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Oral Health Access for Young Children

Overview

**When:** January 2011 – August 2012

**What:** The Oral Health Access for Young Children (OHAYC) program provided preventive dental screenings and supplies, fluoride varnish applications, oral health education and dental referrals to high-risk children and families with limited access to dental health care.

**Who:**

<table>
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<th>Local Partners →</th>
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**How:** The OHAYC program was funded by the Health Resources and Services Administration (HRSA) through a 3-year grant program: *Grants to States to Support Oral Health Workforce Activities*, Grant #T12HP14997. Of this grant, $890,000 was distributed to partner organizations across the state to implement and evaluate OHAYC.

**Why:**

- Tooth decay causes pain and can affect how kids eat, speak, play, learn and grow.\(^1\)
- A 2005 survey of Nebraska 3\(^{rd}\) graders showed that almost 60% had tooth decay.\(^2\)
- Children living in rural areas of Nebraska are more likely to have oral health problems.\(^3\)
- Children in Nebraska without private insurance are more likely to have poor oral health.\(^4\)
- Nebraska children whose primary language is not English are over 10 times more likely to have poor oral health.\(^5\)
- Of 43 pediatric dentists in 2011, only seven were located outside of Omaha and Lincoln.
- Fluoride varnish can effectively prevent tooth decay in high-risk children.\(^6\)

**Where:** The Local Health Departments and Federally Qualified Health Center partners represented 64 of Nebraska’s 93 counties.
**Nebraska**

- Population: **1,826,341**
- Land Area: **76,824.2 mi²**
- Dentists: **1,562**
- Dental Hygienists: **1,261**

**Outcomes**

- Children Seen: **19,086**
- Client Visits: **26,131**
- Fluoride Varnish Treatments: **24,167**
- Clinic Hours: **6,813**

**Community Site – WIC:** 53
- Staff involved with project: 62
- Satisfaction Rate (WIC): 96%
- Intended/Actual Referral Rate (WIC): 95%

**OHAYC Racial Ethnic Distribution**

- Hispanic: 49%
- White/Caucasian: 38%
- Black/African American: 9%
- American Indian/Alaskan Native: 1%
- Asian: 1%
- Other: 2%

**OHAYC Age Distribution**

- 0-5 years: 91%
- 6-10 years: 7%
- 11-14 years: 2%

**OHAYC Oral Health Status**

- Unhealthy Gums: 8.2%
- Need Further Care: 14.0%
- Early Childhood Caries: 15.8%

**OHAYC Access to Oral Health Care**

- No Dental Home: 47.8%
- Medicaid: 78.1%
- No Dental Insurance: 85.8%
Evaluation
Independent evaluation by the Creighton University Center for Health Services Research and Patient Safety (CHRP) concluded that OHAYC successfully expanded the Young Children Priority One pilot program model to communities across the state and demonstrated the ability to successfully reach high-risk families and children with preventive services in both urban and rural areas. They report that parents were very satisfied with the services provided and were likely to refer others to the program, and that the OHAYC program increased the confidence of parents and guardians in their ability to prevent decay in children’s teeth. CHRP also reported that this program increased the capacity of local communities to improve the oral health of children through the initiation and development of new partnerships, and was strengthened by a focus on influencing parental behavior through education.

The OHAYC program provides a promising model for provision of dental services to communities and populations with limited access to care that are traditionally hard to reach. For a few local health departments, this program was the first to prioritize oral health since the health department had been established. Prior to the conclusion of this project period, local communities were at the threshold of adapting the programs even further to incorporate their own needs and local resources by adding components such as dental sealants, mobile dental clinics, school-based services, and increased collaboration with local dentists. Eleven out of the 15 grantees indicated that they intend to continue the program in some capacity after the loss of continuation funding in August 2012.

For a detailed chart of the OHAYC program model, see Appendix A on page 29.

Program Summaries
The following pages outline program summaries for each of the fifteen OHAYC partner programs. Here are the sources that were used to put together this information.

Health Department data were calculated based on information from:

- US Census Bureau, State and County Quick Facts for Nebraska
  - [http://quickfacts.census.gov/qfd/states/31000.html](http://quickfacts.census.gov/qfd/states/31000.html)
- DHHS Dental Licensing information as of December 31, 2012
  - [https://www.nebraska.gov/hhs/lists/search.cgi](https://www.nebraska.gov/hhs/lists/search.cgi)

Outcomes data were collected from:

- OHAYC Monthly and Annual Report Forms
- OHAYC Dental Screening Forms
- OHAYC Parent Satisfaction Surveys

To see examples of these forms, see Appendix B on page 30.
Central District Health Department

Population: **72,447**
46 People/mi²
Land Area: **1,575 mi²**
1,393 People/Dentist

