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MAKING MEDICAID CHILD DENTAL SERVICES WORK: A PARTNERSHIP IN WASHINGTON STATE

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ABSTRACT

Eighty-one percent of general dentists and 86 percent of pediatric dentists who are members of the local dental society in Spokane County, Washington, participated in a pilot program to provide dental care in private offices to children up to 5 years of age from low-income families served by the Medicaid program. Outreach staff from the local public health agency recruited and enrolled families in the program. University faculty provided special training in the care of young children to the dentists participating in the program. In the program's first year, 37 percent of the enrolled children had made at least one visit to the dentist, in contrast to 12 percent of children who were not enrolled in the program.

As part of a larger effort by the Medical Assistance Program and the Washington state Legislature to expand Medicaid dental services for children, a pilot program is being conducted in Spokane County, Washington. The program is a partnership of the Medicaid program, Spokane District Dental Society, Spokane Regional Health District, Washington State Dental Association and the University of Washington. Dentists in the program are trained and certified and receive enhanced payments to provide an array of improved dental services to children younger than age 5 years who are enrolled in Medicaid.

Outreach services are carried out by the health district to notify eligible families about the availability of services and to encourage early childhood visits to the dentist. The program also aims to minimize the number of missed appointments.

Medicaid is a complex program guided by federal laws and administered by the states. Its Early Periodic Screening, Diagnostic, and Treatment Program, enacted by Congress in 1967, requires every state to provide certain preventive dental services for all Medicaid-eligible children. This involves recruiting dentists and informing eligible families about the available services. National data show that less than 20 percent of eligible children receive the required services, and 75 percent of the states report that they have served less than 30 percent of eligible children. No state exceeded a 50 percent utilization rate.[1]

For 1993, Washington state reported a utilization rate of 29.3 percent for all Medicaid-enrolled children up to age 20 years.[2] For 1995, 27.6 percent, or 143,860 of the 518,922 eligible children younger than age 21 years, received at least one dental service. The rate, which varied by county, ranged from 16.9 percent in Benton County to 38.5 percent in Spokane County.[3] The number of children younger than age 5 years who had at least one dental visit in 1995 in Spokane County was 1,825 out of the 12,873 children who were eligible, or 14.2 percent.

Some states, such as Washington, opt to provide ad-

ditional Medicaid dental services. The rationale for the dental services program stems from epidemiologic data showing that, in general, children in Washington state have a greater incidence of untreated dental disease than that reported nationally, and that children from minority groups and low-income families are especially needy.[4]

Private-practice dentists are the ones who primarily provide the range of services, which are similar to those offered in commercial prepayment programs, and they are paid on a fee-for-service basis. About one-half of practicing dentists in Washington state have signed agreements to be participating dentists with the state's Medicaid program, although the number who actually participate at a meaningful level is much lower.

PROBLEMS WITH MEDICAID

The reasons for the low use of Medicaid dental services are complex. Both the attitudes and experiences of low-income families, as well as the adequacy or availability of the dental work force, are factors affecting this low utilization level. A 1992 study of S95 Seattle children, aged 5 to 11 years, from low-income families showed that visits to the dentist were unrelated to actual oral health status.[5]

Two factors predictive of an episode of care were the number of years that a child's mother had lived in the United States and race. African-American parents were only half as likely to take their children to the dentist as were parents of other races. More recent immigrants were more likely to take their child to the dentist than were parents born in the United States. Children's fears about receiving dental care and absences from school due to family problems were also associated with lower rates of use of dental services.

On the other hand, factors associated with a higher probability that parents would take their children to a dentist were their willingness to take the children to a physician for preventive medical visits and their assessment that the children needed dental care, as well as a belief in the value of dental care. Children of mothers who were more satisfied with their own care and oral health and children covered by insurance of any type were more likely to receive dental care.

The Access to Baby and Child Dentistry program focuses on preschool children from birth to 6 years of age.

