

Trends in Oral Health Care for Children in Head Start Programs Before and During the COVID-19 Pandemic—Program Years 2018, 2019, 2021, and 2022

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Background

Oral health is a critical component of overall health. Providing oral health care to children in Head Start programs is a critical national priority, especially because of the COVID-19 pandemic, which has exposed many oral health inequities, including among children from families with low incomes.

This brief describes national trends in Head Start oral health care spanning program years beginning before COVID-19 and continuing during the pandemic. Information presented in the brief is based on Head Start Program Information Report (PIR) data on oral health performance indicators for program years 2018, 2019, 2021, and 2022 (see Appendix 1 and Appendix 2). Data for program year 2020 is not available because programs were not required to submit PIR data during that year owing to the pandemic. Data was obtained from the *Office of Head Start—Program Information Report (PIR)—PIR Indicator Report—National Level*.

The brief discusses the primary reason that children who needed dental treatment did not receive it (see Table 1). Data was obtained from the *Office of Head Start—Program Information Report (PIR)—Summary Report—National Level*. The brief also includes qualitative input derived from a convenience sample of several Head Start administrators and coordinators and state dental hygienist liaisons (DHLs) (see Table 2).

In addition, the brief contains data on medical performance indicators for program years 2018, 2019, 2021, and 2022 (see Appendix 3 and Appendix 4). Data was obtained from the *Office of Head Start—Program Information Report (PIR)—PIR Indicator Report—National Level*.

National Trends in Head Start PIR Oral Health Performance Indicators for Program Years 2018, 2019, 2021, and 2022

PIR Oral Health Performance Indicators

Data for the PIR oral health performance indicators are presented in appendix 2.

- 114.1 The percentage of children with a dental home decreased (concerning trend) across all programs.
- 132 The percentage of preschool children completing dental exams decreased (concerning trend) in Head Start programs and in Migrant and Seasonal Head Start programs. The percentage of preschool children completing dental exams remained roughly the same in American Indian/Alaska Native Head Start programs.
- 133 Of preschool children receiving professional dental exams, the percentage of preschool children needing dental treatment decreased (favorable trend) in Head Start programs and

in Migrant and Seasonal Head Start programs. However, the percentage increased (concerning trend) for American Indian/Alaska Native Head Start programs.

134 Of preschool children needing dental treatment, the percentage of preschool children receiving needed dental treatment decreased (concerning trend) in Head Start programs, in American Indian/Alaska Native Head Start programs, and in Migrant and Seasonal Head Start programs.

Note: Receipt of dental homes (114.1) is the only oral health indicator collected for children in Early Head Start programs. The indicators for completing a dental exam (132), needing dental treatment (133), and receiving needed dental treatment (134) are not collected for children in Early Head Start programs.

Comparing data for program years 2018 and 2022, three of the four PIR oral health performance indicators decreased, a concerning trend. The percentage of children with a dental home (114.1) decreased for all programs, the percentage of preschool children completing dental exams (132) decreased in Head Start programs and in Migrant and Seasonal Head Start programs, and the percentage of preschool children receiving needed treatment (134) decreased in Head Start programs, in American Indian/Alaska Native Head Start programs, and in Migrant and Seasonal Head Start programs. The percentage of children with completed dental exams and the percentage of children who received needed dental treatment decreased the most. Completion of dental exams for children in Head Start programs and in Migrant and Seasonal Head Start programs decreased by 16.5% and 11%, respectively. Receipt of needed dental treatment for children in Head Start programs, in American Indian/Alaska Native Head Start programs, and in Migrant and Seasonal Head Start programs decreased by 15.9%, 10.6%, and 13.3%, respectively.

However, there were small improvements in a few PIR oral health indicators in program year 2022 as the impact of COVID-19 began to wane. From program year 2021 to 2022, completion of dental exams (132) increased in Head Start programs, in American Indian/Alaskan Native programs, and in Migrant and Seasonal Head Start programs by 13%, 17.1%, and 19%, respectively. While it is too early to know whether these increases mark the beginning of a trend indicative of a return to post-pandemic “normalcy” or whether they are outliers, the improvements provide hope that future program years will continue moving toward pre-pandemic levels.

Also hopeful is that the percentages of children needing dental treatment (133) in Head Start programs and in Migrant and Seasonal Head Start programs, the only indicator with an inverse relationship to good oral health, decreased by 7.3% and 20.7%, respectively, during program years 2018 and 2022. It is not known whether the decrease is wholly or partially due to fewer children completing dental exams because of COVID-19–related concerns in program years 2021 and 2022. However, the percentage of children needing dental treatment in American Indian/Alaska Native programs increased by 8.2%.

Figures 1 through 5 illustrate trends from program years 2018, 2019, 2021, and 2022 for the four PIR oral health performance indicators.

