



# Dental Public Health Activities & Practices

**Practice Number:** 18008  
**Submitted By:** Iowa Department of Public Health, Oral Health Bureau  
**Submission Date:** September 2009  
**Last Updated:** September 2009

## SECTION I: PRACTICE OVERVIEW

### Name of the Dental Public Health Activity:

### I-Smile™ Dental Home Project

### Public Health Functions:

- Policy Development – Oral Health Program Policies
- Assurance – Population-based Interventions
- Assurance – Building Linkages and Partnerships for Interventions
- Assurance – Building State and Community Capacity for Interventions
- Assurance – Access to Care and Health System Interventions

### Healthy People 2010 Objectives:

- 21-1 Reduce dental caries experience in children
- 21-2 Reduce untreated dental decay in children and adults
- 21-10 Increase utilization of oral health system
- 21-12 Increase preventive dental services for low-income children and adolescents

### State:

Iowa

### Federal Region:

Region VII  
Mid-West

### Key Words for Searches:

Dental home, prevention, infrastructure, systems development, systems building, access to care, dental services, dental treatment

### Abstract:

The I-Smile™ Dental Home Project is an initiative to ensure at-risk children have early and regular dental care. It was created in response to state legislation requiring Medicaid-enrolled (ME) children age 12 years and younger to have a dental home. In Iowa, the dental home is a network providing comprehensive care using a multi-disciplinary approach to help children achieve optimal oral health. The Iowa Department of Public Health, Oral Health Bureau, coordinates I-Smile™ through an agreement with the Department of Human Services. The I-Smile™ Project is implemented within the state's existing Title V child health system. Twenty-four dental hygienists, hired by local Title V child health contractors, work as regional I-Smile™ coordinators. The coordinators are liaisons between community organizations, families, health care providers, and dentists to establish dental homes for Title V children. Health care professionals provide screenings, risk assessment, education, anticipatory guidance, and prevention to ME children. Through referrals, dentists provide diagnosis and treatment as needed. In addition to Title V contractors' activities, the I-Smile™ Project also builds infrastructure at the state level with activities, such as creating new and enhancing existing public-private partnerships, improving the state's child health database, and developing policies. The I-Smile™ annual budget covers contracts with local Title V child health centers to implement the program and the administrative costs for the Oral Health Bureau. The I-Smile™ multi-disciplinary network of care and dedicated oral health staff within the state's Title V system is improving children's ability to access dental care. In 2007, the first year of I-Smile™ activities, an additional 16 percent (4,890) of ME children ages 0-5 years received a dental service compared to the year prior to the start of I-Smile™. This number rose another 9 percent in 2008 when 3,157 more children ages 0-5 years received a dental service.

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## SECTION II: PRACTICE DESCRIPTION

### History of the Practice:

In 2005, Iowa's governor signed health care and Medicaid reform legislation<sup>1</sup> into law that included a mandate that all Medicaid-enrolled (ME) children will have a dental home:

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

In response to the new legislation, the Iowa Department of Human Services (DHS), which oversees the state Medicaid program, worked with the Iowa Department of Public Health (IDPH), the Iowa Dental Association (IDA), the Iowa Dental Hygienists' Association (IDHA), Delta Dental of Iowa, and the University of Iowa College of Dentistry (UI) to create the I-Smile™ dental home initiative.

The I-Smile™ concept was the result of a meeting in 2005 sponsored by the Centers for Health Care Strategies (a Robert Wood Johnson-funded initiative). Stakeholders from 13 states were invited to Philadelphia where they received technical assistance to create plans to improve access to oral health services for ME children. The Iowa workgroup included representatives from public health, Iowa Medicaid Enterprise, the Iowa Dental Association, and a child health advocate. Following the meeting, a draft policy proposal was further developed with additional input from Delta Dental of Iowa and the University of Iowa College of Dentistry. The collaborative effort resulted in the I-Smile™ Dental Home Project. An interagency agreement between DHS and IDPH began funding the I-Smile™ project in SFY 2007.