Dentists: **52**
30.3 mi²/Dentist
Dental Hygienists: **51**
0.98 RDH/Dentist

Outcomes

Children Seen: **2,110**
Client Visits: **3,030**
Fluoride Varnish Treatments: **3,451**
Clinic Hours: **871**

Community Site – WIC: **1**
Staff involved with project: **3**
Satisfaction Rate (WIC): **99%**
Intended/Actual Referral Rate (WIC): **95%**
Charles Drew Community Health Center

Population: 482,112 People
Land Area: 331 mi²

Dentists: 460 Dentists
Dental Hygienists: 285 RDH

Outcomes

Children Seen: 1,959
Client Visits: 4,056
Fluoride Varnish Treatments: 2,701
Clinic Hours: 1,065

Community Site – WIC: 1
Staff involved with project: 5
Satisfaction Rate (WIC): 79%
Intended/Actual Referral Rate (WIC): 87%

CDHC Racial Ethnic Distribution

CDHC Age Distribution

CDHC Oral Health Status

CDHC Access to Oral Health Care
East Central District Health Department

Population: 51,325
Land Area: 2,219.2 mi^2

Dentists: 22
Dental Hygienists: 28

Outcomes

Children Seen: 1,309
Client Visits: 1,963
Fluoride Varnish Treatments: 1,831
Clinic Hours: 781

Community Site – WIC: 2
Staff involved with project: 3
Satisfaction Rate (WIC): 97%
Intended/Actual Referral Rate (WIC): 92%

ECDHD Racial Ethnic Distribution

ECDHD Age Distribution

ECDHD Oral Health Status

ECDHD Access to Oral Health Care

Unhealthy Gums Need Further Care Early Childhood Caries

No Dental Home Medicaid No Dental Insurance

65.3% 72.6% 82.6%
Elkhorn Logan Valley Public Health Department

Population: 59,548 People
Land Area: 2,067.2 mi²

Population Density:
- 28.8 People/mi²
- 1,654 People/Dentist

Dentists: 36
Dental Hygienists: 28

Dentists Per Million People:
- 57.4 mi²/Dentist
- 0.8 RDH/Dentist

Outcomes

Children Seen: 744
Clinic Hours: 71

Client Visits: 703
Community Sites – CC-PS: 3

Fluoride Varnish Treatments: 597
Staff involved with project: 3

ELPHD Racial Ethnic Distribution

- Hispanic: 4%
- White/Caucasian: 11%
- Black/African American: 1%
- American Indian/Alaskan Native: 1%
- Asian: 0%
- Other: 84%

ELPHD Age Distribution

- 0-5 years: 17%
- 6-10 years: 82%
- 11-14 years: 1%

ELPHD Oral Health Status

- Unhealthy Gums: 0.0%
- Need Further Care: 16.0%
- Early Childhood Caries: 5.0%

ELPHD Access to Oral Health Care

- No Dental Home: 48.1%
- Medicaid: 47.0%
- No Dental Insurance: 52.8%
Four Corners Health Department

Population: 45,105
20.8 People/mi²

Land Area: 2,172.8 mi²
2,148 People/Dentist

Dentists: 21
103.5 mi²/Dentist

Dental Hygienists: 21
1 RDH/Dentist

Outcomes

Children Seen: 245
Client Visits: 455
Fluoride Varnish Treatments: 431
Clinic Hours: 140

Community Site – WIC: 2
Staff involved with project: 4
Satisfaction Rate (WIC): 100%
Intended/Actual Referral Rate (WIC): 98%

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FCHD Racial Ethnic Distribution

- Hispanic: 23%
- White/Caucasian: 72%
- Black/African American: 1%
- American Indian/Alaskan Native: 1%
- Asian: 2%
- Other: 1%

FCHD Age Distribution

- 0-5 years: 9%
- 6-10 years: 5%
- 11-14 years: 86%

FCHD Oral Health Status

- Unhealthy Gums: 6.0%
- Need Further Care: 14.3%
- Early Childhood Caries: 17.1%

FCHD Access to Oral Health Care

- No Dental Home: 69.6%
- No Dental Insurance: 74.1%
- No Dental Insurance: 85.8%
Lincoln-Lancaster County Health Department

Population: 261,545   Land Area: 838.9 mi$^2$
311.8 People/mi$^2$   994 People/Dentist

Dentists: 263   Dental Hygienists: 232
3.2 mi$^2$/Dentist   0.9 RDH/Dentist

Outcomes

Children Seen: 404
Client Visits: 367
Fluoride Varnish Treatments: 340
Clinic Hours: 82
Community Sites – CC-PS: 3
Staff involved with project: 4

