



San Francisco
Department of Public Health

Improving Access to Oral Health Services for Head Start and Early Head Start Children

A Guide for Developing Partnerships between Head Start/ Early Head Start Programs and Federally Qualified Health Centers' Dental Clinics

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Introduction

Dental caries, or dental decay, is among the most common, and easily preventable, chronic childhood illnesses in the United States. Dental caries has a large impact on not only the child's physical health, but also socio-emotional development and learning. Untreated tooth decay can cause infections and pain, poorer health outcomes, behavioral problems, malnutrition, poorer self-esteem and learning difficulties. In addition to immediate effects on the child's development, dental disease in childhood has been linked with problems in their adult life, such as continued oral health problems, greater likelihood of cardiovascular disease, as well as lower educational attainment and limited employability, thus perpetuating the cycle of poverty.

Children in low-income families, as well as those who are racial/ethnic minorities, have higher rates of dental caries. Nationwide, between 2011 and 2012, 20.8% of African American children 3-5 years old experience untreated dental decay in their primary teeth, compared to 6.1 % of their White, non-Hispanic peers¹. Similar disparities are seen in California.

Many parents may dismiss early childhood caries as something that will disappear when the "baby teeth" fall out, and therefore does not need treatment or attention. However, the primary teeth are essential to the development of the mouth, jaw bone, and speech. They guide the eruption of permanent teeth, and support the proper alignment of new teeth in the mouth. Preventing decay and alleviating the effects of decayed primary teeth on the child's physical and socio-emotional development, training children and families to care for their first set of teeth through regular brushing and flossing, as well as developing good relationships with dental care professionals are all important in leading to a lifetime of healthy teeth and builds strong preventative oral care habits.

Treating childhood dental caries comes at a cost for both the family, and the community. Costs of treating severe dental decay can be seen on many levels. The family may feel a financial impact due to a caregiver's lost wages when they miss work to take their child to dental treatment visits, costs of transportation to these visits, and other medical or dental bills. Missed school days take a financial toll on childcare providers', and school districts' attendance-based reimbursement funds. Extreme decay cases take a toll on the medical and dental system through emergency room visits, need for additional staff, or surgical interventions. The California Smile Survey² (2006) reports that for the same amount of money, a community can treat a few children with severe decay or provide preventative and screening services to many. As childhood dental problems prevent youth from reaching their educational potentials, the community economy suffers the loss of a potential healthy and well-educated workforce.

By building partnerships between federal programs such as Head Start/ Early Head Start and Federally Qualified Health Centers, or other dental care providers and stakeholders, agencies and communities can support underserved children and families to prevent the spread and the impact of dental disease on their population and their economy.

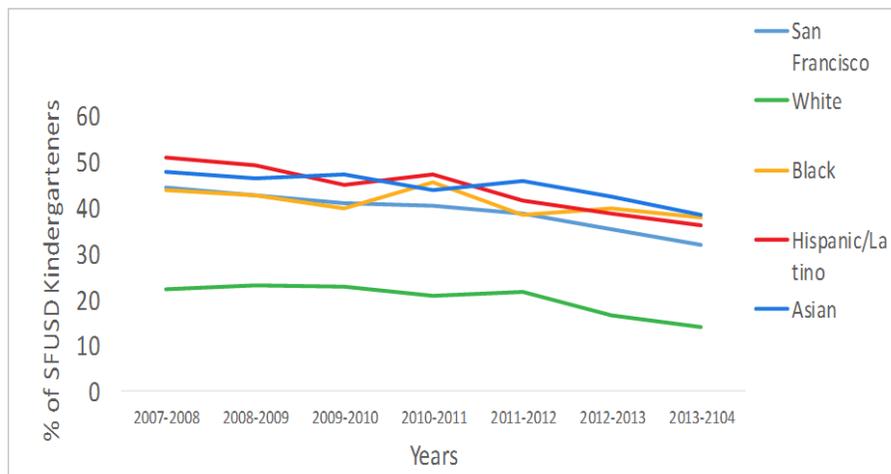
Status of Children's Oral Health

The Center for Disease Control reports that as many as one in five children ages five to eleven have one or more untreated decayed tooth. One in four low-income children between five and nineteen, have an untreated tooth, compared to 11% of their higher income peers³. The greatest disparity among is seen in Mexican American children and African American children.

Though the overall number of children affected by caries is decreasing, there is still a long way to go. The baseline data for the national Healthy People 2020 goals shows that between 1999 and 2004, 33.3% children ages 3-5 had dental caries in their primary teeth. Their goal was to reduce this number to 30.0% in the year 2020. This goal was surpassed when the percentage fell to 27.9% in 2011. However, disparities still remain. The rate of dental caries in 3-5 year olds from families living below 100% FPL was 49.3%. The rate of caries of African American children of the same age was 42%, and 38.3% for Mexican American children. While limited data on Head Start children is available, by third grade, as many as 70.9% of California's children have experienced tooth decay (treated or untreated), compared to the nationwide average of 54.2%⁴.

Similar trends have been observed in San Francisco. Although overall the city's kindergarteners are experiencing less and less caries each year, and while the overall rates of caries are approaching the Healthy People 2020 goal of 30% (or less), the racial disparities are widening. Children in some of the San Francisco neighborhoods experience 2-3 times more dental decay, namely low-income children and children of color. The rates of caries in children of color were 2.1 times higher than those of their white peers in 2007-2008, rising up to 2.7 times higher in the 2014-2015 school year.

Children of color are twice as likely to suffer dental decay in San Francisco

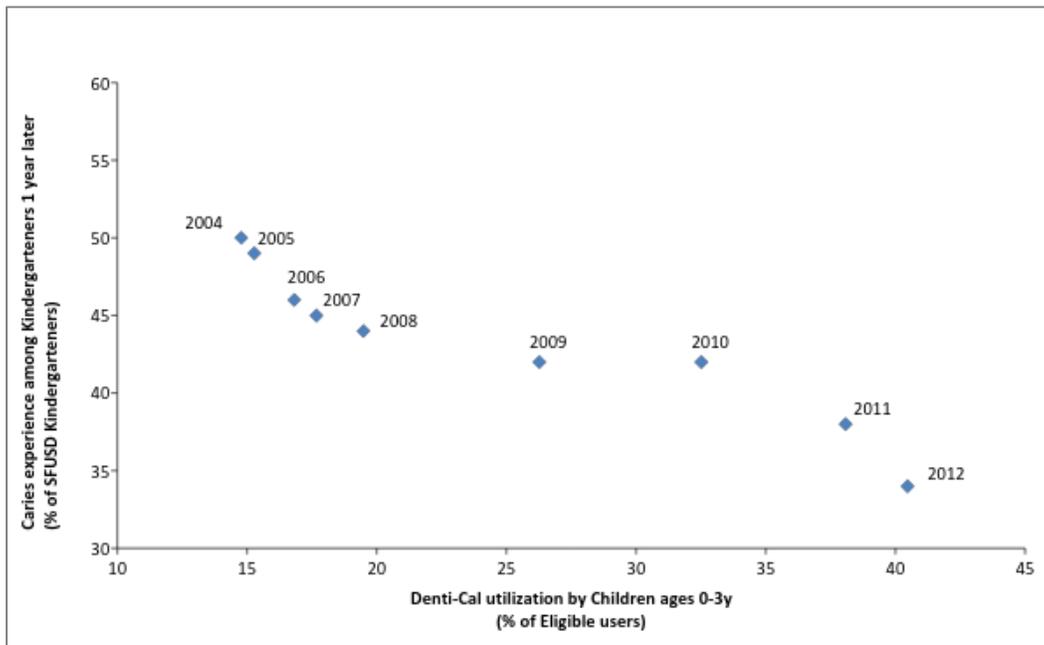


Great successes in oral care have been seen in the last five years. With the introduction of the Affordable Care Act in 2010, the reinstatement of adult Denti-Cal services in California in 2014, and the 2015 CA State Bill 4 which allowed all children to receive full-scope Medi-Cal (and Denti-Cal) benefits regardless of immigration status, more youth and adults are now able to access dental care services. However, the successes in expanding dental services to a larger portion of Californians has resulted in increased demand for services, which had certain drawbacks. Increased wait times in clinics added to the ongoing challenges in accessing

services for children, especially for the youngest patients whose apprehension in an unfamiliar environment can make appointments challenging for dental staff used to working primarily with adults. Nationwide, preventable dental problems accounted for over 830,000 emergency room visits in 2009 (a 16% increase since 2006)⁵.

Access challenges for children are even further compounded by the lack of pediatric dental providers accepting Denti-Cal insurance. In 2011-2012, over half (52%) of Denti-Cal enrolled young children 0-3 years old in San Francisco did not see a dentist within the last year. While more 4-5 year olds have been to a Denti-Cal dentist, still close to 40% of eligible children did not access the services they were entitled to.

Access to care is associated with reduced risk in SF⁶



As the San Francisco data show, improving access to care and increasing the utilization of dental services by children aged 0 to 3 is correlated with lower rates of caries in kindergarten.

Advocating for improved access to services, integration and promotion of dental services within medical care models, public health programs, insurance plans, and local and states public health departments' plans can improve the overall state of children's (and adults') oral health and wellbeing.

Want to find a Denti-Cal provider in your county?

Visit the [Denti-Cal website](http://www.denti-cal.ca.gov/) for a complete listing of providers accepting this insurance:

<http://www.denti-cal.ca.gov/>

Click on "Find a Medi-Cal Dentist" in the upper left corner, and select your county from the list. The providers listed in the "Dental Clinics" category are most likely FQHC providers!

Head Start/ Early Head Start

Over 50 years ago, in 1964, President Lyndon B. Johnson announced the beginning of a comprehensive government plan in response to high poverty rates and to support low-income Americans in their efforts to improve their lives. The War on Poverty, as it became known, included the Food Stamp Act and the Social Security Act. Out of the new Federal Office of Economic Opportunity came Project Head Start, which provided comprehensive child development programs to disadvantaged preschool children and families. Project Head Start was designed to support not only their educational needs, but also provide them with services addressing socio-emotional, health and nutritional needs, and give low-income children and families an equal opportunity to enter the school system on equal footing as their higher-income peers⁷.

Currently, Head Start and Early Head Start (HS/EHS) programs serve children from birth to five years old. Besides providing educational programs for the children, Head Start and Early Head Start provides families with social, nutrition and health services, and strives to reduce the impact of poverty and health disparities on children's development and the family's success in life.

The Head Start/ Early Head Start philosophy holds parents and caregivers as the first and most important teachers in a child's life, and holds family empowerment and positive caregiver-child relationships as key to a family's success.

In 2012-2013



932,164 children 3-5 years old were served by Head Start nationwide

150,100 children 0-3 years old were served by Early Head Start nationwide

99,025 children ages 0-5 were enrolled in a California HS/EHS program⁸ - the highest number of funded enrollment opportunities of any other state. This number has grown to over 101,000 children the following school year⁹.

Qualification Criteria for Head Start/ Early Head Start

Head Start eligibility is based primarily on the family's income, which in most cases must be at or below the poverty level. In some cases, families up to 130% of poverty level may be eligible for services, though these enrollment opportunities are limited. Families who are experiencing homelessness, children in foster care, or families receiving SSI or TANF also are eligible, and may be given a priority for enrollment¹⁰.

In 2015, the Federal Poverty Level (FPL) was \$16,020 for a family of two; \$24,300 for a family of four¹¹.

In 2014, to be able to afford a one-bedroom apartment (pay for rent only) in San Francisco, a family would need to make a combined income of \$62,046, according to a report by the National Low Income Housing Coalition¹². Although the FPL is adjusted annually, it does not adjust for the regional differences in earning and cost of living.

The high cost of living with a slowly increasing city minimum wage are an additional challenge to accessing Head Start services in cities like San Francisco, Oakland, and Los Angeles. The

growing population and increasing income inequality in these cities is prompting city governments to address the rising costs of living through increases to the minimum wage earned by workers in these cities. As the \$10.00 minimum wage increase takes effect in the whole state of California in 2016, a family of two (caregiver/child) with one minimum wage income will earn \$20,800 annually, an equivalent to 130% of the current FPL. In San Francisco, this may mean that the family's income is too high to qualify for Head Start services, but not sufficient to even cover rent. As a result programs are having to re-evaluate their qualification criteria, and work with families with much higher needs than ever before. Families are living in sub-optimal conditions, many are sharing small crowded rooms, or even garages, living in Single Resident Occupancy (SRO) hotels, or with many extended family members. When community support networks are unavailable, the families who previously would have been eligible for Head Start services in these metropolitan cities are forced to move away, to areas where culturally relevant social, medical and dental services may not be available.

School Readiness

So what is the connection between the children most affected by dental decay and children who qualify for HS? They are often one and the same, and the presence of cavities in these children can negatively affect their performance at HS. Poor oral health can decrease children’s school readiness as children, which is defined by the Office of Head Start (OHS) as “children being ready for school, families ready to support their children’s learning, and schools ready for the children who enter their doors.”¹³ The key measures of the child’s school readiness, in relation to oral health are:

School Readiness Domain	Oral Health Connection
Language and Literacy	Children with decayed or missing teeth, and children with untreated caries who experience dental pain may develop language skills slower than their peers with healthy teeth. Children with decaying teeth are often referred to speech therapy instead of the dentist, as teachers are taught to spot speech delays quicker than dental health issues.
Cognition and General Knowledge	Surveys of adults have found that poor oral health is associated with poorer cognitive functioning throughout adult life ¹⁴ . Since healthy habits begin forming in childhood, the lessons learned (or not learned!) in Head Start can make a lasting impact on the life of the child.
Approaches to Learning	Children with poor oral health often cannot focus in school, and/or miss school days and learning opportunities due to pain, setting them back even further than their peers. Over 51 million school hours are missed each year due to dental disease, setting more and more children back in learning ¹⁵ .
Physical Development and Health	In addition to the possibility of infections and oral abscesses, dental pain may lead to poor appetite, malnutrition, poor sleep quality and attention deficits. Children who miss school due to dental pain miss the opportunities to develop healthy habits, as well as fine and gross motor skills taught in Head Start sites.
Social and Emotional Development	Children who are experiencing dental pain can also have behavioral problems, such as aggression, or being withdrawn. Much like speech referrals, children with dental problems often first see a mental health specialist rather than the dentist. Poor oral health affects children’s self-esteem - up to 35% of young children with caries in one study said that they do not like their teeth, compared to 0% of the children who were caries-free ¹⁶ . Poorer self-esteem in preschool can limit the children’s social and emotional development, as well as lead to poorer self-esteem later in their youth and adulthood.

Federally Qualified Health Centers

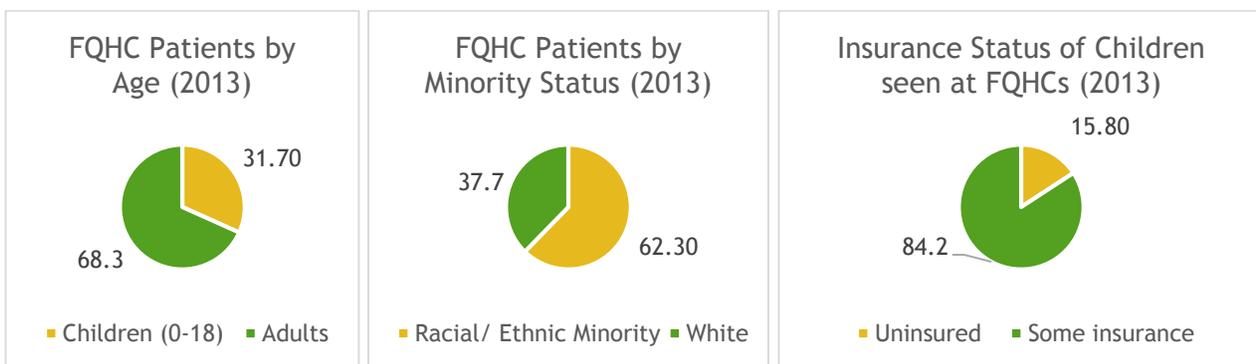
Another product of the War on Poverty was the concept of Neighborhood Health Centers, which are now called Federally Qualified Health Centers (FQHCs). The Neighborhood Health Centers were created to provide health (including dental) services and social services to the poor and underserved communities, who had limited or no access to care. In 1989 the title of “Federally Qualified Health Centers,” or FQHC, was adopted under the Public Health Service Act (PHSA). In order to qualify for the designation, a clinic must¹⁷:

- Serve an underserved population or area
- Offer a sliding-scale fee schedule, based on individuals’ ability to pay for services
- Provide comprehensive primary care services
- Offer supplemental social services
- Have a regular quality assurance program
- Be governed by a board of directors

To find an FQHC in your area visit:
<http://findahealthcenter.hrsa.gov/>

Head Start/ Early Head Start programs and Federally Qualified Health Centers are both tasked to serve similar populations, support disadvantaged communities, and provide culturally competent and relevant services to these communities. By working together to provide high quality, affordable care that is sensitive to the families’ challenges, FQHCs and Head Start partnerships can improve children’s health outcomes and reduce health disparities.

