

MPR
2014-09-16 OHI WEBINAR

Hello everyone, and thank you for attending today's webinar, "Improving Oral Health Through Access: Building a Partnership Between Medicaid and Head Start." Before we begin, we wanted to cover a few housekeeping items.

You can expand your slide area by clicking on the maximize icon on the top right of the slide area or by dragging the bottom right corner of the slide area. At the bottom of your audience console are multiple application widgets you can use. A copy of today's slide deck is available in the resource list widget that looks like a green folder at the bottom of your screen.

If you have any questions during the webcast, you can click on the Q&A widget at the bottom of your console and submit your question. We will have time for questions at the end of the presentation. If a fuller answer is needed or we run out of time, it will be answered later via e-mail. We do record all questions received during the webcast.

If you have any technical difficulty, please click on the help widget. It has a question mark icon and covers common technical issues. An on-demand version of the webcast will be available after the webcast and can be accessed using the same audios link that was sent to you earlier. Additionally, CMS will be posting this webinar on medicaid.gov within approximately three weeks.

Now I would like to turn it over to Laurie Norris. Laurie, you now have the floor.

Thank you, Brice, and good afternoon everyone, and good morning to those of you on the West Coast. We are so glad that you've been able to join us today for the seventh webinar in our CMS Learning Lab Series, and we especially want to thank our partners at Medicaid CHIP Dental Association for collaborating with us on these learning labs. Today we'll be focusing on how Medicaid and Head Start can partner to get needed dental services to Head Start children. Next slide, please.

These are our learning objectives for today's webinar. First of all, to understand the federal Head Start dental requirements and its infrastructure; second to become aware of the oral health resources available from the Administration for Children and Families Office of Head Start; and third, to learn the step-by-step process used in Pennsylvania to build a partnership between Medicaid and Head Start; and, fourth, to be able to detail the elements of Pennsylvania's collaborative intervention and lessons learned so far. Next slide, please.

We have three excellent speakers to hear from today, but before I turn the mic over to them, I wanted to say a few words about the Medicaid benefit for children and adolescents, also known as EPSDT, or early and periodic screening, diagnostic, and treatments. Every state Medicaid program is required to have a pediatric dental periodicity schedule in their EPSDT benefit. As many of you know the American Academy of Pediatric Dentistry recommends that the first dental visit occur at the eruption of the first tooth or by age one, whichever occurs first. You can view your state's Medicaid periodicity schedule at the link on the slide.

In addition, EPSDT requires a direct dental referral, starting at the first age in the dental periodicity schedule. A dental referral must be an encounter with a dentist or with another dental professional, such as a dental hygienist or dental therapist, working under the supervision of a dentist. More detail about these topics can be found in the EPSDT Guide for States at the link shown on the slide. Next slide, please.

So we'll kick it off right with our first presenter, Marco Beltran. Next slide, please. Marco has been involved in Head Start for over 15 years. He works in the Office of Head Start National and State Training and Technical Assistance Division as the health lead and on the federal project office for the National Center for Health. Marco has an extensive background in the field of early childhood and with programs serving low-income children and families. Prior to joining OHS, he worked at the National Institute of Health, the National Institute of Dental and Craniofacial Research as a public health educator. And before that, he worked at the Migrant and Seasonal Head Start Technical Assistance Center.

MPR
2014-09-16 OHI WEBINAR

In addition to working at the national level, Marco has also had the opportunity to work as a health and disability specialist as the Oregon Child Development Coalition. Marco has a Bachelor's degree from the University of Rochester in health and society, and cultural anthropology, and also a Masters in public health from the University of Michigan, and a doctorate in public health from George Washington University. Welcome, Marco.

Thank you, Laurie, and good afternoon. On behalf of the Office of Head Start, I want to thank CMS for inviting us to be part of this CMS learning lab and for folks seen on Head Start. Next slide, please.

As many of you know, Head Start was initially launched as an eight-week summer program in 1965 by President Lyndon Johnson as an assault on the war on poverty. It was designed to help preschool children prepare for school by changing, for the better, the effects of poverty and address the whole child's social and emotional health and nutrition needs. So from the beginning, health (including oral health) has always played a central role in the design, development, and implementation of Head Start programs. Next slide, please.

In the next several slides I want to take a closer look at what we know about Head Start programs based on information collected from our Head Start grantees through our program information report that we collect on a yearly basis. As of 2012/2013 program year, the office of Head Start funded over 2,853 programs. This included over 57,000 individual classrooms and over 1.5 million children and pregnant women served. Head Start programs nationally employed over 250 administrators, teachers, content specialists in health, mental health, disabilities, as well as family service workers and home visitors that provide in-home services to some of our early Head Start families. Next slide, please.

Broadly speaking, our Head Start program serves children ages zero to five, from families with income below the poverty level, foster children, as well as homeless children, from communities across the United States, including the territories, as well as tribal lands and migrant season farm worker communities. In addition, at least 10% of Head Start enrollment opportunities are for children with disabilities. In the 2012/2013 school year, program year, Head Start and Early Head Start provided services to over 136,250 young children with disabilities.

I like to think about our Head Start programs in four distinct types. We have our Head Start program, which serves children three to five years old, and last year we served over 932,164 preschool age children. Early Head Start program serves children from birth to age three and pregnant women, and last year our early Head Start program served more than 150,100 children, and 15,634 pregnant women. Our migrant seasonal Head Start program served almost 31,907 children, birth to age five, from migrant seasonal farm worker communities or families. And our American Indian Alaskan native program serves over 25,777 children in 26 states, including Alaska. Next slide.

The majority of the children enrolled during the last program year were three and four year olds, which represent about 82% of the children and pregnant women served by our program. Sixty percent of our children are under three years of age. Next slide, please.

As many of you know, Head Start serves a diverse ethnic and racial population. About 37% of our children are identified as Hispanic and/or Latino, while white children make up 42% of our population. We also serve -- 29% of our children are African American, 4% are American Indian/Alaska native, 2% are Asian, 10% are identified as Hawaiian Pacific Islanders; and we have a about 9% who identify as biracial or bicultural, and we have 13% of children who are unspecified. Next slide, please.

Children and families who come through our doors speak many different languages from around the world. We increasingly hire staff and utilize parent support to meet the language needs of our families. Last year about 70.6% of our families spoke English and 24.8% spoke Spanish, with about 4.6% speaking other languages. Next slide, please. In the next several slides I want to take a little closer look at what health services look like for Head Start. Next slide.

MPR
2014-09-16 OHI WEBINAR

Head Start program service and assistance are governed by federal mandated requirements called the "Head Start performance standards." Head Start performance standards include standards for services for children and their families, as well as pregnant women. Our performance standards include requirements for early childhood development and health services, community and family partnerships, and program design and management. It is not just that we are required to address all areas of child development but for us it is critical that we address all areas considering the populations that we serve in order to prepare children for school, and this includes ensuring that they are on a healthy path of social and emotional development, have a clean and safe play place to learn and play; providing healthy meal options for children who may not get the same at home; coordinating mental health services for children and families affected by violence, substance abuse, and natural disasters and to create an individualized plan for learning for children with disabilities. Next slide, please.

As it relates to our requirements, our performance standards require that all our programs must determine if the child has an ongoing source of continuous, accessible health care, including dental care. If not, the grantee must assist the parents in accessing a source of care; obtain from a health care professional a determination as to whether a child is up to date on a schedule of age appropriate prevention and primary health care based on the state EPSDT. If not, the grantee must assist the parents in making the necessary arrangements; track and coordinate the provision of health-care services; obtain or arrange further diagnostic testing, examination, and treatment by an appropriate licensed or certified professional; and, finally, partner with community agencies and medical and dental providers and others to meet the needs of children and families in our programs.