LLCHD Racial Ethnic Distribution

LLCHD Age Distribution

LLCHD Oral Health Status

LLCHD Access to Oral Health Care
Loup Basin
Public Health Department

Population: **32,340**
Land Area: **72,340 mi²**

0.4 People/mi²
2,940 People/Dentist

Dentists: **11**
Dental Hygienists: **21**

**6,576.4 mi²/Dentist**
1.9 RDH/Dentist

Outcomes

Children Seen: 906
Client Visits: 906
Fluoride Varnish Treatments: 901

Clinic Hours: 67
Community Sites – CC-PS: 8
Staff involved with project: 5

**LBPHD Racial Ethnic Distribution**

- Hispanic: 0%
- White/Caucasian: 0%
- Black/African American: 1%
- American Indian/Alaskan Native: 0%
- Asian: 0%
- Other: 1%

98%

**LBPHD Age Distribution**

- 0-5 years: 0%
- 6-10 years: 0%
- 11-14 years: 100%

**LBPHD Oral Health Status**

- Unhealthy Gums: 5.3%
- Need Further Care: 9.2%
- Early Childhood Caries: 21.7%

**LBPHD Access to Oral Health Care**

- No Dental Home: 8.2%
- Medicaid: 48.2%
- No Dental Insurance: 59.1%
North Central District Health Department

Population: **48,941**  
**3.4 People/mi²**  
Land Area: **14,455.4 mi²**  
**2,039 People/Dentist**  

Dentists: **24**  
Dental Hygienists: **30**  

**Outcomes**

Children Seen: **419**  
Client Visits: **610**  
Fluoride Varnish Treatments: **587**  
Clinic Hours: **185**  

Community Site – WIC: **1**  
Staff involved with project: **3**  
Satisfaction Rate (WIC): **93%**  
Intended/Actual Referral Rate (WIC): **95%**  

NCDHD Racial Ethnic Distribution

NCDHD Age Distribution

NCDHD Oral Health Status

NCDHD Access to Oral Health Care
One World Community Health Center

Population: **482,112**  
1,456.6 People/mi²  
Land Area: **331 mi²**  
1,048 People/Dentist  
Dentists: **460**  
0.7 mi²/Dentist  
Dental Hygienists: **285**  
0.6 RDH/Dentist

### Outcomes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Count</th>
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<tr>
<td>Client Visits</td>
<td>3,269</td>
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<tr>
<td>Fluoride Varnish Treatments</td>
<td>3,362</td>
</tr>
<tr>
<td>Clinic Hours</td>
<td>960</td>
</tr>
<tr>
<td>Community Site – WIC</td>
<td>1</td>
</tr>
<tr>
<td>Staff involved with project</td>
<td>3</td>
</tr>
<tr>
<td>Satisfaction Rate (WIC)</td>
<td>95%</td>
</tr>
<tr>
<td>Intended/Actual Referral Rate (WIC)</td>
<td>95%</td>
</tr>
</tbody>
</table>

### OWCHC Racial Ethnic Distribution

- Hispanic: 6%
- White/Caucasian: 3%
- Black/African American: 0%
- American Indian/Alaskan Native: 0%
- Asian: 0%
- Other: 0%
- Total: 91%

### OWCHC Age Distribution

- 0-5 years: 4%
- 6-10 years: 95%
- 11-14 years: 1%

### OWCHC Oral Health Status

- Unhealthy Gums: 8.5%
- Need Further Care: 18.0%
- Early Childhood Caries: 20.1%

### OWCHC Access to Oral Health Care

- No Dental Home: 40.5%
- Medicaid: 90.0%
- No Dental Insurance: 96.1%
Panhandle Public Health District

Population: **87,917**  
6.5 People/mi²  
Land Area: **13,441.5 mi²**  
3,663 People/Dentist  
Dentists: **24**  
560 mi²/Dentist  
Dental Hygienists: **26**  
1.1 RDH/Dentist

Outcomes

Children Seen: **616**  
Client Visits: **909**  
Fluoride Varnish Treatments: **885**  
Clinic Hours: **363**  
Community Site – WIC: **7**  
Staff involved with project: **3**  
Satisfaction Rate (WIC): **99%**  
Intended/Actual Referral Rate (WIC): **99%**

PPHD Racial Ethnic Distribution

- Hispanic: 15%
- White/Caucasian: 21%
- Black/African American: 4%
- American Indian/Alaskan Native: 6%
- Asian: 1%
- Other: 1%

PPHD Age Distribution

- 0-5 years: 93%
- 6-10 years: 6%
- 11-14 years: 1%

PPHD Oral Health Status

- Unhealthy Gums: 0.7%
- Need Further Care: 18.9%
- Early Childhood Caries: 18.3%

PPHD Access to Oral Health Care

- No Dental Home: 41.2%
- Medicaid: 61.5%
- No Dental Insurance: 82.7%
Ponca Tribe of Nebraska