Figure 1. Oral Health Performance Indicator 114.1

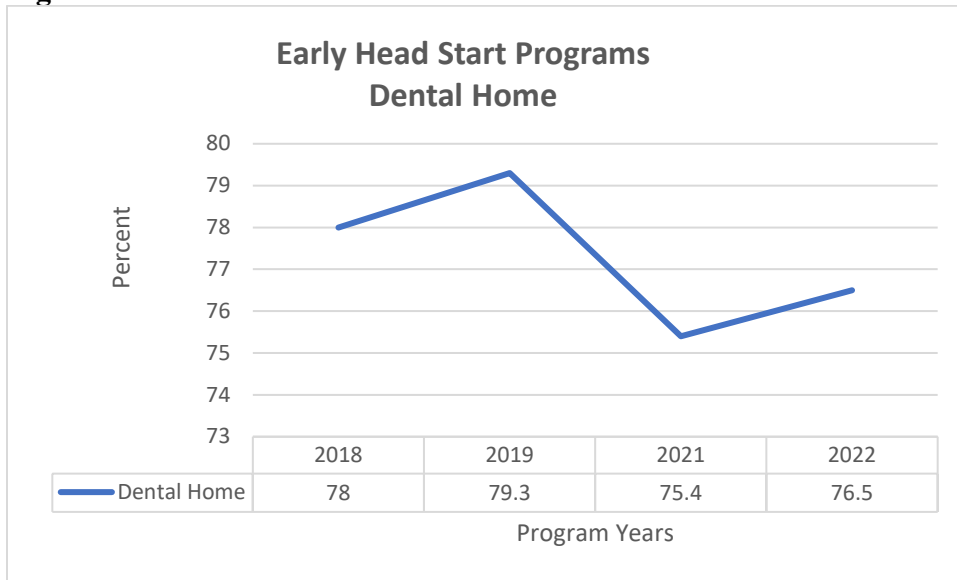


Figure 2. Oral Health Performance Indicators 114.1, 132, and 133

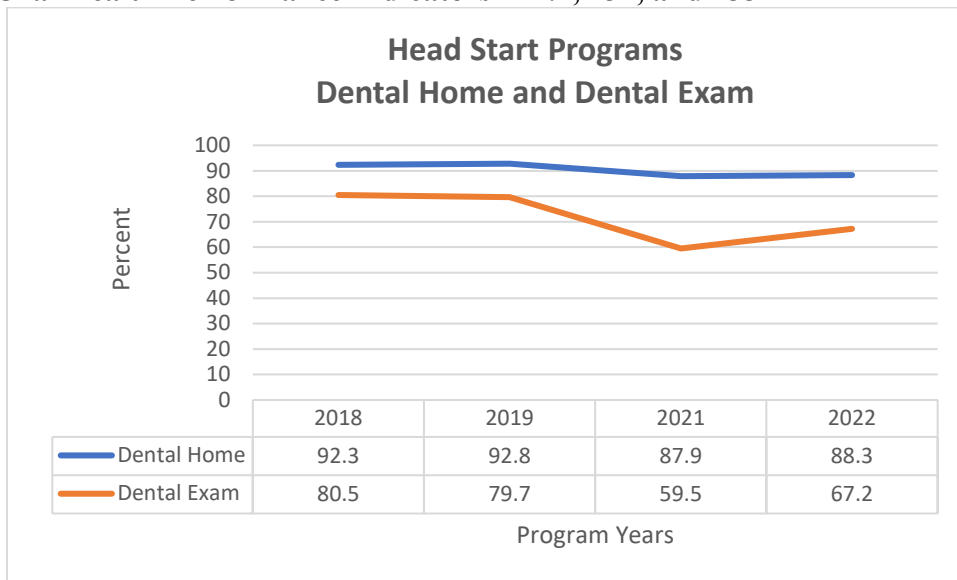


Figure 3. Oral Health Performance Indicator 134

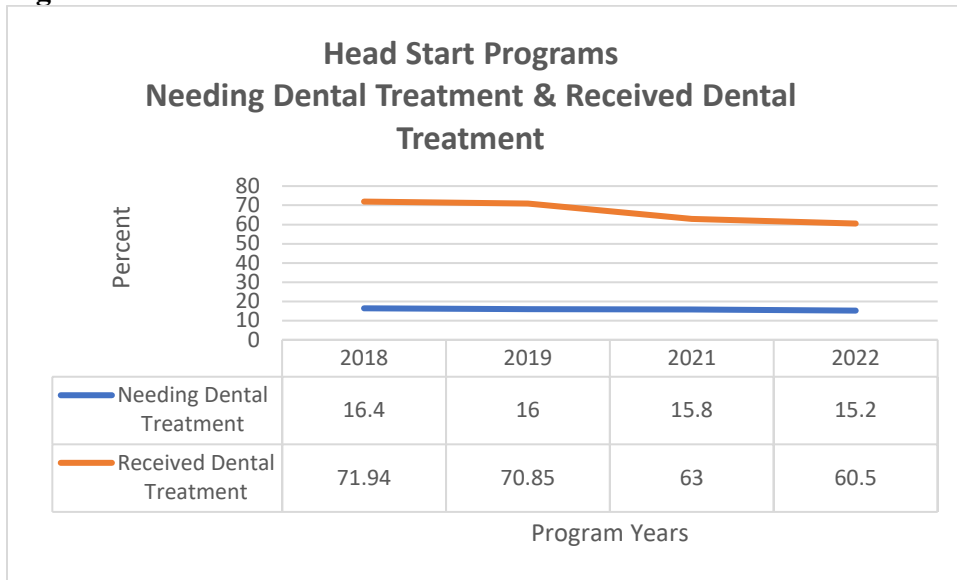


Figure 4. Oral Health Performance Indicators 114.1, 132, and 133

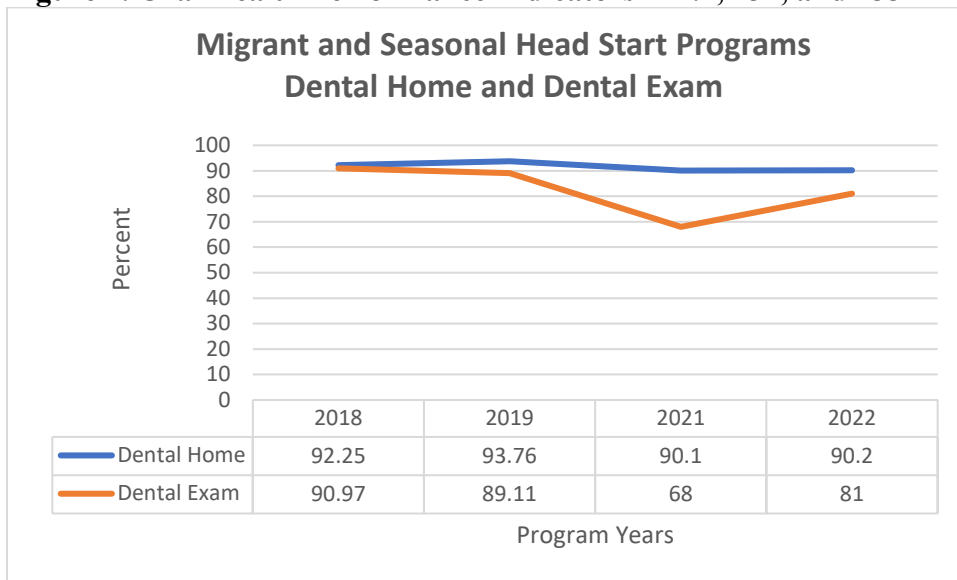
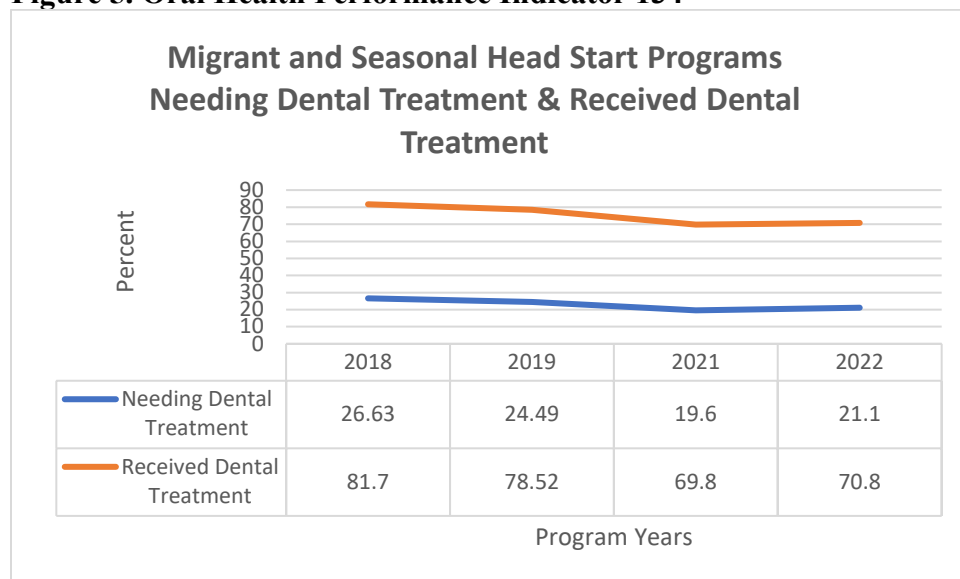


Figure 5. Oral Health Performance Indicator 134



There is an additional point to consider related to PIR oral health data. The percentage of children with a dental home in all Head Start programs decreased only slightly during program years 2018, 2019, 2021, and 2022, whereas the percentage of children with completed dental exams and the percentage of children who received needed dental treatment decreased more significantly. Since completing a dental exam and receiving dental treatment are related to having a dental home, a larger decrease in the percentage of children with a dental home would be expected. Children who have not completed a dental exam or have not received needed dental treatment do not have a dental home; this shows that the dental home concept is not well understood. Therefore, analysis of the dental home indicator should be secondary to the analysis of the other three PIR oral health performance indicators addressed in this brief.