Recent program information with report data shows that Head Start is doing well in the minimum health requirements based on our performance standards. In fact, when we look at it the PIR numbers for continuous accessible care for health care and dental care over the past four years, those numbers look pretty good. Except we struggle with our Early Head Start programs, which are not shown on this particular graph. One of the issues is that it is harder to find dentists to see zero to three children, and we are lucky to find a pediatric dentist in areas where Early Head Start programs are located. In the 2012/2013 PIR data, we also had that almost 20% of the children that received a dental examine have been diagnosed as needing dental treatment, yet only about 80% of those children actually receive treatment. Next slide.

As it relates to oral health, this continues to be an area of great concern for us and for our programs. For a while now, we have been trying to figure out what do to help support our programs around oral health. We have engaged in different initiatives and provided different grant opportunities to try to identify best practices or good interventions, or try to help our programs develop partnerships with providers in their communities in hopes that some seeds will be planted to help our local programs meet the oral health needs of our children and pregnant women enrolled in our program. Next slide, please.

The Head Start performance standards require that staff track the provision of oral health care and help parents obtain oral examinations and follow up care for their child. These activities must take place within 90 days of an infant or child's reentry into the program. Information about examination results, plans for follow-up care, treatment completed, oral disease, and prevention activities are kept in the child's health record. Head Start programs activities also promote good dental hygiene in the classroom. Each day, staff wipe infant gums and assist children in brushing their teeth with fluoridated toothpaste, and, in most cases, tooth brushing is conducted in conjunction with a meal or snack.

While oral health is emphasized in Head Start and the Head Start performance standards, many infants and young children enrolled in the Head Start program continue to encounter barriers for care. For example, there is a shortage of dentist, as I mentioned earlier, serving the Medicaid population, and furthermore, many dentists do not feel comfortable providing services to infants and young children. Next slide, please.

I wanted to provide you with an idea of some of the activities and services that our programs are engaging in as it relates to oral health. This might be a little bit dated, but I think the information is still relevant. This information comes from the Oral Health Initiative evaluation that was conducted and funded

MPR
2014-09-16 OHI WEBINAR

in 2006. As it relates to outreach activities, most of our programs are working around increasing knowledge and importance of oral health for families and policymaker. As it relates to oral health education, they're spending a lot of time primarily around the importance of visiting a dentist, addressing tooth decay, and the importance of fluoride. Many of our programs spend a considerable amount of time trying to identify dental homes and establishing relationships with dentists in hopes of obtaining the dental homes for children and pregnant women. They're also scribing to work around figuring out how to work in providing fluoride varnishes in collaboration with the dental home.

As it relates to support services, they're assisting families with making appointments, arranging or providing transportation, providing or arranging for interpretation services, sending out reminder notices, and accompanying families to appointments, and, finally, some of our programs are still providing toothbrushes and toothpaste to the children in the program. Next slide, please.

This is a little bit of a complex kind of slide, but I wanted to give people an opportunity or to show people how our system kind of works. There is a lot of confusion about Head Start in our systems, and what it is and who is responsible for doing what. This diagram describes our training and technical assistance system and the different ways of supporting our local programs. We have ten federal regions, as many as other federal agencies have, but we have two additional regions that are national in scope, one that serves migrant seasonal farm workers, and the other one that serves American Indian and Alaskan natives. In addition, we have five national TANTA centers. One of them is the National Center on Health, which I will describe in an upcoming slide, and then we have our state TA system that is managed out of our regional offices, and they are key because they're the ones that provide the direct onsite support to your programs. Next slide, please.

Our regional offices, as I mentioned, we have ten federal regions and two national regions. The two national region offices are based here in D.C., within our central office. The primary role of all the regional offices are to be a conduit to meeting the needs of children and families in their region. They also administer grants, they monitor program progress, and they help to identify program needs and to help to connect the technical assistance to make sure that the programs are getting what they need at the local level. Next slide, please.

Many people have heard of our national collaboration offices, as it relates to the work that they do. They are connected to our regional offices and they exist in every state and Puerto Rico and the two national regions, so we have two national collaboration offices. They exist to facilitate collaboration among Head Start programs and entities that carry out activities designed to benefit low-income children from birth to school entry and their families. They also provide the structure and a process for the Office of Head Start to work with the state and local entities to leverage their common interests around young children and their families, and we're hoping that working together they formulate, implement, and improve state and local policies and practices. Next slide, please.

Overall, this slide is my description of the Head Start National Center on Health. The overall mission of the National Center on Health is to improve the health outcomes of Head Start children by helping Head Start and Early Head Start programs implement effective evidence and informed approaches to medical and dental access, health awareness, obesity prevention, emergency preparedness and environmental safety. Some of the work that they're doing is to provide evidence and practice-based information and materials to the Head Start community to work collaboratively and cooperatively with leaders in the health, early childhood, and childcare fields to improve the health of Head Start children and families and to work with national, state, tribal, and local organizations and agencies to enhance the health care infrastructure that impacts and serves Head Start children and families. Next slide, please.

In this particular slide I just wanted to provide you the information for how to get ahold or how to contact your state's Head Start collaboration director, as well as the link to our Office of Head Start site as it relates to all the resources of the National Center on Health are located. Next slide, please.

So one of the things that I mentioned earlier regarding the National Center on Health is one of their emphases is to provide material and resources to our Head Start community. This particular form, this is

MPR
2014-09-16 OHI WEBINAR

one of our resources. It's the oral health form. There is one for pregnant women and one for children. Originally, this form was one single form that was called form five. That was an outdated form that a lot of people in the field and a lot of our programs really wanted it updated and needed something a little bit fresher. So, listening to what they needed, we turned around, through the National Center, and developed this particular form. The form collects information on dental home status, current oral health status, oral health care services delivered during the visit, whether all treatment is complete, and future appointments as needed. The one thing about this form is that programs are not required to use this form. This is a form that's just a resource that programs are -- that's available for them to use if they choose. Next slide, please.

We also have a health services newsletter that covers various topics. We address the importance of helping children and pregnant women establish a dental home in our February 2014 issue. I ask you to constantly look at our website because the topics are always changing, and we will continue do topics around oral health in the future. Next slide.

One of our particular publications that a lot of people really like, especially our grantees, is our "Brush Up on Oral Health" newsletter. That's also developed by the National Center on Health. This particular monthly e-Newsletter targets our Head Start staff, with a secondary audience being health and social service providers, and the newsletter was developed to provide information on current practice, practical tips for staff to share with parents for promoting oral health, and to provide simple recipes for healthy snacks. Next slide, please.

Another one of our resources is our series for health managers and families. The topics include oral health, active play, health literacy, healthy breathing, mental health, safety and injury prevention. And we have many other resources, so please visit us on our link that was placed up on the slide a little bit earlier -- or an earlier slide. Sorry. Next slide, please.

So Head Start has -- at least I think -- Head Start has a lot to be proud of in terms of what we do for health services for our children. But we know that we have a lot of work that needs to be done. Thus, we are concentrating our efforts on the following: help our programs figure out a more effective way of individualizing the needs of each child and family; work with staff to learn new ways to engage parents in a meaningful way and to educate them on the importance of quality parent/child interactions and healthy physical, social, emotional, and cognitive development; leverage federal resources and such things as the Affordable Care Act, because we know that some of our communities in which our programs are located are underserved, which makes it difficult for our programs to identify providers, and not all providers accept Medicaid, which many of our families and children qualify for. And we work with programs to continue -- or we want to work with programs to continue to establish and maintain partnerships with community organizations to help leverage resources, especially in a time of budget cuts.

