

2018



EFFECTIVE PARTNERSHIPS GUIDE

Improving Oral Health for
Migrant and Seasonal Head Start
Children and their Families



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ACKNOWLEDGMENTS

To improve the health of all Americans, national efforts are underway to promote health and prevent disease.¹ These efforts reach the most vulnerable and underserved populations, including migratory and seasonal agricultural workers (MSAWs) and their families. In 2013 and again in 2018, a Memorandum of Understanding (MOU) was signed between the Health Services and Resources Administration (HRSA), Bureau of Primary Health Care (BPHC) and the Administration for Children and Families (ACF), Office of Head Start (OHS), Migrant and Seasonal Head Start (MSHS) Regional Office.² The MOU expresses a joint commitment to coordinate resources and align policies at the national level. This MOU fosters partnerships at the national, state and local levels to ensure access to comprehensive, high quality, culturally-competent preventative and primary health services to the MSAW population.

This collaboration between MSHS programs (ACF/OHS) and the Health Center Program (HRSA/BPHC) affords both programs an opportunity to advance their respective missions and achieve improved programmatic as well as population-based health outcomes. MSHS programs and health centers already coexist in many communities and together, they support the improved health of MSAWs and their families. More and more partnerships are specifically addressing the oral health needs of MSHS children and their families. The lessons they have learned about oral health care are incorporated into this guide.

The purpose of this guide is to create an opportunity for MSHS and health centers to learn more about each other's programs, share resources, foster new partnerships and strengthen ones already in place. Although the guide focuses primarily on oral health, there is some information about medical health services too.

The guide is designed for many audiences:

- Directors and health staff of MSHS programs
- Health Services Advisory committees
- Technical assistance and training (T/TA) providers
- Directors and staff of the health centers
- Families and community stakeholders

The introduction provides background information on the key players: MSHS programs and the health centers.

MIGRANT AND SEASONAL HEAD START (MSHS) PROGRAMS

Head Start is a federally funded program that serves over one million children and pregnant women each year. It provides comprehensive services to support children's school readiness and family well-being. MSHS was established in 1969 to meet the unique needs of agricultural workers and their children. Among the designated regions in the Office of Head Start (OHS), MSHS is referred to as Region XII.

MSHS has always served infants, toddlers and preschoolers. Because the parents work long hours in the fields or the agricultural sector, MSHS centers operate for longer periods of the day, opening earlier in the morning and closing later than most Head Start programs. Some MSHS programs are short-term. They may be open for less than 90 days of the year, depending on the migratory cycle of the agricultural workers. The majority of MSHS programs are center-based; some grantees have opted to provide services in family child care. All MSHS children and families qualify for the same services in both settings.

¹ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. "Healthy People 2020." https://www.healthypeople.gov/sites/default/files/HP2020_brochure_with_LHI_508_FNL.pdf

² The 2018 Memorandum of Understanding (MOU) between MSHS, Office of Head Start and HRSA, Bureau of Primary Health Care will soon be available on the websites of the government agencies.

The majority of MSHS families originate from Mexico and Central America. The predominant home language is Spanish (82%); followed by English (12%) and indigenous languages (5%)³. It is important to recognize that the MSHS children and families represent multiple cultural and linguistic groups. The cultural, linguistic, migratory and agricultural experiences of MSHS children impact their development.^{4,5}

62 MSHS programs are funded to serve families and children in 38 states, providing an array of services to approximately 28,591 children of migrant and seasonal agricultural workers.

From the “Head Start Program Information Report (PIR); Region 12 Summary Report as of August 31, 2017.”

Migration can be a source of stress as families search for work and children acclimate to new living environments and early childhood settings. The agricultural environment presents unique hazards for young children. For example, they may be exposed to pesticides that can affect their developing brains. As a result, some children of agricultural workers have demonstrated poor fine motor skills in comparison to their peers. Data on MSHS children indicates that nearly one third are above the range for a healthy Body Mass Index⁶. Food insecurity and a sedentary life style at home may contribute to this alarming statistic.

An extensive review of the research on the development of the children of agricultural workers provides some insight into their strengths and challenges.⁷ Children are reported to be happy and secure in their family and community. Family bonds are strong and emerging literacy is supported in the home environment. A 2008 survey of MSHS staff indicated that the children demonstrate behavioral well-being. As expected, higher levels of child or family stress increase the likelihood of behavioral challenges. A multi-year, longitudinal study is currently underway to collect both qualitative and quantitative developmental data on MSHS children.⁸

ORAL HEALTH IN MSHS PROGRAMS

In 2008, OHS established the Dental Home Initiative (DHI) [formerly the Oral Health Initiative (OHI)] in response to the alarming national trend that depicted a steady increase in dental caries, the need for dental treatment among Head Start children, and a notable inability of Head Start families to access oral health care services.

Grounded in the former 1998 Head Start Program Performance Standards, the aim of the DHI was to ensure that all Head Start children and their families had access to a dental home—oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. OHS launched a national campaign to educate Head Start program personnel, families, providers and others about the importance of oral health and accessing routine dental care services. A variety of support services to achieve these family and program goals were disseminated.

Since the start of the DHI, many Head Start programs demonstrated success in their ability to obtain dental care and sustain dental homes for Head Start children and their families. MSHS programs also showed improvements in the oral health status of children and in effective service delivery.

Data from the 2017 Region XII Program Information Report (PIR), an annual report required of all Head Start programs, presents information about dental services for the MSHS program year (keeping in mind that some programs operate for 90 days or less).

³ Office of Head Start. “Head Start Program Information Report (PIR). Region 12 Summary Report as of August 31, 2017.” Retrieved on 10-17, 2017.

⁴ The CDM Group. “MSHS Design Project; Final Design Report.” May 2011. https://www.acf.hhs.gov/sites/default/files/opre/migrant_design.pdf
<https://www.acf.hhs.gov/opre/resource/design-for-migrant-and-seasonal-head-start-survey-final-design-report>

⁵ Some footnotes in this guide may reference sources in abbreviated form.

SUMMARY OF ORAL HEALTH SERVICES ACROSS ALL MSHS PROGRAMS¹⁰

	Dental Home	Preschool Preventative Care	Preschool Completed Dental Exam	Preschool Needed Treatment	Preschool Received Treatment	0-2 Up-to-Date on Dental EP-STD Schedule	Pregnant Women Completed Dental Exam
% enrolled in MSHS	94.77%	88.52%	91.91%	24.02%	84.37%	88.28%	52.61%

These 2017 statistics on the availability of oral health care for the MSHS children are compelling, although less so on the availability of care for pregnant women. Care for pregnant women is important because their poor oral health can affect their baby's health. Many preschoolers, nearly one fourth of the total MSHS preschoolers, needed treatment. Not all of them received it. It is likely that an adequate tracking system was not in place for the children whose families relocated. Without documentation of prior treatment, they would need to be re-evaluated in the new MSHS program. They would be counted as children who needed treatment and did not receive it. Relocation without adequate documentation also may explain the findings for pregnant women.

The PIR data indicates wide variation among the MSHS programs state-by-state. A handful of states reported 100% service delivery on some indices, some reported less than 50% on the indices. Although the overall trend for oral health services for MSHS children and pregnant women in 2017 is positive in comparison to earlier years, there is much room for improvement. The goal is to reach 100% service delivery in every MSHS program for every child, birth to five, and for every pregnant woman. This guide is designed to help MSHS programs make progress toward this goal.

Agricultural workers report that their oral health problems often are untreated, more so than their children's. Services are far away from their worksites; they cannot take time off from work. The cost of dental services is high in the United States, and some families decide to return to Mexico for treatment. Because family oral health practices impact the oral health of the children, it is important that MSHS continue to support oral health for all family members.

THE HEALTH CENTER PROGRAM

For more than five decades, the Health Resources and Services Administration (HRSA) has supported the Health Center Program. This is a national network of community-based health centers that provide comprehensive, culturally competent, quality primary health care services. Migrant health centers are part of this national system. The Health Center Program requires that all health centers provide and/or arrange for comprehensive primary health care services, including preventive oral health services - and as appropriate, oral health services beyond prevention - as well as vision, behavioral and substance abuse services and health education. Health centers also are required to provide /and or arrange enabling services, such as transportation, interpretation, and medical-legal assistance.

