



# Dental Public Health Activity Descriptive Report

**Practice Number:** 48006  
**Submitted By:** Tennessee Department of Health, Oral Health Services  
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## SECTION I: PRACTICE OVERVIEW

**Name of the Dental Public Health Activity:** Tennessee School-Based Dental Prevention Program

**Public Health Functions:**

"X"	Assessment
	1. Assess oral health status and implement an oral health surveillance system.
	2. Analyze determinants of oral health and respond to health hazards in the community
x	3. Assess public perceptions about oral health issues and educate/empower them to achieve and maintain optimal oral health
Policy Development	
x	4. Mobilize community partners to leverage resources and advocate for/act on oral health issues
x	5. Develop and implement policies and systematic plans that support state and community oral health efforts
Assurance	
	6. Review, educate about and enforce laws and regulations that promote oral health and ensure safe oral health practices
x	7. Reduce barriers to care and assure utilization of personal and population-based oral health services
	8. Assure an adequate and competent public and private oral health workforce
	9. Evaluate effectiveness, accessibility and quality of personal and population-based oral health promotion activities and oral health services
	10. Conduct and review research for new insights and innovative solutions to oral health problems

**Healthy People 2020 Objectives:**

"X"	Healthy People 2020 Oral Health Objectives	
x	OH-1	Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth
x	OH-2	Reduce the proportion of children and adolescents with untreated dental decay
	OH-3	Reduce the proportion of adults with untreated dental decay
	OH-4	Reduce the proportion of adults who have ever had a permanent tooth extracted because of dental caries or periodontal disease
	OH-5	Reduce the proportion of adults aged 45 to 74 years with moderate or severe periodontitis
	OH-6	Increase the proportion of oral and pharyngeal cancers detected at the earliest stage
x	OH-7	Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
x	OH-8	Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year

	OH-9	Increase the proportion of school-based health centers with an oral health component
	OH-10	Increase the proportion of local health departments and Federally Qualified Health Centers (FQHCs) that have an oral health component
	OH-11	Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers each year
x	OH-12	Increase the proportion of children and adolescents who have received dental sealants on their molar teeth
X	OH-13	Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water
	OH-14	Increase the proportion of adults who receive preventive interventions in dental offices
	OH-15	Increase the number of States and the District of Columbia that have a system for recording and referring infants and children with cleft lips and cleft palates to craniofacial anomaly rehabilitative teams
	OH-16	Increase the number of States and the District of Columbia that have an oral and craniofacial health surveillance system
	OH-17	Increase health agencies that have a dental public health program directed by a dental professional with public health training
<b>"X"</b>	<b>Other national or state <a href="#">Healthy People 2020 Objectives</a>: (list objective number and topic)</b>	
X	Principle 2: Access to Care - Goal 2d	State Health Plan: People in Tennessee are able to obtain appropriate quality health care services to meet their needs.
<b>State:</b> TN	<b>Key Words for Searches:</b> Sealants, access to care, school-based oral health, oral health, prevention, school-based dental sealants, oral health education, fluoride varnish, Medicaid	
<b>Abstract:</b>		
<p>Tennessee's School Based Dental Prevention Program (SBDPP) is a statewide comprehensive preventive program that has been operational in its current design for 15 years. It is contracted by our State's TennCare program and provides services to eligible children for free. TennCare is the state of Tennessee's Medicaid program that provides health care for approximately 1.3 million Tennesseans and operates with an annual budget of approximately \$10 billion. TennCare members are primarily low-income pregnant women, children and individuals who are elderly or have a disability. TennCare covers approximately 20 percent of the state's population, 50 percent of the state's births, and 50 percent of the state's children.</p> <p>Staffing consists of 77 licensed dentists and registered dental hygienists who are providing services. The SBDPP is supported by an additional 14 clerical staff.</p> <p>The program aims to reach high-risk children from low income families who have reduced access to care. Children in grades K – 8<sup>th</sup> in schools with 50% of the student population on free and reduced lunch programs are eligible to receive the SBDPP services regardless of economic status.</p> <p>Details for program implementation in each school and region vary. Program's core include component areas:</p> <ul style="list-style-type: none"> <li>• Oral Health Education</li> <li>• Dental Hygienist General Screening – <b>Definition:</b> oral screening performed by a registered dental hygienist to evaluate dental needs – sealant placement and dental referral need (s)</li> <li>• Dentist oral evaluation – <b>Definition:</b> oral evaluation performed by a licensed dentist to chart existing conditions and treatment need(s)</li> <li>• Sealant Application</li> <li>• Fluoride Varnish</li> <li>• Referral for Treatment</li> <li>• TennCare Outreach (Tennessee's Medicaid program)</li> </ul> <p>Production for Fiscal Year 2014/2015:</p> <ul style="list-style-type: none"> <li>• 118,590 dental screenings</li> <li>• 12,265 dental evaluations</li> <li>• 179,107 oral health education</li> <li>• 224,665 sealants placed on 41,213 children in 357 schools</li> <li>• 1,432 high priority children identified with unmet dental needs (a high priority child is any</li> </ul>		

- child with immediate dental needs such as abscess and rampant decay)
- 633 direct contacts made by professional outreach workers with the Department of Health.

The Fiscal Year 2013-2014 SBDPP was funded by TennCare in the amount of \$6,215,019.00. Coordinated School Health component areas are aligned with the Centers for Disease Control and Prevention's (CDC) Whole School, Whole Community, Whole Child (WSCC) model. Partnership with Coordinated School Health (CSH) in our target schools is a promising new partnership that can aid in maintaining and ensuring our presence in schools.

The need to have staff in isolated areas share programs, ideas, techniques has been recognized. Regional meetings have been put in place to facilitate an exchange of best practices. The opportunity to network face-to-face is invaluable. As a result of better communication, programs are being shared from region-to-region.

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## **SECTION II: PRACTICE DESCRIPTION**

### **History of the Practice:**

The origin of the Tennessee Department of Health's (TDH) current School-Based Dental Prevention Program (SBDPP) was shaped by a number of state and national historical events. These historical events ultimately contributed to the establishment Tennessee's current public health school-based dental disease prevention program, implemented in 2001 and operational today in all 95 Tennessee counties. The key factors that led to the establishment of the SBDPP are as follows:

- Community water fluoridation which began in the city of Milan, Tennessee in 1951;
- Oral health surveys conducted at the national and state levels which revealed a change in the pattern of decay from smooth surfaces to pit and fissure surfaces of permanent teeth due to decades of exposure to fluorides both systemic (water fluoridation) and topical (primarily toothpastes); Findings from these surveys also showed that 90% of tooth decay in children is found on pit and fissure surfaces of permanent molar teeth;
- Advances in adhesive restorative techniques beginning with Dr. Michael Buonocore's research that led to pit and fissure sealant development and utilization;
- Clinical trials required for approval of second and third generation dental sealants conducted in the South Central Public Health Region of Tennessee by Dr. James R. Hardison of the Oral Health Services Section;
- Transition of State's Medicaid program to Medicaid Managed Care in 1994;
- The first-ever Surgeons General report on oral health in 2000, which raised awareness of the "silent epidemic" of oral diseases and called for a national effort to improve oral health for all Americans;
- Promotion of sealant application on pit and fissure surfaces of permanent molar teeth in children (*Healthy People 2010 and 2020 objectives for the nation*).