So on behalf of the Office of Head Start, I really want to thank for giving us this opportunity to participate. Thank you.

Thank you so much, Marco, for giving us that terrific introduction to Head Start program and the health aspects, and especially the oral health aspects. So now we're going to turn -- next slide please -- to learn how one state developed a partnership between Medicaid and Head Start. We are very excited to have with us today both Paul Westerberg, Pennsylvania Medicaid's Chief Dental Officer, and Amy Requa, the State Oral Health Coordinator for the Pennsylvania Head Start Association.

Dr. Westerberg is a graduate of Temple University School of Dentistry and began his professional career in private practice in the Philadelphia area, serving patient populations in both inner city and suburban locations. After earning an MBA at the University of Delaware, he transitioned to the corporate environment as a program dental consultant and then as dental director, administering managed care, Medicaid, Medicare, and CHIP Healthcare Services in southeastern Pennsylvania. Moving to public service in state government, Dr. Westerberg originally joined the Office of Medical Director in the Office of Medical Assistance Programs in the Pennsylvania Department of Public Welfare as the executive dental consultant. He has served in his present position as the chief dental officer for the department since 2002.

MPR
2014-09-16 OHI WEBINAR

Amy Requa is a pediatric nurse practitioner and the state oral health coordinator for Pennsylvania Head Start. Amy has 20 years of experience in public health nursing, maternal and child health, family and community health promotion in project director management, clinical, and training and technical assistance roles. Amy has extensive health expertise in oral health, childhood obesity prevention, and child nutrition, with a proven record over 12 years for building consensus and engaging public/private stakeholders and multiagency partners at the local, state, regional, and national levels. Amy has developed nationally recognized health promotion programming for the Office of Head Start, and in 2006, was the recipient of the administration for children and families partnering for HHH excellence award.

So welcome to you both, Dr. Westerberg and Amy. And Dr. Westerberg, I think you're the first speaker in this section.

Yes, next slide, please. Well thank you, Laurie, and to our audience a good morning or afternoon, as appropriate for your time zone. I'm pleased and honored to have the opportunity, along with Amy Requa, to outline the details of the Head Start Liaison Project that we've developed here in Pennsylvania. It has truly been a collaborative effort involving multiple stakeholder partners. In our presentation today, we will attempt to provide perspectives from two of the primary stakeholder entities, the Pennsylvania Department of Public Welfare's Office of Medical Assistance Programs and the Pennsylvania Head Start Association. In doing so, we will also endeavor to identify other stakeholders who have been and continue to be essential partners in the development and ongoing functionality of the project. We will start with some historical perspective and move through the progressive stages of the project's inception and maturation and then provide some insights and lessons learned in the process, and end with some preliminary data that we feel is both encouraging and exciting. Next slide, please.

The Medicaid program, known as Medical Assistance in Pennsylvania, has been transitioning from a direct state administration model to a managed care delivery system model since 1997 when the first zone of Health Choices went live. The Health Choices program operates as a 1915B waiver demonstration project and provides for mandatory enrollment of medical assistance eligibles into managed care health plans. Under Health Choices, the state, through the Pennsylvania Department of Public Welfare's Office of Medical Assistance Programs, contracts with physical health managed care organizations, which we will refer to as MCOs, that are licensed as HMOs within the state to deliver medically necessary physical health services to enrolled medical assistants and officaries. Oral health services delivery is included among the types of services for which MCOs are responsible. The MCOs have the option to administer dental benefits directly using in-house staff or to subcontract with a dental benefit management entity and delegate administration of those services. Such subcontracts may be on an administrative-services-only basis or an at-risk basis. Within the Office of Medical Assistance Programs, the Bureau of Managed Care Operations has primary responsibility for oversight of the Health Choices Program and the physical health MCOs, including direct contracting and approval of subcontracts. Next slide, please.

As mentioned previously, the rollout of managed care in Pennsylvania has been a gradual geographic and population-based transition over the past 17 years. This slide presents the progression of the mandatory managed care delivery system under the Pennsylvania medical assistance program by providing two maps of the state. The 2010 map shows the state around the time of the initial formative events leading to creation of the Liaison Project as it existed between 2004 through 2012, during the geographic rollout of Managed Care Delivery System. The color coding and legend identify the counties according to whether managed care or the directly state-administered delivery system dominated or were contemporaneously active.

The 2014 map shows the current distribution of managed care across the state since the completion of statewide expansion in 2013. There are five distinct zones depicted and differentiated by distinct color shadings, and the legend identifies the year in which the zone was activated. Next slide, please.

Structure of the managed care delivery system under Health Choices has contained several advantageous aspects that provide utility in the area of care management. All MCOs are required to maintain a special needs unit that serves to provide members with enhanced care, coordination, as

MPR
2014-09-16 OHI WEBINAR

necessary. Member assistance for scheduling of appointments and arrangement of transportation, when needed, are examples of available services provided through the special needs units and general member service departments.

Improvement of oral health levels, especially for children, has been a priority for Pennsylvania Medical Assistance and the Health Choices program since the initial implementation in 1997. That priority has been clearly communicated to the MCOs, with the Office of Medical Assistance Programs holding MCO medical directors and quality management staff responsible for improvement of oral health measures as part of overall health improvement efforts.

The MCO Pay for Performance program was implemented in 2005 by the Office of Medical Assistance programs as a shift toward paying for quality, care as opposed for just paying for care. In 2009, 2010, the HEDIS annual dental measure was added as one of the 12 measures considered as part of the pay for performance incentive program for Health Choices MCOs. The pay for performance measures and incentive payouts are contractually tied to achievements, related both to national benchmarks and yearly incremental improvements. Next slide, please.

This slide contains two charts that show Pennsylvania recent progressive achievements on two different dental services-related quality measures. The first chart relates to the Health Effectiveness Data Information Set, also known as HEDIS. The chart shows the weighted health choices average scores for the years 2011 through 2014. The chart conveys that a majority of eligible children under Health Choices have received dental services during the measurement years, and that the numbers have shown incremental improvement in each of the last four years. The second chart relates to the CMS form 416 report data for the years 2011 through 2013. The chart shows values that are particularly related to the current CMS Oral Health Initiative related to increasing the percentage of children enrolled in Medicaid who receive a preventive dental service. The chart shows that while there has been a yearly increase in the total number of children eligible for EPSDT services under Pennsylvania medical assistance, the number of children receiving a preventive dental service has also increased at a higher rate, generating an incremental four percentage point increase after two years from the baseline, which was set in 2011. Next slide, please.

Thank you Paul. It certainly is a pleasure to present with you today. So now let's take a look at how we're doing with our Pennsylvania Head Start oral health services. This chart displays self-reported and aggregated data from all Pennsylvania Head Start programs for 2012 to 2013, on specific oral health indicators, in comparison to national Head Start data. This data includes what percentage of enrolled children in Pennsylvania Head Start programs have a dental home, receive preventive care, complete a dental examine, are diagnosed as needing treatment, are receiving or have received care, and children under age two who are up to date on dental care according to the state's dental EPSDT schedule. We see by comparison that our Pennsylvania programs on whole are not doing as well as compared to national Head Start data, so we clearly have room for improvement. It is important to note that Pennsylvania is geographically a large state, with 67 counties and over 40,000 enrolled children across 92 Head Start programs. Also, much of our state is quite rural, so this poses additional challenges to access to all these services. Next slide, please.