FQHCs rely on both Medicare and Medicaid funding to provide low-cost services to individuals and families regardless of their ability to pay or insurance coverage status. In 2007, FQHCs in California served 2,314,271 individuals, 45.2% of whom were uninsured¹⁸. FQHCs are required to address issues of access to services by underprivileged populations, which in many cases means bringing services outside of the traditional clinic settings and utilizing new service delivery models. Some of the non-traditional settings where FQHCs are able to provide services include school-based health centers, WIC programs, Head Start or state preschool programs, residential or transitional housing facilities, or migrant farm worker camps¹⁹.



5.2% of children 0-17 years who were seen at an FQHC in 2013 were homeless²⁰.

FQHC Dental Provider's Role in Protecting Children's Oral Health

Dental providers working at an FQHC Dental Clinic, or other dental providers working with Head Start children should be aware of their state's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedules, Medicaid requirements for types of services provided, and Head Start requirements.

HS/EHS grantees are required to assist families with receiving dental services, according to their state's EPSDT periodicity schedule, within 90 days of a child's enrollment in the program. In California, children insured by Denti-Cal (Medicaid dental insurance) are entitled to a full clinical oral examination, every 6 months (or more frequently if the need is documented) *starting at 6 months of age*. Both dental providers and HS/EHS staff should stay informed of any changes to their state's periodicity schedules.

The dental periodicity adopted by Denti-Cal follows the American Academy of Pediatric Dentistry (AAPD) recommendations and can be found in full here:

https://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_26_Number_7.pdf

For periodicity schedules of other states visit:

http://www.aapd.org/advocacy/state_periodicity_schedules/

As discussed in the introduction, getting children into a dentist's chair is one obstacle that HS/EHS programs face, but there are many more. Being able to document that visit, and having the correct and complete information to support a family's follow-up on the dentist's recommendation is a challenge that many HS/EHS program staff struggle with throughout the country. One of the ways that a dental clinic can support their local HS/EHS program is to provide parents with a fully completed dental examination form(s) at the time of the visit, and/or developing data-sharing agreements which allow for easy transfer of required paperwork within HIPAA guidelines. Many programs now include a release of confidential information statement on their dental exam forms which would allow your clinic's staff to discuss limited information pertinent to a specific exam, and/or treatment plan. Work with your local HS/EHS program to ensure that both agencies' needs and protocols around confidential information sharing are met.

FQHC partners, whether providing dental services or not, are encouraged to learn more about Head Start programs in their community, participate in the Head Start Health Services Advisory Committee to learn about the health needs of Head Start children, as well as build their own referral network when FQHC patients ask about affordable childcare in the area.



For additional information for Dental Hygienists, refer to:

<http://mchoralhealth.org/PDFs/HSRDH.pdf>

For additional information for Dentists, refer to:

<http://mchoralhealth.org/PDFs/HSDentists.pdf>

Primary Care Provider’s Role in Protecting Children’s Oral Health

Medical providers, such as physicians, pediatricians, nurse practitioners, and nurses, usually see infants and young children upwards of 11 times before a child sees a dentist or another oral health care provider. Primary Care Providers (PCPs) are uniquely poised to provide preventative oral health services, such as oral assessments, fluoride varnish application, and key messages on oral hygiene and importance of regular dental care. **Integration of oral health** into regularly-scheduled well-child visits for all children, but especially for high-risk groups, can lead to prevention of caries, early detection of problems and appropriate referrals for treatment, as well as building a stronger individual knowledge base of oral health of families and children.

Tactics to improve integration of oral health into medical care recommended by the San Francisco Children’s Oral Health Initiative include:

- Institution of fluoride varnish applications and oral health education at well-child pediatric visits especially targeting clinics accepting Med-Cal patients;
- Standardization of Electronic Health Records to prompt PCPs to ask about oral health, place dental referrals as needed, and allow for documentation of services provided;
- Incorporation of oral health care more prominently into Managed Care Health Plans, as has been recommended by the National Institute for Healthcare Management²¹, so that medical providers can be reimbursed for any additional expenses, like fluoride;
- Professional development opportunities, and the integration of preventative oral health practices into medical and nursing school curricula, so that the new graduates are armed with the knowledge and skills to address oral health needs of their patients.

The California Child Health and Disability Project (CHDP) EPSDT schedule of required services at each “well child” exam include a dental assessment at *every visit* from birth until age 20.

Age (years)	12 Month Dental Referral	6 Month Dental Referral*
1 - 20	Once a year <u>minimum</u>	Most CHDP children are at moderate to high risk. Refer every 6 months** Special needs children may need more frequent referrals

* Dental home should be established by age one

** Denti-Cal will cover preventive services (exam, topical fluoride, and prophylaxis) once in a six month period, and more frequently if there is a documented necessity.



For additional information for your local medical providers, refer to the brochure published for OHS by National Maternal and Child Oral Health Resource Center: http://mchoralhealth.org/PDFs/HS_med.pdf

For more information on CHDP procedures for a dental assessment for children visit: <http://www.cdph.ca.gov/programs/MCAHOraHealth/Documents/MO-OHP-OralHealthInfantToddler.pdf>

Head Start Role in Protecting Children's Oral Health

First and foremost, Head Start staff must be aware of the Head Start Performance Standards (HS PS) and the Head Start Act requirements in the area of Oral Health. All HS/EHS grantees are required to comply with these laws. HS PS §1304.20 Child Health and Developmental Services require all Head Start programs to ensure that within 90 days of the child's enrollment in the program:

- Children have access to continuous, accessible health care, including dental care;
- A qualified healthcare professional has made a determination whether a child is up-to-date on the state's EPSDT schedule for primary health care, including dental care.

Via the agency's Program Information Report (PIR), each Head Start grantee must report annually the number of children who:

- Had a dental home at the beginning enrollment, and at the end of enrollment
- Received preventive care since the previous year's PIR was reported
- Have completed a professional dental exam since the previous year's PIR was reported

Early Head Start grantees are required to report:

- Number of children who are up-to-date on the state's EPSDT schedule (which includes oral assessment at each well-child visit)
- Number of all pregnant women (if served) who received a professional dental exam and/or needed treatment since the previous PIR was reported.

Active inclusion of dental professionals in the Health Services Advisory Committee (HSAC) is key to staying up-to-date on changes in available services in your community, and to dental insurance coverage. Inclusion of representatives of your local Dental Association, Department of Public Health, or the local dental school can help connect children and families who are underinsured (have inadequate dental insurance coverage), or who need extensive or specialty treatment, with appropriate and affordable care.

For families struggling to pay for dental (or other health) services, HS PS § 1304.20(C)(5) states that "Early Head Start and Head Start funds may be used for professional medical and dental services when no other source of funding is available."²² Most frequently, HS/EHS funds have been used to assisting families with private dental insurance (through employer, for example) with unmanageable co-pays or an easily exceeded annual maximum. However, this can be avoided if the child is enrolled in Medicaid, as dental care coverage is automatically included in these insurance plans.

Head Start Tip:

In California, families (as well as staff), are not always aware that their child has always had dental insurance coverage as part of their Medi-Cal health coverage. This is one of the reasons why many children have never seen a dentist prior to Head Start enrollment.

Make sure that the Family Services staff at your program know, and are able to communicate to families, at minimum the basic services that are covered by your state's Medi-Cal, your state's Medicaid program, CHIP, or other primary insurance provider in your community.

Preventative Oral Health Services

Preventative oral health services such as regular dental exams, treatment and health education not only improve the well-being of children, but also improve educational outcomes for youth and adults, decrease unemployment, and reduce the economic burden of disease on healthcare networks. The Center for Disease Control and Prevention (CDC) provides the following evidence-based recommended strategies to improve the oral health status of children as well as that of adults:

Advocating for Community-wide Water Fluoridation (CWF) - Fluoride is a naturally-occurring mineral that helps strengthen the tooth enamel, and protect teeth from caries by reversing early signs of decay²³. Communities that CWF saw a 14.6% decrease in new dental decay, and significantly lower rates of dental problems. There has been *no* evidence to suggest that CWF can result in fluorosis, or poses other dangers to health.²⁴

Is the water in your California community fluoridated? Click [HERE](#) to find out!
Is the water in your community outside of California fluoridated? Click [HERE](#) to find out!
Nationwide map of fluoridation can be accessed [HERE](#)!

School-based sealant programs - A dental sealant is a plastic-like material applied to the teeth, sealing deep grooves in teeth that are harder to brush and thus preventing cavities. School-based sealant programs are effective at reducing rate of decay in school children by more than 70%²⁵ and for over 5 years²⁶. Since x-rays are not needed for sealant placement, partnerships with schools can be an effective way of reaching underserved populations.

Topical fluoride varnish application for the younger children in settings that children and families frequent (e.g. childcare). Fluoride Varnish provides an additional layer of protection to the teeth of younger children, and has been proven to prevent 37% of early childhood caries. It can be applied by any trained person in less than 5 minutes in almost any setting.

Education and promotion of proper oral hygiene practices and early and routine professional dental care.

Policy Opportunities:

Both Head Start staff and families find that lack of access to oral health services is the number one issue affecting Head Start children nationwide²⁷. Local Head Start agencies can play a powerful role in advocating for policy changes on local, state and federal levels by:

- Staying educated on new legislative efforts
- Supporting the development and revision of local, state and federal guidelines
- Advocating for continued and expanded Medicaid coverage and the Affordable Care Act
- Encouraging medical and dental providers to work together
- Educating the public about the importance of safety-net clinics, Head Start and other social services
- Educating and encouraging families and staff who are able to vote, to participate in local, state and federal elections and speak out about the ballot measures that affect children's oral health

The Spectrum of Prevention - Children's Oral Health

<p>Influencing Policy and Legislation - contacting and involving legislators and elected officials in order to create larger scale change on a state or federal level</p>	<p>Participating in local, state and federal policy-making efforts by regularly keeping abreast of proposed legislation changes. Building relationships with local city council members, state legislators, as well as senators and congress people, and keeping them informed about the oral health needs of your community in order to gain their support and influence decision making in regards to oral health promotion funding and programming.</p>
<p>Changing Organizational Practices - Advocating for changes in agency policies and procedures, reviewing organizational priorities, supporting both staff and clients in achieving better health outcomes</p>	<p>Changing agency policies around dental exam requirements for EHS children - first exam by age 1. Providing dental hygiene supplies for all family members, as part of childcare enrollment process. Requiring tooth brushing after every meal <i>and</i> snack, and setting brushing best-practices as part of program curriculum. Re-evaluating staff oral health benefits to ensure that the organization supports staff's preventative oral health practices as well as clients'. Prioritizing oral health alongside other Head Start requirements. Incorporating oral health and fluoride varnish into primary care. Incorporating oral health into medical and nursing school curricula.</p>
<p>Fostering Coalitions and Networks - partnerships within the community, industries, and across systems and professions</p>	<p>Community engagement and coalition building through HSAC and local Dental Association meetings. Participation in cross-sectional efforts and improvement plans. If none exist, bringing together community stakeholders and educating them about needs, then establishing possible tactics to address needs.</p>
<p>Educating Providers - Medical professionals, public officers, teachers, coaches, librarians, school administrators, university professors, future medical and dental providers</p>	<p>Educating teachers and family services staff, as well as Head Start management, about oral health needs of the children in program, the effects of dental disease on educational attainment, and children's development across Head Start School Readiness Domains. Outreach to FQHCs, hospitals, and local dentists around the needs of HS/EHS children, as well as the services offered by Head Start. Educating nursing and medical students about oral health and meaningful ways that they can incorporate it into their future work.</p>
<p>Promoting Community Education - building community awareness through campaigns, trainings and events.</p>	<p>Head Start wide oral health promotion messaging through agency-wide Oral Health Month, or similar activities. Oral health education booth/table at community fairs (even non-health related fairs, such as back-to-school nights). Oral health education through public health campaigns by the local Health Department, or other municipal agencies.</p>
<p>Strengthening Individual Knowledge and Skills - educating and empowering individuals about the risks and healthful practices</p>	<p>Raising individual oral self-care skills and knowledge of children through teacher-led activities in Head Start and daily classroom tooth brushing. Oral health education workshops and one-on-one messaging to parents and families about the importance of caring for young children's teeth, as well as adult teeth. Incorporation of oral health messaging via children's books and activities in libraries or other non-traditional settings, as well as in primary care settings and other non-dental environments.</p>

Dental Home

A “dental home” is a setting where comprehensive, competent, coordinated, accessible, and culturally-sensitive routine dental care can be provided to a child by a qualified professional. A dental home should be established at a child’s first tooth, or by 12 months of age. It is usually a dental office, or clinic, but as will be described, can also include school-based dental providers, as long as the provider is able to provide comprehensive, ongoing and routine services. Per Head Start requirements, a dental home must be able to provide: (change numbers to bullets just for consistency)

- Dental examination and risk assessment, including oral health history, and diagnostic tools such as x-rays as needed;
- Individualized preventative care, such as fluoride varnish or sealants, and anticipatory guidance relevant to findings of the oral health risk assessment;
- Individualized, and language-appropriate and age-appropriate oral hygiene recommendations and instruction for the caregiver and child;
- Treatment plan to address any oral health needs determined by the comprehensive oral examination, including surgical or orthodontic care referrals;
- Coordinate care delivery with primary care providers, and health and social services as appropriate;
- Build a foundation for future positive and supportive relationships between family and oral health providers.

Establishment of a dental home is a requirement for all Head Start children within 90 days of enrollment, per HS Performance Standard (HS PS): §1304.20 (a)(1)(i) Child Health and Developmental Services²⁸. The number of children who had a dental home at beginning of Head Start enrollment, and at the end of enrollment is also reported annually on the Program Information Report (PIR).

Need help finding a Dental Home in California?

For Denti-Cal, call 1-800-322-6384 or visit: www.denti-cal.ca.gov

The California Department of Public Health is also here to help with a FREE downloadable Brochure:

[Every Child Needs a Dental Home](#)



Oral Exam

A dental examination provided by, or supervised and reviewed by a licensed dentist. A dental exam includes a comprehensive evaluation of the entire mouth, jaw and other structures. For most states an oral exam is part of the EPSDT schedule starting at 36 months. For Head Start children HS PS §1304.20 requires a complete oral exam is within 90 days of enrollment (not usually for EHS, refer to your state’s EPSDT). An Oral Exam must include an evaluation of:

- General health, growth and pain level
- Status of teeth - caries risk, etc.
- Health of lips, gums, bone and jaw
- Oral hygiene and behavior
- Diagnosis, and treatment or follow-up plan if necessary

Oral Health Screening

Dental assessments and/or screenings can be delivered by primary care providers, nurses, dental hygienists and other professionals in addition to dentists. Dental screenings usually include a brief visual assessment of the child's teeth, gums and tongue, a tooth count, and limited evaluation of hygiene practices. Referrals to a dentist, and recommendations for improvements of dental hygiene are usually included in an oral health screening.

Screenings and assessments do *not* result in a diagnosis, and do not count as an oral exam neither for Head Start requirements and HS PS §1304.20, nor for PIR for Head Start children. Depending on your state's EPSDT schedule, an oral health screening may be required at each "well baby" physical exam for Early Head Start children ages 1-36 months old, and should be completed by the child's pediatrician, or a qualified professional.

Still confused?

The Office of Head Start's ECLKC has [this great report](#) with more information about the difference between an Oral Exam and an Oral Health Screening.

Fluoride Varnish



Fluoride varnish is a prescription-strength fluoride solution that can be applied to the surfaces of teeth in less than five minutes by any trained staff member in almost any setting.

