The American Dental Association and Head Start: Envisioning Future Collaborations to Improve Oral Health

Chicago, Illinois
October 29, 2004

Prepared for:

Health Resources and Services Administration and
Administration for Children and Families

Prepared by:

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I. Background on the Forum and ADA

In 1999, the Head Start Bureau (HSB), the Health Resources and Services Administration (HRSA), Centers for Medicare and Medicaid Services (CMS, then the Health Care Financing Administration), and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) convened a National Head Start Partners Oral Health Forum to focus attention on early childhood oral health. The purpose of the forum was to discuss strategies for improving oral health status among young children, and for increasing collaboration at the Federal, State, and local levels to enhance access to oral health services.

One outcome of this National Forum was the formulation of an Intra-Agency Agreement between the Head Start Bureau, Administration for Children and Families (ACF) and HRSA's Maternal and Child Health Bureau (MCHB) to develop linkages to support oral health in Head Start. As part of this agreement, the Bureaus decided to sponsor a series of forums to determine how organizations and agencies could work together to improve the oral health of participants in Head Start.

One of the professional organizations targeted for inclusion in this series of forums was the American Dental Association (ADA), the professional association of dentists committed to the public's oral health. On October 29, 2004, representatives from ADA met at the ADA Headquarters in Chicago, Illinois to discuss ways that ADA can collaborate with MCHB and Head Start to address oral health issues and implement strategies to enhance education, prevention, and access to dental care. (An agenda for the forum appears in Appendix A.) Participants at the forum included representatives of the ADA's Council on Access, Prevention, and Interprofessional Relations (CAPIR) as well as other dentists in practice identified by the ADA as having a special commitment to the oral health needs of low income children. These dentists represented different geographic regions across the United States, in addition to a broad range of experience and expertise working in the public, private, and nonprofit sectors. The ADA's CAPIR staff was instrumental in the identification and selection of participants, as well as the development of the forum agenda.

II. Introductions

Dr. Ronald E. Inge, the Associate Executive Director, Division of Dental Practice, of the American Dental Association welcomed the participants and expressed his support for this collaborative effort in light of the Surgeon General's Report on Oral Health and the need to bring multiple resources together to meet oral health needs for Head Start children throughout the country. He indicated that the ADA is interested in finding ways for its membership to be involved in this effort. He noted that through collaboration the whole result becomes greater than the sum of the parts and that working with the case management supports inherent in the Head Start program, positive outcomes could be achieved in the future.

John Rossetti, D.D.S., M.P.H., Oral Health Program Consultant to MCHB, followed Dr. Inge's remarks with the suggestion that the participants introduce themselves and briefly describe their experience working either with Head Start programs or with other community oral health programs. Although a full list of attendees is available in Appendix B, what follows is a summary of experiences the participants brought to the discussion of relevant issues in building collaborative partnerships with Head Start.

NAME	COMMUNITY	RELATED EXPERIENCE
Jim Crall	UCLA School of Dentistry, Section of Pediatric Dentistry	National Maternal and Child Oral Health Policy Center, Head Start experience in Hartford, Connecticut.
Vincent Filanova	Albany, New York	CAPIR member, serves on Head Start Health Services Advisory Committee, 40% patients have disabilities.
Frank Graham	Northern New Jersey	President, NJ Dental Association, focusing on fluoridation and access to care.
Jane Fosberg Jasek	ADA, Manager, Access and Community Health	CAPIR Staff and one of the key ADA support staff for *Give Kids a Smile Day*.
Morris Griffin	Durham, North Carolina	CAPIR member, local public health experience, not currently working with Head Start.
Hal Haering	LaBelle, Florida	Has worked with Migrant Head Start for 18 years of practice and treats Medicaid patients.
Gloria King	Houston, Texas	Seven years with Public Health Service, currently works closely with Head Start.
John Klyop	ADA, Director, within the Division of Dental Practice	CAPIR Staff.
Rob Lauf	Mayville, North Dakota	CAPIR Chair, works locally with Head Start and Migrant Head Start; serves on Head Start Health Services Advisory Committee and Head Start Policy Council.
David Neumeister	Brattleboro, Vermont	Experience with Head Start, Medicaid and setting up a for-profit dental clinic in collaboration with Head Start and other community partners.

Pete Paulson	Decatur, Illinois	Past CAPIR Chair, Past President Illinois Dental Society, urban practice general dentist; involved in the development of a county dental clinic in Illinois.
Kirk Westervelt	Sedona, Arizona	Recent dental school graduate, 40% Medicaid practice, retirees, some Migrant Head Start patients and their families.