Primary Reason Children Who Needed Dental Treatment Did Not Receive It During Program Years 2018, 2019, 2021, and 2022

To target technical assistance effectively and to efficiently address the challenges all Head Start programs face related to oral health care, it is important to understand the range and scope of existing challenges, presumably exacerbated due to COVID-19.

The *Office of Head Start—Program Information Report (PIR)—Summary Report—National Level* indicates the number of children in Head Start programs and Migrant and Seasonal Head Start programs diagnosed as needing dental treatment during the program year, and of these children, the number who received or are receiving dental treatment at the end of enrollment. It also provides the primary reason that children who needed dental treatment did not receive it (see Table 1).

During program years 2018, 2019, 2021, and 2022, the three most frequently reported primary reasons that children who needed dental treatment did not receive it were (1) the parent did not make or keep the appointment for their child, (2) the appointment was rescheduled for a future date, and (3) children left the program before their appointment date. In program years 2021 and

2022, compared with program years 2018 and 2019, a significantly higher number of parents did not make or keep the appointment for their child, more appointments were rescheduled for a later date, and more children left the program before their appointment date. These increases were presumably due in whole or in part to COVID-19 and the multitude of specific oral-health-access problems that resulted from the pandemic. In light of these issues, it would be beneficial to develop strategies to encourage parents to make and keep a dental appointment for their child who needs treatment and to support them in doing so while their child is in the program.

Table 1

Primary Reason That Children Who Needed Dental Treatment Did Not Receive It				
	2018	2019	2021	2022
The number of children diagnosed as needing dental treatment during the program year	107,188	101,459	50,128	58,515
Of these, the number of children who have received or are receiving dental treatment at end of enrollment	77,368	72,094	31,712	35,576
Of these, the number of children who needed dental treatment who did not receive it	28,820	29,365	18,416	22,939
The primary reason that children who needed dental treatment did not receive it				
Health insurance doesn't cover dental treatment	5	21	109	211
No dental care available in local area	28	31	169	455
Medicaid not accepted by dentist	16	16	56	174
Dentist in the area do not treat 3–5 year old children	32	41	225	304
Parent did not keep/make appointment	808	755	6,417	7,844
Children left the program before their appointment date	134	149	1,221	1,669
Appointment is scheduled for future date	277	274	4,363	5,456
No transportation	7	5	86	116
Other	79	70	1,695	1,619

Note: PIR reports obtained from Head Start Enterprise System on November 7, 2022.

Challenges to Oral Health Care Pre-COVID and During COVID-19

In general, challenges to accessing oral health care fall into three general (and sometimes overlapping) categories: family issues, provider issues, and policy and financing issues. To help the Office of Head Start and the National Center on Health, Behavior Health, and Safety, funded by the Office of Head Start, understand these challenges, a convenience sample of Head Start administrators and coordinators and state DHLs were asked to identify challenges in accessing oral health care for children from their perspective of working with families. A list of the challenges appears in Table 2, which documents both pre-COVID (PC)- and COVID-related (C) challenges that Early Head Start programs, Head Start programs, American Indian/Alaska Native programs, and Migrant and Seasonal Head Start programs may face. Both types of challenges are listed to illustrate that many, if not most, of the challenging oral health issues impacting all Head

Start programs are not solely the result of COVID-19 but certainly were exacerbated by it. It is assumed that all PC issues, while only listed as PC, also persist(ed) throughout the pandemic.

Table 2

Pre-COVID (PC) and COVID (C) Oral Health Challenges		
Family Issues	Provider Issues	Policy and Financing Issues
<ul style="list-style-type: none"> • Lack of education/knowledge about the importance of oral health (PC) • Families’ fear of dentistry (PC) • Families do not have access to healthy foods; poor nutritional practices (PC) • Lack of cultural sensitivity in educational materials (PC) • Lack of case management/continuity of care impacting availability of a dental home, source of continuous routine care (PC) • Lack of transportation to dental office, long distance to dental office, long waiting times, missed appointments (PC) • Fear of dentistry exacerbated by “scary” new personal protective equipment worn by dental providers (C) <p>Families reluctant to take children to dental office due to fear of COVID (C)</p> <ul style="list-style-type: none"> • Families unable to leave other children at home, unable to take time off work, or leave exhausted due to COVID-related issues (C) 	<ul style="list-style-type: none"> • Lack of dental providers, especially pediatric dentists, in rural areas (PC) • Lack of dental providers accepting Medicaid patients (PC) • Dental providers reluctant to provide care to children due to too many “no shows” and missed appointments (PC) • Legal documentation/incomplete paperwork leads to delays in care (PC) • Dental providers reluctant to provide care to children, children from families with low incomes, children with special health care needs (PC) • Oral health screenings not completed by medical providers (e.g., physicians, nurses) (PC) • As a result of COVID, dental office closed or short-staffed resulting in overbooking patients, providers overwhelmed with new and more 	<ul style="list-style-type: none"> • Decreased Medicaid funding in many states (PC) • Inadequate Medicaid dental reimbursement rates (PC) • Lack of dental providers enrolled in Medicaid (PC) • Lack of emphasis by payors or inconsistency in approaches to prevention (PC) • Bureaucratic delays for Medicaid participants seeking treatment authorization, dental providers seeking reimbursement (PC) • Supervision/licensure issues for dental hygienists to conduct dental exam (PC) • Lack of dental case management workers (e.g., community health workers due to

<ul style="list-style-type: none"> • Families not scheduling dental appointments believing that dental offices closed due to COVID (C) • Families prioritizing receiving COVID immunizations rather than receiving oral health care (C) • Families cancel appointment or no-show since having to quarantine due to COVID (C) • Higher tooth decay rates since toothbrushing in programs ceased and children not brushing at home (C) • Families not comfortable with COVID protocols in dental offices; parent not allowed in dental operatory with their child (C) 	<p>patients, and some offices not able to accept patients (C)</p> <ul style="list-style-type: none"> • Lack of dental office staff due to COVID (sick or quarantined) resulting in cancelled appointments or office closure (C) • Dental provider hesitancy to provide care in Head Start programs because they may lack proper infection-control protocols/equipment (C) • Dental provider concern that a COVID case would be traced back to them, thus restricts access to care (C) • Some dental providers not vaccinated for COVID (C) 	<p>credential requirement and/or lack of Medicaid reimbursement causing appointments not being scheduled, “no shows,” and/or missed appointments (PC)</p>
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National Trends in Head Start PIR Medical Performance Indicators for Program Years 2018, 2019, 2021, and 2022

PIR Medical Performance Indicators

The effects of COVID-19 on Early Head Start programs, Head Start programs, American Indian/Alaskan Native Head Start programs, and Migrant and Seasonal Head Start programs may extend beyond oral health. It is useful to analyze additional PIR performance indicators to ascertain whether access to medical care, as well as access to oral health care, has been negatively impacted. Data for the PIR medical performance indicators are presented in appendix 3.