Fluoride varnish is "painted" onto all teeth using a disposable brush and individual solution cup. Fluoride is safe to use with infants as soon as their first tooth erupts, and is recommended by the American Dental Association, American Pediatric Association, Center for Disease Control, California Public Health Department, and the Office of Head Start.

Applying fluoride varnish even once a year can prevent 37% of caries in high-risk groups of children ages 0 to 5²⁹. In a 2006 San Francisco study, the prevention rate was as high as 52%-92%³⁰. Fluoride varnish is most effective if applied 2 or more times per year. As part of the SF COH Strategic Plan's efforts, the team has recommended applying fluoride varnish every 3 months. It is an easy and affordable addition to a routine oral health exam or screening, and can bring many benefits to the children in your care.

Typical fluoride varnish kits can be purchased without a prescription through many retailers of oral health supplies, such as School Health (<https://www.schoolhealth.com/>), and Plak Smaker (<http://www.plaksmacker.com/>) for less than a \$2.00 per kit. This small expense can provide extra caries protection to children and support their oral health for a lifetime.



Check out these handouts for families about the effectiveness of fluoride varnish in English and Spanish on ECLKC!

<http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/oral-health/education-activities/OralHealthEduca.htm>

Dental Sealants

Brushing and flossing does a great job keeping out food particles, but sometimes, especially with younger children, brushing alone is not enough to reach all the crevices on a tooth surface. Sealants provide a physical barrier between these vulnerable areas and food particles³¹. Sealants are made of a plastic-like material that is generally applied to the top surfaces of the back teeth (premolars and molars), where decay usually occurs in children. Once hardened, the sealant literally seals any grooves on the tooth where decay is more prone to developing before it turns into a cavity.



Before



After

Unlike fluoride varnish, sealants can be applied *only* by a trained dental professional, such as a dentist (DDS), a dental hygienist (RDH), or a dental assistant (RDA). Applying sealants requires some specialized equipment, and takes about 30 minutes. Sealants are recommended for school-based application, and prevents up to 88% of decay in permanent molars³².

Most insurance plans, such as Medi-Cal and Denti-Cal, do *not* usually cover sealant placement on primary (“baby”) teeth, but sometimes they are recommended as a part of a younger child’s treatment plan developed during the oral exam. Head Start staff should be able to provide parents or caregivers with information on the benefit of sealants, and assist the family with getting the sealants if they have been recommended by the dentist.

Head Start Tip:

Because of the different billing practices between FQHC clinic providers and “regular” dental providers, the local FQHC dental clinic *may* be able to absorb the costs of providing sealants on primary molars of young children as part of their preventative care model.

Ask your local FQHC dentist if they do or do not place sealants, and discuss different treatment options available to the children in their care.

Silver Diamine Fluoride

Silver Diamine Fluoride (SDF) is a topical antibiotic solution that is used to stop tooth decay, and treat tooth sensitivity. Silver Diamine Fluoride has been used for centuries in other countries and is beginning to gain popularity in the U.S. The silver in the SDF solution kills microorganisms that cause cavities, and stops cavity growth. A recent study of SDF applications in preschool children found that annual application of Silver Diamine Fluoride on existing cavities can stop the active caries in as many as 79% of children, whereas applying it every six months increases the rate of stopped carries up to 91%³³. Silver Diamine Fluoride is approved by the Federal Drug Administration (FDA), just like regular fluoride varnish.

Although 100% success is not guaranteed, SDF may be a great low-cost alternative for children needing extensive treatment. Silver Diamine Fluoride is applied easily in a dental office, by a qualified and trained professional on a dry cavity surface using a small brush, much like fluoride varnish; once applied, it is allowed to dry and is then rinsed off.

The biggest drawback to using Silver Diamine Fluoride is that over the course of the week after the application of SDF, the cavity and the affected tooth surface will permanently stain black. However, as you can see from the photos below, the color of the stained tooth is not that different from the color of the cavity that was treated. The healthy part of the tooth will *not* stain, and any discoloration to the gums or skin will be temporary. No other side effects of SDF use have been discussed or noted in recent literature.

Tooth Discoloration After Silver Diamine Fluoride Application



Image source: J Dent Res 88:116/Horst. J.

Furthermore, the benefits of receiving SDF, outweigh the impact on the aesthetics and appearance. If the tooth decay is not stopped the cavity will only grow, resulting in the need for further and possibly more extensive treatment. In a clinic on the Umatilla Indian Reservation in Oregon³⁴, the need for dental treatment under general anesthesia dropped from 16 children per year to 2 in just two years of using SDF to treat active cavities. The SDF treatment can be started immediately at the initial diagnostic visit, instead of waiting for the next available appointment.

FQHC Partner Tip:

Is your clinic providing Silver Diamine Fluoride treatment?

Support the Head Start partner and your patients in understanding the benefits and drawbacks of the SDF treatment. If your clinic is not using this tool, educate yourself on the recent literature on the effectiveness of SDF on primary teeth, children with special needs, as well as with adult patients.

Follow Up and Treatment Planning

After a comprehensive oral exam, the dentist will develop a follow up plan for each child. Below are some of the protocols adopted by the Head Start programs in San Francisco.

Class 1: Healthy Teeth

The best-case scenario is that a child's mouth will be found healthy, and they will receive prophylactic (preventative) services. Typically, dental staff will consider this child as having "no caries." As part of the San Francisco Children's Oral Health Initiative, Head Start children with a healthy mouth were considered as "Class 1"ⁱ.

In this case, the child's follow up plan, will be to return for a "recall visit" usually in 3 to 6 months' time. Although Head Start only requires an oral exam once a year, pediatric dentists typically recommend two, and sometimes more, exams per year to ensure a child's health. Denti-Cal, and most insurance carriers, will cover a dental exam every 6 months, or as recommended by the treating dentist. It is best practice to follow the child's dentist's recommendation for the frequency of follow up visits, and support the family in accessing care at recommended intervals.



ⁱ The American Academy of Pediatric Dentistry uses the Class I designation to include only teeth that have some restorative needs (i.e. sealants, preventive resin composites), and does *not* include healthy teeth. Talk to the dentists in your area and with your HSAC to come to a conclusion that is best for your program.

Class 2: Non-Urgent Treatment Needed, Moderate Decay

Children in this class category have some sort of decay, ranging from the beginning signs of caries, such as white spots, to the presence of several new cavities. They may need sealants, or may have one or more cavities that require fillings. These fillings can be done on the same day, or could require follow up appointments, as will be indicated on the dental exam form returned to the program staff by the dental office. Adding a box for the provider to check regarding whether or not *all* treatment was completed on your program's oral exam form can prevent some confusion around whether or not the treatment was done at the visit, or requires the family to schedule a follow up visit.

FQHC Partner Tip:

You can help Head Start programs and your patients' families by being as specific as possible when completing Head Start Oral Exam forms. The more information you provide in writing, the easier it will be for Head Start staff to support the family in following your directions.

HS Performance Standard §1304.20(c)(3) requires Head Start staff to follow up and support family in completing the necessary dental treatment "as recommended by a dental professional," as well as provide (or assist the family with acquiring) fluoride supplements, if fluoride levels are not sufficient in the community. Numbers of children needing treatment, and having received treatment are also reported annually on the program's PIR, and must be carefully recorded.



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You can find sample Oral Exam forms on ECLKC, at:
<http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/docs/oral-health-form-children.pdf>

Class 3: Urgent Treatment Needed, Severe Decay

A child with urgent dental care needs such as pain, swelling, inflammation, inability to eat or participate in regular activities, or a child with a large number of cavities, will need urgent treatment. Such children may not want their mouth examined or even touched. They could be fearful of adults looking their mouths, and may cry even thinking about the examination. Toddlers may exhibit a delay in speech initiation, and poor eating habits. A good relationship with a dental home, and a dentist specializing in caring for young children, is key for diagnosing and treating children with severe decay.

This type of treatment cannot wait! The child's overall health is at risk. In most cases the child will require either multiple treatment visits, including visits to desensitize the child to a dental care setting, or a referral to surgical dentistry, where the child can receive treatment under general anesthesia. Other types of sedations, such as nitrous oxide gas, oral sedation using a pill, sedation using an injection, or a suppository may also be used. These options must be explained and discussed with the child's family in a culturally and linguistically appropriate manner.

Families can experience many barriers to accessing care, and will require the staff's timely and consistent support to ensure that the appropriate referrals are made, follow up visits are completed, the needed paperwork is submitted (to the dentist, pediatrician and/or other involved in the treatment plan) and that child's health needs are met in a timely manner.

Potential obstacles for a family accessing timely follow up care, even at their well-established and culturally appropriate dental home, may be:

- Lack of childcare for other children
- Access to transportation
- Unpredictable work schedules, or
- Difficulty with scheduling visit at a clinic with long waiting lists.

In cases of conscious sedation, there are some exceptions for Denti-Cal payment which may pose another barrier. For example, if the dentist uses multiple sedation aids at the same, like Nitrous Oxide ("laughing gas") *and* an oral sedation pill, only one of these tools will be covered. Families (or staff) should call the dentist and ask for a breakdown of costs, insurance coverage and expected deductible prior to beginning treatment. Family may need to pay out of pocket even for children insured by Denti-cal.

Many clinics accepting Medicaid (Denti-Cal in California) have long waitlists even for routine visits, and may be scheduling patients for 3-6 weeks in advance. Other clinics may not "open their schedule" for the next month, until close to the end of the previous month. In this case, the receptionist may not be able to make an appointment for a day in March until late January or even February. This would require families to call back to the clinic often; they would be unable to pre-schedule a 6 month recall visit at the immediate visit, as one typically could at a private practice. When this is the case, scheduling work, or even using pre-paid phone minutes can be an obstacle to obtaining care that the child needs.

If access to specialized care and surgical dentistry is a major challenge in your area, the local Public Health Department, or the local chapter of the Dental Association, may be able to help the family to the care that he or she requires at little, or no cost to the family.

Head Start Tip:

HS PS §1304.20(c)(5) states that Head Start and Early Head Start programs can use the Federal Grant funds or other program funds to help families pay for health and dental services if all other funding sources have been exhausted and cost is the only limiting factor that prevents the child from getting treatment they need.

Refer to the Addendum: "Dental Caries Classification and Staff Responsibilities" for more information on dental office and HS/EHS staff follow-up responsibilities.

Building Partnerships

In order to succeed in implementing a sustainable oral health program more individuals than just the passionate Health Manager and an excited FQHC dentist will need to be involved. By building partnerships and communicating a common interest to all, you can work with the whole community on promoting children's oral health. Some of the benefits of partnering with individuals and organizations across different sectors, like public health, dental professionals, insurance providers, universities, and others, include:

- Maximizing everyone's efforts and impact
- Improving relationships, and outreach efforts
- Increasing visibility of your program and messages to a wider sector of community
- Reducing the duplication of efforts
- Co-branding campaigns, leading to increased credibility to each partner agency
- Building on the expertise, tools and resources of each other
- Improving the health status of the whole community

Although partnering with various stakeholders brings many gains, there are potential risks as well. These include conflicts of interest, implementation challenges due to changes in staffing, resource and time costs of maintaining partnerships, as well as challenges in communications across different sets of vocabularies and priorities. With thorough planning and by maintaining open communication, these challenges can be overcome and a successful program can be established³⁵.

Identifying Partners: Public Health Department

Begin by contacting the local Public Health Department's Children's Oral Health staff, Child Health and Disability Prevention (CHDP) representative, a representative of the Dental Services Department, or a member of the Maternal, or Child and Adolescent Health (MCAH) unit staff. Some of the benefits of networking with the Public health Department include:

[CLICK HERE!](#) To find out more about the California Child Health and Disability Prevention (CHDP) services and to locate your local county CHDP office.



Data sharing: The data collected by, or available to the Public Health Department staff can help you identify community needs faster, as well as help you communicate the impact of your efforts.

Matching goals and objectives: The Public Health Department may have goals, objectives and programming related to children's oral health that can include HS/EHS. Connecting with these efforts can put your agency in touch with existing stakeholders, and potential funding streams that can support programming.

Networking and community outreach: The Public Health Department connections can help you share information about what you are doing at Head Start. Many healthcare providers and public health officials are not aware of the full scope of services Head Start provides, nor the extent of the needs of the population that you work with. This is especially true if you serve minority groups that may be overlooked when large scale plans are made. Invite public health officials to present at, attend, and join your next Health Services Advisory Council meeting. This will begin building a relationship between agencies as well as individual staff, if no relationship exists.

Identifying Partners: FQHCs

To find an FQHC in your area visit: <http://findahealthcenter.hrsa.gov/>

Each FQHC clinic has a unique and different staffing structure, so it is difficult to identify a specific position that you will find at all FQHCs. However, the majority of FQHC dental clinics will have a Dental Director, or a dentist in charge of the dental clinic/ dental department. Often, the Dental Director will be able to direct you to the appropriate staff person on their team with whom you can speak more about the details of setting up portable dental clinic services until you are ready to present a final proposal. The Dental Director may also be the one who takes on that role, as they are likely to be the most knowledgeable about the clinic's capacity as well as the scope of the burden of oral health disease in your community.

If you are unable to contact the Dental Director, many FQHC clinics will also have a Community Liaison or a similar person who works with various community partners. Requesting to speak with a person in these types of positions will get you started.

Head Start Tip:

Meeting your FQHC partner for the first time? Come prepared with a program data snapshot, an annual report print-out, recruitment flyer, and/or other print materials that showcase your program as well as all Head Start services.

Remind the FQHC staff that Head Start is not just childcare, but a comprehensive child and family development program.

The first step to building a successful partnership with your local FQHC clinic is to build trust between the two agencies and groups of staff. While there are many things the FQHC partner will bring to Head Start, it is important to remind the clinic staff about all the great services Head Start provides to the children and families they see in the clinic. As is the case with many social services programs that work with at-risk populations, follow up and case management may be a challenge for the FQHC teams. Letting clinic staff know that Head Start is required to help families follow the doctor's recommendations and recall schedules can help secure their buy-in.

Medical and dental professionals have very limited time to spend on community partnership building, and respond well to data and evidence-based approaches to solving health disparities. The health and dental professionals are also dedicated to making their community healthier. When meeting with the FQHC team share the following information both verbally and in writing:

- Brief data about the needs of HS/EHS families
- Research showing the positive impact of Head Start
- Basic model of your proposed project

Partnering with your local Department of Public Health will help you with supporting data, and background needs assessment, and give your proposal more strength.

Providing dental services at your childcare sites will involve some upfront costs for your FQHC partner. They may need to purchase portable/additional equipment and supplies, as well as dedicate staff time to coordinating, planning and starting-up services. Be prepared to discuss alternative start-up funding strategies and grant writing with your FQHC partner. As the portable dental services program is established, the FQHC clinic will be able to bill the state Medicaid insurance (such as Denti-Cal) for the services provided at your sites to the children who have insurance. This billing mechanism should also cover the cost of treating uninsured and under-insured children.

The general suggestions to creating successful partnerships with your FQHC (and other) partners begin with building trust, setting clear goals, finding enthusiastic champions, sharing data, and maximizing productivity by ensuring mutual benefit and recognizing partners' contributions³⁴. Think about each of these points as you develop Memorandums of Understanding (MOUs).

Identifying Partners: Head Start Staff

Steps to Successful Partnerships

Build trust

Set clear goals and expectations

Find excited champions

Share data and successes

Seek mutually beneficial approaches

Recognize contributions

Head Start staff at all levels have challenging positions and many requirements that they have to address. Nationwide, the demanding workloads are the biggest source of stress for HS/EHS staff. Adding a new and unfamiliar program can be met with resistance from staff. Ensuring the program's success will take time and training, as well as buy-in across all levels.

Begin by identifying at least one champion at each level the organization: think about Teachers, Site Supervisors, Family Services staff, Management staff, and the Executive Director. Usually, you already know who on your team is easier to engage and include problem solving around health and nutrition initiatives. These staff are the teachers who ask you for additional resources on lesson plans, family advocates who frequently work with you to support children with challenging health needs, and fellow managers who actively involve you in their programming.

Regardless of how you begin establishing partnerships, input must be sought from all levels of staff prior to the project implementation. Provide each staff stakeholder background information on the needs, benefits, goals and expectations. You should already have a draft of these based on your communication with the FQHC and DPH partners. Seek input from your staff on whether the best practices suggested in this manual will work for your organization, and for individual childcare site teams. Allow staff to voice concerns as well as suggestions to achieve consensus. Once your team organization collectively develops a plan, remember to empower the champions to lead their site teams through ongoing mentorship, technical assistance and regular check-ins.