The format of the meeting included an overview of Head Start Oral Health Partnership activities, and discussion by the attendees of the challenges and best practices they see regarding the oral health care of this population. The informal daylong discussion touched on many issues. This report consolidates the overall discussion into broad themes and recommendations for future activity.

III. National Update on Oral Health and Head Start

Following introductions, John Rossetti, D.D.S., M.P.H., Oral Health Program Consultant to MCHB, provided a brief historical overview of the interactions between oral health programs and Head Start. In the 1970s, the Public Health Service had significant involvement in assuring dental services under the Head Start program, and for many years there existed strong linkages between the public health and Head Start communities. By the mid-1980s, however, these linkages had deteriorated, and by the 1990s very limited activity was occurring between Head Start and the dental community at the Federal level. During this same time period, children enrolled in Medicaid experienced decreased access to dental services. A 1996 report published by the Office of the Inspector General (OIG) cited disparities in dental care for this population, and stimulated activity at the Federal level for improving oral health service delivery to Medicaid recipients. Following the release of the OIG report, officials at the then Health Care Financing Administration (now CMS) approached Dr. Rossetti and his colleagues at the Maternal and Child Health Bureau to organize a meeting to discuss oral health issues. This meeting provided the impetus for setting up an oral health initiative with the aim to build partnerships among organizations in an effort to improve oral health care for all populations.

As mentioned previously, the 1999 oral health forum sponsored by HSB, HRSA, CMS and WIC generated recommendations to create a series of follow-up forums across the country at both the regional level and within States and Territories to assess how groups can partner on this issue. These forums represent only one mechanism by which the sponsoring agencies are ensuring

further activity around oral health. Other activities include: State and Territorial Forums funded through the Association of State and Territorial Dental Directors to assess current relationships between oral health, Medicaid/SCHIP programs and Head Start programs, the National Maternal and Child Oral Health Resource Center, the National Maternal and Child Oral Health Policy Center, Head Start Fellows with the three Centers for Leadership Education in Pediatric Dentistry, and the funding of Regional Dental Consultants to assist the Head Start Technical Assistance Network in meeting the oral health needs of Head Start and Early Head Start children. Dr. Rossetti's handouts on the activities of the Intra-Agency Agreement, and the status of Regional and State Oral Health Forums can be found in Appendix C.

Dr. Rossetti emphasized that persistence and strong partnerships are needed to maintain momentum around oral health issues. He noted that strategies to improve oral health outcomes for Head Start children must attack the issue from National, Regional, State and local levels. He thanked participants for their dedication to the process and said the goal of the meeting is to set in motion an ongoing system to gather ideas, recommendations, best practices and insights from ADA members on how to best proceed with collaborative efforts to meet the oral health needs of Head Start children. In conclusion, Dr. Rossetti noted that follow-up to the recommendations discussed will be critical to the partnership's success.

IV. Head Start Overview

After Dr. Rossetti's presentation, Jane E. M. Steffensen, M.P.H., CHES, Consultant for the Head Start and Oral Health Partnership Project, provided participants with an overview of the Head Start Program, referring frequently to the Head Start Questions and Answers materials distributed prior to the meeting. The following statements provide a synopsis of Ms. Steffensen's remarks:

- Head Start began in 1965 as an effort to combat poverty by providing low-income children ages 3 – 5 years with a range of educational, developmental and health-related services
- Head Start is a comprehensive program of case management and wrap-around health services that views parents as partners in the decision making process
- Head Start is linked to the neighboring community through Advisory Committees, including a Health Services Advisory Committee

- In the late 1990s, Head Start was expanded to include prenatal services to the mothers of Head Start children and services to infants and toddlers through the Early Head Start program

- Head Start is a leader in providing services to children with disabilities, children of migrant and seasonal farm workers and Native American families

- There are currently 18,865 Head Start centers in 1,5750 grantees throughout the country housed in a variety of settings, including Community Action Program (CAP) agencies, nonprofit organizations, public schools and faith based organizations

- Federal funding goes to Regional Offices that distribute funds directly to Head Start Grantees which are required to provide a 20% local match. (NOTE: This allocation process bypasses State government.) Recently, Head Start State Collaboration Offices have been established tocreate a visible collaborative presence of Head Start at the State level that assists in the development of significant, multi-agency, and public-private partnerships within each State.

Ms. Steffensen noted that Head Start and Early Head Start programs use a variety of instruments and tools to evaluate, review, and monitor activities. Screening and assessments instruments are combined with tracking systems to measure children's progress in Head Start and Early Head Start Programs. Head Start programs conduct ongoing assessments of each child's progress using local assessment procedures and analysis of child outcomes. Head Start programs gather information in all aspects of development and learning. In addition, the newly implemented National Reporting System assesses four and five year old children in Head Start on a specific set of indicators using the same evaluation methods at the beginning and end of the program year.

