

MCHB/DCAFH March, 2009 Webcast

Accessing Oral Healthcare through WIC

March 10, 2009

PAMELLA VODICKA: Hello, you thank for joining us. I'm the moderator, Pamella Vodicka here at the Maternal and Child Health Bureau oral health program. Before we get started I'll quickly go through some housekeeping rules and then we'll move on to introducing the speakers and move then right into the speakers because we have a lot to share with you today. For housekeeping, the slides will appear in the central window and should advance automatically. They're synchronized with the speaker's presentation. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window.

We encourage you to ask the speakers questions at any time during the presentation. You simply type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you are participating from. The questions will be relayed on to the speakers periodically throughout this broadcast. I'll correct that we're going to hold all questions to the end because of the length of the presentation. We want to make sure you hear the entire presentation. If questions are asked and aren't given answers to at the end of the presentation, know that you'll receive all answers in the archived piece. If we don't have any opportunity to respond during the broadcast as noted, you'll be emailed afterwards. We encourage you to submit questions at any time during the broadcast and I'll ask when you submit your questions when we have several speakers indicate the speaker you wish the question to go to, that would be kind.

On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider accessing by clicking on the loudspeaker icon.

The interface will close automatically and you'll have the opportunity to fill out an online evaluation. Take a couple minutes to do so. Your response will help us to plan future broadcasts in this series and improving our technical support. I'll note this will be an archived presentation. Any questions asked not answered during the presentation answers will be available in the archived version. Welcome to "Accessing Oral Healthcare through WIC." The speakers for today include Patti Mitchell, a senior program analyst food and nutrition services from Alexandria, Virginia, Wynne Grossman, the director of the Dental Health Foundation. Next is Ed Martinez. Then is Linda Franklin, the WIC program director at the Alameda County WIC program in Oakland, California. Jared Fine the dental health administrator from the Alameda Public Health Department and concluding will be Nicholas Mosca the director of oral health from Jackson, Mississippi. I'll turn over the presentation to Patti who will do an opening statement on behalf of WIC followed by Wynne who make her presentation.

PATTI MITCHELL: We administer the WIC program at the federal level. I would like to thank Pam for inviting me to provide opening remarks today. WIC agencies around the country are keenly aware of the devastating effects that poor oral health can have on low income children. One of the biggest problems facing our local WIC agencies and clinics are finding dentists and oral healthcare programs to refer WIC participants. The projects you'll hear about today offer some examples of how WIC and the dental community can work together to ensure that low income children and pregnant women receive necessary dental services. I would like to take a few minutes to provide a little background on WIC.

WIC programs supplemental food, nutrition education and referrals to social and healthcare services. Our target population is low income, pregnant, breastfeeding and postpartum women, infants and children up to age five at nutritional risk. WIC serves as well as good healthcare to help prevent the occurrence of health problems and improve the health status. As an adjunct to health services their role in education and referral is to support existing funded health services. Indeed, the WIC program's role in preventing oral health problems in women, infants and children is through the education and referral programs. Depending on local priorities, WIC local agencies may provide nutrition counseling and classes to parents and guardians of infants and children on proper care of the gums and teeth at home and feeding practices that reduce the risk of developing early childhood caries, many WIC programs have developed training modules and other oral health resources. Many local agencies have improved the links between participants and the local dental community through referral and networking. Some WIC programs have collaborated with the local dental community to come in and provide dental screenings and fluoride varnish in a WIC setting. You will hear about one such program today. To know about when working with WIC. State WIC agencies have broad discretion over program implementation within the regulations established by USDA. A great deal of variation exists among states and specific program characteristics as well as local priorities. There are a couple things that you can do when working with -- when the two programs come together to provide services and I think you'll hear about some of those today as one of the things that impressed me about when I read these presentations. Communicate on a regular basis between the programs. Develop key messages on nutrition education and breastfeeding that relate to oral health that are evidence-based and consistent between the programs. Seek some practical solutions to issues such as staffing and space and time management. And priorities. Develop formal agreements between the programs and most of all understand the value of each program.

Finally, as I mentioned before, as an adjunct to health services the WIC program's role in education and referral is to support existing funded health services. And that means that WIC's funds are limited to its mission of education and referral. And because I've gotten a couple questions about this WIC funds cannot pay for dental screenings or varnishes or dental hygienists or oral healthcare. That's what you'll hear about today some more.

Thank you for inviting me to participate. I'll sit back and enjoy the rest of the presentations with you. I would like to turn it over to Wynne Grossman the executive director of the Dental Health Foundation.

WYNNE GROSSMAN: I'm Wynne Grossman. We're a California-based organization. You'll see that I have my website up there so there is more information about the program on the website. Right now I would like to give you a little bit of background about how we started providing dental visits at WIC sites.

Next slide. As I mentioned, the Dental Health Foundation is a state-wide organization and we partner with lots of other organizations throughout the state.

Next slide. One of our biggest programs, which started in 2004, was called the first smiles program. This was a statewide initiative that was really designed as a workforce initiative to provide training and education to dentists, to physicians, to other oral healthcare providers and to early childhood caregivers about the prevention of dental decay in children 0 to 5.

Next slide. As part of this program, we developed a core curriculum with the advice of a scientific advisory committee. That committee was chaired by Jared Fine, who you'll hear

from shortly. The curriculum was adapted to various lengths and formats ranging from a full day to one hour and developed a consumer brochure using key messages from the curriculum that was called healthy teeth begin at birth available in ten languages and distributed widely throughout the state.

