



WIC: Early Entry into Dental Care Guidebook

Center
for Oral
Health



Collaboration Innovation Advocacy

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Preface

In California, more than 40% of children have already experienced dental decay by the time they enter kindergarten; by third grade, this number has risen to 70%. Dental decay can lead to serious consequences if left untreated; 5.5% of low-income children attending school need immediate care due to severe dental decay and abscesses. Other consequences include pain, chewing difficulty, malnutrition, and low self-esteem. Early dental decay in the primary (baby) teeth can also lead to decay in the permanent teeth. This is almost entirely preventable if families begin to receive counseling during pregnancy and if they themselves have good oral health, a regular source of care, and value and practice health-promoting behaviors.

With this in mind, The Center for Oral Health (COH) created this guidebook to assist dental providers, WIC personnel, and public health advocates in developing *Early Entry into Dental Care* programs in their own communities. This guidebook provides background information on WIC and the benefits of early preventive oral health care, tools and guidance for planning dental care and education services, and advice on building successful relationships between WIC staff and dental service providers. It is based on the recognition that a collaborative effort between dental providers and a trusted community-involved organization like WIC is the most effective method of providing low-income children with accessible and affordable preventive dental services.

COH is one of the few organizations in the nation dedicated to the vision of “oral health for all.” COH provides leadership in advocacy, education, and public policy development; promotes community-based prevention strategies; encourages the integration of oral health into total health; and works to improve access to and the quality of oral health services. In a collaborative effort with the California Primary Care Association, it launched the Oral Health Access Council to work toward improving the oral health status of the state’s traditionally underserved and vulnerable populations.

A special thanks to the two pioneer programs that offered dental services in WIC sites – Alameda County Department of Public Health, Office of Dental Health, and the Humboldt County Department of Health and Human Services, Public Health Branch. Due to their perseverance, creativity, and commitment, thousands of children have received preventive care and are now integrated into the dental care system.

Thanks are also due to the leaders and staff in the other eleven counties where this program was piloted, as well as to our funders, both private and governmental.

How to Use this Guidebook

The PDF version of this guidebook contains external links to websites and documents and internal links to the glossary section at the end of the guidebook. External links are blue (e.g. [Center for Oral Health](#)), while internal links are orange (e.g. [Knee-to-Knee Position](#)). Additionally, all diagrams in this guidebook are linked to printable stand-alone versions for use as handouts or reference sheets.

Section 1. Introduction and Program Overview

Purpose

This online manual provides an overview of the *WIC: Early Entry into Dental Care Program*, developed by the Center for Oral Health in California, and lessons learned, guidance, and tools for groups interested in implementing the program in their own locales. This program uses effective strategies, integrated on-site with other WIC services, to prevent dental disease in infants and young children of low-income families. It uses WIC (the Special Supplemental Nutrition Program for Women, Infants and Children) as the entry point for oral health assessment, preventive services, and referral for regular follow-up care. The specific goals of the program are:



- Increase the number of infants and toddlers who receive preventive dental services and early dental care.
- Provide dental services in non-traditional settings.
- Increase caregiver knowledge of oral health and preventive oral health strategies.
- Develop and implement systems that will enable WIC to serve as an early entry point for oral health services for caregivers and children.
- Create dental homes through referrals from WIC sites.
- Create a model that is integrated with WIC services and sustainable.

Planning and implementing this program is not easy. It will require dedicated professionals who are committed to communication and coordination, as well as state medical and dental practice acts and a [Medicaid](#) reimbursement system to make the programs professionally and financially viable. Groups who have experience working in public health settings with diverse populations of low-income families and a variety of community-based partners will probably have the greatest success. Dental professionals working in community health centers or in private practice may require guidance in adapting to this unique venue, while WIC or public health staff may require additional oral health care training. This handbook attempts to address some of the knowledge and skills that will be needed, as well as some tips regarding planning, implementation, and evaluation. In addition to reading this manual, The Center for Oral Health strongly recommends asking for consultation in selecting and implementing a model.

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How the Program Works



A successful WIC-based preventive dental services program is based on a solid, trusting, motivated relationship between a dental provider and a WIC center. The two partners play very different roles so they must be organized, committed to the success of the program, and able to effectively communicate and work together.

The dental provider offers oral health education and counseling to participants and performs simple preventive oral health services, like [fluoride varnish](#) applications, on participants' young children and infants. The dental provider may also train WIC personnel on key oral health messages to share with participants. The provider could be from a private practice, a community clinic, a state or county health program, or a [Federally Qualified Health Center \(FQHC\)](#).

The WIC center provides space in which the program can operate (generally one or two half-days per week, but sometimes less), encourages its participants to utilize the dental services, and may assist in educating participants, setting appointments, and collecting participant billing data (usually [Medicaid](#)). The WIC center could be operated privately, publically at the state or county level, or as part of an FQHC.

One of the many factors that makes WIC such an ideal portal for preventive dental services is its access to low-income, underserved, Medicaid-eligible children. Medicaid dental benefits cover some preventive services, so in theory the vast majority of dental services provided could be billed to Medicaid. This would be a win-win situation; underserved children could receive much-needed preventive care and dental providers could acquire new patients through a sustainable outreach program. Unfortunately, this ideal is not always realized.

The greatest barrier for the dental provider is funding. In low-volume WIC centers, there may not be enough participants to cover costs. Medicaid managed care plans may not allow fee-for-service billing by the provider. Participants may forget to bring their insurance cards or be hesitant to provide their information out of fear that they may lose other benefits or be charged for services. Other barriers are noted in Section 3, Information for Dental and Medical Professionals, and Section 5, Program Models in California. The dental provider needs to cover personnel and materials costs and may not have access to

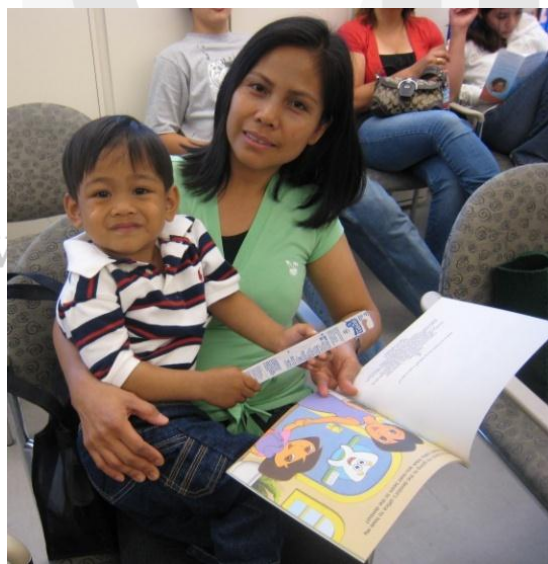
much—if any—external grant funding, so one of the key components of a successful program is an organized, cooperative system for obtaining participant billing information.

For the WIC center, the two most significant barriers are space availability and the preservation of WIC's core mission. WIC centers are rarely large and sometimes very busy, so the space necessary for oral health education and services may not be available often, if at all. Furthermore, especially in light of the lack of space and other issues, a WIC center may be hesitant to host and allocate resources for a program that does not clearly relate to nutrition. Dental providers know that preventive oral health care and proper nutrition extensively overlap, but this is not necessarily obvious to those outside the oral health community, so this point should be clearly articulated.

Despite the difficulties, however, developing a successful and sustainable program based on Medicaid reimbursement is possible. Sustainability and Medicaid reimbursement are discussed in more detail in Sections 3 and 4, as well as in the program models highlighted in Section 5. It is also highly recommended that prospective program developers ask the Center for Oral Health for consultation on these topics.

Making Preventive Oral Health Services More Accessible to Families

In California, more than 40% of children have already experienced dental decay by the time they enter kindergarten; by third grade, this number has risen to 70%. Dental decay can lead to serious consequences if left untreated; 5.5% of low-income children attending school need immediate care due to severe dental decay and abscesses. Other consequences include pain, chewing difficulty, malnutrition, and low self-esteem. Early dental decay in the primary (baby) teeth can also lead to decay in the permanent teeth. This is almost entirely preventable if families begin to receive counseling during pregnancy and if they themselves have good oral health, a regular source of care, and value and practice health-promoting behaviors.



Unfortunately, infants and toddlers from low-income families in California rarely receive early oral health assessments or care unless they are offered these opportunities through community-based programs. Locating dental professionals who both participate in the Medicaid program and are comfortable caring for infants and toddlers is difficult in many areas, and seeking oral health care (which is already not among the highest priorities of most low-income families) at private practices or community clinics can be impractical and expensive.

An important component of WIC is referring children to health and social services, and it is often the first point of contact between low-income families and the health care system. WIC is an ideal location

for preventive oral health services to be provided; it is an efficient, natural, community-based venue where there are significant incentives for attendance. Families already visiting WIC to receive food vouchers and education can also receive preventive oral health services for their children with little to no extra effort, which is important when transportation and other costs are a significant burden.

Benefits of an Oral Health and WIC Collaboration

Nationally, WIC is one of the largest providers of service to low-income young children who may be at high risk for developing dental decay. More than 60% of all children born in California are served by WIC. To receive WIC benefits like food vouchers and education, [caregivers](#) are required to go to a WIC site with their infants and young children.

The *WIC: Early Entry into Dental Care Program* builds partnerships between WIC sites, public health clinics, community health clinics, and private dental practitioners and provides onsite oral health services as well as ongoing care. By offering oral health services at WIC sites, providers can reach caregivers and children early enough to prevent dental decay. Collaboration with WIC staff helps ensure that oral health education and services are delivered in a culturally-relevant and language-appropriate way. This collaboration also builds the shared goal of promoting nutrition and feeding practices that contribute to both oral and overall health.



Oral health services are typically offered on days when participants are already scheduled to pick up food vouchers or attend classes. Infants and older siblings are given an oral health assessment and preventive services such as [fluoride varnish](#) applications. Caregivers receive individual counseling and/or group educational sessions on healthy feeding practices, nutrition, and oral hygiene. Families are referred to dental practices or clinics for follow-up care beyond the preventive services delivered at WIC sites. Since most children enrolled in WIC are [Medicaid](#) eligible, dental and medical providers may be able to bill for this service according to their state Medicaid regulations and state practice acts.

WIC at a Glance

Population Served

The WIC target population is low-income, nutritionally at risk:

- Pregnant women (through pregnancy and up to 6 weeks after birth or after pregnancy ends).

- Breastfeeding women (up to infant's 1st birthday)
- Non-breastfeeding postpartum women (up to 6 months after the birth of an infant or after pregnancy ends)
- Infants (up to 1st birthday)
- Children up to their 5th birthday

At the end of FY 2009, 9.3 million women, infants and children received monthly WIC benefits. One-half of infants born in the U.S. are enrolled in the WIC program.

WIC Benefits

The following benefits are provided to WIC participants:

- Supplemental nutritious foods via food vouchers (some are now electronic cards) redeemable for specific items at a local grocery stores or farmers markets; WIC guidelines were recently changed to better align with U.S. Dietary Guidelines for Americans and with AAP infant/toddler feeding guidelines
- Nutrition education and counseling, including breastfeeding promotion and support at WIC clinics
- Screening and referrals to other health, public assistance, and social services such as prenatal/[well-child care](#) services, [Healthy Families \(CHIP\)](#), and child support services



Program Delivery

WIC is not an entitlement program; Congress does not set aside funds to allow every eligible individual to participate in the program. Rather, it is a Federal grant program for which Congress authorizes specific funds each year. WIC is:

- Administered at the Federal level by Food & Nutritional Service;
- Administered by 90 WIC state agencies, through approximately 47,000 authorized retailers;
- Operated through 1,900 local agencies in 10,000 clinic sites, in 50 State health departments, 34 Indian Tribal Organizations, the District of Columbia, and five territories (Northern Mariana, American Samoa, Guam, Puerto Rico, and the Virgin Islands).

Examples of where WIC services are provided

- County Health Departments
- Hospitals

- Mobile clinics (vans)
- Community Centers
- Schools
- Public Housing sites
- Migrant Health Centers and camps
- Indian Health Service facilities

Rationale and Evidence Base for Early Childhood Oral Health Programs

Risk Assessment and Anticipatory Guidance

While [risk assessment](#) for dental decay, referred to as “caries risk assessment,” is not yet precise, the American Dental Association (ADA), Centers for Disease Control and Prevention (CDC), and American Academy of Pediatric Dentistry (AAPD) agree that the single greatest risk factor for future dental decay is having had tooth decay as a young child.ⁱ

[Anticipatory guidance](#), as used in pediatric health care, is the process of providing practical, developmentally-appropriate health information about children to their caregivers in anticipation of significant physical, emotional, and psychological milestones. This information guides caregivers by alerting them to upcoming changes, teaching them their role in maximizing children's developmental potential, and identifying children's special needs. Pediatricians have been using anticipatory guidance for years in clinical practice.ⁱⁱ Each [well-child-care visit](#), for example, involves physical examination, immunization, and anticipatory guidance keyed to the child's developmental stage.



Oral health anticipatory guidance is now widely promoted as part of *Bright Futures*; a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community. In addition to their use in pediatric practice, many states implement *Bright Futures* principles, guidelines, and tools to strengthen the connections between state and local programs, pediatric primary care, families, and local communities.ⁱⁱⁱ

Lower Treatment Costs

Children who have severe dental decay are difficult to manage and treat under normal clinical conditions without the aid of conscious sedation or general anesthesia. These factors make this disease expensive to treat, and many caregivers cannot afford to follow the dentist's recommendations. Early

preventive oral care results in lower treatment costs later in life; it is estimated that for every dollar spent on prevention services, \$8 to \$50 are saved in treatment. Dental costs for children enrolled in Medicaid for five continuous years who have their first preventive dental visit by age one are nearly 40% less (\$263 compared to \$447) than for children who receive their first dental visit after age one.^{iv}

Fluoride Varnish

This fast-drying resin is a safe and effective preventive agent painted onto tooth surfaces to prevent tooth decay. It is particularly effective for high-risk children under 5 years of age. It can be applied quickly and is available in several flavors.