So now let's rewind to late 2009, when a small but powerful steering team of key leaders came together to launch our Oral Health Initiative for Head Start in Pennsylvania. Our team included the Head Start state collaboration office director, the Pennsylvania Head Start association executive director, the chief dental officer at the PA Department of Public Welfare, the region three office of Head Start dental consultant, and a technical assistance provider for Head Start in Pennsylvania at that point in time.

As Marco stated earlier, the purpose and priority of this Head Start state collaboration offices in each state is to facilitate collaboration among Head Start agencies and entities that carry out activities designed to benefit low-income children from birth to school entry, and their families. In 2009 the region three office of Head Start and the Pennsylvania Head Start state collaboration office had already identified the health priority to promote access to timely health-care services, including oral health services. When our leadership team was initially formed, we made a conscious decision to limit the size of

MPR
2014-09-16 OHI WEBINAR

our decision-making group so as to be more nimble and action oriented. We also agreed it was necessary to give this work a name, so we wanted our initiative as the Head Start Healthy Smiles, Happy Children, a Dentist for Every Child Initiative. Next slide, please.

There were many environments that shape the environment and led to the creation of the Liaison Project in 2012. The 2008/2009 recommendations by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry were released, calling for much earlier timeframes for initial dental examinations. In May of 2009, OMAP issued an MA bulletin, effectively incorporating early preventive intervention and more effective medical/dental collaboration into program policy, announcing a specific dental periodicity schedule that indicated the first dental visit should occur between 6 and 12 months of age, and outlined other recommendations of early utilization of diagnostic and preventive dental services.

I received the invitation to meet with Head Start in late 2009 and viewed it, at the time, as a routine request for collaboration and assistance from an OMAP stakeholder group. Such request for assistance or participation in collaborative efforts are generally pursued in a responsible fashion. In April 2010, CMS announced the Oral Health Initiative to be implemented in 2011. In outlining potential strategies for states, collaboration with Head Start and other stakeholder organizations was specifically identified by CMS as a strategic component of state oral health action plans. Also that month, OMAP implemented MA compensation to physicians for topical application of fluoride varnish to teeth of children ages four and under. And in August 2011, the Office of Medical Assistance Programs released a whitepaper proposing the implementation of statewide expansion of Health Choices to be completed in 2013. That promised the additional outreach and care management capabilities embedded in the managed care delivery system would be available in all areas of the state. Next slide.

So our first step was to engage stakeholders by convening three regional oral health forums in the spring of 2010, bringing together Head Start program directors and Head Start health coordinators and staff, as well as dental providers in the eastern and western regions of Pennsylvania, with an urban and rural population mix, as well as the central northern tier, with a predominantly rural population. Each region had unique access to care gaps and barriers and challenges to communication, as well as collaboration. And they had their own geographical considerations. The forums were very well attended. They were very fruitful. Written summaries of identified issues and barriers and compiled, and agreed upon action steps and recommendations were distributed.

One concrete outcome of our forums was a unanimous call for the formation of a state-level oral health task force for Head Start, which we named the Healthy Smiles Task Force. To keep our momentum going, the Pennsylvania Head Start state Colab office provided funding support for our very first task force meeting in the middle of the winter, in January 2011. They also funded me as an independent consultant to take on the role of co-chair of the task force, along with in-kind support from the Pennsylvania Head Start Association and Blair Hyatt, executive director as the other co-chair. Our Healthy Smiles Task Force membership includes Head Start program directors, Head Start health coordinators, state agency leaders from the PA Department of Health and the Department of Public Welfare, as well as the leaders from the dental schools and Pennsylvania oral health champions from the American Academy of Pediatric Dentistry, the Pennsylvania Dental Association, and the Pennsylvania Dental Hygienists Association.

In addition, our efforts were further leveraged during a special dental home initiative launch meeting of state-level stakeholders in May of 2011, funded by the Office of Head Start's Dental Home Initiative. At this meeting we developed additional plans to address the barriers to access to dental homes, with the technical assistance and support from the national office of Head Start. Marco came up from Washington to participate in our meeting and to assist us with planning. Next slide, please.

From the very beginning, our Healthy Smiles task force goals have been to establish dental homes and to secure timely access to follow-up treatment for children, to educate adult caregivers to prevent oral diseases by fostering health promotion practices early in life, to forge collaborations to benefit children, families, and service providers, and to engage those providers who would serve our Head Start children

MPR
2014-09-16 OHI WEBINAR

by building lasting relationships with the dental community as a foundation for sustaining our work together. Next slide, please.

We are committed to cultivating state-level partnerships to improve access to comprehensive oral health services in local communities, as well as to provide oral health education to empower our families to utilize these services. Through our collaboration, we are raising the bar and closing the gaps, and we feel that we are moving oral health policy forward to improve the oral health and wellbeing outcomes of our at-risk families.

One task force subcommittee focuses on access to dental homes and the other addresses the educational needs of Head Start parents, children, staff, as well as education for the dental providers who serve them so that they understand the needs of families on medical assistance. Our task force meets face to face about two to three times a year, usually in the western, central, and eastern regions of the state to broaden our reach and to remain relevant. Next slide, please.

Now let's talk about the pilot project phase of our MCO Head Start collaboration. Twelve Head Start programs have been identified through the dental home initiative, that were struggling most, with access to follow up dental treatment for enrolled children. They had less of a problem finding preventive care through dental homes, but when a child needed treatment it was very difficult to find follow up at the right level of care. Discussion of the needs of those programs and brainstorming towards solutions was a major topic of our fall 2011 Head Start task force meeting. The MCO Head Start Liaison Project was initially piloted in January to July of 2012, in two Head Start programs with strong leadership, which were experiencing significant barriers to obtaining follow-up services for children with oral health treatment needs.

Yeah, it was during that discussion at the fall 2011 task force meeting that it became clear to me that a real opportunity existed for a collaborative synergistic effort between the Head Start programs and the managed care organizations of Health Choices. The vast majority of Head Start program enrollees are Medicaid beneficiaries and would, therefore, be members of managed care health plans as well. Types of assistance at the Head Start programs required were care management services, the MCOs were already designed and responsible to provide for their members. Getting them connected in a meaningful way seemed to be the missing link. Brief deliberations among task force leadership led to the concept of a pilot program rollout in order to have some focus on control in bringing the concept to functionality. As Amy indicated a moment ago, we selected two programs with adequate administrative infrastructure, a demonstrated need and location in one of the more mature Health Choices zones. Using direct contact, the special needs care coordination staff in the Office of Medical Assistance Programs and the southwest zone MCOs, we were able to get the pilot in place for initiation in early 2012.

We were happy to hear that improvements in gaining access to a appropriate follow up treatment services were reported by the Head Start pilot sites as a result of this increased communication and collaboration with the MCO Head Start liaison. So let me explain how this partnership work. Each MCO assigns one MCO Head Start liaison, a real person, who is housed in their special needs unit to work directly with each Head Start program located within their service areas or zones. Each Head Start program assigns a point person to work with the MCO Head Start liaison. Usually this is the Head Start's health coordinator or the family services coordinator. Both the MCO Head Start liaison and the internal Head Start point person are called upon to reach out to each other to shake hands figuratively and to build their relationship, being responsible to communicate unique needs to each other to describe any barriers or challenges and to do real problem solving, working together to bring children into dental homes and to obtain the appropriate level of care through follow-up treatment. The two pilot project programs were pleased with this new collaboration. They reported preliminarily a 10% increase in access to follow-up services as a result. How the assistance was provided varied depending upon specific needs and how the Head Start programs wanted to engage the liaison. Next slide, please.

