Sealants Save Smiles
Pilot Report

August 2014

SONOMA COUNTY
SCHOOL SMILE PROGRAM

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"Participating in the Sealant Saves Smiles program has provided an opportunity to contribute to the welfare of the underserved in a big way.

Having spent most of my 32 years as a dental hygienist working in private practice in an affluent county, I discovered that serving this community is entirely different. The children I see in the private dental practice usually have dental/medical insurance and have had the best of preventive care for the entirety of their young lives.
But the children I'm seeing in the sealant program have not been so fortunate.

This week I saw a 7 year old boy who had stainless steel crowns on virtually every one of his primary molars. This tells me that his parents did the right thing in taking him to a dentist.
But they did not do it soon enough for their son to receive any preventive care or to avoid his need of more invasive dental work. I can only imagine how traumatic it must be for a young person to visit a dentist, probably for his first time, and receive extensive treatment of this kind, possibly under general anesthesia.

It is not at all uncommon to see such extensive dental work in the mouths of children coming from low income families.

The group of hygienists working within the Sealants Save Smiles program are in a unique position; not only to help markedly curb the decay in these high risk children, but also to give them a dental experience that can be gentle and kind and in a familiar setting.
I am excited about the challenges and opportunities that the next school year will bring."

Jennifer Hahn, RDHAP

Jennifer Hahn RDHAP, wheels in her equipment to set up for her day.

The United States Preventive Services Task Force has identified fluoridation and school-linked sealant programs as the only community based oral health interventions recommended for caries prevention
-US Centers for Disease Control and Prevention

I. Background:

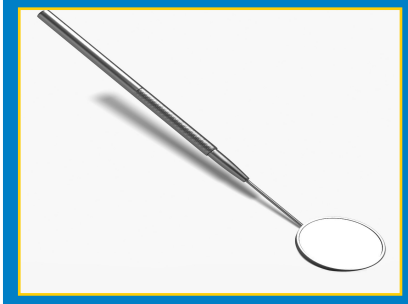
The Sonoma Smile Survey of 2009 assessed the dental health of 1483 kindergarten and 3rd grade students in 15 elementary schools. A key finding was that only 17% of Sonoma County children had dental sealants, a well-accepted clinical intervention to prevent tooth decay on molar teeth. There is currently no school-based dental center in Sonoma County. The **Healthy People 2020** Oral Health Objectives regarding Dental Sealants are listed below:

OH-9.1 Increase the proportion of school-based health centers with an oral health component that includes dental sealants. Target 26.5%
OH-12 Increase the proportion of children and adolescents (age 6 to 9) who have received dental sealants on their molar teeth. Target 28.1%

II. Pilot Intervention:

The Sonoma County Department of Health Services (DHS) has contracted with Community Action Partnership of Sonoma County (CAP) to develop and test a School Based Dental Sealant program pilot. Two financial models were tested: 1) a fee for service program with independent providers (RDHAP) and 2) a Federally Qualified Health Center (FQHC) affiliated model. Both models will be evaluated for sustainability and program expansion.
The pilot program supports 4 of the 5 pillars of dental health outlined by DHS. They are comprised of community education, fluoride varnish, community water fluoridation, sealants and access to dental care.

The Sealant Saves Smiles program is a dental disease prevention program which provides:



School--based dental assessment

Fluoride application

Sealant placement on eligible teeth

Classroom education

Referral for treatment needs

Case management

RDHAP Training Group

III. School-Based Dental Program Description:

Participation in the program is offered to 2nd, 3rd and 6th graders in each school to reach those who have either their first molars or both the first and second permanent molars fully erupted[1].

Active consent from parents or guardians is required for program participation. All children returning consents are first screened then have a fluoride varnish treatment and are finally evaluated for sealant need. These assessments take place in the back of the classroom while a classroom education lesson on healthy eating, drinking, and oral health is presented in the front. Results of the assessment are sent home to parents. Program staff returned over the next several weeks to place sealants on the children that need them. Both models follow the same protocols. CAP staff is available to assist families with insurance applications. The Sealant Saves Smiles program was based upon several other existing programs across the country: Chicago, Colorado, Ohio and Washington. The "Seal America, the Prevention Invention" manual was used as a guideline for program planning. [2] The Sealant Efficiency Assessment for Locals and States (SEAL) data collection software, authored by the Center for Disease Control, was used to capture and compile data[3].

"Thank you so much for providing this service. We are so blessed to be working in a community that cares so much for the children. I hope that this is a program that can continue next year."
Maureen Rudder
Principal McDowell Elementary School

[1] J Public Health Dent. 1989 Winter;49(1):7-14.
Eruption pattern of permanent molars: implications for school-based dental sealant programs Kuthy RA1, Ashton JJ

[2] Carter NL, with the American Association for Community Dental Programs and the National Maternal and Child Oral Health Resource Center. 2011. Seal America: The Prevention Invention (2nd ed., rev.). Washington, DC: National Maternal and Child Oral Health Resource Center