Numerous studies have documented the effectiveness of fluoride varnish to prevent decay.^v Reductions in dental disease depend on children's risk for tooth decay and the number of fluoride methods used.^{vi} Most studies indicate four applications over two years as the interval that demonstrates overall reductions in tooth decay of approximately 30 percent (0-69%) in at-risk populations.^{vii,viii} For those with active dental decay, three to four applications annually may be more effective; however, the strength of evidence is limited to a few studies and the recommendation is based largely on opinion or information extrapolated from related studies.^{ix}



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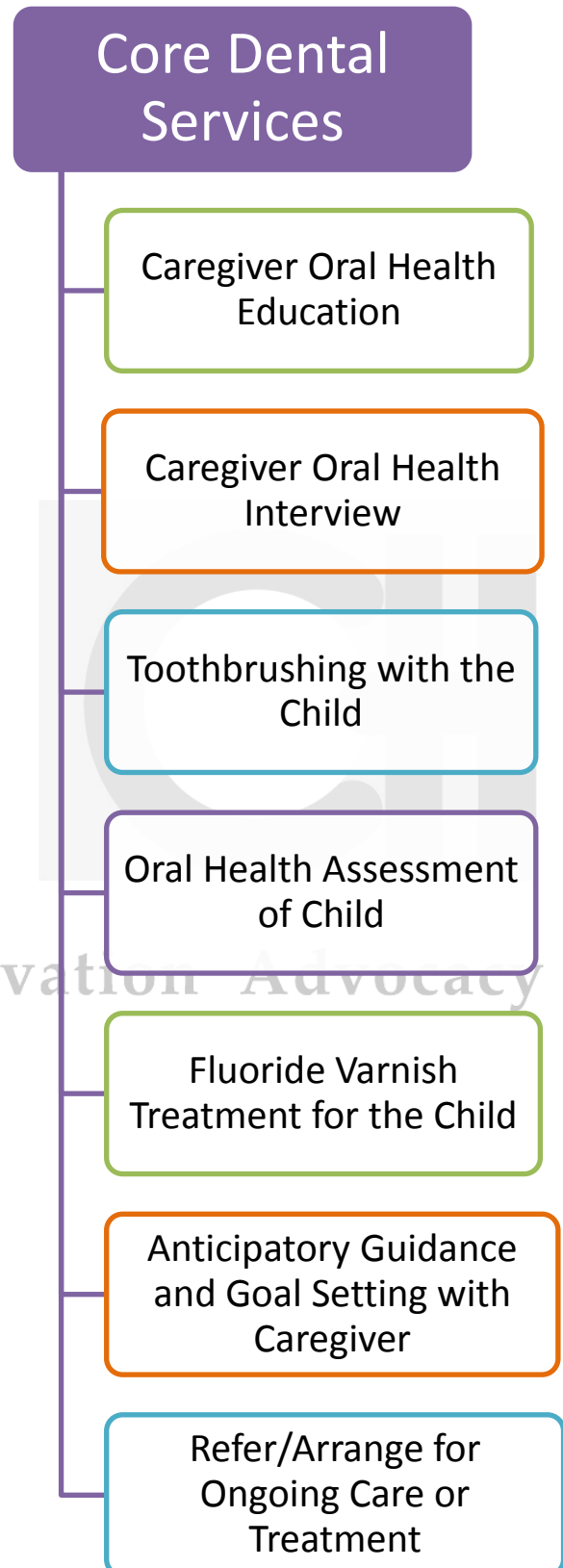
Core Dental Services of the WIC: Early Entry into Dental Care Program

These core dental services are the minimum services recommended to be provided at WIC sites. Some programs may need to work up to this level over time. Providing these services typically takes between 15 and 20 minutes per child for an initial visit and less for repeat visits, depending on paperwork and other issues.

Dental / health professionals should provide all core dental services unless arrangements have been made for WIC staff to provide the caregiver education. Education can be provided either through individual counseling sessions or group classes.

Core preventive services that must be provided by dental / health professionals include:

- [Interviewing the caregiver](#) about health and dental history, identifying risk factors for oral health problems, reviewing current home dental care practices, and having the caregiver sign consent and other forms
- Brushing the child's teeth to remove plaque or food debris and serve as a skill-building opportunity for caregivers
- Inspecting the child's mouth to check for normal growth and development and any signs of tooth decay
- Painting a small amount of fluoride varnish on the teeth to protect them from dental decay
- Discussing the child's risk factors for dental problems and setting realistic goals and activities for home care to promote oral health and healthy feeding practices
- Helping families arrange for ongoing care and a [dental home](#), as well as treatment for decay and other conditions if necessary



Children will need regular oral health care beyond the initial preventive services provided at the WIC site. Further collaboration with public health organizations, [Federally Qualified Health Centers \(FQHCs\)](#), community dental clinics, and/or private dental practices is needed to assure that children have dental homes, that a recall system for diagnostic and preventive services is established, and that any treatment for dental problems is completed. Some programs will decide to use case manager models to arrange for dental follow-up.

Target Age Group

To prevent [Early Childhood Caries \(ECC\)](#), the target age group for preventive oral health services should be 9-24 months old. Some programs may extend this to provide fluoride for older children, especially siblings who are likely to be present with the caregiver. Extension of the age group will largely depend on the resources available to providers. WIC can identify children in specific age groups.

Billing for Services

Most children enrolled in WIC are either eligible for, or already enrolled in [Medicaid](#). As a result, dental and medical providers in California and many other states who work in private or public health practice, including Federally Qualified Health Centers (FQHCs), can bill Medicaid for some of the oral health services provided at WIC (please check your state laws on billing restrictions). In some circumstances, WIC staff may be able help assess a participant's current Medicaid status and other insurance coverage (with the consent of the participant, and according to HIPAA restrictions), but this may not be feasible. If billing Medicaid is not possible, then another reliable source of funding will be needed to develop a sustainable program. See Section 3 for more on this topic.



Current Use of the California Models

A HRSA MCHB Targeted Oral Health Services Systems grant in 2007 allowed the Center for Oral Health (COH) to develop the program and pilot it at two WIC sites; one in Alameda County, the other in Humboldt County. (Alameda has since expanded the program to two sites, and Humboldt to three.) The HRSA grant also provided for expansion into six more partnerships. These have included public health departments, [Registered Dental Hygienists in Advance Practice \(RDHAP\)](#) serving rural WIC programs, consolidated tribal health services and private dental clinics. Local [First 5 commissions](#) assisted by providing additional funding for case management.

In 2009, Kaiser Southern California Foundation funded a one-year project to expand the program to serve six communities in Southern California. This model relies on a partnership between public health departments, RDHAPs, tribal health clinics, and Federally Qualified Health Centers (FQHCs). Also in 2009, the COH received a grant from the First 5 Los Angeles County Commission to develop partnerships between seven FQHCs and WIC sites throughout Southern California for 3+ years.

In 2010, First 5 San Bernardino funded a program that was originally intended to provide services to children and pregnant women at WIC. Because of changes in the WIC providers, the same services were successfully initiated in medical clinics by dental providers.

In addition, COH staff has provided consultation to programs in a number of other states.

See Section 5 for details on five different models in California.

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Key Elements of Success: What Works?



Section 2. Collaborative Planning

Identifying Partners and Generating Interest for the Program

In order for the program to get off the ground, someone in the community has to see a need for oral health services for young children and their families, be driven to do something about it, and then translate that drive into action. This champion can originate from a WIC site or grantee; state, county or city health program; local dental professionals; community-based organizations; or [Federally Qualified Health Centers \(FQHCs\)](#). However, while finding a champion is crucial, one person alone cannot create a successful program—collaboration and support from multiple individuals and organizations is needed. Collaboration can begin on a local level first, and then expand if successful. The potential partners can be convened together to introduce the idea of an oral health/WIC collaboration, or the lead group can meet with each potential partner separately to get support and then convene the whole group to discuss the specifics of collaboration.

Making the First Contact

The first contact provides an opportunity to “sell” the oral health program and determine if it is feasible to conduct it at one or more WIC sites.

Discuss the problem and the extent of [Early Childhood Caries \(ECC\)](#) in young children and how oral health is an integral part of overall health and nutrition. Describe how oral health / WIC collaborative programs are structured in other communities and highlight some of their successes (see Section 5 of this manual for

program models.) Discuss ways in which the goals of the *Early Entry into Dental Care Program* and those of WIC overlap and how they might also fit with the goals of other partner groups. Ask each group to explain explicit and implied mandates, staffing patterns and staff skills, site capacity for adding oral health services, and what procedures are used when working with families. The following questions provide some guidance.



What knowledge do key WIC staff have about oral health?

- Have WIC staff received previous oral health training? If so, who provided the training, what was covered, and how was it incorporated into their interactions with families?
- Do WIC staff currently assess the oral health status and risk factors of their participants' children? If so, how?
- What is the best way to schedule additional oral health training for WIC staff?

How can the oral health program fit into WIC's general programming?

- What days and times are the WIC sites open and which days might be best for integrating oral health services?
- How many participants are seen per month and how often are they seen per year?
- How is participant information collected and verified? How can this process be used to efficiently share information with the dental team?
- How does WIC keep track of [Medicaid information](#)? Is there any way to provide the dental team with Medicaid numbers with the participants' permission, especially since participants may not bring their Medicaid cards to the WIC visit?
- Who helps caregivers complete permission forms and other paperwork?
- Some WIC sites provide educational classes. How often are they scheduled? Should oral health be part of the curriculum WIC currently provides or should it be separate?
- What space(s) could be made available to the dental team? Is there any storage space for supplies?
- Would WIC provide any materials or supplies?
- Do WIC staff schedule appointments with families, or do they have a walk-in policy? How can families be routed for a dental visit? Should dental visits use appointments?
- What languages do most families speak and which WIC staff speak those languages? Who provides translation services for families who need them? Will these individuals be available for the dental visits if needed?
- Would WIC staff assist with case management or administrative duties?
- What are the best ways to market the program to families?
- What does WIC liability insurance cover and what insurance will the dental team need?
- If dental services were initiated, how might they be sustained financially?

What relationships do WIC staff members currently have with dental professionals or clinics in the community?

- Is the WIC site part of an organization that provides dental services in another branch or location? What types of services are provided and how are they arranged?
- Does WIC currently provide families with dental referrals to dental offices or clinics in the community? If so:



- How was the list of dental offices/clinics developed, and do all the providers participate in [Medicaid](#) or [CHIP \(Healthy Families\)](#), in California)?
- Does the WIC staff track the results of the referrals to see what care was provided and if the family will be receiving care on a regular basis?
- How much contact does the WIC staff have with dental providers in the community?
- Have these providers ever received an orientation to WIC and how to work with WIC families?
- Are families satisfied with the care they receive from providers?

Answers to these questions will help determine how supportive WIC staff will be of an oral health program at the site and how much effort and time will be needed to set up and maintain the program. Some WIC sites may simply be too small or otherwise unable to incorporate oral health services on-site. Relationship-building takes time but is an important first step in program development. Clear establishment of roles, responsibilities, policies, and procedures prior to the program debut is crucial. Agreed-upon goals and objectives, along with methods of measuring progress and determining what constitutes success, are key elements for any oral health program.

Determining Details of Collaboration

The WIC staff, dental team, and any other community partners should convene additional planning meetings to work out the details of the oral health program. This provides an opportunity to share objectives and gain a better understanding of how everyone will contribute to the overall vision of the oral health program. Such meetings help to foster credibility, a shared knowledge base, mutual respect, and trust. Discussions should cover best times for scheduling, use of space, participant flow, paperwork, facilitating referrals, and shared responsibilities. Enthusiasm for the program will grow if all staff (not just administrators) buy into the program early and if families value and take advantage of the services.

Creating a written [Memorandum of Understanding \(MOU\)](#) that covers the basics of the program and outlines responsibilities of all partners will help keep the program on track and accountable. See Section 6 for more information about MOUs and a sample MOU.

Schedule

The schedule will depend on how frequently WIC services are provided at a site and how often professionals are available to perform the clinical services. Some WIC sites may operate full-time while others are only open a few days per month. Generally, the dental team will want to spend 4-5 hours at a site to maximize their time and the flow of participants. To make the program cost-effective, providers at larger



sites should average 15-25 participant visits (clinical dental encounters for billing purposes) during that timeframe. In small or rural sites this volume will not be possible. The WIC director should try to schedule the visits at times that would maximize the number of participants for the dental team and be the least disruptive to core WIC services.

The team will also need to determine whether children will return for additional [fluoride varnish](#) visits if a dental home is not found, and how many visits per year would be appropriate and realistic to achieve the best oral health outcomes. This may be difficult to achieve if an appointment system is not used. Also determine how appointments are made or how “walk-ins” are approached to be offered services.

Space at the WIC site

At a minimum, WIC dental visits require:

- For each clinical provider, two conventional chairs to facilitate performing a knee-to-knee position for the oral assessment and preventive services with the caregiver and child;
- A table to place supplies and paperwork;
- A waiting area, either a separate one or easy access to a main waiting area with toys/books to keep children entertained;
- A garbage can.

When space is available, a small room or cubicle is best for privacy. A larger open space partially divided by a table that is in close proximity to the waiting area may also be used.

Be aware of infection control issues when looking for appropriate space and traffic flow. See Section 3 for more information on infection prevention and control.



Staffing

Staffing will depend on how many participants can be seen in one day, how involved the WIC staff will be with various aspects of the program, what type of dental or health professionals are available to participate in the program, the procedures that state practice acts allow dental and other health care providers to perform, and Medicaid coverage for the various procedures, including who can bill and receive reimbursement.

A typical dental team consists of one dental or health professional (who can bill for services) to provide the clinical services and one administrative person or educator to interact with families and facilitate completion of paperwork and referrals. Enough staff support should be available to minimize waiting

time for families and to provide them a positive experience that promotes two-way communication. See Section 3 for more details on staffing and billing.

Process for verifying Medicaid status

Determine who on the WIC staff can access and share this information (some WIC sites may not provide this information), or if the dental team will need to verify the information directly with families. Brainstorming potential problems during the planning stage will prevent bottlenecks and possible lost opportunities for seeing children if their status cannot be readily verified. In some cases (but not all), WIC staff have been able to check their [participant information system](#) when a participant arrives and immediately print the participant's information. This process minimizes errors and provides reliable information to use for case management, follow-up with families, and billing.

