# California Head Start Oral Health Grant Report

**June 7, 2004**

*From the living room to the classroom, from the exam room to the nap room, parents, teachers medical and dental professionals and early education program staff believe that good oral health is a key element in preparing children for success at school. For almost 40 years, Head Start programs have searched for local resources and applied national standards for the benefit of enrolled children. Today, we see increasing challenges and barriers to meeting Head Start's commitment of ensuring children are ready to learn. This report examines many oral health issues confronting California Head Start programs and their children. The Head Start Oral Health Planning Committee, building on the efforts of national and regional committees, gathered information directly from the Head Start providers and their community partners. The resulting action plan is a tool to continue state and local collaborations well as keep the importance of oral health in the forefront of individual work plans. We will work to move this agenda forward to advance the evidence based information and share the impressive efforts of individuals.*

## Background

In June 2002, representatives of more than 80 federal, state, local and private early education, health and dental organizations from Hawaii, Nevada, Arizona, the outer Pacific and California, came together for a Region IX Oral Health Summit. The Region IX Summit was sponsored by the Administration for Children and Families (ACF), the Health Resources and Services Administration (HRSA) and the Centers for Medicare and Medicaid Services (CMS).

During this one-day meeting, participants identified a number of barriers at the regional and state levels to reducing the incidence of dental caries, including:

- Inadequate or spotty fluoridation regionally
- Inadequate provider rates
- Cultural and diversity issues
- Inadequate cross-training between the various health and dental professions
- Inadequate numbers of dentists trained to work with children
- Inadequate coordination and collaboration between agencies and organizations responsible for early care, education, health and dental services

Participants brainstormed a number of future tasks and activities intended to reduce or eliminate some of these problems in the region. The work they began became a foundation of data and ideas used by a California-based team to apply for a grant from the Association of State and Territorial Dental Directors (ASTDD).

## Grant Overview

In 2003, the California Head Start Association (CHSA), California Department of Health Services (DHS) Office of Oral Health, and the California Department of Education Head Start – State Collaboration Office (CHSSCO) were awarded a grant from the ASTDD to conduct a Head Start Oral Health Summit. The grant led to a number of activities related to improving oral health outcomes for Head Start children, including, instead of a Summit, a series of three regional Head Start Oral Health Roundtables. This report describes these activities and California's resulting strategic plan of additional steps needed to improve oral health outcomes for Head Start children. In this respect the report describes a work in progress.

## Current Challenges

- California Head Start programs currently serve more than 117,000 low-income children, the largest population of Head Start children in the nation.
- Head Start program statistics[1] indicate that 80 percent of enrolled children have had a source of continuous, accessible dental care.
  - Of these, 75 percent had a dental exam by the end of their first year in Head Start, while 60 percent received preventive care.
  - Of the 27 percent of these children who reportedly needed dental treatment, 80 percent actually received such treatment.
- While many would consider these levels of access to be quite good, there is some evidence that differing interpretations of Head Start Performance Standards may be artificially inflating these statistics.
  - For example, the 1993-94 California Oral Health Needs Assessment of Children[2] found that 46 percent of all Head Start children, and 79 percent of Asian children, had untreated decay.
  - In addition, 47 percent of Head Start children were in need of dental treatment, 9 percent were in *urgent* need of treatment, and 30 percent had never seen a dentist.

One of the intended outcomes of the California Oral Health Forums is a State plan of actions to help ensure that ***all*** Head Start children receive periodic exams and the treatment they need.

Some Head Start programs search in vain for adequate dental resources for their families. In some communities dentists are loath to serve young children at Medicaid rates. Some Head Start programs report dentists charging a "calming" fee to quiet children prior to an exam or treatment. Such fees are not Medicaid

[1] 2002-2003 Program Information Report data

[2] Pollick HF et al. *Report of the California Oral Health Needs Assessment of Children, 1993-94*. Oakland, CA, The Dental Health Foundation, 1999.

reimbursable, forcing the program to utilize scarce funds in order for their children to receive services. Head Start program staffs are not universally clear on the oral health requirements set forth in the Head Start Performance Standards. At the Region IX Summit, participants told of families, and some staff, who believed that there is no need to care for "baby teeth" as they will eventually be lost. More education, discussion, and review of best practices need to occur in Head Start programs. Families, and State and local partner agencies need a common understanding of both program requirements and the oral health needs of children.