[3] CDC. http://www.cdc.gov/oralhealth/state_programs/infrastructure/seals.htm

Two Financial Models

Fee for Service Model:	FQHC Model:
The Fee for Service model uses a private dental provider (Registered Dental Hygienist in Alternative Practice [RDHAP]) who bills dental insurance (private and public) for reimbursement. They can bill for each sealant placed and fluoride varnish. Medi-Cal pays about $20.00 per sealant and $7.20 for application of fluoride varnish. In our pilot, uninsured children are treated pro bono and families are offered assistance with insurance enrollment by CAP staff.	The FQHC model affiliates with a Federally Qualified Health Center Dental Program, whose clinical staff provides services to the students. The FQHC must include school-based dental services in their Scope of Services in order for them to be able to bill for reimbursement. If not, they must apply for a change in scope which can take up to 3 months. They serve only the schools in their service area and are compensated by the encounter rate which is set for each FQHC. Since billing is based on encounter, not service, the encounter rate is the same for each child, regardless of the number of sealants placed, and encounter rates range from $150-200 in our area.
Equipment and Support: Providers use their own equipment and supplies. All copying, printing and incentives are provided mainly from the program with some by the school and some by the provider. Provider does their own billing.	Equipment and Support: FQHCs bring their own portable equipment and supplies, forms and parent information, and purchase their own incentives. Health center staff does the billing, record keeping and entering all patient information into their system.
Time frame: 10/28/13-5/14/14	Time frame: 2/7/14 to 3/28/14
Schools: All 5 Bellevue Union District schools were completed; 4 elementary schools and 1 Charter Middle school.	Schools: 2 Petaluma City elementary schools.
Personnel: Schools require two adults to be present when alone with the child. The RDHAP is the provider and the second adult is a volunteer hygienist, Community Health Worker (CHW) intern, CAP staff person, or a provider-paid assistant. The program is staffed on the average of 1-2 times a week. There may be multiple providers on one day or a single provider for the day.	Personnel: For the assessment phase of the program, a dentist, one registered dental hygienist and one support staff member were used. For the sealant phase of the program a dentist and one assistant were used. The Health Center visited the schools one day a week.

Education:
Health education is an important part of our program. We have been fortunate to have the help of the DHS and their Santa Rosa Junior College Community Health Worker student interns to provide the classroom curriculum in both models. The interns alone have provided 125 hours of their time working for the program. Besides providing development of the presentation and classroom presentation of the lesson, they have assisted with preparation of the parent packets that go home to parents informing them of the program as well as serving as support staff for the providers.

The education component of the program provided a clear and succinct message for all schools and all grade levels visited. Evidence-based key messages for the targeted age groups were derived from the California Department of Public Health, the American Academy of Pediatrics and the American Dental Association. The curriculum is comprised of 4 content areas: Re-think Your Drink, How Cavities Are Made: An Experiment, Brushing Demonstration, and finally Re-think Your Snack.

Monica Sandoval de Luna, a CHW Intern, gets students to Re-think their Snack.

Re-think Your Drink
The presentation begins with a discussion and demonstration of sugary beverages under the model of Re-think Your Drink. Rethink Your Drink is an obesity prevention program of the Centers for Disease Control and Prevention. Students are asked to categorize drinks based off of a stoplight example. Red light beverages have a high amount of sugar in them, Yellow light a moderate amount, and Green light beverages have little to no sugar in them. The lights are a visual example of what you should do when you come into contact with these beverage choices. Red lights you stop and think before you drink, yellow light you can drink sometimes, and green lights are good all the time. Examples of red light drinks are then shown to the class with the corresponding amount of sugar they possess. Students learn to make better choices when it comes to beverages, and how to empower others to do the same.

How Cavities Are Made: An Experiment
The students then start an experiment with the presenter using antacid tablets and vinegar to demonstrate what happens to teeth when they bathe in acidic or sugary beverages and what happens when they bathe in water. We also include a tie-in with this experiment to show how a sealant can protect a tooth from sugary beverages by wrapping an antacid tablet in plastic wrap before bathing it in an acidic solution. The experiment will last for 15 minutes and be revisited and discussed at the end of the presentation. Students can see how an

acid works to break down enamel and create cavities. It is both a reminder to try not to drink sugary beverages, but also how well sealants work to protect teeth.

Brushing Demonstration

The presenter will then continue on with a discussion of tooth brushing and a demonstration. The children help to instruct the presenter on how to brush a large model of teeth while also learning how long, how often and the mechanics behind brushing. Flossing, fluorides in toothpaste and mouth wash are also discussed in this segment. Second and Third grade classes also are empowered to demonstrate their knowledge of brushing by physically showing the presenter on a stuffed-animal model how to brush. Any one-on-one modification and / or encouragement of the student are done at this time.

Re-think Your Snack

The presentation ends with a discussion and demonstration on sugary snacks verses healthy snacks. Students are shown pairs of snacks and asked to pick the healthiest one for their teeth. We engage in a discussion with the students about why a particular snack is healthy or not. The actual sugar content is revealed for each pair once the class picks a winner. We discuss healthy snack choices and encourage the students to shop smarter, request better options, and spread their knowledge to their family and communities.

Dental Assessment: A visual survey of the mouth which assesses the presence of untreated decay, treated decay, urgent dental problems and dental sealants. A dental assessment does not take the place of a regular dental exam in a dental office.

Fluoride Varnish Application: A fluoride treatment contained in a resinous base that is painted onto tooth surfaces to prevent decay.

Sealant Placement: The sealant is a thin plastic coating applied to the biting surfaces of molars. They may remain on the tooth for several years, providing lasting decay prevention.

