Message from Bob Russell, Public Health Dental Director

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Message from Bob Russell  
Public Health Dental Director

The US Surgeon General, in his 2003 “Call to Action” report, listed dental disease as a silent epidemic. For Medicaid-enrolled, uninsured, and underinsured children in Iowa this is indeed true; the current dental care system is failing the underserved. Our purpose within the I-Smile project is to prevent or identify this silent threat early on and help eliminate dental disease in our vulnerable children.

The task is difficult and will present each of you many challenges in the upcoming years; however, the rewards are equally great. I welcome each of you aboard as we develop an innovative oral health system that will improve access to care and prevention for Iowa’s underserved children.

The silent disease will be silent no more…
Overview

- The I-Smile Dental Home Project
- Iowa’s Title V Maternal and Child Health System
- MCH Pyramid of Core Public Health Services
- The I-Smile Dental Home Project within the Title V Child Health System
- I-Smile Dental Home Care Plan Diagram
In 2005, the Iowa legislature passed HF841, a Medicaid reform initiative called “IowaCare.” The following mandate was included within the legislation:

“By July 1, 2008, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated **dental home** and shall be provided with the dental screenings and preventive care identified in the oral health standards under the Early and Periodic Screening, Diagnosis, and Treatment program.”

In response, the Iowa Department of Human Services partnered with the Iowa Department of Public Health (IDPH), the Iowa Dental Association, the Iowa Dental Hygienists’ Association, Delta Dental of Iowa, and the University of Iowa College of Dentistry to develop a proposal that would fulfill the dental home mandate.

The result is the **I-Smile dental home project**.

★ **The Purpose of a Dental Home**

The ultimate goal of creating a dental home is to ensure that children receive age-appropriate comprehensive dental care. The American Academy of Pediatric Dentistry’s (AAPD) definition of a dental home is the conceptual framework for the I-Smile project. The AAPD recommends children be referred for preventive and routine oral health care as early as six months of age and no later than 12 months of age. Periodicity of re-appointment should be based on risk assessment.

A dental home provides:
- Acute care and preventive services;
- Assessment of oral diseases;
- Individualized preventive care based on risk assessment;
- Anticipatory guidance about growth and development;
- A plan for dental trauma;
- Information about proper care of teeth and gums;
- Dietary counseling; and
- Referrals to dental specialists

★ **I-Smile: A Conceptual Dental Home**

Using the AAPD definition, IDPH envisions a conceptual dental home, allowing a team approach to manage oral disease. Primary prevention and care coordination are the focus of the I-Smile project and will be centered in Iowa’s existing public health network. Through referrals, dentists will serve as the providers of treatment and definitive evaluation. Additional health professionals such as dental hygienists, physicians, nurse practitioners, registered nurses, physician assistants, and dietitians will be part of a network providing oral screenings, education, anticipatory guidance, and/or preventive services as needed.
The result will be an integrated dental home system that assures children, particularly Medicaid-enrolled, receive early and appropriate oral health care services.

★ Objectives of the I-Smile Dental Home Project
The I-Smile project has four objectives. The first objective – improving the dental support system for families – will have the most impact on the public health system and is outlined below.

Additional details about each objective may be found within I-Smile: The Iowa Dental Home Proposal in the Resources section of this handbook.

Objective 1. Improve the dental support system for families.

Provide funding to Title V child health agencies to increase dental program infrastructure.
- Establish a dental hygienist in each child health agency as oral health coordinator
- Purchase dental supplies and equipment

Increase funding to strengthen the state Title V child health database system for tracking patient care coordination and appointments.
- Modify the data system
- Develop an internet database of all participating dentists

Fund oral health education and promotions.
- Conduct an oral health education campaign
- Increase oral health promotion and outreach activities

Fund a training program for dental and other healthcare providers regarding children’s oral health.
- Provide training to dentists on treating very young and disabled children
- Provide oral health training to non-dental professionals

Objective 2. Improve the dental Medicaid program.

Objective 3. Implement recruitment and retention strategies for underserved areas.

Objective 4. Integrate dental services into rural and critical access hospitals.

★ Outcomes of the I-Smile Dental Home Project
The outcome of the I-Smile dental home project will be an integrated service delivery system that provides early identification of disease risk, prevention, improved care coordination, and strengthened parental involvement. Ultimately, at-risk children who are currently excluded from the dental care system will be reached and will have a dental home.
The Iowa Department of Public Health (IDPH) contracts with private/non-profit and public agencies throughout the state to implement the Title V maternal and child health (MCH) program. The MCH agencies are responsible for ensuring that underserved women, children, and their families have access to quality health services, including oral health care.

As part of a coordinated system between IDPH and the Iowa Department of Human Services, MCH agencies have been designated as Medicaid maternal health centers and child health screening centers. Through this collaboration, MCH agencies coordinate health care and bill Medicaid for services provided to prenatal and postpartum women and to children enrolled in the Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Care for Kids program.

★ MCH Core Public Health Services
The core public health services delivered by MCH agencies can be illustrated using the pyramid structure (refer to end of this section for pyramid diagram). The ultimate goal of the MCH system is for each maternal and child health client to have a dental and medical home. Therefore, the focus of agency activity is on those services in the lower tiers of the pyramid – infrastructure building, population based, and enabling services. These services provide support to the existing health care systems to meet the needs of underserved families. Direct services through the MCH agencies are to be provided as “gap-filling” only, for those clients who do not have access to a medical or dental home.

- Infrastructure building services
  Infrastructure building services are the foundation for assuring that children and families have access to health care. Infrastructure building activities improve health status by developing and maintaining health services systems. This can include community planning and assessment, policy development and support, training, and data system development.

- Population Based Services
  Population based services are preventive interventions and health services provided to an entire group rather than in a one-on-one situation. Programs and services are designed to meet the specific needs of groups so that many people can benefit at once.

- Enabling Services
  Enabling services help families overcome barriers to establishing a medical or dental home. Enabling services include outreach, informing, and care coordination.
Outreach - Through outreach activities, the MCH agency helps families and community partners become aware of health services available through their agency. Outreach messages are distributed at targeted sites throughout a community and include details about agency services and contact information.

Informing - Informing is a key component of the EPSDT Care for Kids program. Each month, child health agencies are alerted to all children newly enrolled in Medicaid. Informing is the act of contacting the families of those children and advising them about the services available through the EPSDT Care for Kids program. For maternal health clients, informing is provided as health education.

Care coordination - Care coordination services link women and children to health care and help them to establish and maintain medical and dental homes. Through personal contact with families, MCH agency staff assists with appointments and arranges support services such as transportation, translation, and child care.

MCH agencies are responsible for providing enabling services to all maternal and child health clients regardless of payment source. For MCH clients enrolled in Medicaid, enabling services (informing, care coordination, and health education) are reimbursable.

- Direct Care Services
  Most direct care services for MCH clients are provided through private medical and dental providers. Agencies establish written agreements with the providers and sometimes use MCH funds to pay for limited allowable services.

  When gaps in service provision are identified through a local needs assessment, direct services may be provided by the agency. Examples of services include well-child screenings, lead testing, immunizations, oral health screenings, and fluoride varnish applications. These may occur in public health clinics, WIC clinics, Head Start/Early Head Start centers, or other community settings.

★ Documenting Services
  MCH agencies are required to document all services provided to clients, including informing, care coordination, and direct services.

The Women's Health Information System (WHIS) is the database used by maternal health (MH) agencies to document services provided to prenatal and postpartum clients. Child health (CH) agencies use the Child and Adolescent Reporting System (CARes) database to record the services provided to children.

When direct services are provided by the MCH agency, a client chart is also required for detailed documentation. All records of patients receiving services associated with the MCH agency are the property of IDPH as stated in the MCH Administrative Manual.

Refer to the WHIS or CARes User Manuals and the MCH Administrative Manual for specific information on documentation of services.
MCH Pyramid of Core Public Health Services

DIRECT HEALTH CARE SERVICES (Gap Filling)
Examples
- Clinics - Family Planning Special Populations, Medically Underserved Areas, and Child Health Specialty Clinics Gap filling Services

ENABLING SERVICES
Examples
- Early ACCESS Service Coordination, Transportation, Translation, OB Indigent, Respite Care, Health Education, Family Support Services, FP Education & Counseling, EPSDT Informing & Care Coordination, Outreach, WIC, Enhanced Services, Ill & Handicapped Waiver, and Continuity of Care Program

POPULATION-BASED SERVICES
Examples
- Universal Newborn Screening, Abstinence Education, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, HCCI, Outreach/Public Education, Newborn Hearing Detection, and Screening Clinics

INFRASTRUCTURE BUILDING SERVICES
Examples
The I-Smile dental home project relies on an integrated health system using different levels of care and different types of providers. Title V child health (CH) agencies have an existing network of community partners and health related services for Medicaid-enrolled, uninsured, and underinsured children. These agencies are optimal sites for implementing I-Smile and have been designated as the center of the care coordination, prevention, and referral network for the conceptual dental home.

An oral health coordinator will be responsible for implementing the I-Smile dental home project within each CH agency.

★ Entry into the I-Smile System
Although the IowaCare dental home mandate targets Medicaid-enrolled children ages 12 and under, all children served by the CH agency are to be included in I-Smile activities.

A child's entry into the I-Smile system will primarily come from the list of children newly enrolled in Medicaid that each CH agency receives monthly. Other possible system entries may include physicians’ offices, other local public health agencies, community health centers, hospital-based dental clinics, WIC clinics, Head Start/Early Head Start centers, schools, and preschools. Providers and staff within these entry points will be able to directly refer children to the local CH agency.

Upon entry into the I-Smile system, an oral screening and risk assessment will be completed on each child by the oral health coordinator or delegated staff (refer to the Forms section for the Oral Screening and Risk Assessment forms).

★ I-Smile Levels of Care
The risk assessment will identify the appropriate level of care for each child.

- Level One Care – A child has no observable disease and is considered to be at low or moderate risk for decay.
- Level Two Care – A child has observable disease and is considered to be at high risk for decay.
- Level Three Care – A child has severe disease and is considered to be at high risk for decay.

The level of care establishes the preventive and education services that will be provided through the CH agency, as well as the immediacy and frequency for exams and treatment in a dental office.
Through the I-Smile system, dental offices will benefit by having the local CH agency as the primary provider of regular education and prevention services and the single point of contact for managing patient appointments and referrals. This will provide dentists with more time to focus on treatment services. In addition, patient non-compliance and “no-show” appointments in dental offices will be reduced.

The oral health coordinator will work with dental office staff to make them aware of a child’s health needs. The coordinator will also work with families to make them aware of the importance of oral health and regular care, as well as the dental office protocols.

Refer to the I-Smile Dental Home Care Plan diagram at the end of this section.

★ I-Smile Pyramid Services

The I-Smile dental home project includes activities within all four levels of the MCH pyramid. Examples of oral health activities from each pyramid level include:

- Infrastructure building
  - Visit medical and dental offices to introduce the I-Smile project
  - Organize oral health coalitions and forums
  - Participate in community health improvement planning
  - Assist local public health agencies and boards of health with collecting, analyzing, and evaluating oral health data

- Population based
  - Present oral health education for Head Start/Early Head Start parent classes or school parent/teacher group meetings
  - Incorporate oral health promotion at health fairs and cultural events

- Enabling (outreach, informing, care coordination)
  - Distribute informational fliers at school registrations
  - Develop oral health public service announcements
  - Educate parents about the benefits of regular preventive dental care
  - Provide families with the names and locations of dental providers
  - Assist families with scheduling dental appointments
  - Arrange dental support services, such as transportation and translation

- Direct Services
  - Oral screenings
  - Fluoride varnish applications
  - Sealant applications
  - Prophylaxes
  - Radiographs

Although the focus of CH agencies has traditionally been on the lower tiers of the MCH pyramid, the I-Smile concept recognizes that Iowa’s current dental workforce is inadequate to meet the needs of low-income and Medicaid-enrolled children. This will
require that CH agencies identify clinical resources and increase opportunities for direct care prevention services to underserved children.

Many CH agencies already provide some aspect of direct dental preventive services. Some have on-site clinical capacity, while others utilize partnerships with other public health service agencies such as WIC, Head Start/Early Head Start, school-based clinics, local health departments, and community health centers. Each of these service locations and partnerships are acceptable and effective strategies for direct health care services.

★ Title V CH Compliance
Because I-Smile is a component of the CH program, project activities must adhere to all requirements and regulations associated with Title V. This includes client confidentiality, maintaining data and client records, billing, release of information, consent for services, and HIPAA requirements.

Refer to the MCH Administrative Manual, approved grant applications, and agency contracts in order to assure compliance when providing services.
I-Smile Dental Home Care Plan Diagram

I-Smile
Oral Health Coordinator
Oral Screening and Risk Assessment
Preventive Care
Education

Level 1
Low Risk
No observable
disease
Care
coordination
Referral for
dental exam
within 1 year
Oral screening,
risk assessment,
and preventive
care in 6 months

Level 2
Moderate Risk
No observable
disease
Care
coordination
Referral for
dental exam
within 6 months
Oral screening,
risk assessment,
and preventive
care in 3-6
months

Level 3
High Risk
Observable
disease
Care
coordination
Referral for
dental exam
within 3 months
Oral screening,
risk assessment,
and preventive
care in 3-6
months

High Risk
Severe
disease
Care
coordination
Immediate
referral to
dentist/specialist
Oral screening,
risk assessment,
and preventive
care in 3 months

PLAN

Medicaid, uninsured, and
underinsured children from
birth-12 years
I-Smile Oral Health Coordinator Responsibilities

- Oral Health Coordinator Overview
- Partnerships and Planning
- Local Board of Health Linkage
- Child Health Agency Staff Training
- Agency Oral Health Protocols
- Healthcare Professional Education
- Oral Screening and Risk Assessment
- Care Coordination
- Preventive Oral Health Services
Establishing an oral health coordinator in each Title V child health (CH) agency is the first step for building local capacity in the I-Smile dental home system. Each coordinator is responsible for managing the agency’s I-Smile project. The coordinator will serve as the oral health prevention expert and the liaison between the public health agency, families, and dental offices to ensure completion of dental care.

Responsibilities of the coordinator are outlined below. The following pages provide details related to each responsibility.

1. Work within all counties in the service area to strengthen the public health dental system - develop partnerships, participate in health planning and needs assessments, and establish the I-Smile referral network.

2. Link with the local board(s) of health - assist in assessment, policy development, and assurance of local oral health initiatives.

3. Provide training and oversight of child health agency staff involved with oral health services.

4. Work with child health agency staff, particularly EPSDT care coordinators, to develop oral health protocols.

5. Provide education and training for healthcare professionals regarding children’s oral health.

6. Ensure completion of periodic screenings and risk assessments on children ages 12 and under.

7. Ensure oral health care coordination services.

8. Provide fluoride varnish applications, prophylaxes, and/or sealants as gap-filling services.
Partnerships and Planning

1. Work within all counties in the service area to strengthen the public health dental system - develop partnerships, participate in health planning and needs assessments, and establish the I-Smile referral network.

Developing community partnerships may be the most important aspect of an I-Smile coordinator’s job. Identifying and meeting with local partners in all service area counties will strengthen the I-Smile initiative and is necessary for developing a coordinated referral network.

It is crucial to make local dental and medical offices aware of the coordinator’s presence within the community and to familiarize office personnel with the availability of screening, tracking, and referral services through the I-Smile project.

In addition to private providers, partners such as Head Start/Early Head Start, WIC, local public health agencies, Empowerment, schools, businesses, and faith-based organizations are vital in oral health infrastructure building activities. There may also be other health organizations and partners that are unique to the community and who could be included as members of the I-Smile network.

Local partners can be particularly helpful in health promotion and outreach activities. These activities will help families and others in the community become aware of I-Smile as well as the dental services available through CH agencies.

Community outreach and health promotion examples include:
- Posters for physician and dental offices
- Grocery bag advertising
- Library displays
- Radio public service announcements
- Newspaper articles or advertisements
- Health fairs and cultural events
- Education for parent groups

Most communities regularly complete needs assessments in order to develop strategies that protect and promote health. To foster partnerships, the I-Smile coordinator can initiate local oral health coalitions and assure that oral health program priorities are included in comprehensive community health plans.

