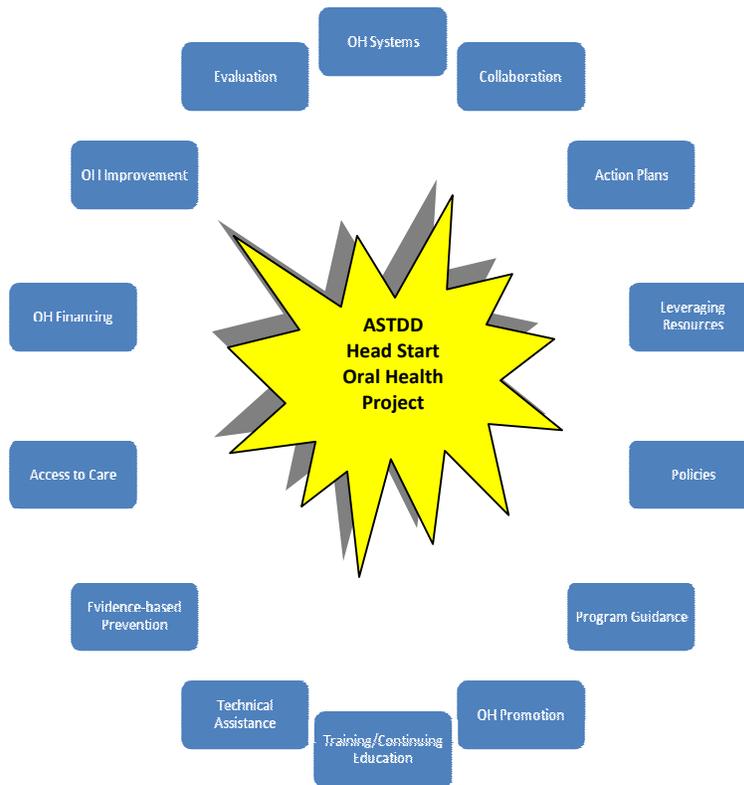


Association of State and Territorial Dental Directors (ASTDD)

Head Start Oral Health Project

Evaluation Report

2001-2008



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PURPOSE

This report provides a summary of activities conducted by the Association of State and Territorial Dental Directors (ASTDD) and states between 2001 and 2008 in support of Head Start oral health collaboration, as well as evaluation strategies and outcomes.



INTRODUCTION

Lack of access to comprehensive oral health services has long been the number one barrier affecting the oral health of Head Start children and families, including pregnant women, infants, and toddlers. From 1966 to the mid-1990s, the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) and its predecessor dental programs worked closely with the Administration on Youth and Families (ACYF), Head Start Bureau (HSB). MCHB dental professionals and consultants provided training and technical assistance (T/TA) to Head Start programs across the country, and assisted the HSB in developing dental program policies and standards. Dental T/TA networks were developed using the infrastructure of established state oral health programs, professional dental organizations and educational programs for dental and dental hygiene students. In an effort to consolidate T/TA services, the HSB ended its relationship with MCHB in 1993 and revised its T/TA system.

Between 1993 and 2000 a disconnect occurred between Head Start programs, oral health experts and dental care systems, with little communication or coordination. With publication of *Oral Health in America: A Report of the Surgeon General* in 2000, however, collaborative activities at the national, state, and local level developed out of a growing understanding that oral health has a clear and long-range impact on a child's general health and well-being and influences physical and mental health, social and emotional growth and readiness to learn. In 2001 a new Intra Agency Agreement (IAA) was established between the ACYF Head Start Bureau and the HRSA Maternal and Child Health Bureau. Six consecutive IAAs continued this arrangement through 2007. This collaboration sought to improve the oral health of Head Start children and families and to provide oral health expertise, training and technical assistance (T/TA) to the Head Start community.

Starting in 2000 the Association of State and Territorial Dental Directors (ASTDD) received the first of two five-year cooperative agreements from the MCHB. In 2001 ASTDD received a supplement via the

IAA to conduct a Head Start oral health project and to partner with other organizations in this collaboration. ASTDD is a 501 (c)(6) non-profit organization representing the directors and staff of state and territorial public health agency programs for oral health, and one of 17 affiliates of the Association of State and Territorial Health Officials (ASTHO). Its mission is to provide leadership to advocate a governmental oral health presence in each state and territory, to formulate and promote sound oral health policy, to increase awareness of oral health issues, and to assist in the development of initiatives for prevention and control of oral diseases.

Although the IAA officially ended in 2007, the MCHB has encouraged ASTDD to continue to use limited cooperative agreement funds to sustain some state-level and national Head Start collaborative efforts. HSB became the Office of Head Start in 2007, with oral health funds now primarily funneled into a Dental Home project coordinated by the American Academy of Pediatric Dentistry. The Head Start Bureau continues to fund a Head Start oral health resource center as part of the National Maternal and Child Oral Health Resource Center.

BACKGROUND ON THE COLLABORATIVE PARTNERSHIPS

Figure 1. Overall IAA Partnerships

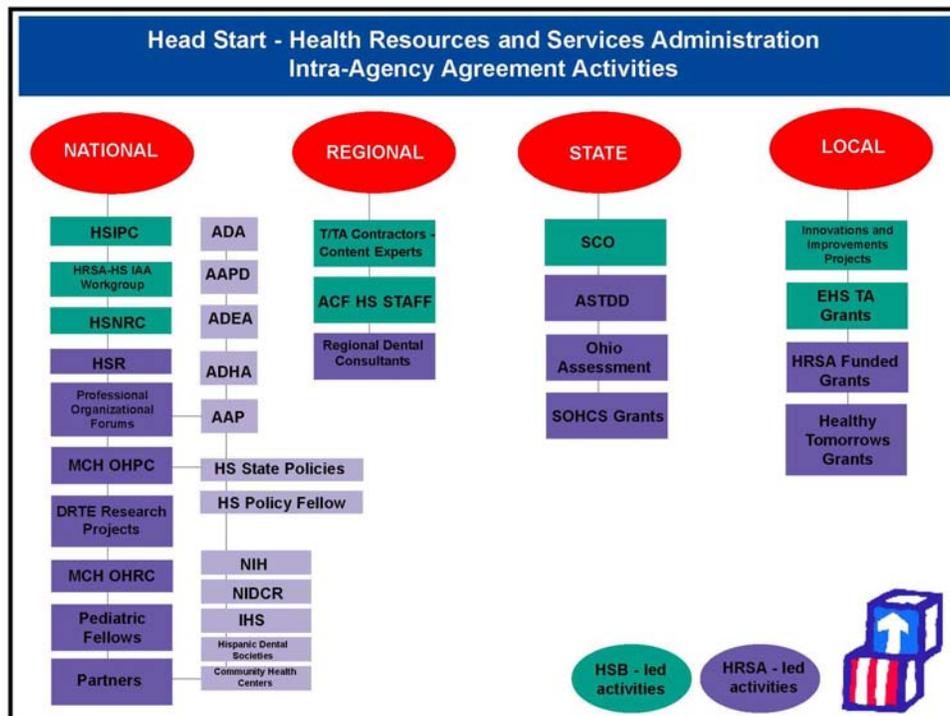


Figure 1 highlights the many partners involved in the IAA. This report will only discuss those partners that relate most directly to ASTDD and state activities. ASTDD activities were facilitated through the following partnerships.

MCHB Liaison with HSB

Through regular meetings, staff discussed the progress of projects supported by the IAA and promoted model programs at the national, regional, state and local levels in Head Start and Early Head Start. Two oral health IAA national workgroup meetings were held throughout the project.