Health centers provide services at times and locations that assure accessibility and meet the needs of the population. They have a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. In addition, health centers serving agricultural workers address environmental health needs and hazards.

⁶ "Farmworker Justice. "Health Policy Bulletin." Winter 2018. <https://www.farmworkerjustice.org/sites/default/files/HPB%20Winter%202018%20FINAL%20%281%29.pdf>

⁷ The CDM Group. "MSHS Design Project; Final Design Report." May 2011. https://www.acf.hhs.gov/sites/default/files/opre/migrant_design.pdf

⁸ The CDM Group. "MSHS Design Project; Final Design Report." May 2011. https://www.acf.hhs.gov/sites/default/files/opre/migrant_design.pdf

⁹ American Academy of Pediatric Dentistry. "Council on Clinical Affairs, Reference Manual." v 32 / no 6 10 / 11

¹⁰ Office of Head Start. "Head Start Program Information Report (PIR). Region 12 Summary Report as of August 31, 2017." Retrieved on 10-17, 2017.

HRSA continues to work with national partners to provide oral health training, technical assistance, and resources to health centers and to explore ways to improve access to oral health care to underserved populations. HRSA seeks to improve access by increasing awareness of the connection between oral health and overall health by integrating oral health and primary care, improving oral health literacy, and promoting prevention.

35% of the children enrolled in MSHS received services from migrant health centers in 2017.

From the Head Start Program Information Report (PIR). "Region 12 Summary Report as of August 31, 2017."

In 2017, the Health Center Program served over 27 million patients who otherwise would have little or no access to care.¹³ Designated migrant health centers (MHCs) focus their efforts on the primary healthcare needs of migrant and seasonal agricultural workers (MSAWs) and their families. In 2017, there were 174 MHCs across the nation that served over 875,000 patients; of those, 35.12% were children under age eighteen. Nearly one million MSAWs were served by all health centers.

Although this guide was originally developed to improve oral health for Migrant and Seasonal Head Start children and their families, it can be used by other service areas at the health centers, including primary medical care, behavioral health services and vision services.

HOW TO USE THIS GUIDE

This guide is divided into nine chapters. Chapters III – IV focus on oral health and the work of the health centers.

- **Chapter I Introduction.** Overview of Migrant Seasonal Head Start and the Health Care Program
- **Chapter II About Head Start.** Description of the Head Start model of comprehensive services and the Head Start Program Performance Standards
- **Chapter III Oral Health.** Description of important aspects of oral health and risks.
- **Chapter IV Dental Care.** Information about various kinds of dental care.
- **Chapter V Financing Dental Care Services.** Description of various payment options.
- **Chapter VI Planning Ahead.** Guidance on creating formal partnerships, such as MOUs.
- **Chapter VII Education Programs and Resources.** Description of oral health learning goals and curricula.
- **Chapter VIII Building Effective Partnerships.** Identification of barriers and keys to success.
- **Chapter IX Conclusion.**
- **Appendices.** Tools and resources for MSHS programs and health centers.

Throughout the guide, key messages and practical tips are highlighted: **What MSHS and Health Centers Need to Know.**

This guide is intended to help both MSHS programs and health centers better understand oral health, dental care, their programs goals, and their complimentary roles to improve access to dental care for MSHS children and their families.

¹¹ Health Resources and Services Administration. "Health Center Program." <http://bphc.hrsa.gov/about/what-is-a-health-center/index.html>

¹² In this document, unless otherwise noted the term "health center" is used to refer to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended (referred to as "awardees") and health centers Look-Alike organizations, which meet all the Health Center Program requirements but do not receive Health Center Program grants. It does not refer to health centers that are sponsored by tribal or Urban Indian Health Organizations, except for those that receive Health Center Program grants.

¹³ Health Resources and Services Administration. "Health Center Program." <https://bphc.hrsa.gov/about/>

II. ABOUT HEAD START

THE HEAD START COMPREHENSIVE SERVICES MODEL

Since 1965, the Head Start program has provided grants to local public and private non-profit and for-profit agencies to provide comprehensive child development services to low-income families and their children. In fiscal year 1995, the Early Head Start program was established to serve pregnant women and children from birth to three years in recognition of the mounting evidence that the earliest years impact children's growth and development.

All Head Start and Early Head Start programs are designed to promote children's school readiness. They provide quality early childhood education, health, nutrition, and other services to ensure children's success in kindergarten and beyond. Programs are required continuously improve their service delivery. Programs are inclusive, enrolling children with disabilities and children who are dual language learners (DLLs) and ensuring their full and effective participation.

All Head Start and Early Head Start programs engage parents in their children's learning and support them in their role as their child's first teacher. Programs help them progress toward their own educational, literacy and employment goals. Significant emphasis is placed on the involvement of parents in the governance of local Head Start programs.

WHAT ARE THE HEAD START PROGRAM PERFORMANCE STANDARDS?

The Head Start Program Performance Standards (HSPPS) are federally mandated program requirements for health, education, parent involvement, nutrition, family services, transition, program management, financial management, facilities, and other program areas. They are established under federal law as part of 42 U.S.C. 9801 et seq., subchapter B of 45 CFR chapter XIII of the Improving Head Start for School Readiness Act of 2007. Like all Head Start programs, MSHS programs are responsible for reviewing and following the HSPPS to ensure quality services for children and their families.

Head Start Program Performance Standards pertaining to oral health needs and oral health care
<https://eclkc.ohs.acf.hhs.gov/policy/pi/acf-pi-hs-16-04>

§1302.40 Purpose.

§1302.42 Child health status and care.

(a) Source of health care.

(b) Ensuring up-to-date child health status.

(c) Ongoing care.

(d) Extended follow-up care.

(e) Use of funds.

§1302.43 Oral health practices.

§1302.46 Family support services for health, nutrition, and mental health.

(a) Parent collaboration.

(b) Opportunities

§1302.80 Enrolled pregnant women.

(c) (See Appendix A for the HSPPS relevant to oral health care and services)

The 2016 Head Start Program Performance Standards (HSPPS) support the oral health needs of enrolled children (§1302.40, 1302.42, 1302.43).¹⁴ The HSPPS require programs to obtain determinations from health care and oral health care professionals as to whether or not children are up-to-date on a schedule of age appropriate preventive and primary medical and oral health care, based on the well-child visits and dental periodicity schedules as prescribed by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the state in which they operate. In addition, programs must facilitate and monitor necessary oral health preventive care, treatment and follow-up, including topical fluoride treatments. In communities where there is a lack of adequate fluoride available through the water supply, and for every child

¹⁴ Office of Head Start. "Program Performance Standards." 2016. <https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/part-1302-program-operations>

with moderate to severe tooth decay, a program must also facilitate fluoride supplements, and further oral health treatment as recommended by the oral health professional. Programs are required to promote tooth-brushing with fluoride for children who have teeth. Programs also must provide education support services to families to promote children’s oral health and preventative care (§1302.46). Programs also are required to facilitate access to oral health care for enrolled pregnant women (§1302.80).

Other HSPPS that are not detailed under the health area, apply to oral health services. For example, requirements about educational curricula (§1302.32) and program improvement (§1302.102) are relevant. An in-depth knowledge of the HSPPS helps to ensure implementation of quality oral health services.

ONGOING SOURCE OF CARE IN MSHS

The HSPPS (§1302.42) require that programs determine if a child has an ongoing source of continuously accessible oral health care. Efforts to begin and complete all annual dental care as early as possible in the program year are essential. When treatment completion is impossible due to the family’s migratory work schedule, a specific referral site for treatment completion needs to be identified and an appointment scheduled when possible. Assistance to families and providers in the transfer of dental records is recommended to assure continuity of care for the Head Start child. Many MSHS programs and health centers share electronic records.

EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) REQUIREMENTS IN MSHS

The HSPPS (§1302.42) refers to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services program. This is a comprehensive and preventive child health program for children and youth enrolled in Medicaid. EPSDT was first defined by the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) and includes requirements for periodic primary health care screening, including vision, dental, behavioral health, and hearing services. It requires state Medicaid agencies to pay for services that are deemed medically necessary. Under the Medicaid EPSDT program, each state must:

- Ensure the availability and accessibility of required health care resources; and
- Assist Medicaid recipients and their parents or guardians in the effective use of these resources.

What MSHS Programs Need to Know

Timing is Important.

