

## **Increasing Dental Access for Children through Community and State Programs**

### **The Access to Baby and Child Dentistry (The ABCD Program)**

Access to dental care for children served by Medicaid continues to be a problem in the state of Washington. There are many physical and psycho-social barriers that prevent this population from seeking early dental education, prevention and treatment. These barriers include attitudes of the caregivers, lack of appropriate dietary and home-care knowledge, transportation, child care and cultural factors. In an effort to reduce these barriers, the ABCD Demonstration Program was developed in the state of Washington as a pilot project. ABCD specifically improves the dental health of children 0-4 years old. A coalition was established between the State Medical Assistance Administration (Medicaid), the University of Washington, the Spokane District Dental Society, the Washington State Dental Association and the Spokane Regional Health District. The ABCD Program demonstrates the significant roles each component addresses to assist in reducing barriers through education, assessment, outreach services, and patient/provider linkage and referral. Now in its fifth year, ABCD continues to target caregivers, providers and children to decrease the barriers for dental access and create an awareness of the importance of oral health as it relates to general health. In addition, ABCD serves as a model for other communities across the state and nation that are interested in implementing similar programs. Strategies and information are provided to assist communities in their community mobilization, networking and forming oral health coalitions.

## **The Kauai Dental Health Task Force Revisited**

Art Tani, MPH

Over the past 4½ years, the Kauai Dental Health Task Force (KDHTF) has endeavored to change the alarming prevalence of dental decay in Kauai's kids. The Task Force started on June 20, 1995 after a community needs assessment sponsored by the State Health Planning and Development Agency and a State resolution to study Kauai's dental health problems and develop a comprehensive strategy for dental disease prevention. From a core group of health and social service agency people, a Hawaiian Health organization, and a dentist, the KDHTF has expanded to include childcare providers, Headstart parents, state and county legislators, physicians and dental hygienists, health insurance representatives, Area Health Education Center students and staff, and volunteer moms and dads. The KDHTF developed a 5-year plan, focusing work in four areas: School Dental Health, Dental Care, Community Education, and Fluoridation. Over the past 4½ years, we helped pass legislation for children to get dental checks/treatment upon entering school and requested state grant-in-aid money to provide dental services to the uninsured. With the State Dental Division, we supported more school fluoride rinse programs. Community education included training primary care providers on BBTB prevention, education in schools and at health fairs, and yearly mass media campaigns. We sponsored three dental health conferences on Kauai that brought in statewide participation and speakers from the national, state and local levels. Now we are strategizing with communities to start a demonstration fluoridation project on Kauai and we will be involved in a statewide fluoridation initiative in 2000.

## **Community Partnerships to Expand Access to Dental Care for Children: Washington's ABCD Programs**

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Community-based research activities have served to expand access to dental care for previously neglected children in Washington. In 1994 students, faculty and staff in collaboration with local school districts and members of the Washington State Dental Association performed dental exams in third grade classes in all 39 of Washington's counties. This activity provided data for a statewide conference on the expansion of dental services for children in the state. The conference, held in June 1994, stimulated interest in special Medicaid programs in the state and led to the initiation of the first Access to Baby and Child Dentistry (ABCD) program in Spokane in February 1995. Two-thirds of the Spokane dentists participated in the initial training and thus were eligible to receive the enhanced ABCD Medicaid fees. More than 1,000 children under 4 years have been enrolled. The increase in utilization of dental services by ABCD families is impressive: 43% by ABCD vs. only 12% by non-ABCD children. The second ABCD program began in Stevens County, just north of Spokane in 1996. About 250 children who were 12-36 months of age were enrolled in this program. The third program, called the "Mom & Me" program, was initiated in Yakima County in June 1999. More than 725 children 5 years and younger have been enrolled in 1999. Thirty-five dentists, more than 1/3 of the licensed dentists in the county, are certified to participate in the program. The fourth program was initiated in Benton and Franklin Counties in November 1999. Twenty-nine dentists were certified to participate in this program.

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S.R. Slavkin

**Statement of Objectives:** Our mission is to provide comprehensive dental care for low income children and adults. In 1993 we had a two chair dental center that serviced 1500 clients per year from a location near downtown. Our objectives were to expand the number of clients served, and accessibility in outlying communities, using collaborations and partnerships, and to attract enough revenue to make the program revenue neutral.