- 113.1 The percentage of children with up-to-date immunizations, all possible immunizations to date, or exempt (only one measured for children in Early Head Start programs) decreased (concerning trend) for all programs.
- 122 The percentage of children up to date on a schedule for preventive and primary health care per the state's EPSDT schedule at the end of the enrollment year decreased (concerning trend) for all programs.
- 123 Of children up to date on health screenings, the percentage of children diagnosed with a chronic condition needing medical treatment.
- 124 Of children diagnosed with a chronic condition needing medical treatment, the percentage of children who received medical treatment increased slightly (favorable trend) in Early Head Start programs and decreased (concerning trend) in Head Start programs, in American Indian/Alaskan Native Head Start programs, and in Migrant and Seasonal Head Start programs.

Comparing data for program years 2018 and 2022, the percentage of children with up-to-date immunizations (113.1) decreased for children in Early Head Start programs, in Head Start programs, in American Indian/Alaskan Native Head Start programs, and in Migrant and Seasonal Head Start programs, by 2.9%, 2.1%, 2.9%, and 4.9%, respectively. A promising trend for this measure in the wake of the COVID-19 pandemic is an increase between program years 2021 and 2022 for Early Head Start programs, Head Start programs, and American Indian/Alaskan Native Head Start programs. However, the percentage of children up to date on preventive and primary health care screenings (122) for program years 2018 and 2022 decreased for children in Early Head Start programs, in Head Start programs, in American Indian/Alaskan Native Head Start programs, and in Migrant and Seasonal Head Start programs by 16.4%, 13.5%, 16.4%, and 9.3%, respectively. For this measure, there was an increase between program years 2021 and 2022 for all Head Start programs, which could portend an improvement in this measure from the peak of pandemic. The percentage of children diagnosed with a chronic condition needing medical treatment (123) for program years 2018 and 2022 increased for children in Early Head Start programs, in Head Start programs, and in American Indian/Alaskan Native Head Start programs by 26.8%, 23.2%, and 26.7% respectively, and decreased for children in Migrant and Seasonal Head Start programs by 13.9%. And the percentage of children diagnosed with a chronic condition receiving medical treatment (124) increased for children in Early Head Start programs by 1.5%. However, the percentage decreased for children in Head Start programs, in American Indian/Alaskan Native Head Start programs and in Migrant and Seasonal Head Start programs by 16.8%, 11.5%, and 18.8%, respectively.

Figures 6 through 14 illustrate trends from program years 2018, 2019, 2021, and 2022 for the four PIR medical performance indicators.