Next slide. One of our key partners in the first smiles program was the California WIC association. They assisted us in adapting the core curriculum to meet the needs of WIC agencies and also provided training for WIC staff at regional and statewide meetings. Additionally we developed a mini grant program for the WIC agencies that were most interested in oral health. These agencies agreed to train parents using the curriculum and distribute evaluation forms to determine changes in parent and caregiver knowledge. And the Alameda County WIC program was one of the agencies that received these mini grants.

Next slide. In 2007, HRSA, through the targeted oral health systems program, came out with a program announcement in which they really wanted us to focus on getting at-risk children one year old to have dental visits. In California, we knew that despite training over 15,000 dentists in our first smile program, that it was going to be really, really difficult to get California dentists to see significant numbers of low income, high risk, 1-year-olds. Was nothing -- we could just not think of a strategy that was going to increase number of private dentists that were going to see these children. However, because we had this relationship with WIC that was built through the first smiles program, we realized we could potentially serve these same children through WIC and that WIC had actually served as the entry point for dental care for large numbers of low income babies.

Next slide. For those of you who are not familiar with WIC in California, California has the largest WIC program in the country serving over 1.4 million participants through 82 agencies in over 600 centers. Most of the children in WIC are either eligible for our Medicaid program, which is called Medi-Cal or eligible for enrollment in the program. This means that the dental providers who are part of the dental portion of the Medicaid program and in California we call that Denti-Cal can actually bill for services. There are two ways that you can bill for services. One is fee-for-service and in California you can bill for a dental exam, a toothbrush or a fluoride varnish application and the second way is to federally qualified health center. If WIC falls under their scope of service they can bill their encounter rate for conducting a dental visit. Ed Martinez will go through that in more detail.

Next. So what we tried to do is develop a learning collaborative with numbers of partnerships between WIC and dental providers as part of our grant. Our purpose was to increase the number of at-risk 1-year-olds receiving preventative dental services and wanted to increase caregiver knowledge about early preventive care and we wanted to develop and implement system to have WIC serve as an entry point for dental care. As part of the collaborative process the Dental Health Foundation provides two yearly meetings in which we share materials and best practices and find we're codifying the learnings that all of the sites are doing. And we're also providing technical assistance on program startup, billing and also how to receive matching federal funds. We've also developed software for tracking results and will have an evaluation component.

Next. I just want to say a couple words about our software, which we call the Healthy Teeth Toolkit. This is designed to manage information for essentially public health programs serving children either at WIC sites or in schools. And it's really for the delivery of preventive dental treatment to children and also to help case manage the families so

that they can receive restorative dental care. It also helps you track results over time. It is a web-based system that's accessible via a browser.

Next. And very briefly, it contains two essential segments. One is service and on this screen you can see this is the service record, which allows you to put in the various services you're providing to the child. So it could be for a varnish, sealants, the oral health assessment, etc. Next. The other portion of it is really case management. And the case management side documents through chronological records personal contacts with the client family. So that you can view the whole case history at a glance. It will tell you who made the contact, when the contacts were made, how the contacts were made, the substance of the contacts and also the results, what happened. Did the child actually go in and have a visit.

Next slide. The dental providers were required to provide caregiver education, so parent education, either an exam or assessment. That really depended on who provided it. If it's a dentist exam, if it's a hygienist. A risk assessment is very brief. The children in WIC are typically high risk. A fluoride varnish application, a toothbrush PROFI. If we see children who need care they refer them into care.

Next slide. The way that we've designed this whole grant program, it is a four-year program, is that the first year we have a benchmark site and that's San Ysidro. We have two pilot sites. One is in Alameda County and the other is Humboldt County. In the future years we're adding three more sites a year and I'll tell you something about both of those. Now, in California, we're a very, very large state. And so no model is going to work in every place. And the reason that we are bringing in Alameda County and San Ysidro today is to tell you how two very different models work. And I'm going to turn this over now

to Ed Martinez so he can talk about what they do in San Ysidro Health Center. It was chosen as our bunch mark because they were the first organization to actually provide the dental visits at WIC and this is the site that we first learned from. Next and over to you, Ed.

ED MARTINEZ: Thank you, it's pleasure to be part of the program today and tell you a little bit about San Ysidro Health Center's activity in terms of integrating oral health with programs. Just as background, I've been with the health center since 1998. The health center is a large federally qualified health center located in south San Diego county along the border, probably about 90% of our patients are of Latino descent. Since the beginning of the health center in 1969, we've had a comprehensive mix of services to offer our community, which included oral health, WIC programs, primary care and behavioral services.

If we go to slide number one, please. I just wanted to start out by talking about the organizational readiness of our health center in terms of implementing the integration approach to the program that we're speaking of today. And the first slide I have shows that about a year and a half after I arrived at the health center, it was obvious to me in talking to some of our primary dental staff that there was a great need in our community in the area of early childhood caries. And I had worked several years before arriving here with Dr. Francisco Gomez at the UCLA dental school and looking at ways of doing a community survey of the incidence -- prevalence of early childhood caries and I went to our board and asked them for the budget to develop a community survey. Our board was very interested in this topic and approved a scientifically designed study that surveyed -- it was 2000 children. It was done in the year 2000. We sent our dentists out into the community and surveyed the children 0 to 5, preschool age children and head start and local schools and found that 69% of the children surveyed had untreated dental disease.