Altarum Institute (formerly Health Systems Research, Inc)

Altarum coordinated a series of 12 Regional forums held during 2001-02, focused on enhancing partnerships for improvements in Head Start and oral health. Forum participants included representatives of federal, regional, and state government; universities; private partners; dental providers and various Head Start and early childhood related organizations. Professional organization forums were held between 2003-2006 with the American Dental Association (ADA), American Dental Hygienists' Association (ADHA), American Academy of Pediatric Dentistry (AAPD), Hispanic Dental Association (HDA), American Dental Education Association (ADEA), and a group of community based organizations and community-oriented foundations.

ASTDD Head Start Oral Health Project

The primary purpose of ASTDD's Head Start Oral Health Project was to assess relationships between state oral health programs and other state and regional programs and organizations around Early Head Start/Head Start oral health issues; facilitate collaborative linkages among partners; provide TA and support for state/territorial Head Start oral health forums, action plans and follow-up activities; and identify models and recommendations to address the oral health needs of Head Start programs and families.

ASTDD was selected to be part of the IAA because of its unique relationship and communication network with state/territorial oral health programs and their partners, as well as other national organizations. Throughout this report, references to "state oral health programs" also include oral health programs in US territories and jurisdictions. ASTDD contracted with Kathy Geurink, RDH, MA as a consultant to coordinate the project and to serve as a liaison to national and regional Head Start efforts. Major focus areas for the ASTDD project are displayed on the cover of this report and address the core public health functions of assessment, policy development and assurance.

Regional Head Start Oral Health Consultants (RHSOHC)

A network of regional Head Start oral health consultants provided professional, clinical, and public health expertise and support to the 10 ACF regional offices and the American Indian/Alaska Native and Migrant and Seasonal Farm Workers program branches. The background of these individuals included former state dental directors, USPHS commissioned dental officers, board certified dentists in pediatric dentistry and dental public health, dental and dental hygiene educators, and public health dental hygienists. The ASTDD Head Start consultant also served as the RHSOHC for Region VI.

Maternal and Child National Oral Health Resource Center (OHRC)

Since 1999 the OHRC, housed at Georgetown University, has provided information services to enhance the quality of oral health for pregnant women, infants, and children enrolled in Head Start. Beginning in 2005, with support from the IAA, OHRC has served as the principal vehicle for the collection, review, and dissemination of Head Start oral health technical and programmatic information and materials, working in collaboration with key Head Start oral health partners, especially ASTDD.

Maternal and Child National Oral Health Policy Center (NOHPC)

NOHPC, originally affiliated with Columbia University and then with UCLA, provided policy research and analysis to support other MCHB-funded projects, including those concerned with Head Start. The center, through TA, publications and presentations, increased understanding of how issues such as Medicaid reimbursement rates, professional practice acts and guidelines affect Head Start children's access to oral health care. The Center worked with state Medicaid/SCHIP programs and state oral health programs to advise on policies relating to Head Start and oral health.

The Ohio Head Start Special Project

Ohio was an early leader in state oral health program involvement with Head Start. The Ohio Department of Health conducted multi-pronged assessments of 1) HS children's oral health status, 2) dental provider attitudes and practices related to serving Head Start children, and 3) one-on-one interviews and focus groups with Head Start staff and parents to determine attitudes and practices related to accessing dental care. They analyzed results, published a number of papers in peer-reviewed journals and prepared a compendium of "models that work" for Ohio Head Start programs.

Head Start Dental Screening/Triage Training Project - Chester County, PA

This project provided training to dental professionals and dental students to use a standardized data collection tool, ASTDD's *Basic Screening Survey (BSS)*, and to apply fluoride varnish for Head Start populations. The *BSS* allows for estimates of the prevalence of dental conditions and dental sealants at the population and community level. This project helped Head Start programs to collect required dental screening data to meet Head Start performance standards and be comparable to other programs using the same data instrument. Many states subsequently decided to use the *BSS* to collect oral health data on Head Start children.

National Advisory Committee

In 2001 ASTDD convened a national Head Start Oral Health Advisory Committee of MCHB and OHS representatives, a Head Start regional health specialist, a HRSA regional dental consultant and representatives from the IAA partner groups. This committee was established to:

- develop and conduct needs assessments
- recommend support to states for collaborative activities
- identify model Head Start oral health programs

- promote standardized oral health data collection and surveillance
- translate findings and recommendations into a coordinated national effort.

It continued to meet until the summer of 2006.

EVALUATION METHODOLOGY

An MCHB contractor is compiling a final summary report of overall IAA activities and outcomes that will be available on the OHRC website. This ASTDD report focuses mainly on the ASTDD Head Start Oral Health Project, primarily on the following evaluation questions:



1. How did relationships among state oral health programs, state Medicaid/SCHIP programs, state HS collaboration office, state HS associations and other organizations change in terms of a) leadership, b) communication, and c) collaboration?
2. What role did state oral health forums and follow-up activities have in building linkages?
3. What resources were leveraged to conduct forums and follow-up activities?
4. Was access to preventive services increased for EHS and HS children? How was this accomplished in states?
5. Did the type of preventive services performed in HS settings change? Did they become more evidence-based?
6. Was access to treatment services increased for EHS and HS children? How was this accomplished in states?
7. What types of promising models were presented or collected, especially for the ASTDD Best Practices Project?
8. Were any new workforce models developed? Did they require changes in state policies or new legislation?
9. Did oral health data collection and surveillance activities of preschool populations increase in states and territories?
10. How did states integrate HS recommendations into larger state plans?
11. How did states or communities use information from all these efforts to apply for federal or other grants and funding opportunities?
12. How did states use information to advocate for legislative or policy changes?

13. Is there now more emphasis on evaluation of HS related activities?

A variety of quantitative and qualitative evaluation methods were used to try to answer these questions.

Initial Needs Assessment

In 2002 ASTDD conducted a needs assessment of state and territorial dental directors via email, assessing the involvement of state and territorial oral health programs with Head Start programs and other organizations. The assessment tool asked about collaboration with selected organizations in the region and state/territory and what role the oral health program played in efforts related to health promotion, legislation, oral health education, access to care and funding for Head Start oral health programs. Forty-one states responded to the survey.

Evaluation of State/Territorial Oral Health Forums, Action Plans and Follow-Up Activities

Two online evaluations collected data on process and outcome measures from the ASTDD-funded state/territorial Head Start oral health forums and action plans. Of the 55 funded forums, 14 states and 2 territories participated in the 2004 evaluation, with a different set of 12 states and 2 territories participating in the 2006 evaluation (total N=30). Other states/territories either did not respond because of personnel turnover or they had not yet been funded. Final reports submitted from 16 of 26 states/territories funded for follow-up activities in 2004 -2005 were reviewed and summarized for information on the activities conducted, resources leveraged and which of the 19 items considered important by ASTDD in the request for proposals and funding letters they had actually included. The process was repeated for 10 of 13 reports submitted by states/territories funded in 2006 – 07. Information from the other states is being analyzed as activities are completed and the reports are submitted. These evaluation reports are available on the ASTDD website at http://www.astdd.org/index.php?template=head_start.html.

Evaluation of Educational Activities and Materials

ASTDD participated in a number of presentations at national meetings and via webcasts; when evaluations were used by the sponsoring agency, these results were reviewed and used to plan for future presentations. Each year since 2005 ASTDD has sent an annual feedback questionnaire via email to its members (state dental directors) and associate members to acquire information on their needs and their use of materials. Head Start materials that were developed jointly with the National Maternal and Child Oral Health Resource Center were evaluated via this survey. The OHRC also collected information on distribution and use of the materials during national meetings and by states and local communities.