**Methods:** A marketing plan was developed, involving partnerships with Duval County Schools, Jacksonville Urban League Headstart, University of Florida, Florida Community College at Jacksonville, City of Jacksonville, We Care Jacksonville indigent Care program, I. M. Sulzbacher Homeless Center, Jacksonville Dental Society, and many others.

**Results:** There are five health department dental center sites throughout the county, and two mobile dental centers. In FY 1999-2000 the health department will serve 15,000 dental clients, a tenfold increase in six years.

**Funding mechanisms:** Grants and legislative funding have been obtained from many sources with the help of our community partners, for the start-up expenses of our new facilities.

**Sustainability:** The program is now self sustaining, with revenue generated by patient treatment now exceeding \$1.5 million annually.

**Conclusion:** Community partnerships have been used very effectively to expand access of low income residents to comprehensive dental care in Jacksonville, Florida.

## **The Community Partnership for Dental Health**

Liza Pertuzzelli

The Community Partnership for Dental Health, established in November 1997, is a collaborative effort funded in part by the Forsyth Early Childhood Partnership (Smart Start) and facilitated by the Forsyth County Department of Public Health (FCDPH). The mission of the Partnership is to coordinate and facilitate community-based dental clinics; to provide dental care and preventive dental education for children age five and under and their families who have limited access to care; and to expand these clinics in the future to provide dental care and preventive dental education for all age groups in Forsyth County.

The Community Partnership for Dental Health is a working group of the Healthy Carolinians Task Force, and addresses one of the five areas of need identified in the 1997 Community Health Assessment. It is a working group consisting of volunteer dentists, dental hygienists, dental assistants and community members. The CPDH has been in existence for 18 months and has been funded by the Forsyth Early Childhood Partnership since its inception. The partnership has developed dental clinics with the collaboration of volunteers through agencies such as Iglesia Cristiana Wesleyana, Triad Hispanic Ministries and Living Water Family Resource Center. To date, these clinics have screened/treated approximately 3,200 children along with over 850 immediate family members and continue to have appointments booked three months in advance. The need for dental care in Forsyth County is far greater than what can be met with the current infrastructure. The CPDH plans to expand the dental services in Forsyth County by joining forces with Wake Forest University Baptist Hospital and opening two new dental clinics that will accept Medicaid and NC HealthChoice to better serve the community.

## **Collaborative School-Based Dental Programs: An Effective Way to Reduce Disparity and Improve Oral Health of Underserved Child Populations**

Buddhi M. Shrestha, DDS, MS, Ph.D.

The problem of access and utilization of dental care services among underserved Medicaid child populations has been well recognized. According to 1996 Inspector General's report, only one out of five Medicaid children receive federally mandated EPSDT dental services, despite the fact that full dental benefits are available to these children. Clearly, providing access to dental care by itself will do no good unless the insured child is able to utilize available dental services. Thus, "Access – Utilization = No Access". One of the many reasons cited in the report was parent's failure to take their child to dentist, giving dental services a low priority because of other competing family priorities. The most logical way to provide much needed dental care to high risk and difficult-to-reach children is through school-based dental programs.

Recognizing these facts, in 1994 University of Rochester Eastman Dental Center in collaboration with school districts, county health and social service departments, NYS Bureau of Dental Health and Rochester Primary Care Network launched a major collaborative school-based outreach dental program in Rochester inner-city and neighboring rural communities. The program focused on providing preventive and primary dental care to Medicaid school children that have no dentist of their own. The outreach dental services were provided using Smilemobiles, on-site portable school dental units and year-round part-time school/satellite clinics. The program has not only been very successful in providing cost-effective/cost-efficient dental services each year to thousands of Medicaid children, who otherwise would not have received care, but has also been financially self-supporting. The program has grown from 11 service sites, serving 2200 underserved school children in 1994 to 37 sites serving over 10,000 children in 2000.

Our experience and service/outcome data strongly suggest that a well-planned collaborative school-based dental program is the best and probably only way to reduce disparity and enhance access and utilization of dental care to improve oral health of difficult-to-reach underserved child populations.