Many other factors also keep children from receiving the necessary preventive care and treatment they deserve: opposition to and lack of community water fluoridation (only 30 percent of Californians have access to optimally fluoridated public water supplies), transportation to services, language barriers, and cultural traditions are just a few. These barriers have been identified through the Surgeon General's Report, a statewide oral health needs assessment done by the Dental Health Foundation, focus groups throughout the State, advisory committees, and other oral health forums.

California has been the site of several dental summits or meetings in the recent past. In January, 2002, the Dental Health Foundation, along with the California Dental Association (CDA) and DHS collaborated to bring together stakeholders with an interest in reducing dental disease. Together they produced the *Blueprint for Oral Health Infrastructure,* which considered the systems, people, relationships and resources needed to support oral health in California. Although the meeting did not focus specifically on Head Start children, the ideas and strategies developed at the meeting may be utilized to help reduce the incidence of dental disease among that population.

California has also been the site for a series of "Town Hall" meetings co-sponsored by the DHS and CDA in 2002. These meetings were conducted in six different areas of the State with the goal of improving the Denti-Cal program. Some recommendations that were submitted to the DHS as a result of this meeting included increasing reimbursement rates, adding preventive services, allowing resin fillings on posterior teeth and decreasing the paperwork involved in billing for services. Again, Head Start was not specifically addressed, but the suggestions made at this meeting could benefit the HS/EHS population.

The strategies that are developed at all oral health summits are universal to reducing the incidence of dental decay. Community water fluoridation is always identified as the number one way to reduce dental decay and is also the most inexpensive. Increasing the number of providers, or the number of people who can deliver preventive services, such as fluoride varnish, is another popular solution. This can be accomplished several ways, including educating medical providers and their staff to incorporate oral health into total health and training them to apply fluoride varnish; and expanding the scope of practice of allied

dental staff. Developing strategies to combat dental decay is an important factor in the fight against the disease. The collaborative effort between many key organizations is what will drive those strategies to implementation.

Partly due to recommendations from California's previous oral health summits, former Governor Gray Davis signed Assembly Bill 2022, authorizing registered dental hygienists working in public health settings to provide preventive services (e.g., cleanings, topical fluoride applications, sealants) without having a licensed dentist examine the children first. The bill, which took effect January 1, 2003, should have some impact in reducing the incidence of dental decay among California's children. Programs that serve children in a school-based setting often have difficulty finding a dentist to examine or screen children. This bill allows the people already working in such programs, the dental hygienists, to bypass the search for a dentist and eliminate the time it takes to coordinate the screening with the dentist. However, as many children have untreated decay and many dentists are unwilling or unable to treat younger children, lack of access to a dentist remains a major barrier to care for Head Start children in California.

**Grant Activities in California-Our Response to the Challenges**

The first step taken by the CHSA, CHSSCO and DHS Office of Oral Health was to form *an Oral Health Planning Group*[3]. This group was comprised of a number of professionals at the State and federal level involved in various oral health projects and offices. This group provided, and continues to provide, oversight for this project. Activities have included:

- A review of the results of the Region IX Summit and other relevant documents;
- Development of a *Head Start Oral Health Survey*[4] that was disseminated to every Head Start grantee and delegate agency in the State;
- Development of a *Matrix of Head Start Oral Health Issues and Promising Practices*[5] gleaned from the results of the Oral Health Survey and the three Oral Health Roundtables;
- Three regional *Oral Health Roundtables* where Head Start health specialists and local partners heard about State, federal and other oral health resources, and successful strategies used by their peers and partners to better meet the oral health needs of the families they serve.

**Regional Roundtables**

[3] See Attachment A for membership
[4] Attachment B
[5] Attachment C

The Oral Health Planning Group met during the latter part of 2002 and throughout 2003 to oversee the ASTDD grant. The original plan was to hold a California Oral Health Summit, patterned somewhat after the Regional Summit held in 2002. As the group reviewed the results of that Summit as well as other action plans that have been convened in the recent past, a consensus began to emerge against focusing on developing yet another plan. Instead, the group decided to convene a series of Roundtables where health specialists from Head Start programs in the surrounding region could come together with their local partners to:

- Learn from Planning Group members and others about State, Federal and other local resources available to assist them in meeting the oral health needs of the Head Start population;
- Learn the results of the *Head Start Oral Health Survey*, from challenges to promising practices;
- Learn how other Head Start programs meet the Performance Standards related to oral health services from panels of local Head Start health specialists and their partner agencies.