### Justification of the Practice:

Iowa faces several challenges that impact children's access to dental care:

- The dental workforce is aging, and many dentists who retired are unable to find a provider to take over their practice. This is especially evident in rural Iowa.
- Although it is recommended that children receive dental examinations within 6 months after their first tooth erupts, most dentists prefer to wait to see children until they are 3 years of age or older. A recent University of Iowa study found that approximately half of Iowa's general dentists always refer children younger than 3 to pediatric practices.
- There are not enough pediatric dentists in the state to see all of the children in need, particularly those younger than age 3. In addition, most are located in Iowa's urban areas – leaving many families with the burden of driving long distances to see them.
- Many dentists will not see new, if any, ME children/adults, citing low reimbursement and patient compliance issues.
- Although a large number of Iowa families have medical insurance, one in five children do not have a way to pay for dental care. Many insurance plans have low yearly maximums or large deductibles, making it difficult to pay for care – even for those families with some sort of coverage.

To address these barriers, the I-Smile™ Dental Home Project works to ensure that children (especially children experiencing barriers to accessing care) have a dental home.

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

#### I-Smile™ Objectives

The I-Smile™ Dental Home Project, in response to new state legislation mandating every ME children age 12 years and younger to have a dental home, aims to ensure that at-risk children have early and regular dental care.

<sup>1</sup> <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?Category=billinfo&Service=Billbook&frame=1&GA=81&hbill=HF841>

There are four objectives for the I-Smile™ Dental Home Project:

1. Improve the support system for families;
2. Improve the dental Medicaid program;
3. Implement recruitment and retention strategies for underserved areas; and
4. Integrate dental services into rural and critical access hospitals.

#### Administrator and Funding for I-Smile™

The Iowa Department of Public Health, Oral Health Bureau (OHB), coordinates the I-Smile™ Dental Home Project. An interagency agreement between the Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) allows state general funds to support I-Smile™. In July 2007, the DHS provided funding to IDPH to begin developing the I-Smile™ Project and addressing its objectives. In addition, the Health Resources and Services Administration (HRSA) Targeted Oral Health Service Systems (TOHSS) grant also supports IDPH staff to implement I-Smile™ promotion and surveillance activities.

#### I-Smile™ Staffing

I-Smile™ staffing includes:

- **3.95 IDPH Oral Health Bureau (OHB) FTEs** (full-time equivalents) are funded through the interagency agreement. This includes portions of time of the public health dental director, two community health consultants who are I-Smile™ project leads, two public health dental hygienists who assist in project oversight, a program planner who manages contracting and fiscal issues, and an administrative assistant.
- **1.45 OHB FTEs** are funded by the HRSA TOHSS grant to implement I-Smile™ health promotion and surveillance activities. This includes a portion of time of a community health consultant as project lead and oversight of oral health surveillance activities, a program planner to manage contracting and fiscal issues, and a program planner to implement health promotion initiatives.
- **24 I-Smile™ regional coordinators** (dental hygienists) employed by local Title V contractors throughout the state. Each works a minimum 20 hours a week (0.5 FTE). The coordinators oversee referrals, provide care coordination, and act as liaison for families with community organizations and health care providers.

#### Strategies

For the first objective to improve the support system for families, I-Smile™ first focused on the state's existing Title V child health system. Iowa has a strong public health system, and the state's Title V child health program offers an existing network of community partners and health-related services for at-risk children. Therefore, use of the Title V child health contractors was ideal for implementing major components of I-Smile™.

I-Smile™ strategies used best practices and lessons learned through the Iowa Access to Baby and Child Dentistry (ABCD) projects. It was found that ABCD projects with dedicated oral health staff proved to be most effective in building local infrastructure. In addition, those projects that focused on partnerships were very effective in strengthening Title V contractors' abilities to help families access dental care.