As previously mentioned the MCO structure maintains a strong care management and member outreach component under Health Choices, with the establishment of a mandatory special needs unit within each MCO. The need expressed by Head Start staffers for aid in understanding the Health Choices program

MPR
2014-09-16 OHI WEBINAR

and navigating the system on behalf of their enrollees was balanced by an opportunity to access additional high-touch care coordination resources that would be synergistic to MCO efforts. Working with Title 5 and other stakeholder entities to improve performance for EPSDT measures was a preexisting and ongoing responsibility of the Health Choices MCOs. Next slide, please.

Now, simultaneously, with the expansion of Health Choices, another opportunity for more synchronicity and support presented itself in 2011, when the DentaQuest Foundation released a venture fund for oral health. DentaQuest is a family of affiliates that include the dental benefits administrator, a national philanthropy focused oral health, an oral health quality improvement research institute, and a care delivery organization dedicated to delivering quality health care to underserved communities, all of which share a common mission to improve the oral health of all.

The Massachusetts Head Start Association had experienced significant success in building their early childhood oral health consortium and improving access to oral health care services using a previous DentaQuest Foundation grant. So they decided to scale up their model for building successful collaborative state oral health consortiums in another state where Head Start programs were struggling with access to services. So in late 2011, the Mass. Head Start Association, in partnership with the PA Head Start Association, successfully submitted the collaborative grant proposal, which funded a full time state oral health coordinator for Pennsylvania. This grant support leveled or foundational Head Start state collaboration office's long-standing oral health priority focus. The new state oral health coordinator was able to lend more support for the MCO Head Start Liaison Project, and in early 2012, we gained much more traction in our work with our key partners, leading to the full implementation of these promising practices and strategies. Next slide, please.

In replicating the work of Massachusetts, we rolled out or Cavity-Free Kids Train the Trainer workshops to provide oral health education for staff, children, and families. We currently have over 250 Cavity-Free Kids trainer, including Head Start health, education, and family services staff, as well as community dentists, dental hygienists, managed care organization representatives, and health-care partner. Another focus is improved medical/dental collaboration and consistent oral health messaging across children's medical, dental, and educational homes, and connecting Head Start children to dental homes, beginning with the age one dental visit. Next slide, please.

In addition to the interaction of the Head Start Association, local Head Start programs, Department of Public Welfare office and Medical Assistance programs and the Health Choices MCOs, other stakeholder groups in Pennsylvania launched collaborative projects during this timeframe, spurred by the availability of philanthropic funding. Pennsylvania chapter of the American Academy of Pediatrics established the Healthy Teeth Healthy Children project under a DentaQuest Foundation grant in 2012, that supported physician education efforts to increase oral health awareness, to promote topical fluoride varnish application by physicians, and closer collaboration with oral health professionals.

The Pennsylvania Association of Community Health Centers received a DentaQuest Foundation grant also in 2012 to improve effectiveness and efficiency of dental service delivery and medical/dental collaboration in federally qualified health centers, rural health centers, and community health centers. These co-recipient organizations brought additional opportunities for coordination and minimization redundancy through the collaborative efforts of both the Department of Public Welfares Office Medical Assistance Programs and the PA Head Start Association. Next slide, please.

Because of the success of the initial MCO Head Start Liaison Project in 2012, Head Start leadership representatives were invited to the June 2012 Managed Care Organization Medical Directors' Meeting to discuss the Head Start Dental Home Initiative and to solicit MCO support and participation in the Head Start task force. At that meeting, the Bureau of Managed Care Operations announced that an operations memorandum was being prepared for release that would supply the Office of Medical Assistance Program guidance on appropriate managed care organization interaction with Head Start programs in Health Choices.

MPR
2014-09-16 OHI WEBINAR

An operations memorandum was issued by the Bureau of Managed Care Operations on July 23rd, 2012, outlining OMAP's request to the Health Choices physical health MCOs for establishment of a single point of contact for communication between the special needs coordinator and the individual Head Start programs. The office memo effectively expanded the existing pilot project from the two county programs in the southwest zone to all counties in active health choices zones. Responsibilities were clearly defined for establishment of collaborative care management, in tandem with Head Start staff that would include educational outreach, assistance in accessing dental care, and appropriate follow up to resolve presenting barriers. With the completion of statewide expansion of choices in early 2013, functionality of the Liaison Project became operational and available to Head Start programs in every county. Next slide, please.

After July of 2012, when the internal operations memorandum from the Bureau of Managed Care Operations was directed to the MCOs, a hundred percent of the Medicaid managed care plans participated in our October 2012 Healthy Smiles task force meeting, which we believe to be a marker of excellent progress. We absorbed the MCO leaders into our task force membership and developed an action plan delineating our next steps as partners, with specific roles and responsibilities. We provided guidance and structure to operationalize the relationship and to avoid redundancy in this new collaborative care coordination system.

To continue to cultivate the state-level partnership and collaborative care coordination system, we scheduled face-to-face meetings, which add glue to the relationship. We invite the MCO Head Start liaisons to every task force meeting, every Head Start administrator's meeting, the annual Pennsylvania Head Start Association Conference, and our Head Start health roundtables. Currently, we have initiated monthly conference calls for Head Start programs and the MCO Head Start liaisons, and at least once per year, Pennsylvania Head Start Association is invited to present to the MCO medical and dental directors to get their buy-in as well. Next slide, please.

Head Start programs are being encouraged to reach out to their designated MCO Head Start liaisons. This is similar to a pyramid model. The Head Start staff work in an ongoing way at bottom of the pyramids on the day-to-day collaboration with families to connect them to dental services. And as challenges to accessing dental homes and follow-up services emerge and persist, these specific needs rise to the top of the pyramid, requiring MCO liaison assistance and involvement in problem solving and care coordination.

Now building these collaborative relationships between nine MCO liaisons and the 92 Head Starts is a process. We are nurturing these relationships through frequent face-to-face networking, which binds us more and more, and over time we have learned that these personal relationships are the true foundation, enabling us to pave the way for new discussions and efforts at promising practices.

The operations memo described how the Office of Medical Assistance Programs, the Health Choices Managed Care organizations, and their participating dental networks would collaborate to develop a process of coordinated dental care for the children enrolled in the local Head Start programs across the state. The memo indicated there was a great need for better care coordination between the MCOs and the local Head Start programs in each county and zone served by the MCOs. Issues pertaining to other EPSDT-related services were also to be addressed through the effort. The memo served as the stimulus to initiate the handshakes of introduction that could then progress into productive and mutually beneficial relationships. Next slide, please.

Now, naturally there are multiple factors influencing how the MCO Head Start Liaison Project is being implemented across Pennsylvania. It is an ongoing challenge to cultivate broad, uniform, and consistent implementation, simply because we're meshing two systems which are complex to begin with; namely, the 92 Pennsylvania Head Start programs with a variety of organizational structures and the Health Choice system with its nine MCOs, each with its own organizational structure and culture as well. So logistically it takes time to communicate with so many entities at once. Staff turnover is always an issue, impacting continuity of understanding about roles and responsibilities, necessitating frequent refreshers and repetitive messaging to all of our partners, and frequent changes to the landscape of health-care

MPR
2014-09-16 OHI WEBINAR

delivery are naturally expected. There are time and labor barriers due to competing priorities and limited resources, and it simply takes time to build relationships. Trust is not built over night, it requires years to establish and then to maintain.