Population: **482,112**
1,456.6 People/mi²

Land Area: **331 mi²**
1,048 People/Dentist

Dentists: **460**
0.7 mi²/Dentist

Dental Hygienists: **285**
0.6 RDH/Dentist

**Mission:**

**Outcomes**

Children Seen: **140**

Client Visits: **237**

Fluoride Varnish Treatments: **221**

Clinic Hours: **238**

Community Site – WIC: **1**

Staff involved with project: **3**

Satisfaction Rate (WIC): **95%**

Intended/Actual Referral Rate (WIC): **99%**

PTN Racial Ethnic Distribution

PTN Age Distribution

PTN Oral Health Status

PTN Access to Oral Health Care
Public Health Solutions
District Health Department

Population: **57,761**
18.3 People/mi²

Land Area: **3,154.7 mi²**
1,925 People/Dentist

Dentists: **30**
105.2 mi²/Dentist

Dental Hygienists: **21**
0.7 RDH/Dentist

**Outcomes**

Children Seen: 983

Client Visits: 983

Fluoride Varnish Treatments: 733

Clinic Hours: 106

Community Sites – CC-PS: 7

Staff involved with project: 3
South Heartland District Health Department

Population: **46,400**
20.3 People/mi²

Land Area: **2,286.6 mi²**
1,254 People/Dentist

Dentists: **37**
61.8 mi²/Dentist

Dental Hygienists: **38**
1 RDH/Dentist

**Outcomes**

Children Seen: **1,713**

Client Visits: **2,380**

Fluoride Varnish Treatments: **2,241**

Clinic Hours: **622**

Community Site – WIC: **4**

Staff involved with project: **6**

Satisfaction Rate (WIC): **99%**

Intended/Actual Referral Rate (WIC): **99%**

**SHDHD Racial Ethnic Distribution**

- Hispanic: 2%
- White/Caucasian: 32%
- Black/African American: 14%
- American Indian/Alaskan Native: 0%
- Asian: 2%
- Other: 66%

**SHDHD Age Distribution**

- 0-5 years: 2%
- 6-10 years: 14%
- 11-14 years: 84%

**SHDHD Oral Health Status**

- Unhealthy Gums: 1.0%
- Need Further Care: 4.1%
- Early Childhood Caries: 3.5%

**SHDHD Access to Oral Health Care**

- No Dental Home: 34.6%
- Medicaid: 81.2%
- No Dental Insurance: 90.4%
Two Rivers
Public Health Department

Population: 93,550
Land Area: 4,623.8 mi²
Dentists: 60
Dental Hygienists: 65

Outcomes

Children Seen: 4,146
Client Visits: 5,425
Fluoride Varnish Treatments: 5,113
Clinic Hours: 928

Community Site – WIC: 11
Staff involved with project: 5
Satisfaction Rate (WIC): 92%
Intended/Actual Referral Rate (WIC): 93%

TRPHD Racial Ethnic Distribution

TRPHD Age Distribution

TRPHD Oral Health Status

TRPHD Access to Oral Health Care
West Central District Health Department

Population: 47,077
11.8 People/mi²
Land Area: 3,993.6 mi²
1,962 People/Dentist

Dentists: 24
166.4 mi²/Dentist
Dental Hygienists: 25
1 RDH/Dentist

Outcomes

Children Seen: 436
Client Visits: 838
Fluoride Varnish Treatments: 773
Clinic Hours: 336

Community Site – WIC: 1
Staff involved with project: 2
Satisfaction Rate (WIC): 95%
Intended/Actual Referral Rate (WIC): 98%

WCDHD Racial Ethnic Distribution

WCDHD Age Distribution

WCDHD Oral Health Status

WCDHD Access to Oral Health Care
Lessons Learned

The Oral Health Access for Young Children program provided dental care to many children in many places throughout Nebraska. Some of the local partners had their own dental clinics; some of them had never had an oral health program before. Some of the partners were in cities and visited by many families; others were in small rural towns where families came as they were able. Differing program settings and capacities made providing services easier for some and more difficult for others. Below are some of the strengths and challenges of the OHAYC program identified by local partners.

**Strengths**

**Consistent Community Presence**

The OHAYC program provided dental care through working partnerships with existing community organizations. This made the program very accessible for families that were already involved in WIC clinics, Head Start programs, or child care.

**Home Care and Prevention**

Families involved in the OHAYC program received more than a check-up and fluoride treatment – they also received toothbrushes and toothpaste to take home with them, as well as education on their proper use.

