State	% Pregnant Women w/ Dental Examination	Rank
REGION 3/US	20.24/34.08	x
Delaware	7.41	6
Maryland	15.46	4
Pennsylvania	22.15	2
Virginia	20.10	3
Washington, DC	62.86	1
West Virginia	10.91	5

Delaware
Migrant Children

- Migrant and Seasonal Head Start
  - Age: 0-5 years old
  - Income: Low income, must qualify based on income guidelines
  - Agriculture: Primary source of family income must come from qualifying agricultural activities
  - Mobility: To qualify as a migrant farmworker, the family must have relocated for the purposes of engaging in agricultural work in the last 24 months. This does not apply to seasonal farmworkers.

Delaware

Migrant and Seasonal Head Start Programs

- East Coast Migrant Head Start Project
  - Private, non-profit agency supported by Migrant programs Branch of the Head Start Bureau, ACF
- Telamon Corporation
  - Smyrna – Head Start
  - Georgetown – Early Head Start
- Excellent PIR dental data results
  - Infants and toddlers (ages 0-3)
  - Pre-school children (ages 3-5)
  - Pregnant women

ACF/HRSA IAA
Accomplishments

- ASTDD Head Start Committee
- Head Start included in National Oral Health Policy Center and National Oral Health Resource Center
- Oral health in Head Start Learning Center
- Funding & grant opportunities
- Oral health a top priority for Head Start
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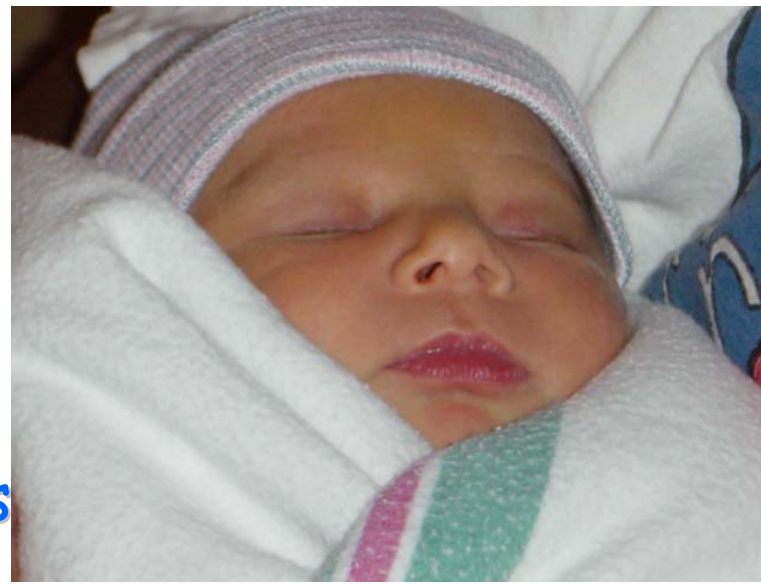
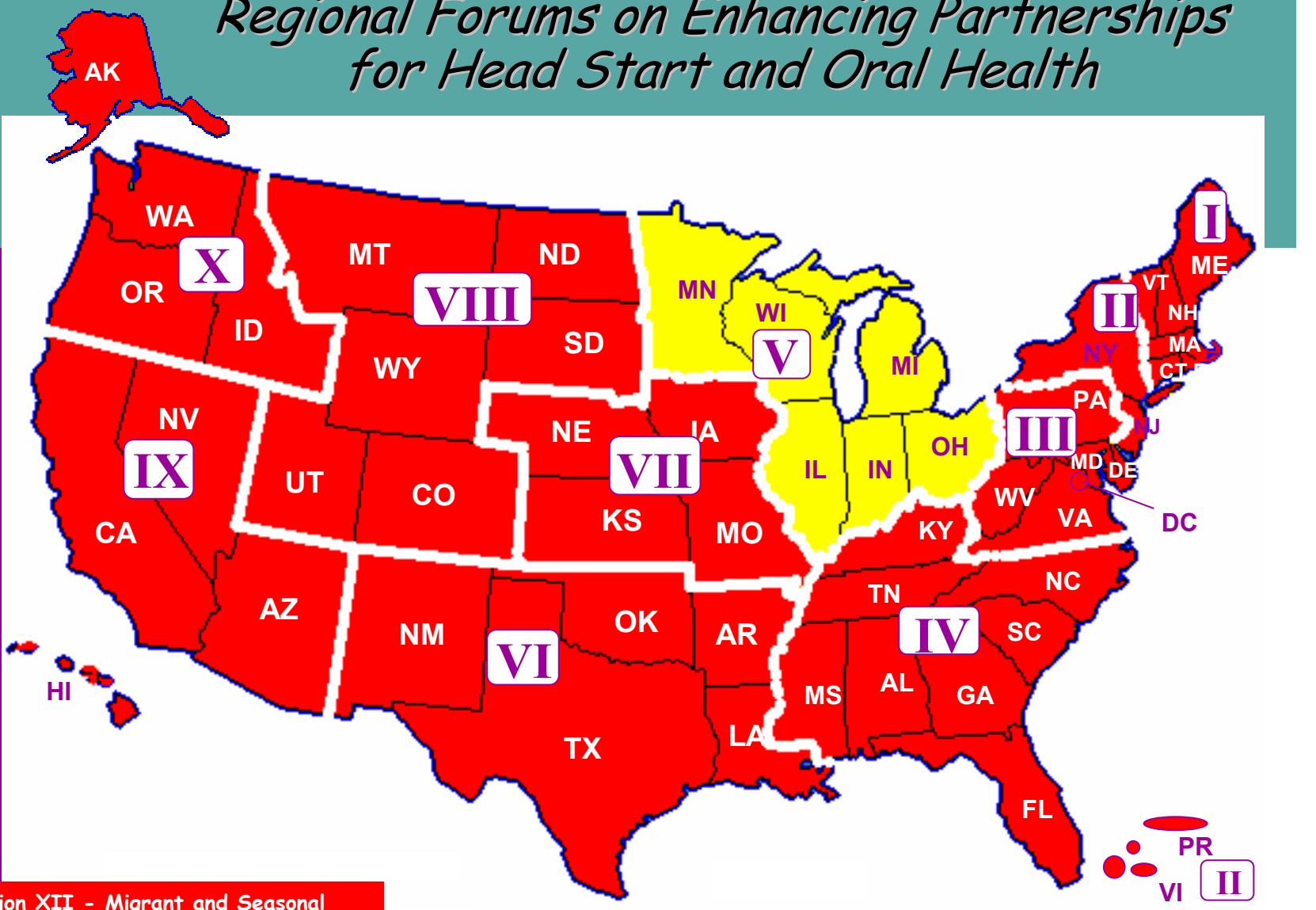