Caregiver Education

There are many things to consider when planning a successful caregiver education program. Partners should attempt to determine in advance which topics and methods are most appropriate, but allow for flexibility as extensive evaluation and revision may be required to better suit the needs of participants and staff. See Section 5 for more information on different program models and their education strategies.

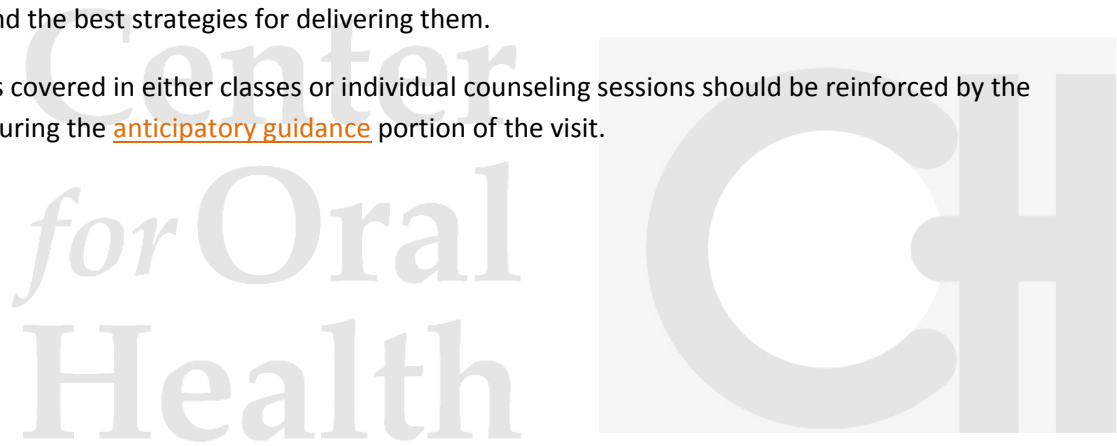
The following questions should be discussed:

- Will education be done in a class setting, or through individual counseling? This is largely determined by participant volume; classes may not be possible in small or rural WIC sites, for example, but will likely be more time-efficient than individual counseling in high-volume urban WIC sites.
- How and when will classes or counseling sessions be scheduled and how long do they last?
 - If classes will be held, the classes should be conducted on the same days as the dental visits, if possible, with the participants first attending the class and then receiving dental services.
 - Counseling sessions are generally conducted by a dental assistant, educator, or [promotora](#) as participants wait to receive the clinical services.



- If classes will be held, will they be taught in different languages? How will this be scheduled? In the Alameda County model (see Section 5 for more on this model), for example, classes are taught in English on some days and in Spanish on others.
- What curriculum or key messages will be taught? Are the oral health messages consistent with WIC health and nutrition messages? See Section 6 for the Center for Oral Health’s recommended educational materials, available electronically.
- Can the oral health education be developed to fulfill one of the [WIC educational requirements](#) for participants? This would be an additional incentive for families to attend and receive oral health services.
- Who will be providing the education? Are the educators adequately prepared to address the oral health content and answer questions in a way that meets the learning needs of the audience? If not, then a staff training session should be conducted to explain the key messages and the best strategies for delivering them.

Key points covered in either classes or individual counseling sessions should be reinforced by the clinician during the [anticipatory guidance](#) portion of the visit.



Collaboration Innovation Advocacy

Section 3. Information for Dental and Medical Professionals

Facilitating Access for Children and Caregivers

Delivering oral health services at WIC sites is an excellent opportunity to become more involved in the local community and provide a much needed service to low-income families. Integrating oral health services into WIC programs, however, requires preparation, organization, efficiency, and flexibility; especially for dental professionals who are used to providing comprehensive clinical services in dental operatories with a full complement of staff. The dental team also needs to develop a public health mindset that values population-based approaches in multidisciplinary community-based settings. Valuing and understanding the job responsibilities of community health professionals and WIC staff is crucial to successful integration of oral health messages and services.



The oral health services provided at WIC sites focus on important components of preventive oral health care, but do not represent complete diagnostic and comprehensive care. One of the goals of these services is to link children to a [dental home](#). For infants and toddlers to have the best chance of enjoying a childhood free of dental disease, it is crucial to reach caregivers with preventive messages and services before a child is one year of age. This is best done in a comfortable environment where families can receive other services at the same time. For low-income families, many of whom receive a variety of supportive services, places such as WIC sites, health center clinics, and public health departments provide opportunities to make the most of limited time and resources. Most of these families do not have enough money to pay for the child care or transportation required to make multiple appointments during a week, or even the time to make them if they are working, attending classes, or taking care of other family members. Making preventive oral health services available where caregivers can realistically and easily access them will help reduce potential barriers to care as well as frustration by dental providers due to missed appointments.

Accomplishing More with Less

Oral examinations and fluoride varnish applications for young children do not require much equipment; things like high intensity dental lights, dental chairs, air/water syringes, and suction are not needed. Additionally, the few necessary supplies (listed later in this section) are almost all disposable.

The best position for performing the exam and preventive services is with the dental provider and caregiver each sitting in a chair and facing each other in the [knee-to-knee position](#). The child can sit in

the caregiver's lap facing her/him and recline into the provider's lap. This puts the child in the same position used in pediatric dental practices with dental chairs and allows direct eye contact between provider and child, while still allowing the child to see and touch the caregiver. A table next to the chairs can hold all supplies and paperwork, and a garbage bin can be placed within reach.

A dental assistant (or another second person) can help with paperwork, set up and dispose of used supplies, and continue to educate the family after the clinical procedures. This model is efficient: the provider can accomplish an oral inspection, review oral care recommendations, apply fluoride varnish, and involve the caregiver in discussion at the same time. It allows the caregiver to be an integral part of the process, to see what the child's needs are, and learn how to manage them.

Marketing the Program for Success

Marketing is crucial for any program. Although there are many strategies for marketing this program, one critical strategy is for WIC staff to inform families early of 1) the importance of both home and professional oral health care for their child and 2) the availability of preventive and educational services at the WIC site. Dental providers will need to educate WIC staff on the importance of good oral health and the relationship to the other services WIC provides so WIC staff can then market these services to families.

One way to involve WIC staff early on is to offer to demonstrate the services on their own young children as a free service. This places them in the caregiver role and gives them the perspective they need to best explain the process to their participants. In most sites, on dental visit days, the WIC staff or the dental team will need to go into the WIC waiting room to promote the oral health services directly to families. "Selling" the services and their benefits requires excellent communication skills, and knowledge of [motivational interviewing](#) techniques is as important in this early encounter as it is for the actual dental visit. WIC staff are often more effective at this; they have an established, trusting relationship with their participants, and many are already trained in motivational interviewing. Thus, marketing to WIC staff is necessary on an ongoing basis. WIC staff's priorities are the core functions of their organization, so they may need periodic reminders and motivation to educate WIC participants about dental days and the importance of the services. Refer to Section 4 for specific suggestions on marketing dental days and to Section 6 for examples of materials.

Dental Days at WIC!



Your Child Can Be Cavity Free!

Bring your children ages 9 months to 5 years to meet
The Dental staff and get a free Dental Screening
Held weekly at
Sign Up now or when you arrive!
Please bring your Medi-Cal card with you if you have one.

Your Child is Special

Learn how to protect your child's teeth!
After the WIC class, your child can see the dentist for a free dental
screening. We will talk to you about your child's teeth and apply fluoride
varnish to prevent cavities.

It is fun, easy, and painless!

Staffing

Reimbursement Regulations

Basic staffing and responsibilities will vary by site or in other states according to who can bill for services and under what conditions.

The American Dental Hygienists' Association (ADHA) has compiled [a list of states that allow direct reimbursement to dental hygienists](#), as well as [a list of states that allow "direct access" to a dental hygienist](#) (can initiate preventive care based on his or her assessment of a patient's needs without the specific authorization of a dentist, can treat the patient without the presence of a dentist, and can maintain a provider-patient relationship).

Information on each state's status regarding Medicaid reimbursement to medical primary care providers for providing dental caries prevention services can be found in [this document](#), published by the American Academy of Pediatrics. Relevant oral health coding information can be found [here](#).

Typical staffing model for California sites

1 Clinician (Dentist in FQHC; Registered Dental Hygienist in Alternative Practice [RDHAP] for fee-for-service in CA, due to billing issues)

- [Risk assessment](#)
- [Clinical assessment](#)
- [Fluoride varnish](#)
- [Toothbrush prophylaxis](#)
- [Anticipatory guidance](#)
- [Goal setting](#)

1 administrative person/educator (could be a dental assistant, public health educator, or dental hygienist)



- Assist caregivers in completing forms (listed later in this section)
- Caregiver education
- Referrals and planning for follow up
- Data entry
- Translation to other languages, if necessary

In large, busy WICs, a third person may be needed to help with participant flow and paperwork.

Public Health Nurses

Note that the Humboldt County model (see Section 5 for more on this model) uses Public Health Nurses, rather than dental professionals, to provide oral health services. Some programs may want to involve PH nurses or other medical professionals if they can bill for oral health services or if other funding will support their employment.

FQHC Staffing

Some FQHCs have on-site WIC programs; this is ideal, as it allows for a more seamless provision of preventive services and a dental home. FQHCs without on-site WIC programs will likely still be able to implement this program, but there are additional considerations regarding collaboration with WIC programs outside the walls of the health center. FQHC dental directors need to discuss long-term commitment for any collaboration with WIC with their CEOs and get assurance that appropriate staff will be available. They will also need to determine whether providing oral health services at WIC is in their scope of project and which WIC sites are within their geographic service area. WIC sites are considered “portal” dental sites, so certain requirements must be met if services are to be provided at these locations. If FQHCs do not have a WIC program, they can locate a local WIC agency and negotiate a scope of service change in order to bill for services. See Section 6 for FQHC resources.

Skills Training

Working with diverse populations of caregivers and young children requires good listening and communication skills, as well as excellent time management. This applies to both clinicians and dental assistants/educators. Additional skills in risk assessment and motivational interviewing are also needed. In many ways, some of the skills for interacting with families resemble those of [community health workers](#) or [promotoras](#). One example is being conscious to speak at a low volume; WIC is a public space so care must be taken to protect the privacy of participants. If you have not had much experience working with families and young children in your professional education or practice and would like to improve your confidence and skills, contact the Center for Oral Health for additional assistance (info@tc4oh.org).

Cultural Competency

Particularly in ethnically diverse areas, cultural competency among dental staff is critical. People from different cultures have different attitudes toward subtle behaviors that others may not be aware of, and dental staff should be trained and educated about common concerns among local populations. These may include diet, gender roles, attitude toward eye contact, personal space and sensitivity to physical contact, expectations of the relationship between a participant and a professional, and the amount of time spent at the visit, among others.

Supplies

Assemble a WIC Site resource kit that can be easily transported and restocked. There are many ways to do this. Plastic rolling carts or bins tend to be the easiest solution as they are lightweight, inexpensive, and can be labeled and stacked.



Required Supplies

- Fluoride Varnish (unit doses)
- Gauze squares
- Gloves
- Child or infant toothbrushes
- Paperwork/forms
- Pens
- Referral information for local area or laptop computer
- Hand sanitizer
- Paper towels/table covers



Optional Supplies

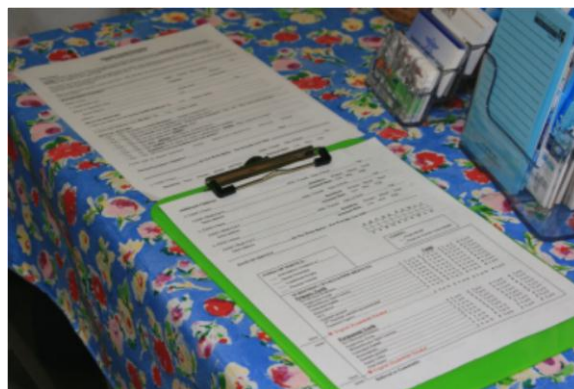
- Child friendly dental puppet
- Adult brushes (for caregivers)
- Stickers or incentive gifts
- Cotton swabs
- Vaseline
- Goo B Gone or equivalent solvent
- Clipboards
- Colored pens
- Hand cream or moisturizer
- Extra zip-lock bags
- Kitchen size garbage bags (in case there is no access to a trash container)
- Small baskets or plastic containers in which to store items during the visit

If resources permit, small incentives are always appreciated by families. Toothbrushes specifically designed for infants and toddlers are available at reasonable bulk prices. Children love stickers. Adult toothbrushes and small tubes of toothpaste are always appreciated by adults, as well as any other items that will help them maintain their or their child's oral health.

In the Alameda County model (see Section 5 for more on this model), the dental team also gives out a *Dora the Explorer* book titled *Show Me Your Smile!: A Visit to the Dentist* (see Section 6 for bibliographical information). According to the team, it is the best children's book available on the subject and it often dramatically improves children's anxieties about the dental visit.

Paperwork

The paperwork used for gathering information, assuring consent, facilitating follow-up, and tracking program outcomes is important. All paperwork used to gather information or educate caregivers should be written in the most common languages used by the majority of participants (usually English and Spanish, in California); WIC staff can determine whether other languages should be considered. A small, lockable file folder should be used to secure [HIPAA](#)-protected information and to transport the forms at the end of the day. Permission forms and screening forms should never be placed where others might accidentally view them. Suggested forms are listed below.



Alternatively, there is a paperless option available—the Healthy Teeth Toolkit (HTTK) available through COH. See page 38 for more details.

Suggested Forms

See Section 6, Participant Forms for templates and samples of these forms.

Caregiver Commitment Form

This worksheet allows the dental provider to negotiate with the caregiver to set reasonable goals and follow-up care plans. It includes pictures and descriptions of several measures the caregiver can circle and commit to take to improve her / his child’s oral health.

Caregiver Permission and History Form

This form is used to elicit informed consent from caregivers plus gather personal information and some health and dental history. Information from this form is used for tracking and case management so it must be easy to read and to complete.

Caregiver Summary

This take-home form should summarize, in easy-to-understand words and in the participant’s own language, the results and recommendations from the oral health visit. It could also include information about local low-cost or free dental resources and / or specific referral information.