The HSPPS (§1302.42) set these timelines:

- Within 30 calendar days after the child first attends the program:
 - parents must be consulted to determine whether each child has ongoing sources of health care provided by a health care professional that maintains the child’s health records.
- Within 90 calendar days after the child first attends the program:
 - the program must obtain determinations from health care and oral health specialists as to whether the child is up-to-date on dental periodicity schedules
- Exception: If a program operates for 90 days or less it has 30 days from the date the child first attends the program to satisfy the requirements stated above.

What MSHS Programs Need to Know

You should be aware that each state has the ability to define “medically necessary”. What may be deemed “medically necessary” in one state, may not be in another. Under all state Medicaid EPSDT programs, comprehensive dental examinations, x-rays, dental prophylaxis (cleanings), fluoride and sealants and restorative treatment are covered benefits. Yet, these benefits differ in each state by: 1) age of beneficiary; 2) who is the provider (dentist, dental hygienist, dental assistant; physician); 3) frequency of services per visit and per year and in some cases by the materials used. Understanding these specifications will assist budget conscious administrators when developing business plans that include payment for dental services.

DENTAL PERIODICITY SCHEDULES IN MSHS

The American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) have developed recommendations for the routine provision of professional pediatric health and oral health care services. These recommendations, also called periodicity schedules, represent a consensus by both organizations and have been designed to emphasize the importance of continuity of care and the need to avoid fragmentation of care. The dental periodicity schedules specify the ages and intervals when children should receive specific dental services.

What Health Centers Need to Know

You can be very effective in collaborating with MSHS to ensure the following services, as outlined in the EPSDT, are provided to the children.

1. Enrollment in Medicaid or CHIP
2. Dental examination
3. Treatment plan
4. Prophylaxis (dental cleaning)
5. Fluoride treatment
6. X-rays if indicated
7. Therapeutic (restorative) services if indicated
8. Referral to specialty care if indicated
9. Transition plan: Referral to other providers
10. Provision for emergency care
11. Provision for after-hour care
12. Linkage to primary care provider- medical care

¹⁵ American Academy of Pediatrics; <http://practi ce.aap .org/ popup.aspx?aID=16 25&language =>

¹⁶ Academy of Pediatric Dentistry. “Guidelines on Periodicity of Dental Examination.” http://www.aapd.org/policy_center/state_dental_ periodicity_ schedules/

What MSHS Programs and Health Centers Need to Know

Many state Medicaid agencies have adopted the AAPD dental periodicity schedule, but others have not. It is important for you to be aware of each state Medicaid agency's periodicity schedule for dental services. If a state Medicaid periodicity schedule does not specifically list a designated dental service, or if the state does not have an available periodicity schedule, it may not cover the dental provider's fee for that service. This may impact your budget and planning processes for dental care services for the respective age group. You can find the dental periodicity schedules for each state at the website for the American Academy of Pediatric Dentistry.

PROGRAM INFORMATION REPORT (PIR)

The Head Start Program Information Report (PIR) provides comprehensive data on the services, staff, children and families served by Head Start, Early Head Start and MSHS programs. All grantees and delegates are required by federal law to submit annual PIRs to OHS. These reports provide service data for each Head Start program.

OHS has established five oral health- and dental care-related PIR performance indicators.¹⁷ These indicators (or measures) align with HSPPS §1302.42. All Head Start programs are expected to comply with the HSPPS and document their program performance annually on their PIR.

MSHS data from the 2017 PIR are presented in Chapter I of the guide and indicate that a high percentage of children are receiving oral health services. However, there is wide variation from state-to-state on the oral health indicators reported by MSHS programs.



What MSHS and Health Centers Need to Know

You need to consider the transitory nature and limited residential period of the migrant family when planning for primary health care and oral health services of MSHS children. MSHS children need to receive comprehensive oral examinations as early as possible following enrollment. This would allow for adequate time for the scheduling and completion of any needed restorative treatment. When the completion of a treatment plan is not possible, the health centers and the MSHS program can help the family transition to the next provider by passing on the necessary records.

¹⁷ Office of Head Start. "PIR Program Indicator Formulas." <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/2017-2018-pir-performance-indicator-formulas.pdf>

III. ORAL HEALTH

IMPORTANCE OF ORAL HEALTH

Oral health is essential to the health and well-being of young children as they grow and develop in the first five years. A pregnant woman's oral health also is important for her developing baby. Oral health is the condition of being absent of disease and chronic pain allowing the craniofacial tissues and structures to function, and the condition which is necessary to maintain optimum oral-facial structure and function. It allows individuals to speak, smile, kiss, taste, chew, swallow, and communicate to others an array of feelings and ideas both verbally and non-verbally. Oral health contributes to the school readiness of all children.

Oral health among MSHS children is variable. Due to a variety of environmental and socio-cultural conditions, many MSHS children and their families experience disproportionate levels of dental disease (dental caries). This means that MSHS children and their families not only experience more disease than other children and families, but also more extreme levels of disease. The result is increased pain, suffering, and a reduced ability to excel in school or in the workplace. Data from a 2008 survey of MSHS staff reported health concerns for the children, primarily anemia, asthma, and oral health. Helping MSHS children and their families access dental care services is an important step in helping them attain and sustain oral health.

Under the U.S. Department of Health and Human Services, The Healthy People 2020 initiative serves as a roadmap for tracking the nation's health, including oral health. Like general health, oral health status in the United States tends to vary based on social and economic conditions. In 2012, an oral health indicator was selected to be one of the 12 leading health indicators for the nation. The objective monitored is:

Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year.

From the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. <https://www.healthypeople.gov/2020/leading-health-indicators/2020-LHI-Topics>

What MSHS Programs and Health Centers Need to Know

MSHS children and their families not only experience more oral disease than other children and families, but also more extreme levels of disease. Consequently, the children's learning and development can be adversely affected.

DENTAL CARIES— “Cavities” or “Tooth Decay”

Dental caries, also known as “cavities” or “tooth decay,” is the most prevalent chronic childhood disease. It is an infectious, progressive and destructive disease of the teeth that continues to be one of the major health problems in the United States, especially among low-income and minority children. This disease is preventable, but when left undiagnosed and untreated, imparts chronic pain and suffering. A child’s ability to chew food, speak, and develop socially and cognitively is impacted. Children in pain are unable to direct their energy and attention to learning.



What MSHS Programs and Health Centers Need to Know – and Communicate to Families

“Baby Teeth” are important. The best way to protect a child from dental caries (tooth decay) in their permanent (adult) teeth is to prevent it in the baby teeth.

Dental caries is infectious. The bacteria that cause cavities are transferred through the saliva from mother/caregiver to child when they test the temperature of the milk in their mouth first, or when cleaning pacifiers/bottle nipples with the mouth before giving them to the child.

Dental disease is manageable. Once the disease-producing bacteria are transferred from mother to child, cavities can still be prevented. Teeth exposed to fluoride toothpaste twice daily are more resistant to tooth decay.

What Can Be Done?

Establish a dental home by age one. Accessing routine dental care services helps prevent and manage dental disease.

Maintain oral health during pregnancy. Women of childbearing age should receive routine dental care even during pregnancy to ensure optimum oral health for both mother and child. Periodontal disease may be linked to adverse pregnancy outcomes such as preterm birth and low birth weight due to chronic inflammatory oral bacterial infection.

From “Oral Health in America: A Report of the Surgeon General. Executive Summary.” 2000.

¹⁹ The CDM Group. “Design Project; Final Design Report.” May 2011 <https://www.acf.hhs.gov/opre/resource/design-for-migrant-and-seasonal-head-start-survey-final-design-report>

²⁰ US Department of Health and Human Services. National Institute of Dental and Craniofacial Research, National Institutes of Health. “Oral Health in America: A Report of the Surgeon General-- Executive Summary.” Rockville, MD. May 2000. <https://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Report/ExecutivSummary.htm>

IV. DENTAL CARE

THE DENTAL HOME

Establishing and maintaining a good relationship with an oral health provider is important and will help to prevent tooth decay (cavities) and sustain oral health. The dental home is the dental office or clinic where the comprehensive oral exam takes place. A health center can serve that purpose. Health centers along the family's migratory route can serve as "extenders" of the dental home.

The first dental visit is critical for establishing a good relationship and should take place usually at the time of the eruption of the first tooth and no later than 12 months of age. This is referred to as the Age One Dental Visit.