The supply of dentists also may influence access to care. Communities in Washington state vary as to the number of dentists who are available in the work force. In a recent demographic study, Leroux and colleagues[4] estimated the availability of services based on the number of dentists who currently served or who could serve the Medicaid program. The larger urban areas had greater access to dentists than did many of the rural counties. However, in almost all cases, relatively few dentists bore the burden of serving most of the program participants who actually received care. Moreover, many of those who did receive care had only symptomatic treatment to relieve pain.

There have been relatively few national studies that have examined factors influencing the participation of dentists in the Medicaid program.[6] However, there is widespread agreement that maximum allowable fees in the programs are unrealistically low and that in many states, flaws in program administration often result in slow and inefficient payments to vendors. High no-show and cancellation rates further decrease the rate of return for dentists who treat patients receiving Medicaid. Racial discrimination may also be a factor.[7]

Nevertheless, there is little evidence in the literature that merely increasing fees would increase access by much.[8,9] Planners working within the current delivery system, therefore, face the dilemma of finding a way to reduce the barriers to participation by both dentists and Medicaid clients.

ACCESS TO BABY AND CHILD DENTISTRY PROGRAM

The Access to Baby and Child Dentistry, or ABCD, program focuses on preschool children from birth to 6 years of age. The goal is to provide early intervention to prevent and control major dental problems and costs that could otherwise escalate in the future. Previous research has demonstrated that children from low-income families are most likely to benefit from meaningful access to insurance and dental care.[10] In addition, the program provides an opportunity to introduce low-income parents to regular dental care and to allow them to assume responsibility for appropriate visits and recall ap-

pointments for their children. At the same time, by focusing on the prevention of dental problems among the youngest poor children, the program allows dentists in the private-practice community to make a commitment to the Medicaid program without overwhelming their practices. As a result, it could reverse the dental community's long-standing antipathy to this important service benefit program.

Another reason for the focus on young children was to circumvent the cycle of painful emergency treatment that is common among low-income recipients of dental care and that often results in the development of permanent fears and avoidance of dental care.[11] A prevention-oriented program offers children an opportunity to receive care on a routine basis. This benefit, along with prevention-oriented follow-up, should result in children who are not only healthier but more accepting of treatment and easier to treat.

This preliminary report covers the first year of the program from Jan. 25, 1995, through Jan. 30, 1996. We anticipated the following results:

- the number of eligible children enrolled in the ABCD program who visited the dentist at least once would be greater than the number of children who were eligible but not enrolled;
- the number of services received by eligible children enrolled in the ABCD program would be greater than the number of services received by children who were eligible but not enrolled;
- the majority of dentists in the community would be certified and would participate in the program.

METHODS

Community. Spokane County is located in the eastern portion of Washington state on the border with Idaho. It consists of one major city (Spokane) and surrounding suburban and rural areas, with a population of about 400,000.[12] About 37 percent of the population is younger than age 25 years. Per capita income in 1991 was $16,857. The largest employers are the federal, state, county and city governments as well as hospitals and school districts. The largest industrial employer is Kaiser Aluminum.

The fees for the ABCD program were enhanced beyond the previously existing level by a series of add-on fees.

Program description. In cooperation with the Spokane District Dental Society, local dentists received special training and were certified to receive enhanced payments for dental services under Medicaid. The training, provided by University of Washington faculty, consisted of a full-day program of instruction on child management, preventive education and use of fluoride varnishes (Duraflor, PharmaScience) and fluoride-releasing glass ionomer fillings, both as sealants and filling material. Instruction also covered emergencies and related topics. A periodic newsletter, which was distributed as part of the program, offered clinical tips on caring for young children and kept participants aware of program activities.

Outreach. The State Medical Assistance Administration entered into a cooperative agreement with the Spokane Regional Health District to provide funds for outreach. Health district staff carried out efforts to market the program to potential clients through community agencies and the media. These outreach efforts included multiple contacts with parents at health fairs; Women's, Infants' and Children's Supplemental Nutrition Programs centers; Head Start; food banks; churches; welfare offices; and immunization clinics. The health district also provided orientation and follow-up for families to ensure that they understood how to identify a certified provider and to use care appropriately.