Regional Forums on Enhancing Partnerships for Head Start and Oral Health



Region XII - Migrant and Seasonal Head Start Program Branch

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

December 2004

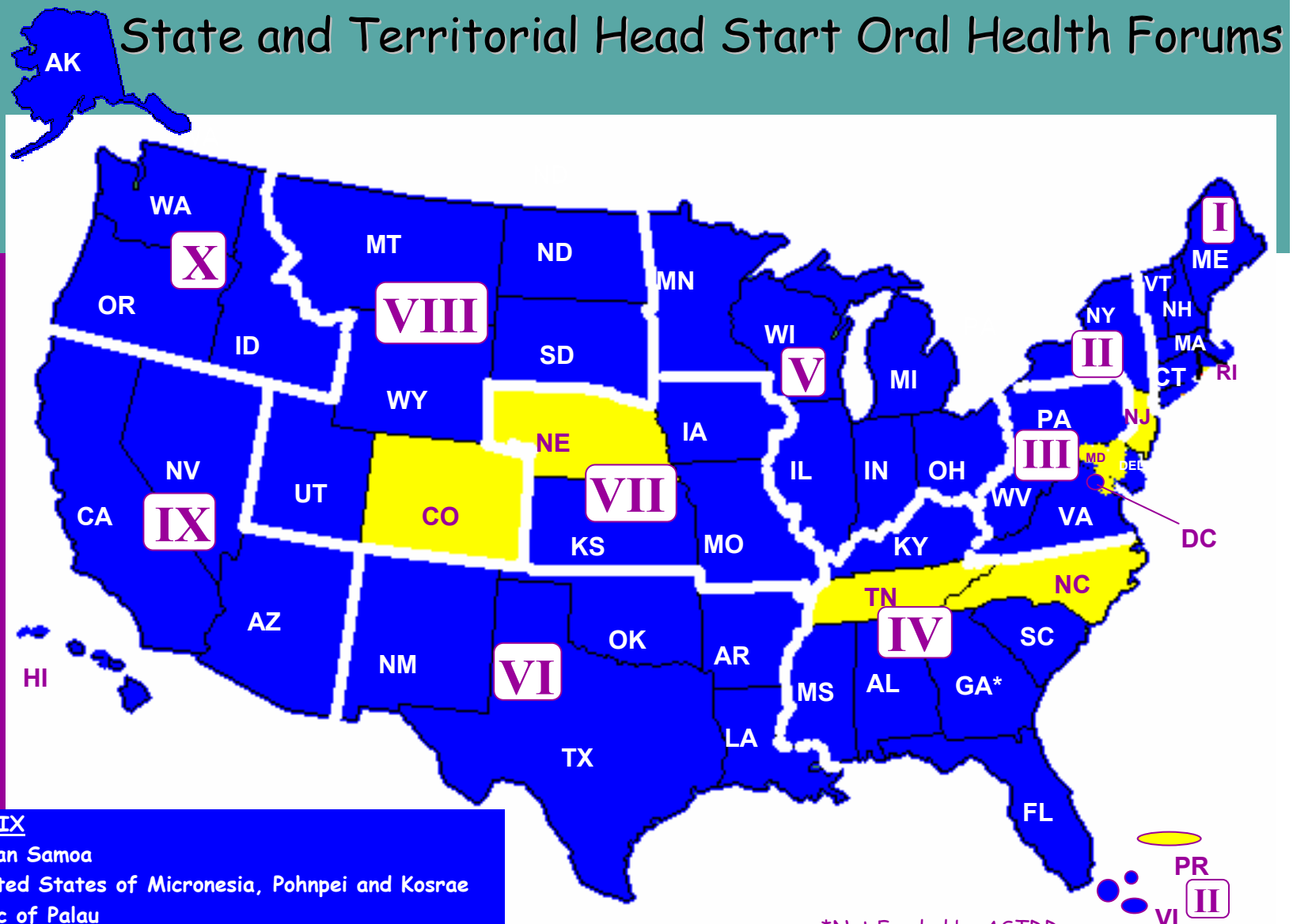
Forum Held

No Forum Held*

* Forum Planning in Process

www.theodora.com/maps

State and Territorial Head Start Oral Health Forums



Region IX

American Samoa
Federated States of Micronesia, Pohnpei and Kosrae
Republic of Palau
Republic of Marshall Islands

Commonwealth of the Northern Mariana Islands
Federated States of Micronesia, Yap and Chuuk
Guam

December 2004

State and Territorial Head Start Oral Health Forums

- Supported by Association of State and Territorial Dental Directors (ASTDD) through the Inter-Agency Agreement
- **48** Initial Forums Funded
- **17** Follow-up Activities Funded
- Lead Organizations: State Oral Health Programs, State Head Start Collaboration Offices, State Head Start Associations, State Dental Association
- Several Dental Schools and Dental Hygiene Programs participated in the Forums

State Head Start Forums
Goals

1) Develop strategy plans through assessment of state issues, gaps, practices and problems
2) Identify strategies and key roles of state agencies and others for future action
3) Develop an Oral Health State Action Plan to address issues on:

   ACCESS

   PREVENTION

   EDUCATION

State Head Start Forums
Issues and Strategies

- Best practices
- Education of families, HS teachers/staff, dental and other health professionals
- Workforce development
- Data and surveillance
- Insurance and access (Medicaid/SCHIP)
- Coordination, collaboration, and leadership
- Funding issues

Innovative Oral Health and Head Start Programs Developed in Communities

Collaborative Resources/Partnerships Reported at Forums

- Migrant and Community Health Centers
- Local Health Departments
- Health and Hospital Systems
- Community Foundations
- Community Organizations
- Charitable and Civic Organizations
- Dental Schools and Dental Hygiene Programs
- Dental and Dental Hygienists' Associations
- Federal and State Government
- Donations
- Corporations (e.g., Colgate)

Multiple Funding Sources

- Public grants (federal, state, local city/county government)
- Private grants
- Reimbursement / payment for dental care (state, federal, local reimbursement, private insurance, sliding fee scale adjusted by ability to pay, personal "out-of pocket" payment)
- Volunteer providers
- Dental & Dental Hygiene Programs – community-based service learning
- Donations – equipment & supplies

Thank You!