In Iowa, the dental home is defined as a network of individualized care based on risk assessment that includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services<sup>2</sup>.

To establish dental homes, the I-Smile™ Project relies upon dental hygienists, nurses, and physicians to provide preventive dental services and determine disease risk, easing the burden on dentists to provide all of these services. Dentists can then be responsible for definitive diagnosis and treatment when needed. Also, by providing I-Smile™ services in locations or settings where at-risk families are accessible, such as in physician's offices, child care centers, and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics to reach as many children as possible and deliver preventive care is maximized. The end result is a coordinated effort to ensure optimal oral health for children.

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<sup>2</sup> Iowa Administrative Code 641, Chapter 50 Oral Health. <http://www.legis.state.ia.us/asp/ACODocs/DOCS/9-9-2009.641.50.pdf>

Contracts with the state's Title V child health programs to carry out I-Smile™ activities were initially established in December 2006. Title V contractors were first required to hire a dental hygienist to serve as I-Smile™ Coordinator, working at least 20 hours per week. Each contractor created an I-Smile™ action plan based on local needs and assets, using the following strategies:

- Develop partnerships, participate in community health planning and needs assessments, and build a referral network;
- Link with local boards of health;
- Provide training and oversight of Title V staff for oral health services;
- Develop oral health protocols;
- Provide oral health education and training for health care professionals;
- Ensure completion of oral screenings and risk assessments;
- Ensure care coordination services; and
- Ensure gap-filling services (e.g. fluoride varnish applications).

The I-Smile™ coordinators work with community organizations and health care providers, in a multi-disciplinary approach, to provide disease-preventive dental care and determine disease risk, and oversee dental referrals and provide care coordination.

The I-Smile™ activities are funded through a DHS-IDPH agreement, Medicaid billing, and other local funding sources. Proposals for I-Smile™ activities are now a component of the Title V child health contractors' annual re-application process.

I-Smile™ activities within IDPH included enhancements to the state's child health database and communication and trainings for I-Smile™ coordinators. IDPH OHB staff increased efforts to enhance partnerships throughout the state to promote the importance of children's oral health.

### Partnerships

Key partners include the Iowa chapter of the American Academy of Pediatrics, Early Childhood Iowa Council, Head Start Association, the Department of Human Services, Iowa Public Health Association, Iowa-Nebraska Primary Care Association, Iowa Community Empowerment, Prevention of Disabilities Policy Council, Rural Health and Primary Care Advisory Council, Iowa Dental Association, and Iowa Dental Hygienists' Association. These partners contributed to the development of a web-based curriculum for medical practitioners on oral screenings and fluoride varnish application, endorsement of oral health policy recommendations, and support in funding of local oral health initiatives.

The Health Resources and Services Administration (HRSA) was also a key partner. The HRSA's Targeted Oral Health Service Systems grant funded the creation of a surveillance system to measure impact and enhanced promotion of I-Smile™.

### I-Smile™ Activities

Activities by IDPH Oral Health Bureau include:

- Created and provided trainings for I-Smile™ coordinators, nurses, pediatric residents, and other health professionals.
- Recommended and developed oral health policies.
- Worked with state health care reform efforts via workgroup participation, presentations at conferences, and meeting displays.
- Provided consultation and technical assistance for organizations regarding children's oral health.
- Improved data collection by working with IDPH staff to make enhancements to the Child and Adolescent Reporting System (CAREs).

Activities by Title V contractors and I-Smile™ regional coordinators include:

- Developed water fluoridation facts and present to city officials where water is less than optimally fluoridated.
- Trained medical office staff to perform oral screening, apply fluoride varnish, and bill Medicaid.
- Built referral networks.
- Worked with WIC programs to provide services for clients.
- Provided oral health education for area early childhood programs and parents.
- Provided oral health outreach materials for local employers.
- Coordinated *Give Kids A Smile* events.