## **Dental Care Needs Acuity Index (DCNAI): A Method for Determining Dental Care Needs among Thirty-six Rochester Inner-city Elementary Schools**

Buddhi M. Shrestha, DDS, MS, PhD; Mark E. Moss, DDS, PhD; and Andrew S. Doniger, MD, MPH

Our previous school dental health survey (1992-93) showed the existence of pockets of children at high risk of dental caries, especially among recent immigrant children, in Rochester inner-city schools. The aims of this study were to a) determine the baseline oral health status of Rochester's thirty-six elementary schools and b) develop a method for determining dental care needs among these schools for allocation of dental resources.

A total of 1,666 seven to twelve-year old children, 846 male and 820 female, received oral examinations (without x-rays) by a trained registered dental hygienist. Five oral health parameters, namely tooth decay (dfs/DMFS), % children with active caries (d/D), presence of sealants, malocclusion and enamel fluorosis, were used to develop a "Dental Care Needs Acuity Index" (DCNAI) using Multiattribute Utility Assessment Methods (Edwards and Newman, 1982; Guttentag and Snapper, 1974). Based on DCNAI data, Schools #14, 5, 42, 50 and 29 were identified (in descending order) as the top five "Most Needed" and Schools # 7, 1, 43, 33, and 52 as the bottom five "Least Needed" schools. The DMFS (permanent teeth) scores were 60-64% lower, as compared to 1986-87 national Caries Prevalence Data for Region II for the same age groups. There was no reduction in dfs (primary teeth) scores. Nine schools with a school-based dental program (Smilemobile) showed positive patterns in improvement of oral health of the children.

Based on the findings of this study we conclude that a) the DCNAI provides a rational method for ranking dental needs in elementary schools, and b) the schools with school-based dental programs generally scored better than schools without these programs indicating that DCNAI adequately reflects the impact of oral health care in an elementary school population.

This study was partially supported by a three-year grant from Monroe County Health Department.

## **Dental Sealant Programs**

### **A Community Partnership to Make Preventive Work**

Lynn Pilant

The Children's Dental Health Program aims to reach a large population of children from diverse ethnic and economic backgrounds. The vast majority of these children are uninsured or underinsured. They frequently have limited access to dental care, preventive services, and fluoridated water. We know that just because a child has dental insurance, does not mean s/he has access to all necessary services. For example, the provision of dental sealants is not always a covered benefit. Although dental sealants have been proven to be one of the most effective means of preventing decay in permanent molars, many insurance companies do not include them in their benefits. In 1986, we initiated countywide dental sealant activities – with clinics at a local community college, adding clinics in private dentist offices in 1988, expanding to school-based clinic sites by 1999.

Program objectives include: 1) providing dental sealants to children who do not have the means to obtain them, 2) assessing a child's wellness exam status and linking child to appropriate care, 3) identifying resources for dental treatment and ongoing care, 4) recruiting and maintaining a network of dentists and specialists to work with this project, 5) building a coalition to develop strategies for improving access to dental care for children. Since 1986, over 2,500 children have received dental sealants, at a value of over \$500,000. Children have received dental treatment, referrals to medical providers (including EPDST, Healthy Families, Medi-Cal), and results from one school indicate an 8% increase in the number of children who received dental sealants. Program expansion continues with strong foundation and community support.

## **Developing a Children's Dental Health Strategic Plan**

Cheri Pies

In September 1999, the Family, Maternal and Child Health Program on Contra Costa Health Services initiated an effort to develop a strategic plan to improve dental health services for children in East Contra Costa County – an underserved, non-fluoridated area of the county. Census and Department of Finance estimates suggest that there are approximately 60,000 children under 18 years of age residing in this part of the county, with 23,000 under six years. A total of 22,000 children attend elementary schools (K-6), approximately 13,000 participate in our free lunch programs, and an estimated 7,000 children are enrolled in DentiCal. In 1999, there were 73 dentists in East County, nine who take DentiCal, and only four who are pediatric dentists. Results of dental screenings in one area indicated that 437 children (26.4%) out of 1,656 screened had visible decay.

We identified 30 individuals from community-based organizations, schools, dental societies, parent groups, local foundations and the public health department to participate in developing a plan designed to improve the dental health of children in East County, expand existing resources, and create an integrated child health care system. At two 3-hour meetings, we developed an up-to-date list of all the children's dental health resources available in East County, generated a list of potential goals for our plan, and identified related issues to be addressed and activities to be implemented as part of our strategic plan. This planning effort serves as an important step in mobilizing already existing coalitions and partnerships to engage additional community support and identify key agencies that will take the lead on specific activities and projects.