Benefits under the program. Enrolled children received enhanced benefits that included coverage for three fluoride varnish treatments per year for children at high risk of caries, glass ionomers used as sealants and fillings in primary teeth and family preventive oral health instruction once per year. All routine dental services for children were included.

Fees. The Medicaid program pays dentists on a fee-for-service basis. The fees for the ABCD program were enhanced beyond the previously existing level by a series of add-on fees. This was done to raise the level of maximum allowable payments to the 75th percentile of all usual and customary fees, as determined by a review of fee filings to one of the state's major nonprofit insurance carriers in eastern Washington. Dental office staff were trained and given assistance in following billing procedures so delays in payment could be substan-

TABLE 1

ABCD AND NON-ABCD CLAIMS DATA*

SUBJECTS' AGE (MONTHS)	NON-ABCD PROPORTION (%)†	ABCD PROPORTION (%)†	χ^2 (P-VALUE)	ABCD FAMILY ORAL HEALTH EDUCATION PROPORTION (%)‡	ABCD FLUORIDE VARNISH PROPORTION (%)‡
< 12	135/5577 (2.42)	45/1004 (4.48)	13.591 (< .001)	19/45 (42.2)	3/45 (6.7)
12 to 23	72/2295 (3.14)	257/882 (29.14)	455.672 (< .001)	150/257 (58.4)	139/257 (54.1)
24 to 35	159/2069 (7.68)	377/943 (39.98)	461.779 (< .001)	195/377 (51.7)	195/377 (51.7)
36 to 47	363/2112 (17.19)	519/908 (57.16)	490.685 (< .001)	245/519 (47.2)	251/519 (48.4)
48 to 60	958/2638 (36.32)	346/407 (85.01)	341.494 (< .001)	148/346 (42.8)	173/346 (50.0)

* ABCD: Access to Baby and Child Dentistry.
† The numerator is the number of children for whom at least one claim for dental services was made; the denominator is the total number of enrollees or nonenrollees.
‡ The numerator is the number of children receiving the dental service; the denominator is the number of children for whom at least one claim for dental services of any type was made.

tially reduced. The program also accepts electronic claims.

Population. All children 5 years of age and younger who resided in Spokane County, Washington, and who were signed up for Medicaid-covered dental services were eligible for the ABCD program. Low-income children in Washington state are eligible for dental benefits under the Categorically Needy Program (H). Income limits for this program are based on 200 percent of the federal poverty level. In 1996, a child in a family of three (two adults and one child) was eligible if the family had a monthly income of $2,164 or less.[13] Children in families at this income level who were enrolled in the ABCD program by their parents make up the ABCD population. For the purpose of this evaluation, only children who were younger than 4 years of age at the time of eligibility, enrollment or both were included.

Between Feb. 1, 1995, and Sept. 30, 1995, 931 parents, primarily mothers, completed an enrollment questionnaire; this represented about one-half of the children enrolled in the ABCD program by that time. The questionnaire, which was available in English, Russian and Spanish, collected demographic, health status and health care utilization data on each family's youngest child. It also elicited information about the parents' levels of satisfaction with their child's dental care and asked about the child's fear concerning a visit to a dentist.

From these data, we know that the typical ABCD household had one child younger than age 4 years and two adults, and that almost 90 percent of the children were residing with their mother. The mean age of the mothers was 26 years, and the youngest child in the family was typically younger than 30 months. Only 14 percent of the children had previously visited a dentist. Mothers of approximately 20 percent of the children rated their children's oral health as either fair or poor. Nearly 75 percent of the mothers were receiving Medicaid benefits for themselves as well as for their children, and 52.2 percent said that they had a regular dentist. No questionnaire data were available regarding the nonenrolled population.

Sources of data. There were three sources of data for this report. The Medicaid Management Information System, a computerized database consisting of both eligibility and claims files for the Medicaid program, provided enrollment and utilization data for the program as a whole. The eligibility file contained data on 18,835 children in Spokane County who were younger than 5 years of age. This file also contained the date of birth and the race of the child.