Tracking Changes in State Programs and Oral Health Status of Head Start Populations

ASTDD offers technical assistance to states and territories on oral health needs assessment methods and creation of oral health surveillance systems. States have used the *Basic Screening Survey* with school-aged populations since 1999 and increasingly have adapted it for use with Head Start populations. States also submit information to ASTDD for an annual *Synopsis Report of State and Territorial Dental Public Health Activities*. This allows tracking of programs targeting preschool populations, among other things. *BSS* data and *Synopsis* information since 2000 were analyzed for trends.

Evaluating Changes in Head Start Program Performance

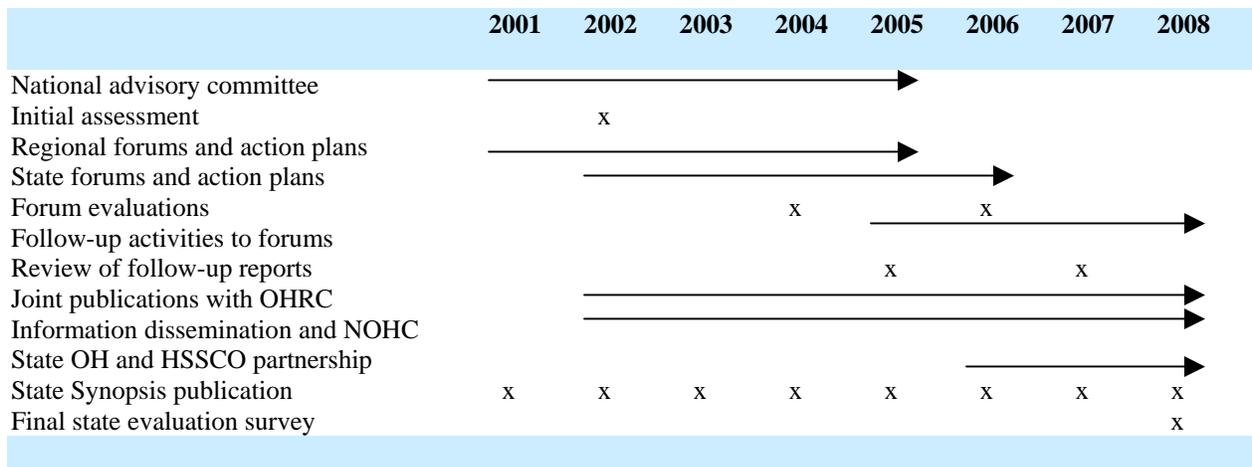
One member of the National Advisory Committee, who was also the lead for the regional Head Start oral health consultants, reviewed HSB national Program Information Report annual data from 2003-2007 looking at the percent of children who had 1) a dental home, 2) an oral examination, 3) preventive dental care, 4) dental needs requiring treatment, and 5) who had received treatment. The advisory committee also looked at better ways to standardize the definitions of the performance indicators and the process for reporting information.

Final Survey of State Oral Health Programs and State Head Start Collaboration Offices

In September 2008 ASTDD emailed an evaluation instrument to all state dental directors and a similar instrument to all state Head Start collaboration office directors. The instrument focused on relationships and collaborations among organizations around Head Start oral health issues, the role of ASTDD in relation to outcomes from these activities and continuing needs. Responses were completed by 33 state dental directors and 18 state HS collaboration office directors. Follow-up phone calls were made to respondents and non-respondents to clarify or obtain additional information, especially examples of success stories and continuing needs. Lower than expected response rates were in part due to the high turnover and vacancies in these positions. Because of the high turnover rates in both groups, many of the 2008 respondents were not the same people who had been in those roles during the past six years of the project. Previous directors were contacted in some instances. This situation creates limitations in reporting frequency distributions for some evaluation data and in documenting outcomes over time. It also attests to the problems of sustaining collaborations.

SUMMARY OF ASTDD ACTIVITIES AND OUTCOMES

Figure 2. Timeline of ASTDD Head Start Oral Health Activities



Initial Needs Assessment

The 2002 initial needs assessment survey demonstrated that while some states and territories were actively involved with Head Start programs and issues, others had completely no involvement. Table 1 displays responses about state oral health program collaboration with other groups.

Table 1. State Oral Health Program Collaboration with Other Groups in 2002 (N=41)

Does the State Oral Health Program collaborate about Head Start with any of the following organizations at the regional level?	Yes	No
Regional HRSA Dental Consultant	20	21
Regional CMS (formerly HCFA) Health Insurance Specialist - Dental Consultant	13	28
Regional Head Start Consultant(s)	12	29
Regional Head Start Quality Improvement Center (QIC) Consultant(s)	5	36

Does the State Oral Health Program (you or your staff) collaborate with any of the following organizations in your state?	Yes	No
State Head Start Association	22	19
Head Start State Collaborative Office	17	24
American Indian Head Start Program	7	33
Migrant Head Start Program	13	28

Does the State Oral Health Program involve Early Head Start or Head Start in any of the following?	Yes	No
State Oral Health Program Advisory Committee	15	26
State Oral Health Coalition or Task Force	25	16

At the beginning of the project more than 50% of the state oral health programs noted they were not involved with the majority of these groups, with the exception of Head Start Associations and Head Start representation on oral health coalitions.

Comments about the responses showed a variety of types of collaborative relationships and highlighted the need to expand and strengthen these relationships. Respondents described challenges in trying to improve the oral health of Head Start children and reported a need for resources and training in working with this population. Table 2 displays examples of responses. ASTDD and the National Advisory Committee used these responses to help target their activities.

Table 2. Challenges and Future Resources Needed to Address Head Start Issues

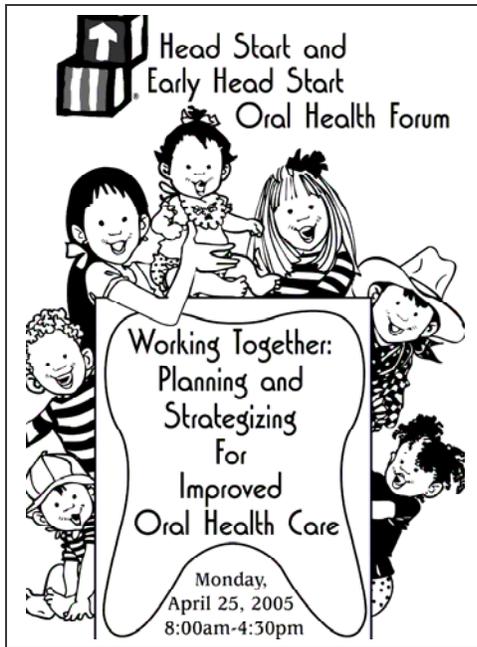
Challenges	Resources Needed
<ul style="list-style-type: none"> • Limited access to dental care • Medicaid problems: low reimbursement rates, not enough providers • Workforce issues: supply and distribution • State practice acts limiting roles of dental hygienists • Lack of incentives for professionals to work in shortage areas • Children in need of hospitalization or advanced behavior techniques for dental care • Lack of oral health knowledge of Head Start staff and families • Lack of transportation to access care • Lack of funding for preventive community- based oral health activities • Multi-language/cultural issues not being addressed 	<ul style="list-style-type: none"> • Funding for a variety of activities • Educational materials • Dental consultants for TA • Support from policy makers • Models for replication • Increased roles for dental hygienists • Education/training for both dental professionals and Head Start staff • Support for EHS/HS oral health forums

State/ Territorial Head Start Oral Health Forums and Action Plans

Participants at a 1999 National Head Start and Partners Oral Health Forum called for forums to address Head Start oral health issues at the regional and state/territorial levels. In support of this effort, ACF, Altarum and HRSA regional offices held twelve regional oral health forums where key stakeholders identified common issues affecting the oral health of children enrolled in Head Start and developed regional strategic plans. Many state dental

directors participated in these regional forums. ASTDD called for proposals from states and territories for partial support of Head Start oral health forums and action plans. Initially in 2002, 22 states and territories expressed interest in holding a Head Start oral health forum; 19 states reported no interest. From 2002 through 2006, ASTDD offered six cycles of support (\$5,000 per state or territory). The RHSOHCs and ASTDD worked together to enable all states and some territories to eventually apply.