## **Working Together Improving Community Health**

Gwendy Meginnis, MA, RDH

A community-wide assessment of health needs that included neighborhood focus groups, door-to-door surveys, and analysis of existing community health data found improved access to health and dental care to be a priority need in the most at-risk neighborhoods of Lincoln, Nebraska. The most prevalent access issues were determined to be lack of transportation, language barriers, absence of health and dental insurance, and mistrust or lack of understanding of how to utilize existing health systems. The community assessment revealed that bringing health and dental care to neighborhoods as an extension of existing services would significantly improve access to care. To accomplish this, the Lancaster County Public Health Foundation took the lead in educating area leaders from business, health care, foundations, government, education, and human service agencies about the health and dental needs in at-risk neighborhoods. It also proposed the solution, a mobile health and dental clinic that would be primarily operated through the Lincoln-Lancaster County Health Department with assistance from area health and human service agencies. The resulting partnership generated the necessary financial donations to acquire a state-of-the-art mobile clinic that is currently serving the dental needs and the basic health needs of hundreds of children and adults annually in Lincoln's highest need neighborhoods. The partnership continues to evolve with area dental and health agencies bringing resources together to effectively provide services in the most at-risk neighborhoods and to expand services to other high priority community sites. A primary example of the significance of this partnership is the relationship between the Health Department's Dental Division and Lincoln's public and parochial schools. For years, the Dental Division has worked closely with school nurses to accomplish dental screenings on hundreds of children annually. Now, with the mobile health clinic, children with priority dental needs can receive treatment services on-site. During the 1998-99 school year, 4540 children were screened with 240 of these children being identified with priority dental health needs.

# **CHILDREN OF FARM WORKERS IN COLORADO RECEIVE DENTAL CARE ESSENTIAL FOR DENTAL, MENTAL AND EMOTIONAL HEALTH**

Magda A. de la Torre

**CONTEXT:** Barriers to health care are considerable to migrant and seasonal farm workers and their children. Poverty, language, lack of trust, cultural and educational factors, and lack of transportation are barriers to dental care. Long working hours interfere with daytime clinic appointments. Also poor continuity of care due to mobility have been identified as barriers. Rural health resources already at full capacities, prejudice and discrimination are also obstacles to be overcome. These barriers can be minimized by a well organized plan of action.

**OBJECTIVE:** The mission was to participate in enhancing the physical, mental, social and economic well being of migrant farm workers and their families. A major focus for this summer program is migrant children.

**METHODS:** Conducted during the summer of 1998, 2,029 migrant children in the State of Colorado received medical and dental screenings and health care. Children's ages ranged from 5-21 years, with the majority from 5-12 years old. The focus of this project were the children of farm workers in Pueblo, CO. The children at the 7 week summer school program were predominantly of Hispanic origin, with the remaining being Anglo, African American and American Indian. The dental assessment of 94 children consisted of screenings determining 3 levels of needs: urgent care, dental care and preventive care.

**FINDINGS:** Migrant children are in need of continuous dental care. Six percent of children had urgent dental care needs, 46% needed restorative dental care, and 48% needed preventive care only at the Pueblo site. The State of Colorado sets goals: 95% screening, 90% fluoride treatments, 60% sealants, 70% restorative, 100% urgent care completed. In Pueblo: 100% screening performed, 100% fluoride treatments performed, 81% sealants performed, 100% restorative performed, 100% urgent care performed. Referral and follow-up dental care was coordinated with the Pueblo Community Center. Along with clinical care preventive education was also performed in the summer program.

**CONCLUSIONS:** Migrant children were able to receive competent and thorough dental care. The program incorporated an interdisciplinary health team approach working closely with the educational staff in the school setting. This program reduced barriers for children's dental needs providing emotional and mental health along with reduced fear and improved self-esteem.

**IMPLICATIONS:** With the collaboration of teachers, social workers, local dental personnel, community clinics, foster grandparents, artists, and volunteers these benefits for children in underserved populations can be met. The community as a whole benefits and unites.