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Office of Planning, Research and Evaluation

Administration for Children and Families

A Guide to Emerging Strategies for Promoting Prevention and Improving Oral Health Care Delivery in Head Start: Lessons from the Oral Health Initiative Evaluation

Contract No.: 233-02-0086
MPR Reference No.: 6247-700

A Guide to Emerging Strategies for Promoting Prevention and Improving Oral Health Care Delivery in Head Start: Lessons from the Oral Health Initiative Evaluation

Final Report Volume II

June 25, 2008

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CHAPTER I

INTRODUCTION

Dental caries is the most common chronic disease among children, with low-income children and ethnic minority children bearing a disproportionate burden of the disease (U.S. DHHS 2000, 2003). Studies show that children living in poverty suffer twice as many dental caries as their higher-income peers (U.S. DHHS 2000, 2003). Since the publication of *Oral Health in America: A Report of the Surgeon General* (2000) and its companion document, *A National Call to Action to Promote Oral Health* (2003), increased national attention has focused on the unmet oral health needs of many of the nation's children and families. This crisis was further brought to light by the deaths of two young children in 2007 from complications related to untreated oral health needs (Berenson 2007).

In addition to the high prevalence of caries, low-income children face barriers to accessing dental care. Data from the National Health and Nutrition Examination Survey indicate that from 2001 to 2004, low-income children and adults were more likely than their higher-income peers to have untreated dental caries (Centers for Disease Control and Prevention 2007). Commonly cited factors contributing to these unmet needs in dental care are cost of care; lack of insurance coverage; lack of understanding about the need for oral health care for young children; and an overall inadequate supply of dentists, including dentists willing to treat Medicaid-eligible children (Mouradian et al. 2000).

Promoting oral health is an important concern for the Office of Head Start, since many of the risk factors for dental caries—children from racial and ethnic minority families and low-income families are disproportionately affected by caries—characterize the Head Start population.[1] The Head Start Program Performance Standards require that a health care professional determine within 90 days of enrollment whether children are up to date on a schedule of age-appropriate preventive dental care. Dental followup must include necessary preventive measures and further dental treatments as recommended by the dental professional. Many Head Start grantees, however, face challenges in meeting these requirements because of barriers to accessing oral health services faced by many Head Start families.

To address issues of access to care and difficulties achieving full compliance with Head Start Program Performance Standards in the area of oral health, the Office of Head Start invested $2

[1] Throughout this report, references to Head Start programs and families include Head Start, Early Head Start, and Migrant/Seasonal Head Start programs and families unless otherwise noted.

million in grants to 52 Head Start, Early Head Start, and Migrant/Seasonal Head Start programs to implement the Head Start Oral Heath Initiative (OHI) in 2006. The OHI grantees receive supplemental funding over a four-year period to develop, implement, and disseminate culturally sensitive, innovative, and empirically based best practice oral health models that meet the needs of the communities and populations they serve.

To ensure consistent, systematic collection and analysis of information on OHI's implementation, the Office of Head Start contracted with Mathematica Policy Research, Inc. (MPR) and Altarum to conduct a two-year evaluation of OHI. The evaluation focused on documenting implementation strategies and challenges, and identifying service delivery strategies that showed promise for replication. Data sources for the evaluation included (1) telephone interviews with program directors and other key staff from all 52 OHI grantees; (2) administrative records on the characteristics of the children, families, and pregnant women enrolled in OHI and the oral health services they received; and (3) site visits to a subset of 16 grantees.

One of the goals of the evaluation, and the focus of this volume, is to highlight service delivery approaches and strategies that show promise for improving the oral health care delivery system and for promoting oral health care prevention.[2] To make the report as useful as possible for practitioners seeking to replicate these practices, this volume includes descriptions of each of the strategies and provides examples of how grantees implemented the practices in different program settings and with different target populations. This analysis is based primarily on data collected during site visits.

MPR and Altarum identified nine approaches that were key to OHI implementation among the 16 grantees that participated in site visits:

1. Adopt staffing structures that support the delivery of oral health services.

2. Train staff to achieve staff buy-in regarding the importance of oral health and to enable staff members to carry out oral health education with children and families.

3. Recruit dental providers to serve Head Start families.

4. Implement case management procedures to increase rates of preventive care and needed treatment children receive.

5. Provide preventive care to children on site, at special events, or through referrals.

6. Offer support services to families to help them make and keep dental appointments.

7. Educate parents about the importance of oral health.

8. Educate children about how to care for their teeth and what to expect during dental services.

[2] Volume I of this report includes a cross-site discussion of the community context for OHI, the demographic characteristics of participating Head Start children and families that were enrolled in the record-keeping system; the service delivery strategies developed by the grantees; the oral health services and education provided; grantees' plans for sustainability; and their successes, challenges, and lessons learned.

9. Integrate oral health–related activities and services into existing management systems.

For each approach, the research team identified a range of strategies that show promise for improving the oral health care delivery system and for promoting oral health care prevention. A summary of the strategies identified within each approach is included in Table I.1. Chapter II describes the methodology the research team used to identify the strategies. Chapters III through XI of this volume include detailed descriptions of each strategy, including the context in which it was implemented and the issues program staff should consider prior to implementing it.

The strategies included in this volume are labeled "emerging" because the design of the OHI evaluation did not include rigorous tests of the effectiveness of these strategies. Moreover, because the strategies were developed by grantees to respond to the specific strengths and needs of their communities, they may not be appropriate for all Head Start programs. Nevertheless, analysis of descriptive information about levels of enrollment and service receipt and program operations (as described in Chapter II of this volume) indicates that these strategies show promise for helping Head Start programs promote oral health among the families and children they serve.

Table I.1. Emerging Implementation Approaches and Strategies

Hire staff to support the delivery of oral health services
1. Hire a dental hygienist who can provide on-site dental services 2. Hire someone with a background in oral health to oversee oral health activities 3. Hire someone familiar with the language and culture of the community who is able to communicate effectively with families 4. Contract with one or more dental hygienists to provide on-site services
Train staff to achieve staff buy-in regarding the importance of oral health and to enable staff members to carry out oral health education with children and families
1. Train teachers and other direct service staff on materials and curricula to facilitate lessons on oral health 2. Train all agency staff on oral health–related topics during preservice training 3. Conduct ongoing in-service training for teachers, home visitors, and family services workers on oral health education
Recruit dental providers to serve Head Start families
1. Join oral health stakeholder groups to familiarize providers with Head Start 2. Work with a key stakeholder in the community to engage dental providers 3. Provide training opportunities for health care professionals and other potential partners 4. Work with local college and university departments to familiarize professionals with Head Start 5. Individualize Head Start tracking systems to meet the needs of dental providers
Implement case management procedures to increase rates of preventive care and needed treatment children receive
1. Report results of dental screenings to parents and direct service staff to encourage followup 2. Update risk-assessment and dental screening results throughout the year to track receipt of dental services 3. Assign an oral health coordinator (or other designated staff person) to follow up with families that are unresponsive to requests by direct service staff
Provide preventive care to children on site, at special events, or through referrals
1. Provide preventive care on site, conducted by a community partner or dental hygienist 2. Offer dental fairs and/or clinics at which Head Start families and children can receive preventive care 3. Team with local medical providers (pediatricians, family practice doctors, nurses, nurse practitioners) to provide oral health screenings and/or fluoride treatments during doctor visits 4. Establish partnerships with local dental providers willing to accept referrals of Head Start children and pregnant women
Offer support services to families to help them make and keep dental appointments
1. Transport families to appointments or arrange transportation 2. Send reminder notices/make reminder phone calls to families about upcoming appointments 3. Make appointments for families or help families make appointments 4. Assist families in covering the costs of needed dental care
Educate parents about the importance of oral health
1. Provide education for parents during on-site dental services or during dental appointments 2. Offer parent meetings or workshops focused on oral health

3. Include information on oral health at all parent meetings
4. Offer incentives to parents who attend parent meetings and workshops
5. Reinforce education conducted during parent meetings, workshops, and appointment with informational materials that are sent home to parents
6. Tailor educational materials to parents' reading levels and primary languages

Educate children about how to care for their teeth and what to expect during dental services

1. Have dental hygienists, dentists, or other oral health specialists conduct oral health education with children
2. Provide education during on-site services and at dental appointments
3. Integrate an oral health curriculum into daily or weekly lessons
4. Conduct oral health education with children prior to dental services to familiarize them with dental services

Integrate oral health–related activities and services into existing management systems

1. Implement program policies and procedures on oral health components (screenings and exams, education, toothbrushing, fluoride varnish)
2. Integrate monitoring of oral health policies into agency-wide monitoring

CHAPTER II

METHODOLOGY

As described in Chapter I, a main goal of the OHI evaluation was to identify service delivery approaches and strategies that showed promise for promoting oral health prevention principles among Head Start families. To achieve this goal, MPR and Altarum analyzed a full year of program record-keeping system data and data collected during site visits to 16 grantees. The data were then used to systematically identify approaches and strategies used by the 16 grantees that participated in the site visits that showed promise for replication. The methodology used by the research team is described in this chapter.

As discussed in Volume I, the 52 OHI grantees were diverse in terms of their community contexts, populations served, and oral health promotion strategies. This diversity posed a significant challenge for the implementation evaluation. To address this challenge and to ensure a systematic and objective analysis of the data collected, the research team used the RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) analytic model as an organizing framework and, ultimately, to identify 16 grantees to participate in the site visits (Glasgow et al. 1999; Dzewaltowok et al. 2006). The research team used the RE-AIM framework to facilitate a systematic analysis of each OHI grantee's early performance by employing a set of consistent measures to assess performance on each of the five RE-AIM dimensions.

To apply the RE-AIM framework to the OHI evaluation, the research team (1) developed measures within each of the five RE-AIM dimensions, (2) collected the necessary data for each measure using information obtained during the telephone interviews and from the record-keeping system, (3) conducted the analysis using the RE-AIM framework, and (4) examined the results for specific subgroups. Using the results of the analysis, the research team, in consultation with the Administration for Children and Families (ACF), selected a subset of 16 grantees for in-depth site visits. The selection included a mix of both high- and lower-ranking grantees. In addition, the grantees selected represented the various contexts in which OHI was implemented. The 16 grantees were geographically diverse; they included 10 of the 12 ACF regions and 15 states. Most described their service areas as primarily rural and most served less than 600 children annually. They included Head Start, Early Head Start, and Migrant/Seasonal Head Start programs, with programs providing Head Start services only as the most common. Grantees provided a mix of home-based and center-

based services. Detailed information about the methodology used for selecting the 16 grantees for participation in the site visits is described in Volume I, Appendix C.

To identify emerging strategies, the research team used a three-step process that involved (1) identifying implementation approaches and strategies, (2) assembling information about grantee's use of the approaches and strategies, and (3) using site visit and record-keeping system data to assess the strategies. Figure II.1 illustrates this process.