Caries Risk Assessment Form

The questions on this form can be used to determine if a child has moderate or high risk factors or specific protective factors. The form used in this manual is the most recent one adopted by the American Academy of Pediatric Dentistry (AAPD).

Dental Assessment / Preventive Services Form

Transfer some of the information from the caregiver permission and history form, record the results of the oral inspection (screening) and the services provided. This form may be designed to contain as much information as desired, including [Medicaid](#) billing information.

WIC Attendance Sheet

This caregiver sign-in sheet lets the program know at a glance how many caregivers and how many children were seen each working day. This assists with record keeping and preliminary accounting.

Referral / Case Management Information

Before implementing the program, identify dental practices, public health clinics, and/or community health centers that 1) are geographically close, 2) have agreed to provide care to children of WIC participants, and 3) are enrolled as Medicaid providers. Provide a short list of those resources to families.

Without referral arrangements, you will be providing preventive services but not addressing additional diagnostic or dental treatment needs. If available, case managers can be used to facilitate referrals and follow-up. Case managers work with families to assess dental insurance eligibility, assist in overcoming barriers to seeking care, link families to dental professionals who can provide care for their child, and follow-up to ensure that dental care was acquired.

Regardless of whether you use a case manager model, someone will need to determine how referrals will be made for dental treatment and the extent of assistance that participants will need in order to obtain necessary services. InsureKidsNow.gov lists dentists who are Medicaid dental providers by state, but keep in mind that this may not be an all-inclusive list.

Educational Handouts

Caregiver Brochures

Brochures can be distributed to families to help retain the knowledge taught during the visit and teach other family members at home about oral health care. The First Smiles *Healthy Teeth Begin at Birth* pamphlet is available in nine different languages; contact the Center for Oral Health for more information.

Fluoride Varnish Handout

These should explain what fluoride varnish is and does and include directions on what to do/not do during the few hours directly after application and into the next morning. See Section 6, Educational Materials for a sample handout.

Caregiver Satisfaction

It is important to acquire feedback about the visit from caregivers in order to determine the degree of satisfaction and learning and initiate improvements to the program. If the WIC site uses family satisfaction forms, then you might want to create one for the oral health services. Caregivers could then be encouraged to complete the form and place it in a box for later review by WIC staff and the dental team. Assure them their feedback will remain confidential and that they are not required to include their names unless they want someone to follow up with them. If the WIC site does not use such forms, encourage families to give you immediate feedback or to provide feedback to the WIC staff. If there are any concerns, caregivers are usually more comfortable discussing them with WIC staff, who can then follow-up to resolve any issues and improve the program. Satisfied families are more apt to recommend services to other families.

Infection Control and Prevention

It is critical that adequate infection control be maintained while providing dental services at WIC sites. The goal of infection control is to prevent or reduce the risk of transmitting microorganisms that could cause disease. Assessing the WIC site prior to selecting a place to provide services is the first step in infection control.

The Organization for Safety and Asepsis Prevention (OSAP) has developed a Site Assessment Checklist and an Infection Control Checklist (both found [here](#)) for use in alternative sites using either mobile vans or portable equipment. Although you will not be using portable equipment per se, both checklists include items that may be useful in developing an infection control plan for WIC sites.

The following table outlines the four principles of infection control recommended by the U.S. Centers for Disease Control and Prevention (CDC) and gives tips for providing oral health assessments and fluoride varnish for young children.



Prevent the spread of communicable disease

Wash hands before and after each child (use of alcohol-based hand sanitizer is also acceptable). Do not provide services if you are sick.



Avoid contact with blood and other body fluids

Always wear gloves for oral health assessments and fluoride varnish applications. Change gloves after each child.



Make items safe for use

Use only disposable items for clinical work to eliminate the need for instrument sterilization.



Limit contamination

Set up materials on a paper towel or tray cover. All disposable items (including gloves) can be wrapped in the paper towel and disposed of in a trash container after each child.

A Typical WIC Dental Day

Intake / Education	Clinician Encounter	Referral / Case Management
<ul style="list-style-type: none">• Establish Rapport• Dental services promoted• Consent forms completed• Caregiver education (individual counseling or class)• Insurance information collected	<ul style="list-style-type: none">• Oral Health Interview (Risk Assessment)• Hygiene Instruction• Toothbrush Prophylaxis• Oral Assessment• Findings Recorded• Fluoride Varnish• Anticipatory Guidance• Goal Setting	<ul style="list-style-type: none">• Determine need for follow-up care• Referral to clinic, private dental practice, FQHC, etc.• Case management services

Arrival and Preparation

Become familiar with the physical site before the initiation of the program. Locate entrances and exits, the waiting area, restrooms, water sources for hand washing, and the WIC teaching and interviewing areas. Locate where WIC staff conduct participant intake and where oral health services will be provided. Inspect the space carefully with WIC staff to decide what materials must be removed at the end of the day and what can be stored neatly and safely and with HIPAA consideration. If WIC has agreed to confirm Medicaid enrollment, know where that will take place. Discuss how participants proceed through the facility and identify any potential bottlenecks when dental services are added. Review respective responsibilities of participating WIC staff and the dental team.

Plan to spend 4-5 hours at the WIC site each dental day. Try to arrive at least 15 minutes before the scheduled first visit to set up supplies, get paperwork ready, and review participant flow with the WIC staff. Cover the top of any workspace with a plastic table cover that can be wiped before and after use to prevent contamination. Clipboards or writing surfaces and pens should be readily available for completion of forms.

Although total time for a dental visit can be 15-25 minutes, clinicians should plan on seeing participants every 15 minutes if patient flow allows, as a caregiver's time will be split between the assistant and the clinician.

Establish rapport and have participants complete paperwork

Depending on the model used, the oral health team may need to meet and greet caregivers in the WIC waiting area and solicit their participation in the program. If marketing efforts have been effective (marketing strategies can be found in Section 4), then less time will be needed to describe the program to families. Determine what languages participants speak so that translation can be



arranged if needed and language-appropriate forms will be used. Initial communication is crucial for caregivers to establish trust and to understand the benefits of the oral health visit to themselves and their children. A warm welcome and a brief session playing with the child will help establish rapport. Introductions might include that the dental team is made up of professionals (team members might mention where they normally work), the team is working in partnership with the WIC staff, and the service is covered by their Medicaid dental benefits (or another funding source, if they are not on Medicaid). This initial stage of establishing rapport is crucial for generating an adequate participant flow and for families to have a successful visit.

Use the Attendance or Sign-in Sheet to document the names of participating caregivers and their children. This level of detail has been found to be important as caregivers may arrive with 2 or 3 children with different last names. A Sign-in Sheet provides a quick tally of the number of caregivers and children seen for dental services each day. Names can be cross-checked with permission forms.

Even in very busy WIC offices, choices can be made to facilitate the completion of paperwork so the flow of participants is smooth and bottlenecks do not occur. One option is to assist caregivers in completing the initial Permission and History Form in the waiting area just after they sign in. The clip board and paperwork could be made available to pick up and complete, WIC staff may assist with the paperwork, or the dental team may assist in completing forms. Since forms can be confusing and caregivers will vary in their literacy levels, offering assistance with forms is strongly recommended.

If the caregiver does not have time to complete the forms in the waiting area, then dental staff should be available to guide them through any questions as they wait to receive the service. This is the time to discuss and record insurance information and check Medicaid status. This may be achieved with an on-site point of sale (POS) device, the telephone, or via a computer with the correct database. Medicaid status can also be supplied by WIC staff if that was arranged during planning meetings. Since this step can be time consuming, the process should be thoroughly understood by all staff prior to beginning the program.

Provide the educational session (10 minutes)

Caregivers will benefit more from the clinical session if they receive some initial education about key oral health issues. A few different models exist for accomplishing this. This session may be conducted in a classroom or with individual families while they are waiting for the clinical portion of the visit. Some programs hold multiple short classes throughout the day so that families are automatically routed to the class and then to the dental visit. The following is one suggested format and sequence for presenting the information during an individual session. See Section 6 for an example of ways to convey the information and engage families in a group session.

Step 1: Establish the goal

Discuss what tooth decay is, what causes it, and what roles caregivers can play in preventing it. All caregivers want their children to be healthy. Reinforce the concept that oral health is an important part of total health!

Step 2: Tell a story

Tell a story from your life or ask the caregiver to relate an example of how they changed a particular behavior based on new information, e.g., use of seatbelts, eating habits. Acknowledge how difficult it is to change some behaviors and that knowledge alone isn't effective without motivation and knowing what goal you want to reach. During the educational part of the visit, assess what knowledge is already known and what new information will help the child to have a healthy mouth.

Step 3: Teach key oral health messages

Consider using the *Preventing the Spread of Tooth Decay in Babies and Young Children* flip-book (available through the Center for Oral Health) and other educational materials listed in Section 6. This is the opportunity to share the four key messages noted in the box. Determine if this is new information or not, and how the caregiver feels about each message. Do they agree or disagree with the messages? What home oral care do they already perform and how often? Have they encountered any problems or do they have specific questions that will make home oral care easier for them? Is there anything they would especially like more information on or a particular behavior they want to be able to change? A specific plan can be discussed during the [anticipatory guidance](#) portion of the clinical encounter.

Key Oral Health Messages

- Baby teeth are important
- Take baby to dentist by first birthday
- Help children brush daily with pea size amount or smear of fluoride toothpaste
- Don't share toothbrushes or food or lick pacifiers to clean them

Clinical Encounter (10 minutes)

After the educational session, the child(ren) will be treated by the clinician.

Step 1: Conduct a risk assessment

Use the items on the Caries Risk Assessment Form to further engage the caregiver in conversation about home oral care habits and feeding practices. [Motivational interviewing](#) is used to elicit the caregiver's perceptions about certain behaviors, including ability to perform behaviors considered "protective factors" and changing any behaviors that serve as "risk factors" for dental decay. For additional information on motivational interviewing, see Section 6.

Step 2: Conduct a knee to knee assessment to determine the oral health status of the child

Use a [toothbrush prophylaxis](#) ("prophy") to clear any oral debris and plaque and to assess the caregiver's brushing techniques and demonstrate any adaptations that would be more effective. Be sure to compliment the caregiver's efforts to clean the child's mouth. Note that some states do not reimburse for a toothbrush prophylaxis, and use of a [rubber cup prophylaxis](#) is not recommended by the American Academy of Pediatric Dentistry (AAPD) for young children; it also entails use of a dental cart with a hand piece and suction.

Perform a quick visual assessment to count the teeth and determine if there are any white spot lesions on teeth that can be remineralized, if there are any obvious areas of decay, and if the child has previously received any restorative treatment. Determine if tooth eruption is on schedule and check occlusion. Note if there are any soft tissue lesions, inflammation or indications of oral trauma. Show the caregiver if there are areas of concern and how to recognize when there are problems.

Apply [fluoride varnish](#) quickly to cover all the teeth, giving the caregiver instructions about the child's eating and toothbrushing for the next day. Then let the child sit up in the caregiver's lap. To review the procedures for applying fluoride varnish and caregiver instructions, consult Section 6.



Use the Dental Assessment Form to record the results of the oral assessment. Although the findings would certainly be a part of the discussion and anticipatory guidance, they also need to be transferred to the Caregiver Summary Form. This form serves as a reminder about what services are needed and that the child should be seen on a regular basis for dental checkups.

Step 3: Provide counseling to the caregiver based on the risk assessment and the oral health status of the child

Counseling should be selective and based on the results of the interview and the oral screening. It should address any concerns and questions the caregiver may have, as well as clinical observations. If transmission of bacteria from caregiver to child is a problem, then discuss ways to change the behaviors that are putting the child at risk. Discuss any recommendations for use of fluoride toothpaste and any feeding or dietary practices that are of concern. Help caregivers understand what to expect in their child's oral growth and development in the upcoming months and how to prevent or minimize problems. This is a time-sensitive opportunity for the caregiver to reflect on goal setting and be engaged in possible behavior changes. It is also an opportunity to emphasize key oral health messages.

Consider using the Goal Setting Form to help the caregiver set one or two realistic and attainable goals. This form is easy to read and allows caregivers to simply circle some changes they plan to make based on what they have learned. Try to discuss what occurs during a typical day in the family's life and set goals that are realistic. The form serves as a reminder when they get home and a tracking form to note progress when the child returns for another WIC visit. Negotiate an appropriate interval of time for the child to have established a [dental home](#) in the community or to have another dental visit at WIC based on risk factors, usually 3-6 months.

Reinforce the educational messages and the caregiver's commitment with additional educational materials if they have not been given out earlier, and provide an incentive for the caregiver as well as the child (toothbrush, stickers, coupons, etc.).

The Ten Most Successful Strategies

1. Encourage WIC staff to promote the program and engage caregivers about the importance of oral health and the "free" oral health services.
2. Assure that the dental visit team and WIC staff are well organized and ready to go!
3. Suggest to caregivers that it is their "LUCKY DAY" because they are at WIC on a Dental Day!
4. Assure that the whole dental visit team and WIC staff are adequately trained to perform the best possible service in the shortest period of time.
5. Use [Risk Assessment](#) and [Anticipatory Guidance](#) wisely. Small steps with only a few key messages work best.
6. Don't be afraid to go to the waiting room to sell the benefits of the program yourselves! Sitting around



waiting for families to elect to participate in the dental visit is not productive.

7. Empathize with families. Point out that by preventing dental problems now, caregivers can reduce the number of expensive dental procedures their children will need and save them from a great deal of pain and discomfort later in life.
8. Have toys or books available for children who may have to wait for siblings.
9. Provide at least one non-dental incentive for caregivers, such as discount coupons.
10. WIC staff are your new best friends. Teamwork yields the most success! Help WIC staff to understand and value the program.

Referral, Case Management, and Follow-Up

Recommendations for referrals and any specific follow-up considerations should be recorded on the appropriate form or in an electronic management system. This information is given to whomever has been assigned to do referrals and case management and is discussed with the caregivers. Dental professionals and WIC staff need to work together to establish a successful referral system and to assure that families complete any follow-up appointments.