Sealant placement diagnostic criteria: A tooth is selected for sealant placement if it is erupted and there is no existing decay, filling or previous sealant. The procedure also requires a cooperative child.

Referral protocol / Case management: A list of students with early or urgent decay is given to the school nurse for case management. The clinical definition of urgent describes one of the following clinical conditions:
Pain, swelling, abscess, multiple lesions in 3-4 quadrants. For the FQHC providers, referrals are made to the Health Center's dental clinic if children are eligible. Health insurance enrollment assistance is also offered. For several schools, referrals were made to the St. Joseph Dental Clinic's Mighty Mouth program where treatment occurs in the mobile clinic at each school.

Funding:

Funding for this pilot was included in a DHS contract with Community Action Partnership of Sonoma County. The scope of work for the $90,000 contract also included a 2014 Smile Survey to assess dental health of 1800 elementary school students, and for the completion of a final report for the Sonoma County Oral Health Task Force. Originally the Sealants Save Smiles pilot was to be implemented in two schools. The contract for the pilot program was for a period from 1/1/13-12/31/14.

The local RDHAP group received a $5000 grant from the Wrigley Foundation for clinical supplies, sealant material and small equipment such as curing lights necessary for sealant placement.

In-kind assistance came from the SRJC Community Health Worker program, DHS staff, community volunteers, school personnel and from CAP staff leveraged through other grants. The RDHAP's also provided dental units for this pilot program.

CHW Interns, Erica Beltran and Monica Sandoval de Luna, demonstrate proper tooth brushing techniques to children at McDowell Elementary School in Petaluma.

Interagency Communication

Interagency communication was accomplished through email, face-to-face visits and phone conversations. A more formal protocol will be developed in future planning to connect providers, school staff, and administrative staff. RDHAPs have suggested an encrypted online information site to share program data both logistical and clinical.

Pilot Timeline

Planning for the pilot began in April 2013 and continued into September 2013. Although the program was based on several nationally recognized existing models, we needed to customize it to our own community. We began by gathering community support. Presentations to school personnel explaining the need and how the pilot was to work were made. Discussions and agreements with dental providers helped us move forward. Memoranda Of Understanding (MOU), program design, program forms, data tracking forms and clinical procedures were developed. A provider training course was developed and presented to interested and participating providers so that all personnel were aware of procedures and policies. Educators also attended training courses in order to provide clear and age-appropriate messaging during presentations.

Implementation timeframe

From the time that the consent forms were sent home to students, until the final sealant was completed at schools, the program averaged 2 months at each school. Some variations to this average were due to testing at schools, scheduled school breaks, and other unforeseen school events.

IV. Program Results

A. Services

The services offered for each model were the same: education, dental screening, fluoride varnish, dental sealant, and referral for treatment if indicated. Figure 1 below illustrates the total services rendered during this pilot phase.
The Fee for Service model servicing the Bellevue Union School District educated 837 students, screened 396, applied fluoride varnish to 304, applied dental sealants to 258, and referred 72 students to further treatment. Out of the 72 students referred for further treatment, 13 needed urgent care and were categorized as such.
The FQHC model serviced both McDowell Elementary School and McKinley Elementary Schools. The results for the FQHC model are as follows: 183 students received education, 132 students received a dental screening and fluoride varnish, 68 students received dental sealants, 19 students were referred for further treatment, and 8 of those referred needed urgent care.
Of the students identified with treatment needs, 18% of those students in the FFS model were considered to have urgent needs which require immediate attention. The FQHC models demonstrated a 42% of students exhibiting urgent care needs and were referred as such.