- Worked with dental advisory groups on community health needs assessment and program planning.
- Provided resource and referral information to faith-based organizations who work with minority families.
- Developed oral health curriculum for nursing program students.
- Attended local legislative forums to provide education on local and state oral health needs.
- Provided materials at back-to-school registrations.
- Sponsored oral health events at “family fun” centers.

Outputs of the I-Smile™ Dental Home Project

1. Services provided by Title V child health staff during the first year of the I-Smile™ Project (2008) are summarized in the table below. Services increased significantly when compared to 2005 before the I-Smile™ Project was initiated. For example, more than three times as many fluoride varnish applications were provided in 2008 compared to 2005.

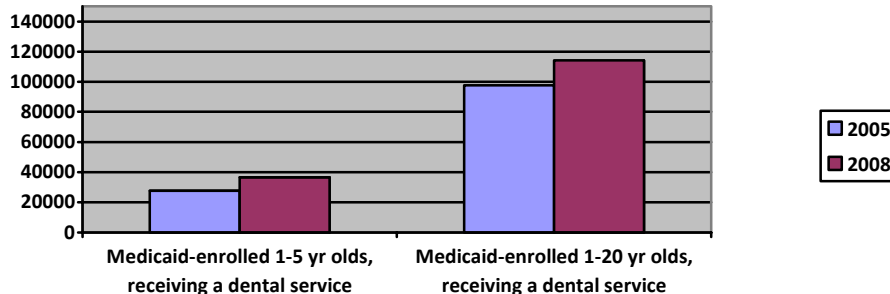
Service Provided By Title V Child Health Staff	Year	Total
Fluoride varnish application	2005	10,090 applications
	2008	34,320 applications
Oral screening	2005	14,437 screenings
	2008	43,490 screenings
Care coordination	2005	38,524 clients
	2008	41,354 clients

2. I-Smile™ coordinators provided training to 76 medical practices on oral screening and fluoride varnish application in 2008.
3. Health promotion materials developed:
  - **I-Smile™ Web site** ([www.ismiledentalhome.org](http://www.ismiledentalhome.org)) – Provides information about I-Smile™ and children’s oral health to parents, health care professionals, and the general public.
  - **I-Smile™ public service announcements (PSAs)** – Has been used in a targeted campaign in one Iowa television market. The PSAs focus on transmission of decay-causing bacteria, good oral hygiene, and the importance of good oral health for young children (<http://www.youtube.com/watch?v=zMdrAurZewU>). The PSAs were originally developed by the South Dakota Department of Health, who granted IDPH rights to use and edit.
  - **I-Smile™ media campaign** – Includes posters, toothbrush bags, stickers and print advertisements to promote I-Smile™ and children’s oral health in a state television market
  - **Tabletop I-Smile™ display** – For use at conferences and meetings to explain the I-Smile™ program.
  - **I-Smile™ lapel pins** – Has been distributed with I-Smile™ program information to legislators and other policymakers during Children’s Dental Health Month.
  - **“With a smile like this, I can do anything” poster** – Promotes age one dental visits. Has been distributed at conferences and used by I-Smile™ coordinators for outreach.
  - **“With a healthy mouth, I can focus on learning” poster** – Promotes good oral health to help children focus on learning. Has been distributed at conferences and to I-Smile™ coordinators for outreach.
  - **First birthday postcard** – Informs parents of the need for a screening or exam. Has been distributed to I-Smile™ coordinators for clients who turned age one.
  - **Various oral health brochures and fact sheets for parents** – Promotes oral health (available on the OHB and I-Smile™ Web site, or ordered from OHB).