Since its inception, over 3.6 million sealants have been placed on children's teeth through this program.

## **Justification of the Practice:**

Cross-sectional dental surveys of school children conducted in Tennessee beginning with baseline pre-fluoridation surveys completed in 1954 and subsequent periodic oral health surveys as recent as 2008, demonstrate there has been a continuous and marked decline in dental decay in children. Comparisons in Tennessee with pre-fluoridation surveys conducted in the early 1950s showed that by 1988 there was a 75% reduction in decay experience in permanent teeth of children as a result of water fluoridation and greater use of topical fluoride products like fluoride toothpastes. The decline in dental decay observed in Tennessee is similar to findings from national oral health surveys. Program administrators are working with a program designer to bridge the gap in data with the development of a new program for data collection proposes. A detailed description of the new software program, expected to be launched summer of 2016, may be found further in this document under the heading, "Addressing Change".

Evidence at national and state levels which indicated that despite sealant effectiveness and promotion, a relatively low percentage of children have had sealants applied to their permanent molar teeth by dentists.

Findings from an oral health survey conducted by the TDH and published in Journal of the American Dental Association (JADA) in February 2001 entitled, "Community socioeconomic status and children's dental Health", corroborated findings from the Surgeon General's report and other studies at the time which showed disparities in the oral health of children. The TDH study revealed that socioeconomic status (SES) is an important predictor of dental health. Children from low SES communities had significantly worse dental health than those from high SES communities. They experienced more tooth decay, greater treatment needs, more trauma to the oral cavity and fewer preventive services such as dental sealants.

In 2008 the Tennessee Department of Health conducted a survey of children ages 5-11 years of age. Children in schools from each of the three grand divisions of the state, East, Middle and West Tennessee, participated in the survey. A copy of the survey results may be requested by contacting Oral Health Services Director (see contact information included with this report).

### Key findings:

- By 5 years of age, 1 in 3 children has dental caries (decay) experience in one or more primary teeth; and by 7 years of age, 1 in 2 children has dental caries (decay) experience in one or more primary teeth.
- By 8 years of age, 1 in 9 children has dental caries (decay) experience in one or more permanent teeth; and by 11 years of age, 1 in 4 children has dental caries (decay) experience in one or more permanent teeth.
- By 7 years of age, 1 in 2 children has dental caries (decay) experience in one or more primary and/or permanent teeth.
- On average, children ages 5-9 years who have dental caries experience in their primary teeth have more than 13 primary tooth surfaces affected by tooth decay.
- On average, children ages 5-11 years who have dental caries (decay) experience in their permanent teeth have more than 3 permanent tooth surfaces affected by tooth decay.
- Children as young as 9 years of age have permanent teeth missing due to dental caries.
- 1 in 6 children ages 5-11 years has unmet dental treatment needs, and 20% of children with unmet needs have dental problems that call for urgent dental care.
- 1 in 34 children ages 5-11 years needs to have one or more primary and/or permanent teeth extracted.
- By 10 years of age, 1 in 2 children have dental sealants on one or more permanent teeth.
- 3 in 4 children ages 5-11 years need dental sealants on one or more permanent teeth.
- By 10 years of age, 1 in 10 children has suffered a dental injury to at least one permanent incisor.

It was determined that a focus on prevention by use of a multi-pronged program was needed. It was decided that a program that included protective sealants, proven to reduce dental decay, combined with early recognition of disease and prompt referral for treatment through screening populations of children at high risk for oral disease was needed. This led to the proposal to expand the scope and size of existing sealant programs into all 95 counties in Tennessee in 2001.

In 1972, Tennessee became the first state to bring portable dental equipment into schools to provide pit-and-fissure sealants to children. Dr. Buonocore visited Tennessee to see the sealant projects being conducted by Dr. James R. Hardison for TDH in middle Tennessee. Following this early work, Tennessee continued to expand its public health sealant program.

It is important to note that key events in the history of Tennessee led to the initiation of this program and are included as part of the program timeline to show supporting historical events critical to the inception of the program. In the late 1970s, the Tennessee Public Health Association sponsored a Centennial Celebration for 100 years of public health in the state. To summarize, the major contributing factors leading up to the statewide program implemented in 2001 include:

- Community water fluoridation
- Dr. Buonocore’s research in plastics and adhesives
- Tennessee’s work in area schools to provide some level of dental information/service
- Efforts by public and private dental professionals to work in Tennessee schools

**Implementation Timeline and Milestones:**

The state-wide program began in July 2001.

Milestones that have occurred since the inception of the program in 2001, specific to this program are:

- Increasing the number of children who receive preventive oral health service every 6 months
- Reducing the decay rates in school-aged children.
  - The program objectives have proven to be effective in increasing the number of children receiving preventive services. In 2013 the Dental Practice Act was amended to allow a registered dental hygienist to perform a General Screening. This amendment to the Dental Practice Act enhanced the program’s flexibility by allowing a screening to identify a child’s need for a preventive dental services offered by the school based program as well as referral for dental need(s). This has provided a significant opportunity for our program staff to increase the number of children seen in the programs across the state providing preventive dental services and providing referrals for dental services beyond the scope of the school based program. Previously, all children receiving any preventive services offered by the program required an exam by the licensed dentist. While we made great strides in seeing children prior to this Dental Practice amendment, program outcomes have increased.
- Flexibility of program development to maximize program efficiency and effectiveness.
  - This flexibility allows programs to position the workforce to best serve the target population in a school year. The programs are monitored through a biannual evaluation to ensure quality. The Dental Directors perform these evaluations in both the rural and metropolitan areas. The metropolitan programs will have one annual audit performed by Oral Health Services central office to meet contract requirements. This biannual evaluation includes review of the following:
    - Current professional license maintained
    - Current Cardiopulmonary Resuscitation (CPR) certification-annually
    - Occupational Safety and health Administration (OSHA) annual training completed-annually
    - Exposure Control review annually
    - Program Audit
    - Database Audit
    - Infection Control Audit
    - Records Review Audit

**Inputs, Activities, Outputs and Outcomes of the Practice:**

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	OUTCOMES
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Funding source – TennCare - An expenditure of just under \$7,000,000 provided more than 76,829 at risk children with dental screenings, more than 4,899 dental exams, more than 186,168 with oral health education, and 49,125 students with more than 298,345 sealants in 386 schools statewide in the Fiscal Year 2014 - 2015.

Staff – Tennessee’s School Based Dental Prevention Program (SBDPP) is a statewide comprehensive preventive program that has been operational for 15 years. The program is designed to allow flexibility to administer the program in each school district as needed. The SBDPP operates with a staff from 80 to 90 full and part-time dental health care professionals. The staff consists of dental directors, dentist, dental hygienist, dental assistants, and administrative support.