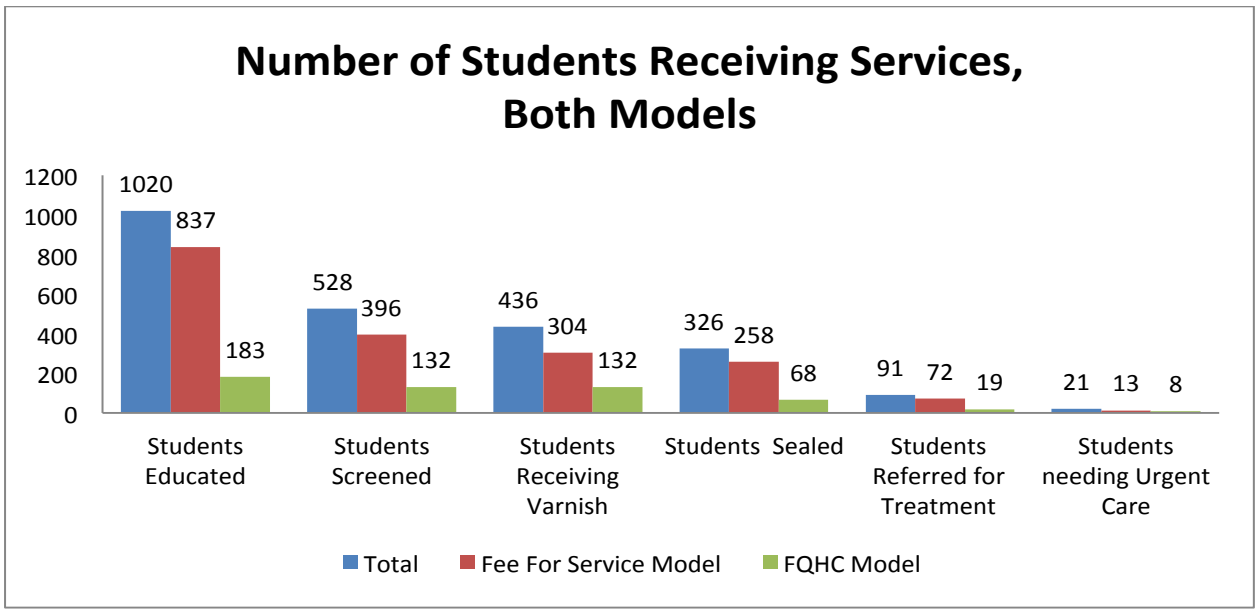


Figure 1

B. Sustainability

The sustainability of this program relies on many factors, some tangible and some intangible. The data in this section reflects the factors that we are able to quantify during the pilot program. Significant but not yet quantifiable long-term benefits include the prevention of pain and suffering to a child, an improvement in learning, a change in health behaviors, positive financial savings to both families and the community and decreased school absenteeism.
The sustainability result measures the value of the program within the school's community, and also creates an income stream for both FQHC's and entrepreneurial RDHAP's. Figure 2 below demonstrates the value of sealants both immediately in savings to the child, their family and the community at-large. The Fee for Service Model (FFS) averaged 3.8 sealants placed per child, while the FQHC model averaged 3.2 sealants per child. When savings are calculated based on the number of sealants placed per child, and filling replacement over a lifetime is taken into account, we can quantify a lifetime savings for that child due to sealant placement. The total savings for all students receiving sealants in each program are calculated at $203,195 for the FQHC model and a little more than $1.1 million for the FFS model (based on average fees for private dentists in Sonoma County.)

Figure 3 reflects the cost associated with each model as well as the net revenue collected by billing insurance. It should be noted that 45% of the FQHC input new equipment purchased for this program. Figure 3 shows the total cost for the FQHC model with the initial input cost of equipment amortized over a 5 year period. The FFS model has experienced a lag in billing information, and does not have the final net revenue results at the time of this publication. The current data shows a significant gap between costs for the program and net revenue, the problems encountered with billing and the FFS model have been, and will be discussed at length in this report.