The findings were quite astounding. There were children participating in the programs up to ten or more cavities and there were -- they were not being treated and they were still in school and there was no real treatment program that was designed to screen and refer them to treatment. Obviously our board of trustees for the health center was very committed to oral health because they were aware of the problem in the community. As a requirement for a federally qualified health center, we're required to have at least 51% of our board as consumer representatives. Many of the board members had friends or, you know, relatives had experienced this problem in the community. Our management team was also very committed to the concept of integrating oral health services with our WIC program. The program from the medical side as well as the oral health side and the WIC program. Our adult director played a key role in being a champion for this integration initiative. He had the very good relationships with the WIC program managers as well as the dental team and our support staff.

If we go to slide number two, please. This illustrates sort of the organization and the magnitude of our programs both in dental and WIC services. We currently have four dental clinics combined they offer 26 fully staffed dental offices. We have three full-time pediatric dentists as well as three general dentists that see probably at least 30 to 40% of children in their own practices. So we have a total of six dentists that are very interested and involved in treating infants and children. Our dental program in terms of registered patients 0 to 5 by 7,300 patients. Total count of our registered patients, mental health, dental, primary care is 67,000 patients now. In terms of dental screenings in local schools, five elementary schools that we work with very closely here in the southern part of San Diego County, this last year the numbers for 2008 we screened just over 7,200 children. A very busy outreach program that our dental program manages each year. In terms of our WIC programs we have four WIC centers throughout the area with a staffing of 23 full-time

equivalents. Registered dietitians, four are degreed. In terms of patients or users for the WIC program we have 3700 women, 7,000 children and just over 3,000 infants. It's a very large program.

Next slide, please. Slide three. It shows the corporate structure of abbreviated version of it but under the clinical services the dental and WIC are two of the key components and organizationally I have a chief operating officer who oversees the activities of both the dental program as well as the WIC program. And he has an experience -- he and I both worked in Las Vegas, Nevada, years ago and were very involved in working with the private dental community in developing our oral health services for the homeless population. So we're very much committed to the concept of integration and improving the level of service in the community between the dental program as well as the WIC program.

The next slide, please. Just a little bit about the barriers that we experienced when we first started on the initiative to integrate our two services. This goes back probably to early 2000. Is that prior to my arrival at the health center there really wasn't much of an interest or emphasis by the management on two areas of integration or care coordination. My experience in Las Vegas really emphasized our sort of -- made it very obvious that the concept of integration when you have programs that you work with are key in terms of the quality of care. So without a management emphasis on integration or coordination of care, it is no mystery that the WIC program historically was doing a wonderful job in delivering their services as the WIC program at the state and the regional level had sort of identified and they had not really been given the opportunity or been involved in any discussions on -- prior to the year 2000 in terms of the integration. So you had to some extent at our center and our center is unique, but our dental program and the WIC program really are

operating in different sort of silos. They were not encouraged to integrate their programs so because of that, there was an absence of a care model to really operationalize the concept of integration. It wasn't really spelled out. There was no sort of educational effort or discussion about the importance of doing this or how to go about doing it. In addition there wasn't any real methodology or strategy for case finding children or infants that could take advantage of the initiative to integrate the two programs.

Next slide, please. The care model that our dental and WIC program developed here in San Ysidro is based on the importance of integrating all of our services as well care as coordination. In terms of case finding strategies, we -- like I said earlier in 2008 there were just over 7,000 children in our local schools that were screened and many of them referred on to our dental clinics if treatment was required. The leadership of our dental director and the manager of our WIC program was have you instrumental. They were both committed to the concept of integration and worked collaboratively in working with management in terms of making the support systems to make it happen. Screenings, protocols, referral protocols and recall strategies weren't in place at the time. The director and the program manager were able to identify those and as the administrator, I found them very innovative and very easy to approve and get the corporation to support them. The primary care dentists were the key to the screening not just in the schools but the WIC centers that the health center operates.

This next slide illustrates our early approach to providing the screening service in the WIC centers. At the time we were using a portable dental chair. It started out a half day a week with screenings. The dental assistant as well as a WIC employee would encourage the parents waiting in the waiting room to take advantage of the screening program and many of the parents did. And that's initially how it started out. We no longer use a portable dental

chair. It's a knee to knee examination by the dentist and the mother holding the child with just some typical -- chairs that are available in the WIC center.

The next slide, please. This slide talks to the exporting or the importing of innovations or new technology and how to facilitate that process. The leadership of the health center as well as the clinical departments really have to be champions for this and have to want to make it happen and they have to encourage the staff in terms of strategies for doing it and develop strategies for patients such as our health center. The concept of integration has to be explained in a way that it fits within the mission of the institution. Our mission has always been to provide the highest quality of care and care coordinate the services between our departments. And it also had to be demonstrated in a way that by expanding the services within the community for outreach as well as within the WIC centers, we had to demonstrate to our board it was financially feasible and possible to do. Developing a business plan for the concept of the integration. And for all the employees in the dental program, the screening program as well as the WIC program, it had to make sense on a day-to-day basis in terms of how it was set up and how the mechanics of the activity would take place.