All 50 states, DC and 4 territories eventually held forums, developed action plans and submitted final reports.



The purpose of the forums was to solicit input from a multi-disciplinary, multi-organizational group of stakeholders to develop action plans to improve the oral health of children enrolled in Early Head Start/Head Start and their families, as well as eligible pregnant women and infants. The goals of the forums included:

- Fostering leadership, collaboration, and communication among stakeholders
- Increasing access to regular and appropriate dental services
- Expanding evidence-based oral disease prevention in Head Start
- Promoting the use of culturally and developmentally appropriate oral health promotion and education materials
- Leveraging additional resources for conducting the forums and implementing the action plans
- Evaluating forums and action plan outcomes

Approximately 50% of primary contacts were state oral health programs and 50% were Head Start collaboration offices or Head Start associations; in one state the dental association was the primary contact.

The call for proposals and subsequent list of state contacts was widely circulated to enlist participation from national groups with state affiliates, including the Association of Maternal and Child Health Programs (AMCHP) and the American Academy of Pediatric Dentistry (AAPD). ASTDD's support for forums required states to collaborate with a broad-based group of stakeholders. ASTDD

provided technical assistance in selecting a representative planning group that would leverage additional resources and coordinate activities in support of the forum, final report and action plan. Each planning group decided on the format and the agenda for their forum. While most forums were held at one central site, some rural states used teleconferencing for their forum and others held 2-4 regional forums at different locations within the state. Attendance ranged from less than 50 people to more than 150. Most state dental directors and their staff were actively involved in the forums and assumed leadership roles in developing the oral health action plans. All final reports and action plans are posted on the Head Start page of ASTDD’s website as well as on OHRC’s website. No specific report format was required. Many states used forum reports and action plans from other states to inform their own planning decisions.

In 2004 and 2006 ASDD surveyed the primary contacts and 2-3 stakeholders involved with each state forum to determine if the forum goals were being met. Table 3 shows the percentage of primary contacts who responded positively that the listed goals had been met.

Table 3. Percentage of State/Territorial Primary Contact That Felt Forums Had Met Goals

State and Territorial Head Start Oral Health Forum Goals	2004 Evaluation N=16	2006 Evaluation N=14
Fostering leadership, collaboration, and communication among stakeholders	89%	83%
Increasing access to regular and appropriate preventive and treatment services	57%	61%
Expanding evidence based disease prevention in Head Start	60%	50%
Promoting the use of culturally and developmentally appropriate oral health promotion and education materials	61%	60%
Leveraging resources for conducting the forums and implementing the action plans	89%	67%
Assessing and evaluating program outcomes	46%	28%

The greatest achievements were fostering leadership, collaboration, and communication, as well as leveraging resources from partners for conducting and implementing action plans. More than 80% of survey respondents indicated the forums were instrumental in initiating these partnerships.

In addition to meeting some of the forum goals, these accomplishments are also essential elements for sustainability of efforts. Partnerships were initiated between Head Start groups, dental and dental hygiene schools, professional organizations, private foundations, faith-based organizations, coalitions, policymakers, community health centers, advocacy groups, and preschool/other educational programs.

Some of these partnerships led to the establishment of MOUs (memoranda of understanding) between state agencies and Early Head Start/Head Start Programs with dental/dental hygiene schools, private dental offices, and community health centers to provide oral health services for pregnant women, infants and EHS/HS children with the intent of promoting early intervention and establishing dental homes. An example of a successful outcome from the Texas state forum and action plan was the partnership and leveraging of Office of Head Start Program Improvement Funds that initiated the start up of a dental clinic

to serve Head Start children. Kansas was able to convince the state legislature to establish an Office of Oral Health and allocate funds to hire a state dental director. Another state received an RWJ grant to integrate OH into 9 EHS/HS programs in the county.

At least 15 descriptive summaries of promising models from the forums and action plans of 12 states/territories have been posted as part of the Best Practices Project on the ASTDD website (search on “Head Start” on the Best Practices Descriptive Summaries page) and integrated into the Best Practice Approach Report on State Oral Health Plans and Collaborative Planning. Others are still being collected by ASTDD and some stories and models are being highlighted through other agencies or within the states.

Some of the challenges that emerged for the states/territories were 1) measuring forum outcomes, 2) identifying evidence-based preventive services and dental care and determining ways to increase access to them, and 3) providing appropriate oral health educational materials. Only 30% to 40% of respondents to the two rounds of forum evaluation surveys noted they had any tools in place to measure outcomes, and they did not have an evaluation plan. Respondents noted that the forum alerted them to the need to include Head Start children in state oral health surveys and to develop evaluation plans. Respondents also reported that they were presently revising their state plans to include evaluation measures.

ASTDD continues to offer technical assistance to states to improve their evaluation focus and capacity, to share resources on evidence-based practices, and to work with the Oral Health Resource Center and states to identify, develop and promote appropriate educational materials.

State/Territorial Forum Follow-Up Activities

35 states, DC and 3 territories have received support for follow-up activities.

ASTDD offered four cycles of follow-up support (\$2,500 per state/territory) between 2005 and 2007 for partial assistance in implementing action plans. Since the original cycles, other states have applied and been given support on an individual basis as funds are available. As with the forums, states and territories partnered with other groups to secure additional resources and in-kind support. The two summary reports conducted in 2005 and 2007 provide information on the activities facilitated through follow-up funding. Examples of accomplishments include:

- Follow-up forums or workgroup meetings to discuss and evaluate progress
- Surveys to assess progress on action plans
- Developing and distributing tool kits and CD ROMs of educational materials
- Training medical and oral health professionals about Head Start standards, barriers to care and providing oral health care to young children
- Educating and empowering Head Start parents and staff around oral health issues and care

- Supporting and introducing legislation for improving access to oral health care for pregnant women and children
- Supporting collaborative efforts among state oral health programs, state Medicaid/SCHIP programs, and state Head Start collaboration offices
- Using evidence-based preventive measures such as fluoride-varnish in community-based settings, including Head Start programs
- Developing contractual or other relationships among agencies to provide services or to leverage other resources
- Designing and implementing evaluation plans.

The initial 16 states conducting follow up activities received awards totaling \$40,000, and then reported leveraging an additional \$60,911 to support their activities.

Leveraging of additional resources was significant, although some in-kind services such as professionals' time, use of equipment, space and supplies were not quantified by the states. Among the successes, the West Virginia Head Start oral health forum/action plan eventually was the catalyst for the Claude Worthington Benedum Foundation's contribution of \$225,000 to the West Virginia Head Start Association. The

funds were awarded to provide assistance in accomplishing the goals and objectives of the Head Start oral health action plan. Some funds were used to develop an oral health tool kit and DVD to promote oral health education among children and families in Head Start; these now are being disseminated nationally. These efforts influenced another successful grant for Head Start in a safety domestic violence project. More than 13 other foundations also have supported Head Start activities in states.