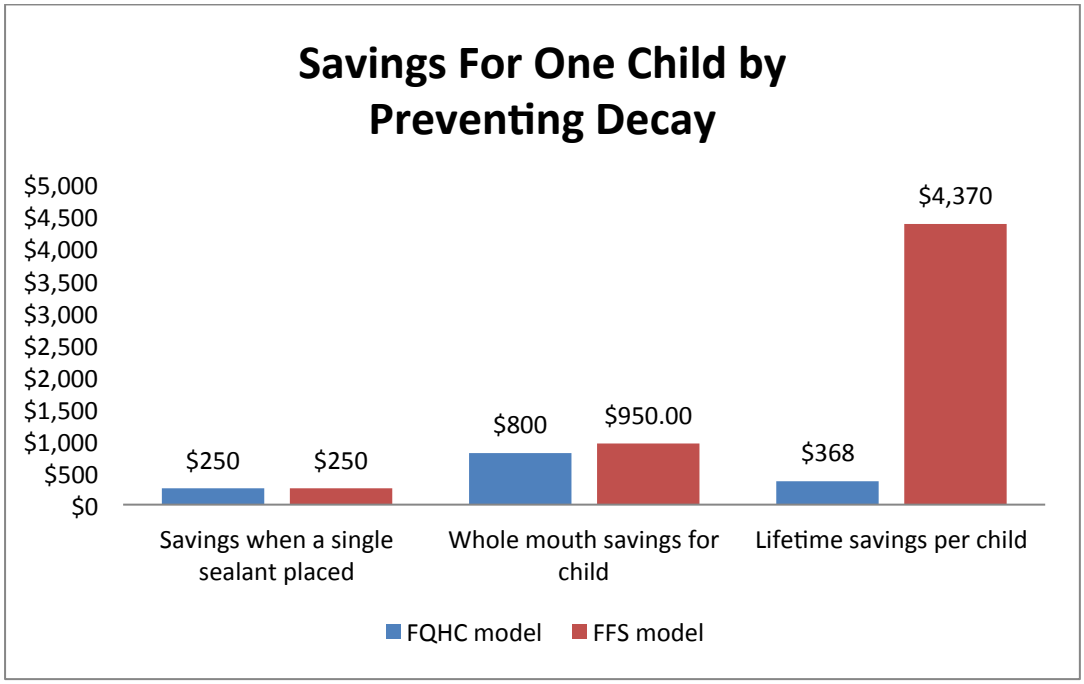


Figure 2

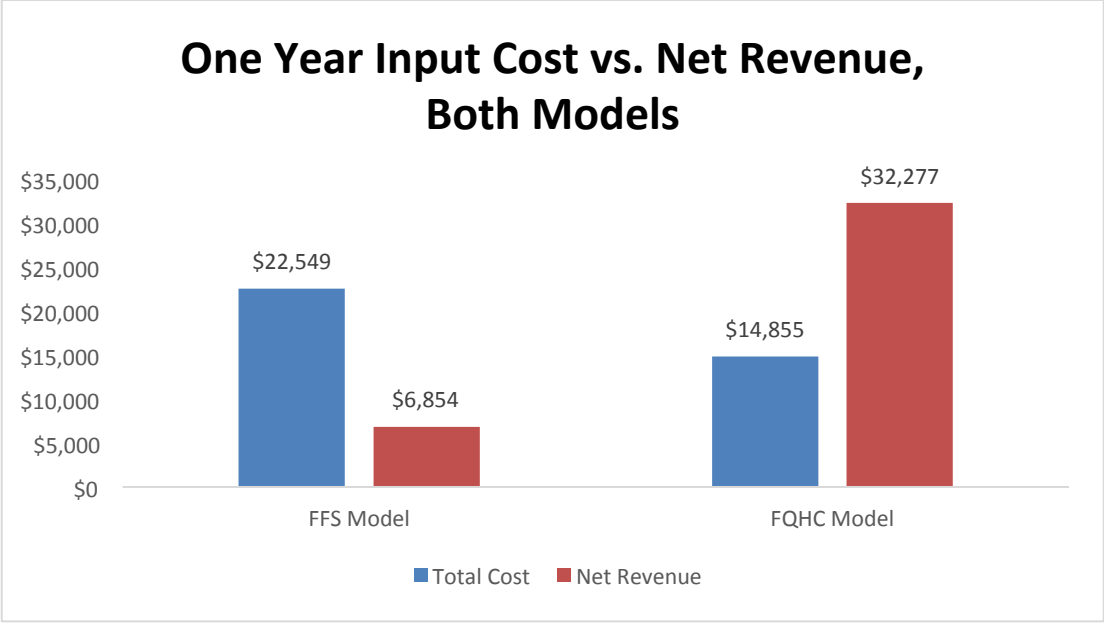


Figure3

C. Quality Assurance

Retention checks to ensure the sealants remained on the tooth were performed by Susan Cooper DDS and Kathy Kane, RDHAP. A random sample of 10%- 15% of students receiving sealants at each venue were chosen for review. All sealants that were lost were replaced for Bellevue and Kawana Schools. Time did not permit follow-up at Mountain View or Taylor Mountain. These students will have replacements next fall when the program resumes. The dental retention rate of the schools was averaged. Ideally there should be 90% retention. If the percentage of sealants retained falls below this level, a retraining program or personnel replacement will be required. Best practices according to Seal America endorse short-term and 1 year sealant retention checks. This program implemented the short-term checks at all schools, averaging 3 weeks between placement and checks, with a future plan to recheck retention rates at 1 year.

School	Sealant Retention Rate
Bellevue	94%
Kawana Academy	87%
Stony Point Academy	100%
Meadow View	83%
Taylor Mountain	63%
McDowell Elementary	100%
McKinley Elementary	100%
Average Retention Rate	89.6%

Since some schools experienced a retention rate under the expected rate, we will need to review the individual provider's rate and provide retraining as the program moves forward. Analysis of materials and the challenges of being in the non-clinical setting will also need to be analyzed.

D. Data Collection

The data collection tool used was the Center for Disease Control's SEALS: Sealant Efficiency Assessment for Locals and States. This data base allows us to generate summary reports both for an individual event and for the program as a whole. While this system is a fairly comprehensive tool, it is limited for future use as the CDC no longer provides any technical support for the program.

Based on the forms in the SEALS program, digital fillable forms for on-site screening and treatment records were developed for ease of use and portability. Providers are responsible for filling out treatment records for each child seen at the school on the program's laptop computer.

Submitted statistics is currently only 35% complete. Current statistics show that of the reported 1,085 sealants that were done, 434 claims were able to be billed. Of that number, only 338 of the patient claims were paid, for a total reimbursement to date of $6854.40. Total hours spent for this time is 276.5 hours for a total of $25 per hour reimbursement rate. Future viability of the program and provider involvement may be compromised by such low reimbursement rates, and steps must be taken to gather complete billing information in order to raise reimbursement levels.

V. DISCUSSION & RECOMMENDATIONS

Data Results:

The data collected during the pilot program is a view into the health and inequities of the participating schools at a certain point in time. One compelling group of data that was collected demonstrates the level of untreated decay that is prevalent as well as the overall caries experience of a school (Figure 4.) When we take into account all of the children in each school we see that Stony Point experienced the lowest caries experience with 57%, while Kawana Academy had a 72% caries experience. The caries experience tells us the percentage of students with the presence of either untreated or treated (restored or filled) tooth decay.

We also gathered information about the impact of untreated decay in our participating schools. As you can see in the figure below Bellevue Elementary experienced the highest rate of untreated decay at 30%. Bellevue had 20 students who needed further treatment for decay with 5 of those students needing urgent treatment. Students in Stony Point Academy and Taylor Mountain Elementary Schools were referred for treatment, but out of those students none needed urgent treatment. Students who needed further treatment were serviced by Mighty Mouth's mobile dental van at Bellevue Elementary School only. Students from all other schools had treatment referral forms sent home with the student and the District Nurse counseled parents on when and where to take their child for treatment. The nurse also contacted parents in order to follow up to make sure that the urgent students received treatment.