Identifying Implementation Approaches and Strategies. The first step in analyzing the site visit data was to identify implementation approaches and the strategies associated with the various approaches. For example, we identified parent education as a common approach used by grantees. However, the strategies used by each grantee to educate parents varied. For example, OHI grantees sent written materials home with children, and provided information at enrollment, during parent meetings and workshops, home visits, and visits to the dentist. Table I.1 in Chapter I provides a comprehensive list of the approaches and strategies identified through the evaluation.

Assembling Information about Grantees' Use of the Approaches and Strategies. After identifying these approaches and strategies, the research team assembled information from all data sources about grantees' use of them. First, researchers systematically coded the site visit reports to identify which of the 16 grantees were using the approaches and strategies. Second, researchers used strategies present in the record-keeping system to constructed relevant variables to quantify use of the strategies, such as the number of months parent education was provided and other measures of service receipt and intensity.

Using Site Visit and Record-Keeping System Data to Assess the Strategies. Next, the team identified the number of grantees using each of the identified approaches and strategies and compared the use of each strategy across high- and low-ranking sites to determine which strategies could be deemed "emerging." A set of consistent rules were applied during this step (Figure II.1). If only high-ranking grantees used an identified strategy and the available quantitative data suggested the strategy worked, the research team identified the strategy as emerging (see Table II.1 for an example). If no high-ranking grantees used an identified strategy and the available quantitative data did not suggest that the strategy showed promise, the team did not identify it as emerging. In all cases, the research team further assessed the strategies by determining if qualitative and quantitative data agreed. If they did not, researchers attempted to determine the reason and then selected the data source that more reasonably reflected the strategy. For example, the research team used the quantitative data on the percentage of services that included specific types of support services to determine if offering a support service increased the rate of service receipt. However, for some support strategies, such as sending reminder notices and helping families cover the costs of care, appropriate measures did not exist in the quantitative data. As a result, the research team relied decided instead to rely on the qualitative data to triangulate these strategies.

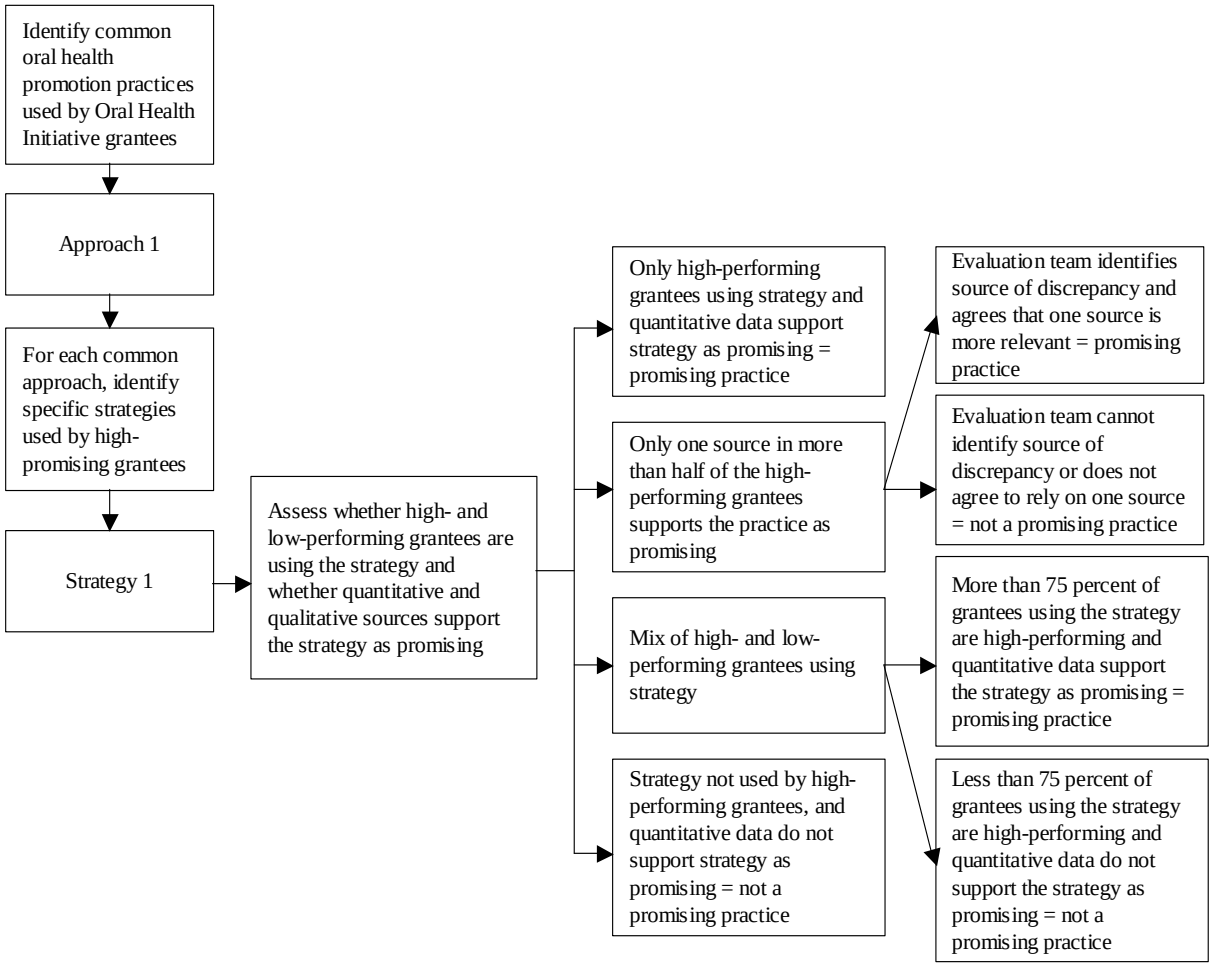
Most strategies, however, were used by both high- and low-ranking grantees. In these cases, the research team considered the ratio of high- to low-ranking sites using a strategy. If more than 75 percent of the grantees using the strategy were classified as high ranking and

the quantitative data suggested the strategy showed promise, the team identified the strategy as emerging. The team used 75 percent as the threshold because it aligned with the ratio of high- and low-ranking sites (12 to 4, respectively) selected for site visits. If more than 75 percent of the grantees using the strategy were classified as high-ranking but the quantitative data did not suggest that the strategy showed promise, the research team used qualitative data from the site visits to identify a reason for the discrepancy. When a reason could be identified, the research team used this information to assess if the strategy showed promise. If fewer than 75 percent of the grantees using the strategy were classified as high-ranking and the quantitative data did not suggest the strategy showed promise, the team did not consider the strategy as emerging. If the quantitative data did suggest the strategy showed promise, the research team used the qualitative data from the site visits to identify a reason for the discrepancy.

Table II.1. Process for Identifying Emerging Strategies When Strategy Is Used by Both High- and Low-Ranking Grantees

Approach	Implementation Strategy		
	A	B	C
Number of Grantees Using Approach	6	5	7
Number of High-Ranking Grantees Using Approach	4	2	3
Number of Low-Ranking Grantees Using Approach	2	3	4
Differences in Implementation			Strategy C used in combination with strategy A by high-ranking grantees
Relevant Record-Keeping System Data	Confirms strategy shows promise	Does not confirm strategy shows promise	Confirms strategy shows promise
Relevant Information from Site Visit Reports	Record-keeping system and site visit data consistent	Record-keeping system and site visit data consistent	Record-keeping system and site visit data consistent
Emerging Practice Assessment	Emerging	Not emerging	Emerging, when used in combination with another strategy
Rationale	All data suggest strategy shows promise	No data support the strategy as emerging	Data suggest combination works well but not sufficient alone

Figure II.1 Identifying Emerging Strategies



CHAPTER III

HIRING STAFF

As described in Volume I of this report, the OHI grantees used two main staffing approaches for OHI: (1) rely on existing staff or (2) create a new staff position using OHI funds. More than half of the grantees (58 percent) reported creating new staff positions; 42 percent relied on existing staff. The grantees that relied on existing staff most commonly reported that the program's health coordinator or other health-related staff oversaw the initiative and carried out oral health–related activities and services. Grantees that created a new staff position stressed the importance of identifying appropriate individuals to fill the position. Most of these grantees hired someone with clinical dental experience or someone with a background in oral health. Despite any differences in main staffing approach, all grantees described existing staff as playing critical roles in activities associated with oral health.

Hiring staff based on the experiences of grantees, the research team reported four strategies for identifying and hiring appropriate staff to carry out oral health activities: (1) hire or contract with a dental hygienist who can provide on-site dental services, (2) hire someone with a background in oral health to oversee oral health activities, (3) hire someone familiar with the language and culture of the community who is able to communicate effectively with families, and (4) contract with one or more dental hygienists to provide on-site services. The remainder of this chapter contains detailed information about each strategy.

Strategy III.1. Hire a Dental Hygienist Who Can Provide On-site Dental Services.

Description	Adding a dental hygienist to the Head Start staff reportedly increased grantees' capacities to provide on-site preventive care for children and their families and for pregnant women. Grantees that used this strategy reported that dental hygienists oversaw activities related to oral health, conducted oral health screenings and fluoride varnishes, and brought extensive background knowledge about oral health to education initiatives. In addition, dental hygienists often had contacts with dental professionals whom they were able to engage to serve Head Start children and families. Grantees that added dental hygienists sought candidates with specific skills and characteristics (Strategies III.2 and III.3). For example, grantees that served large Spanish-speaking populations recruited bilingual dental hygienists. Grantees also described identifying dental hygienists with experience serving young children.	
Examples from the Field	At one grantee, a dental hygienist was hired as the project's oral health specialist in order to decrease the program's dependency on hygienists from the community and to enable the grantee to offer more preventive services. The oral health specialist's responsibilities included maintaining the grantee's tracking system on oral health services, conducting oral health screenings and fluoride varnishes, and leading education and outreach activities. In addition, she worked with families to help them establish dental homes.	
Considerations	Staff Level of Effort:	Grantees explained that salary scales for dental hygienists were typically beyond what they were able to offer. As a result, some grantees reported hiring dental hygienists for less than full time; others chose to contract with one or more dental hygienists instead (Strategy III.4).
	Program Characteristics:	Both large (annual enrollment over 600) and small (annual enrollment under 600) grantees recruited dental hygienists. However, in larger programs, the capacity of one hygienist to provide on-site services throughout the service area had the potential to hinder implementation; larger grantees often benefited from having more than one hygienist available to provide services. There were no differences in implementation by grantee location or program type.
	Target Population:	Grantees reported trying to identify dental hygienists with experience working with low-income and racially, ethnically, and linguistically diverse families.