This program covers Tennessee’s 95 counties, which are divided into 13 regions (six metropolitan areas and seven rural areas) with local coordination in each region. The six metropolitan regions serve one individual county each while the seven rural regions cover multiple counties. Each region is overseen by a full time public health dentist serving as the regional dental director.

Collaboration with the Coordinated School Health Staff may take place prior to the school-based programs, during and after the programs. The school-based staff may work with the Coordinated School Health Staff to make connections within the school system and make the process of getting into the schools a much smoother process. They may aid and assist with the school’s schedule while we provide services within the school and they may provide a copy of the completed data from the program to the administrative staff.

Collaborations with the local school nurses, the school administration, and the Tennessee Department of Health’s (TDH) Community Outreach Program all work to facilitate our mutual target goals. At the completion of each program a referral list is compiled and presented to the school nurse and/or the school’s administrative staff. The school-based staff first sends out a letter to all of the children who have urgent needs. The referral list is then given to the TDH Community Outreach Program staff, which is located in 89 rural counties in Tennessee. The six metropolitan areas of Tennessee contract with the TDH and may collectively employ up to an additional 80 Community Outreach staff. The outreach staff will make up to three attempts to reach the parent or guardian of the child on the referral list in need of dental services. Many of the Community Outreach staff may go above and beyond to reach the parents by sending written communication and/or physically travel to the residence.

Strategic partners include:

- Local and county school systems
- Tennessee Department of Education
- Coordinated School Health program
- Early Periodic, Screening, Diagnosis and Treatment (EPSDT) program
- Other health department programs that support children’s oral health such as:
  - Supplemental Nutrition Program for Women, Infants, and Children
  - Primary Prevention Impact Services Call Center Outreach program

INPUTS	<b>PROGRAM ACTIVITIES</b>	OUTPUTS	OUTCOMES
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The School-Based Dental Prevention Program (SBDPP) is a year-round dental prevention program funded by TennCare and administered by the Tennessee Department of Health, Oral Health Services. Offered are preventive services to include, but not limited to, screenings, referrals for care, immediate need follow-ups, oral health education, oral evaluations, fluoride varnish, prophylaxis (teeth cleaned), and dental sealants to children in grades K-8 in the school setting. A screening is performed by a registered dental hygienist to identify teeth that would benefit from the placement of a dental sealant as well as to evaluate the child’s oral health status. An oral evaluation is performed by a licensed dentist and includes diagnosis of oral health status and dental needs. Children identified as having needs beyond the preventive services provided by the school-based program are referred to the TDH Dental Clinic in their county or region located within the TDH Health Departments.

Schools with 50% free and reduced lunch populations are targeted for these services but all children in these schools are eligible for the program. Each region receives a list from the Tennessee Department of Education that identifies the schools state-wide where 50% of the population (or more) are on the free and reduced lunch program. The region reviews the list and compiles their “target list” of schools and submits this list to the Dental Director of Oral Health Services.

If a program completes programs in each of the schools on the “target list”, they may consider other schools that are within 5% of meeting the 50% mark. These schools are considered an “exception”. Exceptions – A school considered an “exception” is any school that falls under (less than) 50% free and reduced. All schools on the 50% free and reduced lunch population must be completed first prior to a program being granted permission to take the program into a school not on the target list. Portable dental equipment is used to provide these services in the school setting. Each target school must receive all phases of the preventive program to be considered complete. At no time does the school based staff bill for any services they provide or will be associated with billing for services provided.

Working in the school setting requires a very close and comfortable working relationship with teachers, school nurses, and office staff. Effective communication is key to providing these services  
*Practice #48006 Tennessee School-Based Dental Prevention Program*

as well as follow-up of the “immediate need” cases. “Immediate need” is defined as a child who may be in pain, rampant decay, severe decay, and who needs to see a dentist within a short period of time.

**Oral Health Education** – All students in grades K-8 receive oral hygiene and preventive education prior to the application of sealants. This is the only aspect of the program that does not require consent from the parent/guardian. Explanation is provided to the students as to what sealants are, how they are applied, proper tooth-brushing, proper nutrition, etc. Usually during this education session, the permission for oral evaluation and sealant application form is handed out to the students and additional forms are left with the office staff. Consent forms have also been made available on the TDH [Oral Health Services Website](#). Dentists, dental hygienists, or dental assistants can provide the classroom oral health education. Many innovative programs have been implemented across the state.

**Oral Evaluation/General Screenings**- Parental/guardian consent is required for participation in the services aspect of this preventive program. An oral evaluation by a dentist or a general screening by a hygienist is completed on every child who returned a completed and signed consent form. Progress notes are required and include the date of services provided. Included in the progress notes are any findings; this constitutes a legal medical record. A “Report of Dental Inspection (PH-1688)” is completed and sent home with each student. Any student(s) receiving an “immediate need” rating is to receive follow-up in addition to the “Report of Dental Inspection (PH-1688).” This follow-up is mandatory and should consist of at least one follow-up letter of referral to the parents and up to three outreach attempts. The initial follow-up letter is provided by the SBDPP staff and subsequent outreach attempts are provided by the *Tennessee Department of Health’s Community Outreach Program*.

**Dental Screenings**- Provision of dental screenings for children not participating in the preventive aspect of this program is optional and only provided when completed consent forms have been returned.

**Fluoride Varnish Programs** When “fluoride varnish” programs are conducted, Form PH-0172 must be completed and kept as this procedure requires consent and progress note documentation. This program may be offered to schools that cannot accommodate our entire program due to space and/or scheduling constraints. The staff may offer this program to pre-K programs and to daycares, which house younger children who, by age, typically do not have teeth to seal but would benefit from the application of fluoride varnish. The fluoride varnish program can consist of the same components as the full program, except for the sealants. This would be coded as a community project with the required consent and record of fluoride varnish application. This is a medical record and is maintained according to RDA 150 guidelines.

**Sealant Application** – Sealants are applied after an oral evaluation by a dentist or a general screening by a hygienist working under remote supervision. An oral evaluation performed by the dentist is a clinical evaluation only; no radiographic (x-rays) exam is completed. Sealant application by a hygienist working under remote supervision follows TDH protocol. Sealant application after an oral evaluation by a dentist can be performed by a dental hygienist working under remote supervision.

**Referred for Treatment** - All students with a rating of “immediate need” or “treatment at an early date” on the “Report of Dental Inspection (PH-1688)” have unmet dental treatment needs and should be referred to private offices in the area or to a Tennessee Department of Health county public health operated dental clinic for care. It is important that the dental staff in the schools work closely with the nursing, office staff and TennCare Kids to insure a proper referral.

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	OUTCOMES
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The SBDPP has provided the following serves to at risk children in Tennessee since its inception in 2001:

- oral dental screenings - 1,711,564
- referred for additional dental treatment 422,862
- provided oral examinations - 687,673
- general screenings performed by hygienist -102,781
- provided sealants to 649,212 children
- placed sealants on 3,663,756 teeth
- provided education to 2,361,889 individuals
- provided TennCare Outreach for 1,649,861
- completed 4,678 school programs

The accomplishments of the program are vast, from preventing decay, to helping reduce a child's apprehension of sitting in a dental chair. Many of our children have had issues in the private practice setting, not cooperating, but with the relaxed atmosphere of our portable clinics, in the comfort of the child's school and with seeing his buddy complete the same procedure the child is eager to hop into the chair.