Get to know your community. Talk to others. Learn as much as you can about possible resources. These linkages are the key to strengthening the I-Smile dental home project!
Local Board of Health Linkage

2. Link with the local board(s) of health - assist in assessment, policy development, and assurance of local oral health initiatives.

Local boards of health (BOH) are responsible for health assessment, policy development, and assurance of health services in all 99 Iowa counties. Working with boards of health is an integral infrastructure building activity of CH agencies.

BOH members may have limited knowledge about oral health, including the I-Smile dental home initiative. I-Smile coordinators can be a valuable resource for increasing awareness and assuring that oral health issues are included in community assessment and planning activities.

Linking with the BOH may be accomplished in several ways:
- Develop and present oral health reports
- Provide members with packets of information about oral health
- Assist with oral health planning and promotion
- Participate in the local Community Health Needs Assessment and Health Improvement Plan (CHNA & HIP) process

A personal visit to BOH meetings may not always be necessary. At times a written report may be just as useful. It is important to communicate with the person(s) responsible for planning the BOH agenda and administering their activities. This communication will help the oral health coordinator understand the best way to contribute to BOH activities.

Child Health Agency Staff Training

3. Provide training and oversight of child health agency staff involved with oral health services.

All agency staff, whether involved in informing, care coordination, or direct care service activities, should receive ongoing oral health education and training.

The I-Smile coordinator is responsible for promoting optimal oral health for children and assuring that proper techniques and consistent oral health messages are included within all the family-centered services. Education should be ongoing and may occur through one-on-one sessions, in-service trainings, and written updates.
4. Work with child health agency staff, particularly EPSDT care coordinators, to develop oral health protocols.

Educating families about the importance of early and regular dental care and linking families to that care is critical to the success of the I-Smile project. The I-Smile coordinator should work closely with the EPSDT care coordinator to develop and/or update agency protocols for oral health informing and care coordination.

Protocols for direct care service delivery should also be developed in collaboration with appropriate staff.

5. Provide education and training for healthcare professionals regarding children’s oral health.

The conceptual dental home relies on multiple healthcare providers to assure that children receive dental services. This allows the workforce to be used most efficiently; the dentist provides the most skilled levels of dental care and other healthcare partners provide preventive services and education.

The I-Smile coordinator is responsible for assuring that non-dental healthcare providers are informed about the I-Smile dental home system. The coordinator will serve as a liaison between the non-dental and dental providers in the I-Smile network and will facilitate linkages and a smoother referral process.

Physicians, nurse practitioners, registered nurses, physician assistants, and dietitians routinely see children from birth. Currently, these providers refer their patients who need dental care directly to dental offices. Because few dentists accept children under the age of three or those enrolled in Medicaid, many non-dental providers face barriers and frustrations that discourage them from making referrals.

As part of the I-Smile project, these providers will now refer children to the local oral health coordinator for a risk assessment. When indicated, the coordinator will refer the child to a local dentist based on the level of risk and urgency.

Because most non-dental health professionals have not had formal oral health training, the I-Smile coordinator will be the primary oral health education resource. Physicians and other medical professionals are important allies who can learn to identify oral abnormalities, educate parents, and apply fluoride varnish. Dietitians should also be trained to provide oral health education as part of their nutritional counseling.
Refer to the Education Guidelines and Resources sections for information for physicians and other healthcare providers.

**Oral Screening and Risk Assessment**

6. **Ensure completion of periodic oral screenings and risk assessments on children ages 12 and under.**

Children are at different levels of risk for developing dental disease. The I-Smile dental home concept requires that an oral screening and risk assessment be completed on each child to determine the child’s current oral health status and possibility of future disease.

It is recommended that the I-Smile oral health coordinator or other agency dental hygienist(s) assume responsibility for the oral screening and risk assessment. Depending on workforce availability, the oral health coordinator may train other licensed health professionals within the CH agency (registered nurses, nurse practitioners, or physician assistants) to provide oral screenings and complete the risk assessment.

This screening and assessment will guide the child’s preventive care and treatment plan and will also provide insight about the counseling and education needs of a family. The I-Smile coordinator should work with agency staff to determine the best means to provide preventive care and education for parents.

The I-Smile Risk Assessment tool and a sample screening form are included within the Forms section of this manual. Risk assessment data will be collected within CAReS. Refer to the Direct Care Services Guidelines section for more information on oral screenings.

**Care Coordination**

7. **Ensure oral health care coordination services.**

Linking children to a dental home is the foundation of the I-Smile project. All child health agencies are required to provide care coordination services to help families establish and maintain a dental home.

The role of the I-Smile coordinator is to enhance the oral health component of care coordination services, integrating multiple providers and types of care. Families, dentists, physicians, and community partners will become part of a network to assure that each child has access to preventive dental care and treatment.

Ensuring enhanced oral health care coordination may require the oral health coordinator to also develop an improved tracking system of patient appointments and referrals.
The I-Smile coordinator may provide care coordination services and/or oversee the oral health component of services provided by other agency staff.

Care coordination activities include:
- Developing a relationship with local dental office staff
- Notifying medical providers of available referral services
- Assisting families in finding a local dentist
- Assisting families in setting up and keeping appointments
- Corresponding with area dental offices
- Developing referral/recall systems
- Reminding families when they are due for appointments
- Providing anticipatory guidance and oral health education
- Assisting families in finding payment sources for dental care
- Assuring data entry of oral health services

**Preventive Oral Health Services**

8. Provide fluoride varnish applications, prophylaxes, and/or sealants as gap-filling services.

Based on community needs and resources, gap-filling preventive services will be included as part of I-Smile. Fluoride varnish will likely be applied to all children in conjunction with an oral screening. When indicated by local needs, prophylaxes and sealants may also be provided.

The oral health coordinator may provide the services or train other appropriate licensed agency staff. The coordinator is responsible for the quality assurance of direct dental services provided by other staff.

Locations for providing preventive services may include child health clinics, WIC clinics, preschools, Head Start/Early Head Start classrooms, child care sites, or other public health settings. Communities may offer unique settings based on local health systems. The I-Smile coordinator should consider these settings as possible preventive services sites.

Refer to the Direct Care Service Guidelines section of this handbook for specific information on providing preventive services.
Direct Care Service Guidelines

- Supervision of Dental Hygienists
  - Public Health Supervision Agreement
- Oral Screening and Risk Assessment
- Fluoride Varnish
  - Iowa Department of Public Health Fluoride Varnish Protocol
- Dental Sealants
- Prophylaxes and Radiographs
- Medicaid Billing
- Maternal and Child Health Agency Direct Care Service Protocols

Revised 1/10
Dental hygienists providing direct care services in Iowa must work under the supervision of a dentist. In public health settings, this would include either public health or general supervision.

Dental hygienists may provide educational services without supervision.

★ Public Health Supervision
The IDPH recommends that all dental hygienists providing direct services through MCH agencies use public health supervision. This allows hygienists to provide services in designated public health settings prior to a patient seeing a dentist.

A hygienist must have a minimum of three years of clinical practical experience to work under public health supervision. A collaborative agreement between a dentist and a hygienist is required (see next page). The agreement must detail what services can be provided, where services will be provided, and standing orders for the services.

While the collaborative agreement allows the supervising dentist and hygienist to list the location of dental records, it is expected that all dental hygienists (employed or contracted) providing services through CH agencies will maintain clinical records within the agency and not at a separate location. All records of patients receiving services associated with a CH agency are the property of IDPH as stated in the MCH Administrative Manual.

Dentists providing public health supervision are not required to provide future dental treatment to patients served by the hygienist.

★ General Supervision
General supervision is required for a hygienist providing direct services who is not working under public health supervision. In order to assure compliance with Iowa Dental Board rules, the IDPH requires that a local dentist be identified as the supervising dentist and the hygienist or CH agency have a written agreement with a dentist providing general supervision.

A dentist is required to see a patient prior to a hygienist providing sealant, prophylaxis, and radiograph services under general supervision.

Detailed rules about dental hygiene supervision may be found on the Iowa Dental Board website link: [http://www.state.ia.us/dentalboard/](http://www.state.ia.us/dentalboard/)
# PUBLIC HEALTH SUPERVISION AGREEMENT

## Agreement Between:

### Supervising Dentist’s Name:

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### Dental Hygienist’s Name:

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**Years of Clinical Practice Experience**: 

* A minimum of three years clinical practice experience is required.
**Location(s) Where Services Will Be Provided:**

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**Duplicate this page as needed**
Consultation Requirements
A dentist in a public health supervision agreement must be available to provide communication and consultation with the dental hygienist. A dental hygienist working under public health supervision must maintain contact and communication with their supervising dentist.

Specify the type (e.g. in person, telephone), frequency, and other details regarding how communication and consultation will be maintained:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Dental Records
Specify the procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Location of Records: _______________________________________________________

Patient Considerations
A dental hygienist working under public health supervision must practice according to age and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient.

Medical conditions that require a dental evaluation prior to hygiene services:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Considerations for medically-compromised patients:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

In addition, for each patient the hygienist must:

- Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services.
- Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs.
Standing Orders

Procedure: Assessment/Screening Age Group: ______________
Standing Orders:

Yes  ☐ No ☐ Assessment/screening can continue to be provided if no dental exam has taken place.

Procedure: Sealant Assessment/Screening Age Group: ______________
Standing Orders:

Yes  ☐ No ☐ Assessment/screening can continue to be provided if no dental exam has taken place.

Procedure: Sealants Age Group: ______________
Standing Orders:

Period of time in which an exam by a dentist must occur prior to providing this service to a patient again: ______________ months.
Standing Orders Continued

Procedure: Fluoride Varnish  Age Group: __________________
Standing Orders: ________________________________________

☐ Yes ☐ No  Fluoride varnish can continue to be provided if no dental exam has taken place.

Procedure: Oral Prophylaxis  Age Group: __________________
Standing Orders: ________________________________________

Period of time in which an exam by a dentist must occur prior to providing this service to a patient again: ________________ months.

Procedure: Radiographs  Age Group: __________________
Standing Orders: ________________________________________

Period of time in which an exam by a dentist must occur prior to providing this service to a patient again: ________________ months.
Standing Orders Continued

Procedure: ____________________________  Age Group: ______________

Standing Orders:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Period of time in which an exam by a dentist must occur prior to providing this service to a patient again: ____________ months.

Procedure: ____________________________  Age Group: ______________

Standing Orders:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Period of time in which an exam by a dentist must occur prior to providing this service to a patient again: ____________ months.
**Other Requirements**

Indicate any other conditions or requirements for your supervision agreement here.


This public health supervision agreement must be reviewed at least biennially. A copy of the agreement must be mailed to the Oral Health Bureau at the Iowa Department of Public Health and made available to the Iowa Dental Board upon request.

A dental hygienist who has rendered services under public health supervision must complete a summary report at the completion of the program or in the case of an ongoing program, once per calendar year. The report shall be filed with the Oral Health Bureau of the Iowa Department of Public Health on forms provided by the department. For reporting forms, contact the department at the address and phone number specified below.

A copy of current board rules is attached.

I agree to provide public health supervision to the dental hygienist named herein according to the details specified in this public health supervision agreement and the rules of the Iowa Dental Board.

---

**Dentist Signature**

Date

I agree to provide dental hygiene services according to the details specified in this public health supervision agreement and the rules of the Iowa Dental Board.

---

**Dental Hygienist Signature**

Date

For questions regarding public health supervision rules, contact the Iowa Dental Board at (515) 281-5157 or visit the Board’s website at [www.dentalboard.iowa.gov](http://www.dentalboard.iowa.gov).

A copy of this agreement must be maintained at each public health location where public health supervision is provided. A copy must also be mailed to:

**Iowa Department of Public Health**

**Oral Health Bureau**

321 E. 12th Street

Des Moines, IA 50319

Phone: (866)528-4020 * (515) 281-3733 * Fax (515) 242-6384

[http://www.idph.state.ia.us](http://www.idph.state.ia.us)
650—10.5(153) Public health supervision allowed. A dentist who meets the requirements of this rule may provide public health supervision to a dental hygienist if the dentist has an active Iowa license and the services are provided in public health settings.

10.5(1) Public health settings defined. For the purposes of this rule, public health settings are limited to schools; Head Start programs; federally qualified health centers; public health dental vans; free clinics; nonprofit community health centers; nursing facilities; and federal, state, or local public health programs.

10.5(2) Public health supervision defined. “Public health supervision” means all of the following:

a. The dentist authorizes and delegates the services provided by a dental hygienist to a patient in a public health setting, with the exception that hygiene services may be rendered without the patient’s first being examined by a licensed dentist;

b. The dentist is not required to provide future dental treatment to patients served under public health supervision;

c. The dentist and the dental hygienist have entered into a written supervision agreement that details the responsibilities of each licensee, as specified in subrule 10.5(3); and

d. The dental hygienist has an active Iowa license with a minimum of three years of clinical practice experience.

10.5(3) Licensee responsibilities. When working together in a public health supervision relationship, a dentist and dental hygienist shall enter into a written agreement that specifies the following responsibilities.

a. The dentist providing public health supervision must:

(1) Be available to provide communication and consultation with the dental hygienist;

(2) Have age- and procedure-specific standing orders for the performance of dental hygiene services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of dental hygiene services;

(3) Specify a period of time in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement; and

(4) Specify the location or locations where the hygiene services will be provided under public health supervision.

b. A dental hygienist providing services under public health supervision may provide assessments; screenings; data collection; and educational, therapeutic, preventive, and diagnostic services as defined in rule 10.3(153), except for the administration of local anesthesia or nitrous oxide inhalation analgesia, and must:

(1) Maintain contact and communication with the dentist providing public health supervision;

(2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;

(3) Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs;

(4) Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services; and

(5) Specify a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist, including where these records are to be located.

c. The written agreement for public health supervision must be maintained by the dentist and the dental hygienist and must be made available to the board upon request. The dentist and dental hygienist must review the agreement at least biennially.

d. A copy of the agreement shall be filed with the Oral Health Bureau, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

10.5(4) Reporting requirements. Each dental hygienist who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the oral health bureau of the Iowa department of public health on forms provided and include information related to the number of patients seen and services provided to enable the department to assess the impact of the program. The department will provide summary reports to the board on an annual basis.

This rule is intended to implement Iowa Code section 153.15.
Oral Screening and Risk Assessment

The oral screening and risk assessment determine what level of care a child should receive through the I-Smile conceptual dental home. The screening and assessment are to be completed on a child at least every six months.

It is recommended that a dental hygienist complete the oral screening and risk assessment. However, depending on workforce availability, the I-Smile oral health coordinator may train appropriate CH agency staff.

Oral Screening

An oral screening includes a medical/dental history and an oral evaluation (soft tissue and hard tissue). The oral screening must be documented in CAReS. Each component of the screening, listed below, must be documented in the client record.

Medical and dental history

- Current or recent medical conditions
- Current medications used
- Allergies
- Name of child’s physician and dentist
- Frequency of dental visits
- Use of fluoride by child (source of water, use of fluoridated toothpaste or other fluoride products)
- Current or recent dental problems or injuries
- Parental concerns
- Home care (frequency of brushing, flossing, or other oral hygiene practices)
- Snacking / feeding habits (exposure to sugar/carbohydrates)
- Parent or sibling decay history (presence of untreated decay, fillings, or crowns)

Soft tissue evaluation

- Gum redness or bleeding
- Swelling or lumps
- Trauma or injury

Hard tissue evaluation

- Suspected decay
- Demineralized areas (white spot lesions) near the gumline
- Visible plaque
- Stained fissures
- Enamel defects
- Decay history (presence of fillings or crowns)
- Trauma or injury
- Sealed teeth
Dental explorers should not be used. A visual oral assessment is sufficient. Using a dental explorer may transfer decay-causing bacteria from one tooth to another or cavitate a demineralized area.

Risk Assessment
Following an oral screening, a risk assessment must be completed on each child. The risk assessment will establish a child’s level of risk as low, moderate, or high for dental disease. Based on the level of risk and presence of decay, the oral health coordinator will then determine one of three appropriate care plans, based on the I-Smile levels of care.

The I-Smile Screening form and the Risk Assessment form, including the three care plan levels, are in the Forms section of this handbook.

Oral Screening Positions
Fluoride varnish is highly effective in preventing decay and re-mineralizing white spot lesions. It is recommended for use on children as soon as teeth begin to erupt.