The claims data file contained information on the number of dental visits, the type of visit and the dates of visits for

TABLE 2

RELATIONSHIP BETWEEN DENTAL CARIES RISK STATUS AND CLAIMS FOR FLUORIDE VARNISH AND FAMILY ORAL HEALTH EDUCATION (N = 1,050)

DENTAL SERVICE	CARIES RISK STATUS, NO. (%) OF SUBJECTS WITH CLAIM		
	Low Risk (n = 518)	Moderate Risk (n = 269)	High Risk (n = 263)
Fluoride varnish*	310 (59.8)	208 (77.3)	179 (68.1)
Education†	297 (57.3)	189 (70.3)	187 (71.1)

* $\chi^2 = 24.7$, degrees of freedom = 2, $P < .001$.
† $\chi^2 = 20.3$, $df = 2$, $P < .001$.

the period from Jan. 25, 1995, through Jan. 30, 1996. The third source of data was the ABCD enrollment file from the regional health district. It covered the period from January 1995 to October 1996 and contained 5,080 records, including the child's Medicaid identifier, birth date and enrollment date. The files were merged using the Patient Identification Code, or child identifier, as the common variable.

To determine the number of services provided to each child, we counted the claims experiences of each recipient while eliminating the billing codes that represented add-on fees. We assumed that the number of separate claims would be a fair representation of the number of individual visits, because it is customary in the Spokane community to file a claim for the services provided at each separate visit.

Analysis. Our analysis was limited to children who were younger than 60 months on Jan. 30, 1996. The primary outcome of interest was the proportion of children who had at least one dental claim during the period from Jan. 25, 1995, through Jan. 30, 1996. We conducted bivariate statistical tests to determine whether participation in the ABCD program was associated with greater use of Medicaid-financed dental services.

RESULTS

Access. Of the 4,144 ABCD enrollees, 1,544 (37.3 percent) had at least one dental claim during the 1995 to 1996 calendar year; in contrast, only 1,687 (or 11.5 percent) of the 14,691 children who were not enrolled in the ABCD program had at least one claim filed ($\chi^2 = 1,5704.54$, $P \leq .0001$). Table 1 presents the raw unadjusted proportion of children with at least one claim, which varied by age group.

Preventive orientation. Table 1 also presents the proportions of children in each age group who had at least one claim filed for the family oral health education and fluoride varnish benefits. Overall, 757 (49.0 percent) of the 1,544 children in the ABCD program who had at least one claim received the education benefit, and 761 (49.3 percent) of the 1,544 children who had at least one claim received the fluoride benefit.

At the initial examination, or during a periodic examination if a child had already been seeing a certified dentist, dentists rated the health-risk status of the children. Of the 1,050 children who were rated, 263 (25.0 percent) were at high risk (that is, caries was already in the dentin), 269 (25.6 percent) were at moderate risk (that is, the child had enamel decalcification or his or her siblings had caries) and 518 (49.3 percent) were at low risk. (Numbers do not total 1,544 because data were missing for some children.) Overall, children who were at a higher risk status were more likely to have been given prescriptions for fluoride varnish and family oral health education by the dentist. Table 2 provides the details of this analysis.

Intensity of utilization. After adjusting for the number of months participants had been in the program ($F = 927.5$, $df = 1$, $P < .0001$), we determined that the mean number of dental visits for the year was 2.4 (standard error, 0.05) for the children in the ABCD program and 0.59 (SE, 0.03) for the children who were not in the program. Table 3 shows the mean number of dental visits by age group.

Participation by dentists. Approximately 134 general dentists and seven pediatric dentists in active practice in Spokane County are members of the local dental society. Of these, 109 general dentists (81 percent) and six pediatric dentists (86 percent) provided services to children in the ABCD program. The median number of children cared for per dentist in 1995 was six, although the number ranged from one to 662.

DISCUSSION

Children from low-income fami-

lies use dental services suboptimally and suffer from disease in numbers disproportionate to their representation in the population. They are also much more likely to receive emergency care and to develop long-lasting fears of the dentist. Among the many reasons for this public-health problem are parental ignorance about dental disease, diet and access to dental care providers. Medicaid dental programs are often underfunded, and dentists often perceive them as being poorly administered. Moreover, most dental practitioners lack the technical and management skills required to treat very young children with extensive dental disease.