Almost 160 local Head Start Health Services Coordinators and local partners attended one of the three events, along with various members of the Planning Committee, Regional Office administrators and others. Following is a brief synopsis of each event.

**Loma Linda Roundtable**

The Loma Linda Roundtable was held at Loma Linda University on October 14, 2003. Twenty-seven of the sixty-one participants were Head Start staff; the others were community partners from organizations such as El Nido Family Center, Latin American Civic Association, the First 5 Dental Project, Loma Linda University School of Dentistry, Children and Family Services Department, Public Health, and Community Health Systems agency. Three local panelists shared their oral health activities and projects: Dr. Jack Luomanen, Community Health Services, Inc.; Dr. Harry Ridgely, Riverside County Office of Education; and Dr. Carla Lindner, Loma Linda University.

**Oakland Roundtable**

The Oakland Roundtable was held at Oakland's Preservation Park on October 16, 2003. A total of sixty-three persons attended, thirty-nine from Head Start programs, and the others from other organizations, such as the Administration for Children and Families, Santa Clara County Public Health Department, DHS-Medi-Cal Dental Services Branch, Asian Health Services Center Clinic, Health Trust, Marin Dental Clinic, Consolidated Tribal Health Project, Sonoma County

CHDP, and others. Three local panelists shared their oral health activities and projects: Jorge Mata, Monterey County Office of Education, Christina Reich, Contra Costa County Community Services Department, and Linda Shepard, Northcoast Children's Services. Jan Len, the Director of the Children and Youth Development Unit of Region IX of the Administration for Children & Families also gave an overview of federal and regional oral health initiatives.

**Fresno Roundtable**

The Fresno Roundtable was held at Franklin Head Start Auditorium on October 29, 2003. Of the thirty-three participants, eleven were from Head Start agencies. The rest were from community partner organizations such as Healthy Smiles Mobile Dental Foundation, the Fresno County Department of Community Health, CHDP, the Fresno Center for New Americans, the Metro Oral Health Advisory Council, Tulare County Health & Human Services, and the Kern County Children's Dental Health Network.

Three local panelists shared their experiences includes: Randa Wallace, health services director from Fresno EOC Head Start; Kathy Williams, RN, CPNP, health coordinator from Tulare County Child Care Education Program; and Lisa Gartin, RN, from Maternal/Child Health & Disabilities, Fresno Economic Opportunity Council Early Head Start. Dr. John Rossetti, Consultant, Maternal & Child Health Bureau, also presented an overview of national oral health initiatives.

**Matrix of Head Start Health Services Issues and Promising Practices**

The Oral Health Planning Group developed the matrix in Attachment C based on the information gleaned from the *Head Start Oral Health Survey* and the three Oral Health Roundtables. Forty-eight percent of the 149 surveys sent to Head Start programs were returned.

The information in the matrix is organized in four topic areas: Access to Care; Collaboration & Local Infrastructure; Oral Health Education, Prevention & Parent Education; and Emerging Issues.

These four topics are also further refined into three "activity areas":

- ***State & Federal Public Policy:*** defined as activities/strategies that may require action at the State or Federal level.

- ***Regional Training & Technical Assistance System:*** defined as activities/strategies that may require additional resources such as training or technical assistance, to address.

- ***Cluster & Agency Activities:*** defined as activities/strategies that can be addressed through existing resources at the agency/cluster level.

The Oral Health Work Group (the successor to the Oral Health Planning Group) has prioritized the issues identified at the Roundtables, developed a list of potential responses and organizations responsible for accomplishing them, and will provide follow-up oversight for at least two years. The plan is presented below.