Figure 6. Medical Performance Indicator 113.1

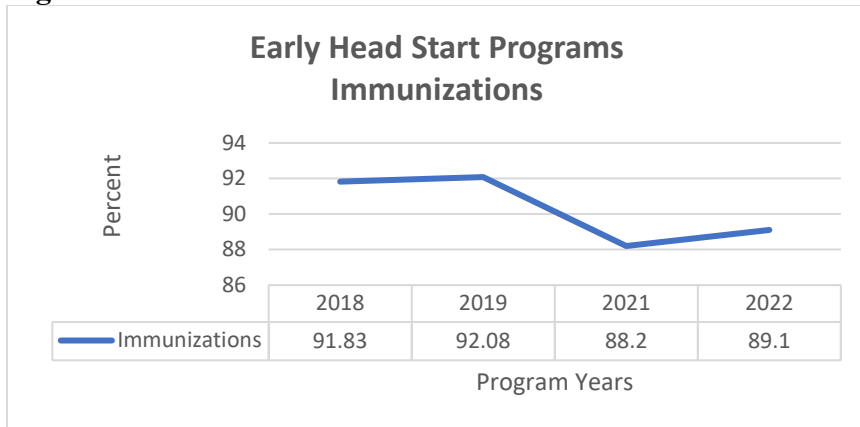


Figure 7. Medical Performance Indicator 122

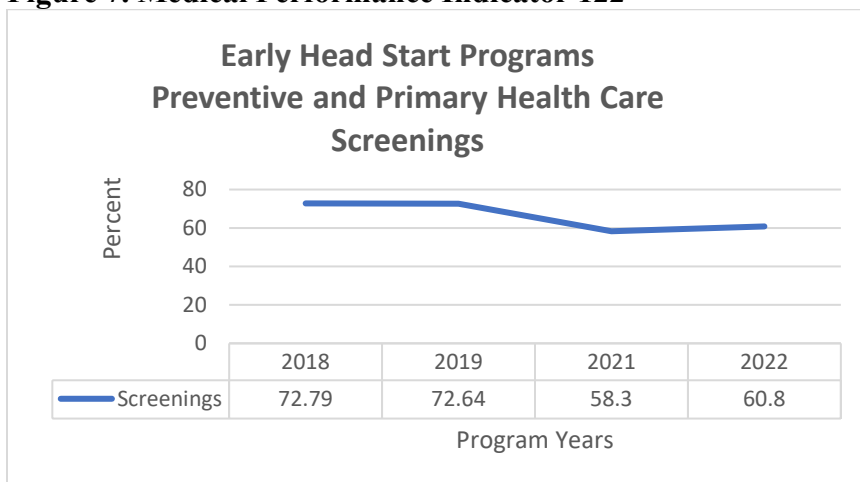


Figure 8. Medical Performance Indicators 123 and 124

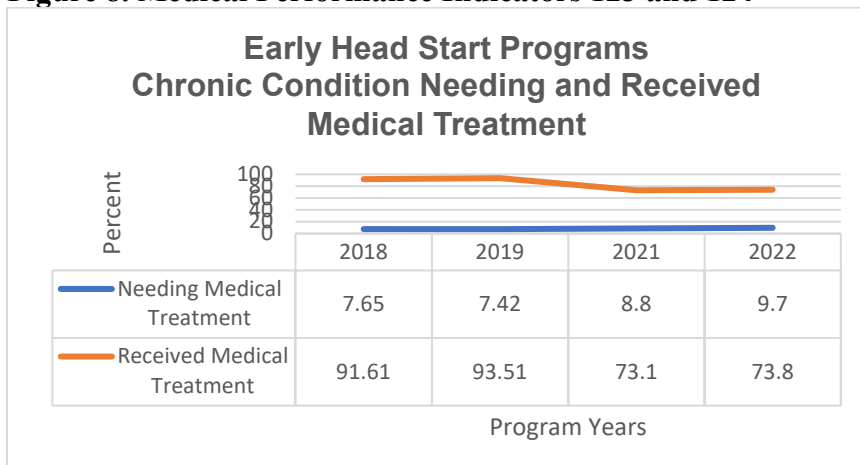


Figure 9. Medical Performance Indicator 113.1

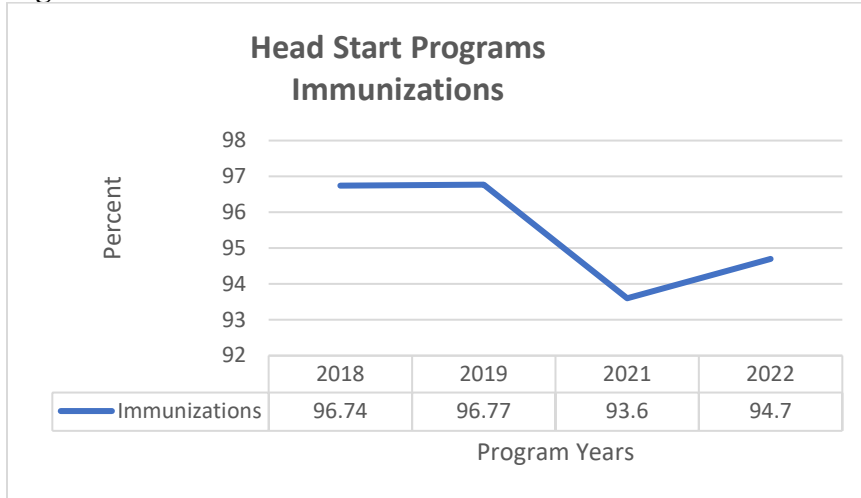


Figure 10. Medical Performance Indicator 122

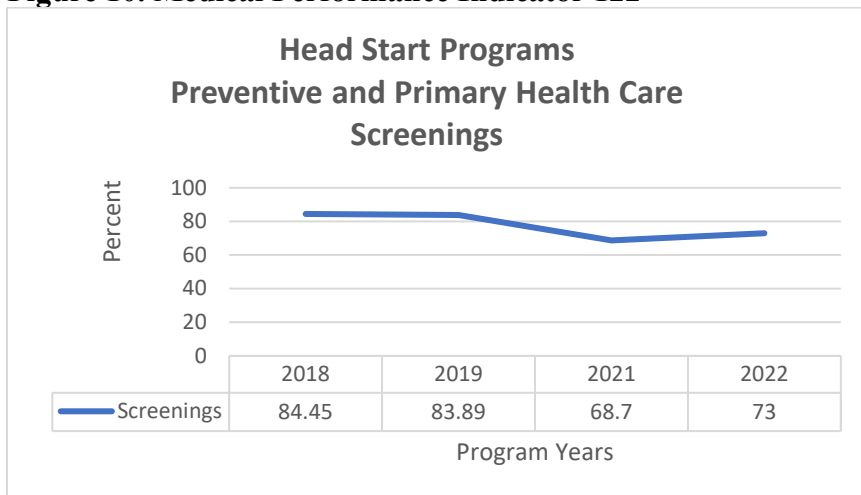


Figure 11. Medical Performance Indicators 123 and 124

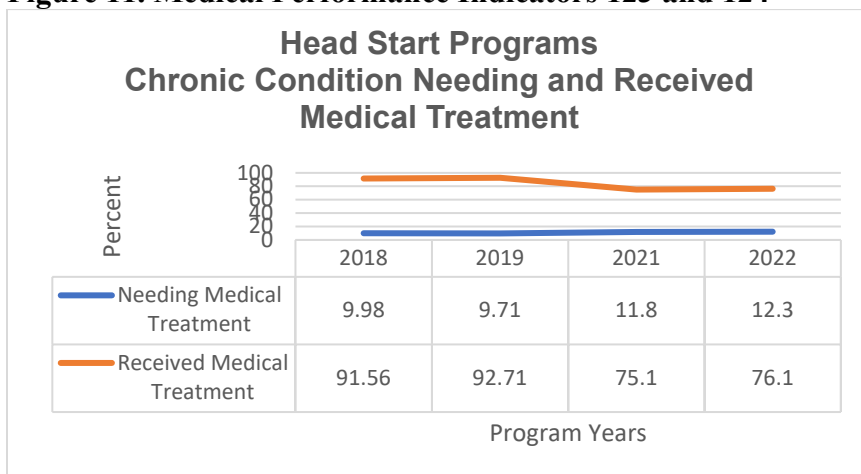


Figure 12. Medical Performance Indicator 113.1

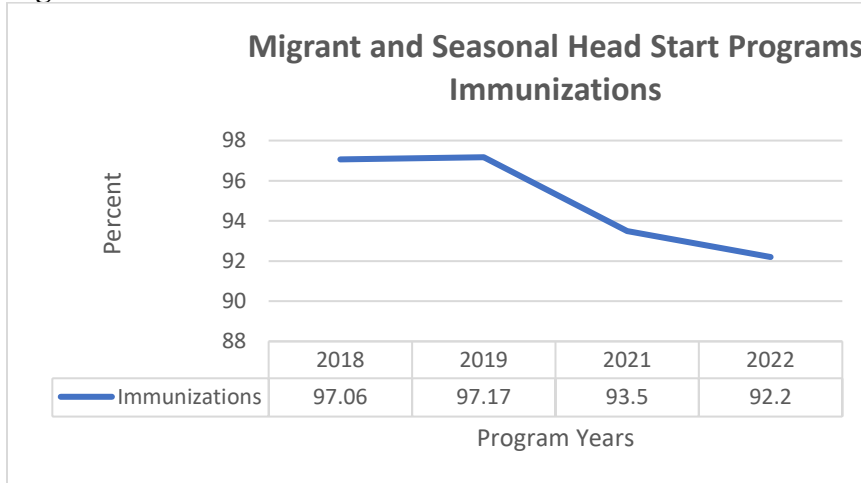


Figure 13. Medical Performance Indicator 122

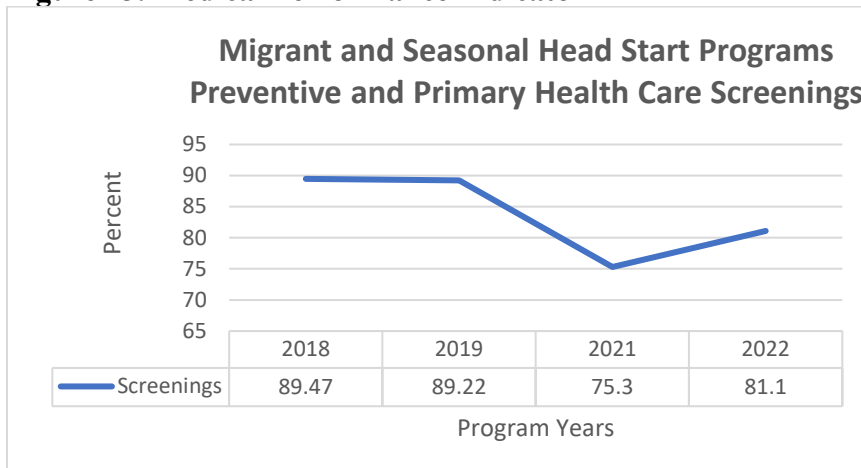
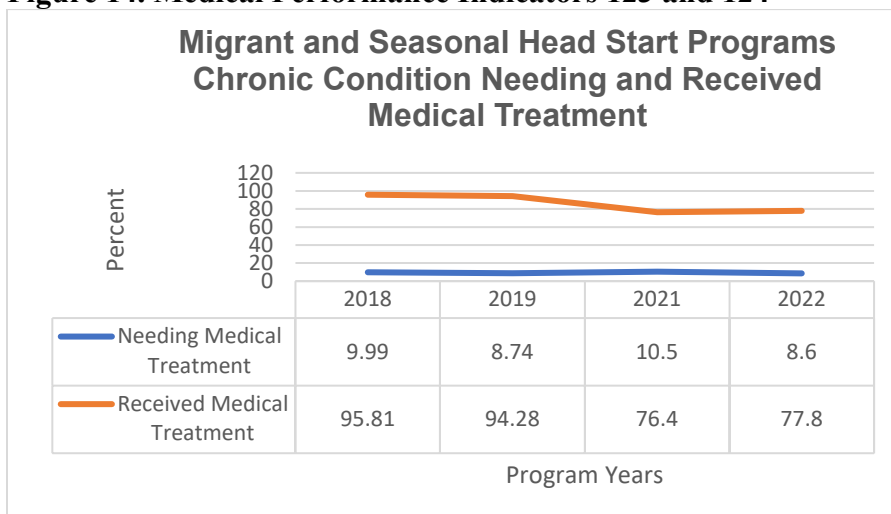


Figure 14. Medical Performance Indicators 123 and 124



Summary

Accessing oral health care for children remains one of the foremost challenges for Head Start programs. This analysis of PIR data suggests that there was a slight decrease in the percentage of children who had a dental home once the pandemic began; however, the analysis also suggests that the percentage of children who received dental exams and needed dental treatment (among those examined) decreased more significantly once the pandemic began. Since completing a dental exam and receiving dental treatment are related to having a dental home, a larger decrease in the percentage of children with a dental home would be expected. Children who have not completed a dental exam or have not received needed dental treatment do not have a dental home; this shows that the dental home concept is not well understood.

