l Public Health Project/Activity Descriptive Report Form

Please provide a detailed description of your **successful dental public health project/activity** by fully completing this form. Expand the submission form as needed but within any limitations noted. Please return completed form to: lcofano@astdd.org

NOTE: Please use Verdana 9 font.

CONTACT PERSON PREPARING THE SUBMISSION AND TO ANSWER QUESTIONS

Name: Beverly Isman RDH, MPH, ELS
Michelle Landrum, RDH, MEd

Title: Association of State and Territorial Dental Directors (ASTDD) Consultant and National Center for Early Childhood Health and Wellness (NCECHW) Dental Hygienist Liaison (DHL) Project Lead Consultant

Agency/Organization: Association of State and Territorial Dental Directors

Address: 3858 Cashill Blvd., Reno, NV 89509

Phone: (210) 254-0574

Email Address: bev.isman@comcast.net
michellelandrum@yahoo.com

PROVIDE CONTACT INFORMATION FOR ONE ADDITIONAL PERSON WHO COULD ANSWER QUESTIONS REGARDING THIS PROGRAM

Name: Katrina Holt, MPH, MS, RD, FAND

Title: National Maternal and Child Oral Health Resource Center Director and NCECHW Oral Health Lead

Agency/Organization: Georgetown University

Address: Box 571272, Washington, DC, 20057-1272

Phone: (202) 784-9551

Email Address: kholt@georgetown.edu

SECTION I: ACTIVITY OVERVIEW

Title of the dental public health activity:

National Center for Early Childhood Education and Wellness:
Dental Hygienist Liaison Partnership Project

Public Health Functions*: Check one or more categories related to the activity.

"X"	**Assessment**
	1. Assess oral health status and implement an oral health surveillance system.
	2. Analyze determinants of oral health and respond to health hazards in the community
	3. Assess public perceptions about oral health issues and educate/empower them to achieve and maintain optimal oral health
	Policy Development
x	4. Mobilize community partners to leverage resources and advocate for/act on oral health issues
	5. Develop and implement policies and systematic plans that support state and community oral health efforts
	Assurance
	6. Review, educate about and enforce laws and regulations that promote oral health and ensure safe oral health practices
x	7. Reduce barriers to care and assure utilization of personal and population-based oral health services
	8. Assure an adequate and competent public and private oral health workforce
	9. Evaluate effectiveness, accessibility and quality of personal and population-based oral health promotion activities and oral health services
	10. Conduct and review research for new insights and innovative solutions to oral health problems

***ASTDD Guidelines for State and Territorial Oral Health Programs that includes 10 Essential Public Health Services to Promote Oral Health**

Healthy People 2020 Objectives: Check one or more key objectives related to the activity. If appropriate, add other national or state HP 2020 Objectives, such as tobacco use or injury.

"X"	**Healthy People 2020 Oral Health Objectives**	
x	OH-1	Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth
x	OH-2	Reduce the proportion of children and adolescents with untreated dental decay
	OH-3	Reduce the proportion of adults with untreated dental decay
	OH-4	Reduce the proportion of adults who have ever had a permanent tooth extracted because of dental caries or periodontal disease
	OH-5	Reduce the proportion of adults aged 45 to 74 years with moderate or severe periodontitis
	OH-6	Increase the proportion of oral and pharyngeal cancers detected at the earliest stage
x	OH-7	Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
x	OH-8	Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year
	OH-9	Increase the proportion of school-based health centers with an oral health component
	OH-10	Increase the proportion of local health departments and Federally Qualified Health Centers (FQHCs) that have an oral health component

	OH-11	Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers each year
x	OH-12	Increase the proportion of children and adolescents who have received dental sealants on their molar teeth
	OH-13	Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water
	OH-14	Increase the proportion of adults who receive preventive interventions in dental offices
	OH-15	Increase the number of States and the District of Columbia that have a system for recording and referring infants and children with cleft lips and cleft palates to craniofacial anomaly rehabilitative teams
	OH-16	Increase the number of States and the District of Columbia that have an oral and craniofacial health surveillance system
	OH-17	Increase health agencies that have a dental public health program directed by a dental professional with public health training

"X"	**Other national or state Healthy People 2020 Objectives: (list objective number and topic)**	

Provide 3-5 Key Words (e.g. fluoride, sealants, access to care, coalitions, policy, Medicaid, etc.) These will assist those looking for information on this topic:
Head Start, child care, access to care, partnerships, coordination, oral health promotion/disease prevention

Executive Summary: Complete after Section II: Detailed Activity Description. Please limit to 300 words in one or two paragraphs.

Provide a brief description of the dental public health activity. Include information on: (1) what is being done; (2) who is doing it and why; (3) associated costs; (4) outcomes achieved (5) lessons learned, both positive and negative.