## California Oral Health Plan

| Issue/Activity (See Attachment C) | Who Will Accomplish | Timeline |
|---|---|---|
| 1.7 Explore partnership with Oral Health Access Council to improve access for Head Start families | Oral Health Workgroup (OHW) | May 2006 |
| 2.1 Promote consistent definition of dental home & dental professional vs dentist; screening vs exam | Upcoming Region IX *Issue Memorandum* | July 2004 |
| 2.3 Advocate for strong partnerships with CHDP & MCH to ensure that prevention message is understood by parents and children | OHW | May 2006 |
| 2.4 Encourage collaboration with state funded local programs such as the California Children's Dental Disease Prevention Program (promotes positive oral health awareness & hygiene habits in classrooms) | OHW | ongoing |
| 3.5 Increase public awareness for prevention and education; develop and implement curricula for parents and caretakers | CHSA (First Five grant) | |
| 3.7 Add an oral health component to nutrition training | CHSA (First Five grant) | |
| 3.8 Add an oral health component to staff annual child abuse training | CHSA (First Five grant) | |
| 4.1 Review and revise as necessary, the existing MOU between Region IX and CA Department of Health Services; then advise stakeholders as appropriate | OHW in cooperation with Region IX and DHS | |
| 9.12 Provide a list of mobile dental clinics in California and community clinics and share with all Head Start programs | DHS, CHSSCO and CHSA will work with Dental Health Foundation/California Primary Care Association Oral Health Access Council | |
| 11.14 Have cultural videos, translated materials, workshops, collaborations-First Five | First Five grant | |

**Next Steps**

*As stated above, this report describes a work in progress.*

- This report and plan will be presented to the Region IX Office, California Department of Health Services (DHS), California Department of Education (CDE), California Children and Families Commission, California Dental Association (CDA) and other relevant/interested agencies to assist in their activities.

- The activities conducted by the Oral Health Planning Group have led to the selection of several planning group members as contractors on the $7 million First 5 California Oral Health Education and Training Project.

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## Attachment A

### Oral Health Planning Group Members

Andréa Azevedo, Maternal and Child Health Branch, California Department of Health Services

Edward Condon, California Head Start Association

Gayle Duke, Children's Medical Services Branch, California Department of Health Services

Robert Isman, Medi-Cal Dental Services Branch, California Department of Health Services

Robyn Keller, Office of Oral Health, California Department of Health Services

Reginald Louie, Consultant, Administration for Children and Families, Region IX

Barbara Marquez, First Five Commission

Gayle Mathe, California Dental Association

David Pisani, California Dental Association

Eileen Yamada, Maternal and Child Health Branch, California Department of Health Services

Michael Zito, California Head Start-State Collaboration Office, California Department of Education

**Attachment B**

# HEAD START ORAL HEALTH SURVEY

Name_____ Title_____ Phone Number ( )_____

Address_____

Phone Number (____)_____Email_____

Agency_____

Circle program location type: Urban Rural Mixed

Circle your grant type: Migrant Tribal Early Head Start
Head Start

May we contact you for more information regarding your program? Yes No

Are you willing to share this information with other programs? Yes No

Would you be willing to present information at a roundtable discussion? Yes No

## Unmet Program Needs

Please circle any of the topics below in which your program could benefit from additional training/technical assistance:

Curriculum Development Staff Training Parent Education Insurance

Material Translation Access to Care Dental Emergency Preparedness

Behavior Management

Please describe any additional unmet needs of your program:

_____

_____

**Oral Health Performance Standards**

Please use this scale to answer the following questions by circling the appropriate answer:

1=Never, 2=Rarely, 3=Sometimes, 4=Most of the Time, 5=Always

1. **Determining Child Health Status**: Within 90 days from a child's entry into the program (30 days for grantees and delegate agencies operating programs of 90 days duration or less):

a. My program is able to determine whether each child has an ongoing source of continuous, accessible oral health care. 1 2 3 4 5

b. If the child does not have an ongoing source of oral health care, my program is able to assist parents in accessing one. 1 2 3 4 5

c. My program is able to obtain in a timely manner, a determination from an oral health care professional as to whether the child is up-to-date on a schedule of age-appropriate preventive and primary oral health care. 1 2 3 4 5

d. The schedule of preventive and primary oral health care used by my program incorporates the Child Health and Disability Prevention (CHDP) program's dental periodicity schedule, i.e., children are routinely referred to a dentist beginning at age 3, or earlier if a problem is detected or suspected. 1 2 3 4 5

e. For **Early Head Start programs only**, at what age do you begin referring children routinely to a dentist? _____ 1 2 3 4 5 NA

f. In addition to the required performance standards, my program follows recommendations made by the Health Services Advisory Committee based on prevalent community oral health problems. (Please specify). 1 2 3 4 5

