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I-SMILE: IOWA'S INTEGRATED DENTAL HOME**Objectives**

The Iowa legislature mandated that all Medicaid-enrolled children ages 0-12 have a dental home. To meet this mandate, the Department of Public Health worked with the Department of Human Services and other partners to create the I-Smile Dental Home project. The I-Smile dental home includes dental and non-dental healthcare providers.

Target

Low-income, minority, and underserved children, with emphasis on Medicaid-enrolled.

Program/Project Description

I-Smile project objectives include improving dental Medicaid, implementing recruitment and retention strategies for dental providers, integrating dental clinics into rural hospitals, and improving the support system for families. To assure regular care and prevention beginning at age 1, the I-Smile dental home uses dental hygienists, physicians, and nurses for education, screenings, and prevention. Dentists provide exams and treatment as needed. The state's 24 Title V child health contractors employ dental hygienists serving as regional I-Smile Coordinators. The coordinators are liaisons between families, dentists, physicians, and community organizations.

Methods

I-Smile Coordinators are responsible for implementing local I-Smile activities. Strategies include: developing partnerships to enhance oral health infrastructure and establish a referral network; training physicians and nurses to do oral screenings and apply fluoride varnish; strengthening care coordination and education systems; ensuring completion of risk assessments and screenings; and ensuring access to gap-filling preventive services such as fluoride and sealant application. State and local partnerships are key components of I-Smile and include collaboration with the Iowa chapter of AAP in development of an online oral health curriculum in an effort to reach as many physicians as possible.

Results

The goal of the I-Smile program is 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 have a dental home. An evaluation of the first two years of I-Smile is underway and will include determining impact of physicians within the network. During the first year of I-Smile, the percent of Medicaid-enrolled children ages 1-5 receiving a dental service increased by 5%.

Conclusions/Key Lessons Learned

A multi-disciplinary approach to a dental home is needed due to barriers families face in accessing dental care. In Iowa, the dental workforce is aging and retiring, pediatric dental practices are mostly within urban areas, too few dentists accept Medicaid, and many dentists will not see children younger than age 3. A dental home – prevention, education, treatment, and diagnosis – may be met through different providers. Previous Iowa initiatives serve as best practices demonstrating the importance of establishing dental hygienists within communities to work with families, organizations, and other health care providers, as well as the benefit of training physicians and staff to increase preventive care and access for children younger than 3. Public-private partnerships are important, and grassroots efforts of I-Smile Coordinators are particularly beneficial. In addition, changes in payment policies are being pursued to allow medical providers to be reimbursed for services and to increase participation within I-Smile