From the outset, it is important to keep track of the oral health status and services that MSHS children and pregnant women receive. This information helps ensure that their needs have been identified and are being addressed. This tracking can feed into the program's self-assessment process and into the PIR data collection. Programs can download oral health forms for children and pregnant women that have been developed by the Head Start National Center on Early Childhood Health and Wellness.²¹ These electronic forms can be filled out by MSHS and/or the oral health provider. Programs also can develop their own forms.

What Health Centers Need to Know

When a MSHS family initiates dental care in a health center, all efforts to complete treatment should be made. Because MSHS families reside for such brief periods of time in each location along the migratory route, your administrators should be keenly aware of the narrow window of time available for the completion of treatment. If treatment plans cannot be completed as planned, use the Migrant and Seasonal Head Start Centers and Health Centers Locator mobile app (Google Play and iTunes) and/or the webpage <http://migranteheadstart.com/#/> to refer the patient to the health center near the family's future work site.



²¹ Office of Head Start. "Head Start Oral Health Form." <https://eclkc.ohs.acf.hhs.gov/oral-health/article/oral-health-forms>.

COMPREHENSIVE ORAL CARE

All children should receive routine, comprehensive oral health care services from their dental provider, often a health center. The care includes an oral (dental) examination as well as preventive and treatment services. When assessing a child's health and oral health record, the following services should be completed and documented:

ASSESSMENT and PREVENTIVE SERVICES	FREQUENCY of SERVICES (BEST PRACTICE)
Dental Examination by a dentist: Examination of teeth and mouth Identification of oral disease and any abnormal oral conditions (Diagnosis) Development of a treatment plan	→ First examination should take place at the eruption of the first tooth and no later than 12 months of age. → Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
Dental caries risk-assessment	→ Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
Radiographic assessment (X-rays)	→ Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
Teeth cleaning (Prophylaxis)	→ Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
Fluoride treatment (fluoride varnish)	→ Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
Assessment and placement of dental sealants	→ For primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures of children at elevated caries risk; sealants should be placed as soon as possible after eruption
Assessment for malocclusion	→ Annually
Parent Counseling: Anticipatory guidance Dietary guidance Oral hygiene Injury prevention Speech and language development	→ Appropriate discussion and counseling should be a part of each dental visit.
TREATMENT SERVICES	FREQUENCY of SERVICES
Treatment services: Tooth restoration (fillings or crowns) Extractions Space maintainers and or other interceptive orthodontics	→ Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease. → All treatment planned should be completed within 6 months of dental examination.

The Dental Examination

Dental examinations are provided by licensed dentists. A dental exam is a type of oral evaluation that includes the comprehensive assessment of the teeth and all of the oral-facial structures. The components of a dental exam include the assessment of:

- General health/growth
- Pain
- Extra-oral soft tissue
- Temporomandibular Joint (TMJ)
- Intraoral soft tissue including periodontal health
- Oral hygiene
- Intra-oral hard tissue (teeth)
- Developing occlusion
- Caries risk
- Behavior

What MSHS Programs Need to Know

Your program is required to obtain a determination from health care and oral health care professionals whether a child is or is not up-to-date on a schedule of oral health care based on the dental periodicity (EPSDT) program. If necessary, your program must assist parents in bringing the child up-to-date or directly facilitate provision of health care services. You must observe the timelines too, you have 30 days to determine if a child has access to continuous, accessible oral health care and then 90 days to determine the child's oral health status. If you have a short-term program, you have 30 days.



The Dental Screening

Dental screenings are a type of oral assessment that makes limited observations of the teeth and other oral structures. The screenings for MSHS children are usually conducted in the centers or family child care homes by dental auxiliary personnel/staff, such as dental hygienists and assistants, and other non-dental healthcare providers, including physicians, nurse practitioners and physician assistants. They identify conditions warranting a follow-up dental exam by a dentist. This exam usually takes place at a health center which has resources for exams and treatment. All MSHS children qualify for screenings because the cost is covered by Medicaid through EPSDT.

²² Academy of Pediatric Dentistry. "2018-19 Definitions, Oral Health Practices and Recommendations." http://www.aapd.org/media/Policies_Guidelines/BP_Periodicity.pdf

THE DENTAL EXAM VS. THE DENTAL SCREENING

Head Start administrators should understand the difference between a “dental examination” and a “dental screening.” The following chart lists the key differences:

DENTAL EXAMINATION (COMPREHENSIVE ASSESSMENT)	DENTAL SCREENING (LIMITED ASSESSMENT)
Clinical oral assessment	Clinical oral assessment
Used to: → Identify healthy and normal oral conditions → Diagnose oral disease and abnormal conditions	Used to: → Identify normal and abnormal oral conditions. → Triage treatment urgency and referrals to dentists and dental specialists.
Performed by: → Dentist	Performed by: → Dentist → Hygienist → Physician → Nurse → Other trained healthcare provider
Establishes a “treatment plan”: → Preventive treatment plan → Restorative treatment plan → Referral for specialty services	Establishes a referral: → Urgent care → Dental home → Dental examination → Diagnosis → Treatment plan → Specialty services

DENTAL CARIES RISK ASSESSMENT

Dental caries risk assessments are used by dentists to quantify a child’s susceptibility to dental caries (tooth decay). They are used to identify and minimize factors that contribute to dental disease. They take into account lifestyle behaviors and other observations made during dental examinations to help determine the best course of treatment. Many dental providers use a caries risk assessment form.²³ The determination of high, moderate, or low risk is based on the balance or imbalance of known risk and protective factors. The major risk and protective factors for dental caries are listed in the following table.

MAJOR RISK FACTORS for DENTAL CARIES	MAJOR PROTECTIVE FACTORS
→ Mother/caregiver has active caries	→ Fluoride
→ Parent/caregiver has low socioeconomic status	→ Dental sealants
→ Child has >3 between meal sugar-containing snacks or beverages per day	→ Daily oral hygiene to reduce bacteria
	→ Carbohydrate regulated diet
	→ Normal salivary function
	→ Age 1 preventive dental visit

²³ American Dental Association. “Caries Risk Assessment Form.” http://www.ada.org/-/media/ADA/Member%20Center/Files/topics_caries_educational_under6.pdf?1a=en

TREATMENT PLANNING

Every time a child receives a dental examination, the dentist performing the examination makes a determination of health. This includes a diagnosis when disease is present and an appropriate course of treatment, also known as a treatment plan.

No Disease Present: When a child presents with a healthy mouth, and no cavities or other diseases and conditions are present, the treatment plan is called a maintenance plan. This aims to maintain or sustain oral health. Depending upon the risk assessment of the child, the maintenance plan may include preventive fluoride and or dental sealant services.

Early Stage Dental Caries:

When the child presents with early stage dental caries (no visible cavities, but evidence of disease), the dentist may recommend fluoride and/or dental sealants.



These services are important because they help to prevent cavities from forming. They are often completed at the same time as the dental examination with additional follow up appointments sometimes recommended.

Late Stage Dental Caries: When the child presents with cavities, this is a later stage of dental disease. At this point, treatment to “restore” the structure and function of the teeth with filling(s) is necessary. A restorative treatment plan includes the full scope of services that are being recommended. The teeth letters or numbers that need restoration, the nature of the restoration and the number of visits to complete care are detailed.

PREVENTING AND MANAGING DENTAL DISEASE

Beginning in early childhood, prevention strategies should be employed to keep children healthy and free of dental disease. Good daily personal hygiene and routine professional services, together, help to ensure the prevention and management of dental disease. Professional oral health care services that help to prevent and manage dental caries include: dental prophylaxis or

cleanings; professional fluoride treatments or fluoride varnish; and dental sealants. The HSPPS (§1302.42) require that programs have in place a plan of preventative care, treatment and follow-up, including topical fluoride treatments. Programs also must provide more intensive fluoride treatment in communities lacking fluoride and for children with serious decay. The HSPPS (§1302.46) also goes one step further, requiring programs to collaborate with parents to promote and learn about oral health and preventative care.

What MSHS Programs Need to Know

Dental cleanings, fluoride varnish, treatments and dental sealants help prevent and manage dental caries. Medicaid covers these services and the number of fluoride varnishes and dental sealants’ coverage may vary per state. You can assist parents in understanding the preventive benefits of these services. Children that have been determined to be at a high or moderate risk for dental caries should receive these preventive services more frequently than those designated as low risk.