Next slide, please. In terms of reimbursement, it's based on a face-to-face visit or contact with a licensed dentist as a federally qualified health center we're required to have providers -- services are required to be done by a licensed physician, dentist, psychologist, psychiatrist, nurse practitioner or physician's assistant. If the dentist was the person that provided the screening within the WIC center, it involved a screening, education, information for the parent or caregiver and a preventive fluoride treatment. Children that required treatment were referred to one of our four dental clinics for follow-up care. Next slide, please. In the year 2008, we screened just over 3,324 children at our four WIC sites

and out of that population we found that 38% were covered by Medicare. The multi-families program, the California SCHIP program. And 60% of the parents reported initially that they did not have dental coverage at the time. In the 2008 number is a anomaly. Prior years we were able to at a higher rate than this but in 2008 the state Medicaid program instituted some additional paperwork requirements related to HIPAA that required and it was more difficult to access the information on their health coverage. In 2009 our program anticipates that the number of children with coverage can go up to at least 70%. It's a major increase over 2008.

The next slide, please. Lessons learned.

>> This is Pam. Can you either speak louder or more direct into your phone, please?

>> I'm sorry. On slide number 10 the lessons learned by our health center is that the board commitment is absolutely essential in approving an encouraging the instillation of the integration program. Involvement of the top management of the WIC and dental program is also key. We have dental blueprints which are really operating programs or statements that are quantifiably measured in terms of expectations on a quarterly basis for the implementation of the different activities that make up the integration process. Clinical support services are also very important in terms of facilitating the participation by children and their families such as case management services, a centralized call Center for appointments and follow-up and transportation for families that don't have transportation to the screening programs. Then the cooperation and support of the WIC personnel is also key in that it requires not just the dental program and key management staff to get behind the program and continue to monitor it and provide services and support when any kind of

additional challenge arises. So that concludes my presentation on our experiences here at San Ysidro Health Center.

LINDA FRANKLIN: Hello, I'm Linda Franklin, the WIC director at Alameda County and I appreciate the opportunity to share some of the history of the collaboration between WIC and the Office of dental health and our Public Health Department. We've had a long history of working together. Initially primarily with the dental team providing staff training and coaching and expanding resources for client referrals as Wynne said finding a dental home for clients has been difficult especially for very young children. The oral health messages are very important part of parent education that WIC provides to parents of young children. Alameda County is a diverse and urban county. We've got 1.4 million residents. For our initial site for dental days at WIC we chose our busiest clinic. It serves over 8,500 clients a month, has very strong management, bilingual staff and the clients tend to keep their group appointments. We wanted this around a group session it seemed like the way the start. The clients at that center are predominantly Hispanic, 67%. 12% black, 8% white, 8% Asian. Most families 54% speak English but there is a large Spanish-speaking population. Most of the families are very low income, 67% appear to receive Medi-Cal. We do have a large portion of working families there who have private insurance. The dental team that's coming to WIC consists of outreach workers and clerical staff, hygienist and the management team is Dr. Fine.

JARED FINE: This is Jared Fine. I'm pleased to participate in sharing our experience. Alameda County is an urban community is relatively resource rich in terms of dental provider services. We have over 1300 private practicing dentists. Only 100 are actually now accepting new Medicaid patients. We have 11 county and community health centers with dental clinics and we have done a lot to facilitate the relationship between patients in

need with getting access to care through case management through augmenting reimbursement where there are gaps in the Medicaid reimbursement system and also in terms of providing some assistance for the children who are uninsured with California and local revenue to support the uninsured children. In addition, we have a history of providing training for dental providers to try to increase their skills to be willing and able and feeling competent to see young children. All that said, we still have an epidemic of dental disease in young children. A quarter of the kindergartners have cavities and one-third of all kindergartners have been demonstrated in our most recent survey to have untreated dental decay which leads to the need for us to go further upstream, the opportunity that WIC provides. Next slide.

>> So the grant from the Dental Health Foundation, the HRSA grant, really just provided a little seed money to get us together and do something that we had wanted to do for a long time so the management team from both programs met and figured out how to create a new function with really no additional funding. We needed buy-in from both teams, space for the services and supplies were needed to promote it to the clients. We didn't know initially how well it would be received and each program had to become familiar with the other program's staffing capacity and procedures. To prepare the WIC staff and the clients really for the launch that we planned in Hayward, we proceeded that with oral health being the quarterly nutrition lesson provided to all clients at all sites. We kicked off with a full day of staff training that was provided by the dental health staff. And WIC staff got to practice the lesson, meet the dental staff, ask their questions. They got T-shirts and posters, toothbrushes for their offices and tried out the fluoride varnish on each other. That started to get WIC staff comfortable with the key messages and focused on the dental concerns. We needed to pick a date that both teams would be able to staff up in the Hayward staff -- in the Hayward site and WIC's schedule is set three months in advance. We began

scheduling clients in April for a July launch. The Hayward team received additional training from the dental team and the office there has weekly site meetings. During the launch month both teams met during site meetings. The clinical staff, the dental staff were able to model client education and we continued to tweak the lesson. The dental department had quite a bit to do to prepare. They had roles and protocols to figure out, plan the operations, record keeping, educational materials, consent forms, clinical encounter and plan the case management. And the hygienist needed to be trained to work with very young children. We needed to plan the evaluation process evaluation, the client satisfaction and data to show success.