All Head Start and Early Head Start programs must adhere to Head Start Program Performance Standards. The Program Performance Standards are the mandatory regulations that grantees must implement in order to operate a Head Start. Head Start measures outcomes through Performance Standards for each service area, including Education and Early Childhood Development; Child Health and Development; and Family and Community Partnerships. Performance standards related to oral health are outlined within each service area. Materials that provide guidance about effective ways to address the oral health related performance standards could be developed and disseminated in the future.

Currently, Head Start and Early Head Start Programs use a data reporting mechanism, the Head Start Program Information Report (PIR) for annual program reporting. Each year Head Start and Early Head

Start grantees are required to submit the PIR and the data collected for the PIR are self-reported at the grantee level. Another tool used for ensuring quality services for children and families in Head Start and Early Head Start programs is on-site monitoring. The Head Start Act requires that each grantee undergo a Federal review process once every three years. The Program Review Instrument for System Monitoring (PRISM) assists Federal Team Leaders and Head Start reviewers in organizing and recording findings during the reviews. During an on-site review, a team of non-Federal reviewers under the leadership of a Federal staff member from the Administration for Children and Families (ACF) assess whether or not the grantee is meeting the Head Start Program Performance Standards and other applicable regulations.

Also the Head Start Bureau supports research, demonstration, and evaluation activities to test innovative program models and to assess program effectiveness. Head Start and Early Head Start Programs utilize community assessments and self-assessment mechanisms to develop strategic plans and annual work plans.

The 2004 renewal of the Intra-Agency Agreement between the MCHB and the HSB, in addition to restructuring of the Head Start Bureau Technical Assistance Network, has elevated the visibility of the oral health needs of HS/EHS children. Oral health has been identified as a priority and this meeting with the ADA has been convened to strategize and identify collaborative efforts to improve oral health, enhance Head Start and Oral Health Partnerships, and address oral health challenges.

V. Challenges to Improving Oral Health Status in Head Start and Early Head Start Programs

Due to the participants' significant experience working with Head Start, Medicaid, Migrant/Seasonal and Native American populations, they had significant insights to share on some of the challenges they face in serving these populations. The ADA representatives outlined the following barriers to improving oral health status in HS/EHS programs, and in making more productive use of dental "chair time". (The order in which these barriers are listed does not indicate prioritization or express the consensus of the group.)

A. Challenges related to Head Start programs/families

- Families challenged with driving long distances to appointments when transportation is unreliable, often resulting in "no shows"
- Migrant/Seasonal Head Start programs vary in the degree to which oral health is a priority and the staff's capacity to manage and facilitate case management (i.e., parental consent forms not signed)
- Language and cultural barriers of immigrant families
- Parental literacy and health literacy levels
- General lack of understanding of the importance of oral health among many families, especially the oral health needs of young children
- Legal consent forms to treat children often forgotten, misplaced or unsigned causing delays in provision of dental care
- Significant inconsistencies between Head Start Programs and staffing levels
- Many children are ineligible for Head Start and/or ineligible for services due to immigration status
- PIR data does not accurately reflect need or provide sufficient documentation of the underserved children in Head Start programs

B. Challenges related to Dental Practice

- High prevalence of full anesthesia cases requiring hospitalization
- Many private practitioners reluctant to get involved due to low reimbursement (i.e., Medicaid reimbursement in New Jersey is only 18 cents on the dollar)
- Lack of follow through by families, and lack of awareness of need
- Some general dentists have very few young children in their practice and may feel uncomfortable with patient management of infants and toddlers
- Maldistribution of dentists related to where the families in need are located (i.e., lack of urban and rural dentists)

- Head Start children can upset the flow of the office (i.e., no-shows, disruptive behavior, and tardiness)
- Critical shortage of dentists in some areas mean that even fee-for-services patients are unable to access care, much less families with Medicaid
- Onerous paperwork for Head Start and Medicaid
- Lack of knowledge by State legislators on Medicaid and other issues
- There can be miscommunication and lack of understanding between Federally Qualified Health Centers and dental societies

Despite these challenges, nearly all the participants at this meeting had overall positive experiences providing oral health services to Head Start or Head Start eligible children and their families. They expressed a special enthusiasm and commitment to working with this population. There was discussion of the "halo effect" that once the first child in a family receives oral health treatment and education, the oral health of the entire family begins to improve.