Comments and Questions:

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

DELAWARE HEAD START FORUM

JUNE 3, 2005

SETTING THE STAGE

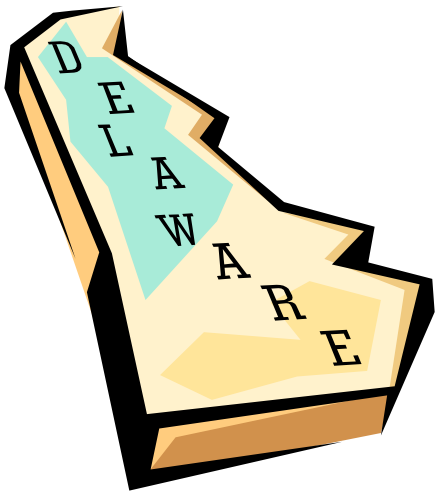
FOR

HEAD START ACTION PLANNING

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Delaware Oral Health Summit
Division of Public Health
December 8, 2004

Take the FIRST



Partnerships

Action

Education

Leadership

for Oral Health in Delaware

SURGEON GENERAL'S REPORT:

ORAL HEALTH IN AMERICA

THEMES:

ORAL HEALTH IS

MORE THAN HEALTHY TEETH

ESSENTIAL TO GENERAL HEALTH

A NATIONAL CALL TO ACTION TO PROMOTE ORAL HEALTH

GOALS

PROMOTE ORAL HEALTH

IMPROVE QUALITY OF LIFE

ELIMINATE DISPARITIES IN ORAL HEALTH

A NATIONAL CALL TO ACTION TO PROMOTE ORAL HEALTH

ACTIONS

CHANGE PERCEPTIONS OF ORAL HEALTH

OVERCOME BARRIERS USING EFFECTIVE AND PROVEN EFFORTS

BUILD THE SCIENCE BASE AND ACCELERATE SCIENCE TRANSFER

INCREASE ORAL HEALTH WORKFORCE DIVERSITY, CAPACITY, AND FLEXIBILITY

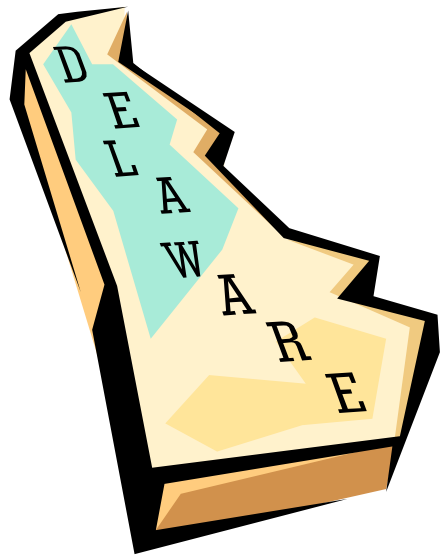
INCREASE COLLABORATIONS

DELAWARE ORAL HEALTH SUMMIT GOALS

Increase Awareness and Support for Oral Health Initiatives

Create Framework for Oral Health State Plan

Stimulate Partnerships and Integrated Actions



Action Plan for Implementing Critical Oral Health Strategies to Improve the Oral Health of Head Start Children in Delaware

Access to Care

- Improve Access to Dental Care for Head Start Children, especially in Kent and Sussex Counties

- Develop financing opportunities for under-insured, un-insured, low income, and undocumented Head Start children and families

Prevention

- Prevention of decay for Head Start children and families who live in non-fluoridated communities

- Infuse dental education and prevention strategies in Head Start Programming for Children and Families

Provider Education Strategies

- Improve the comfort level of general dentists in serving Head Start children
- Enhance the role of the Medical Community for
  - Obstetricians
  - Hospitals
  - Pediatricians
  - Family Practitioners

  In
  - Oral Health Education
  - Prevention
  - Treatment and Referral

Elements of Action Plan

- Identification and Description of Activity
- Responsible Organization/ Individual
  - Federal/ State
  - Community
  - Head Start Program
- Prioritization

Process

- Three Concurrent Sessions- One Hour Each
- Everyone rotates through each session
- Facilitator
- Subject Matter Expert

Summary of Action Plans

NEXT STEPS

Oral Health Plan

Recommendations

Oral Health Advocacy- Coalition

Volunteers

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

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