One example of a new collaborative program initiated by partners from dental professional organizations, state agencies and Head Start is the partnership between the Texas state oral health program and the Texas state Head Start collaboration office to implement the annual Texas Save-Our-Smiles Program (SOS), where Head Start children throughout the state receive free exams, oral health education, fluoride varnish applications and referrals to dental homes. In Missouri follow-up funding and the participation of the HSSCO director facilitated formalization of the Missouri Coalition for Oral Health, including a mission statement, a job description and subsequent hiring of an oral health coordinator, and organizational procedures to more effectively address oral health issues in the state. As a follow-up to the need voiced in the forums and action plans, many states initiated legislative action to increase the role of dental hygienists in providing oral health education, preventive services and referrals to dental homes for Head Start children.

California used their funding to develop an updated Head Start/ Child Health and Disabilities Prevention (CHDP) Program (CA-EPSDT) MOU to serve three purposes: 1) encourage statewide collaborative efforts between the CA CHDP program and Region IX HS program, 2) provide a state-level model for local HS and CHDP program collaboration in using federal, state and local resources effectively, and 3) promote the development of local HS and CHDP interagency agreements.

State Head Start Collaboration Office Partnership

Since 1990 Head Start has funded state Head Start Collaboration offices to support the development of multi-agency and public/private partnerships. Starting in 2006 ASTDD asked the Office of Head Start to help foster more collaborative efforts between state oral health programs and state Head Start collaboration offices. The first effort was a joint memo in January 2006 to both groups asking for collaboration around



the mid-course review of the Healthy People objectives. In addition, all state dental directors were given packets of information on Head Start, including information on the state HS collaboration offices. Carmen Bovell-Chester, the OHS senior advisor on state collaboration, then arranged for an oral health planning team of ASTDD representatives and state HS collaboration office directors to hold conference calls to discuss further collaborative efforts. These calls still continue on a periodic basis. To acknowledge the importance of this collaboration, ASTDD presented a certificate of appreciation to Beverly Jackson, who was instrumental

in coordinating oral health efforts during her Head Start fellowship and in her role as DC HS collaboration office director. In June of 2006 the OHS newsletter, *The Health Information Exchange*, featured Oral Health in a number of articles, including one on the partnership with ASTDD.

The ASTDD project coordinator organized an effort in 2006-07 with the regional oral health consultants to facilitate calls in all the regions. State Medicaid dental consultants were also invited to be on the conference calls to discuss dental care financing and access issues, strategies and solutions. In some regions two to three annual calls were scheduled between state dental directors and Head Start state collaborative directors. Many Head Start oral health activities were discussed on these calls, which led to OHS's decision to sponsor two oral health webinars in May 2007.

Calls between state oral health programs and state HS collaboration offices were held in states in every ACF region, and two national webinars showcased selected state projects. The goal of the calls was to develop an ongoing communications process to share information and resources that would unite state Head Start collaboration offices and state oral health programs to increase services for children ages five and younger.

The webinars, "Successful Partnerships to Improve Oral Health in Head Start," showcased a Head Start oral health project from one state in each region, including California, Minnesota, Missouri, New York, North Carolina, Oregon, South Dakota, Texas and West Virginia. The webinars were designed for local Head Start programs, central and regional office staff and administrators, RHSOHCs, Head Start T/TA network staff, state Head Start collaboration directors and staff, state dental directors and staff, and early childhood partners. Many of these projects are being submitted and reviewed as best practices to be highlighted by the ASTDD Best Practices Project or on the Oral Health Resource Center's website and the Office of Head Start's Early Childhood Learning and Knowledge Center website.

Relationships and Collaborations in States/Territories

Table 4 compares the type of involvement with Head Start by state oral health programs in 2002 and again in 2008.

Table 4. State Oral Health Program Roles with Head Start in Selected Activities

2002 Responses (N=41)

Question	Advise, arrange or facilitate	Perform or conduct	Both	Neither
Assess oral health status	29.3%	9.8%	26.8%	34.1%
Assess access to oral health services (including prevention and treatment)	39.0%	9.8%	14.6%	36.6%
Assess knowledge or behaviors of Head Start staff or parents	17.1%	14.6%	9.8%	58.5%
Community-based preventive programs	22.0%	12.2%	12.2%	53.6%
Head Start staff or parent education	22.0%	17.1%	14.6%	46.3%
Curriculum development	19.5%	9.8%	4.9%	65.8%
Head Start Health Advisory Committee	29.3%	7.3%	7.3%	56.1%

2008 Responses (N=33)

Question	Advise, arrange or facilitate	Perform or conduct	Both	Neither
Assess oral health status	9.1%	39.4%	33.3%	18.2%
Assess access to preventive oral health services	42.4%	18.2%	24.2%	15.2%
Assess access to dental treatment	51.5%	12.1%	18.2%	18.2%
Assess knowledge or behaviors of Head Start staff or parents	33.3%	18.2%	6.1%	42.4%
Community-based preventive programs	33.3%	21.2%	15.2%	30.3%
Head Start staff or parent education	36.4%	30.3%	18.2%	15.2%
Curriculum development	27.3%	21.2%	18.2%	33.3%
Head Start Health Advisory Committee	21.2%	24.2%	12.1%	42.4%

State oral health program involvement with other organizations in 2002 and 2008 is presented in Table 5.

Table 5. Previous Vs Current State Oral Health Program Involvement with Other Organizations Around Head Start Issues

Organization	2002 (Total N=41)		2008 (Total N=33)		
	No	Yes	No	Yes	No Response
HS Collaboration Office	24	17	-	33	
Regional Office HS TA	36	5	14	18	1
State HS Assoc	19	22	1	32	
State OH Coalition	16	25	3	27	3

Overall this comparison shows increased involvement in all areas listed as well as more depth of involvement. Programs significantly increased their involvement with groups that were the primary focus of ASTDD promotional efforts.

“No involvement” across activities ranged from 34.1% - 65.8% in 2002 and from 15.2% - 42% in 2008. Baseline data were not collected on involvement with state Medicaid programs, but responses on the final evaluation survey indicate significantly increased involvement over the years. One reason for lack of survey input from state Medicaid/SCHIP programs over the years is that there is no one central contact person for Medicaid/SCHIP dental issues in many states. In 2004 some of the Medicaid dental consultants formed the Medicaid/SCHIP Dental Association (MSDA) to provide a better mechanism for communication and coordination. They meet in conjunction with the ASTDD, American Association of Public Health Dentistry, and the American Association for Community Dental Programs at the annual National Oral Health Conference.

A number of factors were cited as enabling collaborations, including common goals and missions, an interest/desire to form new partnerships, face-to-face meetings, frequent communication, timely follow-up and “seed money” for activities.

The most frequently cited barriers or frustrations included loss of institutional memory caused by changes in leadership and staff or position vacancies, losing momentum when initial tasks were accomplished, lack of organization and fragmented efforts, state dental practice act restrictions, and oral health not perceived as a priority for non-dental groups. Regional office relationships were interrupted by 1) ACF HSB changing from a Quality Improvement Center system of contractors to a new set of internal TA experts in 2003, 2) changing to a new set of pediatric dental consultants from the original set of regional Head Start oral health consultants who functioned between 2002 until the spring of 2008, and 3) the loss of HRSA regional dental consultants from most regional offices. Some states noted that collaborative efforts greatly decreased at the end of the IAA when funding for the original regional Head Start oral health consultants was discontinued. Some states did increase contact with their CMS regional consultant around Medicaid issues and with the new pediatric dental consultants during this process, however. These relationships are analyzed further in Table 6 by the maturity level of the collaborations from the perspective of the state oral health program and the state HS collaboration office.