Since 2001 the Association of State and Territorial Dental Directors (ASTDD) and the National Maternal and Child Oral Health Resource Center (OHRC) have partnered to provide technical assistance and training (T/TA) to Early Head Start (EHS) and Head Start (HS) programs and since 2015 to child care programs, yet oral diseases still pose a health problem for pregnant women, and EHS/HS enrollees and staff receive inconsistent, confusing, or inadequate oral health messaging.

The American Academy of Pediatrics (AAP) received cooperative agreements from the Office of Head Start (OHS) to support EHS/HS programs (2011–2015) and from OHS and the Office of Child Care to support EHS/HS and child care programs (2015–2020). For both agreements, AAP contracted with OHRC for the oral health component, which contracted with ASTDD to coordinate the Dental Hygienist Liaison (DHL) project starting in 2012. ASTDD partnered with the American Dental Hygienists' Association to help recruit DHLs in all states.

DHLs volunteer to perform several collaborative activities:

- Serve as communication links between the national center and EHS/HS/child care agencies
- Collaborate with state organizations such as oral health programs, HS collaboration offices and HS associations, and child care agencies
- Promote and share oral health information and resources with EHS/HS/child care program staff
- Offer strategies to improve access to oral health care for pregnant women and children
- Work with oral health professionals to provide staff education and T/TA to local EHS/HS/child care programs

ASTDD's annual budget is $160,000 for management, T/TA, and resource development. Nine DHLs receive quarterly $1,500 stipends to serve as regional DHL coordinators to support/mentor their assigned DHLs; state DHLs receive $590 annual stipends to be used for travel and hygiene supplies.

Collaboration with ten stakeholder groups is tracked quarterly and shows consistent accomplishments. The DHL project is recognized by OHS and AAP as an exemplary collaboration model.

SECTION II: DETAILED ACTIVITY DESCRIPTION

Provide detailed narrative about the dental public health activity using the headings provided and answering the questions. Include specifics to help readers understand what you are doing and how it's being done. References and links to information may be included.

Complete using **Verdana 9 font.

Rationale and History of the Activity:

1. What were the key issues that led to the initiation of this activity?

Since 2011, the Office of Head Start (OHS) has funded the American Academy of Pediatrics (AAP) in collaboration with many key partners including the National Maternal and Child Oral Health Resource Center (OHRC) working with the Association of State and Territorial Dental Directors (ASTDD), through a national center model to provide technical assistance and training (TA/T) to Early Head Start (EHS)/Head Start (HS) programs in all states. From 2011 to 2014, the national center was called the National Center on Health (NCH); in 2015 OHS changed the name to the National Center on Early Childhood Health and Wellness (NCECHW).

EHS serves infants and toddlers up to 3 years, pregnant women, and their families; HS serves children aged 3–5 years and their families. HS programs offer a variety of service models. Programs may be based in:

- Centers or schools that children attend for part-day or full-day services
- Family child care homes
- Children's homes (home-based model) where a HS staff person visits once a week and provides services.

Oral health has been a key focus of EHS/HS programs for decades, yet oral diseases still represent a major health problem for EHS/HS participants. Access to oral health care continues to be a problem, but so has inconsistent, confusing or inadequate oral health messaging and misinformation for EHS/HS staff and pregnant women and young children receiving EHS/HS services.

Oral health is one of the focus areas of NCECHW (others include emergency preparedness and environmental safety; trauma and toxic stress; developmental, behavioral, vision, and hearing screening; nutrition; and medical homes and health promotion/disease prevention. The oral health portion emphasizes 1) enhancing a multidisciplinary, multi-level system of oral health services for EHS/HS participants; 2) reviewing data on the oral health status of EHS/HS participants to identify health priorities to inform the delivery of targeted TA/T; and 3) providing TA/T at national and regional meetings for local EHS/HS program staff and parents to promote the use of evidence-based or informed resources and practices. Specific activities included:

- Promoting successful practices at the state and local level
- Working with national organizations and federal agencies to promote improvements in oral health care delivery, financing, and data collection/tracking to improve access to oral health preventive services and treatment
- Promoting collaboration between national organizations and governmental agencies to promote and expand state and local communication networks
- Working with partners to provide TA/T to increase skills of dental and medical office staff, HS regional health specialists, EHS/HS program staff, and EHS/HS families
- Promoting medical/oral health collaboration and use of community support systems
- Providing consistent messaging on oral health for EHS/HS programs and families and health care teams

Since the oral health portion of the NCECHW budget is limited and initially covered only a few OHRC staff and ASTDD consultants, the oral health team brainstormed strategies that might have the greatest impact on oral health for EHS/HS participants in all states. They conceived the idea of establishing a network of volunteer dental hygienists in each state to serve as a communication link to multiple groups and professionals as well as EHS/HS staff to provide evidence-based information and consistent messaging around oral health issues. This model was initiated in partnership with the American Dental Hygienists' Association (ADHA) to help recruit dental hygienists to serve as dental hygienist liaisons (DHLs) to the national center in all states.