Other:	Understanding state rules and regulations regarding the services dental hygienists are authorized to provide or be reimbursed for is necessary prior to hiring a hygienist as an OHI staff member. State rules regarding direct reimbursement by Medicaid for services provided by dental hygienists vary. In states that do not permit direct reimbursement, dental hygienists were limited in their ability to provide preventive care. Even in those states that allow direct reimbursement, grantees reported challenges associated with becoming a Medicaid provider and receiving reimbursement. In addition, state-specific rules exist on the functions that dental hygienists are able to perform, which type of permit they are required to have, and the required level of supervision by a dentist. As a result of these obstacles, some grantees chose to contract with one or more dental hygienists as opposed to hiring one (see Strategy III.4).

Strategy III.2. Hire Someone With a Background in Oral Health to Oversee Oral Health Activities

Description	Rather than hiring staff with clinical dental experience, some grantees hired staff with knowledge of oral health, such as a former dental assistant or a public health educator. Grantees that used this approach often relied on community partners to provide clinical services, such as fluoride varnishes and oral health screenings. Nonclinical staff hired through OHI were responsible for coordinating on-site preventive services; conducting followup with families regarding their children's oral health; selecting or designing educational components for children, parents, and pregnant women; training Head Start staff; and recruiting dental providers as community partners. Grantees that used this strategy reported that they chose to hire nonclinical staff because the grant funds were not sufficient to support a clinical staff person, such as a dental hygienist, whose salary was more than the program could afford. Others used this staffing approach because they already had access to dental hygienists through a community partnership; they chose to add staff to focus on nonclinical components of oral health promotion.	
Examples from the Field	One grantee hired a former dental assistant to serve as its full-time oral health coordinator. Her Work as a dental assistant had given her background knowledge of oral health care that she applied to her work implementing oral health education for parents, children, and staff. In addition, she contacted dental providers she worked with in the past to encourage them to accept Head Start children and families as patients.	
Considerations	Staff Level of Effort:	Nearly all grantees that hired nonclinical staff hired them as full-time employees.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Grantees reported identifying potential staff with knowledge of oral health and experience working with low-income families.

Strategy III.3.	**Hire Someone Familiar With the Language and Culture of the Community Who is Able to Communicate Effectively With Families**	
Description	Grantees that hired both clinical and nonclinical staff for OHI reported that they prioritized hiring staff members who were familiar with the language and culture of the community and were able to communicate effectively with families. Grantees that served families with a home language other than English often hired bilingual staff. Those that served large immigrant populations hired bicultural staff or staff who had experience working with families of another culture. In addition, grantees that served many teenage parents through Early Head Start often looked for staff with experience working with this population. Although all grantees that hired new staff prioritized recruiting job candidates with these characteristics, grantees that hired clinical staff found it more challenging to identify staff with both a clinical background and familiarity with the language and culture of the community.	
Examples from the Field	One grantee hired a former home visitor and classroom assistant from the Head Start agency to serve as its oral health coordinator. She coordinated oral health services and provided education and training to staff, parents, and children. This person was familiar with many of the families served by the program through her previous positions at the agency. In addition, she was bilingual, which equipped her to communicate with the largely Spanish-speaking population served by the grantee.	
Considerations	Staff Level of Effort:	As previously described, grantees that hired clinical staff often hired them for less than full time (see Strategy III.1); grantees that hired nonclinical staff frequently hired them as full-time employees (see Strategy III.2).
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Grantees reported identifying potential staff familiar with the language and culture of the families they served.

Strategy III.4. Contract with one or more dental hygienists to provide on-site services.

Description	As described in Strategy III.1, some grantees that planned to hire clinical staff for OHI, usually as dental hygienists, faced challenges because salary scales for hygienists often exceeded what they were able to offer. Other grantees faced challenges meeting state requirements for dental hygienists regarding supervision and Medicaid reimbursement. As a result, some chose to contract with one or more dental hygienists rather than hiring a staff hygienist. Many grantees using this strategy reported that it worked well, but some explained that contracted dental hygienists worked more limited hours than did a hygienist on staff because they often worked part time in a private dental practice or with another organization. Even though contracted dental hygienists were often available to provide preventive services, they were typically not utilized to provide training to staff, parents, and children; support services to families; and other OHI-related activities.	
Examples from the Field	One grantee contracted with a dental hygienist to work three days a week on OHI. The program had planned to hire a full-time dental hygienist at the time the grant was submitted. However, the program was not able to attract a full-time hygienist at the rate it was able to pay. Instead of hiring a full-time staff member with benefits, the program decided to use that money to contract for a part-time hygienist who worked three days a week. According to the grantee director, three days a week were not enough to do all of the tasks intended for this position, so the health coordinator spent about one day a week on paperwork and other administrative support for the hygienist.	
Considerations	Staff Level of Effort:	Contract dental hygienists typically worked less than full time.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Grantees reported trying to identify dental hygienists with skills and characteristics applicable to the families they served.

CHAPTER IV

STAFF TRAINING

As described in Volume I of this report, most grantees provided some staff training on oral health. According to program record-keeping system data, 79 percent of grantees provided training for staff during at least one month between February 2007 and January 2008. Most grantees conducted training events for a broad range of staff—especially direct service staff, including teachers, family support workers, and home visitors. Trainings were conducted by internal staff such as health, oral health, and education coordinators, as well as by local dental providers. Grantees trained their staff members to increase their capacity to deliver oral health education to children and families by educating them on oral health topics and by implementing and training staff to use oral health curricula. In addition, training was designed to encourage staff to follow up with families regarding dental care for their children by teaching staff the importance of oral health to overall health. They also trained staff to promote sustainability of the models they implemented by integrating oral health into all program activities.

Within this approach, the research team identified three strategies that showed promise for replication: (1) train teachers and other direct service staff on materials and curricula to facilitate lessons on oral health (this strategy emerged as promising when supported by training), (2) train all agency staff on oral health–related topics, and (3) conduct ongoing in-service training for teachers, home visitors, and family services workers on oral health education.

Strategy IV.1. Train Teachers and Other Direct Service Staff On Materials and Curricula to Facilitate Lessons on Oral Health

Description	Grantees reported distributing materials and curricula for teachers, home visitors, and family service workers to be incorporated into classroom lessons and home visits. The lessons were drawn either from one curriculum such as "Cavity Free Kids" or "Bright Smiles, Bright Futures" or from a variety of resources, including multiple curricula and online resources. Grantees that implemented this strategy described creating lesson packets with the information direct service staff needed to conduct the lesson. Some grantees also included in the packets any materials or props staff would need to carry out the lesson. Grantees also reported tailoring materials and curricula to be culturally and linguistically appropriate for the children and families served by the program (see Strategy IX.6). This strategy was implemented by grantees as a means of reducing the amount of time required of teachers, home visitors, and family service workers to plan and implement oral health lessons. This strategy emerged as promising when supported by training. Grantees trained staff on the oral health lessons, sometimes during preservice training (see Strategy IV.2) or while conducting in-service training for staff (see Strategy IV.3).	
Examples from the Field	One grantee implemented a combination of oral health curricula including Healthy Teeth for Mom and Me (a curriculum developed by Colgate) and Integrating Oral Health Measures into Health Care Practices (designed by the Wisconsin Division of Public Health, Oral Health Program). To facilitate the implementation of these curricula, the grantee trained classroom teachers and provided educational binders for each classroom. The binders included curriculum materials, classroom activities, puppets, and other props required to carry out each lesson.	
Considerations	Staff Level of Effort:	Staff time was required to compile the curricula and materials for direct service staff. The amount of staff effort required varied by program and depended on whether the grantee used existing curricula or selected new curricula and materials. The oral health coordinator or health specialist was responsible for carrying out the distribution of materials for grantees that used this strategy.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	The target population consisted of direct service staff, such as teachers, family service workers, and home visitors, who have direct contact with Head Start children and families.

Strategy IV.2.	**Train All Agency Staff on Oral Health–Related Topics During Preservice Training**	
Description	Grantees reported the importance of training all agency staff on oral health–related topics to ensure that oral health knowledge was uniform across staff and that inaccurate information was not passed to parents and children. This all-staff training was often conducted during preservice training. In addition to general oral health trainings, many grantees conducted ongoing in-service trainings with direct service staff (see Strategy IV.3). Preservice trainings for all staff were designed to raise awareness about oral health. Trainings often covered basic oral hygiene, recommended nutritional practices for promoting oral health, and presented more technical aspects of oral health (e.g., transmissible disease caused by bacteria). Grantees stressed the importance of including all staff in training (including, for example, kitchen staff and bus drivers) because these individuals also need to reinforce the same messages about oral health practices if approached by a parent or child. Oral health coordinators conducted trainings along with dental hygienists and other dental providers in the community.	
Examples from the Field	One grantee conducted an annual pre-service training with all staff including teachers, family service workers, bus drivers, kitchen staff, and others. During the training, the grantee's health coordinator trained staff on the impact of oral health on overall physical health and updated Head Start staff on new guidelines and policies (such as the American Academy of Pediatrics' recommendation that children receive a dental visit by age 1 and Head Start Program Performance Standards on oral health). In addition, teachers and family service workers received training on the grantee's oral health curriculum and how to talk to parents about oral health care.	
Considerations	Staff Level of Effort:	Most staff trainings were held once a year and lasted one hour. Staff time was required to plan the trainings. Since preservice trainings were regularly scheduled events, grantees reported that no additional time was required of all agency staff.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	All agency staff members were targeted.

Strategy IV.3. Conduct Ongoing In-service Training for Teachers, Home Visitors, and Family Services Workers on Oral Health Education

Description	Grantees reported conducting ongoing in-service trainings on oral health with teachers, home visitors, and family service workers. Ongoing training was often informal or was incorporated into staff weekly or monthly meetings. Direct service staff received ongoing training pertaining to the dental curricula used in classrooms, the appropriate way to speak with parents about the importance of oral health care, visual inspections for children, proper techniques for brushing, and nutrition for healthy teeth and gums for both parents and children. Some staff members reported receiving state-certified training to perform fluoride applications and to use xylitol gum. Oral health coordinators conducted trainings along with dental hygienists (both on staff and community partner hygienists) and other dental providers in the community.	
Examples from the Field	One grantee offered a series of trainings for teachers, family service workers, and home visitors on oral health: • In spring 2006, the health specialist, oral health specialist, and state oral health staff provided training for all agency staff on an oral health curriculum. In follow-up sessions, the oral health specialist met with the teachers to discuss lesson plans and how to talk to parents about oral health. • In fall 2006, the family service workers, home visitors, and teachers were trained on the clinical aspects of oral health and disease, including caries. • In winter 2007, a more in-depth and hands-on training was provided with the teachers and their supervisors to help implement classroom activities. Each teacher got a copy of an oral health anthology and lesson plans, and time was spent on sharing strategies and creative ways to teach the lessons.	
Considerations	Staff Level of Effort:	Grantees that implemented this strategy reported conducting training one to two times per month. Staff time was required to plan the training topics and to present the information. This was typically carried out by the health, education, or oral health coordinator. Staff at grantees with an annual enrollment of more than 200 children typically required more time and effort to conduct trainings, especially if only one staff member was responsible for the trainings.

Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
Target Population:	The target population included direct service staff, such as teachers, family service workers, and home visitors with direct contact with Head Start children and families.
Other:	Trainings were tailored for specific groups, such as staff who work with migrant or Spanish-speaking populations.

CHAPTER V

RECRUITING DENTAL PROVIDERS

As described in Volume I, nearly all of the OHI grantees reported a shortage of dental providers in their communities, especially providers willing to accept public insurance plans and to serve young children. To address this barrier to care, all OHI grantees partnered with dental providers, including general dentists, pediatric dentists, dental hygienists, and public health clinics, to increase access to dental care for Head Start families. These partners provided more than half of the services children and pregnant women enrolled in OHI and recorded in the record-keeping system received during the evaluation. The OHI grantees described the partnerships they formed as instrumental to their ability to carry out the services and activities they offered through OHI and key to their plans for sustainability of the models they developed. Recruiting and retaining these partners, however, required dedicated staff time to identify providers, encourage them to serve Head Start families, and maintain relationships with them once partnerships were formed.

Emerging strategies for recruiting dental providers include the following: (1) join oral health stakeholder groups to familiarize providers with Head Start, (2) identify a key stakeholder in the community to engage dental providers, (3) provide training opportunities for health care professionals and other potential partners, (4) work with local college and university departments to familiarize professionals with Head Start, and (5) implement procedures to reduce the burden of serving Head Start families by developing tracking systems and reducing the number of missed appointments among families.

Strategy V.1.	**Join Oral Health Stakeholder Groups to Familiarize Providers With Head Start**	
Description	To familiarize providers with Head Start, grantee staff joined and made presentations to local oral health stakeholder groups, such as state or local oral health coalitions, community public health forums, and dental provider association meetings. Grantees reported that members of oral health stakeholder groups were often unaware of the oral health needs of Head Start families or unsure about how they could help. At meetings, grantee staff provided education on the challenges of serving low-income and less-educated populations, such as the limited numbers of dental providers willing to serve low-income families, the potential difficulties finding transportation for appointments, and concern over the effectiveness of written materials for a population with low literacy levels. Grantees also informed the stakeholder groups about the specific needs of the families they served. For example, grantees that served families that spoke a home language other than English stressed the need for providers to offer interpreters at appointments. Other grantees described the challenges of meeting the oral health needs of families that lacked dental insurance. Grantees reported informing these groups about the importance of oral health to encourage them to address these issues in their communities by engaging local providers, organizing dental clinics, or conducting public health campaigns. Grantees also used their membership in these groups as an opportunity to recruit dental providers to serve Head Start families.	
Examples from the Field	One grantee partnered with their state's oral health coalition. The grantee hosted an annual Oral Health Summit which was designed to increase community engagement in the issues of oral health for low-income families. The Summit brought together community stakeholders including the state department of health, dental hygienists, dentists, state primary care association, state dental association, state pediatric dental association, a dental school at a state university, other Head Start programs, federally qualified health centers, area health education centers, school nurses, and local health clinics.	
Considerations	Staff Level of Effort:	The level of effort required for educating oral health stakeholder groups about Head Start varied by grantee with some conducting presentations on a monthly basis and others sporadically throughout the year. Grantees that hired new staff for OHI often assigned these outreach responsibilities to the oral health coordinator. OHI grantees that used existing staff reported assigning these responsibilities to Head Start directors or health coordinators.

Program Characteristics:	Tribal Head Start programs reported that most children were served through Indian Health Service clinics. However, the programs, like other programs, developed partnerships with dental providers because clinics often had long waiting lists and providers were needed for the non-tribal children they served. There were no differences in implementation by grantee location or size.
Target Population:	Most grantees sought out professional groups with a health or dental health focus. Dental hygienist associations as well as broader oral health coalitions were the groups that grantees reported targeting.

Strategy V.2.	**Work with a Key Stakeholder in the Community to Engage Dental Providers**	
Description	Grantees worked with stakeholders from the community who they asked to engage dental providers and encourage them to serve Head Start families. These stakeholders included dentists and chairs of local dental and dental hygienist associations, as well as other oral health providers. These stakeholders often had long-standing relationships with Head Start and were well-connected to the dental community. In addition to networking with community dental providers and encouraging them to serve Head Start families, these stakeholders raised money for Head Start oral health activities through auctions and fund-raisers, chaired oral health coalitions in the community, advocated for Head Start at professional oral health forums and conferences, developed monthly oral health education seminars, and provided oral health pamphlets to families with low reading levels.	
Examples from the Field	One grantee asked a local dentist who they had a history of partnering with to recruit other dentists in the community to serve Head Start families. According to the grantee, having a dentist approach his peers was instrumental in recruiting dentists because he had more influence than Head Start staff. In the past Head Start staff were unable to get dentists to return their calls when they were trying to approach them about serving Head Start families; however, the local dentists were more responsive to a peer.	
Considerations	Staff Level of Effort:	Staff time was required to identify and engage a stakeholder. Once stakeholders were identified and began networking with local providers, grantee staff maintained ongoing communication with the stakeholders and were available for direct contact with potential partners.
	Program Characteristics:	Tribal Head Start programs reported that most children were served through Indian Health Service clinics. However, the programs, like other programs, developed partnerships with dental providers because clinics often had long waiting lists and providers were needed for the non-tribal children they served. There were no differences in implementation by grantee location or size.
	Target Population:	Grantees reported trying to identify key stakeholders that had a strong reputation in the community (usually dental providers), were knowledgeable about the needs of Head Start children, and were in a position to advocate on behalf of the Head Start community.

Strategy V.3.	**Provide Training Opportunities for Health Care Professionals and Other Potential Partners**	
Description	OHI grantees reported offering training opportunities to health care professionals, including dentists, pediatricians, pediatric dentists, dental hygienists, nurse practitioners, and other related professionals. The OHI grantees targeted trainings to the audience. For example, trainings with pediatricians and other medical professionals often focused on the importance of oral health and how to educate parents about how to care for their children's teeth. Trainings for dentists and dental hygienists focused on how to conduct a dental exam with young children. Some grantees offered continuing education credits to attendees in order to make the trainings more attractive. Training sessions were used by grantees to familiarize potential partners about the needs of low-income families, to encourage consistent messages about oral health care across community providers (such as, the age at which children should first be seen by a dentist), and to recruit medical providers to address oral health needs of children during well-baby/child checkups.	
Examples from the Field	The dental hygienist at one grantee conducted educational sessions with partners and other community members including pediatricians, WIC staff, primary care physicians, and general dentists. During the training, the dental hygienist trained partners on the importance of preventive dental care for young children and recommendations by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry on the types and timing of preventive care young children should receive. The goal of the trainings was to encourage general dentists to serve young children and to encourage other medical professionals and WIC staff to send consistent messages to parents about their children's oral health.	
Considerations	Staff Level of Effort:	Trainings were often scheduled annually or carried out periodically throughout the year. Grantee staff time was required to arrange the trainings, recruit providers to attend the trainings, plan the presentations, and conduct the trainings. In addition, some grantees reported that staff often had to conduct the same training multiple times to accommodate providers' schedules and address staff turnover within partner agencies.
	Program Characteristics:	Tribal Head Start programs reported that most children were served through Indian Health Service clinics. However, the programs, like other programs, developed partnerships with dental providers because clinics often had long waiting lists and providers were needed for the non-tribal children they served. There were no differences in implementation by grantee location or size.

Target Population:	The target population included stakeholders that had direct contact with children and families, such as dentists, pediatricians, pediatric dentists, dental hygienists, and other related professionals.

Strategy V.4.	**Work With Local College and University Departments to Familiarize Professionals With Head Start**	
Description	The OHI grantees recruited local college and university departments (such as nursing, dental hygiene, dental, and medical) as community partners. Grantees that reached out to colleges and universities most often had an ongoing relationship prior to OHI with these institutions.. These partnerships were described as helpful for both the grantees and schools by grantee and community partner staff. Head Start families received free services, and schools fulfilled their mandates to conduct community outreach. These partnerships were also beneficial for grantees because students conducted educational presentations for staff and distributed oral health materials and supplies, such as books. Students learned about the community's oral health care needs and gained valuable experience working with young children by applying sealants and fluoride varnishes. Typically, colleges and universities donated their time. In some situations, grantees sought Medicaid reimbursement to offset the costs of colleges and universities providing care.	
Examples from the Field	One grantee partnered with the dental school at a local university and the dental hygiene program at a community college. The dental students participated in the dental clinics organized by the grantee. The students conducted oral health screenings and cleanings. These services were open to all Head Start children and their family members as well as individuals living in the community. Dental hygiene students conducted onsite oral health screenings, cleanings, fluoride varnishes, and dental sealants for Head Start children and their families.	
Considerations	Staff Level of Effort:	Grantees reported meeting with their contacts in the local college and university departments once a week and emailing on a regular basis to coordinate and arrange services.
	Program Characteristics:	Grantees located in urban areas were more likely to implement this strategy than grantees in rural areas. Migrant Head Start programs were faced with the added challenge of serving many families that resided in their service area for a short period of time and, as a result, needed treatment had to be completed in a limited time. To address this challenge, grantees reported developing partnerships with local university hospitals that agreed to prioritize services to Head Start children that had extensive treatment needs. There were no differences in implementation by grantee size.
	Target Population:	Local college and university departments (such as nursing, dental hygiene, dental, medical) offering free or discounted resources and student volunteer services were targeted.

Strategy V.5. Individualize Head Start Tracking Systems to Meet the Needs of Dental Providers

Description	Grantees explained that some dentists were reluctant to serve Head Start families because Head Start programs often required them to complete and submit additional paperwork used for tracking purposes. To overcome this challenge, some grantees implemented procedures to reduce the burden required of dentists. For example, grantees worked in conjunction with provider staff (such as, receptionists and dental assistants) to develop referral and tracking forms that made use of check boxes so they could be completed more quickly than forms that required dentists to describe the services they provided. Other grantees used email and telephone communication to keep track of the services dentists provided to Head Start children. Often grantees reported that they implemented various systems for tracking services so they could meet the individual preferences of providers.	
Examples from the Field	To encourage local dentists to serve Head Start families, they contacted providers directly (weekly or monthly) to get an update of treatment provided. Staff documented this information in children's files. This reduced the need for the dental provider to complete additional paperwork for each Head Start child they served.	
Considerations	Staff Level of Effort:	In order to reduce the burden on dental provider staff, grantee staff dedicated a significant amount of time to implementing and carrying out procedures for tracking services. Grantee staff also offered a wide range of support services to families to help them make and keep appointments (see Chapter VIII).
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Dental providers were targeted.