VI. Promising Practices to Enhance Oral Health Education, Prevention, and Direct Clinical Services for Head Start/Early Head Start Participants

Throughout the day's discussion a number of promising practices were discussed at the meeting. They represent some of the creative ways in which ADA members increase the access to, and quality of, oral health services for young children. Expansion of these practices may be considered for future partnership activities. These best practices have been organized into promising programs, materials, and, strategies

A. Programs

- In Connecticut the "Open Wide" oral health video is shown in WIC offices on a continuous loop in both Spanish and English
- ADA's *Give Kids a Smile* program generates local interest in serving the underserved and the program planning kit for dental societies includes a link to locate Head Start programs

- In Florida, in order to minimize perceived disruption in the waiting room between private patients and Head Start children, dentists have set aside particular days to see only Head Start children. An event is made of it with balloons and special activities

- The California Dental Health Foundation recently received $10 million to train general dentists in the treatment of very young children

B. Materials

- ADA's handbook on Spanish for the Dental Office has been a great tool

- "123 Smile" program in upstate New York has assigned staff to do outreach to WIC offices, prenatal classes, and dentists and increase awareness of need

- The Maternal and Child Oral Health Resource Center Web site houses a number of recommended resources including Connecticut's "Open Wide" Web based oral health curriculum (funded by foundation dollars), reports from the Regional and State Oral Health Forms and a number of oral health tip sheets

- ADA recently passed a resolution to develop materials regarding the care of very young children

Vermont's Model - *The Brattleboro community identified a high need for dental care for their Medicaid population defined as 300% of Federal Poverty Limit. When Kaiser left the area, a salaried dentist was left without a position and an opportunity arose for the community to collaborate on setting up a dental practice to serve these patients. 3500 sq. ft of space was acquired above the Head Start program and funding from provate foundations, State government and CDBG historic preservation funds constructed a $472,000 five-chair dental office. A local committee designed a business model that included a former Kaiser dentist who was interested in remaining in the area. The support group contracted with him to run the clinic and to hire staff and operate his practice in the clinic and to provide comprehensive treatment a minimum of 900 Head Start Children each year. The dentist augments his income by seeing private clients. The dentist's current patient mix is about 2/3 Medicaid clients, including parents of children in the Head Start program who are offered a sliding scale for services, and 1/3 private pay clients. Seven and one half percent of private pay revenue is retained by the support committee and reinvested in the practice to fund new equipment and expansion of services. The dentist is responsible for managing his own business and operating as a self-sustaining for-profit dental practice. He does not own the practice or the equipment and must give one year's notice before leaving. The support committee, Head Start staff, and the county health department oversee his work, provide fiscal oversight, and provide guidance in office management. Head Start and Medicaid clients are being served, and the dentist is happily making a satisfying living. Despite initial concern of other dentists in the area, this independent program now considered a great and growing success.*

C. Strategies

- Triage at the local level and refer complex cases for treatment (get involved at the front end and don't feel you have to fix everything)

- North Carolina recently did a pediatrics study that demonstrated that the earlier a child is seen the lower the total cost of their care

- Head Start children within a specific area of North Dakota are provided with transportation to dental offices for appointments

- Broadbased coalitions can approach Governors and State legislators to increase Medicaid reimbursement rates or, as a last resort, can be compelled to via class action lawsuits

- In Connecticut, the pediatric dentist went into the Head Start classroom to conduct screening
- In Arizona, political advocacy (and a relationship with someone on the State's Allocation Committee) forced an increase in Medicaid reimbursement rates
- In Illinois a retired dentist advocated successfully to create a dental clinic with dental volunteers providing services one day a week and the county providing $70,000 annually to cover overhead costs
- A number of States have conducted needs assessments of Head Start programs and are compiling more accurate oral health status data
- Charge Head Start programs for children who are "no shows"
- Use of portable equipment in the Head Start Centers has proven very effective and efficient
- Many oral health companies are interested in serving the community by donating equipment or supplies, dentists can use their leverage as loyal customers to make requests

This select group of attendees had numerous best practices to share during the meeting. In addition, they had suggestions as to how to improve current policies and practice. During the afternoon discussion facilitated by Jane Steffensen and Dr. John Rossetti, participants identified concrete ways in which the Head Start Bureau, the Maternal Child Health Bureau and the ADA could collaborate to improve the oral health of Head Start children. These recommendations will form as the foundation for future planning activities.

VII. Maximizing Opportunities for Collaboration between ADA, MCHB, and Head Start

The chart below indicates some of the many current activities ADA, MCHB, and Head Start are engaged in to improve oral health outcomes. In some cases future collaborations could incorporate these activities or use them as models. Overall, the participants recommended developing linkages between the three national entities to improve planning and outcomes. In many cases the elements listed below may be able to facilitate collaborations.