To ensure confidence and to address concerns related to HIPAA, special MCO Head Start business associate agreements or BAAs, and/or service coordination agreements have been developed through each MCO's own legal department and signed by both parties. The purpose of the BAA is to mitigate concerns about HIPAA and to send the release of information. Head Start programs are running all of these legal agreements by their policy councils and by their boards of directors for approval before signing. This requires a thorough understanding of the partnership on the part of the Head Start directors and administrators. Every program at a different developmental level, ranging from limited implementation to full implementation of the MCO Liaison Project.

The executive director of the PA Head Start association, Blair Hyatt, and I have scheduled one-on-one calls with our Head Start program directors to assess individual needs, level of understanding of the project, and buy-in for the project. We are continuing to provide individualized technical assistance to our Head Start programs so that they can benefit from this partnership. Next slide, please.

Although the initial handshake between Head Start and the MCOs was around oral health, it was understood from the beginning that the MCOs were being encouraged to address issues pertaining to other EPSDT-related services beyond oral health services. Like the actual process of mapping a road trip in order to develop a helpful and reliable road map with landmarks along the way, one has to travel the route to experience it, learn it, and know it. So we focused on a test case for relationship building for part partnership and for ultimate data sharing, by documenting the pairing up of one Head Start program with one MCO in the southeastern region.

We wanted to see what kinds of data we could share to what end and for what benefit. First, cooperative business agreements were signed between the Head Start program and the MCO, giving permission for each of them to see each other's data. Then spreadsheets were provided by the MCO, the services claims data for individual children, which enabled both partners to see the gaps in delivery of oral health examinations, as well as other EPSDT services. Likewise, the Head Start programs shared their health tracking data with the MCO to help fill in the blanks on what services the children had already received or not received. This data sharing opened the door to a discussion of the health needs of individual children. Both the MCO and the Head Start program found the data sharing to be mutually beneficial to their goals. Going forward, they agreed to share and compare their data on a quarterly basis. Next slide, please.

The MCO Head Start Liaison Project is leading all parties to more quality improvement and innovation by taking concrete steps to share information about individual children and what they need to be up to date on the Medicaid EPSDT schedule for medical and dental services in Pennsylvania. The shared tracking of health services is not limited to the dental period to C schedule. We know that the Head Start programs are constantly working hard to track and document physical examinations, screening, and treatments required by the EPSDT period to C schedule for every child enrolled in the program on an ongoing basis. This helps to ensure the children are healthy and ready to learn when they are enrolled in Head Start, and to prepare them for transition into kindergarten and elementary school. Some of these EPSDT services specific to Pennsylvania Medical Assistance include blood lead level testing, objective vision and hearing screening, anemia screening, and Head Start programs have found these to be perpetually difficult to track, which is why I referred to them as perpetual offenders.

When we are able to identify those health or dental services which are being overlooked, we can intervene through the MCOs to improve the situation with specific programming or technical assistance for their provider networks. One example is in meeting the first dental visit by first birthday requirement. In response to the lack of age-one dental providers, Pennsylvania is now actively disseminating the PA H1 Connect the Dots program, replicated with the help of the Massachusetts Dental Society and the Massachusetts Head Start Association, with grant support from the dental trade alliance foundation. We educate general dentists in teams, with dental hygienists to serve young children, by performing the knee-to-knee exams according to the national standard of care by age one.

MPR
2014-09-16 OHI WEBINAR

By educating general dentists through the MCO provider networks, we are proving access to age-one dental examinations. We are also changing provider culture and paradigms one provider at a time, when you consider that many general dentist who wouldn't feel comfortable to see children under age three are now interested in learning how to do age-one dentistry in their practices. In fact, we've trained over 200 providers already this year. Next slide, please.

So listed on this slide are some of our lessons learned, but we continue to learn more every day through this experience together. It's important to keep reminding our MCO and Head Start partners about why we're in this together, why it's mutually beneficial. It is inspiring and gratifying to be working together to help our children be well, because they are our top priority, and they will define the future for all of us. It is important to cultivate the partnership relationship through communication. This builds trust. And to build an even deeper trust, one must simply follow through on promises. You have to do what you say you're going to do if you say you're going to do it. Next slide, please.

This slide presents two tables that show the progressive achievement of access to preventive dental services by enrolling in one Head Start program that wasn't involved in the original pilot project stage of the Head Start MCO Liaison Project. The charts present what the raw number of eligibles receiving preventive dental services and the percentage of eligibles who received a preventive dental service during the designated calendar year. The first chart presents results for Head Start enrollees who were eligible for medical assistance at any time during the calendar years 2011 through 2014. The calendar year 2014 data is year to date as of August 2014.

The data shows that over the two years of project activity, the utilization of preventative dental services increased by more than two times in the first year, and more than three times in the second year. Year-to-date data for the current year appears to indicate that the higher utilization rates are continuing. The second chart presents results for Head Start enrollees who were eligible for medical assistance at some time during calendar 2011, and then remained continuously eligible through calendar year 2014. The number of eligibles identified that fit that eligibility criteria were 234.

This data appears to indicate that for children who maintain continuous eligibility and enrollment in both medical assistance and Head Start, the results are even better than those children with less robust involvement. Showing the same patterns of utilization increase but also demonstrating an additional three to five percentage point boost. These are very preliminary data points with limited scope, and we intend to widen our analysis as data collection can be appropriately expanded to more programs involved. However, we are much encouraged by what these results indicate in the way of potential effectiveness for the project.

Again, thank you for this opportunity, and I will turn the mic back over to Laurie.

Thank you so much, Dr. Westerberg and Amy, for that fantastic presentation. It really showed that this kind of collaboration is possible and that it can really pay off for kids. It was obviously a very long -- getting a long startup and requires a lot of effort, but you have shown that it is possible. And I hope that all of our listeners haven't been overwhelmed by the amount of work that you all had to get to achieve the success that you have. We know that any collaboration in a different state is going to look different than this, but the Head Start collaboration offices and the Medicaid offices, I'm sure, stand ready to assist. Next slide, please.

So before we get to questions, and we'll get to them in just a moment, I wanted to make sure that everyone on today's call is aware that CMS has available some oral health education materials for free to anyone who is interested. We call them "Think teeth." We have three versions of them, one for babies and toddlers, one for children of all ages, and one for pregnant women. These are available in both English and Spanish. They are available in different formats, such as posters, fliers, and tear pads, and as I mentioned, they can be bulk ordered for free from CMS at the link on this slide. Next slide, please.

And, lastly, I wanted to make sure that you were aware of an oral health tool kit that was developed for the Head Start community through an effort that occurred in New Jersey. It was an 18-month

MPR
2014-09-16 OHI WEBINAR

collaborative between Medicaid and Head Start and that state, and it's a very different approach than the one we heard about today, but we think that it might be of some value to you to take a look at this toolkit as well. Next slide, please.

So, Brice, do you want to -- oh, before I turn it back over to Brice, I just wanted everyone to be able to see how to contact today's presenters. And by the way, there have been a number of requests through the question box for can we reshoot the links to get to various resources like Marco's resources, et cetera. The entire slide deck is available to you on the resources list link at the bottom of your screen, so if you would like to go back and view a different slide or click through to a link on a slide, feel free to pull the slide deck up through the resources list tab at the bottom of your screen.

Okay, turning it back over to you, Brice, to bring us to the Q&A portion of today's program.