CHAPTER VI

CASE MANAGEMENT

The OHI grantees worked extensively with pregnant women and parents to ensure that children received the dental care they needed. Grantees offered on-site services, referrals for families to community dental providers, and a variety of services to support parents and pregnant women in their efforts to make and keep appointments. Coordinating these services and keeping track of the services children needed required grantees to implement and maintain case management systems. Most grantees relied on existing case management systems that were used to track the status of children's health services. To keep track of service receipt, grantees distributed forms to parents to give to dental providers to detail the care children received. Grantees also communicated directly with providers to obtain needed information. Once information from the provider was received, grantees tracked data centrally using databases, such as ChildPlus and the Head Start Family Information System (HSFIS). Staff members were able to identify children who were due for dental exams or required follow-up treatment. They then used this information to target the families that needed additional support to make dental appointments for their children.

Within this approach, the research team identified three emerging strategies: (1) report the results of dental screenings to parents and direct service staff to encourage followup; (2) update risk-assessment and dental screening results throughout the year to track receipt of dental services; and (3) assign an oral health coordinator (or other designated staff person) to follow up with families that are unresponsive to requests by direct service staff.

Strategy VI.1.	**Report Results of Oral Health Screenings to Parents and Direct Service Staff to Encourage Followup**	
Description	Grantees that implemented this strategy conducted on-site oral health screenings. Since parents were often not on site during the screening, grantees developed forms to share results with parents. The forms indicated if the child needed to be seen by a dentist immediately, if the child needed to be seen by a dentist as soon as possible, or if the child should continue with regularly scheduled preventive care visits. The forms were sent home to parents, and, if permission was received by the parent, the information was also shared with the child's teacher and family service worker or home visitor. Since these staff members had the most contact with the children's parents, grantees instructed them to follow up with the parents to encourage them to make a dentist appointment if necessary.	
Examples from the Field	One grantee that provided on-site oral health screenings and fluoride varnishes developed a form for parents that described the results of the screenings. The form indicated the services that the children received and the results of the screening: (1) no visible signs of decay—the child should continue with routine dental exams, (2) some indications of decay—the child should see a dentist soon, or (3) serious decay—the child should see a dentist immediately. A copy of the form was kept in the child's records, and the family service workers were instructed to follow up with parents of children with some indication of decay or serious decay to help them schedule an appointment with a dentist.	
Considerations	Staff Level of Effort:	Completing the forms at the time of the oral health screening required minimal staff effort (approximately two minutes per child). The amount of staff effort required to follow up with parents varied by the results of the child's oral health screenings and by family, but grantees estimated that it ranged from one telephone call to several telephone calls or even a visit to the family's home.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Head Start parents and direct service staff made up the target population.

Strategy VI.2.	**Update Risk-Assessment and Oral Health Screening Results Throughout the Year to Track Receipt of Dental Services**	
Description	Grantees conducted risk assessments with families and oral health screenings with children, recorded the results, and used this information to target families for followup. Many grantees reported that they conducted risk assessments and oral health screenings two or more times per year. By conducting multiple risk assessments and screenings, grantees were able to identify oral health needs early and keep track of receipt of dental services if staff were having a difficult time getting information from a child's parent or dentist. For example, if a child was identified during an initial screening as having signs of decay and needing to see a dentist, staff could observe during a second screening if any work had been done in the child's mouth, which would indicate that the child had been to a dentist. If there were no signs of treatment, grantee staff would follow up with the family to determine if the child had been seen by a dentist but no treatment was required, if the child had an appointment pending, or if the family had not yet made an appointment.	
Examples from the Field	One grantee implemented oral health risk assessments, which were conducted by Head Start teachers during home visits before the program year began, midway through the program year, and again at the end of the year. The risk assessments included questions about the families' dietary and oral health habits, each child's dental history, and a visual inspection of each child's mouth. The teachers reported the results to the oral health coordinator. The coordinator used the information and the results of the visual inspection to track whether children received needed services.	
Considerations	Staff Level of Effort:	The amount of staff time required to implement this strategy varied by grantee. Some grantees chose to have one staff person (often a dental hygienist) conduct oral health screenings of all children; on average, grantees reported that screenings required five to eight minutes per child. Other grantees chose to add visual inspections and risk assessments to home visits by direct service staff. These grantees reported that this added minimal time to the length of the home visit.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Head Start children were targeted.

Strategy VI.3. Assign an Oral Health Coordinator (or Other Designated Staff Person) to Follow Up With Families That are Unresponsive to Requests by Direct Service Staff

Description	As described in Strategy VI.1, many grantees relied on teachers, family service workers, and home visitors to follow up with families regarding children's oral health needs. Some grantees also reported assigning an oral health coordinator or another designated staff person, such as a health coordinator, to follow up with families that were unresponsive to direct service staff. In addition, these staff members were available to help families schedule and coordinate extensive treatment (such as, oral surgery that often required families to travel long distances) and to find resources to pay for care that was not covered by dental insurance (such as, anesthesia).	
Examples from the Field	The oral health coordinator at one grantee sent out reminder notices to family service workers to remind them to follow up with families whose children needed dental services. If families were unresponsive after multiple contacts, the family service worker informed the oral health coordinator. The coordinator then contacted those families to make referrals, help families make appointments, provide transportation, talk with them about the importance of obtaining treatment, and accompany them to dental appointments if needed. These families often required more intensive consultation in order to get them to obtain needed services for their children. However, grantees that used this strategy explained that in time nearly all families complied.	
Considerations	Staff Level of Effort:	Grantees that implemented this strategy reported varying amounts of staff effort required for following up with individual families. For example, one grantee reported that the oral health coordinator had to follow up with about 10 percent of families. Contacting the family and arranging the needed services typically took several hours per family.
	Program Characteristics:	Smaller grantees (those serving less than 600 families annually) were more likely than larger grantees to report using this strategy. Migrant Head Start programs were faced with the added challenge of serving many families that resided in their service area for a short period of time and as a result, needed treatment had to be completed in a limited time. To address this challenge, oral health coordinators or health coordinators followed up with families quickly if they were unresponsive to requests by home visitors and family service workers. There were no differences in implementation by grantee location.
	Target Population:	Head Start children and families made up the target population.

CHAPTER VII

PREVENTIVE CARE

The provision of dental care plays an important role in preventing and more effectively managing early childhood caries and other oral health problems. In addition, oral health screenings can help detect early signs of disease and ensure that children receive an appropriate level of care based on their unique risk profiles. To promote oral health, the Office of Head Start requires programs to (1) determine within 90 days of enrollment whether children are up to date on age-appropriate primary preventive health care, including dental exams; (2) document the need for follow-up treatments; and (3) ensure that children receive follow-up care. Meeting these requirements is difficult for many Head Start programs. To address these challenges, grantees implemented a range of strategies to obtain preventive services and needed follow-up treatments for Head Start children and pregnant women. These strategies included direct provision of services, referrals for services, and a combination of the two.

Within this approach, the research team identified four strategies that showed promise for replication: (1) provide preventive care on site, conducted by a community partner or dental hygienist; (2) offer dental fairs and/or clinics at which Head Start families and children can receive preventive care; (3) team with local medical providers (pediatricians, family practice doctors, nurses, nurse practitioners) to provide oral health screenings and/or fluoride treatments during doctor visits; and (4) establish partnerships with local dental providers willing to accept referrals of Head Start children and pregnant women.

Strategy VII.1. Provide Preventive Care on Site, Conducted by a Community Partner or Dental Hygienist

Description	The OHI grantees recruited providers to perform on-site preventive care, scheduled the event(s), and managed required paperwork. If grantees had a dental hygienist on staff, the hygienist frequently provided these services. The most common types of preventive care provided on site included oral health screenings and fluoride varnish applications. Grantees also arranged for dentists to conduct on-site dental exams. On-site preventive care was provided at Head Start centers. Children whose parents gave consent were brought by classroom to a central location at the center, where they would receive preventive care. Grantees that served pregnant women reported inviting them to on site events for oral health screenings. Grantees using this strategy used parent volunteers, center managers, classroom teachers, and oral health or health coordinators to oversee the services. The children who received care were sent home with information for their parents about the services they received. (see Strategy VI.1)	
Examples from the Field	During on-site oral health screenings and fluoride varnish applications at one grantee, a dental hygienist from a community partner agency and her assistant visited the Head Start centers. They were accompanied by the grantee's oral health coordinator. Parent volunteers brought children to a central location in the centers for services. The dental hygienist conducted an oral health screening with every child and applied fluoride varnish for children whose parents gave consent. The results of the oral health screenings were recorded. Each child received a bag that contained dental hygiene supplies, including toothpaste, a toothbrush, and a timer, and information for the parents about the results of the screening.	
Considerations	Staff Level of Effort:	Even though the direct service was not provided by the Head Start staff, the process required staff time to recruit providers, schedule the activities, obtain parental consent, and coordinate services during the actual event.
	Program Characteristics:	Migrant Head Start programs were faced with the added challenge of serving many families that resided in their service area for a short period of time and as a result, preventive services had to be completed in a limited time. To address this challenge, grantees provided preventive services on site, which allowed them to serve a large number of children during a short time period. There were no differences in implementation by grantee location or size.
	Target Population:	Head Start children and pregnant women were targeted.

Other:	Grantees reported that before implementing this strategy they confirmed that services provided by a dental hygienist were billable to Medicaid. Medicaid reimbursement rules vary by state. If services were not billable, grantees funded these services through the OHI grant.

Strategy VII.2.	**Offer Dental Fairs and/or Clinics at Which Head Start Families and Children Can Receive Preventive Care**	
Description	The goal of the fairs and clinics was to provide preventive dental services, including exams, cleanings, fluoride varnishes, and sealants, to all attendees. The OHI grantees recruited volunteers such as local dentists and dental hygienists, nutritionists, pediatricians, and nurses, to offer free services, health and nutrition information, activities, and some oral health supplies for fair participants. The fairs and clinics were targeted to serve Head Start families but were open to the public.	
Examples from the Field	One grantee offered a dental fair twice a year at a Head Start site. It used the school cafeteria, which was divided into multiple health stations at which participants received a range of services, including dental exams and cleanings (provided by dental school students); fluoride varnishes and sealants (provided by dental hygiene students); nutrition information (provided by WIC program staff); flu shots at $30 each, cholesterol checks, and blood pressure exams (provided by hospital staff); and tooth brushing and hand-washing demonstrations (provided by high school students). Local high school students also staffed a craft table for children. In addition to providing the dental supplies, the Head Start program also handed out bags with health and nutrition information and fresh fruit that was donated by a local grocery store.	
Considerations	Staff Level of Effort:	Staff time was needed to contact and confirm volunteer providers. Staff time was also needed at the event itself—to register participants; guide families through the process; answer questions; and provide general assistance. Grantees reported having Spanish-speaking family service workers on site to interpret.
	Program Characteristics:	Grantees in rural locations (who often reported more limited access to providers) were more likely to implement this strategy than grantees in urban locations. There were no differences in implementation by grantee size or program type.
	Target Population:	The events targeted Head Start families but were open to the public.