Current Functions that could Support Future Oral Health Collaboration (this list is not comprehensive)

AMERICAN DENTAL ASSOCIATION	HEAD START BUREAU	MATERNAL/CHILD HEALTH BUREAU
Give Kids a Smile program	Head Start Collaboration Offices	Funding Head Start Regional Oral Health Consultants
ADA resolution regarding oral health care for young children	New TA Network (including a Head Start Learning Center)	Funding for National MCH Oral Health Resource and Policy Centers
CAPIR	Federal and Regional support of Head Start Oral Health Partnership planning process	Funding for Head Start Fellows with the three Centers for Leadership Education in Pediatric Dentistry
White paper on Medicaid and other resources	Through the Intra-Agency Agreement funding for State and Regional Oral Health forums, TA and leadership activities	Through the Intra-Agency Agreement funding for State and Regional Oral Health forums, TA and leadership activities
Seek sources of culturally/linguistically appropriate materials for diverse patient populations and those with limited English proficiency	Ability to inform partners on Medicaid eligibility rules and coverage.	Linkages to State Title V directors and programs
Support of this partnership forum	Health and Oral Health Case management for Head Start and Early Head Start children	Federal level Chief Dental Officer
Multiple methods for communicating with ADA members	Efforts are underway to develop health literacy materials	Additional TA resources that can be directed to needs
Efforts are underway to devote a section of ADA.org to low oral health literacy	Long standing commitment to comprehensive health care for Head Start children including dental and medical homes	A requirement for a Statewide Needs Assessment from each State every 5 years.
	Focus on services for CSHCN	Focus on services for CSHCN

The above chart captures just a fraction of the activities currently underway that could be integrated into future collaborations. The ADA, HSB and MCHB all share a common mission to improve the health and well being of those they serve. Their practices and volunteerism reaches out to children, families and communities. In addition, they each utilize sophisticated communication systems, cutting edge research, and science and technology to impact public health. Any future collaborative projects would benefit from using the infrastructure already in place. However, the group identified a number of ways in which each entity could enhance or augment their current capabilities to facilitate additional partnership activities.

A. Future Partnership Activities to Enhance Oral Health Collaborations

Dr. Rossetti encouraged participants to identify specific strategies that would enhance the ability of Head Start to partner with professional organizations such as the ADA. Among the

suggestions that emerged throughout the day were the following suggestions. The Head Start Bureau, their Regional and State Collaborative Offices and the MCHB could:

- Encourage more standardization of practice among Head Start Directors regarding the establishment of a dental home
- Recruit an ADA member to serve on the Head Start Health Advisory Committees
- Devise ways to standardize and minimize paperwork necessary to serve Head Start children
- Use home visits to reinforce oral health promotion and oral disease prevention messages
- Create a tool box with a set of model forms for dentists interested in working with local Head Start programs
- Revise search feature on Web site so that a dentist could input his/her zip code and get the addresses and contact information for the Head Start programs in their vicinity (retail store Web sites have great model for this)
- Improve PIR data to accurately reflect unmet need of programs
- Develop and share appropriate health literacy materials that would assist with outreach to Head Start programs

B. Future ADA Activities to Enhance Oral Health Collaborations

In addition to the activities mentioned previously, the ADA could better support collaborative activities with Head Start if it was able to promote or develop the strategies that would improve the ability of individual providers to participate in partnership activities. Suggestions for the ADA to consider include:

- Develop or facilitate Continuing Education courses to inform members of treatment methods for young children and feature these courses at conferences or on the Web
- ***ADA News*** could feature articles to increase awareness of the needs of Head Start children
- ADA members who are actively involved in Head Start and treating young children could consider joining AAPD as an affiliate member, which provides access to journals, and reduced membership registration fees for meetings and CE.
- Make available information and materials regarding effective strategies for working with Medicaid patients and programs

- Encourage local dental societies to collaborate with Head Start for "Give Kids a Smile" or other oral health initiatives
- Encourage development of local initiatives, e.g. create a "Teddy Bear Fund" to raise money to pay for pediatric oral health surgery and other services not covered by insurance
- Develop a recognition program to recognize the dentists who provide services to Head Start programs, children and families
- Enlist ADA consultants and other partners to design a protocol or resource guide for ADA members interesting in working with Head Start programs, families, and children
- Include on ADA.org a Discussion Forum group specific to working with Head Start programs
- Encourage local/State Continuing Education programs where general dentists can observe pediatric dentists treating young children and provide hands on training in patient management and other pediatric interventions
- Continue to participate in efforts to educate legislators about the oral health needs of young children and the need for adequate reimbursement to support comprehensive oral health care

Time limitations prevented additional brainstorming on strategies for increasing ADA's collaboration with Head Start. Participants indicated that if more general dentists had access to information on Head Start and tools with which to develop effective partnerships, they would be willing to increase their level of participation with Head Start Programs. Implementing even a few of the above recommendations would enhance the ability of the HRSA/MCHB Oral Health Partnership and the ADA to work together. Participants expressed optimism about this possibility. They noted that both organizations are geographically diverse and experienced in their ability to facilitate local, regional and national collaborations. Implementing some of these suggestions would create the infrastructure needed to encourage future joint activities, and will have a positive outcome for Head Start children, families and communities.