The benefits of fluoride varnish make it extremely useful within child health and other public health programs. When applied, fluoride varnish sets upon contact with saliva. The hardened layer of fluoride is then absorbed into enamel. If not brushed off the teeth, it will continue to be absorbed for several hours. The absorption time is much longer than for traditional fluoride gels and foams.

Because of the hardening and small amount used, the risk of ingestion and toxicity of fluoride varnish is extremely low, making it safe for very young children.

The criteria for application of fluoride varnish include:
- Visible plaque on primary incisors
- Carious lesions
- White spot lesions
- History of decay
- Low socio-economic status

Using the I-Smile risk assessment, children identified at moderate or high risk should receive fluoride varnish applications at least twice a year.

It is recommended that a dental hygienist apply fluoride varnish. However, depending on workforce availability, the I-Smile oral health coordinator may train other licensed healthcare providers (physicians, registered nurses, nurse practitioners, physician assistants) to provide the service.

Fluoride varnish application must be documented in CAReS. The client record must include the product used and fluoride concentration.

⭐ Fluoride Varnish Application
Multiple dose tube and supplies

Single dose application
Fluoride Varnish Facts

Background
Fluoride varnishes have been used in Europe for more than 30 years, and have recently been approved for use in the United States. They received approval in the United States as cavity varnishes and desensitizing agents, however one of the most promising uses for fluoride varnishes is in the prevention of tooth decay. The use of fluoride varnish by dentists for this purpose is referred to as "off-label" use.  

Fluoride Content and Uptake into Enamel
There are several fluoride varnishes available for use in the United States. Cavity Shield, Duraflor and Duraphat are brands commonly used. All contain 5% NaF. The varnishes contain 2.26% by weight fluoride ion in a colophony base. This forms a sticky layer on the tooth following application, which hardens on contact with saliva. Fluoride is then absorbed into the enamel of the tooth. It is recommended that the varnish be allowed to remain on the teeth for up to four hours for optimal absorption.  

A study by Koch and Petersson measured the levels of fluoride in extracted teeth following application of Duraflor, and found concentrations between 2,250 and 3,800 ppm in the enamel. It was also determined that increasing the time the varnish remained on the teeth from one to six hours more than doubled the fluoride level in the enamel.

Caries Prevention
Most studies have shown 25-45% reductions in the decay rate with the use of fluoride varnish. Of special note is the reduction of decay in pits and fissures, as well as on smooth surfaces of teeth. A two-year study by Holm using 225 3-year-olds resulted in a 44% caries reduction rate following semi-annual varnish applications.

Safety
The concentration of fluoride in varnishes is much higher than that of APF gels or other topical fluorides, however, due to the sticky form of the varnish and the small amount used per application, risk of ingestion and toxicity is very low. Less than 0.5 ml of varnish is usually required to coat the teeth of a young child.

1 Use of approved drugs for unlabeled indications. FDA Drug Bulletin, April, 1982.
Application of Fluoride Varnish

1. Criteria for the use of fluoride varnish include the presence of factors that put a person at risk for caries, including carious lesions, white-spot lesions, and a history of decay. An additional risk factor for young children is the presence of visible plaque on the primary incisors. Socio-economic status (especially income) can also be an indicator of risk, as low-income children and adults tend to experience more caries than higher-income children and adults.

2. Clean the teeth. The teeth need to be “toothbrush clean” before fluoride varnish is applied. Application after a dental prophylaxis is also acceptable.

3. Have the varnish ready. Use one small drop of varnish (.3 ml is enough for a child and .4 ml is enough for an adult), dispensing it on a tray cover or in a small cup. Some fluoride varnishes are now packaged with the pre-measured varnish in a well.

4. Isolate and dry the quadrant to be treated. This can be accomplished with gauze or air. Drying should be thorough, but not excessive.

5. Apply the varnish with any convenient applicator to all exposed surfaces of the teeth, including the chewing and interproximal surfaces. Disposable brushes are very effective, or cotton-tipped applicators can be used.

6. Repeat for all remaining quadrants.

7. Ask the patient not to brush their teeth for at least four hours, and preferably wait until the next day. Adult patients and parents of children should be informed that the patient’s teeth will look yellow until the varnish is brushed off. Manufacturers of fluoride varnish recommend a patient wait 30 minutes after application before eating or drinking.

8. Fluoride varnish should be applied at least twice a year. Applications 3 times a year or 3 times during a 1-week period are also effective.

Personnel Required for Fluoride Varnish Application

Fluoride varnish may only be applied by a licensed dentist, licensed dental hygienist, licensed physician or other health professional functioning within their scope of practice or licensure as provided under Iowa Medicaid rules.
Dental Sealants

The Iowa Department of Public Health (IDPH) recognizes dental sealants as an important preventive service for low-income, uninsured, and/or underinsured children.

Based on community needs, a child health agency may initiate a sealant program as part of their I-Smile project. Sealants are often applied in a school-based setting, offering an excellent opportunity for collaboration with local schools and dental providers.

The teeth most at risk of decay - and therefore most in need of sealants - are the first and second permanent molars. These teeth should be a priority on all children and should be sealed as soon as possible after eruption. This would include children ages 6-8 and ages 12-14. The permanent premolars and primary molars may also benefit, and sealant application on those teeth can be determined on an individual basis.

*CH agencies may be reimbursed for sealant placement on Medicaid-enrolled children for permanent molars and premolars and primary molars.*

A child must first have an exam or a screening to determine which teeth will benefit from the application of dental sealants. The following professionals are able to do this:

- An Iowa-licensed dentist
- An Iowa-licensed dental hygienist practicing under public health supervision, with a collaborative agreement that includes sealant screenings

Based on the findings from the exam or screening, a dentist or dental hygienist may apply dental sealants. Dental assistants may be used to assist dentists and/or dental hygienists. If used, dental assistants must be registered with the Iowa Dental Board.

Periodic retention checks are recommended for quality assurance.

Sealant application must be documented in CAReS. The client record must include the sealant product used, tooth number, and tooth surface.
Prophylaxes and Radiographs

★ Prophylaxes
Based on a community needs assessment, a CH agency may choose to provide prophylaxes as a component of their I-Smile project.

A prophylaxis may only be provided by a dentist or a dental hygienist. Dental hygienists must work under general or public health supervision. With general supervision, a dentist must first examine the child and determine a need for the prophylaxis. For dental hygienists working under public health supervision, guidelines for prophylaxis services must be detailed in a collaborative agreement.

Provision of a prophylaxis must be documented in CAReS and the client record.

★ Radiographs
Because of the need for extensive supplies and equipment, it is not likely that CH agencies will begin providing this service.

Radiographs may only be provided by a dentist or a dental hygienist. Dental hygienists must work under general or public health supervision. With general supervision, a dentist must first examine the child and determine a need for the radiographs. For dental hygienists working under public health supervision, guidelines for radiographs must be detailed in a collaborative agreement.

Provision of radiographs must be documented in CAReS. The client record must include the type of radiograph, number taken, and tooth number if applicable.
CH agencies are allowed to bill Medicaid for services provided by dental hygienists to children enrolled in the EPSDT Care for Kids program.

Agencies must bill their actual cost for a service and Medicaid will reimburse the agency’s cost up to a maximum established rate. In order to determine their costs for services, CH agencies are required to complete and submit a dental cost allocation plan to IDPH each year.

The following table provides the codes and services that are currently reimbursable.

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral screening (Limited to those patients whose caretaker indicates they have not seen a dentist within the previous 6 months)</td>
<td>Every 6 months</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation and counseling with primary caregiver - for patient under 3 years of age</td>
<td>Every 6 months Not to be used for initial screening (CH agency only)</td>
</tr>
<tr>
<td></td>
<td>Includes recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen, and communication with and counseling of the child’s parent, legal guardian and/or primary caregiver.</td>
<td></td>
</tr>
<tr>
<td>D0150</td>
<td>Initial oral screening (Also allowed when provider has not seen patient within a 3-year period)</td>
<td>1 time per patient</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing radiograph - single film</td>
<td>1 time in a 12-month period (dental hygienist only)</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewing radiograph - two films</td>
<td>1 time in a 12-month period (dental hygienist only)</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewing radiograph - four films</td>
<td>1 time in a 12-month period (dental hygienist only)</td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis – adult (age 13 and over)</td>
<td>Every 6 months (dental hygienist only)</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis – child (age 12 and under)</td>
<td>Every 6 months (dental hygienist only)</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish - therapeutic application for moderate to high caries risk patients Risk determined using I-Smile Risk Assessment</td>
<td>3 times a year, at least 90 days apart</td>
</tr>
<tr>
<td>D1310</td>
<td>Nutritional counseling for the control and prevention of oral disease</td>
<td>Every 6 months per 15 min., minimum of 8 min.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Frequency and Notes</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D1330</td>
<td>Oral hygiene instruction - Hands on demonstration of individualized home care techniques to client or parent/guardian</td>
<td>Every 6 months per 15 min., minimum of 8 min.</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant - per tooth&lt;br&gt;Deciduous molars&lt;br&gt;Permanent bicuspid&lt;br&gt;Permanent first and second molars&lt;br&gt;Up to age 18 or those with a physical or mental disability</td>
<td>1 time per tooth (dental hygienist only)&lt;br&gt;Replacement sealants may be covered when the patient record documents medical necessity</td>
</tr>
<tr>
<td>T1016</td>
<td>Dental care coordination</td>
<td>Billed to IDPH based on documented time-in/time-out. Cannot be billed in conjunction with any other billable oral health service</td>
</tr>
</tbody>
</table>

When billing for services, use diagnosis code 528.9 on the Medicaid claim form.

Refer to the Medicaid Provider Manual - Screening Center for more information on billing.
Consent
Active consent is required for fluoride varnish application, dental sealants, prophylaxes, and radiographs. Active consent is also recommended for oral screenings; however, passive (“opt-out”) consent is an acceptable form of permission for oral screenings.

Infection control
Applicable infection control procedures should be followed according to CDC guidelines: http://www.cdc.gov/oralhealth/InfectionControl/guidelines/index.htm
Due to latex allergies, vinyl gloves are recommended. Between each patient, gloves should be removed and hands washed or rubbed with an antiseptic hand rinse before putting on a new pair of gloves and screening the next person. Used gloves and other supplies should be discarded appropriately (e.g. a tightly closed waste basket).

Lighting and retraction
Natural light may not be enough so a flashlight or penlight may be used, if necessary. For retraction and visualization, a disposable mirror may be used, but is not required.

To improve visibility, it helps to have the patient brush their teeth prior to the screening in order to remove plaque and food debris from teeth. A toothpick or gauze may also be used to dislodge debris. A toothbrush, tongue blade or disposable mirror can be used to retract cheeks.

Screening guidelines
• Use of dental explorer is not required or recommended. The explorer can cavitate pre-cavitated lesions and transfer bacteria.

• Position the patient with the best light available. Tip the head slightly down for the lower teeth and up for the upper teeth.

• Follow a consistent routine when screening (e.g. divide the mouth into four quadrants and follow the same sequence each time):
  o Lower right quadrant
  o Lower left quadrant
  o Upper right quadrant
  o Upper left quadrant

• Visually inspect all soft tissues (lips, cheeks, gums, roof of mouth, tongue, floor of mouth) and all tooth surfaces (outside, inside, chewing surfaces). Refer to the I-Smile™ Oral Health Coordinator Handbook and/or the Maternal and Child Health Administrative Manual for further details on the components of an oral screening.

• Record findings from soft tissue and hard tissue evaluation on the screening form. Refer to the Forms chapter of the I-Smile™ Oral Health Coordinator Handbook for a sample screening form.

• A screening must be done prior to fluoride varnish, prophylaxis, dental sealant, or radiograph services. Note: For radiographs, standing orders must be in place with a specific dentist who will read the client’s radiographs, provide an exam, and establish a treatment plan.
Education Guidelines

★ Teething and Tooth Eruption
• Non-Nutritive Sucking
★ Oral Hygiene
☆ Tooth Decay
★ Fluoride
○ Dental Emergencies
Eruption Patterns

Teething usually begins at about 6 months of age.

By age 2-2½, most children have all 20 primary teeth.

The first molars and lower central incisors are usually the first permanent teeth to erupt.

Teething Symptoms

Normal symptoms of teething include:

- Increased irritability
- Crying
- Change of appetite
- Change in bowel habits
- Wakefulness
- Excessive drooling

A fever higher than 100 degrees is probably not associated with teething. Parents must be instructed to consult the child’s doctor!

Teething Recommendations

DO use teething rings or something cool (e.g. a cold washcloth).

Do NOT use teething appliances made of plastic with liquid filling.

Do NOT use teething biscuits due to the decay-causing potential of the sugar and starch.
Primary Tooth Eruption Chart

**Upper Teeth**
- Central incisor: 8-12 mos. / 6-7 yrs.
- Lateral incisor: 9-13 mos. / 7-8 yrs.
- Canine (cuspids): 16-22 mos. / 10-12 yrs.
- Second molar: 25-33 mos. / 10-12 yrs.

**Lower Teeth**
- Second molar: 23-31 mos. / 10-12 yrs.
- First molar: 14-18 mos. / 9-11 yrs.
- Canine (cuspids): 17-23 mos. / 9-12 yrs.
- Lateral incisor: 10-16 mos. / 7-8 yrs.
- Central incisor: 6-10 mos. / 6-7 yrs.

Permanent Tooth Eruption Chart

**Upper Teeth**
- Central incisor: 7-8 yrs.
- Lateral incisor: 8-9 yrs.
- Canine (cuspids): 11-12 yrs.
- First premolar (first bicuspid): 10-11 yrs.
- Second premolar (second bicuspid): 10-12 yrs.
- First molar: 6-7 yrs.
- Second molar: 12-13 yrs.
- Third molar (wisdom tooth): 17-21 yrs.

**Lower Teeth**
- Third molar (wisdom tooth): 17-21 yrs.
- Second molar: 11-13 yrs.
- First molar: 6-7 yrs.
- Second premolar (second bicuspid): 11-12 yrs.
- First premolar (first bicuspid): 10-12 yrs.
- Canine (cuspids): 9-10 yrs.
- Lateral incisor: 7-8 yrs.
- Central incisor: 6-7 yrs.
Non-Nutritive Sucking

Pacifier vs. Finger Sucking

Pacifiers offer two significant advantages over finger sucking:
- It is easier for a child to break the habit
- A pacifier can be less detrimental to the primary and permanent dentitions

Pacifier Recommendations

DO use a pacifier with a plastic shield that is wider than the child's mouth.

DO use a pacifier with ventilation holes.

DO use a pacifier with sturdy, one-piece construction.

Do NOT tie a pacifier around a child's neck.

Do NOT dip a pacifier in sugar or sweet liquids.

Do NOT clean a pacifier in your mouth before giving it to a child.

Weaning

Once a child is about 2 years of age, frequency of non-nutritive sucking may decrease, occurring only at bedtime or when the child is emotionally tense.

Weaning from the habit should begin by age 4 so that the sucking will have stopped entirely by the time the first permanent teeth erupt.
Oral Hygiene

Developing a daily routine is crucial to establishing regular oral hygiene habits.

Infants
(Birth – 11 months)

- Prior to tooth eruption, clean infant’s gums with a damp washcloth at least once a day – preferably at bedtime.
- As soon as first teeth appear, brush child’s teeth with an infant toothbrush at least once a day – preferably at bedtime.
- For children under age 1 at moderate or high risk for tooth decay, use less than a pea-sized amount (a smear) of fluoride toothpaste.

Children
(Age 1 and older)

- Brushing
  - Brush child’s teeth with a child-sized toothbrush at least twice a day – preferably after breakfast and before bed.
  - Parents must help with brushing until children are at least 7-8 years old.
  - After age 7 or 8, children can brush their own teeth with parent supervision.

- Use of toothpaste
  - For children ages 1-2 at moderate or high risk for tooth decay, use a smear of fluoride toothpaste.
  - For all children ages 2 and older, use a pea-sized amount of fluoride toothpaste.
  - All children should be encouraged to spit excess toothpaste into the sink to minimize the amount swallowed.