McKinley Elementary and McDowell Elementary were the two schools using the FQHC as the provider. When combined, 19 students in McKinley and McDowell needed treatment, of whom 8 required urgent care, with 14% experiencing untreated decay. The FQHC did not gather data on caries experience. They did provide whether students were caries free or had caries present when the assessment occured. 86% of students were caries free and 14% of students had caries present during examinations. If these students were members of the Petaluma Health Center, staff attempted to coordinate further treatment.

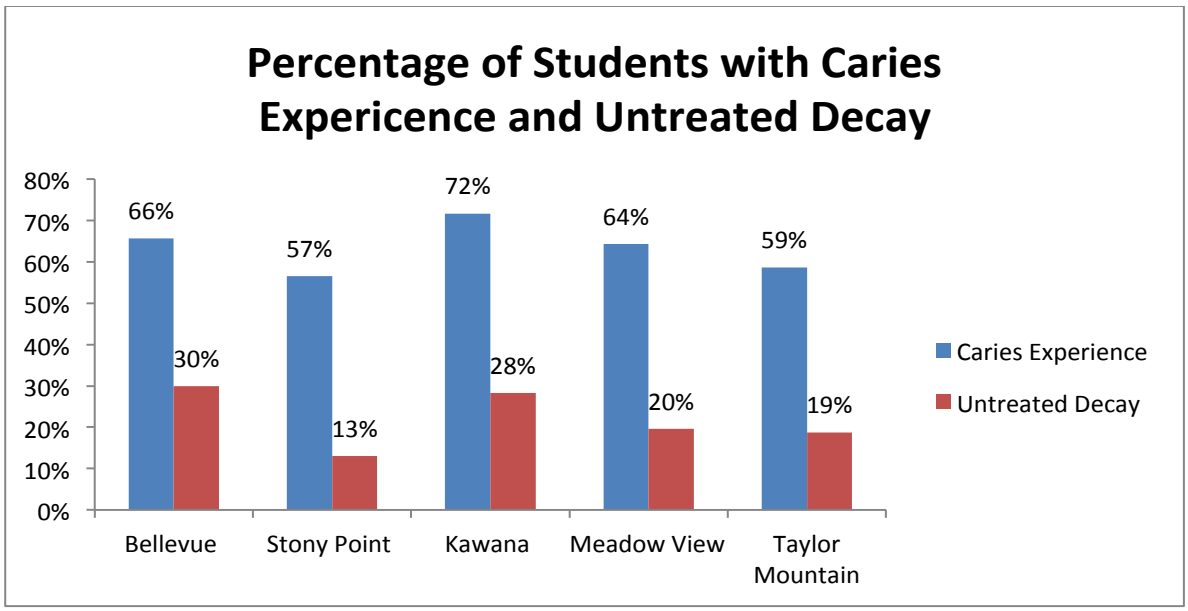
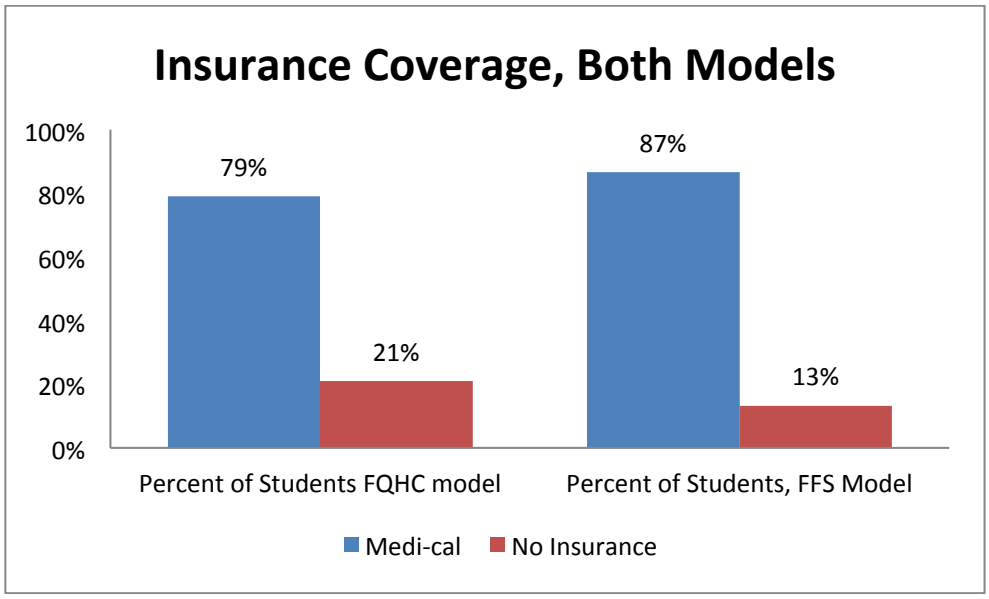


Figure 4

This pilot captured the insurance coverage of students and revealed the importance of the program. Eighty-seven percent of the students who received sealants during the FFS model had insurance through Medi-cal, while 94% of students from the FQHC model had Medi-cal as their insurance coverage. The insurance coverage of these students can demonstrate why these children have not received treatment for decay. There are very few dental homes for children with Medi-cal and long wait times can exacerbate getting treatment completed. The student's insurance coverage also shows that the cost to treat decay is passed onto the public because they have a government funded policy. A school-based dental health program can treat and refer these students at the time of service and have a stable source of revenue for providers due to high Medi-cal use. This will create a savings not only to the family's time and money, but it will be passed on to members of our community and hopefully paid forward with better learning in these student's futures.