**Supportive Partnerships with Host Site**

The WIC, Head Start, and child care host sites provided a lot of support. In addition to providing a place for dental hygienists to work, many of them also helped promote OHAYC to the families involved in their programs through flyers, reminder phone calls, and by directing parents to the fluoride varnish program on the days they were present in the clinic.

**Involving Families in Children’s Dental Care**

Being situated in family-based organizations made it easy for OHAYC staff to communicate with the families of the children they served, and to involve parents and guardians in their care. In WIC clinics, families were often on-site; in Head Start and child care settings, the staff of the host site had established relationships with families which OHAYC was able to build on.

“What worked well was being available in the community. Consistently being there and giving advice, fluoride treatments, and toothbrushes with paste. We had more and more return visits with participants having questions or concerns, or just wanting to keep their children up on the fluoride treatments.” CDCHC

“If the children did have a dental problem the parents were made aware of the problem and early action could be taken to make sure that the problem did not worsen.” ELVPHD
Repeat Visits

In many of the OHAYC clinics, children were able to receive dental care multiple times thanks to effective promotion of the program, its accessibility within the community, and education by program staff about the importance of oral health and the benefits of repeated fluoride application.

Dental Clinic Provides Effective Referral Options

For programs working in partnership with a dental clinic, it was easy to refer children to a dentist for restorative or follow-up care. Sometimes a dentist was available at the same site where the program took place.

Flexible Program Model Allows Programs to Grow

Because the OHAYC program was designed to be administered by local programs to conduct work in community settings (see Appendix A on page 29), local partners were able to determine the best sites for programs to take place, and make changes if necessary. For example, if one site had consistent scheduling conflicts that prevented services from being delivered, it could be removed from the program. On the other hand, if there was a high need for services in a community without an OHAYC program, one could easily be added.

Met an Identified Community Need

The OHAYC program provided needed dental screening, care and referral to children and families who needed it most.

Challenges

Need for Referral Options in Settings without a Dental Clinic

The dental services provided in the OHAYC program were preventive – basic screenings, fluoride varnish applications, and referrals for additional care. Many of the programs that did not have immediate access to a dental clinic had significant difficulties connecting children needing advanced restorative care with local dental providers.

“We were able to cover several locations of WIC and Head Start programs in the northern panhandle. There was obvious need for treatment and we were able to complete it on site in both settings.” PPHD

“We continue to struggle with referral for restorative needs.” TRPHD

“We were able to cover several locations of WIC and Head Start programs in the northern panhandle. There was obvious need for treatment and we were able to complete it on site in both settings.” PPHD

“This program is extremely vital to our community... For some of the families that we saw, this was the only dental care that they could afford to get.” WCDHD

“The greatest challenge to serving children 0-5, is finding dental providers who are willing to accept Medicaid as well as families without dental insurance.” CDHD

“Unfortunately, it is still difficult to get local dentists to see Medicaid patients and often times getting to a dentist in another location causes barriers with transportation, etc.” PHSDHD
**Staff Turnover / Unavailability**

Because each program typically had a small number of staff qualified to carry out the program, OHAYC clinics sometimes had to be canceled or rescheduled due to staff turnover, illness or poor travel conditions.

**Coordinating Schedules and Staff with Host Site**

Occasionally, working around the events and activities presented a challenge for OHAYC programs. In addition, because some OHAYC clinics happened infrequently, families sometimes had difficulty scheduling their appointments for the next available clinic date.

**Children with Dental Anxiety**

Some children were uncomfortable with or afraid of the oral exam and fluoride varnish treatment. OHAYC staff worked with the children and their families to familiarize them with the process by allowing them to touch the disposable brushes, or to watch other children being treated. Children who refused an exam could still receive dental care packets, and many of them became more comfortable with the process as time went on.

**Reporting Structure**

The reports created for the OHAYC program were designed to gather outcomes information monthly, and process information twice per year. The amount and frequency of paperwork became burdensome and time consuming for several of the programs, especially those that saw many kids. Some programs expressed frustration at not having access to equipment that would allow for more thorough screening and more complete reporting.

**Differences in Methods**

The exam and treatment process the programs followed included a procedure that many of the dental hygienists had not used before – the use of iodine to clean the tooth surface prior to the fluoride varnish application. Although dental research exists that supports the procedure, several of the programs remained unconvinced about its inclusion in this particular program.