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	OUTCOMES
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The SBDPP has seen outcome of better oral health, positive impact on the community and more knowledgeable school staff come from our program. From our data we have tracked retention rates, which remained steady during the tracking period, last recorded in 2010.

Although Tennessee's SBDPP is a robust and accomplished program, the area of measured outcomes is not one of our strong points. The data base program that is currently utilized does not allow for tracking from year to year in a manageable fashion. The majority of the information is housed on paper and would need to be manually collected from that physical chart. Moving forward, the new program that is scheduled to roll out Fiscal Year 2017 will allow data collection.

While the program as a whole has not tracked decay-free rates, there has been one regional program that tracked decay-free rates. In 2001 this region tracked decay-free rates in their respective program region. Decay-free rates were tracked over the course of a year, the length of time it generally takes to cycle through the target schools. Once the regional program returned back to the school, the new data was collected and evaluated with the initial data collected. During that initial year, the metropolitan region measured the decay-free rate at 56%. Once the program returned to schools previously seen, and new decay rate data collected, it was noted that the program was in fact, having a positive impact on the children's oral health. It was over this time that the decay-free rate was increasing, reaching some of its highest levels at 82% - 83%. At the program's implementation, dental professionals were performing passive consent screenings (a screening that occurred if the child agreed to allow the dental professional to look in their mouth without permission from the parent). Since this time children only receive a screening if they have returned a signed consent form. Once this screening method was terminated, a slight decline was noted in the measurement of decay-free to 78%. The decay-free rate has plateaued at 78%.

**Budgetary Information:**

1. What is the annual budget for this activity?

The SBDPP program is funded by the Department of Finance and Administration Division of Health Care Finance and Administration Bureau of TennCare with a budget just shy of \$7,000,000. This has been the main funding source for the program since inception in 2001. The funding is divided between the 7 rural regions and the 6 metropolitan areas in Tennessee. From 2001 to 2016, funding distribution was based upon the county or the regional target populations; the larger the target population the larger the funding amount. Beginning Fiscal Year 2017, the funding distribution will be based upon the prior year's production; those regions that have made the most of their resources and provided a greater amount of services will be awarded additional funding to provide the program to a larger population. Monthly reports are submitted by each of the 13 rural and metropolitan program areas to the Oral Health Services central office. Among other criteria, these reports track number of children seen, number of sealants placed, and number of dental hygienists in the specific program area. The reports are then compiled quarterly to provide an average number of children seen per dental hygienist and average number of teeth sealed per dental hygienist.

2. What are the costs associated with the activity? (Including staffing, materials, equipment, etc.)

The annual funding is divided among the 7 Rural Regions and the 6 Metropolitan Regions. The funding covers all aspects for the program including:

- Staffing
- Equipment – equipment is defined as any item that is needed to carry out the function of the program. Examples: Patient chair, evacuation system, ultra-sonic cleaner, autoclave, loupes, lights (for loupes) or overhead, etc.
- Program materials for providing services – disposable inventory; instruments (some programs are using disposable instruments)
- Educational materials



- Program materials – forms used such as Consent/Treatment record, HIPAA notice, Dental Report, Information about Sealants

3. How is the activity funded?

The program is contracted with TennCare (Medicaid) funds. A number of the metropolitan areas provide supplemental funding for their programs from county funds.

4. What is the plan for sustainability?

With the major success of the program and the increased preventive dental coverage for the state the SBDPP has shown to be a valuable resource for the children of Tennessee. This program is in its second generation, we have parents coming to us telling us how we placed sealants on their teeth and they want to make sure their children receive the same benefit. With the program's magnitude and scope we intend to remain a valuable resource for Tennessee and sustain or increase our current funding.

### **Lessons Learned and/or Plans for Addressing Challenges:**

Lesson Learned – Dental hygienists in the schools were being limited by the dentist's need to perform oral evaluations prior to dental sealant placement. An oral evaluation is performed by the dentist and includes a clinical evaluation of the status of the child's oral health diagnosis and involves no radiographic (x-rays) evaluation. State Health Commissioner Dr. John Dreyzehner worked with the State Dental Director to amend the State practice act for dental hygienists. This allowed for another line of access to care by allowing the dental hygienist to utilize their education and provide dental sealants prior to a dental evaluation. As a result, production in the school is better achieved without the time restraints of limited dental personnel.

Lesson Learned – Parents did not understand the implications of passive consent in the consent form. **Definition:** Passive consent – no parent/guardian consent needed to perform a visual inspection of the child's oral health using a flashlight and tongue depressor. As a result, some parents were not pleased with screening being performed. This caused unnecessary stress on the SBDPP staff and school officials. In light of this, the passive consent was eliminated and only children who have a signed consent form receive a dental screening.

Lesson Learned – With the growing number of groups targeting children in the school setting, we recognize the importance of establishing and fostering the relationships with our partners. Together we are able to reach our common goals of providing life-enhancing information and services to the children of our state. We recognize the importance of teamwork with public and private entities to deliver our program in the most effective and efficient manner.

As school systems and officials have changed over the years, we continue to identify key allies in maintaining our place in the school and time with children, teachers and parents. We know that from school-to-school and from one school system to another school system the allies may be different. We have come to know that one of the critical keys to taking a program into the school is to have the full support of the school leadership (superintendent, school director, school principal, etc.). Once in the school it is critical to identify within that school the other core school officials who can be a liaison and/or guide to better ensure a best outcome.

There is growing partnership with the Coordinated School Health representative in our target schools. Their component areas are aligned with those of the CDC's Whole School, Whole Community, Whole Child (WSCC) model. We want to ensure and maintain our place in the school providing free dental preventive services to the State's most at-risk children.

Addressing Change – In the more recent past we have come to realize that our data collection program could be enhanced to for users as well as for data collection purposes. The State Dental Director is currently in the process of identifying and upgrading the data collection component of the program and is working with personnel in data programming and development to design a program specific to the needs of the SBDPP. The modeling of the web-based program is based on the CDC's Sealant Efficiency Assessment for Locals and States (SEALS) software program. After reviewing ASTDD's Best Practice Approach Reports it was determined that a number of these programs found the CDC's SEALS software to meet their

needs. Researching the SEALS program and talking with program developers from another state, it was determined that this program could be greatly enhanced with the development of a program that would capture more data and allow for a more diverse list of queries and reports. It is envisioned that the new program will be an asset to allow for better monitoring of program areas and identifying areas that may need to be adjusted and/or modified. The new system will be able to target long-term tracking of individual students and develop insight on the oral health status of Tennessee's children. Additionally, the new system will help determine changes that may need to be made to our current strategies in delivering the preventive services of our SBDPP.

This new program is scheduled to be launched by summer 2016. Training will be provided state-wide to all SBDPP in each of the 13 rural and metropolitan regions. Training will be facilitated by the central office staff, the State Dental Director and Oral Health Services Administrative Assistant. The format for training will be "Train-the-Trainer" model, allowing Dental Directors opportunity to train all SBDPP staff. It will be provided on site at each of the regional offices to the SBDPP. Training will be provided as needed as future versions of the program are created and launched.