Outcomes of the I-Smile™ Dental Home Project

1. More ME children are receiving dental services, reflected in Centers for Medicare and Medicaid Services (CMS) 416 data for Iowa:

- 32.5 percent more ME 1-5 year olds received a dental service in 2008 than in 2005 (36,642 compared to 27,646)
- 17 percent more ME 1-20 year olds received a dental service in 2008 than in 2005 (114,356 compared to 97,716)
- The overall rate of ME 1-5 year olds receiving a dental service in 2008 was 45 percent (compared to 37% in 2005)
- The overall rate for 1-20 year olds receiving a dental service in 2008 was 49 percent (compared to 44% in 2005)



2. Workforce improvements include:

- An expanded workforce allows for more preventive dental care. Although progress is slower than anticipated, more medical practitioners are providing fluoride varnish applications for children younger than age three. Twenty-five practitioners billed Medicaid in 2009 compared to just three in 2005, providing 249 children with fluoride varnish applications in 2009 compared to just 13 in 2005.
- Dental providers are providing care to more children at an early age. More ME children younger than age 2 received a dental service from a dentist in 2008 (3,040) than in 2005 (1,726), a 76 percent increase. An even larger number of children younger than age 2 received a dental service from MCH agency staff (6,758) in 2008 – more than twice as many as those seen by a dentist.
- The dental public health workforce is growing. The number of dental hygienists working under public health supervision<sup>3</sup> is increasing, as well as the number of services provided and the population served. In 2008, 59 dental hygienists working under public health supervision (compared to 21 in 2005) delivered more than 42,375 screenings (18,942 in 2005), 28,550 fluoride varnish applications (6,098 in 2005), and 28,338 referrals to dentists (8,735 in 2005).

3. New oral health-related policies and changes to existing policies have occurred (I-Smile™ promotion contributes to increasing awareness of the importance of children's oral health):

- In 2007, the state legislature codified (put into statute/law) the Oral Health Bureau and the position of state dental director.
- In 2007, the state legislature passed a bill requiring students newly enrolling in elementary and high school to have a dental screening.
- In 2008, the Department of Human Services reinstated periodontal and endodontic coverage for ME adults.
- In 2008, the department director of IDPH appointed a dentist and dental hygienist to the newly formed Medical Home System Advisory Council.
- In 2008 and 2009, the Iowa Public Health Association's advocacy statements included public policy recommendations regarding oral health.
- In 2009, the Iowa Dental Board made changes to public health supervision rules for dental hygienists, eliminating a requirement that children see a dentist within a year of receiving certain services from a hygienist. The rule was changed to allow dentists and hygienists to determine the specified length of time, potentially increasing it beyond one year.
- In 2009, Iowa became the first state to approve health care reform legislation that included approval of a dental-only option for the Children's Health Insurance program (CHIP). This will allow income-eligible families with medical insurance but no dental coverage to enroll with CHIP for dental insurance.

<sup>3</sup> Iowa Administrative Code 650, Chapter 10. <http://www.legis.state.ia.us/aspx/ACODocs/DOCS/11-5-2008.650.10.5.pdf>

## **Budget Estimates and Formulas of the Practice:**

The annual I-Smile™ budget is approximately \$2,200,000, a combination of state general funds and other (DHS/Medicaid) funds. Budget costs include:

- A total of \$500,000 is used for administrative program costs, such as OHB staff salaries and fringe benefits, travel and training (conferences, quarterly I-Smile™ coordinator trainings, and site visits for technical assistance), database upgrades, and computer hardware/software.
- Title V contractors are allocated \$1,700,000. Their funding formula uses a base of \$50,000 per contract (intended to support a I-Smile™ Coordinator's salary) and remaining funding distributed based on the number of ME children served.