_____

_____

g. For children who are **not** up-to-date on a schedule of age-appropriate preventive and primary oral health care, my program is able to assist parents in making the necessary arrangements to bring the child up-to-date. 1 2 3 4 5

h. For children who are up-to-date on a schedule of age-appropriate preventive and primary oral health care, my program is able to ensure that they continue to follow the recommended schedule. 1 2 3 4 5

i. My program is able to track the provision of oral health services to children. 1 2 3 4 5

j. My program is able to obtain or arrange further diagnostic testing, examination, and treatment by an appropriate licensed or certified oral health care professional for each child with an observable, known or suspected oral health problem. 1 2 3 4 5

k. My program is able to provide follow-up for any condition identified by an appropriate licensed or certified oral health care professional to ensure that any needed treatment has been started. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

2. **Extended Follow-Up and Treatment**

a. My program has a system of ongoing communication with the parents of children with identified oral health needs that is able to facilitate the implementation of a follow-up plan. 1 2 3 4 5

b. My program is able to assist parents, as needed, to enable them to learn how to obtain any prescribed medication, aids or equipment for dental conditions. 1 2 3 4 5

c. My program is able to provide dental follow-up and treatment that includes:

- fluoride supplements and/or topical fluoride treatments as recommended by oral health care professionals in communities where a lack of adequate fluoride levels has been determined or for every child with moderate to severe tooth decay 1 2 3 4 5
- other necessary preventive measures and/or dental treatment as recommended by an oral health care professional. 1 2 3 4 5

d. My program has been able to prepare parents/children for successful dental office visits including the completion of treatment. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

3. **Ongoing Care**

a. My program has procedures that enable identification of any new or recurring oral health concerns and can quickly make appropriate referrals. These include periodic observations and recordings of signs of injury or illness and observations from parents and staff. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

4. **Individualization Of The Program**

a. My program is able to respond and adapt to each child's individual characteristics, strengths and needs based on information from ongoing observations, dental evaluations and treatments, and insights from the child's parents. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

5. **Child Development and Education Approach for Preschoolers**

a. My program is able to integrate education about oral health into program activities. 1 2 3 4 5

b. My program is able to integrate education about nutrition into program activities. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

6. **Health Emergency Procedures**

a. My program has policies and procedures for responding to dental emergencies with which all staff are familiar and trained, and which include:
(1) Posted policies and plans of action for emergencies that require rapid response on the part of staff or immediate dental attention; 1 2 3 4 5
(2) Posted locations and telephone numbers of emergency response systems. Up-to-date family contact information and authorization for emergency care for each child is readily available; 1 2 3 4 5
(3 Methods of notifying parents in the event of a dental emergency involving their child; and 1 2 3 4 5
(4) Established methods for handling cases of suspected or known child abuse and neglect that are in compliance with applicable Federal, State, or Tribal laws. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

7. **Nutritional Services**

a. Program Staff are able to promote effective dental hygiene among children in conjunction with meals. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

8. **Services To Pregnant Women Who Are Enrolled In Programs Serving Pregnant Women, Infants, And Toddlers**

a. My program is able to assist pregnant women to access comprehensive prenatal and postpartum care, through referrals, immediately after enrollment in the program. This care includes oral health promotion and treatment, including dental examinations on a schedule deemed appropriate by the attending health care providers as early in the pregnancy as possible. 1 2 3 4 5 NA

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

9. **Parent Involvement in Health, Nutrition, and Mental Health Education**

a. My program is able to provide dental and nutrition education programs for program staff, parents, and families. The dental health education program: 1 2 3 4 5

(i) Assists parents in understanding how to enroll and participate in a system of ongoing family oral health care; 1 2 3 4 5

(ii) Encourages parents to become active partners in their children's dental health care process and to accompany their child to dental examinations and appointments; and 1 2 3 4 5

(iii) Provides parents with the opportunity to learn the principles of preventive dental health, emergency dental first aid, dental occupational and environmental hazards, and dental safety practices for use in the classroom and in the home. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

10. **Advisory Committees**

a. My program has a Health Services Advisory Committee that includes one or more oral health professionals. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

11. **Partnerships**

a. My program is able to partner successfully with other agencies. 1 2 3 4 5

Please use attached form to list any barriers or successful strategies in meeting the above performance standards