The goal of this private-practice–based partnership was to demonstrate that, by working together, the dental and public health communities, the state Medicaid program and the University of Washington dental school could increase the acceptance and use of preventive dental care. By all measures, the first year of the program was a success. The proportion of children who had at least one dental claim increased, and nearly all of the dental practices in the community participated.

Moreover, the analysis presented here probably underestimates the impact of the program because many children who participated during the initial study period had been enrolled in the ABCD program for less than one year. When findings are adjusted for the number of months that subjects were enrolled in the ABCD program during the one-year period, children in the ABCD program were 12.7 times more likely to visit the dentist than were children who were not enrolled in the

TABLE 3

MEAN NUMBER OF SERVICES CLAIMED BY AGE AND ABCD PROGRAM STATUS*

SUBJECTS' AGE (MONTHS)	MEAN NO. (STANDARD ERROR) OF SERVICES FOR NON-ABCD ENROLLEES	MEAN NO. (STANDARD ERROR) OF SERVICES FOR ABCD ENROLLEES	F STATISTIC (P-VALUE)
< 12	0.01 (0.01)	0.11 (0.01)	47.7 (< .0001)
12 to 23	0.09 (0.03)	1.31 (0.05)	404.5 (< .0001)
24 to 35	0.29 (0.06)	2.06 (0.08)	303.2 (< .0001)
36 to 47	0.69 (0.09)	3.78 (0.13)	375.8 (< .0001)
48 to 60	1.85 (0.09)	7.38 (0.24)	474.8 (< .0001)

*ABCD: Access to Baby and Child Dentistry.

ABCD program (95 percent confidence interval, 12.1 to 13.4). The odds that a 12- to 24-month-old child enrolled in the ABCD program would visit a dentist were 63.7 times greater (95 percent CI, 50.0 to 81.4) than those for a child not enrolled in the ABCD program.

FLUORIDE TREATMENT RATE

On the other hand, the rate of participation by children who had visited a dentist and who also received the new oral health education and fluoride varnish benefits offered through the ABCD program was disappointing. Ideally, every child who visited a dentist for any reason should have received these new benefits. We are not sure why dentists did not provide these services.

Dentists may have been less likely to provide these services to children who were assessed as having a low clinical risk. Claims for these services may also have been underbilled because office staff members were unfamiliar with the new billing codes. In addition, dentists provided fluoride gel treatments, instead of varnish, to 166 children. Nevertheless, even when these fluoride gel treatments were counted, only 60 percent of the children had a claim filed for at least one fluoride treatment. The program newsletter is being used as a vehicle to address this issue.

As of July 1997, enrollment in the program exceeded 6,000, and children are being enrolled at a rate of about 200 per month. Through enhanced publicity and follow-up with families, efforts to further increase participation are being improved, and new members of the dental society are receiving training. Plans for additional evaluation efforts include an examination of the program's caries preventive effect and its costs. In addition, parents and dentists will be interviewed to measure their levels of satisfaction with the program.

The ABCD program was initially limited to children younger than age 60 months.

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Recently, the age limit was raised by one year, and a similar program has been instituted in another county in the state. However, older children and adults served by the Medicaid program do not have this enhanced access. Nevertheless, the goodwill and cooperation engendered by this community-based effort have created an environment in which additional innovative programs can be considered to address these pressing problems.

CONCLUSION

Children from low-income families have the greatest need for and derive the most benefit from dental services of any group in our population. Efforts to serve this population are important, and partnerships to achieve this goal are needed. ABCD is an example of this type of program in one community. ■

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At the time this study was conducted, Ms. Ward was the director of client services, Medical Assistance Administration, Department of Social and Health Services, state of Washington, Olympia.

The members of the ABCD Partnership include the Department of Social and Health Services, Medical Assistance Administration, state of Washington (Dan Conlon, Carree Moore, Ayuni Wimpee); Spokane District Dental Society (Connie Robohn, Dale Ruemping, Robert Shaw); Spokane Regional Health District (John Beare, Elaine Blair, Virginia Bown, Ida Busch, Patti Richards, Debbie Spellecy, Michele Vanderlinde); University of Washington (John Davis, Peter Domoto, Devereaux Peterson, Paul Robertson, Philip Weinstein); and the Washington State Dental Association (Madonna Dunn, Terry Grubb, Stephen Hardymon).