Programs that provide preventive services but do not initiate successful referrals or keep track of a child's progress will not be able to document outcomes that are attributable to the program. If you are unable to motivate caregivers to establish a dental home in the community right away, then it is advisable to recall them at an appropriate interval to check on progress, provide another fluoride varnish application, and continue to emphasize the importance of a dental home.



Billing

To determine how preventive services such as fluoride varnish are billed and reimbursed by Medicaid, check with each state's Medicaid Dental Contact (list available [here](#) 📄) or the State Oral Health Program Director (list available [here](#)).

Billing is different for FQHCs that provide services at WIC facilities. For billing purposes, only a dentist can provide the services. There are multiple ways that FQHCs can receive reimbursement:

- If the WIC clinic is co-located in one of your facilities that is not under your scope of services, you can walk the WIC participants into your dental or medical space and charge encounter rates.
- If you have a dental van, you can make arrangements to provide preventive and restorative dental services in the WIC parking lot and charge encounter rates.
- If the WIC clinic is within your service area, but not any of the above, you can apply to the HRSA Bureau of Primary Health Care for a change in scope of services (but check with State laws first). Once this is received, you can charge the encounter rate. Until you receive the change in scope, there is no reimbursement mechanism through Medicaid.

Billing is for codes D9430 & D1206 Office Visit/Fluoride Varnish, billable at the FQHCs core rate. Work with the state's Medicaid program to ensure the ability to bill the core rate as this may differ between states. Procedure code D9430 Office Visit (without the fluoride varnish) is not billable.

FQHCs can bill PPS if they perform one or more of the following services: dental exam, prophylaxis, or fluoride varnish application.

Detailed information for FQHCs can be found in Section 6.

Using Data for Program Management and Evaluation

During the initial planning stages of the program, a management and evaluation plan should be jointly established by the dental providers and WIC staff. This should include 1) what data will be collected and how often to measure progress, 2) who will collect the data, 3) who will analyze the data, and 4) how the data will be shared and used to document successes and initiate improvements.

During program implementation, make sure that the forms and procedures being used are actually collecting the necessary data. Make sure successful processes (paperwork, participant flow, etc.) are documented, as well as clinical (better oral hygiene, prevention of caries) and educational (appropriate feeding, home care behaviors) outcomes, with both quantitative (numbers of children seen and how often, percentages of caregivers who follow up on referral, etc.) and qualitative (caregiver satisfaction or success stories, marketing successes, etc.) data.

Successful relationships between WIC staff, community programs, and dental providers are also important to document. This kind of information is critical for program sustainability, leveraging additional funding, and/or expanding the program to other sites.

Healthy Teeth Toolkit (HTTK)

The Healthy Teeth Toolkit (HTTK) is a data management tool developed by the Center for Oral Health specifically for managing the delivery of preventive dental services in community-based settings like WIC centers and schools. Designed to track preventive dental services over time, it gives community oral health programs the ability to measure the efficacy of their protocols and intervention strategies.

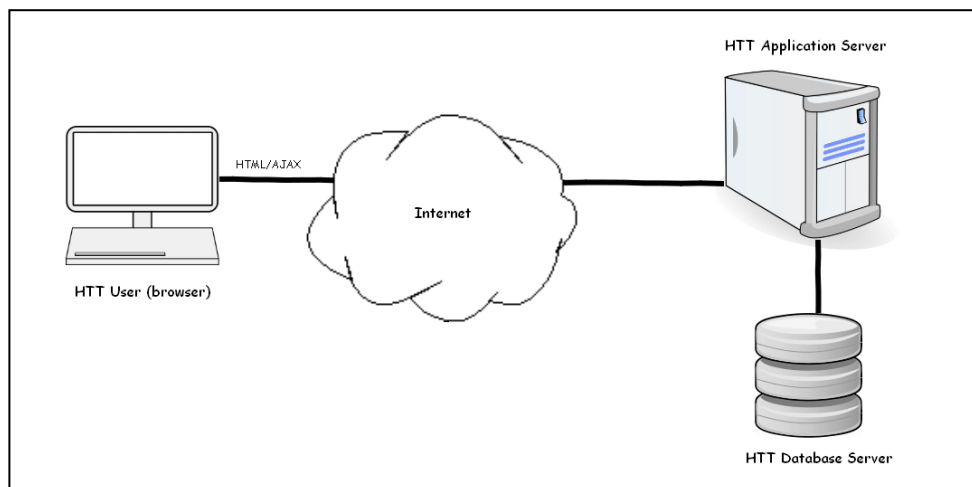
Note: The HTTK is currently used by several community oral health organizations as part of a beta-test of the HTTK system. These organizations provide real-world environments to test the features and functions of the HTTK. The Center for Oral Health plans to release a new version of the HTTK in 2012 which will be available to any community oral health program. Until then, please contact COH if you interested in becoming a beta-test site.

HTTK tracks oral health screenings and preventive dental services including application of fluorides and sealants, prophylaxis (tooth cleaning), oral health education, and risk assessment. It uses well-established public health standards, such as the ASTDD Basic Screening Survey and the AAPD Risk Assessment. It is customizable and can be adapted to record data specific to any oral health program.

HTTK's case management tools allow community dental providers to document progress through their manage-to-care process, matching children to needed therapeutic services. It documents contacts with participants (who, what, when) and with third parties on behalf of participants. The tools can be adapted to model virtually any protocol, documenting the process as a series of predefined tasks and outcomes. This allows case management, typically a dynamic and loosely documented process, to be analyzed with some degree of rigor.

Structure

The HTTK is web-based. Data is stored on a secure server accessible over the Internet. Users of the HTTK access the system through the HTTK website, www.healthyteethtoolkit.com, using a login name and password.



Data

Data stored in the HTK is organized in three primary participant records categories:

Child Records (Personal and family information)

Children (participants) are typically entered in the system by name and date of birth. Additional information can be entered including demographics, insurance status, parent/guardian names, and contact information.

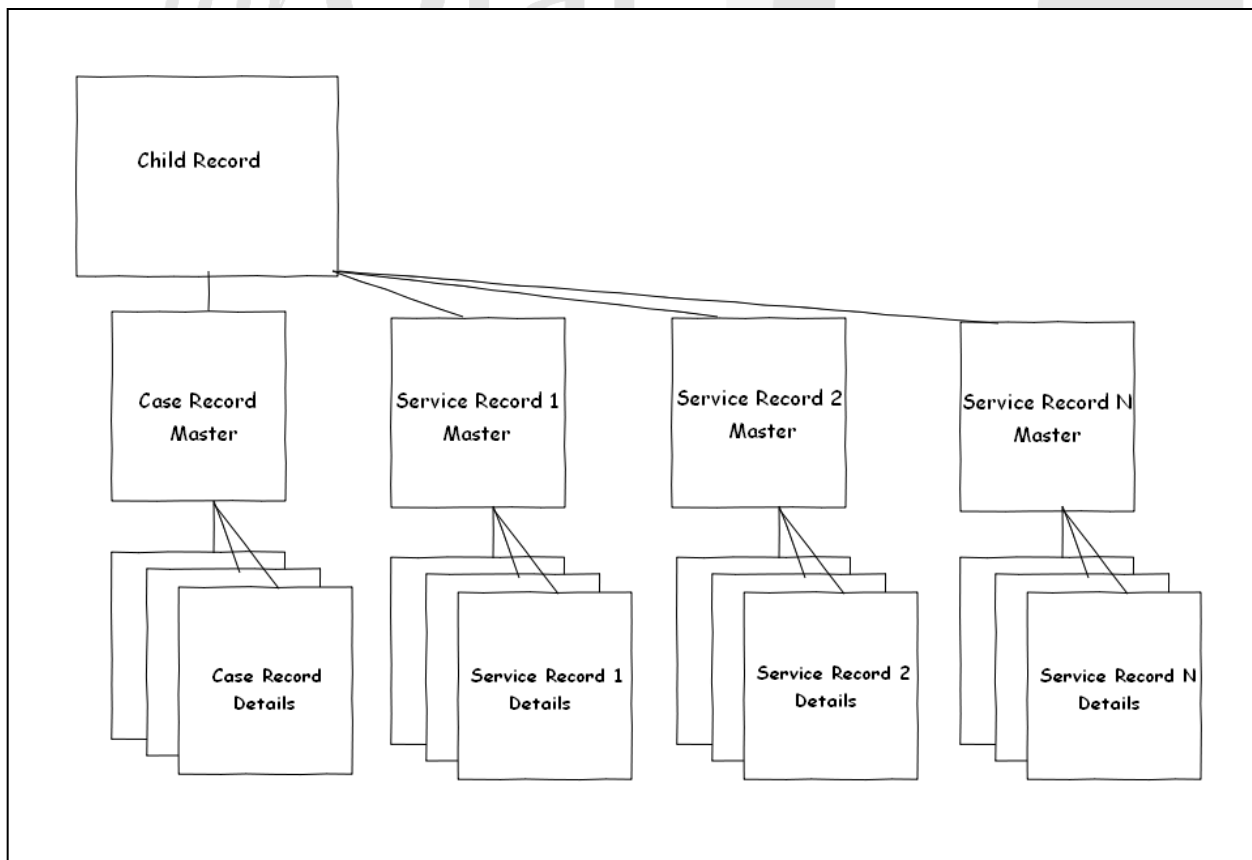
Service Records (Dental service information)

Children can have multiple service encounters, each documented by date, provider, and services rendered.

Case Records (Logs of contacts with/on-behalf of participant)

Case management encounters, whether direct to participant family or to third parties on their behalf, are documented by date/time, case manager, and encounter notes.

A schematic of how data is organized in the HTK is shown below:



HTTK User Interface

The user interface used to view / add / maintain these data records is straightforward and participant-centric. The primary data view is the “Child Record List.” This list can be all-inclusive, showing all children entered in the system, or filtered to show a select few.

Child Record List

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Reminders(0) Welcome Mary! | My Account | Help | Logout

Home Children Tools Providers Users Reports

All Child Records Search Children | Clear Search | Create a New Child

Info Service Case Appointments

Record List

Search/Filter

Results: Viewing items 1-10 of 1000. Previous | 1 2 3 4 5 6 7 8 ... 100 | Next

Name	DOB	Gender	Phone	Primary Address	
<input type="checkbox"/> VANG, Janay	11/12/2003	F	(510)663-2498	233 Timber Rd, Oakland, CA, 94603	
<input type="checkbox"/> WHITFIELD, Ethan	05/02/2001	M	(510)663-6568	61 Pine Ave, Oakland, CA, 94603	
<input type="checkbox"/> NOEL, Rollie	02/17/2004	M	(510)661-2175	124 Blossom Ave, Berkeley, CA, 94601	
<input type="checkbox"/> WHITLEY, Kenneth	07/01/2002	M	(510)664-6463	151 Anchor Rd, #25, Oakland, CA, 94604	
<input type="checkbox"/> VELAZQUEZ, Edward	11/11/1998	M	(510)665-3142	386 Blue Rd, Oakland, CA, 94605	
<input type="checkbox"/> COOKE, Laurence	03/04/2003	M	(510)665-7751	341 Lake Rd, Oakland, CA, 94605	
<input type="checkbox"/> KNOWLES, Earlean	08/05/2000	F	(510)666-1931	360 Arbor Rd, #14, San Leandro, CA, 94606	
<input type="checkbox"/> LANGLEY, Greyson	04/19/1998	M	(510)665-8217	289 Lane Rd, Oakland, CA, 94605	

Filtering is accomplished by setting matching-criteria for one or more data fields of the Child, Case, and Service records using the built in “Search” function. Search is a powerful feature that can be used to quickly determine if a child is in the system (helps prevent duplicate records) or get a count of children for a particular profile or condition (valuable for data analysis).

Service Records

The Service Record documents up to six preventive services commonly performed by community oral health programs:

- Oral Health Evaluation (based on the ASTDD Basic Screening Survey)
- Caries Risk Assessment (based on the AAPD developed survey)
- Fluoride varnish application
- Dental sealant application,
- Prophylaxis (tooth cleaning)
- Oral health education

Child ID:* WHITFIELD, Ethan
DOB: May 02, 2001
Site (School): Temescal Elementary
Program: WIC
Consent: Returned - Yes
Outcome: Treated
Notes:
Created By: Smith, Mary [U-283]

Cancel Save Save as Template

Supported Services

Case Records

Case management contact records document interaction with participants or with others on their behalf. An organization's protocols define the case management goal and the steps to achieve it. Typically, for community oral health programs, the objective of case management is to connect children identified in need of therapeutic services with providers of those services.

Contact By: Smith, Mary [U-283]
Contact Type:* -Select-
Timestamp:* Jun 30 2011 Hour AM 00
Notes:
Tasks
Initial Contact Attempt
Successful
Unsuccessful
Limit Reached
Enrollment
Declined
Accepted
Appointment
Dental Made
Dental Kept - Yes
Follow Up
Successful
Unsuccessful
Save Cancel Exit
Contact By: Smith, Mary Contact Type: Phone - Successful Contact Timestamp: Jun 30, 2010 11:00:00AM
Initial Contact Attempt: Successful Appointment: Dental Made

Protocol Map

Contact Chronology

Healthy Teeth Toolkit Version 2

The new release of the HTTK, version 2, is anticipated to be available by mid-year of 2012. This version refines and extends the current feature set.

Clinical / Practice Management New Features

- More efficient methods for data entry in community-based care environments
 - Prevention/resolution of duplicate records
 - Support for tablet computer (e.g. iPad) based data entry at point of service
 - Input Templates – predefined sets of default values to reduce data entry overhead
 - Bulk data import
- Billing for services
 - Support for CDT coding
 - Electronic and paper based submission
 - Tracking of billing status
 - Optimized for Medicaid
 - Audit trail recording
 - Tiered, privilege-based data entry
- Report generator
 - Documentation of analytic results
 - Support for COHP forms and correspondence
 - Support for customized report output formats
- Interoperability with other software systems
 - Data transfer with other software systems (e.g. practice management systems)
- Data security
 - HIPAA compliance
 - Encrypted data entry and transmission
 - Regular data backup

Case Management New Features

- Coordinates with third party therapeutic providers
 - Automatic confirmation of received care via third party practice management systems
 - Manual confirmation of received care via special third party user login accounts
- Supports calendar-based reminders
 - Reminders linked to participant records
 - General reminders

Program Sustainability

For a program to be “sustainable,” the resources needed to operate it must be sufficient and available when needed. Sustainability also means that the purpose, spirit, and ideals of the program stay intact even when there are changes in personnel, sponsors, or funders. Sustainability should be addressed during the planning stages and throughout the program; otherwise important decisions may be subsumed by day to day operations and re-emerge when a crisis occurs.