Treating the uninsured

Fee for Service: The RDHAP provider will be treating the uninsured for free. The success of this model is for the provider to be adequately compensated, while providing some uncompensated care for the uninsured. Both a lack of dental insurance and, for those with insurance, lack of access to billing information, provide significant challenges to the success of the fee for service model. Children covered by Kaiser well-child plans are assigned to a provider, precluding the RDHAP from billing for the school-based services. Two strategies to remedy this are to increase the number of children returning consents and ensuring that all billing information is complete.

FQHC: In order to serve all children whose parents return consent, the health center will need to agree to extend care to those who are not members of the health center; including the uninsured or the Kaiser insured. Such a decision may need to be made at the level of the individual health center or at the Redwood Community Health Centers regional consortium. Working with a health insurance navigator will minimize this number.

Workforce availability

Fee for Service Model:

There are only a limited number of RDHAPs in the bay area. When planning for the expansion of the school-based dental program, one of the challenges is the year-long training and licensing process for Registered Dental Hygienists to advance to RDHAP. While several newly licensed RDHAPs reside in Sonoma County, after licensing, the RDHAP may need to wait another 3-6 months for Denti-cal provider approval. The RDHAP may also choose to work for a Health Center, rather than being an independent business person. On the other hand, a licensed dentist (DDS) may be interested in the school-based program, offering another option for workforce growth. Marketing the program to fee for service providers will be an important part of the expansion plan.

FQHC:

In the FQHC model, health center personnel (DDS, Dental Assistants or RDHAP) would be sent to schools. New personnel dedicated to this program may be hired or existing personnel trained to deliver services.

CHW Interns: This program experienced a wonderful collaboration between Community Health Worker (CHW) Interns from the Santa Rosa Junior College (SRJC), CAP, and the Department of Health Services (DHS). These CHW Interns were fulfilling a class requirement of 120 hours gaining experience in a community health setting. The CHW interns that participated were an integral piece for success in both the education and assisting portion of the program.
During the fall semester 4 CHW Interns gained experience as in-class educators. Spring semester had 3 CHW interns working as educators and 3 CHW interns working as assistants to the RDHAPs. The interns worked an average of 8.6 hours per week with a total number of hours throughout the entirety of the program of 223.75 hours.
Prior to beginning the education presentations, the CHW interns underwent training on dental health, public speaking and group facilitation strategies, as well as age appropriate messaging for health information. Trainings during the spring semester occurred biweekly and covered topics such as cultural diversity, sensitivity training, qualifying health information, and teaching techniques for specific age groups. All training sessions were supported and facilitated by DHS. While the CHW interns gained experience, the program coordinators were able to effectively schedule out assessments and sealant days because of the extensive group of volunteers on hand. The SRJC Community Health Worker program is ongoing and will have a new class starting in the fall with need for more internship and mentoring hours. DHS will continue to foster this relationship and provide the education and experience desired by these interns.

RDHAP Program Training

A full day of training was held for the RDHAPs who participated in the program. Material covered areas such as clinical technique, case selection criteria, infection control, billing assistance, required equipment and supplies. The training was well received and helpful since it established consistent practices. For future trainings, we would like to add hands-on clinical sections with providers using their equipment on patients to learn clinical technique and share knowledge of what works well in their own hands. Ergonomics will need to be reviewed.
Since dental providers are reporters of suspected child abuse, this needs to be added to the training. School procedures such as using the adult bathroom only, individual school lock-down and evacuation procedures need to be covered as well.

Insurance reimbursement for assessments for fee for service model

Many of the RDHAPs were not getting reimbursed the $7.20 fee for fluoride varnish on the assessment days for the reasons discussed above, making the day essentially one of voluntary service. Timely tracking and resubmission of billing will need to be implemented to decrease uncompensated care if the fee for service model is to succeed. If Denti-cal had been billed previously somewhere else within the last 6 months, the claim will be denied. If eligibility has lapsed the claim will be denied. Some possible options include CAP personnel stepping in to provide the assessments without relying on billing for compensation, while the RDHAPs provide billable sealant placement. Collaboration with St. Joseph's Mighty Mouth program for assessment and varnish application is also a possibility. For best results, RDHAP's need to obtain a dental software program and learn the administrative side of dental care delivery. Using a dental data mangement program increases billing efficiency and accuracy but is costly and time consuming to learn.

Referral base limitations

Referral for urgent or emergent treatment needs is a prerequisite for reversing the dental crisis among county children. Unless urgent problems are addressed, children will continue to suffer and their ability to learn decreases. When emergent problems are not handled in a timely manner, they become urgent.
Referral for treatment begins by checking the child's insurance. If the child is uninsured, enrollment assistance is offered. Even with the expansion of new dental services through FQHC's in Sonoma County, the number of pediatric patients far exceeds capacity and there are long wait times. For children without dental health insurance, space is severely limited. While we plan to work closely with the Mighty Mouth mobile dental health program from St. Joseph to see these patients, there will remain a gap in the dental health system. Working with the clinics to have a referral protocol for school nurses will help identify treatment needs early in the disease course. This will help the child avoid the more costly, painful urgent care that develops without intervention.

This child is receiving sealants from RDHAP Ingri Sparling and her assistant.