Be clear about:

- Who does what task - distribute work as evenly as possible
- Timelines for the school year, or a specific time period
- Minimum participation expectations from clinic and HS/EHS staff, as well as families
- Goals for number of children reached (make sure the goal is realistic)
- Benefits to children, families, staff, and larger community
- Recognition or incentives, if available

Once the work is underway, remember to recognize individual staff contributions. While financial incentives such as gift cards, bonuses and days off are always appreciated by staff, some free recognition strategies can also boost staff morale. For example:

- A feature in the agency's newsletter, or on the program website as an Oral Health Champion of the Month/Year
- Recognition certificate at the End of The Year celebration, or Pre-Service

However, not all staff like public displays of appreciation, for those staff you can:

- Send a "Thank You" card
- Come out to lead a circle time lesson or an outdoor activity for a Teacher so that they can catch up on lesson planning or other paperwork;
- Provide additional support with a family, or a parent meeting, for a Family Advocate to reduce their workload.

Identifying Partners: Outside of the Agency

- Local college, or university - professors, administrators as well as student groups
- Dental Association chapter members and private dental offices
- First 5, or Preschool For All
- Community healthcare providers and pediatricians
- Unified School District staff - school nurses and administrators, parent liaisons, community outreach workers, school social workers
- Private kindergarten administrators

Some Tips for Convincing Different Head Start Groups:

Constituents	Considerations	Topics for discussion
Parents and Families	<ul style="list-style-type: none"> • Inform of the benefits; • Anticipate fears 	<ul style="list-style-type: none"> • Good teeth = good future • Build a good relationship with the dentist • Preventative services = less treatment later in life • Less time off work going to the dentist • No associated costs - be very clear on this • Tooth decay is #1 reason children miss school
Teachers	<ul style="list-style-type: none"> • Impact on school readiness; • Support for programming 	<ul style="list-style-type: none"> • Timely dental problem detection and treatment can positively prevent disruptive behaviors in the classroom, including biting and other aggressive actions. • Healthy teeth support social/emotional development • Healthy mouth supports language development • Dental staff can help with tooth brushing and circle-time lessons or oral health curriculum
Family Services	<ul style="list-style-type: none"> • Reduce family stress; • Improve paperwork collection and ease of follow-up 	<ul style="list-style-type: none"> • Reducing stress around dental services for families • Improving access to all families at your sites(s) • No more calling around to track down dental exams • Added clarity on follow up recommendations • Less need for dental case management, and more time for other needs of the family
Management	<ul style="list-style-type: none"> • Impact on school readiness; • Staffing impact 	<ul style="list-style-type: none"> • Impact on school readiness (see pg.6) • Reduce staff workload in the long run • Impact on program goals and objectives • Benefits to their staff (as listed above)
Directors, Board, and Governance	<ul style="list-style-type: none"> • School readiness; • Chance to target numbers and increase efficiency; • Reduction in financial burden of supporting treatment 	<ul style="list-style-type: none"> • Burden of caries in your program • Short term investment = long term benefits • Examples of success • Impact on program or agency's goals and objectives • Impact on staff workload short term vs. long term

Memorandum of Understanding

FQHC clinics are mandated to address the issues of access to services, and may do so by providing services at “non-traditional”, or “intermittent” clinic locations. The Department of Health Care Services allows FQHC providers to bill for the services provided at sites outside of their “brick and mortar” clinic if they meet certain criteria. These intermittent clinics are exempt from licensures required to establish a formal clinic, but must “meet all other requirements of law, including administrative regulations and requirements, pertaining to fire and life safety.”³⁶

FQHC Partner Tip:

For the purposes of this manual, the term “*intermittent clinic site*” will be used to refer to the portable clinics set up within HS/EHS sites, operating less than 30 hours per week, and meeting other DHCS and HRSA requirements. Other terms used to describe such clinics include “satellite clinics,” or “seasonal satellite.”

A term with which Head Start staff may be more familiar is “dental chair program.”

The criteria which need to be met for an FQHC provider to be able to bill for services, and thus create a sustainable dental chair program at Head Start, are as follows:

- Clinic must serve patients for less than 30 hours per weekⁱⁱ
- *An MOU or a lease must be in place with the host location clearly identifying intermittent clinic space and hours of operation*
- The FQHC must have a fire clearance on file for the intermittent site (Head Start site)
- The FQHC must include the location of the intermittent site and the services provided in their federal HRSA scope-of-projectⁱⁱⁱ
- The FQHC must inform the Department of Health Care Service (DHCS) of the additional site where services will be provided ⁱⁱ

The California Primary Care Association (CPCA) provides some guidance regarding the Memorandum of Understanding outlining the partnership between the FQHC and the Head Start/ Early Head Start partner mentioned above.

The MOU must include the following:

1. **Clearly identify the intermittent clinic space and hours of clinic operation.** The MOU, or the supporting documents/ attachments should include a floor plan with the clinic space highlighted. If setting up a dental chair at multiple sites, the MOU should include floor plans for each intermittent clinic, and be amended if the number of sites changes.

ⁱⁱ [AB 1130](#) signed on 10/01/2015, and effective on 1/1/2016 increases minimum from 20 hr/week to 30 hr/week.

ⁱⁱⁱ The last two requirements need very minimal support from Head Start partners. More information on these items can be sought out by the FQHC partner via the California Primary Care Association (CPCA), or similar oversight body in your state. A sample DHCS letter can be found in the addendum.

2. **Specifically state that the clinic has the control of the operations of that space during the clinic hours.** To qualify as an “intermittent clinic,” the FQHC must “operate” the space. That means that regular HS/EHS staff, and children who are not being seen by the dental staff should have very minimal access and use of the space during clinic hours.
3. **Indicate the associated cost, start date and length of the agreement.** Specific start/end dates and allocation of costs is essential to clarity of expectations. Some potential costs to consider including in the MOU:
 - Portable dental equipment costs
 - Preventative and screening supplies: fluoride varnish, toothbrushes, toothpaste and floss or other dental goodies, stickers, etc.
 - Costs of treatment of uninsured children
 - Printing and copying costs: flyers, parent handouts, patient paperwork
 - Transportation of the dental team to and from preschool sites, and potential parking costs in the more urban settings
 - Insurance and liability costs and responsibilities

Other points to consider when developing the Memorandum of Understanding:

4. Very specific roles and responsibilities of staff at as many levels as possible, such as what services will be provided, by whom and to whom, who completes patient paperwork, who does the data collection/ reporting and how often.
5. Define services provided: screenings, exams, fluoride varnish, sealants, etc.
6. Define billing and insurance information that needs to be collected.
7. Treatment planning expectations and communication - including HIPAA considerations.
8. Frequency of team meetings and follow up expectations.
9. Specific positions (not persons) who will be primary *and secondary* contacts for the duration of the project.

You can review a sample MOU developed for the FQHC-Head Start partnership in San Francisco in the Addendum section of this document.

As soon as you’ve developed the MOU, some limited services, such as health education, dental screenings, and fluoride varnish applications can begin. The paperwork that needs to be in place before full services can be provided at your sites (such as the fire clearances) can take up to a year to complete.

Include staff and parent training in these initial activities as it will help build a culture of caring for a healthy mouth at your sites, and form a trusting relationship between the families, site staff and the FQHC dental staff.



Childcare Set-Up Requirements

FQHC and Denti-Cal Billing Basics

Because of the different laws governing FQHC billing (vs. billing for private clinics), Health Centers are able to provide services in a sustainable way to underserved groups, such as low-income, uninsured and underinsured people, regardless of immigration status.

Unlike other clinics, the Federally Qualified Health Centers are able to receive Medicare payment (also called the “PPS rate”) per each “encounter” or a “documented face-to-face contact between a patient and a provider.” That provider makes a medically-based care plan for the patient. Even if multiple services by multiple specialists (a hygienist and a dentist) are provided on the same day, it is still counted as a single “encounter.” The record of services must stay with the FQHC, but copies can be made for the family and for HS/EHS records³⁷.

FQHCs may also bill Denti-Cal at the higher PPS rate for some dental procedures. These services include a dental exam (by a dentist only), fluoride varnish, and toothbrush prophylaxis for all Denti-Cal children and youth under 21 years old. Special conditions need to be met for billing for services provided by a Registered Dental Hygienist in Alternative Practice (RDHAP) instead of a Dentist (DDS), which can be explored by the FQHC partner.

Same rules as in the “brick and mortar” FQHC clinic, apply to the Denti-Cal billable services at an intermittent clinic site located inside the HS/EHS center. The visit must be³⁸:

- Medically necessary
- Provided by a “billable” provider
- Include Denti-Cal covered service, and
- Provided to a Denti-Cal enrolled individual

FQHC Partner Tip:

For additional information on billing guidelines, how to submit changes to the scope of work, and how to provide intermittent clinic services, refer to the following documents:

[“Reimbursement for Dental Services in a Community Setting: A Resource Guide for Federally Qualified Health Centers”](#) California Primary Care Association (Oct. 2012)

[“Increasing Access to Oral Health: A Technical Assistance Guide for California Health Centers.”](#) California Primary Care Association (Mar. 2016)

Fire Department Clearance

To begin providing full dental services and operate as an intermittent clinic site, each childcare site (or any other community based site) must complete the required Fire Department Clearance within 12 months prior to submitting application. In the state of California use the **Fire Safety Inspection Request form STD 850** (see Addendum).

Cost: Each city's Fire Department may charge varied fees for requesting and scheduling a fire inspection. In 2015 the fire inspections of a childcare facility completed by San Francisco Fire Department ranged between \$120 and \$240, depending on a center's CA Childcare Licensing (CCL) capacity. Check with your local fire department about the costs of fire inspections.

Timeline: Depending on the capacity of your city's Fire Department, the actual inspections can be scheduled several months after the original request has been submitted. Plan on needing at least 2 to 3 months from the date that the request was submitted to completing the inspections.

Preparing for Inspection: Passing the Fire Department inspection can be further delayed if the Fire Inspector cannot locate all of the necessary equipment, documentation or finds unsafe conditions that need to be addressed.



Please note that childcare sites may not need to go through a fire inspection after passing one at the initial CCL inspection. It may have been *years* since each of your program's sites has been inspected. This means that structures may have deteriorated, and/or do not meet the current inspection requirements. Refer to the current OHS Environmental Health and Safety Monitoring Protocols (2016) for some basic fire safety guidelines and related HS/EHS Performance Standards, and consult the local Fire Department if you have any questions or concerns.

The San Francisco Fire Department requires records of testing of all emergency equipment to be on file and available for review during the inspection. Check with your facilities staff, and the building landlords (if renting property in which HS/EHS center is located) prior to scheduling fire inspections that these are up-to-date and accessible. Some of the required documents are^{iv}:

- Facility Emergency Plan (written CCL document)
- Emergency Evacuation Plan (diagram/ floor plan) - With clearly marked exit routes from the clinic space
- Fire Drill log (at minimum Annual)
- Annual Fire Alarm Test Certificate, includes the testing of (but not limited to): Pull Stations, Visual Warning Devices, Audibility of Fire Alarm System, Smoke Detectors, and Heat Sensors.
- Sprinkler/Standpipe (5-yr and Annual inspection) and Shut-Off/ Isolation Valve
- Fire Extinguishers installed, maintained and serviced (Annually)
- Exit and Emergency Lighting (Quarterly) - clearly marked
- Emergency Exit and Release Devices (Annually)
- Smoke Control Systems and Fire/Smoke Dampers (Quarterly)
- Emergency Generator (Weekly and Monthly) and Elevator Emergency Equipment (Quarterly)
- Special Extinguishing Systems - such as UL300 appliance hoods in kitchens

^{iv} For a complete listing of SFFD requirements and pertinent forms visit: <http://sf-fire.org/inspections>

Required Postings:

In addition to the required information about the emergency evacuation routes and procedures, make sure to post:

- Clinic name
- Clinic days and hours of operation

You can also post clinic staff names and photos so that the space has a more professional look when the Fire Inspector comes out to look at your proposed space.

During the First Inspection:

- Prepare the needed materials listed above, or noted by the Fire Inspector
- Include the Center Director/ Site Supervisor, facilities staff, and the Health Manager
- Include the FQHC dental staff that would be present on a regular clinic day
- Set up the dental equipment as if it were an actual clinic day
- Answer any of the Fire Inspector's questions regarding scope and purpose of the project

California Child Care Licensing Requirements

Ratios of children to qualified adults vary from CA Childcare Licensing Requirements to the HS/EHS requirements. The HS PS dictate that agencies always go with the more stringent ratio requirements, which, in the case of California, are the Federal HS PS requirements.

Generally, the FQHC staff do **NOT** count towards ratio. Depending on your program staffing patterns, this may pose difficulty around staffing the dental clinic. Make sure to consult the appropriate manager, your CCL or OHS consultants when planning clinic set-up.

Children leaving the classroom to go to the dental clinic space should *NEVER* be left unsupervised by a qualified staff member who counts towards CCL and HS/EHS ratios.

Remember that supervision of children is one of the most serious findings during OHS monitoring, as well as CCL monitoring. **HS PS 45 CFR 1304.52[i][1][iii] requires that "no child shall be left alone or unsupervised while under [Head Start/ Early Head Start] care."**³⁹ If a child is allowed to leave to the dental clinic space with FQHC staff alone, depending on the physical layout of the classroom space that child may no longer be under the care of appropriate HS/EHS staff. Sending a child to receive dental procedures without a familiar adult, however quick and/or minor these procedures may be, may also cause the child undue stress and prevent them from forming a successful relationship with the dental team.

A potential solution can be to allow a familiar assistant teacher, or a floater teacher who does count towards the licensing ratios to accompany the child to the dental chair while the Family Advocate, the Health Manager or other substitute staff assists the Lead Teacher with the classroom management and regular daily activities. Alternatively, the dental chair services can be set up and provided within clearly defined area of the classroom, thus eliminating the challenges of maintaining ratios and active supervision.

Ratios For California Childcare Licensing ⁴⁰ vs. HS/EHS ⁴¹				
Age	CCL Child: Staff Ratio	HS/EHS Child: Staff Ratio	CCL Max Group Size	HS/EHS Max Group Size
6 weeks	4 : 1	4 : 1	Not Regulated (NR)	8
9 months	4 : 1	4 : 1	12	8
18 months	6 : 1	4 : 1	12	8
27 months	6 : 1	4 : 1	NR	8
3 years	12 : 1	10 : 1	NR	15 or 17 ^v
4 years	12 : 1	10 : 1	NR	17 or 20
5 years	14 : 1	10 : 1	NR	17 or 20

Intermittent Dental Clinic Patient Paperwork Requirements

Because the intermittent dental clinic sites set up in the HS/EHS centers are treated in the same way as a regular “brick-and-mortar” clinic by Medicaid, the patient paperwork requirements are the same for the children seen at a Head Start/ Early Head Start site as they would be in the clinic. This paperwork may include, but is not limited to:

- Demographics and contact information
- Health insurance information
- Health history (and oral care history)
- HIPAA patient privacy notice
- Consent forms for the exam, fluoride, and/or treatment

Head Start Tip:

Completing so much extra paperwork can be an obstacle for many of the HS/EHS families, and overwhelming to the program staff. For best chances of all paperwork being complete:

- Use information already collected at enrollment
- Support families in filling out the paperwork on-site, rather than send it home
- Negotiate with the FQHC if you can photo-copy forms that you already have on file or print out information entered in ChildPlus, such as: health history and family emergency contact/ insurance information!
- Auto-populate the consent forms using the ChildPlus LiveLetter feature!

^v Depending on program option: Double session or regular

Portable Dental Chair

The portable dental equipment can vary slightly in size, type, and complexity, depending on the manufacturer and on the types of services that you plan on providing. Likewise, not all portable dental units are made equal - some are bulkier, make louder sound, and/or require being plugged in, while others are smaller, quieter, and run on batteries. How the equipment works can also determine what kind of treatment services that the FQHC Dental Team can provide at the childcare site. Talk with your FQHC Dental Team about what kind of equipment they have and what they will need to use it effectively, and efficiently.

Dental Chair Set Up and Equipment



The portable patient chair measures on average:

- Length: 44 inches (adjustable)
- Width: 12 inches
- Height: 21 inches (adjustable)

Other equipment includes:

- Portable dental unit
- Provider's tool-kit
- Provider's chair (varies in size)
- Portable Light
- Tray stand for supplies
- Trash can (for gloves etc.)