The need to have staff in isolated areas share programs, ideas, techniques has been recognized. Regional meetings have been put in place to facilitate an exchange of best practices. The opportunity to network face-to-face is invaluable. As a result of better communication, programs are being shared from region-to-region. The effort to re-create the wheel is eliminated.

Plans for Addressing Change – Many program areas experience a 35-45% return rate for the consent form. One of the chief complaints across the state is the return rate for the consent forms. The current document that has been used in the program to date is a two-sided document; one for parent use/information and one for program/office use. The front side of the consent contains program information and information about the child along with a place for the parent's signature. The back side of the current document is the treatment record for that child. By sending the treatment record home with the parent we have come to recognize a missed opportunity to utilize that space for more appropriate information for children and families.

Recognizing this missed opportunity we began to do some research about consent forms in general. Additionally, we utilized the CDC's [Clear Communication Index Widget | The CDC Clear Communication Index | Centers for Disease Control and Prevention](#) to rate the current consent/treatment record. Sadly, this document scored 9%. The document lacked color; focus; behavior messages; numbers; and various other aspects key to good communication for our audience. We studied a variety of consent forms and statistical information pertinent to our program and with the professional assistance of a graphic artist, a new document was created.

This new document has been approved, printed and shipped for use in the upcoming 2016-2017 school year. What is the score of this new document you ask??? The new document has scored a 95% using the CDC's Clear Communication Index. We are excited to be implementing this NEW information/consent sheet and look forward to tracking the return rates.

Plans for Addressing Change – Development of SharePoint. Oral Health Services is actively working with internal Information Technology Department to create a platform where information may be accessed and shared with SBDPP staff. The Oral Health Services SharePoint site is expected to be launched by the fall of 2016. SharePoint will be accessible by all SBDPP staff (Rural and Metro) state-wide, providing opportunity to share ideas, projects, troubleshooting, program resources, continuing education materials, etc. Information available will include:

- Calendar – to include national, state, regional and local meetings
- Library – program educational materials; program documents (forms, Manual) continuing education materials; training; etc.
- Discussion area – discuss ideas; troubleshooting; etc.
- Announcements
- Links

As challenges arise to be given direct time with students to deliver services to students, we continue to seek alternatives to getting the information and/or messages to the children, school officials and parents. The program design has evolved since its inception in 2001 and

to date, is structured differently from one region to the next as well as internal structure. We have grown and adjusted to the changing environment of the school and have been creative in our methods to be successful. Like Coordinated School Health, our systematic approach to promoting student oral health is based on annual data, evidence-based science that a sealant placed prevents decay from occurring, evaluation of our program outcomes and review to identify areas where there may be gaps in services and/or redundancy. In some regions staffing numbers and/or staffing structure may prevent a region from completing programs in their target school in two to three years. This issue may lead to a longer period of return time to schools on the target list. This is something we are currently looking at and are in the process of making some needed staffing adjustments.

In the 15 years of this statewide program's existence, there has not been a designated (100%) support personnel in central office for the SBDPP. This has posed a variety of problems through the years and has required significant amounts of personnel time in providing troubleshooting for program, data, and technical issues. In addition, managing monthly, quarterly, and annual reports and ensuring these are submitted in a timely manner has, at times, been a challenge.

Recently, the State Dental Director was successful in requesting TennCare to increase the SBDPP budget and add a line item to allow central office to hire an administrative staff to be designated to the SBDPP 100%. The hiring process to fill this position will be initiated July 1, 2016. It is expected that this support personnel will greatly facilitate culminating reports and provide prompt expert troubleshooting support statewide.

Space to setup the program is often seen as a barrier by school officials as they think of our dental program needs in line with what would be the typical dental office needs – plumbing, electrical, sinks, and such. One of the strong attributes of our staff is their ability to go into the school and identify space that would meet program criteria – the stage in a gym, concession stand area, breezeway of unused hallways, closets, unused classrooms, science rooms, and others. This is often one of our greatest opportunities to educate the school staff on how 'little' it takes to meet our program needs with regard to space.

The data system currently being used to capture the data is undergoing a major transformation, with hopes of it being ready for fiscal year 2017.

Recently the TN.Gov website underwent significant restructuring. During this process the pages designated to Oral Health Services images were removed from within the content. Oral Health Services is actively working with the TN.Gov webmaster to add graphics and enhance the information about all of our programs and to make available to parents and the public, credible and current information. This is an opportunity to greatly enhance the information available to parents and consumers. In an effort to bring parents and consumers to our website, a Quick Response (QR) Code was included in the new design of our SBDPP Information and Consent form (PH4294/PH4294S).

AA Quick Response Code (QR Code) is a machine readable code consisting of an array of black and white squares, typically used for storing URLs or other information not included on the document. The QR code is typically read using a free application installed on a smart phone or other device such as a tablet or pad.

Communication and sharing of ideas in any statewide program can be challenging. In the past the office of Oral Health Services has held annual multi-day training/continuing education meetings. In an effort to provide continuing education and networking opportunities, the State Dental Director has encouraged the 13 rural and metropolitan regions to work locally to hold an annual single day Grand Division Meetings. To date, four such Grand Division meetings have been held with good success. The remaining Grand Division is scheduled to meet in summer 2016. The intent of the meeting is to have regions come together to network and learn from presentations and through sharing of challenges and overcoming barriers to program success.

The meetings have typically included two rural regions and one metropolitan region. The Grand Division meeting is held in a central location in their respective area of the state. The dental directors of each region participating in the Grand Division work together in the planning process to include meeting location and logistics, presenters, and other aspects involved in planning a single day meeting. Attendees include all dental staff in the region which consists of the SBDPP and the dental clinic staff. Attending the meeting are dental

directors, dentists, dental hygienists, dental assistants and support staff. Continuing education hours are awarded to attendees at the conclusion of the meeting.

**Available Information Resources:**

Website – <http://tn.gov/health/section/oralhealth>

[PH4294-Information and Consent Form - English](#)

[PH4294S-Information and Consent Form - Spanish](#)

## Whole School, Whole Community, Whole Child Model

*Provide a thorough description of how you are implementing each of the ten components of the WSCC Model. Include any challenges you experienced (If applicable) and how you resolved those challenges. If you are not implementing any activities for a component, please signify that by checking the "Not Part of Our Program." If you have tried to implement a particular component and weren't able to resolve those challenges, please provide a brief (1-2 sentences) on what occurred.*

*You may find the resource, "Recommendations for Integrating Oral Health into the WSCC Model" useful for completing this section.*