VIII. Next Steps and Concluding Remarks

Dr. Rossetti thanked the ADA for providing the space and logistical support necessary for the success of this meeting. He said that a draft report will be ready in a few weeks and John Klyop and Jane Jasek of the American Dental Association, Division of Dental Practice will have an opportunity to provide their input. After that, every meeting participant will receive a hard copy

of the report and an electronic copy will be made available to the ADA and the Maternal and Child Health Oral Health Resource Center for posting on their Web sites.

Rob Lauf, CAPIR Chair, also thanked participants for their time and contributions to this collaborative process. He said that meetings of this type benefit the entire membership. He said that the ADA is committed to fostering this partnership and will be working to build interest at a grassroots level. Current ADA public health activities regarding access to care, oral health and nutrition, sealants, and water fluoridation are especially congruent with partnering with Head Start programs at this time. He thanked the dentists attending this meeting for their personal commitment to serving Head Start children and thanked the Head Start Oral Health Partnership for providing the funding to make it possible.

Appendix A: Agenda

American Dental Association and Health Resources and Services Administration (HRSA)/ Maternal and Child Health Bureau (MCHB)

The American Dental Association and Head Start: Envisioning Future Collaborations to Improve Oral Health October 29, 2004

Meeting Agenda

The goals of the Professional Organization Forum are to**:**

- ❖ Assess access to care and other issues that may improve or detract from oral health education, prevention, and clinical services available to the Head Start and Early Head Start populations.
- ❖ Review current ADA activities related to Head Start and other community oral health initiatives.
- ❖ Discuss promising practices to address the oral health needs of Head Start and Early Head Start children.
- ❖ Strategize on future collaborations to enhance the oral health of Head Start and Early Head Start children.

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
ADA Conference Room 2D
Second Floor

Preliminary Agenda

Friday
October 29, 2004

8:00 – 8:30 am	**Registration and Continental Breakfast**
8:30 – 9:15 am	**Introductions**
	Opening Remarks
	❖ Dr. Ronald E. Inge, Assistant Executive Director, Dental Practice, ADA
	❖ John Rossetti, DDS, MPH Oral Health Consultant, Maternal & Child Health Bureau, HRSA
	❖ Jane E. M. Steffensen, MPH, Consultant, Head Start and Oral Health Partnership Project
9:15 – 10:15 am	**Group Discussion**
	❖ Challenges to Improving Oral Health Status among Participants in Head Start and Early Head Start Programs
	❖ Promising Practices to Enhance Oral Health Education, Prevention and Direct Clinical Services for Participants in Head Start and Early Head Start
10:15 – 10:45 am	**Break - Networking**
10:45 – 12:00 pm	**Group Discussion**
	❖ Opportunities to Increase Awareness of Dental Professionals about Addressing the Needs of Head Start Programs and Participants
	❖ Opportunities to Enhance the Roles of Professional Dental Organizations Working with Head Start to Improve Oral Health
12:00 – 1:00 pm	**Working Lunch**
	Group Discussion
	❖ Future Collaborative Efforts and Partnerships between ADA, MCHB/HRSA and Head Start Bureau (HSB)/Administration on Children and Families (ACF)
1:00 – 1:30 pm	**Break - Networking**
1:30 – 2:30 pm	**Group Discussion**
	❖ Resources that Can be Brought to Bear on Improving the Oral Health Component In Head Start
2:30 – 3:00 pm	**Closing Remarks**
	❖ Dr. Robert C. Lauf, ADA, CAPIR Chair ❖ John Rossetti, DDS, MPH, Oral Health Consultant, Maternal & Child Health Bureau, HRSA

Appendix B: Participant List

"The ADA and Head Start: Envisioning Future Collaborations to Improve Oral Health"

A Head Start and Oral Health Small Group Forum

ADA Headquarters
211 East Chicago Avenue
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October 29, 2004