Assuring that the resources are available to operate a program over time also requires the development of a shared vision among those who can manifest the necessary financial, personnel and material resources. This means that shared resources can come from a variety of agencies, like WIC, dental providers, clinics, the local health department, Maternal and Child Health Programs, and other local programs (e.g. county [First 5](#) programs, in California).

Tips to promote sustainability

- Work with the local health department and other State and local agencies to access [Title XIX Federal Financial Participation](#) (FFP) matching funds for non-clinical services. These include case management, program organization, quality assurance, interagency coordination, planning, and other non-clinical services designed to increase access to Medicaid services for eligible participants. These federal funds can be accessed through matching with local or state non-federal dollars. Note that there is a process in place for acquiring these funds; it is not automatic and will require setup. See Section 6 for more on FFP.
- Work with WIC to develop a system to maximize the number of Medicaid-eligible children who are scheduled for dental visits. This will also maximize FFP funding toward reimbursement.
- Promote ownership and celebrate accomplishments among all of the key players:
 - WIC staff
 - Dental providers
 - Participants
 - Other community programs
 - Program managers and policy makers
- Work closely with other community-based organizations or funders to create additional support for the program.



Section 4. Information for WIC Personnel

WIC's Role in Connecting Oral Health and General Health

Families often don't understand the connection between oral health and general health; this is not surprising given how differently dental care delivery, financing, and professionals are treated compared to their counterparts in other aspects of health care. Federal agencies are slowly trying to change this situation by co-locating dental and medical clinical services together in community health centers, allowing medical professionals to bill for certain procedures that promote oral health (e.g., [fluoride varnish](#)), and encouraging dental practitioners to interface with other community agencies. WIC staff can help dental professionals learn to interact more effectively with low-income families of diverse backgrounds, integrate oral health messages with important nutrition information, and help families set goals that are realistic and attainable.

The on-site preventive oral health services delivered through this program will, more often than not, represent a WIC family's first professional oral health encounter. WIC provides the family with a familiar, comfortable environment in which they can introduce their child to dental care, without the sometimes overwhelming and frightening features of a dental office. WIC staff can also help refer children for comprehensive dental care in the community and identify supportive services that will assist families in taking advantage of that care.

Preparing to Initiate an Oral Health Program

In Section 2, a number of questions were posed for the WIC staff and dental coordinators and/or providers to consider when planning the program. Review these questions, as well as the following topics.

Oral Health Knowledge and Education

Discuss the oral health-related questions and key messages already incorporated into WIC's breastfeeding and nutrition counseling. Are they consistent with evidence-based practices that contribute to improved oral health? If not, ask the dental coordinator to provide up-to-date information

How WIC Benefits from the Oral Health Program

- Provide most up-to-date information on how to protect children's oral health
- Does not interfere with provision of WIC services
- Helps cover the oral health portion of WIC curriculum
- Links patients to dental care services
- Added bonus to normal WIC services

via in-service training or some other means so all staff are on the same page and not teaching incorrect or conflicting information to caregivers.

Review the risk assessment forms and educational materials the dental team plans to make sure important messages are reinforced and methods and materials are appropriate. WIC staff can give dental providers and educators valuable input about education materials and strategies to ensure they are effective with WIC participants. This is particularly important if your WIC site serves families who speak a variety of languages. Decide which oral health educational messages need to be translated and who will be the most effective educators. Are there staff or volunteers who can help with translation during dental visits or educational sessions? If possible, try to enlist the help of dental providers in the community who speak the languages and are familiar with the cultures of the majority of the participants.

Scheduling and Participant Flow

The success of the oral health program depends heavily on the management of participant flow and the volume of participants treated by the dental team. Core WIC services should not be disrupted, but the dental team will likely require some assistance from WIC staff in generating interest among participants and acquiring participant information. Finding the right balance may take some brainstorming and negotiation. For dental providers to cover their expenses and time, and to make the program sustainable, they need to be able to either bill [Medicaid](#) for a certain number of services or document to other funders how productive they have been; therefore, participant volume and access to Medicaid information are critical.



WIC staff know what works best for their participants. The day and time of on-site dental services should be decided jointly by WIC staff and the dental providers, but WIC staff will be able to suggest the most opportune time to see as many families as possible. Once services start, participants begin to expect them on a regular schedule.

The WIC director and staff should consider whether it makes sense to have appointments for the dental visit (generally, this makes sense only if the WIC site sets up appointments for other services) or whether the dental staff, WIC staff, or both will need to market the program to participants in the waiting room. In some circumstances, it may be practical to make appointments and, if there are “no shows,” recruit WIC families from the reception area to fill in the open time slots. If an appointment-based system is chosen, it would be helpful for WIC staff to call participants the day before their appointments as a reminder, if possible. Depending on resources, WIC staff may want to offer more

than one kind of appointment reminder to support participant attendance (e.g., a reminder postcard or magnet, or a reminder in the WIC passport, etc.).

The best way to assure effective participant flow is to develop an efficient way to collect and verify Medicaid information and complete the other necessary paperwork needed for the program. Decisions regarding paperwork, including translation into other languages and availability of participant assistance, need to be made well in advance of the program debut. How this is accomplished will vary by WIC site and require WIC staff input and partnership. Although participant flow may be slow and awkward at first, it should grow more efficient as dental providers and WIC staff become more familiar with the program routine.

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Marketing the Program for Success

Marketing is crucial for any program. Although there are many strategies for marketing this program, one critical strategy is for WIC staff to inform families early of 1) the importance of home oral care and professional dental care for their child and 2) the availability of preventive and education services at the WIC site. Refer to Section 6 for examples of materials.

Potential Marketing Strategies

Posters / Flyers

Post well-designed posters and flyers in relevant languages and using appropriate graphics for local populations at WIC sites or other community sites where WIC beneficiaries will see them. This could be a series of posters introducing the importance of oral health and then announcing the services, or one that combines both messages.

Posters should inform caregivers about the new free service available: when, where, and how services will occur, and who will be providing them. Posters should emphasize the relationship between oral health and WIC goals for children and their families. An example (shown here) can be found in Section 6.

Potential venues for poster / flyer distribution:

- Local discount stores
- Grocery stores
- Laundromats
- Bulletin boards in apartment buildings

Participant Handouts

Inexpensive self-designed labels or stickers can be placed on any written materials the participants take home from WIC. The label could advertise the services, remind them to make an appointment, or encourage them to tell their friends and relatives about the services.

Schools

Outreach to state-funded preschools, Early Head Start, and Head Start programs to inform them about the program. Also include such information in any caregiver education classes given through the Health Department. Assure that School Nurses know about the WIC oral health services. They often interface with caregivers of children younger than 5 years old at either Enrollment Centers or in schools when looking for resources for families.



Newspapers

The local *Penny Saver* (or similar free newspaper) is read by many participants, as well as smaller community newspapers.

PSAs

Public Service Announcements on local radio / TV / cable stations in the most appropriate language for the populations in your community.

Religious Communities

Churches located by the WIC site often attract many families. There may also be “Parish Nurses” who can assist in promoting the program and encourage families to seek services if they already promote WIC.

Other Public Service Programs

[Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\)](#) and [California Child Health and Disability Prevention \(CHDP\)](#) program participants are always referred to WIC. Remind CHDP Nurses to inform all providers about the oral health program and to counsel caregivers to take advantage of the free preventive dental services.



In California, cultivate a relationship with the [Transitional Assistance Department](#) (they enroll participants in Medicaid) to inform them about the program and encourage caregivers to participate.

Partner with [Maternal, Child, and Adolescent Health \(MCAH\)](#) Programs at county or city Departments of Public Health. Inform any Home Visitors about the program so they can encourage new caregivers to attend the WIC services.

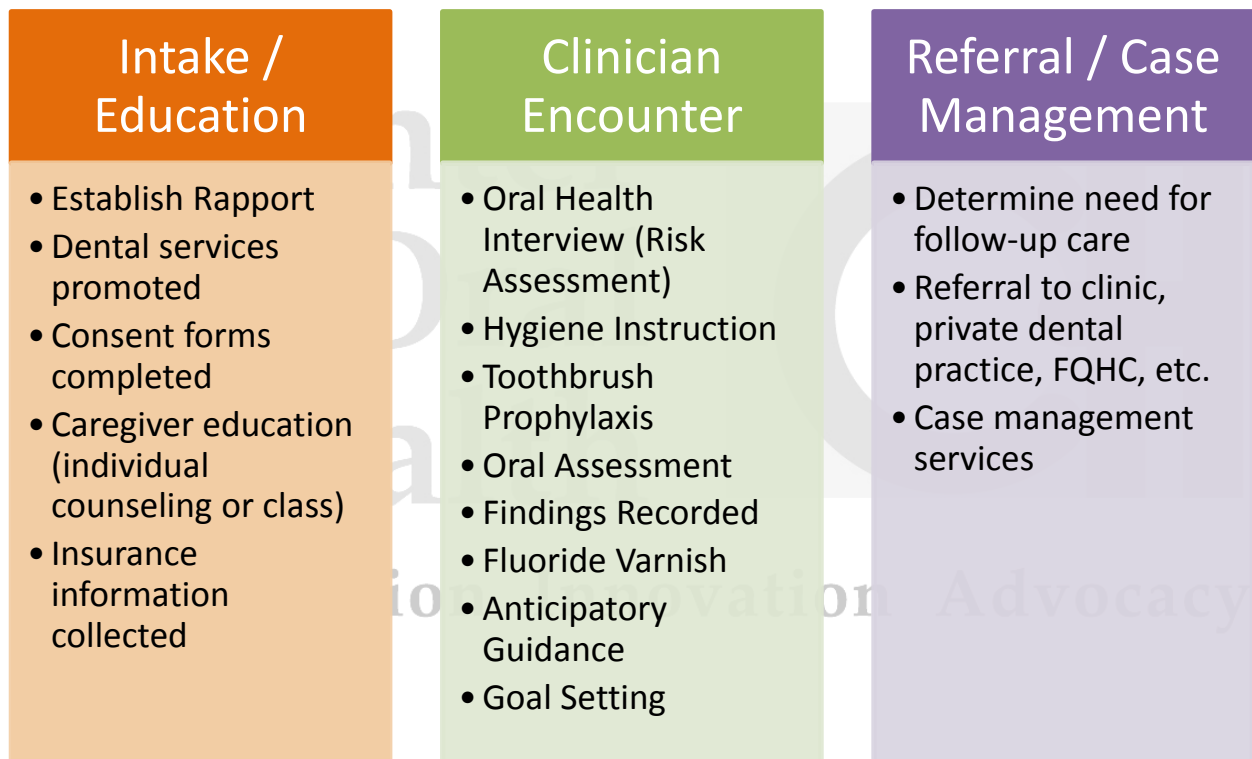
Most states have [Family Resource Centers](#) for families of children with special health care needs. Make sure they have information about the WIC oral health services as many of these families may also be eligible for WIC.

Dental Providers

Place information and flyers at the clinical site(s) of the dental provider for the program, especially if that site is a community clinic or community health center.

Site Setup for Dental Days

Provide the dental team with a tour of the facility so they know where the various WIC services occur and where the restrooms are located. Refer to Section 2 for determining the best physical location to set up for dental visits. Have the dental providers explain their program needs, particularly in relation to hand washing and infection control. Let them know if there is any secure storage where they can keep supplies or participant paperwork. Typical supplies are listed in Section 3. Decide where paperwork should be kept and how additional copies can be made if needed. The sequence and specifics of what occurs on dental days are found in Section 3 and visually displayed below. Have the dental staff walk through the process of a dental visit so you are familiar with the process and paperwork and so you can answer questions that families may have.



Referral, Case Management, and Follow-Up

Depending on the referral and case management model chosen, WIC staff responsibilities will vary. One goal of the program is to make families aware of the need for an ongoing [dental home](#) where their child can receive comprehensive oral health care. Staff members familiar with dental practitioners in the community can be important links to help families schedule follow-up appointments, complete any additional paperwork, and negotiate any barriers that may interfere with them keeping the appointments. This can also help with communication between dental team members providing on-site services and other practitioners who might be seeing the children.

Dental professionals and WIC staff need to work together to establish successful referrals and to assure that families complete follow-up appointments. Programs that provide preventive services but do not initiate successful referrals or keep track of a child's progress will not be able to document outcomes that are attributable to the program. Referrals and outcomes from referrals should be documented for easy retrieval. Specific forms and the Healthy Teeth Toolkit (HTTK) electronic data management system are described in Section 3.

Healthy Teeth Toolkit (HTTK)

HTTK, a data management tool developed by the Center for Oral Health, is designed to track preventive dental services and case management over time. HTTK is a web-based tool, accessible via an Internet browser, so it can be used anywhere. A mobile (laptop) version is also available.

Learn more in Section 3.

Using Data for Program Management and Evaluation

During the initial planning stages of the program, a management and evaluation plan should be jointly established by the dental providers and WIC staff. This would include 1) what data will be collected and how often to measure progress, 2) who will collect the data, 3) who will analyze the data, and 4) how the data will be shared and used to document successes and to initiate improvements.

During program implementation, make sure that the forms and procedures being used are actually collecting the necessary data. Make sure successful processes (paperwork, participant flow, etc.) are documented, as well as clinical (better oral hygiene, prevention of caries) and educational outcomes (appropriate feeding, home care behaviors), with both quantitative (numbers of children seen and how often, percentages of caregivers who follow up on referral, etc.) and qualitative (caregiver satisfaction or success stories, marketing successes, etc.) data.

Successful relationships between WIC staff, community programs, and dental providers are also important to document. This kind of information is critical for program sustainability, leveraging additional funding, and/or expanding the program to other sites.

Section 5. Program Models in California

In this section you will find descriptions of five different models of the *WIC: Early Entry into Dental Care Program* in California, each unique in the way it provides oral health services with WIC.