**Please <u>check</u> all agencies or individuals that are <u>available</u> in your community. Please <u>circle</u> those that you coordinate services with or partner with.**

- □ MCAH (Maternal, Child, &Adolescent Health)
- □ WIC (Women, Infants,Children)
- □ CHDP (Child Health & Disability Prevention Program)
- □ Adult Education
- □ BIH (Black Infant Health Program)
- □ Healthy Start
- □ AFLP (Adolescent Family Life Program)
- □ First Five (Prop 10)
- □ CPSP (Comprehensive Perinatal Services Program)
- □ California Medical Association
- □ Local Medical Society
- □ California Dental Association
- □ CCS (California Children's Services)
- □ California Society of Pediatric Dentists
- □ Pediatric Dentists
- □ CMS (Children's Medical Services)
- □ Local Dental Society
- □ Dental Hygiene Society
- □ Colleges / Universities
- □ Dental/Hygiene/Assisting Schools
- □ California Children's Dental Disease Prevention Program ("SB 111")
- □ Other Local Health Dept. Program
- □ Other (please specify):

_____

**<u>Program Models</u>**

Please describe successful models used by your program regarding:

A. Partnerships

B. Oral health materials and approach to teaching

C. Oral health curriculum development

D. Sensitivity to cultural diversity

E. Children with special needs

# BARRIERS AND SUCCESSFUL STRATEGIES

On the following table, please list any barriers or successful strategies in meeting any of the performance standards described in this survey. Use the example below as a guide. Make additional copies of the table if needed.

Example

| **Question Number** | **Barrier (B) or Strategy (S)?** | **Description** |
|---|---|---|
| **2d** | **B** | **Many of our parents are unable to get their children to follow up with dental appointments after their first experience because the child acts out and the parents don't know how to control them.** |
| **1c** | **S** | **We worked with the local dental society and a local philanthropy to arrange a rotation of dentists willing to complete all treatment on a selected number of children without Medi-Cal or Healthy Families coverage.** |

| Question Number | Barrier (B) or Strategy (S)? | Description |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# BARRIERS AND SUCCESSFUL STRATEGIES

| Question Number | Barrier (B) or Strategy (S)? | Description |
|---|---|---|
| | | |
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## Attachment C

| Topic Area | Access To Care (1.0) | Collaboration & Local Infrastructure (2.0) | Oral Health Education, Prevention & Parent Education (3.0) | Emerging Issues (4.0) |
|---|---|---|---|---|
| **Federal & State Public Policy –**<br><br>Defined as activities / strategies that may require action at the State or Federal policy level | **1.1** Head Start Performance Standards should allow any trained dental professional to screen-such as RDH, RDA.<br><br>**1.2** Fluoride varnish should be available to all students.<br><br>**1.3** Increase resources for the purpose of transportation-such as utilizing chartered buses or school buses or provide vouchers for families to use buses or cabs.<br><br>**1.4** Increase funding resources to bring mobile units to a community.<br><br>**1.5** Extend the CHDP Gateway eligibility period for more than 60 days.<br><br>**1.6** Increase emphasis on prevention of oral diseases and problems, such as providing fluoride varnish to all students<br><br>1.7 Explore partnership with Dental Health Foundation/CA Primary Care Association Oral Health Access Council to improve access for Head Start families. | **2.1** Promote consistent definition of a dental home and a dental professional vs. a dentist, screening vs. exam.<br><br>**2.2** Build relationships with dental colleges and have them work with children 0-5.<br><br>**2.3** Advocate for strong partnerships with CHDP and MCH to ensure that prevention message is understood by parents and children.<br><br>2.4 Encourage collaboration with state funded local programs such as the California Children's Dental Disease Prevention Program. They promote positive oral health awareness and hygiene habits in class. | **3.1** Standardize messages for Head Start parents regarding oral health.<br><br>**3.2** Focus on parents' OH habits and screen them first. Then move on to children. Educate them through media such as videos.<br><br>**3.3** Provide information on available insurance to families.<br><br>**3.4** Encourage more clarity from the Head Start Bureau related to appropriate practices for a Head Start oral health program.<br><br>**3.5** Increase public awareness for prevention and education; develop and implement curricula for parents and caretakers.<br><br>**3.6** Increase understanding of HIPAA compliance within HS performance standards.<br><br>**3.7** Add an oral health component to nutrition training.<br><br>**3.8** Add an oral health component to the staff's yearly child abuse training<br><br>**3.9**. Performance standards should emphasize the development and practice of effective oral hygiene.<br><br>**3.10** Add an oral health component to injury prevention training. Posted policies, locations and phone numbers. | **4.1** Review and revise as necessary, the existing Memorandum of Understanding with the Region IX Administration for Children, Youth and Families and California DHS and then advise stakeholders as appropriate.<br><br>**4.2** Review program & PIR data, annual training, updating policies and work plans. |