2. What rationale/evidence (may be anecdotal) did you use to support the implementation of this activity?

Since 1999, OHRC has provided support tailored to EHS/HS programs to enhance oral health services for pregnant women, infants, and children enrolled in EHS/HS. OHRC and ASTDD partnered from 2001 to 2007 to provide TA/T to EHS/HS programs via an interagency agreement between OHS and the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). One part of that project was to assess relationships between state oral health programs, state Medicaid/CHIP oral health programs, and EHS/HS programs and to rebuild collaborative linkages and propose models and recommendations to address identified needs of EHS/HS programs. This assessment was coordinated with a simultaneous effort by HRSA's regional offices to assess similar information (both quantitative and qualitative) from EHS/HS programs and other programs to arrive at regional plans for TA/T, classroom and parent education, creation of dental homes, and monitoring of HS program performance standards for oral health. ASTDD convened a national advisory committee to translate the findings and recommendations into a national plan for OHS. This project resulted in 12 regional and 53 state/territorial oral health forums and action plans where dental hygienists and state oral health programs were key players.

Extensive evaluations were conducted in 2008 before the conclusion of the project. One outcome showed that about 60% of HS state collaboration offices (HSSCOs) and state oral health programs had integrated recommendations/activities from the state forums and action plans into other statewide plans and used them in several grant applications. A list of continuing needs and recommendations from the evaluation report was used to advocate for future funding and policy changes. From 2008 to 2010, the American Academy of Pediatric Dentistry was selected by OHS to coordinate EHS/HS oral health activities, which involved dental hygienists to a lesser degree. With ASTDD and OHRC partnering again with AAP in 2011 to coordinate national activities, involvement of dental hygienists and collaborations with other groups increased.

New information pathways via the Internet, social media, and other modalities have changed the communication strategies to gather and share information and data and provide TA/T. These advances created an opportunity to build more grassroots strategies to broadly collect and disseminate information about oral health to EHS/HS programs and new opportunities for collaborations.

3. What month and year did the activity begin and what milestones have occurred along the way? (May include a timeline.)

The DHL project began in November 2012 and expanded in 2015 to include child care programs, creating another set of potential partners. ADHA has assisted with recruitment since 2012, including helping to fill vacancies whenever a DHL needed to step away from the role; at the end of 2019 all states had active DHLs. DHLs play an integral role at state and local levels in promoting oral health for pregnant women and children enrolled in EHS/HS and children enrolled in child care. Minimum requirements for DHLs are to:

- Maintain ADHA membership
- Respond to requests in a timely manner
- View DHL informational webinars (webinars are archived for DHLs unable to attend live webcasts)
- Share NCH/NCECHW oral health resources with target audiences
- Submit online quarterly reports in January, April, July, and October

Nine state DHLs were asked to serve as regional DHL coordinators starting in 2015 to support and mentor DHLs in their assigned region and to assist the oral health management team. The budget was increased to allow NCECHW to provide DHLs with stipends up to $1500 per quarter for their time. Regional DHL coordinators meet quarterly by phone and have met annually in person since 2015.

ADHA awarded the Presidential Citation to DHLs during ADHA's conference in 2019 and honored DHLs at a luncheon at ADHA's conference in 2013 and at receptions at the National Oral Health Conferences (NOHC) from 2015 through 2018. In addition, ADHA has highlighted DHL activities in its September/October 2018 and May/June and December 2019 issues of *Access* magazine, its online *Update* newsletter, and its Facebook *Member Mondays.*

The sections below follow a logic model format. For more information on logic models go to: W.K. Kellogg Foundation: Logic Model Development Guide

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	OUTCOMES

1. What resources were needed to carry out the activity? (e.g., staffing, volunteers, funding, partnerships, collaborations with various organizations, etc.)

Inputs are mostly discussed in other sections.

OHRC maintains a national oral health workgroup of individuals who have experience working with pregnant women and children and ethnic/racial minority populations (e.g., American Indian Alaska Native [AIAN], Hispanic, or Latino) and who have expertise related to child care performance standards, HS program performance standards, evidence-based or informed oral health information, community/public health, and Medicaid. The workgroup members provide guidance and feedback on DHL and other project activities, review draft materials, and share updates related to changes in science and practice. One or two DHLs and most members of the oral health management team usually attend the annual oral health workgroup meeting to provide input.

The NCECHW federal steering committee reviews all draft resources, including presentations and materials to share with EHS/HS staff, parents, and health professionals.

INPUTS	**PROGRAM ACTIVITIES**	OUTPUTS	OUTCOMES

2. Please provide a detailed description the key aspects of the activity, including the following aspects: administration, operations, and services.