Strategy VII.3. Team with Local Medical Providers (Pediatricians, Family Practice Doctors, Nurses, Nurse Practitioners) to Provide Oral Health Screenings and/or Fluoride Treatments During Doctor Visits		
Description	Grantees reached out to medical providers, such as pediatricians to encourage them to offer oral health screenings, fluoride varnish applications, and anticipatory guidance to parents during well-baby/child checkups. To facilitate this outreach, grantees teamed with local or state initiatives to recruit and train medical providers.	
Examples from the Field	The OHI grantees from North Carolina provided services to children through the "Into the Mouths of Babes" initiative. Through this initiative, staff trained medical providers to deliver preventive oral health services to high-risk children from the time of tooth eruption until age 3, including oral screening, parent/caregiver education, and fluoride varnish applications. By partnering with this initiative, the grantees were able to secure preventive dental services for Head Start children.	
Considerations	Staff Level of Effort:	Staff time was required to network with local officials to either partner with existing initiatives or to develop partnerships with medical providers that were trained to provide preventive dental services. Additionally, staff time was required to track oral health screenings conducted in the primary health care provider's offices, as well as for maintaining relationships with medical providers.
	Program Characteristics:	This strategy was implemented in states or localities with initiatives that trained medical providers to conduct preventive dental services.
	Target Population:	The targeted population included local medical providers, including pediatricians, family practice doctors, nurses, and nurse practitioners.

Strategy VII.4.	**Establish Partnerships with Local Dental Providers Willing to Provide Services to Head Start Children and Pregnant Women**	
Description	Grantees invested OHI staff resources and time to expand the pool of oral health providers willing to provide services to their population of children and pregnant women (see Chapter V for strategies for recruiting providers). Grantees that implemented this strategy reported that initially, few providers in their area were willing to see young children and Medicaid patients. In many cases, these partnerships made it easier for Head Start staff members and family members to schedule appointments, and providers were more receptive to serving the children once a partnership was established.	
Examples from the Field	One grantee developed a referral network with private dentists. When families did not have a dental provider, the health coordinator referred the family to a provider in their network (see Chapter V for strategies for recruiting providers). Although the network included multiple providers, the grantee referred most families to one of two dentists because they were willing to serve many Head Start families. One dentist provided care for children that were uninsured on a sliding fee based on the families' income. The other dentist reserved a block of time one day a week for appointments for Head Start children and families.	
Considerations	Staff Level of Effort:	Grantees implementing this strategy reported investing significant staff time to establish partnerships with providers (see Chapter V).
	Program Characteristics:	Grantees in rural locations (who often reported more limited access to providers) were more likely to implement this strategy than grantees in urban locations. Tribal Head Start programs reported that most children were served through Indian Health Service clinics. However, the programs, like other programs, developed partnerships with dental providers because clinics often had long waiting lists and providers were needed for the non-tribal children they served. There were no differences in implementation by grantee size.
	Target Population:	Grantees reported attempting to identify general dentists with experience treating young children or, preferably, pediatric dentists. Programs also sought providers who accepted Medicaid and were bilingual.
	Other:	Most grantees relied heavily on a few providers for most referrals, and then drew on a larger network of providers who accepted only a few referrals throughout the year. Programs noted that while some dentists were willing to accept a high number of referrals, others were only willing to see a few Head Start children.

CHAPTER VIII

SUPPORT SERVICES

To facilitate the provision of oral health preventive and treatment services, the OHI grantees reported providing a range of support services to help families make and keep dental appointments. Grantee health specialists were typically responsible for providing or arranging these services. Other grantee staff, such as family service workers and home visitors, also assisted with providing support services to families. Grantees offered a wide range of support services; however, the research team identified four services that were most promising in helping families make and keep appointments: (1) transport families to appointments or arrange transportation, (2) send reminder notices/make reminder phone calls to families about upcoming appointments, (3) make appointments for families or help families make appointments, and (4) assist families in covering the costs of needed dental care.

Strategy VIII.1. Transport Families to Appointments or Arrange Transportation

Description	The OHI grantees provided assistance with transportation to dental appointments because parents often cited a lack of transportation as a major barrier to care. Transportation assistance ranged from helping families access public transportation to arranging transportation for individual Head Start children. Most often, grantees helped parents obtain taxi vouchers when public transportation was not available. Some rural grantees offered round-trip mileage reimbursement to parents. Only a few program opted to transport children directly when parents were not available or did not have the means to do so themselves.	
Examples from the Field	One rural grantee used its own school bus to transport children and their parents to off-site dental screenings. To facilitate this process, staff made reminder calls the day before the appointment and had a bilingual staff member present for the dental screenings, in case there was need for an interpreter. Another program had its oral health coordinator transport Head Start children to appointments, as a last resort. She was reimbursed for her mileage. This program reported both services to be OHI-dependent and difficult to implement without the resources made available through OHI funding.	
Considerations	Staff Level of Effort:	Staff time could be significant, particularly when direct transport by staff was provided.
	Program Characteristics:	Because transportation was reported to be a greater barrier in rural communities, programs in these areas relied on this strategy more often than did programs in urban areas. There were no differences in implementation by grantee size or program type.
	Target Population:	Most programs believed that this strategy should be used primarily to target families with unreliable transportation, those families that had missed previous appointments, or those that had a child who required immediate dental attention.
	Other:	Programs mentioned concerns with liability when transporting children and families. In some states, programs reported they were not able to transport children without a parent present.

Strategy VIII.2. Send Reminder Notices/Make Reminder Phone Calls to Families About Upcoming Appointments

Description	Some grantees assisted families by reminding them to make new appointments for dental care or to keep previously scheduled appointments by sending out written reminder notices or by making reminder phone calls. These grantees implemented systems to keep track of children's upcoming appointments (see Chapter VI for case management strategies). Grantees reported that these activities helped increase the number of dental appointments made and have been instrumental in reducing missed appointments.	
Examples from the Field	In an effort to reduce the number of Head Start families that missed dental appointments with one of the grantee's community partners, the oral health coordinator made reminder calls to parents in advance of scheduled appointments. If the family failed to make the appointment, the provider contacted the oral health coordinator, who then followed up with the family.	
Considerations	Staff Level of Effort:	The level of staff effort varied by program. Most programs did not spend a great deal of time placing reminder phone calls, but a few programs did consider this an important strategy and invested significant staff hours. The responsibility for sending out notices and making calls was typically shared by several staff positions, including the oral health coordinator, the health manager, and family service workers. One grantee said it utilized a "team effort" to reach all families using these strategies to increase the likelihood that they received all necessary dental services.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	All Head Start parents and particularly parents who had missed previous dental appointments were targeted.
	Other:	Reminder notices and phone calls were often provided along with other case management services to identify and help families overcome barriers to dental care (see Chapter VI). Related practices included reaching out more aggressively to higher-risk families, providing financial assistance to help cover the cost of care (see Strategy VIII.4), and providing transportation assistance to and from dental appointments. (see Strategy VIII.1)

Strategy VIII.3. Make Appointments for Families or Help Families Make Appointments

Description	The OHI grantees assisted families and pregnant women by making appointments or by helping them make appointments. This strategy was most often utilized in helping families establish dental homes. At enrollment, most programs asked if a family had a regular dentist or dental home and provided Head Start parents with a list of dental providers in the area that were willing to accept Medicaid and serve young children. Programs also assisted families and pregnant women by calling providers and scheduling appointments for them. This was less frequent, and programs provided this level of support to parents who needed additional assistance, such as those who did not speak English or failed to follow up with prior referrals. Only a few programs consistently made appointments for families and pregnant women. Most grantees were reluctant to do so because they promoted self-sufficiency among parents.	
Examples from the Field	One grantee implemented a new outreach strategy in which the oral health specialist called all families without a dental home in the summer prior to the start of the new program year and referred them to local dentists to schedule an appointment. According to the program staff, this resulted in a much greater number of dental exams scheduled early in the year and a greater number of dental homes being established.	
Considerations	Staff Level of Effort:	The level of staff effort varied by grantee and depended on the number of families needing this type of assistance in the program and the number of providers willing to serve Head Start families in the community.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Families without a dental home and families that may have additional challenges in making appointments, such as non-English-speaking parents were targeted.

Strategy VIII.4. Assist Families in Covering the Costs of Needed Dental Care

Description	Even though most dental services were billed to families' insurance providers, some grantees also helped cover the out-of-pocket costs of care for uninsured and underinsured children and pregnant women. In some instances, grantees used their OHI grant or regular Head Start program funds to pay for care directly. In other cases, grantees connected parents and pregnant women to community financial resources, such as those offered by foundations or private organizations. Some programs also worked with dental providers and were able to obtain some dental services at no cost or negotiated services at reduced costs. In most cases, financial resources were available only for enrolled children or pregnant women, but a couple of grantees did cover dental care costs for parents. However, these funds were much more limited and usually reserved for urgent care needs.	
Examples from the Field	One grantee connected families to a special fund operated by a private foundation that supplied referrals to local dental providers and financial resources to supplement the cost of care for families with insufficient dental coverage. This fund was instrumental in increasing access to comprehensive dental care; dentists were more willing to see participating children because they get reimbursed at a higher rate than from Medicaid. In addition, the fund was more likely than Medicaid to cover the cost of certain extensive treatment services, such as anesthesia and oral surgeries.	
Considerations	Staff Level of Effort:	Applying for Head Start program funds and connecting families to community resources were part of broader case management activities performed by oral health coordinators, health managers, and family service workers. Some grantees required families to show proof of being denied enrollment in insurance or coverage for a service. Grantees reported that it took staff effort to get this necessary paperwork from families. Also, they reported that a lot of time was invested in establishing initial relationships with community organizations offering financial resources. However, once these relationships were established, less time was required to coordinate enrollment and payment for services.

Program Characteristics:	Migrant and Seasonal Head Start programs were more likely than other programs to assist families with the cost of dental services for children and pregnant women because they served many families that were not able to qualify for Medicaid. There were no differences in implementation by grantee location or size.
Target Population:	This strategy targeted primarily enrolled children and pregnant women, but also parents with urgent dental care needs if funds were available.
Other:	Cost was a consideration as some grantees invested significant funds to pay for services.