Great. Thank you, Laurie. So just a reminder to everyone that all attendees can submit their feedback on this webinar using the survey widget, which is going to be located at the bottom of your attendee console. It will be indicated by that little red icon with the three lines and the check box in the middle. Please remember, though, to use the submit button when you have finished entering all of your comments.

So now we are going to move to the Q&A portion of the event, so next slide, please. And just a reminder, you can submit your questions using the Q&A widget located at the bottom of your audio console if it's not currently up on your screen. We do record all questions, so any questions that we're unable to handle during the event will be answered via e-mail. Please note that your questions can only be seen by our presentation team and are not viewable by other attendees, so feel free to ask any questions you'd like. And so with that, I'll pass it back over to Laurie to begin addressing your questions.

Thank you, Brice. So the first question, and I think this question may be addressable, both by Marco and our Pennsylvania presenters. "Is funding available for dental treatment for Head Start children who are not covered by Medicaid?" Marco, do you want to take a first crack at that?

Well, the easy and the hard answer is one of the things or one of the understandings that we have is that Head Start programs are pairs of last resort. So if we run into a situation where we have a child in the program who does not have coverage in Medicaid or private insurance, or any other sort of insurance, first, that the program make every effort to try to figure out how to get those resources in order to meet the need.

If, at the end of the day, they're still not able to figure it out, the program can use their funds to help pay for services, and we have examples in which we've gotten bills. And when I used to be a coordinator, Head Start service manager, I would get bills for \$12,000, and it wasn't uncommon to get that for a number of children who needed treatment. And so we obviously must try to figure out how to pay for that. So sometimes it can come out of the budget, and if the program doesn't have the money, this is the conversation that they need to have with the regional offices so that everybody is aware and on the same page and can figure out how to best support the program.

Thank you, Marco. Amy, do you know how this is handled in Pennsylvania?

Well I would agree with Marco on all those points. There are some other creative strategies that I have seen Head Start programs use, where they work with individual dental providers to maybe agree upon certain kinds of payment, and also pro bono services. So there are donated services being provided to Head Start programs in communities by dental providers, such as through Give Kids a Smile and different kinds of initiatives like that. So those kinds of things can be worked out at the community level if the Head Start program has a good relation with the dental provider in the community. That's about it.

Thank you, Amy. Paul, is there anything you'd like to add on this topic?

MPR
2014-09-16 OHI WEBINAR

Well from the Medicaid perspective, if an enrollee is not also eligible under EPSDT, the Department of Public Welfare Office Medical Assistance programs would not be able to, but we would certainly try to be assistive in other ways. But we are responsible for our beneficiaries particularly, so children not enrolled in Medicaid would not be able to receive funding through the department.

Thank you. Our next question, I think it's for Marco. There's been a lot of interest in getting copies of the Head Start oral health form that you explained to us on Slide 27. Can you tell our listeners where they can download copies of those forms?

If they go to the link that was provided on slide -- the one that had the collaboration director slide and then the National Center on Health National Resources slide, that link will take you to where all the forms are located. And then if anybody is still having issues trying to find it, and, you know, once this is over, they can contact me and I can send it to you directly or send you the PDF.

Thank you, Marco. This next question, I think, is for you as well, Marco. "Are there any plans to support states, the Head Start programs and the Medicaid programs, to be able to use Medicaid benefits across state lines?" And our questioner is asking specifically about children who travel between Florida and South Carolina. And I'm wondering maybe if this is an issue that your programs encounter in the migrant - - concerning migrant children. So maybe you're familiar with how some states have handled this.

I mean it's a problem that we've had for ages. And for those people that are not aware, for a lot of our migrant children, once they leave one state and go to another, they lose their coverage in the state that they're leaving, and then it takes time for them to -- if they qualify, it takes time for them to get coverage. So a lot of times, you know, as they're waiting the coverage comes in and the families might already have moved on again. So it makes really difficult for our traveling families.

There were a series of pilot studies a long time ago that were funded. I think the most successful one was a study that was done between Texas and Wisconsin. So I'm not sure, from the Medicaid side, if that was going to be continued or they were going to continue to look at portability. It's something that we constantly bring up, and we're always kind of excited to figure out and try to have the conversation to see how we can meet the needs. So it's a continual work in progress, and we always try to figure out how to address it from our end. But it's taking a long time to kind of get there.

We have one resource. It doesn't solve the issue of portability, but it solves a lot -- it addresses a lot of the issues that we have in our migrant communities and with our highly mobile populations. We have a partnership guide that was originally developed for the migrant community. So I didn't provide it as part of the resources, but I could provide the link to you guys later on. And there are some really nice things that you can do. One of the most underutilized resources by our programs is the use of federally-qualified health centers, and we know that a lot of federally-qualified health centers have dental providers as part of their team that can help meet the needs of some of their kids. So one of the things we tried to do within this partnership guide was to help programs and give them the tools that they need, and the federally qualified health centers, to establish some of the MOUs, something that was being referred to in Pennsylvania to help better meet the needs of the kids that are there.

So it doesn't address the portability issue. We talk about it, but it's a work in progress and we're constantly thinking about. That's a long-winded answer.

Sorry about that. It sounds like we haven't hit on the ideal solution to that yet, but it sounds like there are approaches that can be explored. Thank you, Marco.

This question is for Dr. Westerberg. "Do the medical MCOs in Pennsylvania Medicaid, do they subcontract the oral health services or do they administer the dental benefits through their own organizations?"

MPR
2014-09-16 OHI WEBINAR

Currently we have a mix. The majority have delegated to a dental benefit management entity, but there are MCOs that have brought the administration in-house, and so there is a difference across the spectrum of our current nine MCOs. But a majority have a dental benefit manager but there are MCOs that manage it within their own staffing, with possibly an ASO, an administrative services agreement only with a claims processor perhaps, but the network management and other parts of the administration of the benefit is handled by the MCO themselves. So it's a mixed situation currently.

Thank you, Dr. Westerberg. This next question I think all of our presenters may have something to say about this. Can you please further address the role of the dental hygienist and provision of dental exams and services in Head Start? Let's start with Amy this time.

Okay. Well, we perceive, in Pennsylvania, that the dental hygienist is a part of the team that serves Head Start. And we also see the dental hygienist as an educator. And so a lot of our Cavity Free Kids training has been directed to dental hygienists in our state who are now turning around and providing training for Head Start programs and parents in those programs, as well as the children. So we definitely see them as part of the team.

Now, as far as the actual examination of the child goes and whether that counts as a dental examination, that would depend upon the state EPSDT requirements. And in Pennsylvania the requirement -- and I'm sure Paul can talk more to this -- but the requirement at this present time is that a dentist needs to provide the dental examination. So in our Head Start programs we rely on dentists to provide the examination and we have to have that documented.

Paul?

Yes, that's correct, Amy. Pennsylvania has both registered dental hygienists who function under the supervision of a dentist and certainly their hygiene services are valued and can be performed either in the dental office or possibly remotely in the community at the Head Start location. However, Amy is correct, that in Pennsylvania examination of the patient is under the scope of practice of the dentist. Hygienists are allowed to screen patients. We actually have a mid-level dental hygiene provider, which is the public health dental hygiene practitioner in Pennsylvania, who are allowed to function in public health settings without the supervision of a dentist. However, there is a mandatory referral to the dentist for examination, because diagnosis of disease is not under the scope of practice of even the dental hygiene practitioner, so they are certainly part of the team and valued; however, examination and, in many cases, what was being looked by the Head Start programs was follow-up care of individuals, not just hygiene services but actual treatment services, and, again, that only falls under the scope of practice of the dentist in Pennsylvania.