- Flossing
  - Daily flossing should begin as soon as teeth touch each other.
  - Parents must help floss children’s teeth until they are at least 8-9 years old.
Pregnant Women

- Brush at least twice a day with fluoride toothpaste.
- To alleviate nausea associated with morning sickness:
  ★ Brush later in the day
  ★ Use a child-sized brush
  ★ Breathe deeply through the nose when brushing
- After vomiting, rinse mouth with water (to remove acid) before brushing.
- Floss at least once daily.
- If there is frequent vomiting, use an over-the-counter fluoride mouthrinse in addition to fluoride toothpaste.
Child Positioning
### Tooth Decay

Three things are needed for decay – a tooth, carbohydrate, and bacteria.

---

| Form and frequency of food and drink | Form and frequency are key risk factors for decay:  
| Form - Stickier food remains on teeth longer.  
| Frequency - Acid remains in the mouth for a minimum of 20 minutes each time carbohydrates are consumed.  
| Sugary and starchy foods should be limited to mealtime only.  
| After brushing/flossing at night, no food or drink (except water) should be given. |

| Transmission of bacteria | Children can acquire decay-causing bacteria from parents, especially the mother.  
| Parents should avoid sharing utensils or a toothbrush with a child, or licking/sucking on children’s hands, pacifier or bottle. |

| Bottles/sippy cups | Bedtime bottles should only contain water.  
| Encourage child to be weaned from the bottle and drinking from a cup by their first birthday.  
| Sippy cups may contain juice or milk only at mealtime—and can be filled with water any other time.  
| Juice should not be introduced before age 6 months, and limited to 4-6 oz. per day. |

| Soda Pop | The sugar and acid content of regular soda makes it extremely erosive to tooth enamel.  
| Diet soda is also erosive due to the acid content. |
Frequent exposure to small amounts of fluoride is optimal.

Water

Community water fluoridation is a safe, effective, and inexpensive way to prevent tooth decay. It benefits people in all socio-economic levels and age groups, including those difficult to reach through public health programs and private dental care.

Optimal water fluoride levels are from 0.7 to 1.2 ppm. Everyone should know the fluoride concentration in their primary source of drinking water. This is particularly important for parents of children under the age of six years.

The fluoride level of public water systems in Iowa is available on the Oral Health Bureau Web site.

Toothpaste

All children ages two and older should use a pea-sized amount of toothpaste with fluoride. The toothpaste should be marked with the American Dental Association (ADA) Seal of Acceptance.

Children under the age of two at moderate or high risk of developing tooth decay should also use a small amount (a smear) of ADA approved fluoridated toothpaste.

Young children, especially pre-school aged children, should not swallow any toothpaste. Parent and caregivers must provide careful supervision, and no more than a small pea-sized amount on the brush is recommended. If not monitored, children may easily swallow over four times the recommended daily amount of fluoride in toothpaste.

Tubes of toothpaste should not be left where young children can reach them. The flavors that help encourage them to brush may also encourage them to eat the paste.
**Varnish**

Fluoride varnish is especially useful in young patients and those with special needs that may not tolerate other forms of topical fluoride.

The advantages of varnish are that it is can be easily and quickly applied to the teeth and it decreases the potential amount of fluoride digested. The fluoride also continues to absorb into the enamel for several hours after application.

IDPH protocol recommends three applications per year for moderate and high risk children and pregnant women.

**Mouthrinse**

Fluoride mouthrinse should be targeted to people at high risk for tooth decay.

Children under the age of six should not use mouthrinse without consulting a dentist or healthcare provider, due to the risk of swallowing the rinse.

**Supplements**

Fluoride supplements may be prescribed for children between the ages of six months and 16 years.

A dentist or other healthcare provider should determine the need for fluoride supplements based on the child’s age, risk for developing tooth decay, and fluoride levels of the primary drinking water.

A fluoride supplement dosage schedule has been established by the ADA, AAPD, and AAP.
## Dental Emergencies

<table>
<thead>
<tr>
<th>Emergency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Toothache</strong></td>
<td>Rinse the mouth with warm water to clean out debris. Use dental floss to remove any food that may be trapped between teeth. To comfort the child, place a cold compress or ice wrapped in a cloth on the outside of the cheek. Call and visit the dentist as soon as possible. (DO NOT use heat or place aspirin on the tooth or gum tissue.)</td>
</tr>
<tr>
<td><strong>Knocked-Out Tooth</strong></td>
<td>If a baby tooth, contact dentist as soon as possible. Do NOT attempt to put a baby tooth back in the socket! If a permanent tooth, first rinse it gently in cool water. Do NOT scrub it or clean it with soap! If possible, replace the tooth in the socket and hold it there with clean gauze or a wash cloth. If the tooth can’t be put back in the socket, place the tooth in a clean glass with milk, saliva, or water. Take the child and the glass to the dentist immediately.</td>
</tr>
<tr>
<td><strong>Broken Tooth</strong></td>
<td>Contact the dentist immediately. Rinse the mouth with water to clean the area. Place a cold compress on the face to reduce swelling. If you can find the broken tooth fragment, bring it with you to the dentist.</td>
</tr>
<tr>
<td><strong>Bitten Lip or Tongue</strong></td>
<td>Clean the area gently with a cloth and apply direct pressure to the bleeding area. If swelling is present, apply a cold compress. If bleeding does not stop, go to a hospital emergency room immediately.</td>
</tr>
<tr>
<td><strong>Orthodontic Problems</strong></td>
<td>If a wire is causing irritation, cover end of the wire with wax, a small cotton ball, or piece of gauze until you can get the child to the dentist. If a wire is embedded in the cheek, tongue, or gum tissue, do not attempt to remove it. See a dentist immediately. If an appliance comes loose or a piece breaks off, take the appliance and/or piece and go to the dentist.</td>
</tr>
<tr>
<td><strong>Objects Wedged Between Teeth</strong></td>
<td>Try to remove the object with dental floss, guiding the floss carefully to avoid cutting the gums. If using floss does not work, call and visit the dentist. Do NOT try to remove the object with a sharp or pointed object.</td>
</tr>
<tr>
<td><strong>Possible Fractured Jaw</strong></td>
<td>Go immediately to the emergency room of your local hospital. Head injuries can be life threatening.</td>
</tr>
</tbody>
</table>
Forms

- Consent Form - sample
- I-Smile Screening Form - sample
- I-Smile Risk Assessment Form
  - I-Smile Levels of Care
- Parent Letter - sample
CONSENT FORM - sample

Child’s name

Age

Date of Birth

Address:

Phone:

Child’s physician:

Child’s dentist:

Medicaid ID number:

YES, I give permission for my child to receive a dental screening and fluoride varnish application.

Please answer the following questions:
1. Is your child currently under a physician’s care? _____ Yes _____ No
2. Is your child currently taking any medications? _____ Yes _____ No
3. Does your child have any allergies? _____ Yes _____ No

Please explain any YES answers:

NO, I do not give permission for my child to receive a dental screening and fluoride varnish application.

Please answer the following questions.
1. Does your child have a regular dentist? _____ Yes _____ No
2. If yes, does your child see that dentist at least once a year? _____ Yes _____ No

3. My child’s most recent dentist visit was within the past: (please check one)
   _____ 6 months _____ 1 year _____ 3 years _____ 5 years _____ Has never seen a dentist

4. How do you pay for your child’s dental care? (please check one)
   _____ Self _____ Medicaid/Title XIX _____ hawk-i _____ Private dental insurance _____ Other

- I understand that this consent is valid for one (1) year.
- I understand that the services that will be received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health (Bureaus of Family Health or Oral Health), the Iowa Department of Human Services, or designee.

Parent/Guardian Signature

Date

Rev. 6/09
### I-SMILE™ Child Oral Health Services Form

**Client Name:** ____________________________  **Medicaid/Client ID:** ____________________________

**DOB:** __________  **Age:** _______  **Service Site:** __________  **Date of Service(s):** __________

**Primary Payment Source:** ____________________________  **Secondary Payment Source:** ____________________________

---

### Parent Interview

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical history reviewed:</strong></td>
<td>Dental visit frequency:</td>
</tr>
<tr>
<td><strong>Parent concerns:</strong></td>
<td>Daily home care:</td>
</tr>
<tr>
<td><strong>Current/previous problems:</strong></td>
<td>Feeding/snacking habits:</td>
</tr>
<tr>
<td><strong>Family decay history:</strong></td>
<td>Fluoride exposure:</td>
</tr>
</tbody>
</table>

---

### Oral Screening

<table>
<thead>
<tr>
<th>Condition of hard tissue</th>
<th>Documentation</th>
<th>Condition of soft tissue</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suspected decay or demineralization:</strong></td>
<td>Gum redness, bleeding, (e.g. when brushing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Visible plaque:</strong></td>
<td>Swelling or lumps:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Decay history:</strong> (fillings or crowns)</td>
<td>Trauma or injury:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stained fissures, enamel defects, trauma or injury:</strong></td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sealed teeth:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Topic(s) of oral health education provided:**  
(e.g. teething/eruption; non-nutritive sucking; home care; dietary habits; bottle/sippy cup use; fluoride; regular dental visits; sealants; injury prevention; tobacco use)

**Education provided to:**

**Notes:**

Medicament recommended, dispensed, or prescribed:

---

### Other Oral Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Documentation/Notes</th>
</tr>
</thead>
</table>
| **Fluoride varnish** | Type:  
Fl Concentration: |
| **Sealant application** | Tooth number(s) and surface(s):  
Product used: |
| **Prophylaxis** | |
| **Radiographs** | Number taken:  
Type:  
Tooth number/Quadrant: |
| **Oral Hygiene Instruction** | Time in:*  
Time out:* |
| **Nutritional Counseling** | Time in:*  
Time out:* |

*Required

---

### Dental Referral / Care Coordination

**Dentist referred to:**

**Notes:**

Referral need (based on risk assessment):  
☐ Immediate  
☐ Within 3 months  
☐ Within 6 months  
☐ Within 12 months

**Provider Name and Credentials:** ____________________________  **Provider Signature:** ____________________________  **Date:** __________

<table>
<thead>
<tr>
<th>Service(s) documented in CAReS</th>
<th>Oral Health Status documented in CAReS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Need(s) documented in CAReS</strong></td>
<td><strong>Risk documented in CAReS</strong></td>
</tr>
</tbody>
</table>

---

1/2010 IDPH
I-Smile Decay Risk Assessment

If a risk factor is present, check the appropriate box(es). Responses should be based on information gathered from an oral screening, parental consent form, and/or parent interview.

High Risk – If box is checked, client is considered high risk for decay.

Oral screening
- Suspected or obvious decay

Moderate Risk – If the client is not high risk and any box below is checked, client is considered moderate risk for decay.

Oral screening
- Demineralization (white spot lesions)
- Visible plaque
- Enamel defects (e.g. deep pits/fissures)
- Stained fissures
- Decay history (e.g. presence of fillings or crowns)
- Other (e.g. presence of orthodontia, dry mouth, gingivitis)

Client Information
- Parent’s socio-economic status < 200% FPL (from consent form)
- Dental visits - less than annually
- Parent or sibling have untreated decay
- Parent or sibling have history of decay (e.g. presence of fillings or crowns)
- Child has special health care needs
- Exposure to sugars/carbohydrates 1-2x/day, other than mealtime
- No fluoride in toothpaste or no fluoride in water
- Brushes 1 or fewer times per day

Low Risk – If none of the high or moderate risk factors above are present, client is considered low risk for decay.
### High Risk
- Primary prevention
- Education and anticipatory guidance
- Care coordination

If obvious or suspected decay present: Needs urgent dental care
- Refer **immediately** to dentist for disease diagnosis and management
- Re-assess risk in **3 months** (or assurance of regular exams by a dentist)

### Moderate Risk
- Primary prevention
- Education and anticipatory guidance
- Care coordination

If demineralization or multiple risk factors are present: Needs dental care
- Refer for dental exam within **3 months**
- Re-assess risk in **3-6 months** (or assurance of regular exams by a dentist)

If no demineralization and less than 3 risk factors present:
- Refer for dental exam within **6 months**
- Re-assess risk in **3-6 months** (or assurance of regular exams by a dentist)

### Low Risk
- Primary prevention
- Education and anticipatory guidance
- Care coordination

If no obvious problem:
- Refer for dental exam within **12 months**
- Re-assess risk in **6 months** (or assurance of regular exams by a dentist)
# I-Smile Levels of Care

## Low Risk / No Decay or Demineralization

<table>
<thead>
<tr>
<th>Level 1 Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Primary prevention</td>
</tr>
<tr>
<td>- Education and anticipatory guidance</td>
</tr>
<tr>
<td>- Care coordination</td>
</tr>
<tr>
<td>- Refer for dental exam within 12 months</td>
</tr>
<tr>
<td>- Re-assess risk in 6 months (or assurance of regular exams by a dentist)</td>
</tr>
</tbody>
</table>

## Moderate Risk / No Decay or Demineralization

<table>
<thead>
<tr>
<th>Level 1 Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Primary prevention</td>
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<tr>
<td>- Education and anticipatory guidance</td>
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<tr>
<td>- Care coordination</td>
</tr>
<tr>
<td>- Refer for dental exam within 6 months</td>
</tr>
<tr>
<td>- Re-assess risk in 3-6 months (or assurance of regular exams by a dentist)</td>
</tr>
</tbody>
</table>

## High Risk / Observable Decay or Demineralization

<table>
<thead>
<tr>
<th>Level 2 Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Primary prevention</td>
</tr>
<tr>
<td>- Education and anticipatory guidance</td>
</tr>
<tr>
<td>- Care coordination</td>
</tr>
<tr>
<td>- Refer for dental exam within 3 months</td>
</tr>
<tr>
<td>- Re-assess risk in 3-6 months (or assurance of regular exams by a dentist)</td>
</tr>
</tbody>
</table>

## High Risk / Severe Decay

<table>
<thead>
<tr>
<th>Level 3 Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Primary prevention</td>
</tr>
<tr>
<td>- Education and anticipatory guidance</td>
</tr>
<tr>
<td>- Care coordination</td>
</tr>
<tr>
<td>- Refer immediately to dentist for disease diagnosis and management</td>
</tr>
<tr>
<td>- Re-assess risk in 3 months (or assurance of regular exams by a dentist)</td>
</tr>
</tbody>
</table>
Dear Parent or Guardian:

As part of the I-Smile program, your child received a dental screening. No x-rays were taken and the screening does not replace a dental check-up by your family dentist or a medical checkup by your family doctor.

The results of the dental screening show that:

- Your child appears to have no obvious oral problems but should _________ continue to have regular checkups by your family dentist.
- Your child appears to have some teeth that should be checked by _________ your family dentist. Your dentist will tell you if treatment is needed.
- Your child appears to have some teeth that look like they need immediate care. Contact your family dentist as soon as possible for a _________ complete check-up.

If you do not have a family dentist or have difficulty making a dental appointment, please contact NAME OF COORDINATOR or CARE COORDINATOR at NAME of AGENCY at PHONE NUMBER.
I-Smile
The Iowa Dental Home Proposal

3/2/06
### I-SMILE EXECUTIVE SUMMARY

<table>
<thead>
<tr>
<th>Background</th>
<th>Iowa House File 841 states: <em>By July 1, 2008, every Medicaid recipient who is a child 12 years of age or less must have a designated dental home.</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td>Less than 45 percent of all children enrolled in Medicaid have a dental visit during a year.</td>
</tr>
<tr>
<td></td>
<td>Low-income children are most at-risk for severe and untreated decay.</td>
</tr>
<tr>
<td></td>
<td>Treatment of severe decay for children ages birth to three often requires hospitalization and costs can range from $2,000-$5,000.</td>
</tr>
<tr>
<td></td>
<td>Tooth decay can be prevented; prevention must begin at an early age.</td>
</tr>
<tr>
<td></td>
<td>Early access to preventive dental services for children has shown significant cost savings compared to delayed access in later years.</td>
</tr>
<tr>
<td>Dental Home</td>
<td>The American Academy of Pediatric Dentistry’s definition of a dental home is the conceptual framework in this proposal. The I-Smile proposal consists of a dentist, supported by a network of dental and non-dental public and private healthcare providers providing preventive and care coordination services. These services include screenings, preventive therapies, education, and referrals for dental treatment by a dentist.</td>
</tr>
<tr>
<td>Current Obstacles</td>
<td>There are an insufficient number of practicing dentists in Iowa, particularly in lower-income and rural parts of the state—79 counties are estimated to be designated dental shortage areas.</td>
</tr>
<tr>
<td></td>
<td>Many dental practices are very busy and do not accept <em>any</em> new patients, especially if patients cannot pay at current market rates.</td>
</tr>
<tr>
<td></td>
<td>The majority of general practice dentists are uncomfortable or unwilling to see children under age three.</td>
</tr>
<tr>
<td></td>
<td>Dentists are reluctant to accept Medicaid-enrolled patients due to low reimbursement and poor dental appointment compliance issues.</td>
</tr>
<tr>
<td></td>
<td>Enrollment of children into the Medicaid program is increasing at an average rate of 1 percent per month.</td>
</tr>
</tbody>
</table>
I-SMILE PROPOSAL

Improve the Dental Support System for Families

Medicaid-enrolled children and families need assistance receiving timely oral health care and locating dentists who will treat children in Medicaid. Strategies to support families in accessing a dental home for their Medicaid-enrolled children include:

- Strengthening the dental infrastructure of local Title V Child Health agencies to focus on children’s oral health and provide oral health care coordination,
- Improving care coordination through improving data tracking systems,
- Using dental hygienists as oral health coordinators within Child Health agencies for preventive care, education, care coordination, and referrals to dentists,
- Increasing oral health education for families,
- Providing trainings for dental providers about care for children under age three,
- Training non-dental healthcare providers, such as physicians and nurses, to provide screenings, fluoride varnish applications, education, and referrals to dentists,
- Partnering with WIC, Head Start, Migrant and Community Health Centers, Iowa’s hospital health systems and other programs, and
- Purchasing portable dental equipment for on-site use in facilities such as Head Start.