The amount of supplies that the dental team will bring and use will depend on the type of equipment the FQHC team decides to use and the space available at the preschool site. One consideration to keep in mind is access to running water - ideally the children and the dental team should have quick access to a sink for washing hands and for practicing tooth brushing with the students that they see.



Portable and digital - these x-ray machines don't require a lot of space, and can bring dental diagnostic tools right into the classroom.

Setting and Location

There are three options for dental chair set up: in a dedicated and separate room, in the staff office, and in the classroom. Each has benefits and challenges that need to be considered.

Separate office: This can be a parent meeting room, a therapy room, or other separate rooms used for screenings and/or evaluations.

- Benefits: there is generally a little more space, and added privacy.
- Challenges: may be far from source of water; supervision may be a challenge.

Staff office: This can be the Site Supervisor's office, Teachers' planning space, or the Family Services staff space.

- Benefits: parents and children may be familiar with the space. In many cases, the space is separate from the classroom and provides added privacy.
- Challenges: furniture or other office supplies may need to be moved in order to accommodate the dental equipment. Staff will have to plan on using a different space for their work. Confidential and sensitive staff and family information needs to be carefully put away and locked, or otherwise inaccessible to the visiting dental staff, children and families. Supervision may be a challenge.

Classroom space: any small group activity center that is already separated by shelving can be easily turned into a dental corner by relocating materials to a different part of the classroom.



- Benefits: supervision is easier since all teachers can see into the area. Curious children can see how problem-free a dental exam can be when their braver classmates go first. Parents clearly see the providers, dental equipment and the set up during drop-off or pick-up, as well as ask any questions they may have. Dental providers can interact and build rapport with the whole class.
- Challenges: children who are scared or apprehensive of the dental environment may become frightened and will need more emotional support - one crying child can scare the whole class. Noise level can be a challenge for both the dental team and for the classroom staff. Privacy is limited.

Dental Team Staffing

Dentist (DDS)

Following the reimbursement requirements for some services provided during the dental exam “encounter” a Dentist must be part of the team providing services at the school-based intermittent FQHC clinic site. The Dentist takes the lead during the oral exam, evaluates the x-rays, develops the treatment plan, and delivers the treatment that is needed (within the constraints of the portable equipment).

Registered Dental Hygienist (RDH) or Registered Dental Hygienist in Advance Practice (RDHAP)

The Dental Hygienist supports the Dentist with the exam, does the cleaning procedures, takes the x-rays, applies fluoride varnish, and can provide limited treatment if trained and certified to do so. A Registered Dental Hygienist in Advance Practice is a Registered Dental Hygienist who also holds a bachelor’s degree, and went through additional certification courses. In the state of California, RDHAPs are allowed to deliver services in settings such as schools, childcare facilities and other sites outside of a traditional clinic setting, making them an ideal match for the FQHCs.

Teledentistry or Virtual Dental Home

The Virtual Dental Home (VDH), or Teledentistry, is an oral health delivery system that relies on Registered Dental Hygienists to deliver the direct services at a community site, and a clinic-based Dentist that reviews the data collected by the Hygienist virtually and makes a treatment plan without leaving the main clinic.

For more on Teledentistry/ Virtual Dental Home check out the Resources section of this manual, or visit <http://www.virtualdentalhome.org/>

Administrative support staff

In San Francisco, the FQHC team came with invaluable support of the AmeriCorps staff. This individual supported Head Start team with oral health education efforts, interacting with children and leading them to the dental chair, tracking and copying screening and clinic paperwork and similar administrative tasks, and other supportive duties as assigned. Student volunteers, interns, or AmeriCorps staff are generally a great fit for this invaluable role that relieves Head Start staff *and* the FQHC staff from a tremendous amount of work.

Head Start/ Early Head Start Staffing

Health Manager

The Health Manager is instrumental in planning and organizing the efforts of the FQHC-HS/EHS partnership. This position is the point person between the FQHC team and the individual site teams, *and* the person most familiar with all of the expectations and procedures of the exam or screening day. The Health Manager should plan to attend as many of the Dental Chair clinics as schedule allows, in order to support the site staff, and ensure that the day goes smoothly.

The various roles of the Health Manager can include, but are not limited to:

- Introduction of all team members and clarifying roles and responsibilities
- Speaking with parents about services that will be provided
- Administrative and paperwork support
- Escorting children to the dental examination area
- “Substituting” in the classroom, when needed
- Providing socio-emotional support to children
- Supporting center staff, and troubleshooting if unexpected problems arise

Site Supervisor or Center Director

Site Supervisors (also known as Center Directors) are the glue that holds each site together. They wear many “hats” at the same time, and are ultimately responsible for everyone’s safety and well-being. The buy-in and involvement of the person in this position is crucial to the success of the exam or screening day.

The Site Supervisor should be informed and kept informed of the flow of the day, planned activities (for example: screening or exam?) ahead of the clinic day. During the exam/ screening day, the Site Supervisor is responsible for keeping track of staff to child ratios, be aware of where children are at all times, and if there are any unexpected changes to the planned schedule of the day.

The Site Supervisor may need to be in the classroom to cover staff breaks, or if a teacher has to accompany a child to the dental examination area. Alternatively, the Site Supervisor may be the person accompanying the child, as they are a regular and familiar presence in the children’s daily lives, and usually count towards the licensing ratios.

Teachers

On the screening day, the primary responsibility of the Teachers is to ensure that the staff to child ratios are maintained, children are supported, and that the correct child is identified for the exam or screening by the dental team. Teachers may be asked to go with the children to the dental chair exam area to support the children throughout the process.

Site Supervisors and the Health Manager need to make sure that the teaching staff themselves are comfortable being in a dental setting, and are given the language they need to talk to the children about procedures that will be done. Since not all Dentists and Dental Hygienists have extensive experience with preschool children, Teachers can also support the dental team in using age-appropriate, supportive language with the children at their centers.

Family Services Staff

Prior to the screening day, the Family Services staff may be asked to support families in completing the necessary paperwork. Since the paperwork can seem overwhelming, and time consuming, finding ways to automate the paperwork in ChildPlus can be of great support.

On the screening day, the Family Services staff can help with interacting with parents and explaining what services will be provided, getting consents at the time of drop-off, and communicating the treatment plans to parents at the end of the day. It is important that the dental team is able to explain all of the Dentist recommendations to the Family Services staff

member, so that correct information can be passed on to the parents. The Family Services staff can also serve as an extra adult in the classroom and support the staff to child ratios.

Additional Classroom Management Resources and Best Practices

Family Participation!

Family members should always be welcome to be present during the exams, and especially encouraged to be present during any treatment visits. Caregivers should be encouraged to meet the dental team, and support their child in establishing a positive relationship with the dentist. Caregivers who themselves have negative past experiences with dental providers may need to be supported and encouraged by Head Start staff to begin forming more positive relationship with dental team, as their hesitance can affect the child's experience as well.



Family participation can greatly improve the ease of dental exams for Early Head Start children by utilizing the **Knee to Knee** method:

The caregiver and Dentist or Hygienist sit knee to knee, with the baby, or toddler, in the caregiver's lap. The child leans back putting their head on the dental professional's lap, but able to see, hear and feel the caregiver. The child can be comforted by the familiar and loved adult, while the dental exam is completed.

Children's Mental Health

The agency's Mental Health Consultant assigned to the center or classroom should be involved in preparing the children for the dental clinic day. The mental health professionals can support the staff, families and children through a variety of appropriate techniques such as:

- Social stories
- Circle time before dental visit
- Regular classroom tooth brushing
- Additional classroom activities - specific small group activities around relevant topics

Mental Health Consultants can also help the site teams identify and support those children who may be the most fearful of strangers, new activities, and disruptions to the classroom routines. Considering the socio-emotional wellness of children of all ages (infants and toddlers, as well as preschoolers!) should be a part of the planning process at every site.

Head Start Data in Child Plus Database

As you review the next section, please keep in mind that the San Francisco Children’s Oral Health Initiative is not in any way affiliated with ChildPlus Inc. and did not receive any funding or compensation for developing this manual. The recommendations below are based solely on the experiences of the San Francisco Head Start/ Early Head Start agencies, all of which have chosen to use the ChildPlus software, and have been using it for many years.

Data Collection Set Up

Your program’s ChildPlus consultant can help your systems administrator set up the events described in this section.

Please refer to the training manual you should have received as part of your agency’s introductory training on the database for more detailed information on how to address each step described.



Visit www.childplus.com

for more info!

Oral Health Events in San Francisco HS/EHS ChildPlus Databases:

Event	PIR?	Timeline/ Expiration	Notes
Dental Exam	YES	Expires in 12 months	Staff can change expiration if recall indicated sooner by the dentist
Dental Assessment	NOT counted	Expires in 12 months	
NEW Fluoride Varnish	NOT counted	Expire in 3 months	

Refer to the ChildPlus training manual for more information on how to set up a new event in the database, and review the pre-set expiration dates and PIR checklist.

Tracking the Dental Home

Knowing where the children go for their dental care is important and helpful on many levels, and is not very time consuming once the initial setup is complete.

Benefits of consistently tracking the dental home and dental providers:

- Family Services and Health Services staff can follow up with the correct provider if the paperwork or the treatment plan needs clarification
- Staff can track which dental office is most popular among families, and prioritize outreach, community education, and HSAC recruitment efforts
- Staff can map areas with high or low concentration of providers - Identify how close are the schools to a provider, and are they seeing “enough” of the eligible children
- Staff can filter exam results by the provider - this is especially helpful for specialty providers, like pediatric specialty or oral surgery centers
- Staff can print a report with all providers and contact information from the database

For best results review with the staff the importance of completing *all* of the fields that list the child’s dental home, including:

- Health Information tab: “Dental Home”
- Individual event details: “Provider” (in Dental Exam, Dental Assessment, Fluoride Varnish)
- Health action details: “Provider”

Head Start Tip

Remember, staff completing the Health Information section in ChildPlus should be checking the PIR boxes regarding the child’s Dental Home at beginning of enrollment and at the end.

Data Entry Best Practices

The more data that the staff are able to enter, the better the quality of the data you will be able to review, analyze and report when needed. Consistency in data entry practices is also important, as you will learn in the Data Calibration section. In the next few pages you will find the data entry guide provided to all staff entering data at the three HS/EHS agencies in San Francisco.

Head Start Tip

One of the most critical (and time saving!) pieces to consider when planning for streamlining your data entry is the use of specific and consistent abbreviations and shortcuts.

<p>Abbreviations:</p> <p>Talk with your local dentist and key agency staff and provide all staff who enter data a key to all possible shortcuts to ensure consistency and understanding.</p> <p>Abbreviation examples:</p> <ul style="list-style-type: none"> ● C1 = Class 1 (healthy) ● C2 = Class 2 (treatment needed) ● C3 = Class 3 (urgent treatment) ● TX = Treatment ● GA = General Anesthesia ● F/U = Follow Up ● Apt = Appointment 	<p>Shortcuts:</p> <p>The ChildPlus system has a great built-in “shortcut” feature that automatically corrects a shortened phrase into a pre-programmed sentence or prompts for staff.</p> <p>Shortcut example:</p> <ul style="list-style-type: none"> ● You type “FUP”: ● ChildPlus auto-completes this to: “Followed up with parent/ guardian about missing results. <p>Spoke with: _____, Reason not completed: _____; Next steps to complete: _____”</p>
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Entering a Healthy Dental Exam

1. Follow the steps for adding a single Health Event on pg. 89 of the ChildPlus Training Guide (2015 edition)
2. Enter the information on the dental exam as completely as possible.
 - a. Date of the exam
 - b. Expiration date is one year from the date of the exam, unless doctor indicates differently (for example, writes “6 month recall”)
 - c. Status “Passed First Screening”
 - d. Results: “c1: healthy” and follow up visit date if indicated on the exam
 - “c1” stands for “class 1” refer to caries classification table for clarity
 - e. Provider name from the provider drop-down menu
 - If not listed, add name/ phone# in the notes
 - f. Provider type “Doctor/Dentist”
3. Enter Healthy Dental Follow-up Notes:
 - a. Use shortcut “dent” that will expand to say: “Exam, cleaning, x-rays and fluoride provided. Next visit:”
 - b. Edit the types of services provided, if needed:
 - For example, x-rays are not done at every dental exam visit, and may not be listed on the dental exam form as a service provided.
 - Write any additional notes, if the doctor wrote anything additional, i.e. “watching #K”.

ChildPlus Database Screenshot: Healthy Dental Exam

The screenshot displays the 'Event Details for this Dental Exam' form within the ChildPlus Database. The form is organized into several sections:

- Event Information:** Includes 'Scheduled Date' (5/28/15), 'Event Date' (5/28/15), 'Expires' (5/28/16), 'Status' (Passed First Screening), 'Description', and 'Results' (c1: hlthy fu 10/2015).
- Health Needs:** A list of checkboxes for 'Referral', 'Follow-Up Assessment', 'Formal Evaluation', 'Treatment', and 'Treatment - Restoration, Pulp, etc. C.19.a'.
- Agency and Provider Information:** Includes 'Agency Worker' (Pecherska, Maryna), 'Provider' (Children's Choice - Mission), 'Provider Type' (Doctor/Dentist), and 'Funding'.
- Costs:** 'Estimated Cost' and 'Actual Cost' are both set to 0.
- Parental Notification:** Includes a checkbox for 'Parents/Guardians Notified' and fields for 'Who was notified', 'By whom', 'Date Notified', and 'Time Notified'.
- Event Notes:** A text area containing the note: '5/28/2015 12:15 PM Maryna Pecherska Health & Nutrition Mgr Exam, cleaning, x-rays and fluoride provided. Healthy. Next visit: October 2015 <end of entry>'.

Entering a Dental Exam That Indicates That Treatment is Needed

1. Follow the steps for adding a single Health Event on pg. 89 of the ChildPlus Training Guide (2015 edition)
2. Enter the information on the dental exam as completely as possible.
 - a. Date of the exam
 - b. Expiration date is one year from the date of the exam
 - c. Status “Failed 1 st Screening, Needs Referral”
 - d. Results: “c2 (c3): treat _____” and follow up visit date, if indicated on the exam
 - “c2” and “c3” refer to “Class 2” and “Class 3”
 - e. Provider name from the drop-down menu
 - If not listed, add name/ phone# in the notes
 - f. Provider type “Doctor/Dentist”
 - g. Check the PIR box that says “Treatment - Restoration, Pulp, etc. c19.a”
 - Just checking “Health Needs: Treatment” will not reflect this need and your efforts to meet it on the PIR at the end of the year.
3. Dental Visit Follow-up Notes:
 - a. Use “dent” shortcut and edit notes, as with the Healthy Dental Exam
 - b. Indicate which teeth need treatment
 - c. Any additional information provided by parents or on the dental exam, such as referrals to specialists or other notes

ChildPlus Database Screenshot: Dental Exam That Indicates Treatment is Needed

The screenshot shows the 'Health Information' tab in the ChildPlus Database. The event is titled 'Event Details for this Dental Exam'. Key fields include:

- Scheduled Date:** (Empty)
- Event Date PIR:** 5/28/15
- Expires:** 5/28/16
- Status:** Failed 1st Screening, Needs Referral
- Description:** (Empty)
- Results:** c2: treat 6/2/15
- Agency Worker:** Pecherska, Maryna
- Provider:** Children's Choice - Mission
- Provider Type:** Doctor/Dentist
- Funding:** (Empty)
- Estimated Cost:** 0
- Actual Cost:** 0
- Health Needs:**
 - Referral
 - Follow-Up Assessment
 - Formal Evaluation
 - Treatment
 - Treatment - Restoration, Pulp, etc. C.19.a (PIR)
- Parental Notification:**
 - Parents/Guardians Notified
- Event Notes:**

5/28/2015 12:15 PM Maryna Pecherska Health & Nutrition Mgr
Exam, cleaning, x-rays and fluoride provided. Needs treatment on #M-DQ
Next visit: 6/2/15 at 12:30pm
<end of entry>

Adding Dental Treatment

1. Refer to the steps for adding an action on pg. 91 of the ChildPlus Training Guide (2015)
2. Select the appropriate type of action:
 - a. If following up with parent/guardian, or the dentist, add a “Follow Up” action:
 - Add in the notes what you talked about, with whom, and the next steps.
 - b. If you or the dentist made a referral to a different clinic, add a “Referral” action:
 - Indicate the referral made.
 - For example: “child was referred to UCSF for sedation treatment”
 - c. If it was a treatment visit, add as “Treatment” action.
3. Complete all of the fields possible in the added action, and select the appropriate treatment status
4. If treatment was received, remember to **mark the PIR box** “Treatment Received (Restoration, Pulp Therapy, or Extraction) C.19.a.1 to get the credit for your hard work
 - a. Use “dtx” shortcut, and fill in the missing information
 - b. Indicate which teeth were treated, and if more treatment is needed
 - c. Note any additional information provided by the dentist or caregivers
5. When any treatment has been received return to the main Dental Exam event and update:
 - a. Event Status: “Follow up in Progress” or “Follow up Completed”
 - b. Event Results: Add a note about the follow up like: “c2: next visit 6/6/16” or “c3: referred to UCSF” or “c2: treat complete” - this is great for running report!