<b>Component</b>	<b>Description of Activity(s) &amp; Process</b>	<b>Not Part of Our Program</b>
<p><b>Health Education –</b></p> <p>Integrate oral health into the health education curriculum or other subjects, (i.e. biology, nutrition, food service, phy ed).</p>	<p>One hundred percent of the schools that are eligible for the program allow some form of oral health education. The SBDPP work very closely with school staff to fit the program into the school's schedule. Staff has forged strong working relationships with schools in their region and has earned a reputation of being efficient and effective with time and space given to them by the schools in their regions.</p> <p>Once the schools are identified for the school year, options are given to them for the type of education preferred. This preference is based on amount of time allotted and appropriate space for students. The School Based Dental Prevention Program (SBDPP) education programs have an excellent reputation with both teachers and administration. This has allowed most schools to continue to allow time for the oral health programs. Teachers recognize the value of the education and the service offered and do not object to giving 20 minutes for this preventive service. Teachers are continually asked for their feedback</p>	

	<p>and the appropriateness of the programs for their students. Because programs are continually enhanced and modified to meet the needs of the target population, a typical response is "I have heard this program for years and I always learn something new!"</p> <p>One example of an educational program is the "Tooth Fairy". The program utilizes audience participation by dressing children as teeth while the program facilitator is dressed as the Tooth Fairy. Demonstrations of oral health are led by the Tooth Fairy along with audience participation. This method of education utilizing a socially acceptable and familiar American icon inspires and educates the audience.</p> <p>Children learn by being inspired by the visualization of fantasy to pay more attention to their teeth. Imagination and humor break down language barriers. These programs are most effective in groups making it an excellent tool for public health. Objectives presented incorporate positive lifelong lessons children can learn from, identify with and practice.</p> <p>Power point presentations or videos that are grade appropriate have been developed to address the majority of the schools. The pictorial progress of decay and relationship of plaque and daily self-care; tooth brushing and flossing, are represented and discussed. Risky behavior such as tobacco use and body piercing are also addressed. Drinking fluoridated water is addressed particularly in schools with high levels of refugee and immigrant students. Sodas and bottled water are discouraged. Flexibility is needed to address individual school needs; these programs are designed to be delivered in any school</p>	
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accommodating any schedule. Whole school assemblies have also been serviced with a student population from 50 to 400. Elementary school programs typically address 60-120 students in each program.

To meet the challenge of “face time with students” our programs continually seek alternatives that are creative, effective and engaging for children, teachers and school officials. With the increased availability of social media and the inclusion of monitors in classrooms, many of our schools will include a video clip to introduce the program or recording of the SBDPP program. These forms of education are often included as part of the school’s morning announcements when attention may be more focused. Examples of this have been a three minute multi-media program developed to be utilized in classrooms, libraries and school wide announcements, recordings of our SBDPP education presentation, Casey Dental Patient Education and the National Maternal and Child Health’s Seal America: Seal in a Smile DVD.

Physical Education teachers, coaches, health educators, general education teachers, and guidance counselors express their desire to incorporate facts and portions of our program into their health related classes. One example of this comes from one of our regions who have a program called “Think B4 U Drink”. This program demonstrates the amount of sugar that is consumed in our choice of drinks. The faculty is often as much surprised as the students. Information is provided for inclusion in future lesson plans as well as a copy of the “Think B4 U Drink” poster. These posters are displayed in the gym areas as a constant reminder to limit sugary drinks.

Annually programs are assessed to ensure the use of the latest and most effective materials to deliver oral health education to students, school teachers and officials, parents and families, and the communities

	<p>served. Information, materials and methods of delivery are modified as needed to ensure the best delivery and comprehension.</p> <p>Administrations are increasingly concerned about instructional time as teacher’s pay is tied to testing results. Some schools are limiting access to children to a certain period of the school day and/or placing time limits on how long students are available. This presents challenges to the SBDPP staff.</p>	
<p><b>Physical Education &amp; Activity</b> – Enforce the use of head/ facial protection to prevent injury during sports or related activities.</p>	<p>While mouth guard safety is featured in various education programs in some regions, this is an area of opportunity for us as we move forward. Oral Health Services will be working with the Commissioner of Health’s office to utilize the Tennessee Department of Health’s social media outlets to include oral health messaging. It is anticipated that messages to prevent injury during sports or related activities will be included in some of these message blasts.</p>	<p><b>X</b></p>
<p><b>Nutrition Environment &amp; Services</b> – school nutrition policies promote optimal dental health.</p>	<p>The Office of Coordinated School Health (OCSH) was established by the Tennessee Department of Education in February 2001. The primary mission of the office is to improve student health outcomes as well as support the connection between good health practices, academic achievement and lifetime wellness. Coordinated School Health (CSH) is a national model that is making an impact on children’s health. The coordinated school health model was developed by the Centers for Disease Control and Prevention (CDC) in 1988. Coordinated School Health works with many partners to address school health priorities. The Tennessee Department of Health is one of their many partners. One of the CSH components is Nutrition making CSH representatives an ideal partner in addressing school nutrition policies to promote health and making positive inroads providing better food services to our</p>	



	<p>students. Various programs have reported that some of the school fund-raisers have been shifted away from food items. As professionals in the school SBDPP staff supports the established efforts and new initiatives directed toward healthy food choices.</p> <p>SBDPP incentivizes by rewarding students with non-food items such as a toothbrush, dental floss, tooth brushing timer, stickers and chap stick. SBDPP has been able to partner with TennCare in some regions to supply water bottles to students returning their consent form for dental sealants. In several schools these water bottles contain fluoridated drinking water, which is given to the physical education teacher to ensure the children are properly hydrated during exercise time.</p> <p>A significant change has been noted across the state in the content of school vending machines. Reports note that sodas have been removed and replaced with water while others report that water is the only beverage option. Healthy snacks are seen more often as options in vending machines, replacing some of the more sugary snacks. Fresh fruits are made available to classrooms for "snack" time.</p> <p>SBDPP education programs promote healthy food choices with an emphasis on the student's ability to think and act on a "best practice" approach. Every opportunity is utilized to educate and promote good nutrition as a part of optimal oral health to the children and to empower them to make healthy food and drink choices.</p> <p>While some schools still allow food to be brought in from the outside, there is a notable increase in healthier foods that are brought in for children's parties and other special events. Some schools give parents a list of acceptable "party" snacks.</p>	
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	<p>In general, as a result of the continuing oral health education and oral health staff working in the schools along with coordinated school health partnership, school nurses and other school administrators, the SBDPP has had a positive influence on this shift toward healthier food and drink choices.</p>	
<p><b>Health Services –</b> Promote a medical/dental integration that includes dental sealants and fluoride.</p>	<p>Once a school is identified for the SBDPP, all students are eligible to participate upon returning a signed consent form. Consent forms are distributed to all K-8 students. All classrooms receive a list of participating students and a second consent form will be distributed to the remainder of the class for another chance to participate in the SBDPP. Many times this is done once our dental staff is in the school and the students get to see what their “treats” for participating are. Students participating receive tooth brushes once they receive their preventive service(s). After the student receives the dental sealant service or hands on brushing, they get a “report of dental screening” to let their parent or caregiver know what service(s) were provided to their child and the level of dental need observed. This form also contains information about public local health dental clinic(s) in the respective area of the program.</p> <p>A list of children with dental needs is left with the school nurse who also is given local health department information to assist the parent in locating a dental home for the child. Students found with immediate oral health needs are followed up by TennCare with a personal call; this is also designed to help the parent or caregiver locate a dental home.</p> <p>TennCare may assist with education in some areas when SBDPP is given sufficient time for presentation. Every student gets a pencil and information about TennCare and how to sign up for it. The education</p>	