The NCECHW oral health management team meets twice a month via conference calls to plan and coordinate activities and discuss administrative issues. They create annual workplans and budgets, solicit feedback via multiple pathways, develop forms and tracking processes to monitor activities, conduct evaluation, approve expenditures and invoices, and prepare quarterly progress reports. They plan and conduct TA/T, prepare resources (materials and presentations), and disseminate information and resources through announcements and discussion lists, newsletters, reports, ASTDD and OHRC websites, and the Early Childhood Learning and Knowledge Center (ECKLC) and My Peers to EHS/HS program staff, child care program staff, the ASTDD Board of Directors (BOD), health professionals, and others. Regional DHL coordinators assist the oral health management team in many of these activities, particularly reviewing draft resources, preparing regional progress reports from state DHL progress reports, and presenting at national and regional conferences and during webinars.

Resources for the state and regional DHLs are posted on the DHL page of the ASTDD website, including:

- DHL roster
- DHL orientation slideshow
- *Dental Hygienist Liaison Project* handout
- *DHL At-A-Glance Activity Guide*
- *DHL Activity Tracker*
- *Key State-Level Contacts for Collaboration*
- Resource materials
- DHL webinar recordings and slides
- Forms

DHLs perform the following duties to address oral health promotion and oral disease prevention, with an emphasis on issues related to access to oral health care:

- Serve as communication links between NCECHW and EHS/HS and child care agencies on topics related to improving the oral health of pregnant women and children (e.g., the MT DHL

exhibited at an early childhood conference, sharing ECLKC oral health resources, and met with HS health specialists and directors. The CO DHL presented to the Department of Public Health and Environment's Cavity Free at Three team to review resources and discuss potential collaboration with HS programs in CO).

- Collaborate with state organizations such as state oral health programs, HSSCOs, HS associations (HSA), and child care agencies (e.g., The NJ DHL is building a relationship with the state oral health program's new dental director and helping the AAP NJ chapter oral health advocate create a parent survey focusing on oral health issues for children with special health care needs, The ND DHL met with representatives from the ND Family Health and Nutrition Department to discuss the DHL project and provided ECLKC resources to distribute in the WIC clinic and to home visiting staff).
- Promote and share evidence-based/-informed oral health information and resources with EHS/HS and child care program staff (e.g., The MS DHL shared the *Steps for Toothbrushing at the Table* video with a health specialist at a local HS program and discussed with the MS HSSCO director the growing number of program in MS implementing brushing as a new standard. The UT DHL discussed at a HS health services advisory meeting how teledentistry could expand access to care).
- Offer strategies to improve access to oral health care for pregnant women and children (e.g., The MN DHL established a direct point of contact for families to schedule appointments at a local oral health safety net clinic where the clinic has also agreed to provide transportation vouchers for the children to receive care. The NE DHL worked with a HS health manager to obtain consent forms for care and assisted in connecting children to dental offices. The CT DHL is the outreach coordinator for the state Medicaid program and has all community health worker and dental health care specialists attend meetings with HS and child care staff, share NCECHW resources, and distribute oral health kits containing hygiene supplies and dental referral information).
- Work with oral health professionals to establish partnerships with local EHS/HS and child care programs to provide staff education and training (e.g., The MA DHL recruited oral health professionals to provide services for children enrolled in HS and child care programs and also had an exhibit table at the MA Dental Hygienists' Association conference to promote the DHL project and recruit hygienists to participate in activities).

Liaison activities are categorized by levels as basic, enhanced and advanced under the five focus areas of 1) assessment, 2) access to care, 3) prevention, 4) education, and 5) collaboration. Types and levels of collaboration with 10 key groups are tracked quarterly (see the outcomes section for results from a 2014 study of DHL collaboration at any time over 2 years with the groups and averages of activity over 5 quarters from 9/30/18 through 12/31/19).

INPUTS	PROGRAM ACTIVITIES	**OUTPUTS**	OUTCOMES

3. What outputs or direct products resulted from program activities? (e.g., number of clients served, number of services units delivered, products developed, accomplishments, etc.)

Resources

As noted, the DHL webpage on ASTDD's website includes extensive resources for DHLs to help them in their roles. Early on the oral health management team developed presentation slides and handouts that have been approved for use by the DHLs in presentations to ensure consistent messaging; presentation topics include special considerations for children with disabilities, migrant and seasonal farm workers, and AIAN EHS/HS participants.