**Cultural and Language Differences**

Many of the OHAYC clinics served families of diverse cultural backgrounds who brought practices, beliefs, and languages that some of the programs felt unequipped to fully address. Although programs were equipped with interpreters, many of them were only English-Spanish bilingual, leaving other immigrant and refugee groups without the benefit of interpretation services.
Partnerships

**OHAYC Connected Children and Families to:**

**Local Dentists**

“We made early referrals so that the children could be treated with a better experience in a local dentist office vs. having to undergo surgical intervention.” PHSDHD

“Dental Home Referral linkages were established/maintained with UNMC Pediatric Dental Clinic, a private practice dentist, and Ponca Dental Clinic.” PTN

**Federally Qualified Health Centers and Public Health Care Facilities**

“We have had referrals to and from the [Maternal Child Health] immunization clinic.” ECDHD

“Clients were informed of not only the local dental providers but of the services at UNMC College of Dentistry in Lincoln and Good Neighbor Community Health Center in Columbus.” FCHD

**State and Community Dental Programs**

“We were able to help encourage people to get the additional care needed through Dental Day, Mission of Mercy and other local resources such as the CAPWN clinic. This also provided a means to check to see if there had been follow through.” PPHD

**OHAYC Connected Local Programs to:**

**Host Sites – WIC, Head Start, Preschool and Daycare**

“We conducted parent educational meetings with the Public Health Dental Hygienist serving as the guest presenter” in the preschool / daycare setting. ELVPHD

“We have shared information about this program with the area Head Start providers and several larger daycare providers, and presented this program at various events for children and families.” FCHD

“Our relationship with WIC has never been stronger and we share common goals.” ECDHD

“Relationships have been built with pre-school, Head Start, and Early Head Start staff, Community Action Agency staff, dentists, and hygienists.” LBPHD
Community Organizations

“A strong partnership between North Central District Health Department and Central Nebraska Community Services – WIC program developed as a result of the program, as well as partnering with the Public Health Outreach Nursing Education (PHONE) program at the health department in order to assist families with establishing a dental home.” NCDHD

SHDHD has had a long-standing partnership with Central Community College-Hastings Dental Hygiene program – and this partnership has been maintained and deepened with the Oral Health Access project. SHDHD

Nebraska Department of Health and Human Services

“We look forward to future collaborative opportunities and projects.” LLCHD

“We enjoyed the opportunity to work with the Office of Oral Health and Dentistry. The resources, training, and conference calls were informative and assisted us in improving our program.” LBPHD

“A positive outcome of this program was the connections established with the State of Nebraska’s Oral Health and Dentistry personnel and others throughout the State who had an interest in the oral health and wellness of children and families in Nebraska.” NCDHD

Continued Connections:

The Oral Health Access for Young Children program established, strengthened and deepened purposeful partnerships at the state, local, and community levels. In some cases, these partnerships built on existing community infrastructure. In others, they laid the foundation for future working relationships. Many of the programs intend to continue developing and expanding on these partnerships even after the end of OHAYC funding. Here are some exciting examples:

“Our hopes were to continue and grow into the schools and begin a school based sealant program. We will still be working to accomplish this but it will take more time with the loss of funding.” PHSDHD

“Daily tooth brushing policies have been established at the two remaining childcare centers that are participating in the project. This environmental change at both centers will benefit children for years to come. Establishing these policies we feel is one of the biggest accomplishments of this project.” ELVPHD

“The data collected, showing that through July, approximately 20.6% of program participants did not have a dental home. This provides us with a community snap shot and some base line data to work toward assuring access to dental homes with WIC, Head Start and Early Head Start children.” LLCHD
“Adolescent health, including Oral Health is a priority for the Health Department and this program may complement other health promotion opportunities in the future for youth.” LBPHD

“Central District Health Department in partnership with Third City Community Clinic and St. Francis Medical Center are providing continuation funding with a reduction in services for a period of 1 year. The hope is that funding opportunities can be found at the local, state or national levels to allow the successes we have attained to be sustained.” CDHD

“We plan to continue the program and model it after the ‘Program in a Box’ [OHAYC].” PTN

“North Central District Health Department credits implementing Oral Health Access for Young Children program as the beginning point to take action towards providing oral health preventative services to meet the needs of children and their families in the health district.” NCDHD

In continued partnership, SHDHD and CCC are going ahead to pilot a program that will provide sealants in 2 elementary schools this year, using funding and supplies secured by the hygiene program.” SHDHD

“We have been able to secure funding to continue and expand our program through DHHS MCH funding and are looking forward to continuing to provide and grow this program for the next two years.” TRPHD

“The enhanced community partnerships, collaboration, and public health exposure continue to facilitate an increased awareness and importance of dental health among community partners and participants.” LLCHD

Missed Connections:

Although OHAYC partnerships built community-level infrastructure, strengthened working relationships and provided needed access to oral health care to children and families across the state, not all of them could be self-sustaining after only a year and a half. From its beginning in January 2011 to the end of funding in August 2012, the OHAYC program built momentum and inspired innovative ideas to increase access to Nebraskans in need of oral care. Here are some examples of the impact of the loss of funding on a growing program:

“The project was just beginning to become established locally.” CDHD

“We are sorry to see it end, as we feel we were making an impact on reducing ECC.” ECDHD

“Chadron Job Corp was very interested... but we were not able to serve them... In our last proposal, which was not funded... we had an overwhelming interest from area schools ...” PPHD

“This program offered a much needed service to these families. Inroads were made... we fear that many will again go without needed oral health education and services.” FCHD

“Inroads were made... we fear that many will again go without needed oral health education and services.” FCHD
Conclusion

Recommendations
The Oral Health Access for Young Children program provided needed oral health care to children and families in Nebraska through the committed work of state, local and community-level partners. Based on lessons learned through the implementation of OHAYC, future versions of the program could benefit from:

A Simplified Reporting System
Recommend quarterly rather than monthly reporting.