CHAPTER IX

PARENT EDUCATION

The OHI grantees emphasized the need to educate Head Start families about the importance of oral health and the potentially devastating consequences of untreated oral disease. The six most common messages on oral health delivered to parents that grantees reported during telephone interviews were (1) the importance of children's oral health to development and systemic health; (2) the causes of oral disease and emphasis on their infectious nature; (3) early detection of oral health problems through visual inspection, such as the "Lift the Lip" method; (4) what to expect at the dental office; (5) oral hygiene instruction; and (6) the importance of oral health prevention for the entire family.

Grantees used a variety of methods to reach parents. The emerging strategies included the following: (1) provide education for parents during on-site dental services or during dental appointments; (2) offer parent meetings or workshops focused on oral health; (3) include information on oral health at all parent meetings; (4) offer incentives to parents who attend parent meetings and workshops; (5) reinforce education conducted during parent meetings, workshops, and appointment with informational materials that are sent home to parents; and (6) tailor educational materials to parents' reading levels and primary languages.

Strategy IX.1. Provide Education for Parents During On-Site Dental Services or During Dental Appointments

Description	Some OHI grantees conducted education with parents while their children received on-site dental services or during dental appointments. When programs provided on-site services to Head Start children, parents were often invited to visit the program and observe the procedures. In some cases, preventive services were also offered to siblings of Head Start children. During these visits, parents were instructed about the importance of regular dental visits, the need to keep appointments, and dental office etiquette, as well as anticipatory guidance on oral health.	
Examples from the Field	One grantee offered oral health screenings and fluoride varnish applications to Head Start children and encouraged parents to schedule an appointment to bring in younger siblings. This allowed the oral health coordinator to explain the benefits of fluoride and conduct education with the parents during this visit.	
Considerations	Staff Level of Effort:	The educational sessions conducted during dental services were fairly informal and were carried out by staff previously trained on oral health issues. Various staff participated in the education, most often the oral health coordinator and family service workers, depending on the nature of the service provided.
	Program Characteristics:	Migrant and Seasonal Head Start programs reported serving a large number of Spanish-speaking families. In order to provide interpretation for these families, grantee staff often accompanied them to dental appointments. These programs used this opportunities to provide one-on-one education with the parents about their children's oral health. There were no differences in implementation by grantee location or size.
	Target Population:	Head Start parents were targeted.
	Other:	Programs with non-English-speaking parents utilized bilingual Head Start staff to conduct education or to interpret educational sessions.

Strategy IX.2. Offer Parent Meetings or Workshops Focused on Oral Health

Description	The OHI grantees conducted education with parents, either during a parent meeting devoted entirely to oral health or a specially scheduled workshop. Programs reported holding these at least once a year and up to several times a year. Typically, this education was conducted by the oral health coordinator, a member of the education staff at the Head Start program, or a community partner—dentist, dental hygienist, or nutritionist. These presentations often involved PowerPoint presentations, videos, or other visual aids. Some were based on existing oral health curricula, such as "Cavity Free Kids" and "Bright Smiles, Bright Futures," while others were based on materials developed specifically for the audience. In addition, some grantees included hands-on skill-building activities and demonstrations, such as teaching parents how conduct a "Lift the Lip" inspection. Topics that programs addressed during these workshops included the transmissibility of bacteria that cause dental disease, proper dental hygiene techniques, the role of nutrition in oral health, what to expect in a visit to the dentist and any associated concerns, caring for their infants and young children's mouths, and benefits of preventive care and treatments.	
Examples from the Field	One grantee offered monthly workshops on oral health. The Head Start director was the speaker at most of these workshops, but other Head Start staff, as well as dental professionals also presented information to parents. The training topics by month were: (1) September- Orientation to the Oral Health Initiative; (2) October- Promoting Awareness, Preventing Pain: Facts on Early Childhood Caries; (3) November- Oral Health and Learning; (4) December- Oral Health for Children & Adolescents with Special Health Care Needs; (5) January- Community Partners; (6) February- Strategies for Improving the Oral Health System in Our Communities; (7) March- Child & Adolescent Oral Health Issues; (8) April- Oral Health in Women; and (9)May- Sharing Parents' Success in the Oral Health Initiative Project.	
Considerations	Staff Level of Effort:	Preparation of presentation materials typically was the responsibility of the oral health coordinator or dental partner. Grantees reported using Head Start staff to assist with demonstrations and interpret information presented during the parent meetings or workshops.
	Program Characteristics:	Programs, including Migrant and Seasonal Head Start programs, with a significant percentage of parents who spoke a home language other than English often used bilingual Head Start staff to simultaneously interpret the presentation. There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Head Start parents were targeted.

Other:	To maximize parent attendance, grantees scheduled meetings and workshops at times that are were convenient for parents and some offered child care and transportation.

Strategy IX.3. Include Information on Oral Health at All Parent Meetings

Description	The OHI grantees discussed oral health at all parent meetings to reinforce key messages and to increase their reach to those parents who may not regularly attend parent meetings. Programs typically devoted a small portion of each meeting to oral health. Some programs used a structured approach to providing education and identified key themes and topics and relevant materials for each month. Other programs used a more informal approach by raising key messages at each meeting or inviting parents to raise topics and ask questions. A few programs that offered refreshments during parents meetings also distributed toothbrushes and toothpaste to reinforce the importance of brushing after meals. Various topics that grantees addressed during parent meetings included the adoption of healthy eating habits such as eating fruits and vegetables, and brushing after meals. A few programs stressed the impact of parents' modeling healthy behaviors on their children.	
Examples from the Field	One grantee that established partnerships with local schools of nursing and dental hygiene invited these students to make brief presentations on oral health and nutrition during parent meetings. These students worked with the oral health coordinator at the Head Start program to develop their presentations and received assistance from Head Start with translation of materials. Family service workers were also present during the parent meetings to interpret.	
Considerations	Staff Level of Effort:	Programs relied primarily on oral health coordinators and the education staff to lead these sessions during parent meetings. When possible, community partners were also invited to conduct presentations.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Head Start parents who attend parent meetings were the target population.
	Other:	This strategy allowed programs to reach a broader group of parents that may attend only a few parent meetings each year. Grantees also mentioned that repeating a message over time and from multiple sources (such as, Head Start staff and community partner) was helpful in reinforcing its importance with parents.

Strategy IX.4. Offer Incentives to Parents Who Attend Parent Meetings and Workshops

Description	The OHI grantees described using incentives to encourage parents to attend parent meetings and workshops. (see Strategies IX.2 and IX.3) Incentives were offered in response to low attendance rates among parents who faced barriers related to transportation, child care, and work responsibilities. Incentives were in the form of gift cards to supermarkets or local stores. Programs also frequently distributed oral hygiene supplies, such as toothbrushes, toothpaste, timers, xylitol gum, infant gum cleaners and wipes, and sippy cups.	
Examples from the Field	One grantee offered parents that attended monthly workshops on oral health $10 gift cards to a local grocery store.	
Considerations	Staff Level of Effort:	Minimal staff effort was required to purchase and distribute the gift cards and supplies.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type; however, larger programs were more likely to use dental hygiene supplies which were donated as compared to incentives that required the use of OHI funds.
	Target Population:	Grantees reported that offering incentives was a helpful strategy with parents who did not regularly attend parent meetings but did note that incentives were not particularly useful with parents who attended regularly.
	Other:	There was a cost associated with offering incentives to parents. Programs used OHI grant funds to purchase gift certificates, which may be prohibitive for programs serving large populations.

Strategy IX.5.	**Reinforce Education Conducted During Parent Meetings, Workshops, and Appointment with Informational Materials That Are Sent Home to Parents**	
Description	The OHI grantees mailed or sent information on oral health home with Head Start children. Programs reported using information from oral health curricula, information they located on oral health websites, or materials provided by their community partners. Programs sent home pamphlets and handouts that were at appropriate reading levels and focused on a few simple messages (see Strategy IX.6). Other programs mailed home monthly or quarterly newsletters that included information on oral health. A few programs purchased books on oral health and distributed these once a year to parents. For those programs that provided preventive services on site, such as fluoride varnish applications, general information was sent home to parents describing the benefits of these services (see Strategy VII.1).	
Examples from the Field	One grantee included oral health information in the agency's monthly newsletter. Each newsletter included information about an oral health-related activity parents could conduct with their children at home and oral health-related facts.	
Considerations	Staff Level of Effort:	Programs reported a range of effort in preparing and identifying educational materials. Some programs used existing materials related to specific curricula, while others chose to develop their own materials. Programs adapted materials to make them accessible to parents, for example the information was presented at a third grade reading level. Programs that served non-English-speaking populations should consider efforts related to translation if materials are not available in multiple languages. Multiple staff members were involved in adapting these materials, including the oral health coordinator, educational and health staff, family advocates, and teachers.
	Program Characteristics:	Early Head Start programs that served pregnant women sent home materials targeting their specific informational needs, which included oral health changes during pregnancy, potential impact of periodontal disease on birth outcomes, oral health–friendly feeding practices, and meeting the oral health needs of infants. There were no differences in implementation by grantee location or size.
	Target Population:	Head Start parents and pregnant women were the target population.

Other:	Some programs were able to download information at no cost or received donated materials from community partners. However, traditionally there is a cost associated with obtaining materials that are part of an oral health curriculum.

Strategy IX.6	**Tailor Educational Materials to Parents' Reading Levels and Primary Languages**	
Description	Nearly all programs reported tailoring materials to parents' needs and made efforts to use materials that were culturally and linguistically appropriate, easy to understand, and not above a third-grade reading level. Some programs have identified materials in multiple languages, while others use staff to translate educational materials from English into other languages, primarily Spanish. Most programs reported that it was standard to make all educational materials available in Spanish. When working with low-literacy populations, some programs found the use of visual aids and photographs to be helpful in communicating oral health messages (such as, how to brush and floss properly and how to identify signs of tooth decay). Several programs incorporated cultural traditions and practices into their educational activities and materials.	
Examples from the Field	One program serving migrant and seasonal families collected information on parental dental history, which was used to tailor education and materials for the Head Start parents. Having this information helped the program have a better understanding of cultural influences on dental hygiene beliefs and behaviors and identify materials that were most relevant to the population. Another program partnered with local universities and used its OHI funds to develop educational tools targeting migrant farm workers and their families and designed audiovisual programs that health educators could use to conduct parent education in various settings.	
Considerations	Staff Level of Effort:	Typically, it was the role of the oral health coordinator or education and health managers to identify appropriate materials. This strategy can require a significant amount of staff labor for grantees that prefer to develop their own materials or that need to translate materials into multiple languages.
	Program Characteristics:	Migrant and Seasonal Head Start programs reported using media and other visual aides to convey messages to parents and pregnant women. One grantee used a commercially available DVD which targets Spanish-speaking families. Another grantee designed their own educational materials, including a DVD depicting how to care for teeth and pamphlets that use pictures to show parents how to care for their children's teeth, rather than relying on written words. There were no differences in implementation by grantee location or size.
	Target Population:	Head Start parents and pregnant women were targeted.