Brush Up on Oral Health is a monthly tip sheet started in 2012 that provides EHS/HS staff with information on oral health and oral health care practices, practical tips for staff to share with parents for promoting good oral health, and a simple, fun recipe for a healthy snack to make in a EHS/HS classroom or at home. Currently, more than 9,700 individuals subscribe to the tip sheet, which is widely disseminated by e-blast and posted to ECLKC, with links on the ASTDD and OHRC websites. Eighty-one issues have been published on many different topics, including the role of DHLs. Statistics from the OHRC and ECKLC websites track numbers viewed and downloaded. The limited grant budget does not allow for surveys of local programs to determine use of the resources, but DHLs often anecdotally report this via their quarterly reports.

Some of the other resources produced by NCH/NCECHW promoted or used by DHLs and posted on ECLKC include:

- *Applying Consultation Skills to Oral Health Promotion*: This module uses a case study approach to identify successful consultation strategies child care health consultants can use to address children's oral health.
- *Checklist for Child Care Staff*: *Best Practices for Good Oral Health*: This handout provides items that child care staff can check to reflect what they are doing to promote good oral heath for infants, toddlers, and young children.
- *Choose and Use: Head Start Oral Health Curricula*: This guide provides information about oral-health-related curricula appropriate for use in EHS/HS programs. Users can search by audience, topics, and availability to find the curriculum that best fits their needs.
- *Fluoride*: This paper provides information about how fluoride can prevent tooth decay and how people receive fluoride. The paper discusses EHS/HS program policies and procedures related to fluoride and offers tips to help parents understand why fluoride is important and how to use it properly.
- *Getting to Know Me, Information for Your Child's Dental Office*: This form for parents to bring to their child's dental appointment provides space to fill in information about their child to help dental office staff understand and meet the child's needs.
- *Head Start Oral Health Forms for Children and Pregnant Women*: These forms and a sample provider letter serve as records of a pregnant woman's or child's dental visit.
- *Healthy Habits for Happy Smiles*: This series of handouts for pregnant women and parents of infants and young children in English and Spanish provides simple tips on oral health issues.
- *Healthy Smiles: Oral Health Webinar for Spanish-Speaking Parents*: This archived webinar offers key oral health messages and best practices for pregnant women, infants, and young children.
- *Oral Health: Tips for Families*: This tip sheet provides information about how to promote good oral health. The tip sheet is available in Amharic, Arabic, Armenian, Burmese, Chinese, English, Hmong, Marshallese, Polish, Somali, Spanish, Vietnamese, and Yiddish.
- *Oral Health: Tips for Health Managers*: This tip sheet provides information about how to promote good oral health for parents, pregnant women, and children.
- *Questions to Ask When Looking for a Dental Office*: This handout for parents presents questions to ask a dental office before making an appointment for themselves or their child.
- *Steps for Toothbrushing at the Table: Growing Healthy Smiles in Early Care and Education Programs*: This video provides child care and HS staff with information about how children can brush their teeth as a group at the table.

In addition to the resources mentioned above, worksheets addressing the oral-health-related tasks outlined in a *Health Managers' Orientation Guide* are used during trainings for health managers. To help home visitors address oral health, the oral health management team produced *Oral Health Educational Resources for Early Head Start and Head Start Home Visitors and Families: Environmental Scan* in 2014 and updated it in 2018.

Presentations and TA

A state dental director, two DHLs, and a community health center (CHC) dental hygienist/clinic administrator presented *FQHC Strategies to Reach Out to Head Start Programs* at the National Primary Oral Health Conference in 2013, as a follow-up to a ASTDD assessment of CHC and HS collaborations. In 2013, ASTDD consultants presented *Getting a Head Start on Oral Health: An Overview of Oral Health Requirements and Programs* seminar sponsored by the University of California San Francisco for all dental public health residents and residency directors in the U.S. Two NCH oral health team members and a dental school faculty presented a workshop on integrating HS learning activities throughout the dental, dental hygiene, dental assisting, and dental residency curricula at the American Dental Education Association conference in 2014. Also in 2014, DHLs presented a workshop, Oral Health in Home Visiting Programs: A Perfect Opportunity, at NOHC.
From October 2015 to December 31, 2019, the oral health management team and DHLs conducted 40 national, 10 regional, 28 state, and 8 local presentations and trainings for various audiences, including HS regional TA staff, EHS/HS and child care program staff, and health professionals.

Oral health management team members and regional DHL coordinators have provided TA/T on oral health to EHS/HS program staff attending the Health Care Institute in Albuquerque, NM, for the past 3 years. The training is an opportunity to share best practices and reinforce health care partnerships among the participants and grow leadership and management skills and a culture of health in the agency. Evaluations for 2019 showed that 85% of those completing evaluations rated the training experience as excellent, with an average score of 4.76 out of 5.0. Participants especially enjoyed the

hands-on session for sharing key oral health messages. Furthermore, 96% of respondents reported that the training increased their confidence in delivering oral health messages to parents, and 98% would be "likely" or "very likely" to recommend the training to other agencies.