A Formalized Communication Plan
Recommend a quarterly conference call at minimum.

Expanded Services and Partnerships
Recommend adding sealants to program services and expanding to additional community settings.

Opportunities
The OHAYC program did more than provide oral health screening, care and referrals to thousands of children across Nebraska. It also sheds a light on some of the significant needs of families struggling to access oral health care and services in our state.

Need for Increased Oral Health Education
Local programs reported that many parents were not aware of some very basic oral health concepts or of the importance of prevention. Increasing oral health knowledge, influencing beliefs about oral health, and equipping parents and guardians to establish preventive oral health habits in the home should be a priority of community-based public health programs.

Need Increased Cultural Competence in Oral Health Care and Oral Health Literacy
Efforts should be made to minimize the social barriers that reduce access to oral health care in the community. These barriers include differences between patients and providers in language, literacy, customs, and/or beliefs that result in underutilization of available services and poor oral health.

Need for More Accessible Oral Health Providers and Programs
While oral health providers and programs exist across the state, they can be inaccessible for some families due to distance, inadequate insurance, or limited availability. These barriers can be addressed by the OHAYC model of building community infrastructure, developing interdisciplinary partnerships, and increasing opportunities for community-level oral health care.

“Coordination of a strong state-based public health program is critical to achieve optimal oral health, especially to those underserved.” CDHD

“We can make a big impact with very little monetary cost.” PTN
Appendix A – Oral Health Access for Young Children Model

Oral Health Access for Young Children Program Model
January 2011-August 2012

Key:
- PHRDH: Public Health Registered Dental Hygienist
- WIC: Women, Infants, and Children
- CC: Child Care Center
- HS: Head Start Center
- Interpreters
- Program Coordinators
- Assistants
- Supplies

Distribution of Local Partners

Grant #T12HP14997
Appendix B – OHAYC Forms

Dental Screening Form

Pediatric Oral Health Screening Form

Preschool/Head Start Setting

| Patient Name: |
| Screen Date: | Site: |
| Therapist’s Initials: | Age: |
| Race/Ethnicity: |
  - White/Caucasian
  - Asian
  - Hispanic/Latino
  - American Indian/Alaskan Native
  - African American/Black
  - Other
| DMF: |
  - # of Teeth
  - # of Decayed Surfaces
  - # of Filled Surfaces
| RIGHT |

Treatment Urgency: Early Childhood Caries: White Lesions: Gingival Health:
- No Obvious Problems
- Early Dental Care
- Urgent Care
- No ECC
- ECC
- S-ECC
- No
- Yes
- Healthy
- Not Healthy

Treatment:
- Iodine
- Fluoride Varnish
- Exam
- No
- Yes
- No
- Yes
- No
- Yes
- No
- Yes

Comments:

ECC = One or more decayed, missing (due to caries) or filled surfaces in any primary tooth in a child 71 months of age or younger.
S-ECC = Any sign of smooth-surface caries is considered severe early childhood caries in children younger than 3 years of age.

Date: Therapist’s Initials: Age: Treatment: Gingival Health: Treatment Urgency: Recommended TX Completed: Note Sent Home:
- Iodine
- Exam
- Fluoride Varnish
- Healthy
- Not Healthy
- No Obvious Problems
- Early Dental Care
- Urgent Care
- No
- Yes
- In Progress

Comments:

Date: Therapist’s Initials: Age: Treatment: Gingival Health: Treatment Urgency: Recommended TX Completed: Note Sent Home:
- Iodine
- Exam
- Fluoride Varnish
- Healthy
- Not Healthy
- No Obvious Problems
- Early Dental Care
- Urgent Care
- No
- Yes
- In Progress

Comments:

Date: Therapist’s Initials: Age: Treatment: Gingival Health: Treatment Urgency: Recommended TX Completed: Note Sent Home:
- Iodine
- Exam
- Fluoride Varnish
- Healthy
- Not Healthy
- No Obvious Problems
- Early Dental Care
- Urgent Care
- No
- Yes
- In Progress

Comments:

This publication was made possible by Grant Number 125-MH14597 from Health Resources and Services Administration (HRSA).
## Monthly Report Form

### Oral Health Access for Young Children
#### Monthly Report

**Directions:** Please complete this report and submit it to Nebraska Office of Oral Health and Dentistry, dhhs.oralhealth@nebraska.gov or 402-471-6446 (fax) on the 1st of each month. For WIC programs, use one form for each program location.