- Provide funding to local Title V Child Health (CH) agencies to increase dental program infrastructure
  - Cost: $1,279,430 (See Appendix I)

- Increase funding to strengthen the state Title V CH database system for tracking patient care coordination and appointments
  - Cost: $210,000 (See Appendix IV)

- Fund public oral health education and promotions
  - Cost: $1,044,855 (See Appendix III)

- Fund training programs and create mandatory continuing education requirements for dental and other healthcare providers regarding children’s oral health
  - Cost: $120,000 (See Appendix III)

Improve the Dental Medicaid Program

Dentist participation in Medicaid is limited, impacting access to dental services for Medicaid-enrolled children. Strategies to improve the dental Medicaid program include:

- Creating a network of dentists willing to see Medicaid-enrolled children through use of a familiar dental insurance carrier with increased reimbursement rates
- Reimbursing non-dental providers for providing screening and fluoride varnish to children in settings beyond a dental office, and
- Reinstating periodontal (gum) treatment coverage for adults, especially pregnant women and new mothers, whose oral health can affect the oral health of their child
Contract with a familiar dental insurance carrier to improve dentist participation in Medicaid, similar to a successful program in Michigan
Cost: Delta Dental/hawk-i equivalent network: **$28.8 million** *(See Appendix IV)*

Create a dental screening code and specific reimbursement for physicians
Cost: **$3,529,230** *(See Appendix IV)* includes current annual Medicaid EPSDT exam oral screening and physician fluoride varnish payments

Allow reimbursement for oral screening and fluoride application by non-dental providers
Cost: **$0** – Medicaid Administrative Rules Change *(See Appendix III)*

Reinstate coverage of periodontal services to adult dental Medicaid enrollees
Cost: **$276,000** *(See Appendix IV)*

### Implement Recruitment and Retention Strategies for Underserved Areas

The shortage of dental providers in 79 Iowa counties decreases the ability of Medicaid-enrolled children to receive dental services. The strategy is to increase the number of dentists and hygienists in underserved counties include creating loan repayment options for dental and dental hygiene program graduates that practice in rural and dental workforce shortage areas.

Create a dentist/dental hygienist student-loan repayment program to increase the dental workforce in shortage areas
Cost: **$250,000** *(See Appendix V)*

### Integrate Dental Services Into Rural and Critical Access Hospitals

Dental services in rural and underserved areas can be bolstered through the use of rural hospitals, especially for care by pediatric dentists in an operating room for severe early childhood caries (baby bottle tooth decay). The strategy is to use rural hospitals in Iowa’s health network systems to increase dental clinic capacity and the availability of primary care services to rural underserved communities

Work with rural hospitals to develop dental clinics
Cost: **$0**-No cost to the state. *(See Appendix V)*
I-SMILE: ANTICIPATED OUTCOMES

- An integrated dental service delivery system that delivers adequate early identification of disease risk, prevention and dental care
- An oral health care coordination network that assures Medicaid-enrolled children receive appropriate oral health care services
- A guaranteed dental provider network that assures an appropriate level of dental care access for Medicaid enrolled children
- A tracking and monitoring system to regulate outcomes and quality of care within the dental home system
- Intensive family-based oral health education to strengthen parental oversight of children’s home care and increase prevention opportunities
- Sufficient oral health education opportunities for health care providers to ensure adequate knowledge to meet the oral health needs of young children
- Recruitment and retention of an adequate number of new dentists and dental hygienists in underserved rural communities
- A decrease in overall dental disease rates among participating Medicaid-enrolled children with subsequent cost savings for the state

To allow sufficient continuity in the I-Smile dental home program and to observe impact on cost and disease rates, a minimum of five years of program implementation and fiscal support is recommended.
I-Smile: A Dental Home For Medicaid-Enrolled Children

BACKGROUND

On May 12, 2005, Governor Vilsack signed HF841 into law, establishing the IowaCare Act. The bill includes the following language:

*DENTAL HOME FOR CHILDREN.* By July 1, 2008, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings and preventive care identified in the oral health standards under the early and periodic screening, diagnostic, and treatment program.

The Iowa Department of Human Services is charged with developing a plan to meet the intent of this legislation. This I-Smile Dental Home Proposal is the result of collaborative discussions between representatives of the Iowa Department of Human Services, the Iowa Department of Public Health, the University of Iowa College of Dentistry and Public Policy Center, the Iowa Dental Association, Delta Dental Plan of Iowa, the Iowa Dental Hygienists’ Association, the University of Iowa Child Health Specialty Clinics, and other interested parties. The I-Smile Dental Home Proposal provides a comprehensive approach to providing a dental home for all children in Medicaid ages 0-12.

RATIONALE

• Less than 45 percent of all children enrolled in Medicaid have a dental visit during a year.¹
• Low-income children are most at-risk for severe and untreated decay.²
• Treatment of severe decay for children ages birth to three often requires hospitalization and costs can range from $2,000-$5,000.³
• Tooth decay can be prevented; prevention must begin at an early age.
• Early access to preventive dental services for children has shown significant cost savings compared to delayed access in later years.⁴
• In SFY 2005, there were 164,965 children six months through 12 years of age enrolled in Iowa Medicaid.⁵
• Of these, just 55,825 (34 percent) received a dental examination from a dentist.⁶
• In SFY 2005, 1,464 Medicaid-enrolled children were hospitalized or received general anesthesia for advanced dental treatment. Over 528 of these children were between the ages of one and three.⁷
• In SFY 2005, the total Medicaid expenditures for all dental services provided to children age 12 and under were $13,799,863.⁸
• Of that amount, only $1,147,176 (8 percent) was for preventive screenings, fluoride varnish and/or sealants provided through local maternal and child health agencies and/or physicians.⁹

¹ CMS 4.16 report
³ Iowa Medicaid Enterprise dental hospitalization cost report 2005
⁵ Iowa Department of Human Services
⁶ Iowa Department of Human Services
⁷ Iowa Department of Human Services
⁸ Iowa Department of Human Services
⁹ Iowa Department of Human Services
Once very young children have severe decay, they often require more expensive treatment – often in a hospital. These children are likely to be seen in a medical office or public health clinic before being seen in a dental office, indicating the need to educate non-dental healthcare workers about preventive dental care.

THE DENTAL HOME

The ultimate goal of creating a dental home for all Medicaid-enrolled children, 0-12 years old, is to ensure they receive age-appropriate comprehensive dental care. The American Academy of Pediatric Dentistry’s (AAPD) definition of a Dental Home is the conceptual framework for the I-Smile Dental Home Proposal.

According to the AAPD, “The dental home is inclusive of all aspects of oral health that result from the interaction of the patient, parents, non-dental professionals and dental professionals. Establishment of the dental home is initiated by the identification and interaction of these individuals, resulting in a heightened awareness of all issues impacting the patient’s oral health.”

The AAPD further states that “Children who have a dental home are more likely to receive appropriate preventive and routine oral health care. Referral by the primary care physician or health provider has been recommended, based on risk assessment, as early as six months of age, six months after the first tooth erupts, and no later than 12 months of age. Furthermore, subsequent periodicity of reappointment is based upon risk assessment.”

A dental home provides:
- Acute care and preventive services
- Assessment of oral diseases
- Individualized preventive care based on risk assessment
- Anticipatory guidance about growth and development
- A plan for dental trauma
- Information about proper care of teeth and gums
- Dietary counseling
- Referrals to dental specialists

Age-appropriate care has been specified in a reference manual from the AAPD titled “Clinical Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment of Children.”

CURRENT OBSTACLES

While it would be ideal for all children, especially Medicaid-enrolled children, to see a dentist by age one, there are many reasons why this goal is difficult, if not impossible, to attain. Some of the reasons are related to the overall dental delivery system in Iowa and others are specific to perceived problems with the Medicaid program.

9 Iowa Department of Human Services
10 http://www.aapd.org/media/Policies_Guidelines/P_DentalHome.pdf
• There is a shortage of dentists in many parts of the state. According to the Iowa Department of Public Health, 72 of Iowa’s 99 counties were designated as Dental Health Profession Shortage Areas (DHPSAs) in year 2001. Current estimates now raise this to 79 counties.

• Many dental practices are very busy - working at capacity - and are unable to accept any new patients. This is due in part to both the overall shortage of dentists and the influx of new procedures into dentistry (e.g. cosmetic).

• Many dentists are uncomfortable or unwilling to see children younger than three years of age. Procedures for very young children are different and can be more difficult to complete than for older patients.

• Many dental offices do not accept Medicaid-enrolled children. The low reimbursement for services, administrative difficulties, and poor patient compliance are often cited by dentists as reasons for not participating in the Medicaid program.

• Elimination of coverage for some dental procedures for Medicaid-enrolled adults affects parents’, particularly mothers’, ability to keep children’s mouths healthy. Poor pregnancy outcomes and transmission of decay-causing bacteria are linked to mothers with poor oral health.
## Improvements to the Dental Support System for Families

**Provide funding to local Title V Child Health (CH) agencies** to increase dental program infrastructure

- The main component of building the capacity of CH agencies will be providing each agency with the resources to establish a dental hygienist as the oral health coordinator. Although agencies are able to bill Medicaid for preventive services provided by a dental hygienist, the funds are usually not sufficient to initiate or sustain a program.

- Few CH agencies have portable dental equipment. However, having this equipment can be particularly helpful for providing preventive and restorative dental services for at-risk and hard-to-reach populations (e.g., at Head Start or WIC centers using a local dentist to provide the care on-site). **Resources are needed to purchase portable dental equipment** to provide care in non-traditional settings.

  **Estimated Cost: $1,279,430**  
  *(See Appendix I)*

**Increase funding to strengthen the state Title V CH database system for tracking patient care coordination and appointments**

- Local child health agencies use the Child and Adolescent Reporting System (CAReS) for tracking child health needs and services. The current **CAReS system will require modifications** to allow effective care coordination and tracking of all dental services provided for children enrolled in Medicaid.

- As the dental home network develops, non-dental providers will need to know where they can refer children for treatment once a child is screened and preventive therapies are applied. The development of an Internet database of all participating dentists and the type of care they can provide will greatly assist the referral process.

  **Estimated Cost: $210,000**  
  *(See Appendix IV)*

**Fund public oral health education and promotions**

- Oral health promotions and improved oral health knowledge among at-risk populations is part of the solution to empowering families and reducing disease rates. An oral health education campaign would be conducted, based on a successful model used by the Iowa Department of Public Health for smoking cessation. A comprehensive plan to potentially decrease healthcare costs must **include a budget for oral health promotions and outreach activities.**

  **Estimated Cost: $1,044,855**  
  *(See Appendix III)*

**Fund training programs for dental and other healthcare providers regarding children’s oral health**

- It will be important to **increase training opportunities for the public health workforce and dental providers** regarding dental disease prevention, treatment, evidence-based practices, education, parental guidance and oral health promotions for children, particularly those under age three. Many dental providers are not sufficiently trained or have limited experience with managing very young children below age three or children with disabilities. In addition, medical professionals receive very limited training about oral health.

  **Estimated Cost: $120,000**  
  *(See Appendix III)*

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12 As the designated administrator for Title V maternal and child health services, The Iowa Department of Public Health (IDPH) contracts with 24 public health agencies to coordinate community-based health services in all 99 counties. These services include informing, care coordination and child health screening services in accordance with the state’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) periodicity schedule.
**Improvements to the Dental Medicaid Program**

Create a program using a familiar dental insurance carrier with increased reimbursement rates for dentists

- In order to improve provider participation, the I-Smile proposal recommends **using a known private insurance carrier (Delta Dental) for Medicaid dental services.** This is similar to Iowa’s current haw-k-i dental program that has a Delta Dental component, (although there could be no annual maximum in Medicaid as there is in haw-k-i). Dental utilization was 9% higher for children enrolled for 11-12 months in haw-k-i than in the Iowa Medicaid program in 2001. To encourage acceptance of referrals, reimbursement rates to dentists may be higher when treating children referred from the oral health coordinator.

  **Estimated Cost: Delta Dental/haw-k-i equivalent  $28.8 Million (See Appendix IV)**

Create a dental screening code and specific reimbursement for physicians

- At this time, physicians are not reimbursed for a dental screening. **Assigning a separate procedure code and fee for oral screenings by physicians** would increase compliance with the Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements of an oral health screening for children ages 0 – 5, as well as provide a more accurate count of children who are receiving screenings and preventive therapies. Physician-based dental screenings has proven very effective in other states and has increased access to dental prevention services.13

  **Estimated Cost: $3,529,230 *includes current annual Medicaid EPSDT exam oral screening and physician fluoride varnish payments  (See Appendix IV)**

Develop specific codes and reimbursement for oral screening and fluoride application by non-dental providers

- Allowing Medicaid reimbursement to non-dental providers for specific preventive services would also be beneficial. Currently, services provided by dental hygienists working for CH agencies can be billed to Medicaid. Extending this provision to nurses, physician’s assistants, and nurse practitioners would enhance the number of children benefiting from preventive care and increase the available workforce to address oral health prevention.

  **Estimated Cost: $0 – Medicaid Administrative Rules Change (See Appendix III)**

Reinstate coverage of periodontal services to adult dental Medicaid

- Reinstatement of periodontal services for Medicaid-enrolled adults has multiple benefits. The oral health experience of a mother closely mirrors the experience of the child. A mother’s ability to access treatment of periodontal disease, in addition to preventive and restorative dental care, will impact the health of her child14 15. In addition, children and adults with disabilities are impacted by loss of coverage. Many of these patients require hospitalization for restorations, and the level of poor oral hygiene prohibits proper care without removal of accumulated tartar and calculus. The lack of periodontal coverage prohibits appropriate care for these disadvantaged patients.

  **Estimated Cost: $276,000 (See Appendix IV)**

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Implementation of Recruitment and Retention Strategies

Create a dentist/dental hygienist student-loan repayment program to increase dental workforce in shortage areas

- Increasing the number of dental providers in shortage areas across the state must become a priority in order to achieve a sufficient oral health network. Strictly increasing dental and dental hygiene school enrollments is ineffective without also increasing Iowa’s retention of program graduates and locating these graduates in Iowa’s health professional shortage areas. The I-Smile proposal recommends establishing a state dental and dental hygiene student loan repayment program and/or Iowa college graduate dental and dental hygiene education scholarship fund.

Estimated Cost: $250,000 (See Appendix V)

Integration of Dental Services into Rural Hospitals

Work with rural health system hospitals to determine their ability to create dental clinics and increase operating room services for children’s dental services

- Using space within existing rural hospitals for dental services provides an opportunity to improve access in some of Iowa’s most underserved areas. In cooperation with Mercy and Iowa Health Systems, dental services will be incorporated into existing space in rural and critical access hospitals in underserved rural communities. The health systems will assist in funding and site development as part of their commitment to primary health care integration in rural Iowa.