Table 6. Current (2008) Levels of Involvement with Other Organizations around HS Issues

State Oral Health Programs (N=33)

	None	Beginning	Committed	Waning	NR
State HS Collaboration Office	-	3	25	5	-
HS Regional Office	6	8	12	6	1
Dental/DH Education Programs	8	5	19	1	-
State Medicaid/SCHIP Staff	4	5	23	1	-
State HS Assoc	1	9	17	6	-
State Primary Care Assoc	11	8	10	2	2
State Dental Assoc	5	5	19	4	-
State DH Assoc	8	4	15	6	-
State Pediatric Dent Assoc	6	9	14	3	1
Oral Health Coalitions	3	1	23	3	3

State HS Collaboration Offices (N=18)

	None	Beginning	Committed	Waning	NR
State Oral Health Program	-	2	16	-	-
HS Regional Office	-	-	17	1	-
Dental/DH Education Programs	3	3	9	2	1
State Medicaid/SCHIP Staff	2	3	8	3	2
State HS Assoc	1	1	15	-	1
State Primary Care Assoc	6	4	2	1	5
State Dental Assoc	1	5	10	1	1
State DH Assoc	4	4	7	1	4
State Pediatric Dent Assoc	4	6	5	2	1
Oral Health Coalitions	3	1	12	-	2

Changes in relationships are somewhat difficult to track as key players in organizations left their positions along the way, and some positions still remain vacant. The data suggest that relationships must be nurtured on a regular basis and new players need to be educated about past and current efforts. The numbers in the “none” “beginning” and “waning” columns show that plenty of opportunities still exist for improving collaborations in support of Head Start oral health issues. This is particularly true for primary care associations that will have an increased investment in Head Start issues as more community health centers add dental services; previous interactions primarily focused around designation of dental shortage areas. Interactions with pediatric dentistry associations increased not only as a result of the Head Start forums, but also during the ASTDD-supported oral health forums for Children with Special Health Care Needs. These relationships should increase as a result of the new AAPD Dental Home initiative, which involves regional pediatric dental consultants and state AAPD chapters.

The number of state programs that have developed and maintained committed relationships as a result of the IAA is impressive.

“The ASTDD Project was the reason for the development of partnerships including the state oral health program , HS collaboration office, dental and dental hygiene schools, AAPD affiliates, HS regional offices, and dental associations. Continued support is needed to keep these alive!”

State Oral Health Program Director

Use of Head Start State Action Plans

State oral health programs and state Head Start collaboration offices were asked questions on the final evaluation survey about use of their Head Start action plans. About 60% of both groups replied that the recommendations and activities from the forums and action plans have been integrated into other statewide plans. This shows progress in attempting to integrate oral health with other health and education messages and to keep oral health issues upfront to foster continued emphasis, collaboration and support. Many state/territorial oral health programs used forum and action plan information in their successful applications for the following federal grant proposals:

More than 45% of both groups indicated they have used information from the Head Start forum, action plan or resulting activities in other grant proposals or requests for resources.

- MCHB State Early Childhood Collaborative System projects (SECCS)
- MCHB State Oral Health Comprehensive Systems grants (SOHCS)
- Targeted Oral Health Service Systems (TOHSS) grants
- OHS Oral Health Initiative
- OHS Innovation and Improvement projects
- CDC State-Based Oral Disease Prevention Program grants

Other examples include:

- Executive order to create a Governor's Task Force on Children's Oral health and to obtain a Migrant Head Start grant
- Partnership with Delta Dental (multiple states)
- Private Foundation funds for a curriculum, materials or services (multiple states)
- CATCH grant to train physicians on oral health assessment and fluoride varnish
- 4-year grant to place the same curriculum in every Head Start program in the state

Legislation and Policy Changes



During the ASTDD Head Start project and in relation to the Head Start oral health action plans, many states including Maine, Massachusetts, Minnesota, Alaska, Florida, Indiana, New Hampshire, Maryland and Montana have been involved in legislative activity and policy changes to improve the oral health status of Head Start children. The action plans called for oral health screenings in schools, expansion of dental hygienists' public health role with less restrictive supervision and establishment of collaborative partnerships between dentists and dental hygienists working in public health settings. In West Virginia a bill established a special volunteer dental hygienist license for retired dental hygienists who wished to donate

their expertise for the care of indigent and needy patients. Some states have expanded the dental hygienists' scope of practice to allow more onsite prevention services in Head Start programs; in some states, dental hygienists can be directly reimbursed as Medicaid providers. Medicaid reimbursement was an issue discussed in every state Forum and an item for action in most state plans. An increase in Medicaid reimbursement to dentists has occurred in some states, which encourages oral health professionals to accept Medicaid clients, many of whom are Head Start children. Some state Medicaid programs also increased reimbursement for fluoride varnishes and allowed reimbursement to health professionals for oral health services. Professional organization policies and some state EPSDT policies that require children be seen for an oral screening or exam by age 1, emphasize the need to train oral health professionals and medical professionals to work together to provide services for young children and their families.

ASTDD passed a resolution supporting collaboration between state oral health programs and other partners such as state Head Start collaboration offices, regional office ACF staff, and Early Head Start/Head Start programs, and resolving that the ASTDD Executive Committee develop relationships (liaison roles) with AMCHP and NHTSA to promote oral health and advance oral health policy issues within Early Head Start and Head Start.

National Head Start Oral Health Grants



In 2005 the ACF Head Start Bureau announced the Head Start Oral Health Initiative for Young Children, Birth to Five, which provided supplemental funding of up to \$75,000 per year for four years to Head Start programs to improve oral health services to enrolled pregnant women, infants, and children. Much of this impetus came from needs identified by the National Advisory Committee. Fifty-two grants were awarded to local programs in 42 states to develop and implement “best practice” oral health models. A number of state oral health programs were involved in assisting with the initial application for funds and in implementing grant activities, including the following activities:

- Oral health training for pediatricians
- Collaboration on defining EPSDT guidelines in relation to Head Start
- Development and dissemination of educational materials
- Facilitation and participation in planning meetings
- Fluoride varnish training for health professionals

The Ohio Department of Health, Bureau of Oral Health Services arranged and facilitated a June 2007 meeting of the three local oral health initiative projects for Ohio funded under this grant program. The half-day meeting permitted representatives from each project to share information and engage in brainstorming and problem solving.

The Office of Head Start contracted with Mathematica Policy Research, Inc and its subcontractor, Altarum, to evaluate the Oral Health Initiative grants. Grantees reported that without continued funding past 2010 many aspects of their projects will need to be reduced or eliminated.

Publications and Materials

In December 2006 the Office of Head Start issued a Program Instruction (PI) to define the federal program's policies and expectations for Head Start grantee compliance with specific oral health requirements of the Head Start program performance standards.

The ASTDD National Advisory

Committee, in collaboration with the RHSOHCs, provided technical assistance in defining the oral health program instruction requirements and posted the final PI on the ASTDD website. The National Advisory Committee also asked the National Oral Health Policy Center to research state Medicaid periodicity schedules, which resulted in a subsequent publication by the Center, *EPSDT Periodicity Schedules and Their Relation to Pediatric Oral Health Standards in Head Start and Early Head Start*.