**Date:**

**Name of person completing report:**

**Organization name:**

**Monthly Summary Report:** Please calculate data from the program log and list monthly totals below:

<table>
<thead>
<tr>
<th>Location of Program:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Circle one:</td>
<td>WIC</td>
</tr>
</tbody>
</table>

List all dates the program was offered this month and available treatment hours for each day (example: January 31 (5 hours); February 7 (6 hours):

<table>
<thead>
<tr>
<th>Date</th>
<th>Treatment Hours</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

**Number of pediatric patients seen by age range at this location this month:**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td></td>
</tr>
<tr>
<td>2-3</td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>6-8</td>
<td></td>
</tr>
<tr>
<td>9-13</td>
<td></td>
</tr>
</tbody>
</table>

**Total number patients age 14 and over seen at this location this month:**

**Total number of fluoride varnish treatments given at this location this month:**

**Comments or Notes:**

---

This publication was made possible by Grant Number T32HP14997 from Health Resources and Services Administration (HRSA).
Annual Report Form

Oral Health Access for Young Children Annual Report
September 1, 2011-August 31, 2012

Directions: Please complete this report and submit it to Nebraska Office of Oral Health and Dentistry, dhhs.oralhealth@nebraska.gov or 402-471-6446 (fax) at the end of the grant period. Please use one form for each program location.

Date: ______________________
Name of person completing report: ______________________
Organization name: ______________________

Annual Summary Report: Please calculate data from the program log and list end-of-the-year totals below:

Location of Program: ______________________

Circle one: WIC  Head Start  Early Head Start  Preschool/Child care

Number of pediatric patients seen by age range:

- 0-1
- 2-3
- 4-5
- 6-8
- 9-13

Total number of pediatric patients seen at this location: ___________
Total number of adult patients seen at this location: ___________
Total number of fluoride varnish treatments given at this location: ___________

Total number of initial patient visits: ___________
Total number of second patient visits: ___________
Total number of third patient visits: ___________
Total number of fourth patient visits: ___________

Comments: ______________________

This publication was made possible by Grant Number T02HP14497 from Health Resources and Services Administration (HRSA) .
Parent Satisfaction Survey

Oral Health Access for Young Children Parent/Guardian Survey

Instructions: Select (x) one response for each question.

1. How confident are you that you can prevent cavities in your child’s teeth?
   - Very confident
   - Confident
   - Neutral
   - Not Confident
   - Not at all confident

2. How would you rate your overall level of satisfaction with the service you and your child received?
   - Very satisfied
   - Satisfied
   - Neutral
   - Dissatisfied
   - Very Dissatisfied

3. How likely are you to refer others to this program?
   - Likely
   - Unlikely
   - I have already referred others to this program

4. Ages of children seen today. (List Ages) __________________________

5. Do you take your children to a dentist?  □ Yes  □ No  □ Not All Children (Specify) __________________________

6. Do you take your children to the same dentist for return visits?  □ Yes  □ No  □ Not All (Specify)

This publication was made possible by Grant Number 1U2HP14997 from Health Resources and Services Administration (HRSA)

Encuesta para los Padres/Guardianes de Niños con Acceso a Salud Oral

Instrucciones: Marque cada respuesta con una (x).

1. ¿Qué tan seguro está usted de que puede prevenir las caries en los dientes de su niño?
   - Muy Seguro
   - Seguro
   - Neutral
   - Inseguro
   - Muy Inseguro

2. ¿Cómo calificaría su nivel de satisfacción con el servicio que usted y su niño recibieron?
   - Muy Satisfecho
   - Satisfecho
   - Neutral
   - Insatisfecho
   - Muy Insatisfecho

3. ¿Cuál es la posibilidad de que usted refiera a otra persona a este programa?
   - Probable
   - Improbable
   - Ya he referido a otra persona a este programa

Esta parte es llenada por los miembros del equipo dental

4. Edades de los niños visitados hoy. (Liste las edades) __________________________

5. ¿Lleva usted a sus niños al dentista?  □ Sí  □ No  □ No Todos (Especifique) __________________________

6. ¿Lleva usted a sus niños al mismo dentista para todas las visitas?  □ Sí  □ No  □ No Todas (Especifique)

Esta publicación fue posible gracias al Numero de Subvención 1U2HP14997 de parte de Health Resources and Services Administration (HRSA)
References