School Personnel Involvement/Expectations

During the pilot, both service models depended on close coordination with the school staff. Fortunately, in the Bellevue Union School District the program was promoted by the school nurse who is a strong advocate for oral health. This school nurse introduced program staff to the necessary school personnel and advocated for the program with the Principals. It was a lot of extra work for her. We may not be as fortunate in other districts or schools. The barrier here is that we had not defined the roles and responsibilities of the school staff. Better definition of expectations from the schools is necessary. Now that the pilot is done for the school year and we have learned more on how to navigate through the schools, the burden on the school nurse will lessen. We have heard from school officials that interest in this program is growing and we can expect that the school and district will understand and accept the need for an increase in their role as site and parent coordinators. An important consideration is whether monetary assistance can be successfully negotiated. These issues will need to be clarified and included in their MOU.

Due to an incident this year at one of the schools, we realized that sealant program staff needs to be aware of the school's policy for lockdown procedures. School staff will need to understand that dental providers are reporters of suspected child abuse and we will need a protocol for reporting any suspicions to appropriate school personnel. The FQHC service model relied on the school Resource Center staff and the office staff. They also had great support from both Principals. Their scheduling problems were complicated by an unscheduled field trip on the day they were scheduled to be in a classroom. Better communication protocols need to be developed to avoid these issues in the future.

Lessons learned

Some of our lessons learned have been discussed in other parts of this report. Below are some additional items:

- Each school and district is unique in the way that they conduct business and the resources that they have available to them.
- We have found all schools to be supportive of this program and school staff very helpful and professional.
- Other school districts wish to participate in the expansion. We will need to draw up specific criteria to determine which schools are our priorities for program expansion.
- We need improved communication systems among all parties involved.
- Job descriptions for all participants are needed to define roles and responsibilities, including coordination..
- We need an effective method of following up on incomplete billing information.
- All program information and parent forms need to be simple and easy to read.
- Parents are more likely to respond for a request for further insurance information when staff calls from a school telephone number.
- When we specify that the services are free, we need to make sure that parents understand that we will be billing the student's insurance.
- The physical location for services needs to have adequate space and access to a sink

Expansion Planning

Besides what has previously been discussed, consideration of the following should be included in expansion planning:

- Research funding opportunities- foundations, school districts, Title XIX and MAA funding
- Explore supplemental funding for reimbursement to RDHAP's for non-reimbursable kids.
- Establish treatment referral pathways for insured and uninsured kids.
- Assist school personnel with case management to insure referral and treatment compliance and overcome obstacles to treatment.
- Develop program roll out timeline for the next 4-5 years.
- Investigate program provider participation RFP/Q.
- Establish MOU with schools and DHS/CAP to share insurance information.
- Market the program to providers- RDHAPs, DDS, FQHC.
- Collaborate with St. Joseph's Mighty Mouth mobile dental clinic program for treatment follow-up.
- Add other optional preventive services for students.
- Develop new software with Oral Health Solutions to be used on-site and for sharing to referral providers.
- Cultivate strong relationships with new clinics (Santa Rosa Community Health Center's™ Dental Clinic and Sonoma Valley's Dental Clinic) in order to connect students with a dental home.
- Create an open line of communication between providers and programs to eliminate the duplication of services and maximize existing resources.
- Rename the program to reflect the true wok of a multi-faceted dental disease prevention program that supports 4 of the 5 pillars of dental health.

"McDowell and McKinley were a success and it takes all sides to make it work. I would love to go back there next year."
Ramona English DMD
Dental Director
Petaluma Health Center Dental Clinic

The Collective Impact

This program is also innovative in that it brings together partners, providers, governmental organizations, and volunteers. The pathways that we have created connect a sea of dental health champions committed to making a direct impact on school children in our community with other entities who hold similar interests. The network of providers and partners shared information on processes, pertinent contacts, and schedules in order to make the project take initial flight. With the support of the Sonoma County Department of Health Services the program took shape and gained access to a capable group of volunteers. The CHW interns not only gained hands-on educational and health specific training, but they also provided a clear link for future interns from the SRJC to seek out and make a difference in the community while also gaining personal experience. As the expansion of the program rolls out to all target schools, the network of partners will be strengthened and widened for greater impact on children's health.

VI. School Smiles Program: A Promising Practice

The School Based Dental Health program provides our county with an unprecedented opportunity to improve health and contribute to academic achievements of our residents.

- Improve learning, because healthy children are healthy learners. Preventing decay with fluoride varnish, dental sealants and dental health education our children will be present and attentive.
- Increase in Oral Health literacy for school personnel, students and parents
- Integrate the Healthy Teeth, Healthy Life dental education campaign into school parent meetings and school newsletters.
- Ensure dental treatment referrals and follow-up by providing resources for school personnel.

RDHAPs Renee Turner and Deborah DeVries placing sealants at Kawana Academy.

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No single organization, however innovative or powerful, could accomplish this alone. Instead, their ambitious mission became to coordinate improvements at every stage of a young person's life, from "cradle to career."
-*Stanford Social Innovation Review on Collective Impact*

Collective Impact is the commitment of a group of actors from different sectors to a common agenda for solving a specific social problem, using a structured form of collaboration.
We express our deepest gratitude to the following partners for working together toward our common goal!

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