In the initial needs assessment, ASTDD requested a description of/samples of oral health manuals and materials used in Head Start and Early Head Start Programs. A subset of the National Advisory Committee reviewed all submitted materials and determined that the majority of those being used and those accessible online were outdated and contained inaccurate information. There was little to no information on oral health for pregnant women and early childhood. Therefore, the need to work with the National Oral Health Resource Center in encouraging states to develop culturally and developmentally appropriate materials that emphasized evidenced based practices was paramount. ASTDD has collaborated with the National Oral Health Resource Center in the collection, review, development, and dissemination of educational materials, including curricula, tip sheets and fact sheets. Examples of materials include:

- *Dental Hygienists and Head Start: What You Should Know and How You Can Help.*
- *Head Start Oral Health Curricula at a Glance*
- *Head Start Oral Health Resource Guide*
- *Working with Parents to Improve Access to Oral Health Care: Oral Health Tip Sheet for Head Start Staff*
- *Working with Health Professionals to Improve Access to Oral Health Care: Oral Health Tip Sheet for Head Start Staff*
- *Head Start: An Opportunity to Improve the Oral Health of Children and Families*
- *Uses for Oral Health Tip Sheets for Head Start Staff*



Responses to the ASTDD final evaluation survey and annual member surveys demonstrate that these materials are being shared and used in many states, including during the forums and other conferences. For example, in Ohio they have become part of the Ohio Head Start Oral Health Resource Guide developed

for Ohio Head Start programs. Some states such as Arkansas, Texas, Colorado, Nevada and West Virginia developed their own Head Start educational materials on prevention of dental disease for pregnant women and Head Start/Early Head Start children and have shared them with other states. Many state respondents to the forum evaluation surveys noted they had not developed many culturally appropriate materials, but had focused more on developmentally appropriate materials and curricula. Hawaii, Alaska and the US territories, however, did focus more on culturally relevant materials.

Numerous newsletter articles were published on the Head Start and oral health connection including in ASTDD's *Oral Health Matters* and in state newsletters. ASTDD's Head Start liaison, Ms. Geurink, also published an article in *Access*, "Dental Hygienists' Role in Establishing Dental Homes for Head Start Children." It highlights some of the partnerships established through the IAA.

Presentations and Meetings

The National Advisory Committee brainstormed avenues for presentations and information dissemination. Presentations on the Head Start project were facilitated or given by ASTDD or state



representatives at many national meetings, including symposia for the American Dental Education Association (ADEA), American Public Health Association (APHA), National Head Start Association (NHSA) and the National Oral Health Conference (NOHC). The session at the 2003 NOHC included one-page summaries of state forums, including the forum dates and model used, major partners, and status of activities and outcomes. The 2005 NOHC featured Rob Reiner from the California First Five Initiative discussing the important link between the oral health of infants/preschoolers and school readiness.

ASTDD sent representatives to two Head Start Interagency Coordinating Committee meetings in DC and to the following topic-focused meetings:

- *Promising Approaches and Lessons Learned for Preventing or Reducing Early Childhood Caries Expert Meeting.* This national forum on early childhood caries (ECC) was convened on May 16–17, 2005, in Washington, DC. Using ASTDD's Best Practices for Oral Health Programs criteria as a framework, participants identified common program elements to develop a knowledge base of promising program approaches, practices, challenges, and lessons aimed at reducing and preventing ECC.
- *Topical Fluoride Recommendations for High-Risk Children Expert Meeting.* This expert meeting was convened on October 22–23, 2007, in Washington, DC, to review professional oral health guidelines on topical fluoride, review populations at highest risk for dental caries, discuss risk assessment and develop a decision support matrix. ASTDD will help to promote and disseminate this information to states.
- *Head Start National Partners Meeting.* This meeting was convened on April 7, 2008 in Chicago by AAPD to introduce national groups to the Dental Home Initiative, a newly funded contract from the Office of Head Start. An ASTDD representative and others outlined the many

collaborations that had developed under the original IAA and asked AAPD to ensure that new activities would build on these collaborations.

- *Dental Home Expert Panel*, convened by MCHB September 18-19, 2008 in DC, was held to address the need for a clear and workable definition of “dental home.” An ASTDD representative stressed the need for inclusion of public health dental homes, the need for an adequate public health workforce to staff these settings, and a shift toward more emphasis on prevention and early detection rather than costly high-end treatment.
- *National Summit on Children’s Oral Health*. This summit was convened by AAP in Chicago on November 7-8, 2008 and supported by AAPD and ADA. The primary purpose was to provide updates of children’s oral health in the U.S. since the release of the 2000 Surgeon General’s Report, *Oral Health in America*. ASTDD contributed oral health information from the *State Synopses* and the *National Oral Health Surveillance System*.

Changes in Prevention Programs, Oral Health Status and Oral Health Care

Prevention Programs

Because low-income children experience dental disease at an earlier age and higher prevalence than children from families with higher incomes, Head Start children have been categorized as a high-risk population for tooth decay (dental caries). Therefore, the prevention of dental caries in EHS/Head Start children is at the forefront of public health strategies. Many Head Start programs in non-fluoridated areas were using daily fluoride tablet programs, and some were inappropriately using fluoride mouthrinses with young children. The application of fluoride varnish 2-3 times per year as an evidence-based practice was promoted and supported by ASTDD and other national and regional partners and in the oral health initiatives supported by Head Start. Based on ease of application, low ingestion of fluoride, and superiority to other topical fluorides, the varnish has become a useful preventive measure in many Head Start Programs. The majority of Head Start oral health forum reports included fluoride varnish as the main prevention strategy for reducing dental caries in Head Start children. Increases in use can also be attributed to the local grantees funded for Oral Health Innovation grants, many of whom hired dental hygienists to coordinate and provide preventive services.



Each year state oral health programs submit programmatic data to ASTDD for the *State Synopses*. Analysis of data from 2000-2007 shows a dramatic increase, from 13% to 52%, in state oral health programs sponsoring fluoride varnish programs for young children. In 2000, only 3,154 children were reported to have received a fluoride varnish through one of these programs compared to 162,531 in 2007;

More than 50% of respondents to both sets of forum evaluation surveys noted increases in evidence-based prevention programs. The final evaluation survey also documented that 60% of state oral health program respondents noted increases and positive changes in preventive services in Head Start programs.

2008 data will undoubtedly show additional increases. The *State Synopses* also tracks state-sponsored early childhood caries (ECC) prevention programs for women and children, many of which probably include the reported fluoride varnish applications. States that sponsored ECC programs increased from 60% in 2000 to 72% in 2007. Although not all of these were children

enrolled in Head Start or Early Head Start, the increases attest to state oral health programs' commitment to supporting this evidence-based practice. In September 2007, as a response to questions from state oral health program directors, the ASTDD Fluorides Committee published and widely disseminated a research brief, *Fluoride Varnish: An Evidence-Based Approach*, to support these programs (available on the ASTDD website.) The 2008 ASTDD annual member survey documented that many states and organizations have used this research brief in developing their varnish programs for preschool populations and in early childhood caries prevention courses for dental and other healthcare professionals.

State Medicaid programs also have enabled better provider reimbursement and tracking of children who receive fluoride varnish applications in public and private settings and some have added reimbursement for application of dental sealants in primary molars. Health care providers such as pediatricians and nurses are beginning to include fluoride varnishes as another preventive strategy in their overall approach to health and wellness.

Oral Health Status and Oral Health Care

A review of states/territories that conducted oral health surveys and included Head Start children revealed 4 states collecting data between 1993 and 1995 and 19 states and 2 territories doing so since 2000; 4 states collected data in multiple years.

Not all states used the *Basic Screening Survey* for data collection. The number of states collecting oral health status data on either preschool or elementary school-aged children using the *BSS* increased from 6 states between 1998-2000 to 37 states in 2007. Some states such as Alaska and Massachusetts have published reports of these surveys, available on their websites or through the OHRC website. ASTDD is in the process of performing a trend analysis of *BSS* data from states collecting data over multiple years. The training manual and videos for the *BSS* were revised by ASTDD in 2008 to include information on Head Start data collection and analysis. ASTDD also plans to recommend that preschool data be added to the National Oral Health Surveillance System (NOHSS) as an oral health indicator for primary teeth.