COMPLETING DENTAL TREATMENT PLANS

All dental treatment prescribed by a dentist and outlined in a treatment plan should be completed within the time the MSHS children and their families are in the community. Planning ahead will help programs complete treatment within a reasonable time period. For children requiring extensive restorative care, a plan should be established that will ensure all prescribed treatment will be completed. Ideally, this means before the child and their family move to their next location. If there is a need for continued care, there needs to be a health center referral plan to assist the family in accessing care in their next location. HRSA advocates the use of electronic health records by health centers; they can be passed on to families and other health centers to avoid duplication of services and ensure treatment plans are coordinated with the next provider.

V. FINANCING DENTAL CARE SERVICES

Oral health care is an essential component of pediatric primary health care. Routine oral health assessment and preventive services help to attain and sustain oral health. The costs of these services are generally minimal once oral health is achieved. However, comprehensive dental care sometimes requires treatment services that exceed routine assessments and prevention. These treatment services, which include restorations or fillings, crowns, extractions and sometimes interceptive orthodontic, can be costly. Although preventing dental disease is the ideal way to minimize dental care costs, consideration for costs of comprehensive treatment regimens for each child is necessary when planning and budgeting overall program costs.

There are several payment models to finance dental care services. During the planning process, it is important for the MSHS program and the health center to have a mutual understanding of how they will handle the financial aspects of their collaboration, including funding mechanisms for both programs; outreach and enrollment in health insurance coverage; and presumptive eligibility for Medicaid or CHIP. A basic description of different financial arrangements follows.

INSURANCE, MEDICAID AND CHIP

Health insurance is a type of insurance that covers medical, dental, and hospital expenses and prescription costs. The benefits are administered by a health insurance company, managed care organization (MCO), state or federal government agency. The amount of coverage varies tremendously depending on the health insurance plan.

Due to their income status, MSHS families are usually eligible for health insurance benefits under the federal-state Medicaid or Children's Health Insurance Programs (CHIP). For Medicaid- and CHIP-eligible children, dental benefits are included in this coverage.

The **Medicaid Program** is the federal entitlement program enacted in 1965 under Title XIX of the Social Security Act. It is jointly administrated by federal and state governments and charged with implementing the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. It pays for “medically necessary” services, including dental care for enrollees (those individuals who meet specific age, health and income eligibility requirements). It is important to note that EPSDT services are federally mandated services that all states must provide. There are core eligibility requirements set by the federal government, but states may increase these lower threshold limits to cover additional low-income beneficiaries. This is why eligibility, benefits and payment for services vary depending upon specific criteria set by each state Medicaid agency.

Under each state's Medicaid EPSDT Program, any dental service deemed “medically necessary” is a covered benefit. States are required by the Centers for Medicare and Medicaid Services (CMS) to establish, update and publish a fee schedule of all allowable dental services covered under the pediatric Medicaid dental benefit. This schedule is most often accessible online via each state's Medicaid website.

What can MSHS programs do to promote accessible and affordable oral health care?

- Facilitate outreach and enrollment of children in Medicaid, CHIP and enrollment in Health Insurance Exchanges as well as other public or private insurance programs.
- Explore the potential for Medicaid reimbursement for children who need dental care services.

The **Children’s Health Insurance Program (CHIP)** is the federal-state medical assistance program that was enacted in 1997. This medical assistance program pays for health care services, including dental care, for children whose family’s income is slightly higher than those eligible for Medicaid. The CHIP-eligibility income scale, similar to Medicaid, differs by state; with the lower level threshold defined by the federal government. CHIP defines the dental benefit as those services “necessary to prevent disease and promote health, restore oral structures to health and function, and treat emergency conditions.

PAYMENT MODELS

Fee-for-Service (FFS) or Traditional Health Insurance is a payment model where fees and payment rates are established for individual services. Under this model, an individual goes to a dentist of their choice, receives dental care and pays a total amount based on the sum of the costs associated with each of the services provided. If the individual has private dental insurance, they may submit the claim to their insurance company for reimbursement of services covered. These insurance plans often require a copayment, impose an annual deductible and apply benefit limitations. FFS is the dominant payment method for dental care in the United States. It is also the model traditionally used by state Medicaid agencies to pay Medicaid dental providers. This model is also widely used by non-Medicaid participating dental providers and by some health centers.

Managed Care is a payment model or system of payment that uses a variety of strategies to reduce healthcare costs and improve the quality of services. Many state Medicaid agencies contract with managed care organizations (MCOs) to manage all or part of their dental benefits program. Under a state Medicaid-managed care contract, the state pays the MCO a capitated set amount per member per month for the services outlined in the contract. Although these contracts vary widely, a contracted MCO may wholly or in-part administer the dental program for the state, establish a network of providers, coordinate care, and manage the payment for services rendered. MCOs appoint case managers to assist Medicaid families in accessing dental services. Often a state Medicaid agency will contract with multiple MCOs to administer the state dental program. Plan benefits differ among the various MCO vendors. In addition, in some states, families may be allowed to select a “plan,” while in other states, they may be assigned. It is often difficult for families to make these choices when their knowledge and understanding of health care and health insurance are limited.

What MSHS Programs Need to Know:

In any given state, multiple MCO vendors may be contracted by the state Medicaid agency. Each vendor may administer a varied dental benefit package with a different fee structure. You can assist families in either selecting a plan or MCO vendor that best meets their needs. By knowing and understanding dental care and the benefits offered by each MCO, you may be able to provide guidance and support to the family. If the MCO establishes case managers, you can establish relationships with them or maybe serve as a liaison with the MSHS families.

Prospective Payment System (PPS) is the primary method of payment for services provided by health centers. It is a reimbursement method where Medicaid payments for healthcare services, including dental care, are made based on a predetermined fixed amount. The fixed amount is established and updated as necessary based on a formula and the actual costs of services. The health centers will generally know the method and amount paid by Medicaid in their state. In the event services are not covered by a third party, such as Medicaid, CHIP, or private insurance, the MSHS program needs to seek other methods for the payment. The HSPPS (§1302.42(e)) allow program funds to be used for professional oral health services when no other source of funding is available. Agencies must provide a written explanation of their unsuccessful efforts to access other funding sources.

The Health Center Program Compliance Manual (“Compliance Manual”) details a number of financial arrangements.²⁶ For instance, health centers are paid a PPS rate under the Medicaid and Medicare program that is unique to each health center based on the cost and scope of services provided. Also, the Health Center Program receives an annual grant from HRSA to subsidize the care for patients whose income falls below 200% of the Federal Poverty Level.

What MSHS Programs Need to Know

You should be aware of which payment models are used in each of the states and provider locations (private office/health centers) where the MSHS children and families will obtain services. This information may be used to strategically budget resources, enroll children and families in specific state Medicaid and CHIP programs; negotiate contracts and plan ahead for dental services. To optimize payment for services, you should carefully consider the eligibility criteria and fee structure when assisting families in the Medicaid enrollment process.

What MSHS Programs and Health Centers Need to Know

You need to be informed about the sliding fee requirements for health centers. All required and additional services within a health center’s approved scope of practice must be offered on a discount according to the sliding fee requirements delineated in the Compliance Manual, Chapter 9, Sliding Fee. A health center sliding fee discount program is based on income and family size and applies to all patients – whether or not they are insured. The sliding fee requirements apply to oral health treatment for MSHS children and pregnant women, and in this way, families are not burdened by the costs of exams and treatment.

²⁶ Health Resources and Services Administration. Health Center Program Requirements. “The Health Center Program Compliance Manual.” August 2018. <https://bphc.hrsa.gov/programrequirements/index.html>.

VI. PLANNING AHEAD

PARTNERING WITH HEALTH CENTERS FOR DENTAL CARE

Collaborating with health centers is an ideal strategy for accessing health care including dental care services for MSHS children and their families. Health centers offer a wide array of primary and preventive care, dental, behavioral health, vision and other ancillary services such as community outreach, translation, care management, transportation and other enabling services making it easier to facilitate access to care. This section discusses the steps for planning and successful partnering between MSHS programs, local health centers and other social and support services providers. The goal is for the partners to develop a Memorandum of Understanding (MOU) that details their collaboration: the shared resources, the services provided, the personnel involved, any timelines and other critical elements. Most often, financial arrangements are detailed in contracts between the partners rather than in MOUs.