The next slide, please. When we started scheduling the WIC client we knew we wanted to get this off to a successful start. We were able to adapt materials that were provided by the Dental Health Foundation's advisory meeting from the Humboldt WIC site. We adapted a flyer for clients and a book mark we gave to clients to explain the dental appointment when it was scheduled. We made reminder calls for this particular appointment that were different than our automated reminder calls and we had to set coding for our automated nutrition education history. And then to get a good number of clients initially scheduled we also ran a query of our database for children who were the right age to be scheduled and had an intern flag those client records to remind staff to schedule the dental appointment. This helped the staff get in sync and we don't find that it's necessary now to keep the dental appointments fully booked.

Next slide. On a dental day at WIC, the WIC staff do what they usually do. They educate the parents of young children. We're scheduling babies age -- parents of babies age 9 months to 15 months on oral health. They use a standardized script and flip chart that was developed by the dental health staff. We have enough copies of the flip chart so clients

can read along and look at the pictures while the class is going on. Then after the class message, the clients are offered the dental services and they have an opportunity to complete their consent forms and fill out contact information.

>> The dental staff then proceed doing what they do, which is to provide dental assessments, in this case a dental hygienist is conducting the assessment. Provide guidance, a toothbrush PROFI. Fluoride varnish. Work with the caregiver on goal setting to help the families identify behaviorally and nutritionally to support the health of the young child. When they don't have a dentist we identify a dentist and determine the process of what eligibility they might have, Medicaid or other. The contact information that was collected during the group education session is continued so that we can actually have good contact information for the case management process that will follow after the dental day itself.

>> We thought that families are appreciative of the services. We launched in the summer and we found parents even going back home to bring back older children for the next class because they had kids at home they knew needed dental services. We find that families are willing to wait longer than normal for the WIC appointment because they value the service they're receiving. Next slide.

>> The case management process, which is really started by developing a relationship with the families during the group education has continued after the clinical encounter. We collect the rest of the contact information from the findings. Provide them the findings of the assessment and make the determination regarding insurance and whatever is needed for referral to dental care. We actually complete the case management process for those children that we want to follow up on. The Office of dental health by telephone and

appointments are actually made for the family at a dental provider. Beyond that we continue an evaluation process of collecting client satisfaction information from each client who attends on the day of their visit. We have staff debriefings every week. We have staff updates and we're looking at the data we collect in terms of age, Medi-Cal enrollment. The numbers of children who are experiencing dental disease and, of course, the numbers of children who are attending the program.

Next slide. On this slide you'll see the results of the first seven months of work in which we schedule basically one day per week starting in July. Of the targeted group of 9 to 15 month olds we were able to reach 40% in that age group. Parents often brought other children and we made a policy decision that we wanted to include the other children in accessing the service as well so we actually had more children than there were parents and so those siblings were also able to get the care. Of those who were in attendance, almost 60% were enrolled in the Medicaid program. We believe that's conservative in terms of eligibility. That's one of the things we'll be doing in terms of making sure everyone is enrolled who is eligible. That's important because ultimately we want to be able to generate a revenue stream to sustain the project based on at the very least fee-for-service revenue from Medicaid or FQHC. In those first 28 days of service, we projected over \$12,000 in revenue and that amounts to \$435 per session or 22 children seen on any particular day.

Next slide. Want of the things that we're interested in is whether or not we're reaching the very population with the greatest need and as you see in this slide, in the group of 9 to 15-month-olds, 17% of them, including white spot lesions they had evidence of the decay process. 59% of them had decay. The group of 6 to 19 years it was all the way up to 74%.

Clearly going upstream and getting to these families and children earlier is critical to our ability to address the prevalence of dental disease.

Next slide. Of course we're concerned about sustainability as was pointed out, the funding from HRSA was more of a catalyst than actual operational funding providing for some relatively few materials and supplies and actually helps us to initiate the process. The funding for the project as we've described it comes from many sources. Our case management is funded through local tobacco tax dollars. The dentist's services are paid for a combination of Medicaid or Medi-Cal or the tobacco funds used for services to children. The program planning and management is coming from a combination of state general fund dollars for dental disease prevention, matched with federal Maternal and Child Health federal financial participation funding. Next slide.

>> The Hayward office we're currently operating just one morning a week. So it's two class sessions. And we know that we're not hitting all of the families who want the services who are located at that site. And then we have two other large sites and one satellite that also would like to have dental services at their locations as well. So we know we need to ramp up. To fund additional clinician time we're considering partnerships with co-located clinics or using the Medicaid revenue to sustain clinicians hired by the Public Health Department or at a clinic. We want to increase the Medicaid enrollment. We realize that many families have Medi-Cal for their infants may not have completed all the paperwork. Since we're scheduling two to three months in advance for these appointments we have time to work with the public health nursing partners and other folks to make sure that folks who are eligible for the Medicaid Medi-Cal can get signed up so that the revenue generation will work. There is also additional funds -- matching funds that may be available through what we in California call Medi-Cal administrative activities and to

expand to additional sites and days of service we'll need the same kind of planning we did for the first site but our model and procedures are in place so we think we'll be ready to launch another site this summer. And that we'll be expanding the size of the number of classes, the number of clients who are served in the Hayward site as well. So I think that wraps up the Alameda County portion of the presentation.

>> Okay. This is Wynne Grossman again. We're on the slide other models used in California. As I mentioned earlier, we were presenting two models that were used early in this project. There are two models in fairly urban areas. I want to go quickly over a couple models that we're using in very rural areas.