While the percentages of children in Head Start programs, in American Indian/Alaska Native programs, and in Migrant and Seasonal Head Start programs who received dental exams increased between program years 2021 and 2022, the question remains whether this is the beginning of an upward trend or a 1-year aberration. Fortunately, the need for dental treatment appeared level during program years 2018, 2019, 2021, and 2022, but with the decrease in the number of children completing a dental exam, it is impossible to know whether children who did not complete a dental exam had dental treatment needs.

During program years 2018, 2019, 2021, and 2022, the three most frequently reported primary reasons that children who needed dental treatment did not receive it were (1) the parent did not make or keep the appointment for their child, (2) the appointment was rescheduled for a future date, and (3) children left the program before their appointment date. In program years 2021 and 2022, compared with program years 2018 and 2019, a significantly higher number of parents did not make or keep the appointment for their child, more appointments were rescheduled for a later date, and more children left the program before their appointment date.

A convenience sample of Head Start administrators and coordinators and state DHLs described challenges that all Head Start programs face related to oral health care (see Table 2). While the pandemic exacerbated existing problems in accessing oral health care for children in all Head Start programs, other problems emerged (e.g., dentists and dental hygienists taking early retirement or leaving the profession) that might be difficult to reverse in a timely fashion.

Regardless of improvements in PIR performance indicator data from program year 2021 to 2022, the oral-health-care-delivery system was significantly impacted by COVID-19; therefore, it is important to continue to encourage local oral health professionals to partner with their local Head Start programs and provide oral health care to children.

The challenges described in this brief, some new, but most exacerbated by COVID-19, suggest the need for a multi-pronged approach involving strategies implemented at the local, state, regional, and federal/national levels to improve oral health outcomes for children in all Head Start programs. Important steps have been taken to promote access to oral health care, such as by promoting in plain language and through multiple networks, including through community-based providers, that it is safe for families to return to dental offices and providing guidance for

families about what to expect when visiting dental offices and clinics. But much more work is needed.

Strategies for Addressing Concerning Trends in PIR Oral Health Performance Indicators

Below are sample strategies to stimulate ideas for how local Head Start program staff, state DHLs, state organizations, regional DHL coordinators, regional health specialists, national organizations, and federal agencies working in partnership with others can address the concerning trends in the oral health performance indicators described in this brief.

Local Head Start Program Staff

Note: Staff includes community health workers, health managers, home visitors, teachers, promotoras, and others involved in the care of children in Head Start programs.

- Encourage families to make and keep a dental appointment for their child who needs an oral exam or treatment, and provide supportive services to help them do so. Gather information about why families do not make or keep dental appointments, and share this information with the program's Health Services Advisory Committee (HSAC) to identify strategies for addressing families' barriers to seeking and obtaining care.
- Be aware of and address families' COVID-19 concerns and reassure families in a supportive manner. Share information about effective infection-control practices that dental offices and clinics should have in place. Share educational materials that explain it is safe to obtain care in dental offices and clinics.
- Share information and materials with families to help them find a dental office or clinic and establish relationships with oral health professionals. Use NCHBHS's handouts [*Questions to Ask When Looking for a Dental Office*](#) and [*Getting to Know Me: Information for Your Child's Dental Office*](#). Plan family education sessions (e.g., ask a dentist or dental hygienist to provide a virtual or in-person presentation).
- Work with HSACs to explore the use of teledentistry, if allowed in the state, to help increase access to oral health care in rural and underserved areas, where there are not enough dentists to provide care to children.
- Develop questions to include in Head Start community needs assessment to determine the capacity of the local oral health workforce.
- Invite a local dentist, dental hygienist, or clinic office manager or staff member to serve on the Head Start program's HSAC to offer suggestions for improving children's access to and use of oral health care.

State DHLs

- Review PIR oral health performance indicators for states to identify concerning trends in PIR oral health performance indicators.
- Facilitate sharing of information about PIR oral health performance indicators by convening groups to discuss it. Meet periodically with key state Head Start and oral health partners (e.g., state DHL, state Head Start association, state Head Start collaboration office, state oral health coalition, state oral health program) to discuss the performance indicators and develop strategies to improve access to and use of oral health care for children in Head Start.
- Present at state meetings to increase Head Start program staff's awareness of concerning trends in PIR oral health performance indicators and strategies for improvement.

- Provide training at state meetings to increase the oral health literacy of Head Start staff. Use NCHBHS’s toolkit on health literacy. Consider a train-the-trainer model with state DHLs providing a training to local Head Start staff who in turn provide a training to families with children in Head Start. Share NCHBHS’s tip sheets, [Accessing Oral Health Care in Rural Areas](#), [Finding Oral Health Care](#), [Oral Health Literacy Matters](#), and [Talking with Children About Dental Visits](#), with Head Start staff.
- Provide training at state meetings to increase the oral health literacy of health professionals and social service professionals who offer oral health education and support services (e.g., case management, dental insurance, transportation) to children in Head Start. Share NCHBHS’s tip sheets, *Dental Hygienists and Head Start: How You Can Help* (forthcoming), *Dentists and Head Start: How You Can Help* (forthcoming), and *Medical Providers and Head Start: How You Can Help Improve Oral Health* (forthcoming) with health professionals.
- Present to dental and dental hygiene students at local dental schools and dental hygiene programs to raise their awareness of Head Start.
- Encourage oral health professionals to be aware of and address families’ COVID-19 and other health concerns and to reassure families in a supportive manner.
- Share information with Head Start staff about effective infection-control practices that dental offices and clinics should have in place. Share educational materials that explain it is safe to obtain care in dental offices and clinics.

State Organizations

- Form a state-focused partnership with a leader and representation from the public health community (e.g., state oral health program, state dental and dental hygiene societies, medical societies, state and/or local oral health coalitions) to encourage oral health professionals and pediatric medical professionals to provide oral health care to children in Head Start. Head Start centers can be identified using the [Head Start Center Locator](#).
- Share PIR oral health performance indicator data to make the case for providing care to children in Head Start. Encourage oral health professionals to partner with Head Start programs and if applicable, to use teledentistry to facilitate access to oral health care for children, especially those who live in underserved areas. Read NCHBHS’s brief, *Using Teledentistry to Provide Care for Children in Head Start Programs* (forthcoming).
- Form a state-focused partnership with a leader and representation from the public health community (e.g., state oral health program, state Medicaid program, state dental and dental hygiene societies, medical societies, state and/or local oral health coalitions) to perform an environmental scan of state health professional workforce providing oral health care and of Medicaid policies.
- Form a state-focused partnership with a leader and representation from the public oral health community (e.g., state dental and dental hygiene societies, state and/or local oral health coalitions) to review state practice acts to ascertain which oral health professionals can legally conduct an oral exam to determine whether the state dental practice act needs to be changed to improve access to care. If needed, work with the state dental board and state boards for dentistry and dental hygiene to change the state dental practice act to allow dental hygienists and mid-level oral health professionals (e.g., advanced dental hygiene practitioners, dental therapists) to conduct oral exams for children in Head Start.