Estimated Cost: $0 (See Appendix V)

CONCLUSIONS

The I-Smile Dental Home Proposal attempts to develop a coordinated service delivery system. This system includes prevention, education, hospital primary care dental integration, and oral health promotions; multiple providers to screen, prevent disease, and refer to dentists; and maximized efficiency of the available workforce. Ultimately, at-risk children who are currently excluded from the dental care delivery system will be reached and will have a dental home.

I-Smile is a concept drawn from several state “best-practice” model programs including Washington State’s “ABCD”16, North Carolina’s “In the Mouth of Babes,”17 and Michigan’s “Healthy Kids Dental.”18 Each of these programs has demonstrated that capacity-building and early prevention can be accomplished through integrating health care systems. This is further improved when these programs are combined for optimum efficiency. Iowa has demonstrated through its own Access to Baby and Child Dentistry (ABCD) community-based project that the ABCD model can empower communities to address the oral health needs of children in effective and innovative methods.19

19 IDPH Oral Health Bureau, ABCD Manual, 2005
To allow sufficient continuity in the I-Smile dental home program and to observe impact on cost and disease rates, a **minimum of five years of program implementation may be necessary**. If there is insufficient dental or other provider participation and anticipated results are not demonstrated, policies will need to be reviewed for potential changes regarding licensing, practice restriction laws, and scope of practice changes for allied mid-level dental providers.
Appendix I: Medicaid and Use of Dental Services

The use of dental services among the nation’s poor and uninsured remains low\textsuperscript{20} despite findings that such disadvantaged children are more likely to have a higher prevalence of caries and more unmet treatment needs than their higher-income counterparts.\textsuperscript{21} According to data gathered in the National Health Interview Survey (NHIS), dental care was reported to be the most prevalent unmet health need among children. Another study indicated that about five percent of children nationally had an unmet need for dental care compared to two percent for vision or pharmaceutical services and less than two percent for medical care. This was especially true among those who lacked insurance and/or lived in low-income families.\textsuperscript{22}

Medicaid (Title XIX) is the largest public dental insurance program in the country, with more low-income people receiving dental care through Medicaid than any other program.\textsuperscript{23} While dental care is a required service for children in Medicaid, it is considered an optional service for adults; states can determine the types of dental services, if any, they will cover for adult enrollees.

Barriers to dental care for Medicaid enrollees have been well documented.\textsuperscript{24 25 26 27 28} These barriers may be related specifically to aspects of the Medicaid program, such as low dentist participation resulting in part from lower reimbursement rates and perceived programmatic challenges. There are also individual factors associated with a lower income population that can delay or stop enrollees from accessing dental care, such as less understanding of the importance of preventive dental care.\textsuperscript{29} Privately insured enrollees can face some of the same issues, such as finding a dentist who will accept their insurance and understanding the importance of preventive dental care. However, the presence of private insurance has generally been found to significantly increase access to dental care.\textsuperscript{30}

\textsuperscript{26} Damiano PC, Kanellis MJ, Willard JC, Momany ET. A Report On The Iowa Title XIX Dental Program. University of Iowa, Public Policy Center, Iowa City, Iowa 1996
\textsuperscript{28} Nainar SM, Tinanoff N. Effect of Medicaid reimbursement rates on children's access to dental care. Pediatric Dent 1997; 19:315-316.
The Iowa Dental Medicaid Program

Use of dental services for children in the Iowa Medicaid program has been found to be slightly better than for children nationally, but there remains significant unmet need for dental care in Iowa. Based on an analysis of Medicaid claims data for Iowa in 2001, just 34 percent of any child enrolled during the year had a dental visit.\textsuperscript{31} If dental utilization is defined according to the Health Plan Employer Data and Information Set (HEDIS) protocol used by the National Committee for Quality Assurance, 46 percent of children who were enrolled for 11-12 months during 2001 had a dental visit.

Through another analysis, limited to children enrolled in the Iowa Medicaid managed care programs, (excluding children enrolled through the Supplemental Security Income-program or Medically Needy Program), the utilization rates were higher and varied by age.\textsuperscript{32} Children ages one through three had the lowest rates, increasing for children ages four through eleven and then decreasing for adolescents 12-15 and 16-18.

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Medicaid plan 1</th>
<th>Medicaid plan 2</th>
<th>Medicaid plan 3</th>
<th>MediPASS</th>
</tr>
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<tbody>
<tr>
<td>1-3</td>
<td>22%</td>
<td>18%</td>
<td>21%</td>
<td>19%</td>
</tr>
<tr>
<td>4-6</td>
<td>63%</td>
<td>54%</td>
<td>57%</td>
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<tr>
<td>7-11</td>
<td>63%</td>
<td>51%</td>
<td>58%</td>
<td>64%</td>
</tr>
<tr>
<td>12-15</td>
<td>56%</td>
<td>47%</td>
<td>51%</td>
<td>57%</td>
</tr>
<tr>
<td>16-18</td>
<td>48%</td>
<td>47%</td>
<td>46%</td>
<td>51%</td>
</tr>
<tr>
<td>Total</td>
<td>50%</td>
<td>43%</td>
<td>46%</td>
<td>51%</td>
</tr>
</tbody>
</table>

\textsuperscript{31} Damiano PC, Momany ET, Flach SD, Jones M, Carter K. Dental care: access, utilization and costs for children in the 
\textit{hawk-i} program. Final report to the Iowa Department of Human Services. Public Policy Center, University of Iowa, Iowa City, IA. March 2005.

\textsuperscript{32} Momany ET, Damiano PC, Carter KD. Outcomes of Care for Iowa Medicaid Managed Care Enrollees. Final report to the Iowa Department of Human Services, June 2005.
The following map shows the number of dentists in each county, the number of Medicaid-enrolled children age 0-12 in each county, the number of children without a dental visit and the percentage of children without a dental visit. The Medicaid dental utilization numbers were obtained from analyses conducted by the Iowa Department of Human Services for CY 2005.
Costs to Title V agencies

Title V Child Health (CH) Agencies throughout Iowa provide a number of health related services to Medicaid and uninsured children in all 99 counties. However, these programs are minimally staffed and equipped for dental related services. The I-Smiles proposal recommends these agencies become the central care coordination, preventive dental care, and referral network for the extended dental home. In order to accomplish this, these agencies must be sufficiently staffed with dental hygienists, in addition to other improvements within their infrastructure.

Table 2, on the next page, illustrates the estimated level of increase in costs each agency will incur in order to implement the I-Smiles proposal for the Medicaid-enrolled children in their region.

- **Column One** lists each Title V Child Health Agency currently contracted with the Iowa Department of Public Health.
- **Column Two** contains the total number of Medicaid-enrolled children ages 12 and under, using FY 2005 enrollment data.
- **Column Three** shows the number of Medicaid-enrolled children that received preventive dental services from each agency in FY 2005.
- **Column Four** indicates the number of children that did **not** receive dental prevention services from the agencies in FY2005.
- **Column Five** uses the number of children in Column Four to determine an estimate of the amount that each agency could potentially be reimbursed by Medicaid. This represents only those children who did not receive preventive care from the CH agency, based on an estimate of $31.74 per child.
- **Column Six** also uses the number of children in Column Four to determine an estimate of the amount of additional money each agency would need in order to serve those children that did not receive preventive care. This is estimated at $9 per child, a cost that is not currently covered in reimbursable Medicaid revenue. The minimum increase for any agency will be at least 83 percent.

Each agency will be responsible for increasing staff, particularly hiring dental hygienists as oral health coordinators; adding computers; upgrading tracking software; and purchasing additional prevention related dental supplies and administrative materials. Using current Medicaid reimbursement rates to Title V agencies for dental preventive services and care coordination, it is estimated that $31.74 per child is potentially billable and at least an additional $9 cost per child would be needed that is not currently billable (used in Columns Five and Six).

**The estimated cost for dental infrastructure increase for Title V agencies is $1,279,430 annually over FY 2005 Medicaid levels.**
Table 2: Estimate of Additional Funds Needed for Title V CH Agencies to Provide Preventive Dental Services for Medicaid-enrolled Children

<table>
<thead>
<tr>
<th>Column One</th>
<th>Column Two</th>
<th>Column Three</th>
<th>Column Four</th>
<th>Column Five</th>
<th>Column Six</th>
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<tbody>
<tr>
<td>Iowa’s Local Title V CH Agencies</td>
<td>Number of Medicaid-enrolled children* in agency’s service area</td>
<td>Number of Medicaid-enrolled children* who receive preventive dental services from CH agency</td>
<td>Medicaid-enrolled children* who do not receive preventive dental services from CH agency</td>
<td>Estimated potential Medicaid revenue for un-served children (Column 4)</td>
<td>Estimated non-billable costs for un-served children (Column 4)</td>
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<td>Black Hawk County Health Department</td>
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<td>9,681</td>
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<td>5,660</td>
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<td>6,802</td>
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<td>Community Opportunities, Inc.</td>
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<td>5,045</td>
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<td>4,211</td>
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<td>4,647</td>
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<td>Lee County Health Department</td>
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<td>Matura Action Corp.</td>
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<td>Mid-Sioux Opportunities</td>
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<td>3,562</td>
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<td>$32,058</td>
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<td>North Iowa Community Action</td>
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<td>Visiting Nurse Services</td>
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<td>20,572</td>
<td>$652,955</td>
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<td>Washington County Public Health Nursing</td>
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<td>$137,847</td>
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<td>Webster County Public Health</td>
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<td><strong>TOTALS</strong></td>
<td><strong>164,965</strong></td>
<td><strong>11,705</strong></td>
<td><strong>153,260</strong></td>
<td><strong>$4,864,185</strong></td>
<td><strong>$1,279,430</strong></td>
</tr>
</tbody>
</table>

* DHS data for FY2005, children ages 6 months through 12 years
Cost effectiveness of early preventive dental intervention

Dentistry has been a leader in promoting the prevention of disease through activities such as water fluoridation and systematic recalls for annual check-ups. There is additional evidence that the earlier a Medicaid-enrolled child has their first preventive dental visit, the less follow-up care and the lower the cost of the subsequent treatment.

In an analysis of children continuously enrolled in the North Carolina Medicaid program for five years, “children who had their first preventive dental visit by age one were more likely to have subsequent preventive visits but were not more likely to have subsequent restorative or emergency visits. Those who had their first preventive visit at age two or three were more likely to have subsequent preventive, restorative, and emergency visits. The age at the first preventive dental visit had a significant positive effect on dentally related expenditures, with the average dentally related costs being less for children who received earlier preventive care. The average dentally related costs per child according to age at the first preventive visit were as follows:

- before age one, $262 dollars;
- age one to two, $339 dollars;
- age two to three, $449 dollars;
- age three to four, $492 dollars;
- age four to five, $546 dollars.

Thus they concluded “that preschool-aged, Medicaid-enrolled children who had an early preventive dental visit were more likely to use subsequent preventive services and experience lower dentally related costs.”

There is very recent evidence of the efficacy of one of the primary preventive interventions that would be used in the I-Smile program, fluoride varnish therapy, in preventing very costly early childhood caries in public health settings. In a randomized control trial with young, low-income Chinese and Hispanic children in San Francisco, the receipt of fluoride varnish either once or twice per year along with preventive counseling significantly reduced early childhood caries over children who just received preventive counseling.

The effectiveness of even one fluoride varnish application per year in a public health setting has very important implications for the potential of the I-Smile program to save money. Very young children (under age three) are the least likely to visit a dentist. However, applying fluoride varnish in the settings where young, Medicaid-enrolled children do frequent such as WIC clinics, physician offices and Head Start, could provide a very cost-effective way to reduce the expensive care that children with severe early childhood caries require in a hospital operating room.

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Appendix II: Conceptual Model of the Dental Home

The I-Smile proposal envisions a dental home for children using different levels of care and different types of care providers. This concept considers where children are currently receiving health services; the ability of at-risk families to access health services; the levels of competency of different healthcare providers and the most effective use of those competencies; the shortage of dental providers; and the availability of a statewide public health system and care coordination network that can be upgraded to strengthen the limitations within the current oral health care system.

Local public health programs are highly effective in increasing oral health awareness and demand for services among low-income populations. Therefore, system improvements will focus on engaging Medicaid-enrolled families at the earliest possible opportunity in their child’s growth and dental development through a network of public health assistance programs.

Currently, Iowa has 24 local Title V Child Health (CH) agencies that network with other local public health organizations and community programs (e.g., WIC, Head Start, community health centers) to meet the needs of underserved and Medicaid-enrolled populations. These CH agencies will become the entry sites into preventive dental care and provide a referral network to local dentists.

Dental hygienists within these CH agencies will serve as oral health coordinators. Dental hygienists are oral health prevention experts and are trained in the provision of preventive services, oral health education, and anticipatory guidance for children and families. The most successful programs around the state for getting children into dental care have been those that use a dental hygienist. In these programs, the hygienist is not only providing screenings, education, fluoride varnish applications, and sealants, but is also assisting families with scheduling treatment with local dental offices. The hygienist acts as a liaison for the public health agency, family, and private dental office to ensure completion of care.

The dental hygienists improve cooperation with local dental practice policies and decrease barriers to oral health care for Medicaid-enrolled children by:

- Prioritizing dental treatment needs and facilitating distribution of children among all local dental offices,
- Providing oral health education and guidance to parents and caregivers,
- Providing prevention services to children below age four that are sometimes considered too young to be seen by the dental office,
- Decreasing cancelled and/or “no show” scheduled appointments,
- Providing a single contact point for dental providers to report patient compliance issues, and
- Arranging transportation and translation services if needed.

In addition, the oral health coordinator will rely on other healthcare providers for different levels of primary dental care. Provision of care through the I-Smile Dental Home Proposal can be broken into three levels, based upon disease risk and provider expertise and capabilities. This breakdown allows resources to be used most efficiently—with the dentist providing the most skilled levels of care, counting on other healthcare partners to provide preventive services.

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**Level One Care:**
Local Title V Child Health (CH) agencies will serve as the point of contact for assuring provision of dental home services. Each month, CH agencies are alerted to all newly enrolled children in the Medicaid program. This existing system will allow these agencies to also serve as the point of entry into the I-Smile system. Following entry into the system, each child will receive an oral screening and risk assessment by the dental hygienist/oral health coordinator. The hygienist can also provide preventive care, such as fluoride varnish application, and provide education and anticipatory guidance for the child and caregiver. If a child has no observable disease and is considered to be at low risk for tooth decay, the child will receive care coordination for regular prevention services and an annual dental examination by a local contracted dentist. Use of this risk assessment and determination of need will reduce the number of children needing to be seen in a dental office—eliminating the need for dentists to provide primary and preventive care for children with no disease.

Other possible system entries can include physicians’ offices, community health centers, hospital-based dental clinics, Head Start centers, schools, and preschools. Healthcare providers and staff within these entry points will be able to directly refer children to the local CH agency for prevention services and care coordination. The dental hygienist can be used to educate nursing staff and other public and private healthcare providers about the I-Smile dental home services and system.

**Level Two Care:**
Children that require restorative or other treatment will be referred to a dentist. The CH agency oral health coordinator will work with dental office staff and families to facilitate the transition into the dental office. Dental office staff can be assured that families are aware of the importance of oral health and regular care, as well as the office protocols. Families can be assured that the dental office will be aware of the child’s health needs. This correspondence will allow for open communication and decrease the potential of patient non-compliance and “no-shows” for appointments.

Dentists will benefit from having the local CH agency as the intermediate contact for patient appointments and referrals by having the agency screen appointments and provide a place to refer non-compliant patients. This will also provide a means to track and determine willingness of Medicaid-enrolled family caregivers to comply with health care system requirements and become responsible users of Medicaid resources.

**Level Three Care:**
Children with severe decay may require referral to a pediatric dentist or hospital dental program to complete restorative care. The oral health coordinator will facilitate these referrals and retain a list of all available state resources for urgent dental care.

It is anticipated that the provision of enhanced patient and family oral health education and prevention services by the CH agency oral health coordinator will decrease the number of children requiring extensive care and will result in savings to the state in the need for level three services. The tracking of these services by the oral health coordinator will provide a means to determine the rate of level three care given and the expected reductions as children are enrolled and given regular preventive care through the CH agency.

