Keeping Health in Head Start: Lessons Learned from Dental Care

The Administration has proposed a change in Head Start that would transfer oversight to some states and give them authority to determine the range of services provided to enrolled preschoolers. These demonstration states would no longer need to adhere to federal program requirements to provide dental services. These proposed changes raise concerns for the fate of health care in Head Start and for the fate of Head Start's core principle that learning depends on children being healthy.

Ensuring *dental* care for Head Start children is notoriously difficult because of Medicaid's low payment to dentists and low numbers of participating dentists. Federal studies report that poor preschoolers suffer more than twice the tooth decay and twice the dental pain as their affluent peers but are only half as likely to visit a dentist[i]. Healthy People 2010 reports that one-in-five (18%) two-to-four year olds have visible cavities and that past efforts to reduce this disease burden have failed[ii].

Meeting children's needs for health care – including dental care – is central to learning readiness.

Young children with significant dental problems are typically distracted by their pain and are often unable to focus on learning[iii]. As these children grow, they are more likely to miss school because of dental problems. The National Center for Health Statistics reports that poor children with dental problems have 12 times more "restricted activity days" (for example, missed school) than high income children[iv]. The Surgeon General reports that America's children miss an estimated 51 million school hours annually because of dental issues[v].

One of Head Start's notable achievements is connecting children to needed dental care. **Low income preschoolers in Head Start are nearly three times more likely to obtain a dental screening than other low income children.** Head Start "Program Information Reports" issued by the DHHS Administration for Children and Families report that over 90% of enrolled preschoolers obtain a dental screening in a year. In contrast, the Centers for Medicare and Medicaid Services' "416 reports" reveal that only 31.6% of all low-income 3-5 year olds in Medicaid obtain a dental visit in a year[vi].

This brief explores oral health in Head Start, offers suggestions for improvements, and calls for safeguards to ensure that health remains a central element of Head Start.

Head Start Dental Requirements

Head Start supports nearly 20,000 community-based agencies to provide comprehensive child development services, including dental services, to nearly one million poor children under age six. Begun in 1964 for preschoolers and extended to infants and toddlers in 1994, Head Start's "overall goal is to increase school readiness" while "fostering healthy development[vii]."

Regarding oral health, Federal regulations currently require Head Start grantees to:

- find a "dental home" (a dental office or health center) for children who do not have a regular source of dental care
- provide oral screenings by dental professionals
- assist families in scheduling an appointment with a dentist for treatment
- follow-up on identified oral health problems[viii].

While meeting these requirements has been a particular challenge for Head Start centers[ix], their ability to do so is a hallmark of program accomplishment. As Congress reauthorizes Head Start this session, it should take note of this success and focus on ways to further strengthen dental and other health components of the program so that all children in need of care obtain it and are ready to learn.

Congressional Opportunities to Improve Dental Services in Head Start

Congress can strengthen dental and other health components in Head Start by

- rejecting "block granting" Head Start to the states
- supporting and expanding interagency activities between Head Start and HRSA's Maternal and Child Health Bureau (MCHB)
- ensuring that Medicaid reform doesn't change currently required pediatric dental and health benefits in Medicaid-EPSDT
- encouraging Early Head Start to update its performance standards by adopting professional recommendations that dental supervision begins by each child's first birthday[x].

Congress can also improve dental services in Head Start by

- establishing Head Start Oral Health Centers of Excellence
- expanding the number of Healthy Tomorrows demonstrations at MCHB
- supporting MCHB's Community Integrated Service Systems that link children to dental providers and encourage case management
- establishing partnerships between dental schools and Head Start and between community health centers and Head Start
- supporting replication of local Head Start efforts that have increased dental care
- providing states with grants that correct structural deficiencies in their dental Medicaid programs as described in the bipartisan Children's Dental Health Improvement Act.

Lessons Learned

Meeting children's needs for health care – including dental care – is central to learning readiness.

Head Start has demonstrated improvements in access to dental care but has also shown that tremendous barriers and obstacles still exist[xi], leaving a quarter of enrolled children without care for cavities and other dental problems.

Key lessons learned from Head Start are that

- assigning Head Start responsibility for dental care works to improve access
- even with this requirement, Head Start confronts systemic barriers to dental care for young poor children
- dental benefits in Medicaid are essential in obtaining dental care but do not, by themselves, ensure access.

Surgeon General Carmona's new *Call to Action to Improve Oral Health* seeks to end the "silent epidemic" of dental disease in the US by challenging policymakers, providers, and families to take needed steps to improve oral health[xii].

Congress can now improve the oral health of millions of our youngest and most vulnerable children by supporting oral health programming in Head Start, by protecting Medicaid EPSDT requirements, and by supporting Medicaid improvements detailed in the Children's Dental Health Improvement Act.

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[i] Edelstein BL. 2000. *Access to Dental Care for Head Start Enrollees*. Journal of Public Health Dentistry
[ii] USDHHS. 2000. *Healthy People 2010*, Second Ed. Volume II, Chapter 21, "Oral Health".
[iii] Maternal and Child Health Oral Health Resource Center. 2001. *Oral health and learning: When children's oral health suffers, so does their ability to learn.* National Center for Education in Maternal and Child Health. Georgetown University.
[iv] Adams PF, Marano MA. 1995. *Current estimates from the National Health Interview Survey, 1994*. USDHHS, National Center for Health Statistics.
[v] USDHHS. 2000. *Oral Health in America: A Report of the Surgeon General*. National Institute for Dental and Craniofacial Research
[vi] 2001 Annual Visit Data from state Medicaid agency 416 Reports provided to the American Dental Association and Dr. Kathy Hayes by the Centers for Medicare and Medicaid Services and compiled by Dr. Hayes.
[vii] Administration for Children and Families web site http://www.acf.hhs.gov/programs/hsb/about/generalinformation/index.htm.
[viii] Bertness J, Holt K. 2003. *Head Start:An Opportunity to Improve the Oral Health of Children and Families*. Maternal and Child Health Oral Health Resource Center, National Center for Education in Maternal and Child Health, Georgetown University.
[ix] *Head Start and Partners Forum on Oral Health*, September 1999; *Forum on Advancing Partnerships for Head Start and Oral Health*, August 2002.
[x] The American Academy of Pediatrics, American Academy of Pediatric Dentistry, Bright Futures, American Public Health Association and other leading professional groups endorse dental supervision beginning at age one, particularly for high risk children.
[xi] Jones CM et al. 2000. *Creating Partnerships for Improving Oral Health of Low-Income Children*. Journal of Public Health Dentistry
[xii] U.S. Surgeon General's *Call to Action to Improve Oral Health* web site http://www.nidcr.nih.gov/sgr/calltoaction/index.asp.pdf.