ChildPlus Database Screenshot: Adding a Dental Exam Action

The screenshot shows the 'ChildPlus Database' interface. At the top, there are navigation tabs: Application, Enrollment, Family Services, Health, Immunizations, Disability, Mental Health, Birth, Transportation, Education, Attendance, and PIR. Below these are sub-tabs: Events, Requirements, and Health Information. The main content area is titled 'Event Details for this Dental Exam' and includes a table of 'Actions Associated with this Dental Exam'.

Action	Action Date	Description	Status	Health Worker
Treatment	5/28/15		Treatment Completed	Corleto, Delmy

Below the table, there are buttons for 'Add Action' and 'Delete Action'. The 'Add Action' form includes the following fields:

- Action Type: Treatment
- Scheduled Date: [Calendar icon]
- Action Date ^{PIR}: 5/28/15 [Calendar icon]
- Description: [Text input field]
- Status: Treatment Completed
- Agency Worker: Corleto, Delmy
- Provider: Children's Choice - Mission
- Provider Type: Doctor/Dentist
- Funding: [Dropdown menu]
- Cost: 0

A checkbox is checked for 'Treatment Received (Restoration, Pulp Therapy, or Extraction) C.19.a.1' with a ^{PIR} label.

The 'Action Notes' field contains the following text:

5/28/2015 12:43 PM Maryna Pecherska Health & Nutrition Mgr
 Child received dental treatment: #M-DQ
 Next visit: routine recall Oct. 2015
 <end of entry>

Adding Fluoride Varnish

If fluoride varnish was provided, follow the steps for adding a single Health Event on pg. 89 of the ChildPlus Training Guide (2015) to add a health event called “Fluoride Varnish”

Remember! Your system administrator will have to set that event up in the system, it is not one of the pre-sets provided by ChildPlus

1. Fluoride varnish expires after 3 months
2. You can leave the “Results” section blank, and for most children, there are no notes
 - Notes can include staff feedback such as “molars only” or note challenging behavior during application
3. If provider name is not in the drop down menu add name/ phone# in the notes
 - Fluoride can be applied by providers other than dental staff such as pediatricians, medical offices, community partners, and even trained HS/EHS staff

Other ChildPlus Features: Live Letter

Chances are, you’ve seen the LiveLetter feature, but never used it. Some of the pre-set forms that come with the ChildPlus software that this feature completes are award certificates, enrollment notices, and immunization notices. You CAN set up your own LiveLetter to complete forms such as notices of missing health information, notices of dental follow up, screening result reports, as well as New Patient Information forms that your FQHC partner may want a copy of.

Fill in your New Patient forms using ChildPlus data:

- It takes a while to learn and set up
- Need a text or excel file of the original (not .pdf)
- Not all data can be completed, BUT, saves time in the long run, especially for direct service staff
- Saves time for staff and families - better compliance!
- Once completed: the guardian checks if correct, adds missing or incorrect data and signs/ dates

Check out: <http://www.childplus.com/liveletter/>

Contact your ChildPlus T/TA staff for training. Check out the Addendum section for a sample of a form completed using the LiveLetter feature.

Data Calibration

Collecting, recording and reporting that data in a systematic and consistent way between programs, partners, and even between staff within an agency is crucial to ensuring that the data you use are relevant and can be reported on a neighborhood scale and larger scales.

Ensuring that all Head Starts in your communities collect data in the same will allow you to effectively measure your success across the entire area. Even if not all agencies are planning on implementing portable dental services at their centers, bringing them “on board” with data collection will allow you to have a “control” group of children when measuring impact. For example, did your program achieve a higher rate of improvement, than other agencies?

When beginning to calibrate data between agencies make sure that you involve all relevant partners. In San Francisco this included:

- Head Start Health Managers from all agencies
- San Francisco Unified School District Nurse
- SF Department of Public Health (SFDPH) Oral Health Consultant
- SFDPH Dental Hygienist in charge of school screenings
- SFDPH Epidemiologist
- FQHC Partner representative
- Representatives from University of California, San Francisco School of Dentistry, and University of the Pacific Arthur A. Dugoni School of Dentistry.

Including these staff members allowed the data to be calibrated not only across Head Start sites but also provide a comparison for the data collected through the SFUSD-SFDPH kindergarten screenings, as well as was relevant for the FQHC dental professionals and staff.

Data entry strategies can vary significantly from one agency to another. Either a limited number of staff, or multiple persons may be responsible for data entry. In either situation - all staff must be clear on data entry procedure and expectations, as well as confidentiality policies established at your agency. Very clear procedures, with visual examples, whenever possible, should be incorporated into staff training around data entry.

Depending on the size and the data technology infrastructure of your program, the health information may be sent to a main office location, where dedicated staff enter data for the whole program. The number one concern of this type of data entry practice is confidentiality. The chain of confidentiality may be jeopardized as medical information is transferred from the childcare center to the main office. Review your agency’s confidentiality policy and procedures with your HSAC members to ensure that this is done accurately, and follows the laws established by the Health Insurance Portability and Accountability Act (HIPAA).



Challenges and Benefits of Different Data Entry Strategies

	Challenge	Benefit
Centralized data entry	<ul style="list-style-type: none"> • Potential HIPAA violations during transfer of documents; • Documents may be lost in transit; • Data entry clerks do not have the on-the-ground knowledge of children and families - deal with abstract data only; 	<ul style="list-style-type: none"> • Easier data entry calibration - the less people enter data, the less chance of mistakes; • Easier to train data entry staff due to centralized location; • Dedicated data entry staff ensure that received documents are entered within expected timelines;
Site-Based data entry	<ul style="list-style-type: none"> • Staff training may require trips to removed locations; • More difficult to calibrate across more staff members; • Staff have different levels of computer literacy, slowing down data entry; 	<ul style="list-style-type: none"> • Lower chance of loss of documents; • Staff know families and children when questions or concerns arise; • Staff can enter additional comments which are not noted on the dental/medical paperwork;

Using the “file attachments” feature of Child Plus can allow for quick review of entered data from any location, and limit the need for physical transfer of sensitive documents from one location to another. Staff can scan and easily upload any documents into the software, as well as run reports listing all of the uploaded documents. ChildPlus technical assistance staff can provide you with the training necessary to effectively use this feature already built into the software.

Remember, if the staff at your sites are using mobile devices, such as classroom tablets, to scan the received medical documents and send via email (to you, or to themselves), these saved files must be deleted or otherwise kept secure and inaccessible to other personnel, and especially families. As agencies begin to update their tools, and incorporate technology in their daily operations, the procedures protecting families’ privacy must also be updated.

The Child Plus website has many quick and useful videos on how to use the software features, such as how to attach a scanned document:
https://www.childplus.com/videos/file_attachments/

Training Resources

Adults, as well as children, have three main ways of learning: visual (seeing), auditory (hearing), and kinesthetic (doing). When planning a training, make sure to incorporate all of these modes of learning so that the most of your staff retain information.

Working With Different Types of Learners⁴²

Visual	Auditory	Kinesthetic
PowerPoint Presentations Videos Flip-Charts Handouts and Manuals Demonstrations	Lectures Group discussions or brainstorms Informal conversations Phone consultation Stories and examples	Role plays and simulations Practical demonstrations Hands-on activities Writing things down Movement-based learning
Training Tip: <ul style="list-style-type: none"> • Provide handouts or reading material to take away • Include relevant visuals and demonstrations • Stick to a color scheme - do not overwhelm the visual senses 	Training Tip: <ul style="list-style-type: none"> • Explain in preferred language whenever possible • Follow up with a phone call • Read out loud when appropriate • Use story-telling or songs when possible • Allow time for discussion and sharing of experiences 	Training Tip: <ul style="list-style-type: none"> • Play-based learning is fun for adults too! • Bring various props • Allow time for group work and ask people to move throughout the room (roundtables) • Include a movement with a concept

Other points to consider when planning a training for the staff and parents:

1. Adults like to know WHY they should care;
2. Adults bring life and work experience to the classroom;
 - Lean on them for great ideas and involve them in opportunities to share their expertise;
3. Adults learn best when they are committed to learning (refer to #1!);
4. Adults are task-oriented;
 - Organize your training around job responsibilities, requirements, or parenting skill.
 - Consider assessing “take-away” information when drafting evaluation surveys.

Staff Training

Staff turnover is inevitable for any employer, including Head Start and Early Head Start programs, as well as the FQHC Dental Clinics. Developing a comprehensive staff training system, and incorporating Oral Health training into the annual staff development opportunities is needed for the sustainability of your agency’s efforts. Training manuals that

are written in simple and thorough way, and include visuals and examples are tremendously helpful for whenever there's a change in key staff, including project leads, and/or management.

Training for staff should accommodate all types of learners: have visual and auditory components, as well as hands-on elements. Staff who are successful at delivering effective oral health curriculum in their classrooms can be invited to lead a workshop for other staff on their experience and practices.

Training is most effective when reinforced. Training for all levels of staff should include a plan for follow up and check-in after they've begun the project or curriculum implementation. They may run into questions they didn't think of previously, or may need additional supplies that they didn't think to ask for.

Tools for the Classroom

ECLKC: Early Childhood Learning and Knowledge Center

The Office of Head Start has many resources that support children's oral health in Head Start and Early Head Start programs. These include, but aren't limited to:

- Information for dentists, hygienists, and pediatricians on how they can support Head Start children and their oral health
- Sample Dental Exam form
- Sign up for the monthly "Brush Up on Oral Health" electronic newsletter

For ECLKC materials visit: <http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/oral-health>

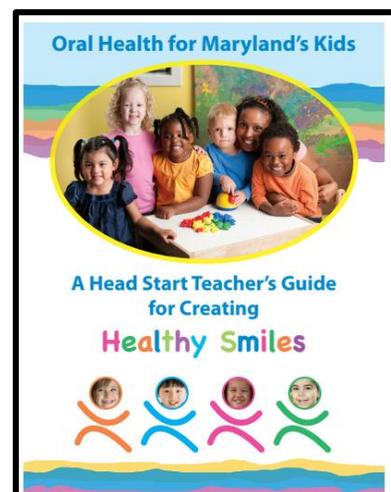
Oral Health for Maryland's Kids: A Head Start Teacher's Guide for Creating Healthy Smiles

This FREE curriculum includes 7 lessons designed specifically for Head Start teachers, children and families. Grab-and-go lessons include topics such as:

- Tooth brushing and general oral health
- Nutrition
- Dental professions

Included in this curriculum are circle time and small group activities for teachers (including cut-out templates), and take-home materials for parents.

The curriculum can be downloaded at: <http://mchoralhealth.org/ohmdkids/>



America's ToothFairy: National Children's Oral Health Foundation

The America's ToothFairy programs include materials for oral health education that can be used in the community, at parent meetings, or in the classroom.

Teachers can sign up for the RDH Esther Wilkins Education Program to incorporate the "ToothFairy 101 Community Education Kit" into their classroom activities. The kits can be purchased with "no strings attached". Programs can also apply for to receive these kits for free, by agreeing to train 100+ children and to collect pre- and post-test information when delivering the lessons. A community outreach specialist may be available in your area. Visit the National Children's Oral Health Foundation website to see if there is a ToothFairy near you.

The ToothFairy 101 Community Education Kit includes:

- Magnetic tooth board with magnet pieces
- Large toothbrush for tooth brushing demonstration
- Tooth brushing and Hand washing songs

Lessons include information on:

- Preventing Germ Transmission
- Tooth-friendly Snacks / Nutrition
- Tooth brushing / Flossing Demonstration
- Injury Prevention



Learn more about the toolkit at:

<http://www.ncohf.org/our-programs/esther-wilkins-education-program>

More Smiling Faces: Oral Health Teacher Activities and Parent Information
From the South Carolina Department of Health and Environmental Control, Division of Oral Health.

The "More Smiling Faces" toolkit comes complete with lesson plans, and printable templates for infants, toddlers and preschoolers. Each lesson comes with further reading suggestions, lists of age-appropriate books, and many popular children's songs adapted with oral health messages.

The accompanying "More Smiling Faces: Parent Information Booklet" has great handouts for parents of infants, toddlers and preschoolers on a variety of topics ranging from caring for infants' gums, and pacifier use, to sippy cups, and responding to dental emergencies.

Find this activity guide at: <https://www.scdhec.gov/library/ML-025192.pdf>

Find accompanying Parent Information Booklet [HERE!](#)

Anticipatory Guidance for Families

Printable materials for families are available for free online from many national and state leaders in oral health, and children's health. Below are some resources that can be accessed online, ordered through the website, and/or printed by your program.

ECLKC Printable Materials

<http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/oral-health>

- Oral Health promotion handouts (Eng/Span)
- Healthy Habits for Healthy Smiles series (Eng/Span)

Child Health and Disability Prevention (CHDP) Program Dental Resources

<http://www.dhcs.ca.gov/services/chdp/Pages/FamilyTools.aspx>

Educational materials for families include resources about:

- Tooth Decay in Babies and Toddlers
- Dental Home
- Fluoride Varnish



National Maternal and Child Oral Health Resource Center

<http://mchoralhealth.org/publications/list.php>

Variety of downloadable and printable materials in English and Spanish.

- Healthy Smile for pregnancy, baby and child
- Fluoride
- Tooth brushing
- Teething



Additional Resources:

Virtual Dental Home Program

The Virtual Dental Home (VDH), also known as “Teledentistry”, is an oral health delivery system that relies on a Registered Dental Hygienist to deliver the direct services at the school site, and a clinic-based Dentist that reviews the data collected by the Hygienist virtually. The Dentist looks at the electronic health records, including digital photographs of the child’s teeth, digital x-rays and the Hygienist’s report. The Dentist then makes a treatment plan, which includes specific procedures that can be done on-site by the Hygienist and procedures for which the family would have to come into the brick-and-mortar clinic and see the dentist.



The staff person out in the community can be Registered Dental Hygienist in Alternative Practice (RDHAP), a Registered Dental Hygienist (RDH), or even a Registered Dental Assistant (RDA). Though the scope of practice varies between these oral care professionals: all can deliver basic preventative oral health services, which, when supported by and signed by an evaluating Dentist, may count towards Head Start requirements, and help support the oral health of children in HS/EHS programs. This type of program can be especially effective for programs in rural or spread-out settings, where pediatric dentists are difficult to access.

The RDHAP, RDH or the RDA can provide the following services at a Virtual Dental Home site:

- Oral health education
- Dental risk assessment, including x-rays
- Fluoride varnish and sealants
- Prophylaxis and cleaning
- Interim Therapeutic Restorations
- Supporting the treatment plan recommendations and case management

Children who need treatment are referred to the “brick-and-mortar” dental office to complete the procedures requiring the skills of a Dentist and/or different equipment. A child who was already seen by the Virtual Dental Home provider at their school can then go immediately into a treatment visit rather than scheduling another exam and delaying the treatment further.

The benefits of the Virtual Dental Home model for the FQHC Dental Clinic are that this model does not require the Dentist to be out in the community. This saves the costs of having the Dentist physically out of the clinic (for example in transit, and not seeing patients), while delivering a similar level of care and treatment at the school-based dental chair clinic.