| Topic Area | Access To Care (5.0) | Collaboration & Local Infrastructure (6.0) | Oral Health Education, Prevention & Parent Education (7.0) | Emerging Issues (8.0) |
|---|---|---|---|---|
| **Regional Training & Technical Assistance System**<br><br>Defined as activities / strategies that may require additional resources such as trainings or technical assistance to address | **5.1** Decrease barriers & educate parents. Be respectful and sensitive to various cultural backgrounds.<br><br>**5.2** Ensure tracking of follow-up and treatment. Screening results are documented in order to remind parents of follow ups.<br><br>**5.3** Develop information at regional office level on applying for Medi-Cal or Healthy Families to continue ongoing dental care.<br><br>**5.4** Strong file review, case management & referral system ensures the program is individualized. | **6.1** Family workers are trained to conduct dental screenings which begin within one month of enrollment starting at age 1. Parents receive a copy of results, followed by a home visit.<br><br>**6.2** Use existing oral health curriculum developed by local CHDP/WIC or other program. Include a strong nutrition component.<br><br>**6.3** Draw from and publicize info and suggestions from local coalition memberships.<br><br>**6.4** Train staff on consistent definition of a dental home, a dental professional vs. a dentist, screening vs. exam. | **7.1** Educate parents and enrolled pregnant women & provide dental screenings for them.<br><br>**7.2** Provide information via transition activities on any school-based oral health resources-such as Healthy Start.<br><br>**7.3** Investigate insurance options and train staff through different media.<br><br>**7.4** Communicate & share data between HS & other agencies.<br><br>**7.5** Develop a list of nutrition related books and distribute it to the teaching staff. Develop a library of health books/activities that can be used in the classroom.<br><br>**7.6** Food program beginning with stating and modeling a healthy food policy; serving nutritious meals prepared on site & reinforcing behavior with exciting, age appropriate food projects conducted weekly including oral health.<br><br>**7.7** Increase understanding of HIPAA compliance within HS performance standards.<br><br>**7.8** Add an oral health component to annual child abuse training. | **8.1** Provide easily accessible resources/repository to access best oral health practices: www.mchoralhealth.org. www.Ruralsmiles.com<br><br>**8.2** Head Start Bureau should develop resources to ensure consistent and accurate information for training the T & TA providers. |