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ORAL HEALTH CARE FOR FAMILIES

A Guide for Public Health Nurses and Non-Dental Professionals

February 1999

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"ASSESSMENT OF CHILDREN FOR COMMUNITY BASED SEALANT PROGRAMS"

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deo: "Assessment Of Children For Community Based Sealant Programs"

I. Population Selection for a Community Program (video count 1:08)
- Geographic location
- Low income
- The number of free and reduced lunches

II. Assumptions of Private or Clinic Based Care (video count 1:26)

A. Individual care programs
- Continuous care
- Monitored treatment
- Full range of diagnostic options
- Full range of comprehensive treatment

B. Community or School Based Programs
- Non-continuous episodic care
- Non-monitored treatment
- Limited diagnostic options
- Non- comprehensive treatment

III. Child Selection (video count 1:73)
- Grade levels
- Resoures
- Consent

IV. Teeth Selection (video count 1:98)
- Eruption status
- Pit and fissure morphology
- Caries activity.

V. Evaluation of the tooth surface (video count 2:40)
- Explores not reliable
- Clean surface with toothbrush, toothpicks, cotton roll or tip, etc.
- Use good illumination devices
- Visually examine teeth

VI. Caries Classification and Treatment (video count 3:07)
- No obvious decay-seal
- Questionable decay-seal
- Obvious decay-refer for treatment
- Interim sealant-refer, note location and limitations of interim sealant

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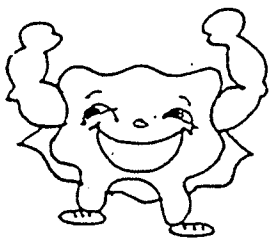

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Circulo de Sonrisas es un projecto colaborativo de la Coalición
de Salud Oral de los Niños en el Condado de Yakima.

March, 1999

Circle of Smiles

Que Hacer y Cuando Hacerlo:

Al comienzo -

- Limpie el interior de la boca de su bebé con un paño suabe y húmedo.
- Use vitaminas liquidas con fluoruro si el agua en casa no lo tiene.
- Comience temprano con buenos hábitos de higiene oral.

A partir de los 6 meses -

- Use un cepillo suave con agua, sin pasta dentifrica para cepillar los primeros dientes.
- Déle un osito de felpa a su bebé envez de un biberón, antes de dormir.

A partir del año -

- Lleve a su bebé donde el dentista para su primer chequeo.
- Añada una gota de pasta dentifrica al cepillo de su bebé.
- Mantenga la slud oral del bebé con chequeos cada seis (6) meses.

A partir del tercer año -

- Siga cepillando y empiece a usar seda dental en los dientes de su niño/a después de las comidas y antes de dormir.
- Chequee cuanto fluoruro toma su niño. Se puede obtener fluoruro en el agua potable, en pastillas para masticar, en las pastas dentifricas, o en la oficina del dentista.

A los 4 y 5 años -

- Mantenga vigilancia de los dientes de leche, ellos son los que dan comienzo a los dientes permanentes de su niño.
- Haga que su niño se cepille los dientes, bajo la supervisón de usted.
- Continúe el cuidado regular de su salud oral.

De los seis (6) años para adelante -

- Esté preparado para la pérdida de dientes y sonrisas huecas, pues los dientes de leche de su niño/a, están de salida.
- Transfiera la responsabilidad de cepillarse y usar seda dental a su niño/a, en forma gradual.
- Continúe con el cuidado regular de salud oral, en el hogar y en la oficina del dentista y mire como crece esa sonrisa.

Children's *dental care* resources in Yakima County

HEALTHY SMILES — 248-1082 — 865-3886

Yakima Valley Farmworkers Clinic — Yakima — Toppenish

Dr. Mark Koday, Director — 602 E. Nob Hill Blvd. - Yakima

El proyecto se enfoca en ninos y mujeres embarazadas. YVFWC tiene un programa para emergencias dentales y acepta ver a unos cuantos pacientes nuevos.