Next slide. The first one I'm going to talk about is Humboldt County, which you heard Linda mention.

Next slide. Humboldt is a rural county that is located in the far north of the state. It has about 126,000 residents in an area that's about the size of Rhode Island. It is a dental health professional shortage area and it has a high overall poverty rate. It's about 18% overall with 24% of the children 0 to 17 living in poverty.

Next slide. Like Alameda County, the health department is organized so WIC and the oral health programs are both co-located under the MCH division. But because this is such a shortage area, there really aren't dental professionals that are either hired by the county or available to work in public health settings. So in the case of Humboldt County, they decided to use public health nurses. When we were first doing the first smile program Dr. Gomez had gone to Humboldt County and done a two-day training for public health

nurses teaching them how to do an infant oral care visit. When we started this program, we did another two-day training for the public health nurses, this time it was hands-on where they actually were working with the babies to get them comfortable in providing the dental visit.

Next slide. The dental visits are provided at the WIC site but they are very widely publicized all over the county. So there are flyers that are put up in WIC but they're also put up in farmers markets. Grocery stores, houses of worship and they have television commercials that they've developed, which we'll try to put into the archive version as well so you can see what they're like. The WIC participants who are coming for the dental appointments actually do make an appointment. Caseworkers set those appointments up at the WIC center. Reminder calls are made to them two days before the appointment. When they get there, parents sign a permission slip that also includes questions and answers about the visit and what to expect.

Next slide. The public health nurses actually conduct the entire dental visit so they do an oral health assessment, they provide fluoride varnish application and also do the education to the parent. There are staff there that if the child does require additional -- does have additional needs, then they are referred to one of two local dental clinics in the area. Parents are also asked to sign a contract, this was designed again by Dr. Gomez that encourages parents to improve the oral health of their children.

Next slide you'll see a picture of what the contract looks like and one of the public health nurses will actually circle the -- some of the areas in here to tell the parents what to concentrate on. So it might be regular dental visits or no bottle for sleeping. They'll circle a few of those.

Next slide. The next place that I would like to talk about is Amador and Calaveras counties. They're so rural there are no WIC -- WIC days are social event and provided at grange halls, fire stations and other municipal buildings.

Next slide. It's really important that there is prevention activities going on in both those counties because they're very, very few dental providers and as far as I know, no dental providers who will accept Denti-Cal or other public insurance. However, they're very lucky in those counties. In California we have registered dental hygienists in alternative practice. It is a license, RDHAT and they are allowed to practice independently and they also can bill Denti-Cal for their services. So in this case the RDHDTs are traveling around the county and providing services. There is no need for an appointment for the parents to make an appointment. WIC sets up in one of these grange halls or municipal buildings, they set up stations and oral health is one of the stations along with breastfeeding and nutrition and a variety of other stations. The hygienists looks at the teeth, provides the fluoride treatment and educates the parents at the dental station.

Next. This program, we've been very, very excited about the various models and the results from this program. And we've talked about it quite a bit up and down the state. And we've been very lucky that funders are actually quite interested in this program.

Next slide. We're starting two new projects. We have two new funders that are funding these slightly different levels. We've already started a southern California WIC dental learning collaborative. That's funded by Kaiser Permanente in southern California and we're currently negotiating to do a project with only dental clinics in Los Angeles, California. That could be funded by the Los Angeles county first five commission. We're

hopeful that's going to happen. Last slide just to tell you in southern California, the one funded by Kaiser Permanente, we've got -- we'll have sites probably in Los Angeles, San Bernardino, possibly riverside, KERN county, San Diego and orange county. In conclusion we're very excited and we're excited that funders are actually coming to us and asking us about this project and very interested in continuing to fund it. So I'm going to turn this over to Nick Mosca, the dental director in Mississippi for the concluding remarks.

NICK MOSCA: I'm the caboose, that means very shortly we'll all be going back to our regular routines but we've heard what I think are great ideas. Now, I know I can no longer max out my credit card as a government employee so now what?

Next slide. I wanted to just review some of the facts that I've learned about working with WIC programs and I know that all states receive WIC funding and that the federal government sets conditions for the receipt of this funding. The conditions include certification of people to receive WIC services if they fulfill their eligibility requirement. Nutrition services that are facilitated learning. We aren't passing out brochures but trying to target educational messages to increase the value and the perceptions of health and well-being. And breastfeeding promotion. There is also a food delivery process so that people can get food items to improve their nutrition. Patti also mentioned that WIC makes referrals to Health and Social Services. So I think for state or all health programs our focus will be on education and referral but we've heard some excellent ideas how we can integrate direct preventive services in WIC. Especially in the distribution centers. Where would I start? Well, first I would look at all of the many different locations and states that have WIC services and we've seen in California that there is a lot of opportunity but the logistics of providing these PORTAL for professional services are great. They'll vary geographically, culturally and socio-economically. One thing for states trying to get an

approach is start with a demonstration project or pilot. Select one or two facilities and begin a collaboration. In Mississippi we have 96 WIC distribution centers. We've actually moved over the last six years from somewhat of a passive approach to a more active approach, which I'll explain shortly.