The Office of Head Start tracks HS program performance through Program Information Reports (PIR) submitted by HS grantees. Analysis of national PIR data showed the following changes from 2003 to 2007.

Table 7. National Program Information Report Trends for Head Start and Oral Health

PIR Indicator	Percentage of Head Start Children*	
	2003	2007
Dental Home	80%	86%
Oral Examination	78%	89%
Preventive Care	61%	85%
Requiring Treatment	22%	25%
Received Treatment	77%	83%

*Children enrolled in Head Start; excluding pregnant women, infants, and young children

Increases in care, including treatment, were noted by more than 50% of respondents to ASTDD's two rounds of evaluation surveys. The increases in care are encouraging, although the fact that more children are presenting with dental decay by the time they enter Head Start programs attests to the importance of reaching more pregnant women, infants and children in EHS with preventive services.

Continuing Needs

Questions on the final evaluation for state oral health programs and state Head Start collaboration offices asked about continuing needs to support oral health activities and Head Start collaborations. Participants were also asked if they would like a phone call with the ASTDD HS project coordinator to provide comments or share success stories; 23 participants requested and received follow-up calls. Needs include:

More than 80% of state oral health programs and 87% of state Head start collaboration offices noted they have continuing needs in relation to HS/EHS where ASTDD could provide assistance.

- Meetings: Review and define a dental home, dental exam and explanation of the EPSDT guidelines around the age one dental examinations; bring the partners together to update the Head Start oral health plan; statewide conference for family service and health coordinators on oral health; state planning session to coordinate initiatives and maximize services; planning/coordination with the new AAPD Head Start Initiative
- Communication and information: Webcasts or online learning on Head Start and oral health; information on oral diseases and oral health problems of HS children; continued work with the NOHRC to update Head Start materials and tip sheets; information on dentists who participate in Medicaid, especially pediatric dentists; information on ASTDD resources for Head Start; follow up to present projects; continued support of collaboration of SOHP and HSSCO and coordination with AAPD activities such as through conference calls
- Oral health surveillance: Support for collection and sharing of BSS data on Head Start; technical assistance and support for surveillance of HS/EHS oral health status
- Preventive services: Funding to engage Head Start in participating in fluoride varnish projects; support for on-site oral health services in Head Start Programs; infant oral health training course previously done needs funding to continue
- Evaluation: Develop an evaluation to assess the accomplishments of the state Head Start oral health plans
- Advocacy: Assure a national advocacy role around oral health for HS families; support the dental hygienists' role in Head Start; support continuation of programs in states not included in the new AAPD Initiative

It is apparent from the number of requests for additional support that ASTDD is recognized as an important organization to facilitate statewide and national efforts to improve the oral health of Early Head Start/Head Start children and families.

Summary, Benefits, Lessons Learned

ASTDD demonstrated its unique relationship and communication network with state/territorial oral health programs and their partners, as well as other national organizations. In addition, state oral health programs demonstrated their ability to assume a leadership role in convening partners, creating an environment for strategic planning, and integrating Head Start concerns into other state plans and funding opportunities. Some states, however, don't have a state dental director to create an infrastructure with sufficient capacity, adequate resources and appropriate authority to enable the state to address oral health in a coordinated, effective manner. Likewise, some states have vacancies in the state HS collaboration office so that allocation and coordination of resources and TA efforts with local programs are difficult.

Conducting evaluation of intermediate and long-term outcomes is difficult when so many key players change. It is easier when partners have detailed accomplishments in writing and updated progress at regular intervals. It is also difficult to evaluate outcomes when whole systems change such as the TA system for Head Start, the HRSA regional office responsibilities and the network of HS dental consultants. Evaluation at the state level is in need of much improvement, both in terms of creating comprehensive evaluation plans at the outset, selecting appropriate measures of success, documenting progress toward those measures and using the information to make improvements.

States that continue to experience successes appear to have taken a more concerted approach to changing systems rather than focusing on one or two activities. Let's use Kansas as an example. After their initial forum, they created Oral Health Kansas, a statewide coalition. The coalition established the Kansas Oral Health website, which includes a wide variety of health education materials for Head Start staff to use. There was an increase in 2004 of 50% of Kansas HS grantees (N = 15) screening HS children for oral health status, with RN health specialists and community-based dental hygienists applying fluoride varnish. In addition, the action plan contributed to increased use of fluoride varnish with very young children in Head Start, local health departments, and other early childhood programs, as well as contributing to the practice of physicians and RN's applying fluoride varnish. The action plan contributed to the design and establishment of Extended Care Permit hygienists in Kansas. Currently, 26 of 29 HS grantees in Kansas utilize ECP hygienists. Kansas built on their successes and models from Head Start in their oral health forum and action plan for children with special health care needs (CSHCN). They are expanding on all of these activities in their HRSA TOHSS grant.

An important factor that enabled Head Start successes at the local, state, regional and national levels was the coordinated effort of organizations at all levels to form synergistic partnerships and coalitions to work toward the common goal of improving the oral health of Head Start children and their families and to coordinate oral health goals with other health and education goals. Sustaining partnerships requires a great deal of time, commitment and resources, as well as champions to maintain the momentum, but results in a greater impact than the sum of individual efforts. As new players enter the scene, existing collaborations should be nurtured, and lessons learned built upon, to create even more success stories. ASTDD is committed to continuing to foster and evaluate such partnerships at the state and national levels.

Recommendations

This report recommends the continued support of projects for the improvement of oral health for Head Start /Early Head Start children through a **health care systems approach** involving existing and new partnerships as well as programs already established at national, state and local levels. The following are recommended actions.

- **Continue and enhance collaboration** among the many partners originating from the original IAA to expand upon current successes.
- **Establish an ongoing system of communication** among state oral health programs, Head Start regional offices, state Head Start collaboration offices, state Medicaid/SCHIP offices, state Head Start associations and other groups. Collaboration between these partners and the new ACF/HSB funded AAPD Head Start Initiative should be fostered to support continued success in improving oral health needs assessment and surveillance; access to, financing and utilization of community-based and private oral health preventive services and dental care; and advocacy/policy development for Head Start and Early Head Start children and families.
- **Sharing promising models and best practice approaches and building funding opportunities** around evidence-based programs is essential.
- Inclusion of EHS/HS and oral health **representation in state coalitions** and **goals for EHS/HS oral health in state plans** should be continued and expanded.

In the area of education, training and technical assistance, there is a need to continue EHS/HS **oral health presentations** at local, state and national meetings and to continue to **disseminate information through webinars and websites**. The NOHRC has developed many excellent educational materials and future collaboration on development and dissemination of materials will be beneficial. Education and training opportunities have been provided for state oral health programs on Head Start and for state HS collaboration offices on oral health. Because of the turnover in state directors and staff, **training opportunities** should be offered on a regular basis.

In the area of **policy development**, collaboration and coordination with the Medicaid/SCHIP Dental Association, the MCHB National Oral Health Policy Center and other groups is still needed to review national and state guidelines and policies that impact oral health and dental care delivery and financing to young children and pregnant women. There is also a need to develop a more public health focused definition of “Dental Home” for Head Start families.

For **strategic planning and evaluation** purposes, it is important to include Head Start populations in Healthy People 2020 objectives and to support routine data collection and oral health surveillance for EHS/HS children. States will need support and technical assistance on evaluation strategies to make sure their collaborations and interventions are effective.

Many good activities and models of Head Start oral health programs have developed and matured, but they may be in jeopardy without the continued support of national organizations and active networks of partners at the state and local level working together towards the same goal of improved oral health for all Head Start children.