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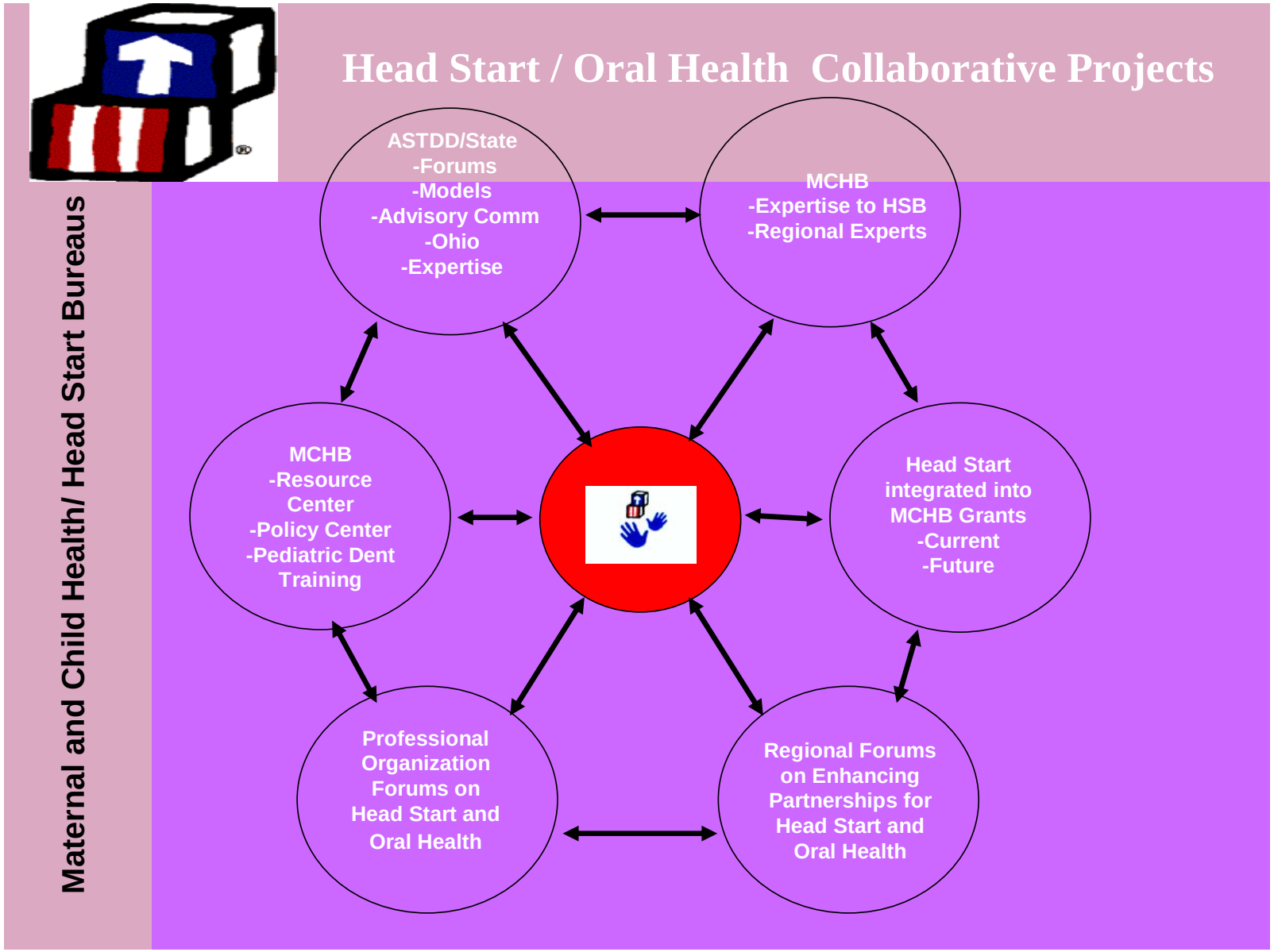
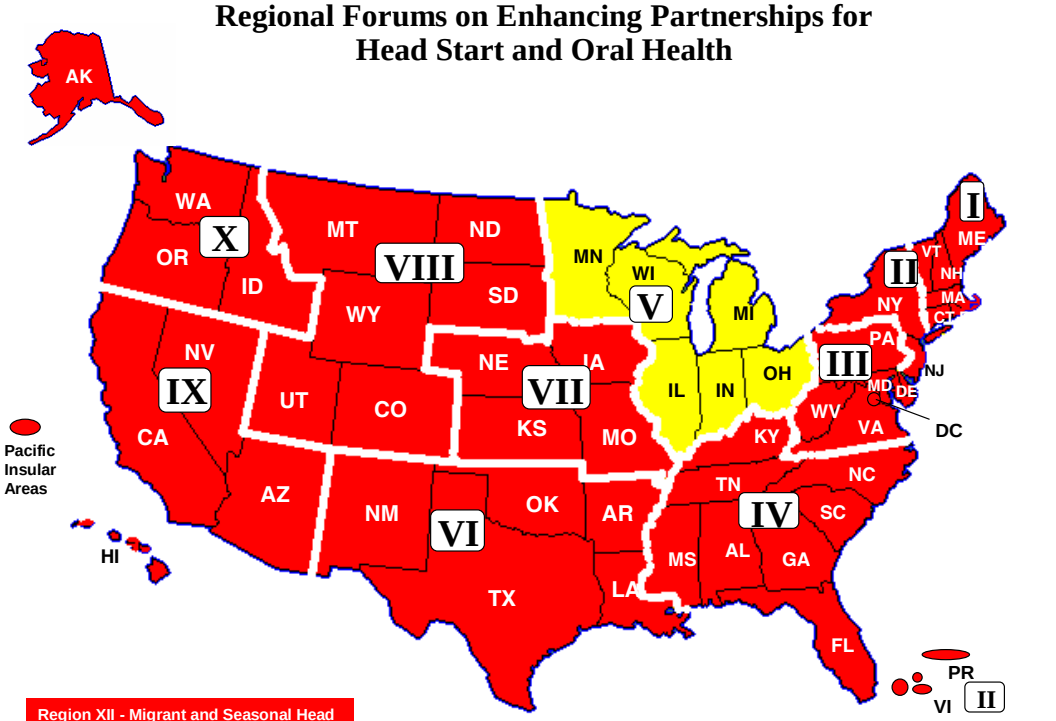
Appendix C: Intra-Agency Agreement Activities