As of September 2014, Medi-Cal will reimburse clinics for services provided via a VDH. According to the University of the Pacific, this law “permanently expands the list of procedures that hygienists and certain kinds of assistants can perform without a dentist being present onsite, including determining what X-rays are needed or providing a special type of temporary fillings designed to stop the progression of tooth decay. The law also calls for dental assistants and hygienists wishing to perform these duties to complete approved training programs.”⁴³

While in a “brick-and-mortar” clinic setting with all of the tools available a Dentist *could* provide more intensive level of treatment to children than an RDHAP, the limitation of the portable equipment can make the difference in allowable duties irrelevant. As mentioned previously, the portable dental equipment can vary based on the manufacturer and is usually limited in function, thus affecting what can be done at the intermittent clinic site. In most cases, using the portable equipment the Dentist will be able to treat cavities only marginally more advanced than what a Dental Hygienist can treat with virtual guidance.

For more information on Teledentistry/ Virtual Dental Home visit:

- Maureen Harrington, Director of Grant Operations and Community Education
415.749.3383, mharrington@pacific.edu
- Dr. Paul Glassman, Director for the Pacific Center for Special Care
415.929.6490, pglassman@pacific.edu

Other Useful Links

- [City of San Diego: Large Family Day-Care Fire Safety Checklist](#)
- [San Francisco Fire Department: Inspection Guideline/Checklist](#)
- [Colgate Oral Care Center: Sedation Techniques for Children](#)

Great Children's Books on Oral Health

Chambliss, Maxie.	I'm Going to the Dentist: Pop-Up Book.
Child, Lauren.	My Wobbly Tooth Must Not Ever Never Fall Out (Charlie and Lola).
Civardi, Anne.	Going to the Dentist.
Dahl, Michael.	Pony Brushes His Teeth (Hello Genius).
Ehlert, Lois.	Eating the Alphabet.
Ehrlich, Fred.	Does a Lion Brush?
French, Vivien.	The Buttons Family: Going to the Dentist.
Mayer, Mercer.	Just Going to the Dentist.
McGuire, Leslie.	Brush Your Teeth Please: A Pop-Up Book.
Miller, Edward.	The Tooth Book: A Guide to Healthy Teeth and Gums.
Miller, Margaret.	Baby Faces.
Padron, Alicia.	Brush, Brush, Brush.
Roper, Robert.	Dora Goes to the Doctor/Dora Goes to the Dentist.
Schuh, Mari.	All about Teeth (Healthy Teeth).
Showers, Paul.	How Many Teeth?
Seuss, Dr.	The Tooth Book.
Scholastic.	Dentist Trip (Peppa Pig).
Swanson, Diane.	The Dentist and You.
Thomas, Pat.	Do I Have to go to the Dentist: A First Look at Healthy Teeth
Verdick, Elizabeth.	Teeth Are Not For Biting.
Webster, Avril.	Off We Go to the Dentist.
Ziefert, Harriet.	ABC Dentist: Healthy Teeth from A-Z.
Spanish / Bilingual	
Admont, Shelley.	Me Encanta Lavarme Los Dientes.
Cousins, Lucy.	Maisy y Rodrigo van al dentista.
Fitterer, Cynthia	Mouth / La Boca.
Huss, Sally.	Libros Infantiles: ¿QUIÉN NECESITA DIENTES?
Rice, Judith Anne.	Esos sucios pegajosos olorosos causantes de caries pero invisibles gérmenes.
San Miguel Martos, Julia.	Oso Y Su Diente De Leche.

Review: Key Terms

CHDP - Child Health and Disability Prevention - program in California which sets the state's health and dental periodicity requirements

CWF - Community-wide Water Fluoridation - controlled increase of fluoride in public water supply to an ideal concentration of 0.7-1.2 mg/L⁴⁴, in order to prevent dental disease among all members of the community. CWF is recommended by the US Public Health Service, and the Department of Health and Human Services

Denti-Cal - California Medicaid dental insurance program

EHS - Early Head Start

EPSDT - Early and Periodic Screening Diagnosis and Treatment schedule

HS - Head Start

HS PS - Head Start Performance Standards - a set of laws and requirements that all Head Start grantees must follow in order to provide high quality programs, and maintain federal funding

HSAC - Health Services Advisory Committee

Fluoride Varnish - topical fluoride solution that can be applied to teeth to prevent caries

FPL - Federal Poverty Level

FQHC - Federally Qualified Health Center

OHS - Office of Head Start

PIR - Program Information Report - an annual report submitted to the Office of Head Start by all Head Start and Early Head Start grantees

Primary teeth - also known as “baby teeth”, or “milk teeth”, are the first set of teeth that humans develop. Children begin losing their primary teeth, and their permanent teeth begin to erupt around the age of six, through age of thirteen. Last permanent teeth, also known as “wisdom teeth,” erupt between 17 and 25 years old

SDF - Silver Diamine Fluoride - an FDA-approved topical solution similar to fluoride varnish that can be used to stop active caries from getting worse. Application results in black discoloration of affected tooth surface

Sealants - plastic-like substance that seals in grooves in chewing surfaces of teeth in order to prevent and/or arrest early caries development

Spectrum of Prevention - a framework designed to address complex, significant public health problems across different levels of constituents involved.

Addendum

1. Dental Caries Classification and Staff Responsibilities
2. Sample FQHC-Head Start MOU
3. Sample FQHC letter to DHCS
4. Setting SMART goals
5. Fire Safety Inspection Request form STD 850
6. Data collected by San Francisco HS/EHS
7. Sample FQHC Patient Information forms:
 - a. Blank form
 - b. Form completed by LiveLetter feature in ChildPlus

Addendum 1: Dental Caries Classification and Staff Responsibilities

Dental Status	Description of Findings	Dental Clinic Staff Responsibility	Head Start Staff Responsibility
Class 1: Healthy	Healthy mouth; Recall visit in 3 to 9 months	<ul style="list-style-type: none"> Get to know the child and family; Provide services according to state dental periodicity schedule, or the AAPD recommendations; Complete HS/EHS paperwork, or provide a detailed record of services provided, and recall plan; Work with family to set a follow-up appointment, and send a reminder when due for recall. 	<ul style="list-style-type: none"> Support family in establishing a dental home and making at minimum annual appointments with dentist, as needed. Collect relevant Oral Exam forms; <ul style="list-style-type: none"> Note in the child's file: Dental provider's name and contact information Exam date and results (C1: healthy) Estimated date (month/year) of recall visit Support the family in keeping that recall appointment.
Class 1: Needs education	Healthy but needs oral health education, such as: <ul style="list-style-type: none"> Oral health habits Nutrition Dental hygiene 	In addition to services for "Class 1: Healthy": <ul style="list-style-type: none"> Note education needs on the completed HS/EHS paperwork so that additional health education can be provided by the HS/EHS staff. 	In addition to actions for "Class 1: Healthy": <ul style="list-style-type: none"> Review dentist's findings with family; Provide additional relevant written information; Provide toothbrushes, toothpaste or other supplies; If available, refer family to oral health workshop.
Class 2: White Spots and/or White Lesions	White spots are a sign of potential decay. Regular tooth brushing, dental cleaning, & fluoride can reverse this.	If during an exam: in addition to services for "Class 1: Healthy": <ul style="list-style-type: none"> Note any additional follow up needed, such as sooner re-application of fluoride varnish; Front desk staff - schedule a recall visit within 1-3 months, or as recommended by the dentist 	<ul style="list-style-type: none"> <u>If found during a screening</u>: assist the family with scheduling a complete oral exam within 1-3 months; the sooner the follow up visit the better. <u>If noted during an oral exam</u>: follow the protocol for "Class 1: Healthy", and: follow the dentist's recommendation for follow up.
Class 2: Early Caries	Child can develop cavities on certain teeth and/or surfaces. Tooth brushing, dental cleaning, and fluoride can help. Schedule a full exam within 1-3 months.	In addition to services for "Class 1: Healthy": <ul style="list-style-type: none"> Identify teeth and/or surfaces "to watch," and note them on the Head Start paperwork; Be clear if treatment appointment is needed, or only routine follow-up and education is needed. 	In addition to actions for "Class 1: Healthy": <ul style="list-style-type: none"> Review with family the dentist's findings; Offer relevant information and education materials; Offer dental hygiene supplies, if possible; It is very important that this child stays on schedule of preventative oral care - remind them about next visits often. If found during a screening: assist the family with getting a complete oral exam within 1-3 months.

Dental Status	Description of Findings	Dental Clinic Staff Responsibility	Head Start Staff Responsibility
Class 2: Needs Treatment	Child has some cavities that need treatment.	<p>Provide treatment during the same appointment, whenever possible – Head Start children experience difficulty accessing dental care, and treatment;</p> <ul style="list-style-type: none"> • Provide anticipatory guidance and education; • Complete the HS Oral Exam form, including: <ul style="list-style-type: none"> ○ Treatment plan: tooth number, surface to be treated, type of treatment needed (i.e.: “Class 2: needs resin-based composite - #O-MOD”); ○ Future appointment date(s), and/or number of visits needed to complete treatment. • Complete new Oral Exam form(s), or provide documentation of what treatment was completed at every treatment visit; • Note on the form(s) when the treatment is complete, and when next recall visit is due; • Call to remind the family of follow up appointment. 	<ul style="list-style-type: none"> • Collect relevant Oral Exam form(s) or treatment documentation; • Note in the child’s file: <ul style="list-style-type: none"> ○ Dentist’s name and contact information; ○ Exam date and results (i.e.: “C2: needs resin-based composite - #O-MOD”); ○ Date and time of follow up visit. • Assist family with scheduling treatment appointment, if not set at the time of the oral exam; • Set up a reminder system for yourself when the treatment visit is coming up; • Remind the family about the next treatment visit; • Collect proof of each treatment visit, and make a note when all of the treatment is complete; • Support the family in making the recall appointment, as recommended by the dentist.
Class 2: Needs Sealants	Child is at high risk for cavities and would benefit from sealants in order to prevent further decay.	<p>In addition to the “Class 2: Needs Treatment” protocols:</p> <ul style="list-style-type: none"> • Explain difference between sealant and filling to the family member(s) accompanying the child; • Place sealants at the time of visit whenever possible, and note on the HS forms if treatment was done, or if another visit for sealants needs to be scheduled; 	<p>If the dentist marked findings as “Class 2,” follow the “Class 2: Needs Treatment” protocol above. In addition:</p> <ul style="list-style-type: none"> • Review difference between sealants and fillings with family to ensure understanding; • Provide additional health education materials, and dental hygiene supplies if needed.
Class 3: Urgent Treatment	Child has one or more severe cavities which require immediate attention, or needs extensive treatment on multiple teeth. Begin treatment ASAP, and within no more than 1-2 weeks.	<p>This treatment cannot wait! Schedule treatment appointments ASAP.</p> <p>In addition to the “Class 2: Needs Treatment” protocols:</p> <ul style="list-style-type: none"> • With family’s permission, work with the Head Start staff to ensure that treatment and follow up needs of the child are met; • Provide the family and Head Start a thorough documentation of treatment plan, and if possible, associated family’s portion of costs. • If unable to provide the needed treatment, clearly indicate the referral(s) provided, and use office staff to support family in making treatment appointment with the new provider. Do not assume that the family is able to follow through on their own, especially if language, or transportation are barriers. 	<p>This treatment cannot wait! Prioritize this child, and communicate with the family regularly. <u>Notify the Health Manager, and teachers in the child’s classroom of the child’s dental status.</u></p> <p><u>If found during screening:</u> full oral exam should be completed within 1-2 weeks.</p> <p>In addition to the “Class 2: Needs Treatment” protocol:</p> <ul style="list-style-type: none"> • If needed, acquire family’s permission to share confidential information with the dental clinic; • Support family’s communication with the dental office, if confusion arises; Seek the Health Manager’s support if you are also confused; • Support the family with following treatment plan – check in frequently; • Use agency resources to support family’s transportation, childcare, and/or other needs; <p><u>If referrals to a specialist is made:</u> help family access services with the provider by your agency procedures.</p>

Dental Status	Description of Findings	Dental Clinic Staff Responsibility	Head Start Staff Responsibility
Class 3: Behavioral Needs	<p>Child has moderate to severe decay, but the child's behavior is preventing treatment initiation/ completion.</p> <p>Challenging behavior can include crying, fearfulness, refusal or aggression. This can be caused by pain, anxiety, developmental delays, or other reasons.</p>	<p>This treatment cannot wait! Schedule treatment appointments ASAP.</p> <p>In addition to the "Class 3: Urgent Treatment" protocols:</p> <ul style="list-style-type: none"> Gain the child's trust and use desensitization techniques with a family member's support; Actively involve a family member – remember, they may have dental treatment anxiety themselves! With family's permission, actively involve the Head Start staff who may have additional and different resources available to support the family; <u>If unable to provide the needed treatment</u>: clearly indicate the referral(s) provided. Discuss sedation options with family members, and note options on the Head Start forms. 	<p>This treatment cannot wait! Prioritize this child, and communicate with the family regularly. <u>Notify the Health Manager</u>, and teachers in the child's classroom of the child's dental status.</p> <p>In addition to the "Class 3: Urgent Treatment" protocol:</p> <ul style="list-style-type: none"> If child has an IEP, a developmental delay, or other health condition, with family's permission, involve the specialists on the child's treatment team. With parent's permission, work with the HS/EHS Mental Health Consultant on behavior support strategies; Support the dental team by using social stories, pretend play or other age-appropriate activities; <u>If referrals are made</u>: support family in accessing services and help the dental team explain options.
Class 3: Conscious Sedation Needed	<p>Severe decay is noted in one or more teeth requiring the use of Nitrous Oxide gas, oral sedation, or other conscious techniques.</p>	<p>This treatment cannot wait! Schedule treatment appointments ASAP.</p> <p>In addition to the "Class 3: Urgent Treatment" protocols:</p> <ul style="list-style-type: none"> Clearly explain family's options in their preferred language. Families may need this explained more than once; If treatment will be provided at a different location, clearly indicate this to the family, and on their Head Start forms; With family's permission, actively involve the Head Start staff who may have additional resources for the family; 	<p>This treatment cannot wait! Prioritize this child, and communicate with the family regularly. <u>Notify the Health Manager</u>, and teachers in the child's classroom of the child's dental status.</p> <p>In addition to the "Class 3: Urgent Treatment" protocol:</p> <ul style="list-style-type: none"> Ensure that the family understands the difference between sedation options offered to them; Use this website for more information on different sedation techniques: http://tinyurl.com/dentalsedation
Class 3: General Anesthesia Needed	<p>The level of decay is severe enough in both quantity and progress of disease, infection and pain levels are moderate/severe, and/or child's behavior is preventing them from completing "regular" treatment plan</p>	<p>This treatment cannot wait! Schedule treatment appointments ASAP.</p> <ul style="list-style-type: none"> Clearly explain family's options and different sedation types in their preferred language. Families may need this explained more than once; With family's permission, work with the Head Start staff to ensure that any referral follow up is done; Head Start staff may have additional and different resources available to support the family; Provide the family and Head Start a thorough documentation of the surgical referral, information about general anesthesia, and associated family's portion of costs, if known; If surgical treatment is provided at a different location, clearly indicate this to the family, and on their Head Start Oral Exam forms; Counsel family when to seek emergency care at your office, and when to go to the Emergency Room, if something goes wrong prior to the surgery. 	<p>This treatment cannot wait! Prioritize this child, and communicate with the family regularly. <u>Notify the Health Manager</u>, and teachers in the child's classroom of the child's dental status.</p> <p>In addition to the "Class 3: Urgent Treatment" protocol:</p> <ul style="list-style-type: none"> Families are understandably very anxious about this type of procedure, surgical involvement and associated risks. Involve your Mental Health Consultant whenever possible; Before general anesthesia the surgical department will need clearance from the child's medical home. You can assist families by sending the appropriate paperwork to the dental and medical offices via email, fax, or mail; Even in these urgent cases, surgical dentistry can take a long time to schedule. Make sure that the caregivers are able to recognize signs and symptoms of shock, or other life-threatening consequences of untreated decay, and have a plan in place for when to call their Dental Home, and when to turn to the Emergency Department, prior to their surgery date.

Addendum 2: Sample FQHC-Head Start MOU

MEMORANDUM OF UNDERSTANDING

_____ Head Start/ Early Head Start Grantee

_____ Health Center

Background:

_____ Head Start Early Head Start Grantee (HS/EHS) provides comprehensive health, mental health, family and child development/education services to low-income, underserved, culturally and linguistically diverse children ages 0-5 years old and their families. Head Start preschools directly serve _____ children ages 3-5 years in _____ licensed childcare facilities located in _____, including areas where there is a shortage of dental services. Early Head Start serves _____ children ages 0-3 years in both center-based and home-based Early Head Start programs.