	<p>revolves around the need for students to have a medical checkup once a year, dental checkup twice a year, get exercise, drink plenty of water, limit electronic device usage to 1 hour per day, and go to bed by 8-9:00 each night. The role of the school psychologist or counselor is discussed as well as the need to talk with parents about medical/dental needs and feelings as adolescence advances.</p> <p>The collaboration our program has with the Department of Education School Nurses continues to be an important part of our program, from referrals for dental care, ensuring students get access to dental care and the additional support in the way of information and supplies provided to the nurses by our SBDPP staff. The school nurses are among those that receive education about SBDPP and the importance of oral health as it relates to total health and well-being and the student's ability to learn. Some regions have the opportunity to provide an orientation about dentistry in general and SBDPP to newly employed school nurses. This opportunity lends to greater understanding and support to the preventive health services provided to children in the school as well as providing a means to get children connected to the oral health services needed.</p> <p>In an effort to prevent undo stress and extra work on school officials/administration, some programs have experienced a greater consent form return rate and less stress on teachers to include the consent form as part of the start of school registration packet. When a program chooses to distribute consent forms in this manner, SBDPP will retrieve the forms from each school as soon as possible. The forms are then sorted to ensure there are no documents that should be returned to the school (non-SBDPP related paperwork such as shot records, etc.). School front desk staff are often vital to the smooth running of any</p>	
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	<p>given program. They are anxious to help their students and are appreciative for the services provided to their school family.</p> <p>Every child receiving services from the SBDPP will be given a Report of Dental Inspection. Referral information for local health department clinic is included with the Report of Dental Inspection that every child participating in our SBDPP goes home with. If the child is found to have a high priority dental need, the parent or caregiver is contacted as soon as possible. With this method of referral, our dental providers are able to speak directly to parents to ensure the parent understands the level of care needed and assist with getting the child connected with the appropriate provider in a timely manner.</p> <p>Additionally, at the conclusion of our program in a school, the school nurse receives a list of students who have further oral health needs. A list of the area clinics is included.</p> <p>At the conclusion of each program, a Dental Report is compiled of students who were identified as having an "immediate need" or "treatment at an early date" referral need. This Report is provided to TennCare Kids Representative in that county or region for follow-up. Three attempts will be made to reach the parent/guardian to provide support to the family for the child's dental need(s). TennCare Kids Representatives are Tennessee Department of Health employees acting on behalf of TennCare.</p>	
<p><b>Counseling, Psychological &amp; Social Services –</b></p> <p>Educate/emphasize the impact that poor oral health has on the ability to learn and on self-esteem.</p>	<p>The majority of the school officials we work with understand the impact of oral health and well-being as it relates to missed school time, the ability to learn, and self-esteem. Ninety percent (90%) of our target schools are repeat customers, school professionals look to provide the dental preventive services to their students as often as it can be made</p>	

	<p>available.</p> <p>Our SBDPP staff use language to raise self-esteem during oral hygiene instruction and general interaction with each student. An extra supply of toothbrushes and toothpaste are often left with the school guidance counselors to be handed out to students in need.</p>	
<p><b>Social &amp; Emotional Climate –</b></p> <p>Establish an environment where oral health prevention practices and programs are supported and valued.</p>	<p>This program has an excellent reputation across the State for the services provided as well as the organized system in which the programs are presented. Having history with the school system is only one component of keeping the programs viable. Administrative school staff change on a regular basis and constant efforts have to be made to keep lines of communication open. The SBDPP is NOT a mandated program; the program operates at the request/invitation of the schools. Many of the principals, school nurses, and school health coordinators actively promote the program in their schools. Many schools utilize this program on a routine biennial schedule. Schools recognize the benefits of preventive services to their students as well as the referral services benefitting student’s mental, emotional and social health. The SBDPP is seen as an ally in supporting healthy and happy students.</p> <p>This has been accomplished through good communication and relationships with school directors, school principals, nurses and other school staff. We have delivered what we promised and that is essential to our reputation. We are invited back because the school values the services we provide and they see the positive impact we have on students and their families, teachers, and school staff. We deliver a service the school family values and our staff work diligently to work into the school’s schedule and deliver the program while maintaining</p>	

	<p>order and continuity to the best of their abilities. Our staff wear scrubs and are recognizable to the students. As a result, children in the hallway tell us they brushed their teeth today and teachers report that they have made needed dental appointments they have been putting off. Repeat invitations to schools are indicative of the importance school officials place on our program. Appreciation and respect for the SBDPP and the health benefit for Tennessee’s children is demonstrated when schools allow us the physical space and the time to get kids out of class.</p> <p>As teachers attend the education program presentations with their students, they are able to reinforce the message(s) of the program with their personal stories and questions. “After my child got dental sealants they have never had a cavity”. This positive interaction contributes to the social atmosphere of the school when teachers and students are asking questions and sharing information in the same forum.</p> <p>The SBDPP staff spends time with in-school or health department translators to ensure program communications are reaching each school population. This time spent with in-school translators is critical to the program, ensuring understanding of the program parameters. Translators are then able to better facilitate parent/student written and verbal communications and parent involvement. Additionally they will be able to provide assistance with dental referrals and setting up dental appointments and other follow-up with the child.</p> <p>Our SBDPP staff is able to model good nutritional behavior when eating with teachers; they see us practice what we teach. Drinking water instead of sodas (of any kind) around children and teachers is one way</p>	
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	<p>to model appropriate nutritional patterns we want duplicated.</p> <p>Some schools have a word of the day, thought for the day or school motto that can be used within our program to “fit in” with the school climate.</p> <p>As the sealant program comes to an end, staff members, including teachers, janitors, lunch room staff, auxiliary staff, administrators and support staff, are given a “Goodie Bag”. It may contain:</p> <ul style="list-style-type: none"> <li>• Thank You note for allowing their students to participate</li> <li>• Toothbrush</li> <li>• Dental floss</li> </ul>	
<p><b>Physical Environment –</b></p> <p>Assure the students and staff have fluoridated water available throughout the day.</p>	<p>Tennessee was fortunate to have excellent leadership in the early days of community water fluoridation. As a result, 88% of Tennessean’s served by community water systems enjoy access to fluoridated water. Immigrant/refugee populations need to be educated about the benefits of fluoridated tap water. Advantages of water fluoridation to the development of healthy teeth are discussed along with the cost of bottled water verses tap water with the students</p> <p>Several staff members have formed relationships with the water plant operators, keeping the lines of communication open for the sharing of new information as well as providing health information to the community as it relates to community water fluoridation and oral health benefits. SBDPP staff have developed partnerships with community members, TennCare, and the Tennessee Dental Association to work hard to get in front of the opponents of water fluoridation. Tennessee</p>	