Head Start / Oral Health Collaborative Projects
Maternal and Child Health/ Head Start Bureaus
ASTDD/State
-Forums
-Models
-Advisory Comm
-Ohio
-Expertise
MCHB
-Expertise to HSB
-Regional Experts
MCHB
-Resource Center
-Policy Center
-Pediatric Dent Training
Head Start integrated into MCHB Grants
-Current
-Future
Professional Organization Forums on Head Start and Oral Health
Regional Forums on Enhancing Partnerships for Head Start and Oral Health

Regional Forums on Enhancing Partnerships for Head Start and Oral Health



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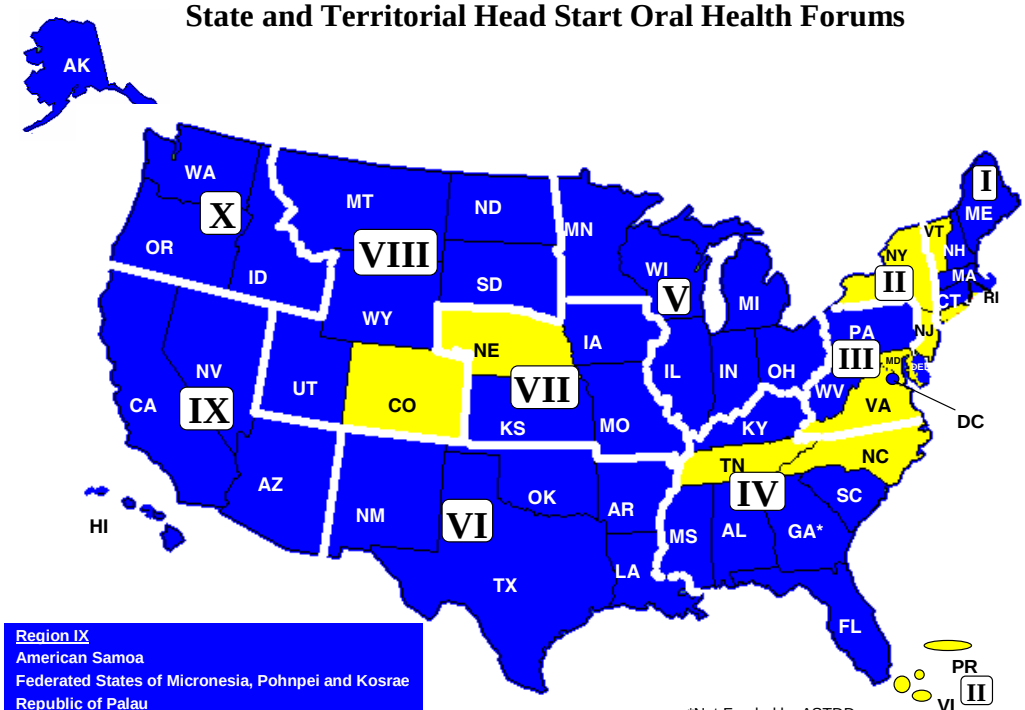
* Forum Planning in Process

State and Territorial Head Start Oral Health Forums



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**Cycle 6 Proposals Due October 29, 2004