Regional DHL Coordinators

- Review PIR oral health performance indicators for states to identify concerning trends in the indicators.
- Conduct presentation at regional meetings to increase Head Start regional health specialists' and Head Start program staff's awareness of concerning trends in PIR oral health performance indicators in region and states in region and of strategies for improvement.
- Encourage local dental schools and dental hygiene programs to have dental and dental hygiene students work with local Head Start programs (e.g., provide a virtual or in-person presentation during a parent meeting to share what happens during a dental visit).
- Present to dental and dental hygiene students at local dental schools and dental hygiene programs to raise their awareness of Head Start.

Regional Health Specialists

- Include oral health topics on agendas for NCHBHS-facilitated content implementation team meetings for health specialists. For example include a discussion of regional and state oral health data to identify emerging oral health trends impacting Head Start recipients and programs.

Federal Agencies and National Organizations

- Encourage the Bureau of Primary Health Care, the National Association of Community Health Centers, the National Association of Community Health Workers, and the National Network for Oral Health Access to urge all community health centers to offer oral health care provided by oral health professionals and primary care professionals.
- Encourage the American Dental Association, the American Academy of Pediatric Dentists, the American Dental Education Association, and the American Dental Hygienists' Association to have dental and dental hygiene students work with local Head Start programs (e.g., provide a virtual or in-person presentation during a parent meeting to share what happens during a dental visit).
- Conduct trainings at national conferences (e.g., Health and Mental Health Leaders Institute, National Head Start Association Conference, National Network for Oral Health Access, National Oral Health Conference) to increase health professional's awareness of concerning trends in PIR oral health performance indicators and of strategies for improvement.
- Incorporate advanced dental hygiene practitioners, dental therapists, and other mid-level oral health professionals into the U.S. Public Health Service Commissioned Corps to enhance the oral health workforce's ability to provide care to children in Migrant and Seasonal Head Start programs and American Indian and Alaska Native Head Start programs.

Appendix 1: Head Start Program Information Report Oral Health Performance Indicators for Program Years 2018, 2019, 2021, and 2022

Notes: Data for program year 2020 is not available because programs were not required to submit PIR data during that year owing to the pandemic. Performance indicators 132, 133, and 134 are not collected in Early Head Start programs.

Table Legend

114.1	Percentage of children with a dental home
132	Percentage of preschool children completing professional dental exams
133	Of the preschool children completing dental exams (132), the percentage of preschool children needing professional dental treatment
134	Of the preschool children needing professional dental treatment (133), the percentage of preschool children who received dental treatment

Early Head Start Programs

Performance Indicator	Program Year	Number	Percentage
114.1: Dental home	2018	175,092	78.0%
	2019	182,319	79.3%
	2021	157,228	75.4%
	2022	163,132	76.5%

Head Start Programs

Performance Indicator	Program Year	Number	Percentage
114.1: Established dental home	2018	728,993	92.2%
	2019	719,309	92.8%
	2021	455,868	87.9%
	2022	488,326	88.3%
132: Completed dental exam	2018	636,236	80.5%
	2019	618,122	79.7%
	2021	308,662	59.5%
	2022	371,292	67.2%
133: Needed dental treatment	2018	104,430	16.4%
	2019	98,754	16.0%
	2021	48,681	15.8%
	2022	56,619	15.2%
134: Received dental treatment	2018	75,127	71.9%
	2019	69,967	70.9%
	2021	30,672	63.0%
	2022	34,245	60.5%

American Indian/Alaskan Native Head Start Programs

Performance Indicator	Program Year	Number	Percentage
114.1: Established dental home	2018	16,401	85.53%
	2019	16,448	86.95%
	2021	9,946	79.5%
	2022	9,912	79.9%
132: Completed dental exam	2018	13,113	68.38%
	2019	13,905	75.51%
	2021	5,803	46.4%
	2022	7,872	63.5%
133: Needed dental treatment	2018	2,848	21.72%
	2019	2,578	18.54%
	2021	1,107	19.1%
	2022	1,853	23.5%
134: Received dental treatment	2018	1,942	68.19%
	2019	1,779	69.01%
	2021	706	63.8%
	2022	1,127	60.9%

Migrant and Seasonal Head Start Programs

Performance Indicator	Program Year	Number	Percentage
114.1: Established dental home	2018	22,409	92.2%
	2019	24,192	93.8%
	2021	15,519	90.1%
	2022	17,451	90.2%
132: Completed dental exam	2018	10,179	91.0%
	2019	10,836	89.1%
	2021	5,641	68.0%
	2022	7,184	81.0%
133: Needed dental treatment	2018	2,711	26.6%
	2019	2,654	24.5%
	2021	1,107	19.6%
	2022	1,513	21.1%
134: Received dental treatment	2018	2,215	81.7%
	2019	2,084	78.5%
	2021	773	69.8%
	2022	1,071	70.8%

Appendix 2: National Trends in Head Start PIR Oral Health Performance Indicators for Program Years 2018, 2019, 2021, and 2022

- 114.1 The percentage of children with a dental home decreased (concerning trend) for all programs.
- From 78% (2018) to 76.5% (2022) for children in Early Head Start programs [percentage difference 1.9%]
 - From 92.2 (2018) to 88.3% (2022) for children in Head Start programs [percentage difference 4.2%]
 - From 85.53% (2018) to 79.9% (2022) for children in American Indian/Alaska Native Head Start programs [percentage difference 6.5%]
 - From 92.2% (2018) to 90.2% (2022) for children in Migrant and Seasonal Head Start programs [percentage difference 2.1%]
- 132 The percentage of preschool children completing dental exams decreased (concerning trend) in Head Start programs and in Migrant and Seasonal Head Start programs. The percentage of preschool children completing dental exam remained roughly the same in American Indian/Alaska Native Head Start programs.
- From 80.5% (2018) to 67.2% (2022) for children in Head Start programs [percentage difference 16.5%]
 - From 63.38% (2018) to 63.5% (2022) for children in American Indian/Alaska Native Head Start programs [percentage difference 0.2%]
 - From 91.0% (2018) to 81.0% (2022) for children in Migrant and Seasonal Head Start programs [percentage difference 11%]
- 133 Of the preschool children receiving professional dental exams, the percentage of preschool children needing dental treatment decreased (favorable trend) in Head Start programs and in Migrant and Seasonal Head Start programs. However, the percentage increased (concerning trend) in American Indian/Alaska Native Head Start programs.
- From 16.4% (2018) to 15.2% (2022) for children in Head Start programs [percentage difference 7.3%]
 - From 21.72% (2018) to 23.5% (2022) for children in American Indian/Alaska Native Head Start programs [percentage difference 8.2%]
 - From 26.6% (2018) to 21.1% (2022) for children in Migrant and Seasonal Head Start programs [percentage difference 20.7%]
- 134 Of the preschool children needing dental treatment, the percentage of preschool children receiving needed dental treatment decreased (concerning trend) in Head Start programs, American Indian/Alaska Native Head Start programs, and in Migrant and Seasonal Head Start programs.
- From 71.9% (2018) to 60.5% (2022) for children in Head Start programs [percentage difference 15.9%]
 - From 68.19% (2018) to 60.9% (2022) for children in American Indian/Alaska Native Head Start programs [percentage difference 10.6%]
 - From 81.7% (2018) to 70.8% (2022) for children in Migrant and Seasonal Head Start programs [percentage difference 13.3%]

Appendix 3: Head Start Program Information Report Medical Performance Indicators for Program Years 2018, 2019, 2021, and 2022

Notes: PIR reports obtained from Head Start Enterprise System on October 6, 2022. Data for program year 2020 is not available because programs were not required to submit PIR data during that year owing to the pandemic.