CHAPTER X

EDUCATION FOR CHILDREN

The OHI grantees educated children about how to care for their teeth and what to expect during dental services. Many adopted oral health curricula to support education. In addition, grantees reported using a variety of materials and props to engage children in oral health topics. Lessons frequently included reading a book about caring for teeth or visiting the dentist. Staff used puppets with oversized teeth and toothbrushes to demonstrate toothbrushing techniques and had puppets of dentists available for children to play with to familiarize them with dental professionals' white coats and tools. Other grantees used models of teeth to demonstrate proper dental hygiene. Dramatic play centers helped familiarize children with the tools dentists and dental hygienists use, such as mirrors and flashlights. These play centers also contained other props, such as white coats, to allow children to become comfortable with the objects they would see at the dentist's office.

Within this approach, the research team identified four strategies that showed promise for replication: (1) have dental hygienists, dentists, or other oral health specialists conduct oral health education with children; (2) provide education during on-site services and at dental appointments; (3) integrate an oral health curriculum into daily or weekly lessons; and (4) conduct oral health education with children prior to dental services to familiarize them with dental services.

Strategy X.1.	**Have Dental Hygienists, Dentists, or Other Oral Health Specialists Conduct Oral Health Education With Children**	
Description	Grantees used dental partners, contractors, and oral health specialists to conduct education with children. In most cases, this education was conducted with Head Start children in each classroom and involved interactive activities and props. These partners conducted education with the children either annually or several times per year, and this activity often coincided with the delivery of on-site preventive care. An on-staff oral health specialist or coordinator played an important role in shaping the education that was provided to children. In some programs, this individual conducted frequent classroom education and in other programs conducted education only several times throughout the year. Community partners, such as dental hygienists and dentists, also provided classroom education for children and visited Head Start programs annually or up to a few times a year. Often these dental partners provided direct services to the Head Start children and used classroom visits to introduce themselves to the children.	
Examples from the Field	One program described the important role the oral health consultant played in classroom education when she visited each classroom approximately four times per year. She taught the children how to care for their teeth by using various materials and props to support her lessons, including puppets, songs, handouts, and dentistry tools. In addition, she modeled activities that teachers could then conduct with children throughout the year.	
Considerations	Staff Level of Effort:	Staff effort varied and was based on the frequency of education provided (e.g., annually or several times a year) and whether education was provided by community partners or the on-site oral health specialist.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Head Start children were the target population.

Strategy X.2. Provide Education During On-Site Services and At Dental Appointments		
Description	The OHI grantees provided education for children during dental appointments or during on-site services. In the cases where the oral health specialists were also registered dental hygienists, they conducted age-appropriate education with children while conducting oral health screenings and applying fluoride varnishes. Programs stated that children also received education during their dental appointments, provided either by the dentist or the dental hygienist.	
Examples from the Field	A few times a year, the oral health coordinator at one program conducted oral health screenings and fluoride varnish applications for all children. As she was conducting the screening and applying the fluoride varnish, she referenced an earlier lesson she conducted in the classroom, asked the children about their brushing habits and reminded them to brush after meals, and described how fluoride would make their teeth strong and protect them from cavities.	
Considerations	Staff Level of Effort:	Minimal effort was reported to be required on the part of the oral health coordinator or other individual providing on-site services.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	The target population included Head Start children able to understand the education and receive the dental service.
	Other:	Programs should also consider conducting education prior to the on-site service or dental appointment to ease children's concerns about the service (see Strategy X.4).

Strategy X.3. Integrate an Oral Health Curriculum into Daily or Weekly Lessons

Description	Most OHI grantees reported integrating a specific oral health curriculum or drawing from multiple curricula to enhance daily or weekly classroom lessons. Programs identified oral health curricula on oral health websites (e.g., National Maternal & Child Oral Health Resource Center or professional dental and medical associations). Curricula commonly used by grantees included "Cavity Free Kids" and "Bright Smiles, Bright Futures." Some programs used a structured approach and sought out appropriate oral health curricula; identified themes or topics to be addressed either weekly or monthly; developed classroom lessons for each topic; and planned skill-building activities and purchased props (e.g., models of giant teeth or puppets), toys, games, and books for these lessons. Other programs were less structured and allowed for more flexibility in how oral health was addressed in the classrooms. Some grantees provided education during toothbrushing, which took place one to two times each day. A number of programs set up areas in the classrooms—oral health corners—that contained books, toys, and props related to oral health. Grantees that hired oral health coordinators involved these individuals in identifying materials, developing specific lesson plans, and developing educational binders for each classroom.	
Examples from the Field	An education specialist at one Head Start program worked with its Head Start training and technical assistance specialist to integrate additional oral health education into the existing Head Start curriculum. To avoid burdening the Head Start teachers with additional activities, they identified language, literacy, math, and science lessons that promoted oral health and healthy practices and were consistent with the Head Start Child Outcomes Framework. These lessons were integrated into the existing Head Start curriculum.	
Considerations	Staff Level of Effort:	Significant up-front staff effort was needed for programs that incorporated a new curriculum and other activities in the classroom lessons. Programs reported that once educational components were integrated, however, they were relatively easy to sustain. The Head Start teachers conducted most of the education, although other staff members, such as the oral health coordinators and education managers, were also involved in classroom education, often by designing or selecting the curriculum.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Head Start children were the target population.

Strategy X.4. Conduct Oral Health Education with Children Prior to Dental Services to Familiarize Them with the Services

Description	The OHI grantees conducted child education focused on familiarizing children with dental services. For programs that provided on-site preventive services, an oral health specialist or coordinator often conducted visits with each Head Start classroom and used this time to introduce herself to the students and to talk about the services that would be provided. The oral health specialist described what would take place during the oral health screening and fluoride varnish application, showed the students the tools that would be used, and addressed any questions the children had. Typically, this education was conducted a day or two before the on-site service so children would be more likely to recall the information. Programs also used classroom time to educate students about what to expect during a visit with the dentist or during on-site preventive services. This strategy was important for children who had no prior experience receiving dental services. Programs used various formats. Some had specific books that described a visit to the dentist; others used dramatic play and had dental instruments and white coats available for the children. In most cases, education with children prior to dental services was conducted by an oral health specialist or coordinator, but some programs had their community partners come into the classrooms to speak with students.	
Examples from the Field	One program had a local dentist and a primary referral source conduct classroom education with Head Start children. The dentist reinforced lessons on oral hygiene and talked to the children about what to expect when visiting a dentist, in an effort to address any potential fears associated with the visit. She described what they would experience during a dental visit and gave them an opportunity to handle dental equipment and ask her questions.	
Considerations	Staff Level of Effort:	Staff effort depended on the number of Head Start classrooms in the program.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Children receiving on-site preventive services or those with no experience visiting a dentist were targeted.

CHAPTER XI

MANAGEMENT SYSTEMS

During site visits, grantees discussed the strategies that they implemented to integrate the OHI service delivery models they developed into existing program operations. Grantees reported developing policies, procedures, and monitoring systems to maintain high levels of implementation during the grant period and to sustain the services after grant funding ended.

Emerging strategies for integrating oral health–related activities and services into existing management systems include the following: (1) implement program policies and procedures on oral health components, including screenings and exams, education, toothbrushing, fluoride varnish and (2) integrate monitoring of oral health policies into agency-wide monitoring.

Strategy XI.1.	**Implement Program Policies and Procedures on Oral Health Components (Screenings and Exams, Education, Toothbrushing, Fluoride Varnish)**	
Description	Grantees developed and implemented policies and procedures on oral health. The policies were most frequently developed by health and oral health coordinators in consultation with program directors and other content coordinators. Grantees reported conducting research to ensure that the policies they implemented met recommendations on oral health released by dental associations and public health departments. For example, they followed American Academy of Pediatric Dentistry recommendations on periodicity schedules of dental exams and other preventive dental services. In addition, grantees developed policies that met the specific circumstances of their programs and the families they served.	
Examples from the Field	Several grantees developed written policies on procedures for toothbrushing in Head Start classrooms. Grantees that developed these policies conducted research on the procedures recommended by the American Academy of Pediatric Dentistry and the American Dental Association. The grantees developed procedures to ensure that the toothbursching process was efficient, minimized the risk of spreading oral bacteria among children and staff, and minimized children's risk of overexposure to fluoride. The policies grantees developed for toothbrushing described (1) how often children should brush their teeth (once a day after lunch), (2) how much toothpaste should be dispensed per child (a pea-sized amount of children's fluoridated toothpaste), and (3) how long children should brush (two minutes per child). Additionally, grantees tailored policies to the structure of their centers. For example, one grantee included guidance for classrooms with sinks and those without sinks: • At sites with access to sinks, children should be called up in small groups to brush their teeth to reduce overcrowding around the sinks and to allow staff to closely evaluate how well each child was brushing his/her teeth. • At sites without sinks, children should remain at their tables after meals and brush while they remained seated. Once they were finished, staff should give each child a disposable cup to spit in. Staff should then dispose of the cups.	
Considerations	Staff Level of Effort:	Staff time was required to research, develop, and train staff on the policies.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Head Start staff was targeted.

Strategy XI.2. Integrate Monitoring of Oral Health Policies into Agency-Wide Monitoring Systems

Description	Grantee management staff integrated all pieces of the OHI including the oral health–related services, education components, and policies into its existing agency-wide monitoring system. As a result, when content managers and other management staff visited Head Start centers and classrooms to observe program activities, they assessed if and how well oral health components were implemented. If staff identified a classroom or center that was not implementing oral health components, it targeted technical assistance to the center and classroom staff to assist with implementation. Grantees reported relying on education coordinators, health coordinators, and oral health coordinators to provide technical assistance.	
Examples from the Field	One grantee conducted internal monitoring annually in November and December of each program year. During the process, content specialists observed Head Start center and classroom operations to assess how well the program was adhering to Head Start Program Performance Standards and the agency's own operational standards. Management at this grantee integrated the policies and procedures related to oral health that the grantee developed through OHI into this monitoring system. If content specialists identified problems or issues, staff with content expertise addressed the issue by providing technical assistance to other staff members. For example, if lesson plans at one center did not include oral health topics, the education specialist worked with teachers to incorporate these topics into their daily routines.	
Considerations	Staff Level of Effort:	Integrating oral health–related activities into agencies' existing monitoring systems required staff time to develop policies, update monitoring systems, and train staff on the additional monitoring requirements.
	Program Characteristics:	There were no differences in implementation by grantee location, size, or program type.
	Target Population:	Head Start management made up the targeted population.

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