There are many different ways to implement a preventive dental care program with WIC.



Which model might work in your community?



Alameda County Office of Dental Health

Urban / Suburban • Dental and WIC both County-operated

Alameda County, located just east of the San Francisco Bay, is an urban and suburban county with over 1.5 million residents and 14 cities. As the most ethnically-diverse county in California, those implementing the program in Alameda County have had to pay special attention to many different sets of cultural concerns.

Model Description

The Alameda County Office of Dental Health (ODH) is currently collaborating with two county-operated WIC centers, which served over 4,000 women and 13,000 infants and children in March 2011. The ODH will include a third site in the near future, and plans to add others in time. The ODH and the county WIC program have worked together for decades as two branches of the county's Department of Public Health; this relationship allowed for much better cooperation in developing and administering this program.

A dental team consisting of one Registered Dental Hygienist (RDH) and one or two case managers visits each of the two WIC centers once per week, usually treating 12-20 participants per day. The schedule was devised to maximize the number of potential participants per visit. Participants in need of further treatment are referred by county case management staff to community clinics or private dentists. Some of these providers have contracts which allow them to bill the county for treatment of uninsured children.

Sustainability

Around three-quarters of participants receive dental benefits through Medicaid, and thanks to strong support from WIC staff in acquiring billing information, all of these participants can be successfully billed. The dental team is reimbursed for uninsured participants by Alameda County through its sponsored care program.

The ODH is able to sustain the program largely through grants, thanks in part to their efforts in publicizing the program and appealing to private and public funding sources. Its main objective, with regard to funding and sustainability, is to attain

- Office of Dental Health and WIC are **tightly integrated**
- Sustainability objective for ODH: **Gain FQHC status**
- High level of public **visibility** helps program earn additional funding

Federally Qualified Health Center (FQHC) status. This would allow dental staff to bill at a higher rate and cover the costs of non-paying participants, thus improving the odds of long-term sustainability.

Marketing and Outreach

Dental services are promoted through posters at WIC centers, face-to-face discussions with WIC staff, and appointments (and reminders) by county case management staff.

Education

Caregiver education is done in two stages: first through a class taught by a WIC nutrition assistant, then through one-on-one guidance with the RDH during and/or after the visual assessment.

The class lesson plan has been revised several times. At first, preprinted lessons from First 5 and the Office of Dental Health were used; while these were comprehensive and contained good information, they were not effective lessons for this population. The class is now based on a PowerPoint presentation with ten key take-home messages, and counts as one of the caregivers' required WIC nutritional education encounters. The classes are given two to three times per day in either English or Spanish, depending on the day.

Communication

The participants generally speak either Spanish (around 60%) or English (around 40%). The case managers that serve on the dental staff are bilingual and often translate for the dental hygienist. In addition to language needs, the Office of Dental Health organizes its dental team so it will represent the ethnicities and cultures of the participants it expects to serve. This has proved invaluable for dealing with health-related cultural concerns, as well as with subtle cultural differences that could easily be missed; for example, expectations of how health professionals should communicate with their participants.

The dental staff also provides a variety of materials including an assessment of findings, referral information, the First Smiles *Healthy Teeth Begin at Birth* pamphlet (contact the Center for Oral Health for more information), toothbrushes, dental floss, toothpaste, and the *Dora the Explorer* book titled *Show Me Your Smile!: A Visit to the Dentist* (see Section 6 for bibliographical information).

The dental team has found this book to be particularly helpful. Not only do they believe it to be the best children's dental book available at the moment, but they have also found it to dramatically ease children's anxiety about their dental visits.

Case Management

The Office of Dental Health case management staff tracks visits, referrals, and referral follow-through with their *Healthy Kids*, *Healthy Teeth* database. WIC staff schedules screening appointments with the on-site dental staff and provides support for follow-up.



Humboldt County Dept. of Health and Human Services

Rural • Community Health Outreach Worker

Humboldt County, located on the far-north coast of California, is a densely-wooded and mountainous rural county with approximately 130,000 residents. Between the county's large size, rugged terrain, and lack of pediatric or low-income dental services, access to dental care can be very difficult.

Model Description

The Humboldt County Department of Health and Human Services (HCDHHS) dental team is collaborating with three WIC centers in the area. Collaboration has gone quite smoothly, thanks in no small part to the project leader's prior experience in working at the same WIC centers now involved in this program. The team accepts repeat visits for continued preventive care, and typically refers participants with signs of decay to a private dental center in the county (or to more advanced centers if severe decay is found). The current model employs a team of one Public Health Nurse, one [Community Health Outreach Worker \(CHOW\)](#), and one office assistant; the team bills through a dentist affiliated with the HCDHHS. The team visits each of the three WIC centers twice per month, roughly three hours at a time. Unfortunately, due to the rural nature of the area, this typically yields only 3-10 participants per visit.

The new model, effective July 2011, will no longer use a public health nurse and will rely on the CHOW to perform visual assessments and fluoride varnish applications. The schedule will also be scaled back to one visit per WIC center per month, and the team will double-book every other appointment to mitigate time lost on participants who fail to attend their appointments (which are more significant here due to the low volume of participants). HCDHHS hopes this will allow the team to see participants more efficiently.

Sustainability

Approximately 90% of participants are covered by Medicaid dental benefits, and a significant majority has been successfully billed; it has been the dental team's experience that almost all participants bring their Medicaid cards, so they have little difficulty acquiring billing information. A small percentage of participants is covered by Children's Health Insurance Program (CHIP), but the majority of the remaining 10% is uninsured.

- Rural county with few pediatric dental services, particularly for those covered by Medicaid
- Utilizes Community Health Outreach Workers for assessments and varnish

In addition to participant billing, the HCDHHS receives some money through state funds, local grants, and the Center for Oral Health.

Marketing and Outreach

Dental days are promoted through posters displayed at WIC, Head Start, and family resource centers, and face-to-face discussions with WIC counselors.

Education

WIC centers in Humboldt County do not have enough participants present at any given time for classes to be feasible, so WIC education is done individually. In addition, the CHOW discusses topics like family dental history, brushing history, and current habits, then works through the goal sheet with the caregiver; under the current model the nurse does the assessment and anticipatory guidance, but when the new model is implemented this will all be done by the CHOW.

WIC and dental staff have not found motivational interviewing techniques or ephemera (aside from the goals worksheet) to be particularly effective with their participants, so they are not used.

Communication

Most of the participants are English-speaking, but some are primarily Spanish-speaking; they are scheduled on days when the HCDHHS interpreter is available.

Case Management

The dental team refers participants to outside care and keeps records of children when they receive dental services at WIC, but does not have the resources to do any further case management.

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Sole-Practitioner RDHAP, Pomona, Los Angeles County

Suburban · RDHAP

The city of Pomona is the fifth largest city in Los Angeles County. It has a population of nearly 150,000, almost two-thirds of which are Latino. While this suburb has no shortage of low-income pediatric dental care options, awareness of and motivation to attain quality oral health care is lacking.

Model Description

Debbie Hartman is a sole-practitioner Registered Dental Hygienist in Alternative Practice (RDHAP). Ms. Hartman, along with two assistants, makes weekly visits to two WIC centers in Pomona, each of which serves thousands of women and children per month. Her team typically treats 5-10 participants per five-hour visit.

Participants who require treatment for caries are referred to one of several venues; one of the local dental practices, the nearby dental school, or one of the two local children's dental clinics. All of these establishments accept Medicaid.

However, despite the high availability of pediatric oral health care, it does not seem to be a priority and participants are often unaware of dental services for which they are eligible. Ms. Hartman has also found knowledge of proper oral health practices to be rare and caries in both in children and adults to be abundant.

- **Predominantly Latino** area, but dental team members all **speak Spanish** and are familiar with Latino culture
- **Many options for pediatric dental services** in the area, but **little motivation** to use them

Sustainability

There are several issues that make sustainability a challenge for this model.

Perhaps the most critical is the small number of participants the team sees during each visit. Other major concerns include the low reimbursement rate for an RDHAP and the difficulty in billing participants with Medicaid managed care. Participants on managed care are often unwilling to provide their billing information for fear of losing benefits that could be used at a dental office. Ms. Hartman estimates that around 70-80% of her participants have Medicaid dental benefits, while around 20% are undocumented. Ms. Hartman's team does not turn away any participants, but many of them are not

billable due to managed care reimbursement restrictions or lack of billing information. Ms. Hartman is considering seeking additional funding to cover some of her non-paying participants.

Marketing and Outreach

Dental Days are announced by WIC staff during nutrition classes. Ms. Hartman also posts a sign and her schedule in each of the WIC centers she visits.

Education

WIC staff does not participate in dental education, so it is provided entirely by the dental team. The lesson is done one-on-one between a caregiver and, usually, one of the assistants. It is based on the *Preventing the Spread of Tooth Decay in Babies and Young Children* flip-book (available through the Center for Oral Health), though Ms. Hartman has added additional content such as xylitol information, discussion of the pH change of saliva after eating, and instructions on brushing and flossing for older siblings.

The team also provides a variety of materials for participants to take home, including informational pamphlets on several oral health topics (also available in Spanish), stickers, toothbrushes, toothpaste, dental floss, mouth mirrors, and two-minute timers.

Communication

Approximately 90% of Ms. Hartman's participants primarily speak Spanish. Ms. Hartman and her assistants are Latina and speak Spanish. Ms. Hartman has found this familiarity with her participants' language and culture to be extremely helpful; it allows her and her team to more readily connect with them and anticipate potential issues.

Case Management

Ms. Hartman uses the Center for Oral Health Healthy Teeth Toolkit to manage participant information. Aside from referrals to other dental services, her team does not provide case management services.



La Clinica de Tolosa, San Luis Obispo County

Rural • Non-Profit Pediatric Dental Clinic

With just under 250,000 residents, San Luis Obispo County is a primarily rural county, best known as one of California’s largest wine-producing regions. Located in Paso Robles, the second-largest town in the county, La Clinica de Tolosa is a non-profit clinic that focuses on providing dental care for underserved children.

Model Description

As a specialized pediatric dental clinic whose main objective is to provide care for the underserved, La Clinica de Tolosa brings a great deal of relevant experience to this program. Its employees are both familiar with the low-income demographic in their area and highly competent at providing dental care to young children.

The clinic’s dental team, consisting of one dentist and one dental assistant, provides care at one local WIC center (located next door to La Clinica de Tolosa) with a participant base of approximately 1,700 women and children per month. The team works at the center twice per month, and sees 10-15 participants at each three-to-four hour visit. Participants requiring further treatment are referred back to La Clinica de Tolosa the following month.

- Dental staff is **highly experienced** in treating high-risk infants and toddlers
- Clinic located **adjacent to WIC center**

Sustainability

The major barriers to the sustainability of this program are the low volume of participants and the high cost of employing a dentist. However, La Clinica de Tolosa does report a high number of billable participants; over 95% of its participants have Medicaid-covered dental benefits, and around 80% of its participants are successfully billed. Aside from the Center for Oral Health grant, they do not have any other sources of funding for the program.

Marketing and Outreach

Dental services are promoted by WIC staff through face-to-face discussions, appointment scheduling, and by handing out Dental Days flyers.

Education

Classes are usually not practical in a rural area such as San Luis Obispo County, so teaching is done one-on-one: first by the dental staff during the assessment, then by a WIC dietician afterward. The WIC portion counts as one of WIC's required educational encounters, so participants have additional motivation to attend. As La Clinica de Tolosa specializes in providing pediatric dental care to this demographic, they are well-versed in educating caregivers about their children's oral health.

Education consists primarily of a verbal discussion about goals and concerns identified in the caregiver questionnaire and the visual screening of the child. Handouts on brushing, toothpaste, diet, infant care, and other topics are provided, as well as age-appropriate toothbrushes, floss, and fluoride toothpaste.

Communication

While San Luis Obispo County as a whole is primarily white and English-speaking, around 65-75% of the participant families participating in this program speak Spanish as their primary language. La Clinica de Tolosa ensures that there is at least one Spanish-speaking member on the dental team to meet this need and provides questionnaires and educational materials in both English and Spanish.

Case Management

Due to lack of resources, La Clinica de Tolosa does not currently provide case management services. WIC staff does assist participants in scheduling appointments at the clinic, however.

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Community Action Partnership of Sonoma County

Suburban / Rural • Dentist and RDHAP

Sonoma County is a suburban and rural county, with a population of roughly 480,000. While this beautiful county has over 250 wineries and attracts more than seven million tourists per year, poverty is not uncommon and low-income dental services—particularly for children—are lacking.

Model Description

The Community Action Partnership of Sonoma County (CAP Sonoma), a non-profit public health organization, is currently collaborating with two of the four WIC centers in Sonoma County. They will be expanding to a third WIC center soon, and hope to include the fourth in the future. In total, these four centers serve over 10,800 participants per month. Their dental team consists of a [Registered Dental Hygienist in Alternative Practice \(RDHAP\)](#), who performs most of the participant treatments; a [Community Health Worker](#); and a dentist, who facilitates the program and provides medical orders when required for the RDHAP to continue providing services.

The team is on-site five times per month and sees between 30 and 60 participants per day (depending on the WIC center and the length of the visit). Between January and March in 2011, the team averaged 211 participants per month. The team treats all siblings up to age 8 if services are requested.

Participants requiring more than preventive care are often referred to a local dental clinic which, conveniently, has a mobile unit that visits WIC centers specifically to treat children. The Sonoma

County Indian Health Project treats a number of Medicaid dental clients in addition to the native population, so some participants are referred there instead. For participants requiring general anesthesia for treatment, the team refers to either a nearby non-profit pediatric dental surgery center, or if they are covered by Kaiser Health Insurance, a local dentist contracted with Kaiser.

- Young, low-income children have **very few dental home options** in Sonoma County
- Dental team at WIC takes **repeat visits**, has established itself as a **preventive dental home**

Sustainability

While 76% of participants have Medicaid-covered dental benefits, only two-thirds of these (48% of its total clientele) are actually billable. It is difficult to make the program sustainable with such a low number of paid claims, but CAP Sonoma has found additional sources of funding. These sources include grants, monetary donations from a local business and a local charity group, and dental supplies from the RDHAP participating in the program.