Information and tips about creating partnerships are available at the Head Start website portal: <https://eclkc.ohs.acf.hhs.gov/local-early-childhood-partnerships/article/partnerships-relationships-resources>

GETTING STARTED ON MOUS

The key to an effective partnership is planning, planning and more planning. The best way to accomplish this is by scheduling an initial contact meeting of the key management staff and decision makers from both the health centers and MSHS programs. Together, they develop a strategy for ongoing planning involving program level staff, such as the clinic manager, nursing and medical/dental provider and MSHS program staff who are responsible for service delivery and planning.

Throughout the partnership, communication is essential. All parties need to be committed to open and honest exchanges - both to solve problems and to celebrate successes!

INITIAL CONTACT MEETING

Why an initial contact meeting?

An initial contact meeting introduces the key individuals from each program who will serve as the decision makers. This face-to-face meeting is important because it builds trust between the potential partners. During this meeting, administrators from both programs share key information that provides insight about the need for services and benefits of collaboration. In addition, the two groups may begin to identify resources, acknowledge services already in place, discuss the potential for collaboration and the involvement of other stakeholders.

What are the goals of the initial contact meeting?

- 1) Introduction of leadership staff from each program, meet the program level staff (staff responsible for service delivery); understand each other's organizational culture; capacity limitations, desired outcomes; identify areas of collaboration, payment arrangements/options; establish care teams from each program.
- 2) Establish a collaborative opportunity between the local health center and the MSHS program to provide primary health care and oral health services to MSHS children and their families.
- 3) Explore additional opportunities between programs to provide a home-base for health care, as well as other social and support services to MSHS children and their families.

²⁷ The OHS National Center for Program Management and Fiscal Operations develops resources, including guidance on creating MOUs and other partnership documents. <https://eclkc.ohs.acf.hhs.gov/program-planning>

When should this meeting take place?

The initial contact meeting takes place approximately 6-9 months before the anticipated need for primary health care and oral health care services. The MSHS executive director or program appointee can develop a letter of invitation to the executive director of the health centers network. The letter or email can include a brief summary of the MSHS program, along with the following information:

- Mission of the MSHS program
- Statement of recognition that the health centers provide community-based primary care/dental care services
- Statement of alignment of services between the two programs
- Statement of need for medical, oral health, behavioral and other health services
- Invitation to partner
- Invitation to attend an initial contact meeting
- A copy of the Memorandum of Understanding between The Administration for Children and Families, Migrant and Seasonal Head Start Program, Office of Head Start and The Health Resources and Services Administration, Bureau of Primary Health Care

Seven to ten days after the letter or email has been sent, a follow-up phone call from the executive director of the MSHS program to the executive director of the health centers can be made. The purpose of the call is to confirm receipt of the letter or email and to arrange for a face-to-face meeting.

Who should attend?

All key strategic partners and decision-makers need to be present at the initial contact meeting. This includes:

- MSHS executive director
- MSHS health manager
- MSHS chief financial officer
- Health center executive director
- Health center medical and dental director
- Health center chief financial officer

What MSHS Programs Need to Know

For future meetings, you may want to include input from other key staff, decision makers and/or community representatives, such as local school administrators, social service agencies and employers.

What information should be shared and discussed?

General information about the MSHS and health center programs can be shared during the initial contact meeting. Each program can prepare and present a brief program description. Listed below is useful information to share. These key items provide critical insight to help both the health center and MSHS administrators decide if a partnership is feasible.

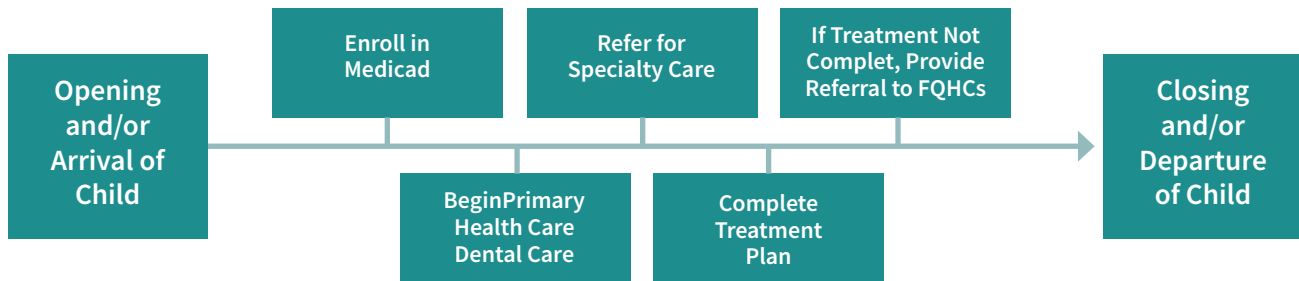
MSHS Programs

MSHS programs can provide a one-to-two-page overview that includes:

- Name of the program
- Contact person(s); name; address; telephone number(s); email
- MSHS eligibility criteria
- Number of sites; number of classrooms
- Number of current MSHS families; number of enrolled children; and number of siblings
- Number of children eligible for Medicaid and/or Children's Health Insurance Program (CHIP)
- Number of children not eligible for Medicaid or CHIP or have any other third-party insurance
- Program data from the previous two years to justify enrollment and service needs
- Timeline with anticipated arrival month/date; length of time in community; departure month/date if known for each family
- Estimated amount of time to begin and complete treatment for each child

²⁸ The 2018 MOU will soon become accessible on the Head Start website under the MSHS Collaboration Office. <https://eclkc.ohs.acf.hhs.gov/programs/article/migrant-seasonal-head-start-collaboation-office>

SAMPLE TIMELINE



Information about the service needs for each child can be presented in chart form.

Service needs for each child, including:

- Enrollment in Medicaid or CHIP if eligible
- Primary healthcare and oral examination
- Treatment plan
- Prophylaxis
- Fluoride treatment and dental sealants if indicated
- X-rays if indicated
- Therapeutic (restorative) services if indicated
- Referral to specialty care if indicated
- Transition plan: Referral list of Health Centers along the migratory route the MSHS family will follow
- Provision for emergency care
- Provision for after-hour care
- Linkage to primary care provider medical care
- Any special health or dental care needs anticipated
- Additional primary health care, social and support service needs of the MSHS program, children and their families
- Primary language of the family and need for interpretation or translation services

Health Centers

Health centers can provide a short overview that includes:

- Name of the health center program
- Contact information:
 - Contact name
 - Address
 - Telephone number
 - Email
- Number and location of site(s) and outreach service locations; such as school-based/linked dental programs; mobile dental vans/units
- Hours of operation

Services provided by the health center by site/location, including:

- Oral health/dental
- Primary care
- Social
- Other support
- Linkages to services not provided by health center
- After-hour coverage
- Provisions for emergency care
- Specialized dental care, such as transitional care; pediatric specialty on site
- Current and anticipated service capacity: health centers need to share information about the number of dental providers in their center, and their ability to augment service capacity by hiring additional temporary providers to meet the needs of the MSHS programs
- Any unique or special information, such as availability of interpreters or transportation services
- Other items for discussion

To facilitate a timely start, and assure that all planning and provisions for services are in place, the agreement should be signed at least 5 months prior to the anticipated delivery of dental care services.

COLLABORATIVE PLANNING MEETING

The purpose of the planning meeting is for MSHS and health center program administrators to meet face-to-face to devise a mutual plan that will address the needs of the children and their families and ensure high-quality service delivery from each of their programs. During this meeting, the joint group identifies, details and documents the following:

- Child and family services that will be provided: oral health care; primary care; social; other support services
- Scope of service(s)
- Who will be responsible for enrolling MSHS children in Medicaid and CHIP
- Provision for continuity of care
- Logistical issues
- Timeline for planning and services
- Fees and/or negotiated rate for services
- Payment for services
- Roles and responsibilities
- Patient records to be shared
- Names of key individuals who will be responsible for the oversight, implementation and evaluation of the program
- Specific needs of the MSHS and the health center programs and their capacity to address those needs. Consider the data sharing needs and reporting requirements, such as the UDS reporting for health centers and the PIR for MSHS.
- Agreement to observe HIPPA requirements
- Agreement to refer the child and family to the health center nearest their future work site when treatment is not completed or follow up is needed. Useful tools are the Migrant and Seasonal Head Start Centers and Health Centers Locator mobile app (Google Play and iTunes) and/or the Head Start website (<https://eclkc.ohs.acf.hhs.gov>).