At NOHC in 2016, DHLs presented a workshop, *What's in Your Toolkit? Changing the Oral Health Conversation with Families.* Presentations at ADHA's annual conferences included *Working in Collaboration to Improve the Oral Health of Pregnant Women, Infants and Children in Head Start* (2015) and *Promoting the Oral Health of Young Children by Working in Dental Public* Health (2018). The 2020 annual conference will feature *Oral Health Literacy: A Wide Open Discussion.*

Assessment and Prevention

Some DHLs report providing oral health screenings and applying fluoride varnish in EHS/HS programs, even though that is not their primary function and they cannot provide services statewide. Their role is to help enable local oral health professionals or students to provide these services. For example, the DHL in Utah developed an innovative approach that includes physician assistant students participating in an oral health screening and fluoride varnish project within EHS/HS programs that serve the Ute tribe. The New York DHL led a team that visited nine HS programs providing oral health screenings, education, and fluoride varnish for 300 children as well as referrals for children who needed follow-up care.

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	**OUTCOMES**

4. **<u>What outcomes did the program achieve</u>? (e.g., health statuses, knowledge, behavior, care delivery system, impact on target population, etc.) Please include the following aspects:**
    a. **How outcomes are measured**
    b. **How often they are/were measured**
    c. **Data sources used**
    d. **Whether intended to be short-term (attainable within 1-3 years), intermediate (achievable within 4-6 years), or long-term (impact achieved in 7-10 years)**

In 2014, an assessment was sent to all DHLs to evaluate the impact of DHL collaborative activities for the first 2 years of the project. Ninety percent of DHLs reported collaborating with HS health managers to find dental homes and facilitating or providing educational and preventive services for children enrolled in EHS/HS. DHLs were working in collaboration with dental hygienists (97%) and state dental directors (90%). Approximately 75% of DHLs were working in collaboration with both practicing general dentists and pediatric dentists; 74% of DHLs reported working in collaboration with CHC staff, with 32% working in collaboration on a regular basis (more than five times/year). Approximately 85% of DHLs were involved in activities to find dental homes for children enrolled in EHS/HS, 87% of DHLs were providing education for EHS/HS staff, and 75% of DHLs were providing preventive measures to children enrolled in EHS/HS. About 75% of DHLs were involved in presentations and trainings at local, state, and national meetings. In addition, DHLs worked with the OHRC and ASTDD in developing resources to share accurate and consistent oral health messages. In 2018, DHLs reported that they had increased their confidence levels in their DHL role, interaction with their assigned regional DHL coordinator, and use of resources such as the DHL webpage. Areas for additional guidance or information were also noted.

Levels of collaboration with various groups fluctuate during the year. Tracking responses on the quarterly reports from 9/30/18 through 12/31/19, averages of activity over 5 quarters, noted collaboration with the following groups:

- HSSCO director and staff (36%)
- State HSA director and staff (31%)
- EHS/HS program director and staff (47%)
- HS health managers (58%)
- HS regional health specialist (26%)
- State or local child care agency staff (24%)
- State oral health program director and staff (54%)
- Dentists (29%)
- Dental hygienists (58%)

- Other health professionals (32%)
- Other groups (sporadic contact)

During the same time period, an average of 36% of DHLs also reported participation in HS health services advisory committee meetings and an average of 15% in state health managers' network meetings.

Another assessment in 2019 was completed by 41 DHLs with the following results: Almost 70% were "extremely confident" or "confident" in their DHL roles, most wanted strategies to increase collaboration efforts, and their highest levels of confidence were in using NCECHW materials for education and presentations. Desired topics for future webinars included teledentistry, silver diamine fluoride, and oral exams and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)dental periodicity schedules. Information on these topics has been shared.

Each DHL completes quarterly reports for their state activities, including collaborations. The results are summarized by the regional DHL coordinators and DHL lead consultant, reviewed by OHRC, and submitted to AAP, the NCECHW federal steering committee, and the ASTDD BOD. Via these reports, DHLs have reported an increase in collaboration with HS health manager networks. For example, the NM DHL tailors the efforts of the Office of Oral Health to establish agreements with HS. Her participation in HS health services advisory committees has allowed her to bring teachers' concerns in the classrooms to the attention of the health managers. For example, teachers complained they were not provided with supplies to implement daily brushing. When she brought this to the attention of the health manager, they communicated to teachers the process to order more supplies, thus collectively eliminating the problem, which led to uninterrupted implementation of daily brushing.