Marketing and Outreach

Dental Days are promoted through face-to-face discussions with WIC staff and word-of-mouth referrals from other participants. Due to the high need for these services in Sonoma County, additional marketing has not been needed.

Education

The class, developed collaboratively by WIC and dental staff, is notable in that it satisfies the WIC requirements for a nutritional education class and therefore provides additional incentive for participants to attend. While WIC staff was originally trained by the dental team to use the *Preventing the Spread of Tooth Decay in Babies and Young Children* flip-book, the lesson was revised to more closely resemble other WIC classes. It now revolves around five key messages, displayed on a large chart in the front of the classroom. The WIC educator explains several examples of each, and holds up photos for the class to examine.

The dental team, whose members have experience with this population and age-group, provide anticipatory guidance during the visual assessment to reinforce topics covered in the class.

Communication

Approximately 75% of participants are Spanish-speaking, and illiteracy is also a concern. The community health worker handles both translation and assistance with forms for the illiterate, and the risk assessment and goal-setting worksheets have pictures to aid comprehension.

Case Management

While most models for this program refer participants to a dental home outside of WIC, Sonoma County is notably lacking in suitable dental services for children in this age range and population. The dental team has therefore taken it upon themselves to become the dental home for their lower-risk participants (Class I and Class II) who require only preventive care. The team provides case management services including referrals to dental providers, help applying for insurance, and participant tracking. They also have a system in place through which WIC staff can reschedule participants for bi-annual visits.

Section 6. Resources

Center for Oral Health Contact Information

Email: info@tc4oh.org

Phone: (510) 663-3727

Early Childhood Oral Health Programs and Preventive Strategies

American Academy of Family Physicians

- [Anticipatory Guidance in Infant Oral Health: Rationale and Recommendations \(2000\)](#)
- [Oral Health During Pregnancy \(2008\)](#)


American Academy of Pediatrics

- [Oral Health Resources for Families, Communities and Professionals](#)

American Academy of Pediatric Dentistry

- [Dental Home Resources, Policies and Guidelines](#)

Association of State and Territorial Dental Directors

- [Best Practice Approach Report: Prevention and Control of Early Childhood Tooth Decay \(2010\)](#)
 - [State and Community Best Practice Approach Examples](#)
- [Fluoride Varnish Policy Statement \(2010\)](#) 

Children's Dental Health Project

- [Improving Perinatal and Infant Oral Health Project](#)

National Maternal and Child Oral Health Resource Center




- [Bright Futures in Health: Oral Health Resources for Health Professionals and Human Services Providers](#)
- [Early Childhood Caries Resources](#)

National Oral Health Policy Center

- [TrendNotes, Strategies for Sustaining and Enhancing Prevention of Childhood Tooth Decay during Challenging Times \(April 2010\)](#) 

- [TrendNotes, Better Health at Lower Cost: Policy Options for Managing Childhood Tooth Decay \(October 2009\)](#) 

Other Articles / Reports

- [Oral Health Program, Iowa Dept of Public Health. 2010 Oral Health Survey Report. Infants and Toddlers in Iowa's WIC Program. 2010.](#) 
- [Ramos-Gomez, Crystal, Ng, Tinanoff, Featherstone. Caries risk assessment, prevention, and management in pediatric dental care. Gen Dentistry. 2010.](#) 
- [Weinstein, Harrison and Benton. Motivating parents to prevent caries in their young children. One-Year Findings. JADA. 135: 731-38, 2004.](#) 

Program Materials


Administrative and Marketing Resources

- [CA Child Health and Disability Prevention Program](#)
- [CA County or City MCAH Directors](#)
- [CA County Welfare Department List](#)
- [CA School Nurses](#)
- [COH - Healthy Teeth Toolkit](#)
- [Family Resource Centers Network of California](#)
- [Head Start Center Locator](#)
- [Sample marketing flyer \(English and Spanish\)](#) 
- [Sample Memorandum of Understanding \(MOU\)](#) 
- [State Medicaid Dental Contacts](#) 
- [Title XIX Federal Financial Participation \(FFP\) Guide](#) 










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Clinical Visit




- [First 5 - Oral Health Assessment: Six Steps for the Medical Team Video](#)  (includes a segment on the knee-to-knee position, among other topics)
- [OSAP - Site Assessment Checklist and Infection Control Checklist for use in alternative sites using either mobile vans or portable equipment](#)

Participant Forms

- Caregiver Commitment Form: [English](#) , [Spanish](#) 
- Caregiver Permission and History Form: [English](#) , [Spanish](#) 
- [Caregiver Summary](#)  (example from San Bernardino County)
- [Caries Risk Assessment Form](#) 
- [Dental Assessment / Preventive Services Form](#) 

- [WIC Attendance Sheet \(English and Spanish\)](#) 

Educational Materials

- [COH - Baby Teeth are Important! presentation](#) 
- COH - *Preventing the Spread of Tooth Decay in Babies and Young Children* flip-book (contact the Center for Oral Health for more information)
- First Smiles - *Healthy Teeth Begin at Birth* pamphlet (contact the Center for Oral Health for more information)
- Fluoride Varnish Handout: [English](#) , [Spanish](#) 
- Ricci, Christine, and Roper, Robert. *Show Me Your Smile!: A Visit to the Dentist*. New York: Simon Spotlight/Nickelodeon, 2005. Print.



FQHC Resources

- [CMS - FQHC Billing Guide](#)
- [CPCA - The WIC Project: A Resource Guide for Federally Qualified Health Centers](#) 
- [HRSA - Find a Health Center](#)

WIC Resources and Information

- [Breastfeeding Promotion and Support](#)
- [Child Nutrition and Health - Oral Health \(WIC Works Resource System\)](#)
- [Coordination Strategies Handbook: A Guide for WIC and Primary Care](#)
- [National and State Program Data](#)
- [Program Fact Sheets](#)
- [WIC at a Glance](#)
- [WIC Special Project Grants](#)
- [WIC State Agencies](#)

Workforce Resources

- [AAP - Caries Prevention Services Reimbursement Table](#) (State-by-state listing of which providers can be reimbursed for which services, and how much)
- [AAP - Oral Health Coding Fact Sheet for Primary Physicians](#)
- [AAP - State Information and Resource Map](#)
- [ADHA - Dental Hygiene Practice Act Overview: Permitted Functions and Supervision Levels by State](#) 
- [ADHA - States Which Directly Reimburse Dental Hygienists for Services Under the Medicaid Program](#) 
- [ASTDD - Oral Health Program Information by State](#)
- [ASTDD - State Oral Health Program Directors Roster](#)

- [CDA - Component Dental Societies](#)
- [CSPD - Search for CA Pediatric Dentistry Society Member by Zip code](#)
- [DHCC - California Registered Dental Hygienist in Alternative Practice - Allowable Duties and Frequently Asked Questions](#)

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Section 7. Glossary

Anticipatory Guidance

Consultation that helps a caregiver prevent disease and establish healthy behaviors in anticipation of her / his child(ren)'s physical and behavioral developmental changes.

California Child Health and Disability Prevention Program (CHDP)

This Federal- and State-funded program delivers periodic health assessments and services to low-income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

Caregiver

A family member or other person (e.g., parent, aunt / uncle, grandparent, legal guardian, etc.) who provides care and assumes responsibility for a child, ill or disabled person, or elderly family member.

Caregiver Goal-Setting

The product of anticipatory guidance, risk assessment, and education that results in actual written goals for a caregiver regarding behavior change that will improve the health of a child or loved one.

Caregiver Interview

Consists of questions and discussion between a health care provider and a caregiver; often designed to elicit responses which will allow the health professional to teach educational messages and gain a better understanding of the caregiver, child, and their needs.

Children's Health Insurance Program (CHIP)

In California, this program is known as Healthy Families. CHIP is a low-cost insurance program for children and teens, funded in part by the U.S. Department of Health & Human Services and administered by state governments. It provides health, dental, and vision coverage to low-income children born in the United States who do not have insurance but do not have a low enough income to qualify for Medicaid.

Clinical Assessment

Also known as a Health Assessment. This is the documented process used to evaluate, diagnose, and treat an individual. Conducted by a health professional, this assessment is used to determine the nature, cause, and potential effects of a participant's injury, illness, or wellness.

Community Health Worker

A member of the community—either a volunteer or agency employee— who works directly with other community members to assist, educate, promote, and in some cases provide, health services.

Dental Home

This is an accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally-effective source of ongoing preventive and routine dental care. An affordable, accessible dental home is essential in keeping a child’s mouth healthy and preventing dental disease.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

This is the child health component of Medicaid. Required in every state, EPSDT is designed to improve the health of low-income children by financing appropriate and necessary pediatric care. This program sets rules all states must follow to ensure access to pediatric health care.

Early Childhood Caries (ECC)

The presence of one or more decayed, missing (due to decay), or filled tooth surfaces in any primary tooth of a child from birth through 71 months. ECC is a significant public health problem often associated with poor eating practices, continuous bottle feeding, poor oral health education, and significant caries risk in the parent or caregiver.

Family Resource Centers

These locally-situated centers provide family support services by creating a central location for health, mental health, educational, and recreational services. These are one-step referral organizations that empower families and enhance lives.

Federal Financial Participation

Created as part of Title XIX, Social Security Act of 1965. Matching funds for non-clinical services, including case management, program organization, quality assurance, interagency coordination, planning, and other non-clinical services designed to increase access to Medicaid services for eligible participants. These federal funds can be accessed through matching with local or state non-federal dollars.

Federally Qualified Health Center (FQHC)

FQHCs provide comprehensive primary and preventive care including general health, oral, and mental health / substance abuse services to persons of all ages, regardless of ability to pay. Patients include underserved, underinsured, and uninsured people. The FQHC title indicates a reimbursement designation in the United States granted by the Federal government.

First 5 California

Created in 1998, First 5, through a voter-approved initiative, increased the tax on tobacco products and placed those monies in a fund to serve every county in California. First 5 dollars support programs and public education efforts focused on children aged 0-5 and pregnant women throughout the state. With these funds, California counties have launched innovative programs and services designed to help children grow up healthy and thrive in both school and life. Each California county has a First 5 Commission overseeing that county's share of tobacco-related funds.

Fluoride Varnish

This fast-drying resin is a safe and effective preventive agent painted onto tooth surfaces to prevent tooth decay. It is a particularly effective preventive treatment for children under 5 years of age, especially those of high-risk. It can be applied quickly and is available in several flavors.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This law protects the privacy of individually identifiable health information. For more information, see the [U.S. Department of Health & Human Services website](#).

Knee-to-Knee Position

This is a safe and effective technique used by a provider and caregiver to safely hold a child in order to provide preventive care. Both adults sit in chairs facing each other; the child is then placed in the lap of the caregiver, and lowered onto her / his back so the head rests in the lap of the provider. A video of the technique can be viewed [here](#).

Maternal Child and Adolescent Health Program (MCAH)

Through state and federal partnerships, this program funds services targeting mothers and their families like reproductive health, family planning, pregnancy, birth defects, infants, children and teens, and human stem cell research.

Medicaid

This is a health insurance program for low-income and disabled Americans. It is jointly funded by federal and state governments, and is state-administered. Each state has its own guidelines regarding eligibility and services.

Medi-Cal

The name given to the Medicaid program in California.

Memorandum of Understanding (MOU)

This is a document describing a bilateral or multilateral agreement between parties, similar to a contract. See Section 6 for a sample MOU.

Motivational Interviewing (MI)

This is a non-judgmental, non-confrontational, non-adversarial counseling approach that seeks to help a participant think differently about her / his behavior and ultimately consider what might be gained through change. This technique is based on the recognition that different participants have different levels of readiness and is used to build a participant's motivation over time.

Promotora

A community member (usually female) who serves as a liaison between her community and health, human, and social service organizations. This model is based on a Latin American program type that reaches underserved populations through peer education. Promotoras are truly members of the community; they speak the same language, live in the same neighborhoods, and share the same life experiences as their peers.

Registered Dental Hygienist in Alternative Practice (RDHAP)

A type of oral health professional licensed in California. RDHAPs provide services in alternative settings where people live or frequent, rather than traditional dental offices. Licensure requires advanced education and training, plus success on a State Examination.

Risk Assessment

Risk Assessment is a process of quantifying the probability of a harmful effect to an individual or population from certain human activities. This is usually accomplished through a variety of interview techniques.

Rubber Cup Prophylaxis (Prophy)

The removal of plaque, debris, and superficial stains from teeth by using an electric hand piece that contains a small rubber cup filled with a cleaning gel or pumice.

Toothbrush Prophylaxis (Prophy)

The use of a toothbrush to provide a complete cleaning of primary teeth to remove accumulated plaque and debris. This is done with a small, soft toothbrush. The provider may or may not use toothpaste.

Transitional Assistance Department (TAD)

This is a federally-funded department in every county in each state that is responsible for financial support programs for the needy. The goals of TAD are to meet the basic needs of families and individuals while promoting work and personal responsibility and helping them become self-sufficient.

Well-Child Visit / Exam

This is a periodic medical examination based on published pediatric guidelines to determine whether a child's needs at different ages and stages of development are being met.

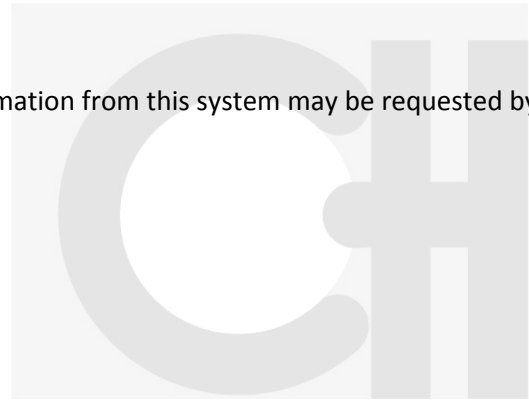
WIC Educational Requirements

This includes topics on breastfeeding and pregnancy to improve the well-being of the pregnant mother. This also includes information on nutrition for babies and young children, the advantages of regular exercise and activity, and the promotion of a healthy lifestyle.

WIC Information System

This dedicated software is available to WIC staff only. Information from this system may be requested by the WIC participant but is shared with no one else.

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