Thank you. Marco, do you have anything?

No, I agree. I mean it's pretty much really state dependent; right? So, you know, it could vary, but it's pretty much on point -- from what I've seen across a lot of the states is pretty much the way Pennsylvania addressed it.

Thank you, Marco. I just want to remind people of the Slide 7 that we began today's webinar with, where we talked about the federal EPSDT requirement. Under federal rules, a direct dental referral is required for EPSDT at the first stage of the periodicity schedule, as we discussed, but that dental referral is allowed to be with a dentist or another professional, such as a dental hygienist or dental therapist, as long as that other dental professional is working under some kind of supervisory relationship with a dentist. So many Head Start programs -- you know, every state makes its own rules. Many rely on the federal EPSDT rules to model their rules after, so I just wanted to make clear to everyone on today's call that the federal rules are a little bit more lenient and more sort of accepting of dentist hygienists or dental therapists doing assessments or evaluations than what was described for Pennsylvania.

MPR
2014-09-16 OHI WEBINAR

So the next question, and this is to probably all of our presenters, it's about the challenges of securing dental services in extremely rural communities. Our questioner asks, "Where do Head Start children go for dental care if there is no comprehensive dental care available within 200 miles of their residence?" And in whatever state she is writing from, the rural health clinics do not offer dental care, and there may not be a community health center or a federally-qualified health center in these remote areas. Do you have any area that would fit that description in Pennsylvania?

I don't have my calipers out. I mean certainly there are areas in Pennsylvania that are. Sometimes you may have to drive south to go north because of mountainous areas, other things, so actual mileages are not something I could speak to directly. I don't believe we have something like 200 miles. We do have, within managed care, some set ideas as far as rural and urban areas, as far as time travel as well, but, again, if there are no dentists physically available, and in Pennsylvania we have as the dental health professional shortage areas, they're both geographic and populational. I'm not sure, because the geographic hurdle is less, most DIPSAs in Pennsylvania are listed as populational not geographic, so it's not easy to tell whether we have any geographic that might fit that 200 miles. But overall, we are, you know, working with our MCOs to overcome those barriers. You know, 200 miles not likely, I would not think.

We do have some situations where the number of dentists actually available within a county may be in the single digits, but, again, so it may be necessary to go outside of the county for dental services. But, again, our MCOs and the special needs units work to try to reduce those barriers. We do prefer that our MCOs work within established networks, enrolled networks, but we do allow them the flexibility to go out of network, so they could make arrangements with a provider in a community for an individual on that basis, but I don't believe we have anything quite so drastic as that 200 miles. I'm not aware of that at this point. But, certainly, that's part of why the statewide managed care expansion and the Liaison Project that we have gives us a higher -- as I mentioned before, the high touch of contact with families and interactive relationships between those connected directly to the families and the plans connected to the networks to try to minimize those types of situations for children, whether it be urban or suburban or rural.

And Pennsylvania has a fairly large rural population, so we're aware of those things, and our Health Choices program, and both the department and our MCOs and the Head Start folks all are involved in trying to minimize those. This is the type of collaboration that you need in those situations to try to work for the best access to care possible for each individual child.

Thank you, Dr. Westerberg. The next question is for Marco. "Does the National Head Start Center provide examples or templates or any kind of coaching or technical assistance on how to obtain grant funding for oral health education and materials and other non-clinical services?"

Not at this point, we don't have a resource to do that. It's a good idea. It doesn't mean that we won't in the future, so I will jot it down as something we could possibly do maybe. But can I respond to last question as well?

Oh, sure. Go ahead, Marco.

So we do have areas that are severe service deserts, 250 miles beyond, and we do have some people -- and I know that people hate the idea of mobile vans, mobile clinics. There are some of our programs in really, really severe rural communities that resort to that. We don't have a particular policy that says they can't use them. The point that we really stress to our programs that are engaging in that is to say the key to performance is continuous accessible care, so it's not just about getting the exam done. It's about assuring there is that continuity there, you know, the premise of the dental home is there, so how do they work together with that particular unit and anybody else within their state or their communities to kind of help figure out how the continuous accessible piece is going to happen.

We also know that there's a couple of programs in California that have ventured into doing teledentistry as a way to kind of meet that need because they're not able to get the provider where the programs are located, so they're starting to venture into that. My understanding, there was a couple of journal articles

MPR
2014-09-16 OHI WEBINAR

Hello everyone, and thank you for attending today's webinar, "Improving Oral Health Through Access: Building a Partnership Between Medicaid and Head Start." Before we begin, we wanted to cover a few housekeeping items.

You can expand your slide area by clicking on the maximize icon on the top right of the slide area or by dragging the bottom right corner of the slide area. At the bottom of your audience console are multiple application widgets you can use. A copy of today's slide deck is available in the resource list widget that looks like a green folder at the bottom of your screen.

If you have any questions during the webcast, you can click on the Q&A widget at the bottom of your console and submit your question. We will have time for questions at the end of the presentation. If a fuller answer is needed or we run out of time, it will be answered later via e-mail. We do record all questions received during the webcast.

If you have any technical difficulty, please click on the help widget. It has a question mark icon and covers common technical issues. An on-demand version of the webcast will be available after the webcast and can be accessed using the same audios link that was sent to you earlier. Additionally, CMS will be posting this webinar on medicaid.gov within approximately three weeks.

Now I would like to turn it over to Laurie Norris. Laurie, you now have the floor.

Thank you, Brice, and good afternoon everyone, and good morning to those of you on the West Coast. We are so glad that you've been able to join us today for the seventh webinar in our CMS Learning Lab Series, and we especially want to thank our partners at Medicaid CHIP Dental Association for collaborating with us on these learning labs. Today we'll be focusing on how Medicaid and Head Start can partner to get needed dental services to Head Start children. Next slide, please.

These are our learning objectives for today's webinar. First of all, to understand the federal Head Start dental requirements and its infrastructure; second to become aware of the oral health resources available from the Administration for Children and Families Office of Head Start; and third, to learn the step-by-step process used in Pennsylvania to build a partnership between Medicaid and Head Start; and, fourth, to be able to detail the elements of Pennsylvania's collaborative intervention and lessons learned so far. Next slide, please.

We have three excellent speakers to hear from today, but before I turn the mic over to them, I wanted to say a few words about the Medicaid benefit for children and adolescents, also known as EPSDT, or early and periodic screening, diagnostic, and treatments. Every state Medicaid program is required to have a pediatric dental periodicity schedule in their EPSDT benefit. As many of you know the American Academy of Pediatric Dentistry recommends that the first dental visit occur at the eruption of the first tooth or by age one, whichever occurs first. You can view your state's Medicaid periodicity schedule at the link on the slide.

In addition, EPSDT requires a direct dental referral, starting at the first age in the dental periodicity schedule. A dental referral must be an encounter with a dentist or with another dental professional, such as a dental hygienist or dental therapist, working under the supervision of a dentist. More detail about these topics can be found in the EPSDT Guide for States at the link shown on the slide. Next slide, please.

So we'll kick it off right with our first presenter, Marco Beltran. Next slide, please. Marco has been involved in Head Start for over 15 years. He works in the Office of Head Start National and State Training and Technical Assistance Division as the health lead and on the federal project office for the National Center for Health. Marco has an extensive background in the field of early childhood and with programs serving low-income children and families. Prior to joining OHS, he worked at the National Institute of Health, the National Institute of Dental and Craniofacial Research as a public health educator. And before that, he worked at the Migrant and Seasonal Head Start Technical Assistance Center.