KIDSPARKLE — 454-4143

Yakima Neighborhood Health Services — Yakima

12 S. 8th St. - Yakima

YNHS se enfoca servicios dentales para la familia. Para hacer citas llame la primera semana de cada mes.

LA-TIS-SHA ("ARE BLOOMING") — 865-1708

Yakama Nation Tribal WIC Dental Program — Toppenish

401 Buster Rd. - Toppenish

El enfasis del proyecto es culturalmente relevante a la educacionde salud oral. El Esmalte de fluoruro y el tratamiento dental secundario para prevencion estan incluidos para los ninos 0 a 10 anos de edad.

KIDSCREEN — 457-1165 OR 1-800-301-1165

El proyecto se enfoca en ninos y el tratamiento dental para prevencion estan para los ninos de 0 a 5 anos de edad.

SMILESAVERS — 576-7860

Jane Moreno, RDH — Yakima

Yesterday's Village Track 29 - Yakima

Cuidado prevencion y restaurativo. Las clinicas ambulantes se situan en lugares o centros que sirven a la communidad como iglesias y escuelas. Se aceptan cupones medicales.

ENGLEWOOD DENTAL CLINIC — 577-8277

3999 Englewood — Yakima

Los Dentistas para la Familia aceptan cupones medicos. (Medicaid)

CHILDREN'S VILLAGE — 574-3220

3801 Kern Rd. — Yakima

Ninos con problemas especiales con la salud. Se estan aceptando personas con cuponas medicos y de bajos ingresos.

COMMUNITY DENTAL CLINIC — 837-7178

1723 East Lincoln — Sunnyside

Los Dentistas para la Familia aceptan cupones medicos. (Medicaid)

YVCC DENTAL HYGIENE PROGRAM — 574-4920

Yakima Valley Community College estudiantes

PAT BROWN — 575-2437

SMILEMOBILE — TBA ANUALLY

Low-Cost Strategies for Getting the (Oral Health) Message Out!

Spend a little, get a lot! Use these techniques developed for the Cavity Free Kids Program of Washington Dental Service Foundation to increase community awareness of oral health issues. You can adapt or add to them for your area and situation.

Newspapers. Work with advertising sales or marketing people to leverage a small amount of money for greater impact through a special promotion or special section of a page. For instance, for Children's Dental Health Month in February, one WDSF ad and some articles and graphics from the ADA promotional package plus a local release helped create a half-page spread in several papers. The papers solicited other ads to go on the page. (And look for another organization to underwrite your costs.)

Send in camera-ready ads in different sizes that can be used as "fillers". They can also be used for school, business and service organization newsletters.

If your paper does a "Health & Fitness" section or something similar, send an article they can use. Tailor articles to other special supplements they feature, such as "Back-to-School". And of course send regular press releases of events and news. Offer to write a column!

Radio. Same idea. Buy a small amount of time and ask for a free matching schedule of ads. Use their on-air talent and facilities to produce the spot, and it's usually free. Get tapes to send to other stations if you can. Combine with print ads for impact. Send press releases to stations with news coverage.

Television. Use the local cable access channel and facilities. They'll also often run videos you provide. Give the network news people a photo opportunity!

Speakers Bureau. Make yourself available to service and civic clubs, sororities, churches, school PTAs, media groups, health advisory groups, health fairs, and conferences of people who can aid your cause. Make sure people know you can be called to "fill in" when another speaker cancels. The idea here is to become well known so that organizations want to include you in their related projects.

Membership in groups such as Rotary, Kiwanis, Chamber of Commerce can provide good opportunities for speaking, networking and linkage. If you have a budget, pay a portion of the fee for one of your advocates to join on your behalf.

Educational Materials. There are several free publications that are very good. (See separate list for oral health.) Order some, put your organization's stamp on them, and spread them around widely. People are always looking for things to hand out. Make simple bookmarks, flyers or posters with your own message on them.