## **Lessons Learned and/or Plans for Improvement:**

Lessons learned include:

- I-Smile™ coordinators (public health dental hygienists) are required to work a minimum of 20 hours a week using the hours for infrastructure-building activities, population-based interventions, and enabling services. Traditionally, public health dental hygienists primarily deliver direct services to patients. Transitioning to a focus on infrastructure-building activities by dental hygienists has been met with some trepidation. However, the gains made through these activities and the ability to hire additional dental hygienists to deliver direct services have help the coordinators understand and accept of the requirement.
- Paid claims data from Iowa Medicaid Enterprise shows many more children are receiving dental services by the age of one. However, this is occurring more through the services provided by the Title V child health system than from the dentists. In 2008, more than 12 times as many children age one or younger received a screening from Title V staff than the same age children receiving an exam from a dentist. Although there has been some improvement in the overall number of young children receiving services from dentists, the increase has not been to the degree expected. The current dental care delivery system is not changing rapidly enough to meet the needs of underserved children. In order to ensure all children receive necessary preventive and restorative dental care, additional workforce capacity is needed. In addition to using medical practitioners and dental hygienists, alternative models must be examined.

Plans for improvement include:

- IDPH will continue to seek additional support for I-Smile™ to expand available workforce, increase preventive services for underserved children, and improve Medicaid dental reimbursement rates (or use a third-party billing system).
- Policy changes may be needed to allow reimbursement for medical practitioners for oral screenings to ME children (outside of the bundled EPSDT well-child exam rate). May need to advocate that insurance companies, including CHIP carriers, reimburse medical practitioners for screenings and fluoride varnish applications.
- Recruitment and retention plans for dentists, particularly in rural Iowa, must also be investigated. This may include partnering with rural hospitals and developing new loan repayment programs.
- Additional training opportunities for expanded function dental assistants and public health dental hygienists would also enhance the dental workforce.

## **Available Information Resources:**

*I-Smile™ Web Site* ([www.ismiledentalhome.org](http://www.ismiledentalhome.org))

The Web site provides information for parents, health care providers and the general public about children's oral health, and includes contact information for the I-Smile™ Coordinator for each county in Iowa.

*I-Smile™: The Iowa Dental Home Proposal*

The original proposal for the I-Smile™ Project was developed in collaboration with the University of Iowa College of Dentistry, the Iowa Dental Association, Delta Dental of Iowa, and the Department of Human Services.

*I-Smile™ Oral Health Coordinator Handbook*

The manual was developed for use by I-Smile™ coordinators. It provides background on the I-Smile™ program, outlines job responsibilities, offers educational information, and provides forms and resources.

*I-Smile™ Risk Assessment*

The risk assessment is used in conjunction with oral screenings to determine a child's risk for tooth decay and the referral and care plan needed in relation to that risk.

*I-Smile™ Screening Guide for Health Care Professionals*

The "pocket guide" for non-dental health professionals provides brief information about children's risk for tooth decay and how to conduct an oral screening and apply fluoride varnish (includes photographs).

*Inside I-Smile™: A Look at Iowa's Dental Home Initiative for Children*

The report summarizes the initial impact of the I-Smile™ Project by reviewing the achievements of the first 18 months of the I-Smile™ Project.



## SECTION III: PRACTICE EVALUATION INFORMATION

### **Impact/Effectiveness**

*How has the practice demonstrated impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence, outcomes of the practice and/or evaluation results)?*

The I-Smile™ Dental Home Project helps at-risk children to access oral health care. I-Smile™ uses all available health care providers as part of a system of organized care, and can be applied in any community. At this time, the impact of I-Smile™ is best demonstrated by the increases in Medicaid enrolled (ME) children accessing dental services, as well as through policy initiatives for children's oral health. In 2008, 32.5 percent more ME 1-5 year olds received a dental service than in 2005, and 17 percent more ME 1-20 year olds received a dental service than in 2005. In addition, oral health has been included in several state policies – including codification of the Oral Health Bureau – ensuring dental public health leadership.

### **Efficiency**

*How has the practice demonstrated cost and resource efficiency where expenses are appropriate to benefits? How has the practice demonstrated realistic and reasonable staffing and time requirements? Provide unit cost analysis or cost-benefit analysis if appropriate.*

Implementing I-Smile™ through the existing statewide Title V maternal and child health system has allowed efficiency by building upon existing community linkages. I-Smile™ has focused on helping local Title V contractors hire dental hygienists to serve as I-Smile™ coordinators and these coordinators have expanded community infrastructure for children's oral health to increase access to dental services for ME children.