I-Smile will rely on multiple care providers affecting a child’s oral health. Because most healthcare providers receive very limited training about oral health, a system must be developed to provide such training at the state and local level. The local oral health coordinator could receive guidance from the Department of Public Health and then provide education and training for local partners.
The I-Smile program will also rely on the development of an integrated health system. Primary dental services will be incorporated into existing rural and acute access hospitals (CAH) in cooperation with Iowa’s network health systems. These health systems will provide additional resources for dentist recruitment and new dental practice management support in rural communities lacking sufficient dental practice infrastructure. In addition, vertical integration of dental services within hospital systems will provide collaboration opportunities with area dental schools and provide rural rotation opportunities for dental students.

The following two pages provide further illustration of the three levels of care and providers, as well as the process of risk assessment and referral into a dental office for restorative care.

**I-Smile Dental Home: Levels of Care**

<table>
<thead>
<tr>
<th>LEVEL ONE</th>
<th>LEVEL TWO</th>
<th>LEVEL THREE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENTRY INTO SYSTEM</strong></td>
<td><strong>CARE PROVIDERS</strong></td>
<td><strong>CARE PROVIDERS</strong></td>
</tr>
<tr>
<td>Identification of children ages 0-12 in Medicaid</td>
<td>General dentists – private practice and community health center</td>
<td>General dentists – private practice and community health center</td>
</tr>
<tr>
<td>Screening for dental problems</td>
<td>Pediatric dentists</td>
<td>Pediatric dentists</td>
</tr>
<tr>
<td>Preventive care and anticipatory guidance</td>
<td>Dental hygienists</td>
<td>Hospital Outpatient Surgery – pediatric dentists, staff general dentists, and dental student hospital rotations</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>MCH and WIC clinic staff</td>
<td></td>
</tr>
<tr>
<td>Risk assessment</td>
<td>Head Start staff</td>
<td></td>
</tr>
<tr>
<td>Referral to a dentist for examination and treatment</td>
<td>School nurses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physicians and staff</td>
<td></td>
</tr>
</tbody>
</table>

**LEVEL TWO**

**ROUTINE TREATMENT**

- Simple restorative care

**CARE PROVIDERS**

- General dentists – private practice and community health center
- Pediatric dentists

**LEVEL THREE**

**COMPLEX TREATMENT**

- Care for severe decay and other disease

**CARE PROVIDERS**

- General dentists – private practice and community health center
- Pediatric dentists
- Hospital Outpatient Surgery – pediatric dentists, staff general dentists, and dental student hospital rotations
I-Smile Dental Home: Process for Risk Assessment and Referral

Oral Screening/Assessment

- **RISK LEVEL** (low, high)
- **DECAY STATUS** (none, initial, advanced)
- **NEED FOR TREATMENT** (basic, urgent)

Low Risk
No Decay

High Risk
No Decay

High Risk
Initial Decay

High Risk
Advanced Decay

Treatment Needs: Basic
- Dental exam within 12 months
- Counseling to maintain low risk
- Anticipatory guidance
- Primary prevention (fluoride, sealants, if indicated)
- Data entry by care coordinator

Treatment Needs: Basic
- Refer to dentist for dental examination & regular preventive care within 6 months
- Risk management strategies developed
- Regular primary preventive dental care and anticipatory guidance
- Continue regular dental exams and review compliance every 6 months
- Data entry by care coordinator

Treatment Needs: Urgent
- Refer to dentist for diagnosis to verify initial disease status immediately
- Dentist will initiate disease treatment and management program
- Regular primary prevention services in attempt to control disease and reduce risk
- Anticipatory guidance
- Reassess in 3-6 months based on risk level
- Data entry by care coordinator

Treatment Needs: Urgent
- Refer to dentist for exam and implement treatment immediately
- Implement advanced disease management and regular primary prevention program to control disease and reduce risk
- Anticipatory guidance
- Reassess in 3-6 months based on risk level
- Data entry by care coordinator

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37 Adapted from Crall JJ, Edelstein BL. Appendix II—Systems Capacity and Integration. www.cthealth.org
Appendix III: Support for improvements to the Dental Support System for Families

Infant oral health program

Key to the I-Smiles program is early identification and prevention of dental disease. Children’s teeth begin to erupt within six months of birth. Decay-causing bacteria, generally introduced by the mother or caregiver lacking good oral hygiene, can lead to rapid decay. Appropriate parental education and close monitoring of children’s teeth from eruption is critical in avoiding extensive decay and high care cost later on.

Physicians, nurses, WIC, Early Head Start, and Title V Maternal and Child Health Agencies are often the first to see a Medicaid-enrolled child after birth and up to age three. (After age three, dentists are more experienced and comfortable managing children.) These care providers are the first line defense for early prevention and screening. I-Smile will rely on early screening and detection performed by primary care health providers in collaboration with CH agency dental hygienists. These hygienists, working as oral health coordinators, will ensure a smooth transition into the dental care system; providing CH medical staff training and caregiver education needed to target children with necessary prevention services.

In order for this system to operate effectively, physicians and other primary care practitioners will need a support system including training opportunities and appropriate reimbursement levels to encourage oral health related services. Current medical practice place little emphasis on oral health care. While EPSDT recommendations include oral screenings as part of well-child examinations up to age three, most physicians do not routinely observe the mouth during these exams. In addition, current Medicaid exam codes do not identify if oral health screenings are performed.

This proposal recommends Medicaid seek an Administrative Rules change to develop a medical provider service code to track physician oral health screening services.

Most of Iowa’s public health agencies and health care programs are staffed by nurses, nurse practitioners, and other mid-level health care providers. These providers are another under-utilized resource that could be used in early oral health screening and topical fluoride application services if Title V Maternal and Child Health Agencies were allowed to bill Medicaid for oral health prevention services rendered by these non-dental providers. Through training opportunities provided by oral health coordinators, mid-level medical providers could serve to extend the oral health safety net for children.

This proposal recommends Medicaid seek an administrative rules change to allow payment to MCH agencies for oral health related screenings and fluoride varnish application for primary care mid-level providers.
Health promotion campaign information (tobacco campaign information)

<table>
<thead>
<tr>
<th>Quitline Iowa Promotion: Media Contractor</th>
<th>Total: $1,044,855</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production of radio advertisements (4 spots x $8,800)</td>
<td>35,200</td>
</tr>
<tr>
<td>Placement of radio advertising ($10,000 p/mo x 8 months)</td>
<td>80,000</td>
</tr>
<tr>
<td>Production of billboards (Ad development = $8,000 + printing 64 boards = $11,200)</td>
<td>19,200</td>
</tr>
<tr>
<td>Placement of billboards (64 boards x 6 months)</td>
<td>160,000</td>
</tr>
<tr>
<td>Production of television advertisements (2 spots x approx. $45,000)</td>
<td>90,000</td>
</tr>
<tr>
<td>Placement of television (7 television markets x 12 months)</td>
<td>660,455</td>
</tr>
</tbody>
</table>

Iowa Quitline and “Just Eliminate Lies” (JEL) anti-tobacco campaign is considered one of the most effective informational campaigns in the state of Iowa. ³⁸ (See chart below)

<table>
<thead>
<tr>
<th>Total people who have called Quitline Iowa for smoking cessation help or information</th>
<th>Referrals from TV advertising</th>
<th>% of incoming non-agency calls who list TV advertising as their referral source</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>59</td>
<td>3</td>
</tr>
<tr>
<td>August</td>
<td>83</td>
<td>7</td>
</tr>
<tr>
<td>September</td>
<td>112</td>
<td>7</td>
</tr>
<tr>
<td>October</td>
<td>100</td>
<td>2</td>
</tr>
<tr>
<td>November</td>
<td>172</td>
<td>23</td>
</tr>
<tr>
<td>December</td>
<td>105</td>
<td>13</td>
</tr>
<tr>
<td>January 1st-10th at 1pm</td>
<td>103</td>
<td>42</td>
</tr>
</tbody>
</table>

I-Smiles plans to utilize many of the same methods and media promotions to increase public awareness of oral health related diseases and how they impact overall health. Families and caregivers will be instructed on how to contact the Title V Oral Health Coordinator and access early care for their children.

The goal of the dental public health promotions will be to empower families with information on how to prevent childhood oral disease and how to access the dental home system. This will produce the added benefits of public awareness and equipping families with knowledge necessary to reduce the burden of advanced childhood dental disease like baby bottle tooth decay. This will further reduce long-term costs for dental treatment due to neglected disease identified in late stages.

³⁸ [http://www.idph.state.ia.us/tobacco/common/pdf/program_eval.pdf](http://www.idph.state.ia.us/tobacco/common/pdf/program_eval.pdf)
Fund training programs for dental and other healthcare providers regarding children’s oral health

The majority of Iowa’s current health care workforce are insufficiently trained and prepared to address the prevention and oral health needs of children between birth to age three. General dentists are not sufficiently prepared to provide, examinations, prevention or invasive treatment for these children. While physicians, both pediatricians and family practitioners, see children from birth to age three, they often ignore the oral cavity during well-child physical examinations.

These problems are associated with the silo effect and limited focus of current health care provider training programs among other issues such as reimbursement rates for such targeted services as oral health evaluations and prevention services. The I-Smiles proposal contains recommendations to address workforce extension and provider reimbursements rates for oral evaluations and prevention services for young children. However, additional training opportunities will be necessary to equip health care providers with skills necessary to treat very young children.

The I-Smile proposal recommends mandatory continuing education opportunities for dentists and physicians targeting early prevention and examination services for children birth to age three. Iowa’s dental and medical schools and their faculty will develop curriculum necessary to accomplish this goal. Both Iowa Boards of Medical and Dental Examiners will review the curriculum recommendations and establish a mandatory minimum requirement for all practitioners engaged or eligible to provide oral health related prevention services of young children.

It is also recommended that Iowa Medicaid Enterprise establish minimum training criteria for health care providers in conjunction with both medical and dental boards. These courses could be offered free or at very reduced rates to providers over the Iowa Communication Network.

Attendance at this continuing education course would be required for dentists to receive any enhanced reimbursement rates and physicians to receive the ability to use the new screening and prevention codes as specified under the I-Smile proposal.

Estimated cost for curriculum development: $120,000

Additional actions required:

- Establishment of mandatory minimum continuing education criteria by both Iowa Boards of Medical and Dental Examiners
- Medicaid Administrative Policy change recognizing minimal continuing education requirements for physicians and dentists participation in I-Smiles enhanced reimbursement rate program
Appendix IV: Support for Improvements to the Medicaid Dental Program

Increased dentist participation by using a familiar dental insurance carrier

As indicated previously, low dentist participation has been found to be a significant barrier to accessing dental care for Medicaid enrollees. To increase dentist participation, the I-Smile proposal recommends replicating an effective Medicaid model in Michigan that has increased dentist participation in that state. The Michigan model uses a familiar dental insurance carrier, Delta Dental, for the children’s Medicaid dental program. Iowa’s State Children’s Health Insurance Plan (SCHIP), hawk-i, is similar, with the dental benefits covered by private insurance carriers.

During the first year of the Michigan program, “dental care utilization increased 31 percent overall and 39 percent among children continuously enrolled for 12 months, compared with the previous year under Medicaid. Dentists' participation increased substantially, and the distance traveled by patients for appointments was cut in half. Costs were 2.5 times higher, attributable to more children's receiving care, the mix of services shifting to more comprehensive care and payment at customary reimbursement levels.” 39

While the state of Iowa has more counties designated as dental health professional shortage areas, the American Dental Association reports similar conditions existed in the Michigan counties that experienced remarkable access improvements once the improved Medicaid insurance plan was implemented.40

An analysis of the Iowa Medicaid and hawk-i programs in FY2001 shows dental utilization was similar when compared for any child enrolled at any point in the year but was higher when only children enrolled for 11-12 months during the year were considered (46% in Medicaid compared to 57% for hawk-i). The higher socioeconomic status of children in hawk-i might account for some of the higher utilization rates. However in a study of the Indiana Medicaid dental program, there was no difference in utilization based on income alone.41 (Indiana SCHIP is a Medicaid expansion so all children are in the same type of Medicaid dental program.)

By using a familiar dental insurance carrier, the belief is that dentists will be more likely to participate. They are familiar with the claims forms and services; they will receive reimbursement closer to their customary charges; and the stigma of Medicaid will be reduced for dental offices and enrollees. In addition, the proposed I-Smile insurance system will require dentists to contract as service providers and will guarantee acceptance of a Medicaid-enrolled child when referred by a CH agency oral health coordinator. This will ensure an adequate network of dentists is available for every Medicaid-enrolled child. Ultimately the responsibility with this program shifts so that the private insurance carrier is responsible for ensuring that they are able to provide enough dentists, so that all children can have a dental home.

Cost estimate for using a familiar dental insurance carrier

Based on a previous analysis, Medicaid paid $5.80 per enrollee/per month for all children’s dental services in FY 2003 resulting in a total cost of $14.4 million for dental care for children. (This includes children through age 18, and does not include dental care provided in hospital operating rooms.)

During CY 2005, there was an average of 133,000 children ages 0-12 enrolled in Medicaid each month (1,589,903 total age 0-12 enrolled during the year). The monthly enrollment of children 0-12 varied from 129,600 to 134,400 during the year. Using the average of 133,000, the cost for Medicaid dental services for children ages 0-12 would have been $9.2 million.

*Higher bound cost estimate based on the Iowa hawk-i program*

Iowa’s SCHIP (*hawk-i*) program pays private carriers approximately $16 pm/pm to provide comprehensive dental care, excluding orthodontics, to enrolled children. The *hawk-i* program has a $1,500 annual maximum. Because Medicaid rules do not allow an annual maximum, and some medically necessary orthodontic coverage must be provided, a higher bound pm/pm must be estimated at $17 per member/per month (pm/pm).

Low estimate= $17 pm/pm 1,589,903 covered months during the year=$27 million

Based on current information, the estimated cost of this program utilizing Delta Dental of Iowa’s broad dental network (representing approximately 90% of Iowa dentists) and assuming no maximum annual benefit is $28.8 million annually. If orthodontia benefits are included, the estimated cost is $37 million annually. This pricing includes projected benefit costs under a *hawk-i* look-alike program and administrative expenses.

Delta Dental would also offer to modify the current provider network to support savings available by limiting access to specialists. Limiting access to general practitioners only (with the exception of pediatric dentists) would save the program $494,000 annually.

**Estimated Total Annual Cost:** $28,800,000

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Physician screening/fluoride varnish program

North Carolina’s “In the Mouth of Babes” program\(^43\) has demonstrated that physicians can form an effective prevention and detection network if appropriately trained and adequately reimbursed. North Carolina combines oral health screening, parental education, and fluoride varnish applications into one payable service code and charge. This code is reimbursed at a rate from $53 to $61 per visit up to 5 visits per year. Current Iowa Medicaid rates for physician office fluoride varnish application are from $11.64 to $13.58 with no separate rate or code for dental screening.\(^44\)

The most effective early disease prevention opportunity for high-risk Medicaid children occurs between first tooth eruption at 6 months to age 3 when general dentists do not traditionally provide dental services. Physicians along with dental hygienists associated with Title V CH programs will be the most effective means to provide early screening and prevention services. This proposal recommends Medicaid increase physician reimbursement rates to $20.00 for oral health screenings and $18.00 for fluoride varnish applications.

Commercial utilization rates among insured consumers for dental services are estimated at 65 percent according to Delta Dental of Iowa. Annual well-child evaluations with oral health screenings should be performed twice or every six months per EPSDT and AAPD recommendations. Current fluoride varnish applications are permitted up to three times a year.

The I-Smile population of Medicaid-enrolled children ages 3 and below in FY 2005 was approximately 57,762. A 65 percent utilization would result in 37,545 of these children receiving a dental screening and fluoride varnish application.

**Estimated annual Medicaid costs: $3,529,230** *includes current annual Medicaid EPSDT exam oral screening and physician fluoride varnish payments*

Increase funding to strengthen the state Title V CH database system for tracking patient care coordination and appointments

Iowa’s Title V Child Health Agencies use the Child and Adolescent Reporting System “CAReS” to report care coordination and primary and prevention health care services.\(^45\) The system currently collects some levels of oral health care information; however, it is essentially a medical service tracking system and does not separate service populations based on source of funding.

For the oral health service enhancements necessary for the I-Smiles program, CAReS will need upgrading to capture oral health services, care coordination, tracking of all Medicaid-enrolled children ages 12 and below, and monitoring periodicity and establishment of dental home relationships with private practice dentists and other dental practice models. In addition, Title V agencies will need trained service and administrative staff on the optimum use of the upgrades.