Table Legend

113.1	Percentage of children with up-to-date immunizations, all possible immunizations to date, or exempt
122	Percentage of children up-to-date on a schedule for preventive and primary health care per the state's EPSDT schedule
123	Of children up-to-date on health screenings, the percentage of children diagnosed with a chronic condition need medical treatment
124	Of children diagnosed with a chronic condition needing medical treatment (123), the percentage of children who received medical treatment

Early Head Start Programs

Performance Indicator	Program Year	Number	Percentage
113.1: Immunizations up to date	2018	206,155	91.83%
	2019	211,737	92.08%
	2021	183,893	88.2%
	2022	189,960	89.1%
122: Preventive/primary care up to date	2018	163,408	72.79%
	2019	167,045	72.64%
	2021	121,677	58.3%
	2022	129,632	60.8%
123: Chronic condition needing medical treatment	2018	12,502	7.65%
	2019	12,396	7.42%
	2021	10,756	8.8%
	2022	12,585	9.7%
124: Chronic condition received medical treatment	2018	11,453	91.61%
	2019	11,591	93.51%
	2021	7,858	73.1%
	2022	9,288	73.8%

Head Start Programs

Performance Indicator	Program Year	Number	Percentage
113.1: Immunizations up to date	2018	764,335	96.74%
	2019	750,340	96.77%
	2021	485,618	93.6%
	2022	523,419	94.7%
122: Preventive/primary care up to date	2018	667,242	84.45%
	2019	650,458	83.89%
	2021	356,131	68.7%
	2022	403,332	73%
123: Chronic condition needing treatment	2018	66,579	9.98%
	2019	63,160	9.71%
	2021	42,144	11.8%
	2022	49,425	12.3%
124: Chronic condition received medical treatment	2018	60,963	91.56%
	2019	58,152	92.71%
	2021	31,654	75.1%
	2022	37,611	76.1%

American Indian/Alaskan Native Head Start Programs

Performance Indicator	Program Year	Number	Percentage
113.1: Immunizations up to date	2018	17,311	90.27
	2019	16,455	86.0%
	2021	10,585	84.6%
	2022	10,870	87.7%
122: Preventive/primary care up to date	2018	13,903	72.5%
	2019	14,265	75.41%
	2021	6,552	52.4%
	2022	7,554	60.9%
123: Chronic condition needing treatment	2018	1,022	7.35%
	2019	801	5.62
	2021	488	7.4%
	2022	584	7.7%

124: Chronic condition received medical treatment	2018	788	77.1%
	2019	736	91.89
	2021	376	77.0%
	2022	477	81.7%

Migrant and Seasonal Head Start Programs

Performance Indicator	Program Year	Number	Percentage
113.1: Immunizations up to date	2018	23,577	97.06%
	2019	25,072	97.17%
	2021	16,103	93.5%
	2022	17,842	92.2%
122: Preventive/primary care up to date	2018	21,735	89.47%
	2019	23,021	89.22%
	2021	12,974	75.3%
	2022	15,678	81.1%
123: Chronic condition needing treatment	2018	2,171	9.99%
	2019	2,011	8.74%
	2021	1,358	10.5%
	2022	1,347	8.6%
124: Chronic condition received medical treatment	2018	2,080	95.81%
	2019	1,896	94.28%
	2021	1,037	76.4%
	2022	1,048	77.8%

Appendix 4: National Trends in Head Start PIR Medical Performance Indicators for Program Years 2018, 2019, 2021, and 2022

- 113.1 The percentage of children with up-to-date immunizations, all possible immunizations to date, or exempt (only one measured for children in Early Head Start programs) decreased (concerning trend) for all programs.
- From 91.8% (2018) to 89.1% (2022) for children in Early Head Start programs [percentage difference 2.9%]
 - From 96.7% (2018) to 94.7% (2022) for children in Head Start programs [percentage difference 2.1%]
 - From 90.27% (2018) to 87.7% (2022) for children in American Indian/Alaskan Native Head Start programs [percentage difference 3.6%]
 - From 97.0% (2018) to 92.2% (2022) for children in Migrant and Seasonal Head Start programs [percentage difference 4.9%]
- 122 The percentage of children up to date on a schedule for preventive and primary health care per the state’s EPSDT schedule at the end of the enrollment year decreased (concerning trend) for all programs.
- From 72.7% (2018) to 60.8% (2022) for children in Early Head Start programs [percentage difference 16.4%]
 - From 84.4% (2018) to 73.0% (2022) for children in Head Start programs [percentage difference 13.5%]
 - From 72.5% (2018) to 60.9% (2022) for children in American Indian/Alaskan Native Head Start programs [percentage difference 16%]
 - From 89.4% (2018) to 81.1% (2022) for children in Migrant and Seasonal Head Start programs [percentage difference 9.3%]
- 123 Of children up to date on health screenings, the percentage of children diagnosed with a chronic condition needing medical treatment increased for children in Early Head Start programs, in Head Start programs, and in American Indian/Alaskan Native Head Start programs (concerning trend) and decreased (favorable trend) for children in Migrant and Seasonal Head Start programs.
- From 7.65% (2018) to 9.7% (2022) for children in Early Head Start programs [percentage difference 26.8%]
 - From 9.98% (2018) to 12.3% (2022) for children in Head Start programs [percentage difference 23.2%]
 - From 7.35% (2018) to 7.7% (2022) for children in American Indian/Alaskan Native Head Start programs [percentage difference 4.7%]
 - From 9.99% (2018) to 8.6% (2022) for children in Migrant and Seasonal Head Start programs [percentage difference 13.9%]
- 124 Of children diagnosed with a chronic condition needing medical treatment, the percentage of children who received medical treatment increased (favorable trend) for children in Early Head Start programs and in American Indian/Alaskan Native Head Start programs, and decreased (concerning trend) for children in Head Start programs and in Migrant and Seasonal Head Start programs.
- From 72.7% (2018) to 73.8% (2022) for children in Early Head Start programs [percentage difference 1.5%]

- From 91.5% (2018) to 76.1% (2022) for children in Head Start programs [percentage difference 16.8]
- From 77.1% (2018) to 81.7% (2022) for children in American Indian/Alaskan Native Head Start programs [percentage difference 5.9%]
- From 95.8% (2018) to 77.8% (2022) for children in Migrant and Seasonal Head Start programs [percentage difference 18.8%]