In 2013, an ASTDD consultant conducted a HS Program Information Report (PIR) pilot project to develop a data-driven model to help NCH and HS regional office staff use PIR data to monitor EHS/HS grantees' compliance with oral health–related PIR requirements. PIR data for six states (CO, FL, KS, MD, OR, and WV) were reviewed to prepare a 2-year trend analysis. The report with recommendations was submitted to AAP. Based on the success of this activity, DHLs continue analyzing PIR data to identify programs in need of assistance in improving the oral health of children. Examples include:

- The LA DHL collaborated with the HSSCO director and Louisiana Department of Health staff to analyze PIR oral health data and identify HS programs that need assistance. She compiled a list of oral health professionals that accept Medicaid, federally qualified health centers, and mobile oral health programs for a HS program struggling to find oral health professionals. She is collaborating with the Louisiana Oral Health Coalition and a representative from a child care organization to recruit speakers for monthly oral health presentations at child care centers across the state. The representative is also interested in initiating a toothbrushing program.
- The TX DHL created a state collaborative that includes representatives from the Medicaid managed care organization, the Texas Dental Association, Texas Primary Care Organization, and the HSSCO director and the HS regional health specialist where she routinely presents PIR data.
- The AZ DHL reviews PIR reports with health managers and presents the information at health services advisory committee meetings.
- The DHL in MS shared PIR data at the Mississippi Dental Association annual meeting, noting that in 2018, 5,000 HS-enrolled children didn't receive a dental exam. She described her DHL role and offered to help them connect with local HS programs; she was able to link four providers in rural areas to HS programs within 1 week of her presentation.

Development of *Head Start Oral Health Forms for Children and Pregnant Women* has helped local programs track dental referrals and follow-up. The forms provide information on dental home, current oral health status, and what oral health care services were delivered during the dental visit. These services include diagnostic and preventive services, counseling, restorative and emergency care, and referral to a specialist for care. The forms also record what oral health care services are needed and any information to share with others.

In 2008, the ASTDD Basic Screening Survey (BSS) training manual and videos were revised to include information on HS data collection and analysis. In 2015, the oral health status of preschool-age children (especially children enrolled in EHS/HS) was approved as a national oral health indicator by the Centers for Disease Control and Prevention (CDC)/ASTDD National Oral Health Surveillance System. The ASTDD data consultants have provided T/TA to states and DHLs on using BSS, resulting in 17 states and the Indian Health Service submitting qualified HS data for the National Oral Health Surveillance System, and have responded to multiple emails from DHLs and EHS/HS programs. Some

DHLs are involved in their state's BSS data collection; the MI DHL routinely reports participating in BSS-related discussions with the MI HSSCO director.

In 2014, the oral health team prepared a brief description of EHS/HS oral health activities in the areas of education, disease prevention, and treatment programs from a few states to highlight success stories. A 2019 webcast, *Dental Hygienist Liaisons: Your State's Perfect Partner*, highlights three DHLs telling about how they are making an impact in their communities and throughout their states.

Because the primary role of DHLs is to serve EHS/HS staff rather than provide direct services to parents or children (although some DHLs provide direct services), the oral health management team does not collect data on number of preventive or screening services provided by DHLs. Individual EHS/HS programs are responsible for reporting on care received by their enrollees.

Budgetary Information:
NOTE: Charts and tables may be used to provide clarity.

1. What is the annual budget for this activity?

The initial focus of the DHL project in 2012 was to find dental homes for pregnant women and children enrolled in ESH/HS with an annual budget of $100,000. In 2015, the focus was expanded to address partnerships for oral health promotion and oral disease prevention, include children enrolled in child care programs, and include stipends for the regional DHL coordinators, so the annual budget increased to $160,000.

2. What are the costs associated with the activity? (Including staffing, materials, equipment, etc.)

- Two ASTDD consultants coordinate DHL activity, with another ASTDD consultant providing administration support, editing expertise, and content/program expertise: $41,828
- Nine regional DHL coordinators help coordinate DHL activities in their assigned states and submit quarterly invoices for a maximum of $1,500 depending on their time commitment $54,000
- Optional annual stipends of $590 for 53 volunteer state DHLs (DC and some large states have 2 DHLs) to cover supplies to attend state and local meetings to provide presentations and trainings (not to be used to cover their time): $31,270
- Communications expenses (e.g., postage, phone, webinars, Internet subscriptions): $2,146
- Administrative expenses (executive director, business assistant, website/discussion list hosting): $16,351
- Travel to national and regional meetings for presentations and trainings: $14,405

3. How is the activity funded?

AAP receives a cooperative agreement (2015–2020) from the federal OHS and Office of Child Care (OCC) to operate NCECHW. AAP awards an annual contract to OHRC at Georgetown University for the oral health project, and OHRC awards an annual contract to ASTDD to coordinate the DHL project. The current cooperative agreement for NCECHW ends September 29, 2020.

4. What is the plan for sustainability?

The oral health management team met in 2013 with a group of national experts to solicit input for a collaboration plan for sustainability and support of national, regional, state, and local EHS/HS oral health activities. A draft plan was created and sent to more than 20 organizations to encourage them to promote EHS/HS activities to their members. Reviewing progress on that plan in 2019 revealed that many of the activities have been implemented, and it is hoped that they will continue.