Next slide. I think one key step is to identify resources. I know that California has this wonderful Dental Health Foundation, but there isn't necessarily the same opportunities in every state. So we have to identify resources and the political will to educate WIC clients about oral health and to conduct oral health screenings and hands-on prevention. Some states will be able to identify staff that are able to do these types of activities and some will not. In some states, the use of non-oral health professionals is key. It's a required piece of what they're able to do. Some WIC programs may benefit from having access to oral health staff resources. In those states it's important to identify the clients that have the greatest oral health needs. One tip to do that is to utilize the WIC certification process. In Mississippi, we've added a question to the WIC certification that identifies the usual source of dental services. Another aspect that I learned in this webinar, there is a WIC regulation that requires and educational lesson plan. More specifically during that six month certification period WIC provides at least two nutrition contacts to their clients. That's another potential avenue to expand the oral health messaging as part of that educational contact around nutrition education. So finally on the slide I wanted to point out who would you contact if you don't currently have an intercollaborative relationship? You can go to the WIC state agencies website listed on the slide to search for your state's WIC director and nutrition coordinator and go to the association of state and territorial dental director's website to locate the state dental director in your states.

Next slide. So while California has this incredible Dental Health Foundation, to my knowledge they currently do not have a state -- a full-time state dental director. It's important to realize that things will vary from state to state. Now, the Maternal and Child Health Bureau has also provided some resources for other states and those states have also chosen to do programming with WIC. For example, in Virginia, dental hygienists assigned to WIC programs provide primary oral health prevention and education at WIC program sites. In Connecticut the staff also trains the WIC staff about oral health and they work to increase the number of WIC parents that have a knowledge and understanding of the value of regular professional oral healthcare. With the goal of making these parents advocates for oral health in their communities. Mississippi does not receive any MCH oral health program funding presently. We have received funding in the past and without a Dental Health Foundation, we do things given the resources that are available to us. So one collaborative that we're currently engaged in is that dental hygienists who work for the oral health program go into WIC program sites and provide the second educational nutrition education program within that six-month certification period. This started as a six-county pilot. We had 82 counties in Mississippi. We started with the demonstration pilot. Started small and our hope is that we'll be able to expand this to all 82 counties so our dental hygienists are part of the WIC education team. Beyond California, when you're looking at implementing some type of sustainability for the delivery of dental services through WIC, you need to look at Medicaid reimbursement policies because they will vary from state to state. For example, some state Medicaid programs have dental directors and some do not. Within the Medicaid program. To achieve what California has done through Medicaid you would have to look carefully and review your state Medicaid policies. For example, some states may not reimburse for work performed in a mobile dental van without additional certification of the van as a Medicaid provider site. While most states only reimburse Medicaid dental providers, some states will reimburse physicians such as

North Carolina. Another concern for planning is the scope of practice for dental professionals as directed by state practice acts and regulatory agencies. In Mississippi and Kansas, for example, mobile and portable dental programs must be certified by the state board of dental examiners.

Next slide. This slide summarizes some of the different issues regarding the delivery of oral hygiene services based on supervisory regulations and policies in states. This slide was prepared by the pew health foundation. I'm including it in 45 states general supervision is allowed or permitted in dental offices in some community settings. In those 45 states that means dental hygienists without the direct present of a dentist can go into WIC programs and provide hands-on prevention and education. Now, the states that do not allow that include my home State of Mississippi, Alabama, Georgia, North Carolina and West Virginia. There are also some states that allow reimbursement of hygienists through the Medicaid program. Those states are listed on the slide.

The next slide. Why should we collaborate? I'm a government employee. I know how difficult it is and how limited our resources are but we need to start developing the political will to do this because as has been pointed out, it is a real challenge to get children into direct dental care in many of our communities. Working with WIC is a portal to professional health services for low income populations is based on a prevention strategies that seeks to identify susceptible children and parents and to offer them some individual protection appropriate to their individual needs and to enhance their motivations to become healthy. One goal is to change attitudes by developing alternate ways of understanding oral health via nutritional counseling. The mouth is connected to the digestive tract. And I would think that we would want WIC clients to know how many teeth their children should have just as much as we want them to know how many fingers and

how many toes they have. Another goal is to set conditions in which people can be healthy by providing primary and secondary oral health to the WIC clients. It was eloquently presented by the other speakers today. There is a lot of potential but it is going to be a decision based on access, personnel, supplies, sustainability and the political will.

Next slide. So to summarize some key themes that I heard was that WIC provides a portal for primary prevention services. These can include things from a tooth brushing program to the direct delivery of primary prevention such as a fluoride varnish program. WIC also provides opportunities to educate parents and to do that both through dental professionals and nutritional professionals. It also provides a portal for targeted risk reduction. We can train non-dental health professionals and the goal of these trainings is to target risks identification and to get children that have the highest risk into the services they need given the limitations on access to dental providers in many communities. And another goal is to lower the age so that children are evaluated earlier in their life span shortly after their teeth erupt in their mouth between the ages of six months and one year of age. Finally WIC as part of its role identifies clients' needs and barriers so I would like to point out again that the WIC certification process provides an opportunity to gain a little bit more understanding of the WIC client's needs or more formal needs assessments such as the needs assessments conducted in California or focus groups can be done.