When should this meeting take place?

The planning meeting takes place at least six (6) months before the anticipated need for services.

Who should attend?

Key decision makers, program managers and key program personnel should be present at the planning meeting.

These individuals may include:

- MSHS executive director
- MSHS health manager
- Health center executive director
- Health center medical and dental director
- Key health center dental clinic personnel
- Other program personnel

Developing and Signing the Agreement

Creating a joint service agreement signed by both parties, such as a memorandum of understanding (MOU), memorandum of agreement or service contract, recognizes and formalizes the partnership and specifies the agreed-upon services and responsibilities. A written agreement will also help to reduce any confusion or uncertainty down the road.

An administrator from either the MSHS or health center program may write up the agreement. Both MSHS and health center program administrators should review it carefully for clarity and accuracy. Executive Directors from both programs and/or their appointees should sign the agreement. It is recommended that the agreement be signed at least five (5) months prior to service delivery.

SUBSEQUENT PLANNING MEETINGS PRIOR TO SERVICE DELIVERY

Once an agreement has been signed by both the MSHS and health center program administrators, a schedule for on-going all-inclusive meetings is established.

The purpose of regular meetings is to ensure that all activities occur as planned. During these meetings, program directors may request additional information from each other or from program staff; program staff may report any emerging issues for consideration and/or resolution by the joint group. The meetings are essential to building trust and camaraderie among the partners.

The following checklist of topics may be used to help develop an agenda for each of these meetings:

- Transportation
- Interpretation
- Scheduling appointments; time “slots” or “blocks”
- Data collection
- Program Information Data (PIR)
- Copies of dental and health records
- Health histories
- Parental consent forms
- Referrals to next health center site
- Arrangements for supervising children during clinic visits, as needed the child’s supervision
- Children with special health care needs
- Needs of other family members
- Policy or protocol for primary healthcare and oral health care services and treatment plans
- Policy or protocol for treatment plans not completed
- Policy or protocol for “no-show” or “missed appointments”



POST-SERVICE DELIVERY MEETING

The purpose of the post-service delivery meeting with the stakeholders is to assess the processes and outcomes of the joint MSHS-health center program. The following questions can be considered in the post-service delivery meeting to assess quality and effectiveness of the partnership:

- Were all program objectives accomplished?
- If no, what services were not completed and why?
- Were any challenges observed or encountered?
- Did all MSHS children receive their planned oral health care services?
- If not, why?
- Was the collaborative relationship beneficial for both the MSHS and Health Center programs?
- Does the infrastructure, format and fees for the delivery of program services adequately support and promote program sustainability?
- Are there any suggested program modifications that could potentially improve the processes or outcomes of the program in future years?
- Were patients who needed additional treatment referred to the Health Center nearest the family's future work site?
- If not, where were they referred?

TRACKING PROGRESS AND IMPROVEMENT

The HSPPS (§1302.102) require programs to monitor their program performance and to use data for continuous improvement. Data on the delivery of oral health services is reported in the PIR. It is important to collect detailed information about the different kinds of oral health services provided to the infants, toddlers, preschoolers, and pregnant women in MSHS programs. This information can be used to guide decision-making and to assess both the strengths and gaps in the health services. On the basis of this and other data, changes can be made to the MOUs to ensure that MSHS programs and the health centers are providing high-quality oral health services (See Appendix B for a tracking chart of oral health services).

VII. EDUCATION PROGRAMS AND RESOURCES

MSSH and health center administrators and staff need to know and understand the inter-relationship of primary health care and oral health in the early years. Healthy children have healthy bodies and teeth! Equipped with knowledge and expertise, MSSH and health centers personnel can educate children and families about the significance of maintaining oral health and its impact on school readiness and quality of life. Program staff also can help ensure that the MSSH families and children have access to preventive oral health care services and treatment, as needed.

LEARNING EXPERIENCES FOR MSSH CHILDREN

All Head Start programs promote the school readiness of young children. Programs use the *Head Start Early Learning Outcomes Framework: Birth to Five (ELOF)* to guide their choices in curriculum and learning materials, to plan daily activities, and to inform intentional teaching practices.²⁹ The Framework is organized into five broad domains of early learning and development. Within each domain, there are goals that are important for success in school and life-long learning.

Oral health care intersects with many learning goals. In the domain of perceptual, motor, and physical development (PMP), there are goals for fine motor skills and health, safety, and nutrition. For example, as children learn to brush their teeth and develop healthy eating habits – aspects of oral health care – they are making progress toward goals from the ELOF that are listed below.

For infants and toddlers (IT)

- IT-PMP 6. Child coordinates hand and eye movements to perform actions.
Example: Child uses toothbrush.
- IT-PMP 9. Child demonstrates healthy behaviors with increasing independence as part of everyday routines.
- IT-PMP 11. Child demonstrates increasing interest in engaging in healthy eating habits and making nutritious food choices.

For preschoolers, 3-5 years

- P-PMP 3. Child demonstrates increasing control, strength, and coordination of small muscles.
- P-PMP 4. Child demonstrates personal hygiene and self-care skills.
- P-PMP 5. Child develops knowledge and skills that help promote nutritious food choices and eating habits.
Example: Child knows that healthy snacks build strong teeth.

Literacy and math, music and art can be integrated into rich learning experiences about oral health and nutrition. Dramatic play centers may be set up as dental clinics and children can put on puppet shows about “going to the dentist.” As children learn about healthy foods, they learn about food preferences of different cultures. Parents may help the children prepare food, presenting opportunities for language development and learning math and science concepts. In many MSSH programs, parents bring in produce from the fields that are prepared in the center’s kitchens. In short, learning about oral health and nutrition connects with multiple learning experiences. These learning opportunities are not an “add on” to the curriculum. They are developmentally, culturally, and linguistically appropriate learning experiences that promote children’s school readiness.

²⁹ Office of Head Start. “Head Start Early Learning Outcomes Framework. Ages Birth to Five.” 2016. <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/elof-ohs-framework.pdf>

What MSHS Programs Need to Know

You can align learning experiences about oral health and nutrition with the goals in the ELOF. You can engage families in these learning experiences too.

Opportunities for MSHS parents to talk about their work and to show their work tools can be incorporated into the curriculum. Such learning experiences strengthen the program-family connections; they also foster children's pride in their parents' work. These learning opportunities support children's social and emotional development, including the ELOF goals related to forming a sense of identity and belonging. Social and emotional development is foundational to success in school and in life.

For infants and toddlers (IT)

- IT-SE 10. Child shows awareness about self and how to connect with others.
- IT-SE 11. Child understands some characteristics of self and others.
- IT-SE 12. Child shows confidence in own abilities through relationships with others.
- IT-SE 13. Child shows a sense of belonging through relationships with others.

For preschoolers, 3-5 years

- P-SE 9. Child recognizes self as a unique individual having own abilities, characteristics, emotions, and interests.
- P-SE 10. Child expresses confidence in own skills and positive feelings about self.
- P-SE 11. Child has sense of belonging to family, community, and other groups.

Some curricula materials target oral health care. They can be used to supplement the early childhood curricula used in the MSHS programs. Some offer teachers' guides and classroom activities that can be downloaded at no cost. The National Maternal and Child Oral Health Resource Center has prepared a comprehensive review of oral health curricula - *Head Start Oral Health Curricula: Choose and Use*.³⁰ This tool is designed for Head Start staff and health professionals to identify curricula appropriate for their audiences and settings. The curricula are rated on a series of criteria, including topics covered, availability in Spanish and cost. The majority of curricula are free.

A must go-to-place for MSHS staff is the Head Start portal, the Early Childhood Learning and Knowledge Center (ECLKC). Click on topics at the top of the screen and then click on ORAL HEALTH. You will see a cornucopia of information and useful resources (<https://eclkc.ohs.acf.hhs.gov/oral-health>).

³⁰ National Maternal and Child Oral Health Resource Center. "Head Start Oral Health Curricula: Choose and Use." 2016
<https://www.mchoralhealth.org/headstart/curricula/>

ANTICIPATORY GUIDANCE FOR FAMILIES

The concept of providing information and guiding health behaviors in anticipation of normal development or onset of risk and disease is called anticipatory guidance. The medical profession has employed this practice as a part of primary health care for decades in their effort to prevent and manage disease. The same principle may be applied by the dental profession. Health center personnel can help families understand their child's risk of disease as well as ways to prevent and/or manage it, by informing parents and caregivers of the conditions that create dental caries and cavities, the natural progression of the disease, and its prevention. Anticipatory guidance can also include advice about injury prevention and a plan for dealing with dental emergencies.