Lessons Learned and/or Plans for Addressing Challenges:

1. What important lessons were learned that would be useful for others looking to implement a similar activity? Was there anything you would do differently?

Dental hygienists are dedicated to their profession and their communities and are willing to devote volunteer hours to improve the oral health and care of young children and their families.

- The DHL network has effectively collaborated and serves as a crucial link between EHS/HS and the child care community and the oral health community (including state oral health programs, dental clinics/offices, and CHCs). For children enrolled in EHS/HS and child care programs, a systems approach for oral health services is crucial. There must be an oral health professional reaching out to EHS/HS and child care programs who will facilitate a process for oral health assessment, prevention, and referrals with follow-up to dental homes. Collaborating with HS regional health specialists is key to successfully training health managers about oral health needs for pregnant women, infants, and children and providing consistent messaging to educate pregnant women and parents.
- DHLs are more successful in broadly disseminating information in states where strong relationships can be developed with the directors of HSSCO, the state HSA, and state oral health coalitions.
- TA/T provided by the regional DHL coordinators has increased state DHL activities and decreased DHL turnover. DHLs within each region are encouraged to collaborate and share ideas.
- Key quotes from DHLs about the most rewarding aspects of serving as a DHL:
    - "Seeing HS programs incorporate what we're teaching into their daily curriculum and telling me they feel more confident to talk to parents."
    - "Knowing I can be an educational resource."
    - "Hands on teaching with the children."
    - "Being a leader in dental hygiene community and helping HS families."
    - "Helping programs find ways to meet the oral health needs of their enrollees."
    - "Connecting with community partners and improving access to oral health."

2. <u>What challenges did the activity encounter and how were those addressed</u>?

Initially, getting approval to share information and resources (publications, presentation slides) was time-consuming due to the review process by the national center's federal steering committee to ensure that only accurate and consistent messages were provided to EHS/HS programs. After operating the oral health projects for several years, numerous resources have been developed and are readily available to use. Also, long-term stability in OHRC staff and ASTDD consultants has created trust and credibility from AAP and the federal steering committee. The DHL project has been recognized by OHS and AAP as an exemplary model of collaboration. In 2019, the DHLs received a letter and certificate of appreciation from OHS director, Deborah Bergeron, who also recognized the DHLs on her vlog.

Over the seven years of the DHL project, recruitment, orientation, and training DHLs has been time consuming, but generally turnover rates have been low. ADHA has been helpful in recruitment efforts and in highlighting the importance of DHLs and recognizing their accomplishments. Since assigning regional DHL coordinators, DHL turnover has decreased dramatically. The regional DHL coordinators provide direct orientation, training, and mentorship to the state DHLs.

The most common challenges reported by the DHLs are limited time and resources. DHLs are volunteers, most with full-time jobs, so they often are faced with competing priorities. Sustainability is a concern when the projects relies on volunteers; therefore, it is important that DHL activities are not overly time consuming. Many of the DHLs who work in public health are able to more easily align their DHL role with their work.

Another challenge is having one DHL cover an entire state. Several large states, such as Texas, have overcome this challenge by recruiting dental hygienists from ADHA local components to volunteer in their local area. Other DHLs collaborate with dental hygiene students.

Key quotes from DHLs about some of the challenges:

- "Convincing the local HS teachers of the usefulness of the resources, education, and services."
- "Recognition of the DHL role on a state level and the importance of oral health with non-health-care providers."
- "It is very challenging as a clinically practicing hygienist to find the time to go to meetings/events because they are often scheduled during my normal work hours."
- "Lots of HS staff turnover, which requires starting over, losing contacts and repeating educational components."
- "Having someone ask me about access for their students and not being able to help them find providers who accept the Medicaid card."

Available Information Resources:

Share any models, tools, and/or guidelines developed by the program specifically for this activity that may be useful to others seeking additional information. Hyperlink resources if possible.

All resources developed by NCECHW for EHS/HS and child care programs are posted on ECLKC. Resources for DHLs, which are also available to ASTDD members and others, including DHL webinar slides, recordings, and links to materials are posted on ASTDD's DHL webpage. Additional resources are maintained on the OHRC website. Specific resources have been mentioned, some with links where available, in other sections of this report.

TO BE COMPLETED BY ASTDD	
Descriptive Report Number:	99004
Associated BPAR:	State and Territorial Oral Health Programs and Collaborative Partnerships
Submitted by:	ASTDD NCECHW DHL Project Lead Consultant
Submission filename:	DES99004STDD-dhl-proj-2020
Submission date:	March 2020
Last reviewed:	March 2020
Last updated:	March 2020