Reinforce your message with incentive items: t-shirts, hats, stickers, etc. Offer them as giveaways for organization fairs, drawings, summer programs, and the like.

Community Visibility. Get oral health included in existing programs such as parenting classes, summer day camps, safety programs, hospital classes, parish nurses, schools, employee wellness programs and newsletters. Give them the information they need to do a good job. Become the "expert."

Other possibilities: tray liners in fast food outlets, grocery bag messages or stuffers, community events such as parades, & fiestas, sponsor a sports night with local teams. Get the Mayor or Council to do a proclamation of support when there is something special happening.

For more information, contact Washington Dental Service Foundation's Cavity Kids Program at:
Phone: 206-528-2331; Fax: 206-528-7373; e-mail: tanthony@ddpwa.com.

AHEC/Community Partners
Materials & Resources

AHEC/Community Partners has materials available which can be downloaded free or purchased. These resources include tip-sheets, articles videos and our Workbook. They address issues of Community-building, Health Care Access and Healthy Communities Massachusetts.

AHEC Programs

AHEC Home Page

Healthy Communities Massachusetts

Health Care Access

Community Coalitions

Materials & Resources

- Community Building
- Health Care Access
- Healthy Communities Mass.
- Order AHEC materials

Community Building

Materials on community-building and coalitions -- now available! Click here to see what's online.

Health Care Access

Materials on access to health care coverage and health care outreach -- now available! Click here to see what's online.

Healthy Communities Massachusetts

Materials associated with the Healthy Communities Movement and Healthy Communities Massachusetts. Click here to see what's online..

How to Download Materials from this website

Materials are currently available on our website as "pdf" files. This means that when you download them and open them, they'll look just as good as the printed versions, and will print up nicely, too. To download, just click o the link associated with the document.

How to Order Materials from AHEC

AHEC has books, videos and issue specific papers which can be purchased. To order on-line, click here. For information or if you have questions, contact us at 413-253-4283 or email us at orders@ahecpartners.org

Contact us:
AHEC/Community Partners:
24 South Prospect Street, Amerst, MA 01002
p: 413-253-4283
f: 413-253-7131
info@ahecpartners.org

Access to Baby and Child Dentistry (ABCD) Program

What is the ABCD Program?

The Access to Baby and Child Dentistry (ABCD) program is an initiative to increase access to dental services for Medicaid eligible infants, toddlers, and preschoolers. The project's goal is to ensure that good dental experiences in early childhood will lead to lifelong practices of good oral health. This is done, in part by identifying and removing obstacles to early preventive treatment, such as the lack of transportation to a dental office, language interpretation issues, etc. For further information, see *How does the ABCD Program work?*

The ABCD program is a partnership between the public and private sectors, including the University of Washington School of Dentistry, the Washington State Dental Association, Local Dental Societies, the Department of Social and Health Service's Medical Assistance Administration (MAA), and Local Health Jurisdictions.

The mission is to identify Medicaid eligible infants and toddlers who have not yet reached their fourth birthday, and to match each child to an ABCD-certified dentist. Children will remain in the ABCD program until their sixth birthday.

The ABCD program encourages the use of proven and effective preventive techniques (e.g., oral health instructions, glass ionomers), while disallowing the use of less effective interventions (e.g., prophylaxis for children 0-5 years of age).

Please note: ABCD children are entitled to the full scope of care as described in the MAA Dental Billing Instructions. These ABCD Billing Instructions identify those specific services that are eligible for "add-on" fees or additional payments.

Contact: Carree Moove (360) 725-1653
D.S.H.S. / Medicaid Dental Program

Who...	Responsibility...
Local Dental Society	Oversees provider activities and performs peer review. Sponsors and supervises an ombudsman for the ABCD program. The ombudsman serves as a liaison for MAA and ABCD program-certified dentists regarding billing and policy issues.
Medical Assistance Administration (MAA)	Reimburses program-certified dentists for services covered under this program.
University of Washington School of Dentistry	Provides technical and procedural consultation on the enhanced treatments and conducts continued provider training and certification.
Washington Dental Services Foundation	Provides funding to support ombudsman position and client outreach and linkage.