Anticipatory guidance supports the HSPPS requirement (§1302.46) that programs collaborate with parents to promote children's oral health. MSHS programs are required to include opportunities for parents to learn about oral health and healthy eating practices at home.

WORKING WITH FAMILIES

Extensive resources about oral health have been developed by the Head Start National Center for Early Childhood Health and Wellness and are available on the Head Start website. All the materials are research-based and support implementation of the HSPPS.

Healthy Habits for Happy Smiles is a series of handouts that provides simple tips on oral health issues.³¹ Head Start staff are encouraged to share the handouts with families to promote good oral health. They are available in English and Spanish. The topics are varied:

- Brushing Your Child's Teeth
- Choosing Healthy Drinks for Your Young Child
- Encouraging Your Child to Drink Water
- Finding a Dental Clinic for Your Child
- Getting Fluoride for Your Child
- Getting Oral Health Care While You Are Pregnant
- Giving First Aid for Your Child's Oral Injuries
- Giving Your Child Healthy Snacks
- Helping Your Baby with Teething Pain
- Preventing Injuries to Your Child's Mouth
- Taking Care of Your Baby's Oral Health
- Taking Care of Your Oral Health When You Are Pregnant
- Toothbrushing Positions for Your Child with a Disability
- Toothbrushing Tips for Your Child with a Disability
- Understanding Why Baby Teeth Are Important

Brush Up on Oral Health Tip Sheets also provide Head Start staff with information on current practice and practical tips to promote good oral health.³² Every tip sheet also includes a simple recipe for a healthy snack. Each month, a new tip sheet is available. There are other resources for families and staff training on the Head Start website.

ADDITIONAL RESOURCES

Appendix C provides an extensive list of online resources about oral health and dental services. The resources were developed by government agencies, professional health and dental organizations, migrant and agricultural workers' groups, insurance companies and companies that produce oral health products. There are a variety of educational materials for different audiences, including parents, schools and dental professionals. Some resources identify best practices and successful strategies for early childhood oral programs.³³ Several entities focus on connecting underserved communities with resources and improving health literacy.³⁴

31 Office of Head Start. "Health Habits for Health Smiles." 2018. <https://eclkc.ohs.acf.hhs.gov/oral-health/article/healthy-habits-happy-smiles>

32 Office of Head Start. "Brush Up on Oral Health Tip Sheets." 2018. <https://eclkc.ohs.acf.hhs.gov/oral-health/article/brush-oral-health-tip-sheets>

33 Association of State and Territorial Dental Directors. "Best Practice Approaches." 2011. <https://www.astdd.org/best-practice-approach-reports/>

34 Health Resources and Services Administration. "Health Center Program." <https://bphc.hrsa.gov/qualityimprovement/clinicalquality/oralhealth/>

VIII. BUILDING EFFECTIVE PARTNERSHIPS – CHALLENGES AND SUCCESSES

BARRIERS TO COLLABORATION

MSSH programs and health centers are dedicated to improving the health and welfare of agricultural workers and their children. Both entities receive special funding to provide access to primary health care and oral health care services. However, there are a number of factors that pose challenges to successful collaboration:

- **Disconnect between local, regional, and national organizations.** There may be misunderstandings regarding roles, responsibilities and resources. Successful implementation of the dental/oral services care plan requires understanding and cooperation among all persons involved. This includes not only the administrators, but all team members, support staff, clinicians and facilitators. Education staff including teachers, family child care providers, and coaches need to be a part of the team - they have direct contact with children. Family advocates are critical to engaging parents. Oral health consultants and members of the Health Services Advisory Committee can make valuable contributions. Their combined input, along with other key stakeholders in planning and implementation, is essential to create the buy-in and presence to make the collaboration successful.
- **Failure to plan ahead. Service demands may exceed capacity if appropriate planning is not addressed before migratory and seasonal agricultural workers are expected in the service area of the MSSH and health center.** Most families move in pursuit of work and their patterns and length of migration can vary significantly. The number of agricultural workers may vary during any given season. This community is often extremely isolated from social networks as well as from social service and healthcare providers. The collaboration between MSSH and health centers must address these issues in their plans and anticipate these complexities.



- **Weak partnerships. Inadequate partnerships between Head Start sites and health centers have been identified as barriers to increased access and improved oral health outcomes.** Many issues have been raised, including liability for children’s care, cultural and linguistic competence of providers, and poor communication between medical and dental providers. Unless the partnerships are strengthened, the challenge of providing adequate oral health care to the MSSH population increases.

The Institute of Medicine’s report *Improving Access to Oral Health Care for Vulnerable and Underserved Populations* (2011) showed that unmet oral health care needs and barriers faced by these populations has a great impact on overall health.

35 Connecticut AHEC Program. “Head Start/Early Head Start Oral Health Forum Final Report. Reaching Consensus Strategies for Implementation Plan of Action Report.” June 23, 2003. <http://www.astdd.org/docs/CTHS-EHSFORUMFINALREPORT.pdf>

36 A number of sources describe best practices approaches, including Association of State and Territorial Dental Directors. 2011. <http://www.astdd.org/best-practices/>

KEYS TO SUCCESS

Research and evaluation studies have identified a number of factors that contribute to the successful partnerships of MSHS programs and health centers.

- **Responsiveness to needs of MSHS population.**

Agricultural workers face many challenges. They are one of our nation's most underserved and vulnerable populations. Strong programs acknowledge the hardship of moving from place to place and the unpredictability of the agricultural seasons. They recognize the toll that this lifestyle takes on parents and children. Yet, the families and their children show resilience. In the midst of change, they form a sense of community. They take pride in their cultural and linguistic heritage. Successful MSHS programs and health centers build on the strengths of the children and families.

- **Use of data.** MSHS programs are required to design and implement systems and services that effectively and efficiently address the needs of the children and families. In order to do that, MSHS programs need to use data. Some data about a program's oral health services is collected for the PIR; other information may be important for program planning, such as updates from the community assessment or child-level assessment. Program improvements need to be based on data collection and analysis. Health centers, too, are required to collect data about their service delivery which feeds into their improvement efforts.

- **Early planning.** Early and thoughtful planning is essential for successful partnering between MSHS and health centers. MSHS programs need to assess their program needs and consult with dental providers and health center staff at least nine (9) months in advance of the anticipated treatment implementation phase of their program. This provides ample time to address the details associated with the comprehensive provision of care.

- **Accountability.** Both MSHS programs and health centers need to understand their complimentary roles and responsibilities pertaining to the provision of dental care for MSHS children and their families. One best practice strategy that helps to improve accountability and ensure success is the development of a comprehensive memorandum of understanding (MOU). An effective MOU details the tasks of each partner and ensures that communication strategies are in place.

- **Programmatic and financial resources.**

Establishing a solid business plan which incorporates the costs for dental care services for MSHS children and their families is essential to ensure sustainability for both MSHS and health center programs. Because budget and financial resources are limited, it is imperative that financial planning consider all available resources. The first step in achieving this objective is to fully understand and anticipate the needs of the MSHS children enrolled in the program. Once this is accomplished, a business plan can be established to address the cost of those services. The plan should consider the availability of third-party payment programs, such as Medicaid and CHIP.

- **Commitment to quality services.** Practices that incorporate early childhood research-based prevention into quality oral health care must be implemented. MSHS programs and health centers need to stay informed about best practices in their fields. Staff training needs to be kept up-to-date. Joint training is often successful when it focuses on the unique strengths and needs of the MSHS population.

IX. CONCLUSION

The purpose of this guide is to support effective collaborations between MSHS programs and health centers to promote oral health. Building on the strengths of the agricultural workers and their children, partners can work together to deliver oral health services in a timely and effective way. Children and pregnant women receive exams and follow-up treatment, and families learn about preventative measures and sound nutrition practices. The road to collaboration is not always easy, it requires commitment and flexibility to make a partnership work. Once a partnership is in place, more planning and hard work are required to sustain it. The effort required for successful collaborations is well worth it – improved outcomes for the MSHS children and their families whose agricultural work contributes to the well-being of our nation.