The _____ Health Center in San Francisco is a 503(c) non-profit health center that serves the underserved in a variety of capacities. The _____ Dental Department consists of _____ general dentists and _____ pediatric dentists. The dental staff regularly provides treatment, outreach and screenings in the community.

The purpose of this MOU is to provide for ongoing services through the Head Start for Oral Health portable dental clinic program at Head Start and partner agency locations.

Agreement:

1. _____ Head Start and _____ Health Center agree to conduct a portable dental clinic program for a 5-year period during which _____ HC will provide dental education, examination, preventive care and basic treatment services at Head Start sites.
2. _____ Head Start will schedule dental clinic dates with the HS centers based on available dates given by _____ HC. _____ HS will distribute parental consent forms (provided by _____ HC) at each location in advance of the clinic date. Only children who have signed consent forms (signed by the child's parent/guardian) on file will receive dental services. All forms and materials will be made available in the child's home language and with prior review by _____ Head Start.
3. _____ Head Start staff will collect the completed program packets, including: consent to services, health history, HIPPA form, and financial/insurance information. These completed documents will be provided to _____ HC staff one (1) week prior to the appointment day. If further information is needed, _____ Head Start staff will assist in obtaining that information.
4. Each initial **screening** site visit will include a 15-minute interactive group presentation for the children (conducted by either _____ Head Start or _____ HC) covering healthy oral habits and hygiene, proper brushing technique, nutrition, and visiting the dentist. The _____ HC dentist will provide individualized dental screenings for all children present that day with parental consent. This will serve as both oral health education, and preparation for receiving dental services in order to familiarize the children with the procedures, and to reduce anxiety.
5. For **dental service delivery**, children who have a signed consent form on file will receive a routine dental examination, cleaning, fluoride varnish application and x-rays, if indicated. Though not required, each child's parent or guardian may (and is encouraged) to be present during the examination if possible and desired.
6. When dental treatment is indicated, _____ HC will provide a treatment plan, to be carried out only upon further consent from the child's parent or legal guardian. _____ HC will provide additional information and answer parent questions pertaining to the child's treatment plan as needed, and/or at the parent's request. If the treatment can be completed on site, _____ HC staff will return to the Head Start site at a later date to complete treatment. _____ HC may also return to complete repeat preventative exams as indicated and when possible. If treatment must be completed off-site (in a dental office or surgical setting), _____ HC and _____ Head Start staff will assist the family with referrals and follow-up, including assistance with making appointments and securing needed dental treatment. Children seen at the HS center are patients of _____ HC and always have the option to be seen at the _____ HC San Francisco office location.

7. ____ HC will own and operate the portable dental equipment and supplies. ____ HC staff will set up the portable clinic in a space agreed upon at each location in the morning and disassemble it at the end of each clinic session. ____ HC will return the space to the condition in which it was found at the beginning of the clinic session.
8. ____ HS staff will assist the ____ HC staff with transportation to and from preschool sites according to a pre-arranged schedule. A qualified and trained ____ HS staff will operate an appropriately insured and maintained agency vehicle large enough to transport all necessary ____ HC staff members and equipment.
9. ____ Head Start will make reasonable effort to collect and provide to ____ HC by the date of the schedule clinic, the dental insurance and other information necessary for billing purposes by ____ HC. ____ HC is solely responsible for billing to insurance providers for services provided under this MOU. ____ Head Start will accept no liability for any claim for un-reimbursed services.
10. The project coordinators for this agreement shall be _____, Health and Nutrition Manager for ____ Head Start and _____, Dental Director for ____ HC.
11. ____ HC agrees to indemnify, defend and save harmless, ____ Head Start, their officers, agents and employees from any and all claims and losses accruing or resulting to any other person, firm or corporation furnishing or supplying work, service, materials or supplies in connection with the performance of this MOU, and from any and all claims and losses accruing or resulting to any person, firm or corporation which may be injured or damaged by the ____ HC in the performance of this MOU. Insurance: See Appendix A
12. ____ HC will be solely responsible for ensuring that all services provided under this MOU comply with all current regulations under the Health Information Portability and Accountability Act. It is understood that the indemnification provided in Appendix A applies to any breach of privacy rights or release of protected health information.
13. ____ Head Start will provide the following to ____ HC;
 - a) Provide a current (within one year) City, County, or State fire clearance for each site prior to services commencing.
 - b) Proactively maintain fire and life safety requirements and ensure fire extinguisher service tags remain current.
 - c) Maintain future copies of fire alarm and sprinkler test reports on site for ____ HC and CDPH and fire inspectors review upon request.
 - d) Cooperate with preparations and access for future fire inspections and promptly respond to additional requests by inspectors.
14. The term of this MOU shall be for a period of five years, starting ____ and ending _____. At the end of the five years, the parties may extend the term of the MOU for a mutually agreed period of time. Either party may terminate this Agreement at any time by mailing or delivering to the other a notice in writing stating that it does thereby terminate this Agreement and stating the effective date of such termination, which effective date shall not be earlier than thirty days after the date of receipt of the notice of termination.

In witness whereof this MOU is executed by authorized representatives of the Parties as indicated below:

 Name: _____
 Head Start/ Early Head Start Director
 Date: _____

 Name: _____
 Chief Operating Officer
 Date: _____

Addendum 3: Sample FQHC letter to DHCS

Complete the blanks, and print on the clinic’s letterhead. Attach a copy of the fire clearance report to the letter before sending.

May 19, 2016

California Department of Public Health
San Francisco District Office
150 North hill Drive, Suite 11
Brisbane, CA 94005

Dear District Office Staff:

Please be advised that the _____ Health Center plans to operate a satellite site providing dental services for 30 or less hours per week as follows:

PARENT SITE:

Name: _____ Health Center
Facility License #: _____
Address: _____
Tel. No.: _____

SATELLITE SITE:

Site Name: Happy Preschool Head Start - __HC
Address: _____
Tel. No.: _____

Attached is a copy of the most current fire clearance.

Please contact _____, Dental manager, at (---) --- ---- with any questions.

Sincerely,

Chief Executive Officer

Cc: _____, DDS
Dental Director

Addendum 4: Setting SMART Program Goals

When planning the program delivery with your partners some of the things you should consider is setting good goals.

S	Specific	Exactly what do you want to accomplish? Who will benefit? What you will achieve? Where? and Why?	What services will be provided, at which schools and for whom? Reduction in new caries rates in children at all sites, or at a specific location.
M	Measurable	What can you measure and how will it tell you that you've succeeded?	Caries rates over time can measure effectiveness of your prevention efforts. # of dental exams, fluoride treatments, or other services provided can help quantify efforts. Remember to take a baseline measurement to show progress.
A	Achievable	Set a reasonable but challenging goal that takes into account your resources and timelines. For example, even with more services, you are not likely to eliminate all cases of caries.	A percentage change in PIR reportable measurements can be a good goal, as long as you avoid the absolutes of 0% or 100%. Knowing your baseline measurements, and consulting with your partners and staff about reasonable goals will help you set a goal that is achievable. Alternatively, refer to local or state DPH goals, and/or the nationwide Healthy People 2020 goals.
R	Relevant	How does this goal fit into your overall objectives? Will it meet your program needs? Is this partnership relevant and mutually beneficial to all partners? Is this relevant for the audience you are trying to reach?	Providing English-language trainings in a program with primarily Spanish-speaking staff and families will not be culturally relevant and thus will not help you achieve your objectives. Similarly, setting up a clinic at one of your sites with high rates of dental home and dental treatment compliance may not be as relevant as trying to reach more isolated schools without access to dental services.
T	Timely	What is the timeframe? When do you expect to accomplish each step of the goal?	Think in terms of months, quarters and school years. Align your school and program year with the FQHC timelines, and be specific about calendars, holidays and vacations, school breaks and other program commitments such as Self-Assessment or Federal Reviews.

Addendum 5: STD 850 Form

The form can be found on the California Department of Public Health website: [Click HERE](#).

STATE OF CALIFORNIA – FORESTRY AND FIRE PROTECTION						
FIRE SAFETY INSPECTION REQUEST						
STD. 850 (REV. 4-2000)				See instructions on reverse.		
AGENCY CONTACT'S NAME		TELEPHONE NUMBER		REQUEST DATE		PROGRAM
EVALUATOR'S NAME		REQUESTING AGENCY FACILITY NUMBER			REQUEST CODE	
LICENSING AGENCY NAME AND ADDRESS <div style="border: 1px solid black; width: 100%; height: 100%; margin-top: 10px;"></div>					CODES	
					1. ORIGINAL A. FIRE CLEARANCE 2. RENEWAL B. LIFE SAFETY 3. CAPACITY CHANGE 4. OWNERSHIP CHANGE 5. ADDRESS CHANGE 6. NAME CHANGE 7. OTHER	
AMBULATORY		NONAMBULATORY		BEDRIDDEN		TOTAL CAPACITY
CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	
FACILITY NAME						LICENSE CATEGORY
STREET ADDRESS (Actual Location)						NUMBER OF BUILDINGS
CITY						RESTRAINT
FACILITY CONTACT PERSON'S NAME			FACILITY CONTACT PERSON'S TELEPHONE NUMBER			HOURS
SPECIAL CONDITIONS						
TO BE COMPLETED BY INSPECTING AUTHORITY						
FIRE AUTHORITY NAME AND ADDRESS <div style="border: 1px solid black; width: 100%; height: 100%; margin-top: 10px;"></div>					CLEARANCE /DENIAL CODE	
					CODES	
INSPECTOR'S NAME (Typed or Printed)		TELEPHONE NUMBER	CFIRS NUMBER	OCCUPANCY CLASS		
INSPECTION DATE	INSPECTOR'S SIGNATURE (Typed or Printed)					
EXPLAIN DENIAL OR LIST SPECIAL CONDITIONS						

Addendum 6: Head Start Oral Health Data Set-Up

Data that were collected, and reported bi-annually to the SF Children’s Oral Health Initiative and the San Francisco Department of Public Health by the Head Start agencies include:

Data	PIR?	Child Plus Data Field	Timeline/ Expiration
# Children with a Professional Oral Exams this program year	Yes	“Dental Exam”	Due every year, or as indicated by the dentist. Programs reported this data twice per year: July - December, January - June.
# Class 1 status: healthy teeth	Inc’d. in above	“Dental Exam”	Due every year, or as indicated by the dentist
# Class 2 status: treatment is needed	Yes	“Dental Exam” event “Treatment needed” check box	Follow up as indicated by the dentist
# Class 3: Urgent treatment is needed	Yes	“Dental Exam” event “Treatment needed” check box	Urgent follow up as indicated by the dentist, usually within 1-2 weeks.
# Children receiving treatment	Yes	“Dental Exam” event “Treatment received” check box in the “Action” section	Based on the dentist’s recommendation and availability of appointments
# Fluoride Varnish	No	“Fluoride Varnish” <i>*NEW</i>	Set up to expire after 3 months

Addendum 7a: Sample Blank Patient Registration Form

PATIENT <u>Last Name & Suffix</u>		First Name:	Middle Name:	Birthdate MM/DD/YY: Sex: M F
Social Security Number: ____-____-____	Home Address:		City and State:	Zip:
Cell phone: () Confidential Msg Ok? Y/N	Day Phone: () Confidential Msg Ok? Y/N	Home Phone: () Confidential Msg Ok? Y/N	Alternative Phone: () Confidential Msg Ok? Y/N	
Are You Homeless? Y/N if so what is your situation(check one) Staying at a: __Family/Friends __Shelter __ Street __Transitional/Program(Name):			Primary Language Spoken: Language Translation Requested? Y/N	
Self-identified Ethnicity (check one): __Hispanic/Latino __Non-Hispanic/Latino __Unknown	Self-Identified Race(check one): __ American Indian or Alaskan Native __Asian __Black or African American __Latino or Hispanic __Mid. Eastern or No. African __ Hawaiian\Pacific Islander __More than one race __Other Race __ Unknown __ White		Tribal Affiliation(if applicable): Tribally Enrolled: Y/N Self/Parent/Grandparent	

PATIENT INSURANCE INFORMATION

Do you have MEDI-CAL? Y/N If Yes, Medi-Cal Number: (Example-12345678A) _____	Insurance Group/Plan Name:
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EMERGENCY CONTACT INFORMATION

Name First & Last:	Phone Number:	Relationship to Patient:
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RESPONSIBLE PARTY/PARENT/GUARDIAN/SELF

Last Name:	First Name:	Birthdate MM/DD/YY: Sex: Male or Female	Relationship to Patient?
Social Security Number: ____-____-____	Home Address (If same write same):		City and State: Zip:
Source Of Income:	Family Size:	Monthly Income:	Are You Currently Employed? (Is so where):

Native American Health Center, Inc. (NAHC) follows rules and regulations set by Indian Health Services (HIS) and the state of California. Patients are financially responsible for all services rendered at NAHC, as NAHC is not a free clinic.

I request NAHC to provide me and/or my family with health care services. NAHC may release billing information to appropriate third-party payers (e.g., insurance companies, Alameda County) to collect payment. The information on this form is correct to the best of my knowledge. I understand that NAHC reserves the right to bill me for the 100% of charges if I fail to prove my eligibility for an assistance program. I hereby agree to abide by NAHC policy, and I understand the terms explained on this form.

Patient/Parent/Guardian Date

Addendum 7b: Sample LiveLetter Patient Registration Form

ChildPlus LiveLetter feature can be used to fill in all of the fields in blue.

 NATIVE AMERICAN HEALTH CENTER <small>Serving the community since 1972</small>		PATIENT REGISTRATION FORM			
PATIENT <u>Last Name & Suffix</u> Obama		First Name: Malia	Middle Name: Ann	Birthday MM/DD/YY: 01/01/2011 Sex: F	
Social Security Number: _____ - _____ - _____		Home Address: 1600 Pennsylvania Ave NW		City and State: Washington DC	Zip: 20500
Cell phone: () _____ <small>Confidential Msg Ok? Y/N</small>	Day Phone: (111) 111-1111 <small>Confidential Msg Ok? Y/N</small>	Home Phone: () _____ <small>Confidential Msg Ok? Y/N</small>	Alternative Phone: () _____ <small>Confidential Msg Ok? Y/N</small>		
Are You Homeless? Y/N if so what is your situation (check one) Staying with or at a: <input type="checkbox"/> Family/Friends <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional/Program(Name):				Primary Language Spoken: English Language Translation Requested? Y/N	
Self-identified Ethnicity (check one): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown	Self-Identified Race (check one): <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Latino or Hispanic <input type="checkbox"/> Mid. Eastern or No. African <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> Other Race <input type="checkbox"/> Unknown <input type="checkbox"/> White			Tribal Affiliation (if applicable): Tribally Enrolled: Y/N Self/Parent/Grandparent	
PATIENT INSURANCE INFORMATION					
Do you have MEDI-CAL? M If Yes, Medi-Cal Number: (Example-12345678A) 1234567890			Insurance Group/Plan Name: Medicaid		
EMERGENCY CONTACT INFORMATION					
Name First & Last: Barak Obama		Phone Number: (111) 111 - 1111		Relationship to Patient:	
RESPONSIBLE PARTY/PARENT/GUARDIAN/SELF					
Last Name: Obama		First Name: Barak	Birthday MM/DD/YY: 08/04/61 Sex: Male or Female	Relationship to Patient?	
Social Security Number: _____ - _____ - _____		Home Address (if same write same):		City and State:	Zip:
Source Of Income:		Family Size: 4	Monthly Income:	Are You Currently Employed? (If so where):	
<p>Native American Health Center, Inc. (NAHC) follows rules and regulations set by Indian Health Services (IHS) and the state of California. Patients are financially responsible for all services rendered at NAHC, as NAHC is <u>not</u> a free clinic.</p> <p>I request NAHC to provide me and/or my family with health care services. NAHC may release billing information to appropriate third-party payers (e.g., insurance companies, Alameda County) to collect payment. The information on this form is correct to the best of my knowledge. I understand that NAHC reserves the right to bill me for the 100% of charges if I fail to prove my eligibility for an assistance program. I hereby agree to abide by NAHC policy, and I understand the terms explained on this form.</p>					
_____ Patient/Parent/Guardian			_____ Date		
SITE: White House Head Start					

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