The agreement with the Department of Human Services (DHS) has allowed OHB to add a position to oversee expenditures, contracts and amendments, which frees up time for the OHB professional staff to address technical assistance, policy development, consultation, and increase efforts for state-level partnerships. The agreement also allows DHS to rely on the state public health dental director and OHB staff for consultation on oral health issues.

### **Demonstrated Sustainability**

*How has the practice showed sustainable benefits and/or how has the practice been sustainable within populations/communities and between states/territories? What mechanisms have been built into the practice to assure sustainability?*

Funding for the I-Smile™ Dental Home Project began in July 2007 and the first year of services began in 2008. The Project is still in its early stage of implementation. However, the project's strategy to build state and local infrastructure aims to sustain an oral health system that would ensure that child have access to care (a referral network, community health planning, and other resources for families). This strategy was integrated into the requirement that I-Smile™ coordinators invest their time in building infrastructure. Yet, sustainable funding sources for infrastructure-building projects are difficult to find. To continue funding for I-Smile™, OHB staff, particularly the state dental director, work to educate state stakeholders on the important role of the I-Smile™ coordinators and their impact on keeping children healthy.

### **Collaboration/Integration**

*How has the practice built effective partnerships/collaborations among various organizations and integrated oral health with other health projects and issues? What are the traditional, non-traditional, public and private partnerships/collaborations established by the practice for integration, effectiveness, efficiency and sustainability?*

I-Smile™ builds relationships and partnerships, an essential function of the project. I-Smile™ has established state and local partnerships with Head Start, state early childhood initiatives, the WIC program, schools, child care centers, local boards of health, community organizations, medical and dental practitioners, community health centers, and private foundations. Non-traditional partnerships include chambers of commerce and economic development groups (recruit dentists for

communities), rural hospitals (build dental clinics), and physicians' residency programs (provide oral health training).

For example, I-Smile™ partnerships helped implement the new state requirement that children newly enrolling in elementary and high school have dental screenings. Training was provided on how to inform families and health care providers about the state requirement, provide gap-filling screenings, and complete audit screening certificates. Dentists and physicians were enlisted to provide the screenings. Local boards of health, public health nurses, and school nurses helped to ensure compliance.

### **Objectives/Rationale**

*How has the practice addressed HP 2010 objectives, met the call to action by the Surgeon General's Report on Oral Health, and/or built basic infrastructure and capacity for state/territorial oral health programs?*

I-Smile™ addresses several Healthy People 2010 objectives: decreasing dental caries experience and untreated decay; increasing use of dental sealants; supporting community water fluoridation; using the oral health care system; providing dental services for low-income children; sustaining an oral surveillance system; and maintaining state and local dental programs.

I-Smile™ also addresses the Surgeon General's call to action for oral health: changing perceptions of oral health; overcoming barriers by replicating effective programs and proven efforts; building the science base and accelerating science transfer; increasing oral health workforce diversity, capacity, and flexibility; and increasing collaboration.

### **Extent of Use Among States**

*Describe the extent of the practice or aspects of the practice used in other states.*

Many states have begun to address ways to ensure children have medical homes. In Iowa, further efforts have been taken by creating an approach that can ensure children have dental homes. Iowa administrative code defines a dental home as a network of individualized care based on risk assessment, which includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services<sup>4</sup>. The I-Smile™ initiative responds to each of these elements and broadens the customary boundaries of the dental care system by recognizing the public health system and the importance of preventive care through non-traditional providers and locations. The Oral Health Bureau is not aware of other states that have adopted a similar stance or definition.

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<sup>4</sup> Iowa Administrative Code 641, Chapter 50 Oral Health. <http://www.legis.state.ia.us/asp/ACODocs/DOCS/9-9-2009.641.50.pdf>