**Estimated costs for CAReS upgrades: $200,000 and agency staff training: $10,000**

**Total upgrade and training costs: $210,000**

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\(^44\) Iowa Department of Human Services

\(^45\) Iowa Department of Public Health/ Family Services Bureau “CAReS” User Manual, 2001
Support for covering periodontal services for adults in Medicaid

Reinstating the coverage of periodontal services for adults in Medicaid is a relatively low-cost approach to improve the oral health of new mothers and ultimately that of their child. According to the American Academy of Periodontology\textsuperscript{46}, untreated gum disease can:

- Contribute to the development of heart disease, the nation's leading cause of death,
- Increase the risk of stroke,
- Increase a woman's risk of having a preterm, low birth weight baby\textsuperscript{47,48},
- Pose a serious threat to people whose health is compromised by diabetes, respiratory diseases, or osteoporosis.

In addition, there is evidence that the oral health of new mothers has a direct affect on the long-term oral health of her child due to the transmission of bacteria between the mother and infant shortly after birth.\textsuperscript{49} The child’s oral bacterial “flora” is established as the child interacts, primarily with the mother, through kissing, tasting food and other activities in which the mother’s oral bacteria come into contact with the child’s mouth. This time period is often called the “window of infectivity”.\textsuperscript{50} During this time, the bacteria that cause dental decay and other oral health problems are spread from the mother to the child. The better the oral health of the mother, the less disease-causing bacteria is spread to the child, improving the child’s chances of starting off life with good oral health and fewer needs for significant, costly dental care.

\textsuperscript{46} American Academy of Periodontology, Mouth Body Connection. \url{http://www.perio.org/consumer/mbc_top2.htm}.
\textsuperscript{49} Tanzer J, Livingston J, Thompson A. The Microbiology of Primary Dental Caries. \url{http://www.nidcr.nih.gov/NR/rdonlyres/73FABD84-9B93-461C-934F-21E2698D8A77/0/Jason_Tanzer.pdf}.
Appendix V: Support for implementing recruitment and retention strategies

Implementing recruitment and retention strategies for the dental workforce

Because of the shortage and geographic maldistribution of dentists and dental hygienists in the state, the I-Smile proposal will rely on establishing a student loan repayment program to enhance the current dental care system. This system will help direct future dental providers to underserved areas of the state and will increase available providers where they are most needed.

It is important that a student loan repayment plan include specific guidance and expectations for participating dentists to include significant numbers of Medicaid and hawk-i enrolled children in their practices. The Association of State and Territorial Dental Directors see the acceptable range of annual Medicaid billing as greater than $10,000 dollars or total dental practice Medicaid volume greater than 15 percent.

Student loan repayment agreements must include such terms as acceptable standards of compliance, not just the location of a practice in an underserved community.

Estimated costs: $250,000 to sponsor up to 3-4 graduating dental and dental hygiene students as loan repayments up to $25,000 annually for three years.

Work with rural health system hospitals to determine their ability to create dental clinics and increase operating room services for children’s dental services

Iowa’s rural and critical access hospitals (CAH) in cooperation with Iowa’s network health systems have started a process that envisions a vertical integrated primary care system that incorporates primary dental care services into available space within rural hospitals in underserved communities. The goal is to ensure that an adequate number of dental professionals are recruited to and practice in rural areas.

The health systems will establish and manage new hospital-based dental clinic sites that will be designed for replication on a state-wide basis. Operational issues will be managed on a system level. Recruitment/retention, billing/collections, purchasing and dental clinic set up will be uniform throughout the state. There will be an integration of dental services and primary care services within rural communities in collaboration with Migrant and Community Health Centers providing a referral system and a dental home for all children. These systems will coordinate services through the care coordination and referral linkages within Maternal and Child Health/Title V Agencies as part of the I-Smiles network.

The vertical integration hospital-based dental program will also establish collaboration with area dental schools to provide rural dental student and resident rotation opportunities in return for recruitment potential of graduating dentists.

No Estimated Cost to State
MISSION: Protecting the health and wellness of every Iowan through the prevention and early detection of dental disease and through the promotion of optimal oral health.

Maternal and Child Health Program
The IDPH contracts with 28 local public health agencies to assure access to health services, including oral health, for low-income children and pregnant and post-partum women through the Title V Maternal and Child Health (MCH) program. The local agencies assure care through infrastructure-building, population-based, enabling, and direct care services.

I-Smile™ Dental Home Program
I-Smile™ was created in response to a 2005 legislative mandate that all children ages 12 and under enrolled in Medicaid have a dental home. Primary prevention and care coordination are the focus of the project. Dental hygienists, serving as I-Smile™ coordinators, are implementing the project within Iowa's Title V child health agencies. These coordinators are developing partnerships, establishing referral systems, providing training and education for healthcare professionals, ensuring completion of oral screenings and risk assessments, working within their agencies to develop oral health protocols, ensuring oral health care coordination, and providing gap-filling preventive services.

School Dental Screenings
Beginning in 2008, children newly enrolling in kindergarten and ninth grade in Iowa are required to provide proof of a dental screening. I-Smile™ Coordinators work with families, schools, health care providers, and local boards of health to implement the new requirement.

School-Based Dental Sealant Program
The IDPH funds seven school-based dental sealant programs through Title V child health agencies. Programs include children in grades two through eight (See I-Smile™ Resources page for link to program information).

Catch a Smile Fluoride Mouthrinse Program
This preventive program has provided oral health education and weekly rinsing with fluoride to approximately 150 elementary and junior high schools in Iowa each year. It targets high-risk children and schools in communities with fluoride deficient water supplies (See I-Smile™ Resources page for link to program information and the list of participating schools).
**Dental Care for Persons with Disabilities Program**
This program is sponsored jointly by the University of Iowa College Of Dentistry and the IDPH. Low-income children and young adults through age 21 with special health care needs and no payment source for dental care are eligible to receive dental services at the University of Iowa or at participating dental offices in the state. *(See I-Smile™ Resources page for link to the program information and list of participating dentists).*

**Oral Health Surveys**
The OHB coordinates periodic open mouth surveys on third grade and Head Start children to gather data on prevalence of dental sealants, tooth decay, and restored (filled) teeth. Additional information collected includes payment source(s) for dental care. *(See the I-Smile™ Resources page for link to Oral Health Bureau reports).*

**TOHSS Oral Health Promotion**
HRSA grant funds have allowed OHB to hire a program planner devoted to health promotion activities. Several activities and materials have been developed including a television and print campaign, an I-Smile™ Web site, two exhibit displays, and various handouts and brochures.

**Oral Health Bureau - Contact Information**
Dr. Bob Russell 515/281-4916  
Tracy Rodgers 515/281-7715  
Sara Schlievert 515/281-7630  
Heather Miller 515/281-7779  
Mary Kay Brinkman 515/281-8309  
Shaela Meister 515/281-4302  
Amy Janssen 515/281-5069  
Nancy Jo Henning 515/281-3733  
Bureau toll-free 866/528-4020  
Bureau Fax 515/242-6384

**Oral Health Bureau Web Site:**
www.idph.state.ia.us/hpcdp/oral_health.asp

**I-Smile Dental Home Initiative Web Site:**
www.ismiledentalhome.org

Revised 1/2010
Fluoride Varnish Application for Medicaid-enrolled Children

Iowa Medicaid reimburses physicians for application of fluoride varnish in conjunction with an EPSDT screening

Iowa Administrative Code, Chapter 441-78.1(24)

Patient Ages 0 to 36 months
Frequency 3 times a year (120 days apart)
Reimbursement $14.19
Provider Types Physician, Advanced Registered Nurse Practitioner

Billing:
- Use the HCFA-1500 Health Insurance claim form or electronic submission
- Diagnosis code: V20.2
- Procedure code: D1206 (fluoride varnish application for moderate to high caries risk patient)
- No modifiers are needed to indicate a separate service

Dental caries is a bacterial disease that can be prevented. Tooth decay affects a child's ability to eat, sleep, speak, learn, and thrive. Low-income children are most at risk for decay. Primary prevention, such as application of fluoride varnish, has been shown to be effective in decreasing very young children's risk.¹

Most studies have shown 25-45% reductions in the decay rate with the use of fluoride varnish. Of special note is the reduction of decay in pits and fissures, as well as on smooth surfaces of teeth. A new study shows that low-income children who do not receive fluoride varnish are four times more likely to develop decay than those receiving biannual applications.²

The concentration of fluoride in varnishes is much higher than that of APF gels or other topical fluorides, however, due to the sticky form of the varnish and the small amount used per application, risk of ingestion and toxicity is very low.³

# Fluoride Varnish Product List

<table>
<thead>
<tr>
<th>Product</th>
<th>Description</th>
<th>Cost</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duraphat</strong></td>
<td>5% sodium fluoride</td>
<td>$25.95</td>
<td>Colgate Oral Pharmaceuticals Sullivan &amp; Schein 1-800-372-4346</td>
</tr>
<tr>
<td></td>
<td>Use with disposable brush</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 ml tube (20 -30 applications per tube)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Duraflor</strong></td>
<td>5% sodium fluoride</td>
<td>$24.49 $25.99</td>
<td>Medicom, Inc. <a href="http://www.medicom.com">http://www.medicom.com</a> 1-800-361-2862 Or contact your local dental supplier</td>
</tr>
<tr>
<td></td>
<td>16 unit dose - 0.5 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 ml tube (20 -30 applications per tube)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CavityShield</strong></td>
<td>5% sodium fluoride Vanish 5% sodium fluoride (white)</td>
<td>$30.50 $155.00 $112.00 $495.00</td>
<td>Omni Pharmaceuticals <a href="http://www.omnipharma.com">http://www.omnipharma.com</a> 1-800-445-3386</td>
</tr>
<tr>
<td></td>
<td>32 unit dose - 0.25 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>200 unit dose - 0.25 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50 unit dose - 0.5 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>300 unit dose - 0.5 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VarnishAmerica</strong></td>
<td>5% sodium fluoride</td>
<td>$21.00 $110.00</td>
<td>Medical Products Laboratories <a href="http://www.medicalproductslaboratories.com">www.medicalproductslaboratories.com</a> 1-800-523-0191 ext 326</td>
</tr>
<tr>
<td></td>
<td>32 unit dose - 0.25 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>200 unit dose - 0.25 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fluor-Opal Varnish</strong></td>
<td>5% sodium fluoride Syringe-type application</td>
<td>$11.49 $29.00</td>
<td>Ultradent Products, Inc. <a href="http://www.ultradent.com">http://www.ultradent.com</a> 1-800-496-8337</td>
</tr>
<tr>
<td></td>
<td>5 unit dose -0.5ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 unit dose – 0.5ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AllSolutions</strong></td>
<td>5% sodium fluoride</td>
<td>$74.99 retail $48.23 gov’t</td>
<td>Dentsply <a href="http://www.professional.dentsply.com">http://www.professional.dentsply.com</a> 1-800-800-2888 1-302-422-4511</td>
</tr>
<tr>
<td></td>
<td>50 unit dose - 0.25 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fluoridex</strong></td>
<td>5% sodium fluoride</td>
<td>$22.00 retail $17.49 for &gt; 6</td>
<td>Discus Dental <a href="http://www.discusdental.com">http://www.discusdental.com</a> 1- 800-422-9448</td>
</tr>
<tr>
<td></td>
<td>16 unit dose -0.5ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fluorilaq</strong></td>
<td>5% sodium fluoride</td>
<td>$19.95 retail</td>
<td>Pascal Co. Inc <a href="http://www.pascaldental.com/">http://www.pascaldental.com/</a> proflu4.htm 1-800-426-8051</td>
</tr>
<tr>
<td></td>
<td>Use with disposable brush</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 ml tube</td>
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<td></td>
</tr>
</tbody>
</table>

This list has been provided by the *Smiles for Ohio* Program. It includes most fluoride varnishes on the market in the United States, but there may be inadvertent product omissions. Some of these products can be obtained directly from the manufacturer. Others can be obtained through a local dental products supplier. Check your local listings for dental supply companies.

The I-Smile Dental Home Project has no financial association with any company that markets fluoride products.

(May 2006)
I-Smile™ Resources Web Site Links:

Oral Health Bureau Programs:
http://www.idph.state.ia.us/hpcdp/oral_health_programs.asp

Oral Health Bureau Reports:
http://www.idph.state.ia.us/hpcdp/oral_health_reports.asp

Oral Health Bureau Resources (educational materials):
http://www.idph.state.ia.us/hpcdp/oral_health_resources.asp

Title V Child Health Program
http://www.idph.state.ia.us/hpcdp/child_health_centers.asp
Agency Map: http://www.idph.state.ia.us/webmap/default.asp?map=epsdt

Title V Maternal Health
http://www.idph.state.ia.us/hpcdp/family_health_maternal.asp
Agency Map: http://www.idph.state.ia.us/hpcdp/common/pdf/mh_map.pdf

Iowa WIC Program
http://www.idph.state.ia.us/wic/agencies.asp
Agency Map: http://www.idph.state.ia.us/webmap/default.asp?map=wic_agencies

Local Public Health Services
http://www.idph.state.ia.us/hpcdp/local_public_health_services.asp
Region Map:
http://www.idph.state.ia.us/hpcdp/common/pdf/local_public_health_services/Region_Map.pdf

Iowa Head Start Program/Map
http://www.iowahheadstart.org/IHSAHome.asp

Iowa Empowerment
http://www.empowerment.state.ia.us/
Area Map: http://www.empowerment.state.ia.us/map/index.html
State and National Oral Health Web Site Links

Healthy Iowans 2010
http://www.idph.state.ia.us/adper/healthy_iowans_2010.asp

Iowa Board of Dental Examiners
www.state.ia.us/dentalboard/

Iowa Dental Association
www.iowadental.org

University of Iowa Pediatric Dentistry
www.iowapediatricdentistry.com

American Academy of Pediatrics
www.aap.org

American Academy of Pediatric Dentistry
www.aapd.org

American Association of Public Health Dentistry
www.aaphd.org

American Dental Assistants Association
www.dentalassistant.org

American Dental Association
www.ada.org

American Dental Hygienists Association
www.adha.org

Association of State and Territorial Dental Directors
www.astdd.org

National Center for Chronic Disease Prevention and Health Promotion, Oral Health Resources
www.cdc.gov/oralhealth/

National Maternal and Child Oral Health Resource Center
www.mchoralhealth.org/

www.surgeongeneral.gov/library/oralhealth/
Glossary of Acronyms
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>AAPD</td>
<td>American Academy of Pediatric Dentists</td>
</tr>
<tr>
<td>ABCD</td>
<td>Iowa Access to Baby and Child Dentistry program</td>
</tr>
<tr>
<td>BOH</td>
<td>Board of Health</td>
</tr>
<tr>
<td>CAReS</td>
<td>Child and Adolescent Reporting System (state Title V child health data system)</td>
</tr>
<tr>
<td>CH</td>
<td>Child Health (Title V child health agency)</td>
</tr>
<tr>
<td>CHNA&amp;HIP</td>
<td>Community Health Needs Assessment and Health Improvement Plan</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>DHS</td>
<td>Iowa Department of Human Services</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis and Treatment Care for Kids Program (Medicaid for children)</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal Year (state = SFY federal= FFY)</td>
</tr>
<tr>
<td>hawk-i</td>
<td>Healthy and Well Kids in Iowa (state children’s health insurance program)</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>IDPH</td>
<td>Iowa Department of Public Health</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health (Title V program)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Title XIX</td>
</tr>
<tr>
<td>MH</td>
<td>Maternal Health (Title V maternal health agency)</td>
</tr>
<tr>
<td>OHB</td>
<td>Oral Health Bureau</td>
</tr>
<tr>
<td>Title V</td>
<td>Title V of the Social Security Act that authorizes the federal Maternal and Child Health Services Program. IDPH is the designated administrator for Title V maternal and child health services in Iowa. Title V funds are awarded to private-nonprofit and public agencies to provide health services at the community level.</td>
</tr>
<tr>
<td>WHIS</td>
<td>Women’s Health Information System (state Title V women’s health data system)</td>
</tr>
<tr>
<td>WIC</td>
<td>Special Supplemental Nutrition Program for Women, Infants, and Children</td>
</tr>
</tbody>
</table>