Next slide. So are there any other opportunities that we should be aware of? Well, there is one that is recently -- was recently enacted as law. The state children's health insurance was recently signed into law by president Obama. There are interesting provisions in the legislation you should be aware of. All states now will be required to guarantee dental services as part of their chip insurance plan. Secondly a wraparound benefit means states will be able to provide dental benefits to children whose parents have medical coverage

but no dental coverage. This might help expand access to services. States will also be required to make public a list of covered dental services and a list of participating dentists through a toll-free number and on a website. But the most interesting provision, I think, is that it will also require clinics that provide or support perinatal care to low income children for education materials to parents on the risks of early childhood caries and a dental visit by age one. What a wonderful opportunity to connect between the programs. As was mentioned earlier we want consistent messages based on evidence and research. I do want to applaud the Maternal and Child Health oral health program. They have been instrumental in funneling federal dollars into states and California projects, as was pointed out, were ceded through the grants the targeted oral health systems. The funds are in the second of four years and funding ends in 2011. For states that receive these funds the carpet has been laid for further collaboration. And then the Bureau of health professions most recently has released an RFT for oral health workforce grants due April 1, 2009. There will be one grantee per state. The state governor has to designate who the organization will be that will apply for these funds. Again, there is potential for collaboration. That's all I have to point out as my reaction to these presentations and I appreciate being part of this program.

>> Okay. I would like to thank everyone for calling in and listening. I'm not going to end here. We have a few minutes for questions and we did have only a few questions written in. I understand there were some technical issues and I apologize for that. Recognizing this will be an archived production you'll be able to access it in the archive at mchcom.com. I'll go ahead and field the questions to our speakers and we'll try to recognize them for a clumping. Most of them were directed to Ed, I think because they came in while Ed was speaking but they seem to be applicable to anyone who runs a WIC program. One question came was are the dentists that come to the WIC clinics employed

by the health center? And then a question along with that, I guess in regards to the health center being a funding source how is WIC reimbursed for adapting in the oral health program? I'll send that to Ed and then for anyone else who would like to follow up.

>> Would you like me to answer?

>> Yes, can you please start and if someone would like to speak as well.

>> Yes, the dentists that work for the WIC program are employees of the health center. They're part of the licensed staff of our dental program and we're able to bill the Medicaid program for the services that they render at the WIC centers.

>> It's fair to say the billing reimbursement you get helps offset some of the costs that WIC would encounter for making space and overhead for this?

>> Yes, the reimbursement is based on our core rates for the health center for the clinic that provides the dental support staff. It does help offset the cost.

>> Thank you. And two other questions specific about children receiving services. This is from a head start program. What happens to the uninsured child once referred to the dental services for screening. I guess it's a matter of continuing care to the uninsured child. Anybody want to offer--

>> I could also answer that. We don't turn any children away regardless of their financial status or health coverage. We receive grants -- we receive a grant from the Bureau of Primary Healthcare to fund patients without insurance. Safety net coverage. We also

receive a grant from the State of California for uninsured patients. So regardless of their coverage or their financial status we'll take care of them.

>> You've incorporated that into your funding is the recognition there are uninsured.

>> Yes.

>> That need to be cared for. Okay. And then again it was directed to Ed but it might be for anyone. What percentage of WIC-referred children end up in the clinic dental home within one year? Do we have that data yet since the program has just started?

>> Not yet.

>> Not yet. It's a little too early for that. Then there was one more question. And I think this is more in regards to recognizing that you have dental dentists providing these services this is a question in regard to they only have dentists but they have children that they see are often in need of sedation or operating room services and how do you go about developing a referral program for attaining those services for those children?

>> In Alameda County we've identified sedation services as a gap that we -- for which we've identified local funding. So our case managers are working with the families based on the findings at the time of the assessment or the examination to make sure that we get a child in to a service that does provide sedation. It might be at a community health center, it might be at the -- at our Children's Hospital and it might be in one of our large private practices but we also augment that funding to fill in the gaps where gaps exist.

>> Okay.

>> The health center in April of this year we assumed the ownership and management of the pediatric dental clinic at our Children's Hospital so we're able to refer the children that require that service to that particular clinic.

>> Pam, this is Wynne. I want to point out the primary reason that we started doing these dental visits at WIC for age 1 was to avoid sedation services. We haven't found a 1-year-old yet that needs sedation. We may, but I hope that's pretty few and far between.

>> Right.

>> If we catch them at that age, we've got a shot at avoiding that.

>> Okay. I may have misread this one question. It says within one year. What percentage of WIC-referred children end up in a dental home within one year. Recognizing the program has just started but do you have an idea of maybe even prior to this how well the referring and following up and accessing dental care is with fitting a child within one year of a referral?

>> Our experience, I don't have the hard data. In my conversations with the staff probably 35 to 40% of the children that are referred to one of our clinics actually do present and go through the treatment program.

>> Okay. Then you have ongoing data collection at this time.

>> Right.

>> Great. Okay. Well, that actually concludes the questions that I have. And so I again thank the speakers for their time. I think those who have joined in on the call and the webcast to listen again recognizing this presentation is going to be archived at mchcom.com. You have that slide there in front of you again for logging in and finding it. We'll note in the slides that you receive you have contact information for Dr. Mosca there in Mississippi will be adapting the California slides to include contact information for Wynne Grossman the executive director at Dental Health Foundation but you have their website and can access contact information at that time. And so I will conclude this webcast at this time. Pamella Vodicka at the Maternal and Child Health Bureau thanking you all for joining us as we shared information on oral healthcare through the WIC program. Enjoy your day.