	<p>has experienced a number of efforts in different areas across the state. The long-standing presence of the program and staff in the community provide many opportunities to be seen as a credible and professional resource.</p> <p>Community water fluoridation issues arise periodically across the state. The partnerships that have been formed on this effort include TennCare and the Tennessee Dental Association. When an anti-fluoridation issue arises the Dental Director in that region or the State Dental Director immediately communicates with our networking partners and follow the steps within the Fluoride Bundle, created by the Office of the Commissioner of Health and State Dental Director.</p> <p>Due to the increasing competition to get into the schools this becomes a barrier to efforts of educating students, parents and school officials on the contributing health factors of the consumption of sugary drinks versus water consumption. This barrier becomes an opportunity for our program to continue efforts to partner with other programs and/or initiatives that are in the schools to work together to get the message into the schools - to school officials, staff, children and parents.</p> <p>Various programs are taking this message out into the community as well as into the schools</p>	
<p><b>Employee Wellness –</b> Support tobacco cessation programs for students &amp; staff using tobacco/e-cigarettes.</p>	<p>Tobacco prevention and cessation is an ongoing component of the SBDPP. Employee wellness and the opportunity for the teachers and school staff to be a role model is addressed by first providing teachers with the names (and in some areas, a photo) of the SBDPP staff who will be providing services in the school. School staff is encouraged to utilize</p>	



	<p>the SBDPP as a resource while the program is in their school. The SBDPP staff is encouraged to eat lunch with teachers, talking with them during their planning time, before and after school all facilitates communication. These relationship building tools provide countless opportunities to contribute to the oral health of the school staff and raise their awareness of the opportunity to model healthy choices and behaviors, including tobacco prevention and cessation.</p> <p>Our staff welcome the opportunity to answer staff's questions about their (or their family's) oral health concerns. In fact, impromptu education is provided when approached by school employees. As a result of this relationship and sharing of information the school staff often informs the SBDPP provider staff that they have made a dental appointment or will ask for a dental referral or ask for personal oral health advice. Teachers and school staff who hear our messages about preventive oral health often become more supportive of our program following their response to what they have learned and after their personal experiences of making dental appointments and receiving needed preventive and/or restorative dental services.</p> <p>Dental supplies such as tooth brushes and dental floss are provided to teachers in the target schools as well as the students. This action reinforces a positive attitude toward our program and reminds them we are in the school providing services related to total health.</p> <p>As school schedules and In-Service agendas allow, our SBDPP staff have been invited to present oral health information to teachers including providing support for tobacco cessation.</p>	
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	<p>Participation in school health fairs, career days and placing posters concerning oral health and tobacco education is another opportunity to address the oral health of employees. School staff as well as students often benefit for these initiatives.</p> <p>The tobacco message is a constant in the program. The message and mode of delivery changes as industry and fads change. Educational programs are evolving even now with the newer trends of e-cigarettes and Hookah fad. The tobacco prevention and cessation message is appropriately altered as needed to fit the target population. The State’s Quitline is provided as a resource in the messaging when age appropriate. To learn more about Tennessee’s Quitline information and resources, click <a href="#">here</a>.</p>	
<p><b>Family Engagement –</b> Promote school and family support for oral health screenings and regular dental visits.</p>	<p>Engaging parents/caregivers of students is essential to providing services with this program. Consent MUST be obtained for preventive services to be rendered. Many parents do not participate because they “have a dentist”. This is encouraged! They are applauded and told to make sure dental sealants are applied to their children’s teeth. More work needs to be done in this area as many parents do not know the difference between a fluoride treatment and a dental sealant. They assume by taking their children to the dentist every 6 months that all preventive services are being rendered.</p> <p>The dental sealant consent form provides information and clarification about sealants and their role in reducing dental decay. General age appropriate oral hygiene information is also provided with each age group. For example, “How to Brush and Floss” is sent home to the parents of children grades Kindergarten – 2<sup>nd</sup> as these parents bear the</p>	

	<p>responsibility of taking care of their child’s teeth until they are old enough to brush themselves.</p> <p>Parent Nights, Health Fairs, Career Day, school registration, Kindergarten registration and developmental screening, are all opportunities at school that can be attended by SBDPP staff to gain access to parents. Demonstrating to parents with models of teeth is a great way to educate everyone. Families are encouraged to access additional information about the SBDPP program on the State’s website, the local health department or the school’s website as information may be available.</p> <p>As stated earlier with regards to our program’s referral service, every child seen in our SBDPP receives a written report of dental services provided and needed. Phone calls are made to parents if the child has an urgent need. This is also an opportunity to help the parent locate a “dental home” for their family.</p> <p>Elementary students participate to the average of 75%. Middle school students participate in about 40%. Some programs have found it beneficial for increasing participation by including the consent form with the School’s paperwork at the beginning of the school year.</p> <p>Consent forms used in this program have been translated into Spanish and Arabic as well as other materials used in the program for children and their families.</p>	
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<p><b>Community Involvement –</b></p> <p>Establish partnerships with local dental professionals to assure access to dental care &amp; preventive interventions.</p>	<p>Many citizens are unaware of the SBDPP program as they may not have school-aged children attending the schools we serve. Community involvement is an avenue for raising awareness about the whole body health benefits of good oral health. SBDPP staff have established extensive partnerships and programs within communities such as:</p> <ul style="list-style-type: none"> <li>• dental and dental hygiene associations</li> <li>• Tennessee Department of Education’s Coordinated School Health program</li> <li>• public libraries</li> <li>• hospitals</li> <li>• school nurses</li> <li>• English as a second language programs</li> <li>• enrichment programs for children</li> <li>• 4H Clubs</li> <li>• Boys and Girls Clubs</li> <li>• YMCA</li> <li>• senior centers</li> <li>• parks and recreation centers</li> <li>• faith-based community centers and churches</li> <li>• summer programs for children</li> <li>• Head Start programs</li> <li>• Family Health Resource Centers</li> <li>• manufacturing industries</li> <li>• parish nurses</li> <li>• St. Thomas Medical Missions at Home</li> <li>• St. Thomas Mobile Health Unit</li> <li>• “Team Health” at the University of Tennessee for</li> </ul>	
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	<p>underprivileged children providing free dental services</p> <ul style="list-style-type: none"> <li>• "Give Kids a Smile Day" with the local dental society providing dental treatment held at Knox County Health Department</li> <li>• "Welcome Baby" which is a program for new mothers with information about caring for their child's teeth and development</li> <li>• "Child Health Week" providing dental screenings at a local Knox County School Pre-school program</li> <li>• Cub Scout troop meet a badge requirement about the importance of good oral hygiene</li> <li>• student members of the Knoxville Robotics Club to assist them in developing a prototype of a new toothbrush; worked with the</li> <li>• worked with the Greater Schools Partnership and the Elgin Foundation to formulate a program offering dental treatment to school children in need</li> <li>• a free Dental Sealant Clinic at Knoxville Interfaith Health Clinic in, which provides care for the working indigent</li> <li>• TennCare Kids coalition and Head Start Health Advisory Panel</li> <li>• Volunteer faculty at a community college Dental Hygiene Program serving as a mentor</li> <li>• Summer reading programs in local public library</li> <li>• Hospital mobile outreach delivering comprehensive health education in the community</li> </ul>	
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