| Topic Area | Access To Care (9.0) | Collaboration & Local Infrastructure (10.0) | Oral Health Education, Prevention & Parent Education (11.0) | Emerging Issues (12.0) |
|---|---|---|---|---|
| **Cluster and Agency Activities**<br><br>Defined as activities / strategies that can be addressed through existing resources at the agency / cluster level. | **9.1** Local HS should collaborate with local CHDP Gateway programs & agencies closely to leverage money.<br><br>**9.2** HS needs to provide information on dental insurance & promote the importance of dental visits.<br><br>**9.3** Train staff to work with agencies such as Denti-Cal Outreach to inform parents of the dental services available to them through their insurance programs & to link them with providers in the community for children who need dental services including children with special needs.<br><br>**9.4** Train how to effectively track follow-up and treatment-such as creating files documenting the results of screening to help remind parents of follow – up needs.<br><br>**9.5** Train Health Coordinator to work with the dentists to follow up on treatment needs.<br><br>**9.6** Provide dental travel funds to help parents with costs.<br><br>**9.7** Work with mobile dental clinics to ensure every child sees a dentist. Most have a dental home & dental insurance, but some don't.<br><br>**9.8** Discuss the importance of taking care of primary teeth, which are just as important as secondary teeth.<br><br>**9.9** Stress the need for a dental examination for children entering the HS | **10.1** Ask local dentists to decrease their fees, and/or volunteer and use newspaper to feature the story.<br><br>**10.2** Collaborate with local dental schools when possible. Retired dentist also make good volunteers.<br><br>**10.3** Collaborate with state funded programs operated at the local level such as the California Children's Dental Disease Prevention Program. They promote positive oral health awareness and hygiene habits in class.<br><br>**10.4** Share ideas on recruiting volunteers from the local community and/or raising resources.<br><br>**10.5** Partner with a medical or dental office to provide oral health education on site for parents.<br><br>**10.6** Work together with local and state programs such as First 5 , WIC, March of Dimes.<br><br>**10.7** Apply for grants (such as First Five) to help fund dental services for uninsured children. | **11.1** Provide dental education resources. Teach kids how to brush teeth, use multi-lingual books, and educate parents through community volunteers. Use programs like Smile Bright and Colgate Bright Smiles.<br><br>**11.2** Update health specialists and providers on oral health best practices.<br><br>**11.3** Use videos to teach oral health to children and parents. Use a pre-test to get discussions going. Follow-up with a post-test.<br><br>**11.4** Utilize resources from the Head Start Bureau to provide oral health education to children and families at the centers.<br><br>**11.5** Publish a monthly newsletter for staff and parents on various health and nutrition topics to include tooth brushing and related topics. In the newsletter provide a health & nutrition activity idea for teachers to use in the classroom.<br><br>**11.6** Promote activities such as talking about visiting a dentist during circle time before the child's first visit.<br><br>**11.7** Use Colgate Bright Smiles, Bright Futures dental health program to conduct dental screenings along with an education session for the children.<br><br>**11.8** Provide access to college level courses which emphasize nutrition and oral health.<br><br>**11.9** Provide children with oral health supplies and education information to take home.<br><br>**11.10** Provide fluoride supplementation to those | **12.1** Provide training for staff to increase skills to access at risk populations.<br><br>**12.2** Engage dental/medical community in providing care and use CHDP dental classification tools. |

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| | program. Before the enrollment application is considered complete, parents need to show proof of their child receiving a dental exam.<br><br>**9.10** Share ideas on partnership such as the "Just One" program, where private dentists are recruited to fulfill the treatment needs of "just one" child who could not otherwise afford the treatment.<br><br>**9.11** Create contracts with local dentists to use HS/EHS funds to pay if all other resources are exhausted.<br><br>**9.12** Provide a list of mobile dental clinics in California and community clinics and share it with all Head Start programs. | | children with parental permission via bottled water with fluoride, tablets or varnish. For those children without insurance, have an account set up at the local pharmacy to pay for the prescription.<br><br>**11.11** Bring in guest speakers throughout the year to talk about their area of expertise such as:<br>dental professionals ➔oral health,<br>nutritionist ➔menu, good snacks / bad snacks.<br><br>**11.12** Use fluoride tablets for HS children with parent permission prescribed by the dental consultant in the HSAC.<br><br>**11.13** Have parent sign a fluoride request form upon entry into the program. Forward the request to the child's primary care doctor who can phone in an Rx. For those children without insurance, have an account set up at local pharmacies to pay for the Rx. The process can be monitored by the Family Services Advocates.<br><br>**11.14** Have cultural videos, translated materials, workshops, collaborations-First 5.<br><br>**11.15** Train family workers to conduct dental screening beginning within one month of enrollment . Provide parents a copy of results, followed by a home visit.<br><br>**11.16** Develop culturally diverse and healthy menu selections<br><br>**11.17** Share examples of ways to encourage parents to take their child to the dentist. Letters can be sent when other efforts have failed. | |

**Attachment D**

**Presentation by Dr. Reg Louie, Oral Health Consultant**

**The presentation by Dr. Louie was presented at each of the three California Head Start Oral Health Round Tables in October 2003.**

**Attachment E**

**Presentation by individual representatives of State agencies who provide oral health resources to Head Start and early childhood programs in California.**

**The presentation was presented by Dr. Bob Isman in Loma Linda, Fresno and by Robyn Keller in Oakland at the three California Head Start Oral Health Round Tables in October 2003.**

**Attachment F**

**Presentation by Edward Condon, Executive Director**

**The presentation by Mr. Condon was presented at each of the three California Head Start Oral Health Round Tables in October 2003.**