Dental Public Health Project Descriptive Report Form

Please provide a description of your organization's successful dental public health project by completing this form. Add extra lines to the form as needed but stay within **word limits**.

Please return the completed form to Lori Cofano: lcofano@astdd.org

Name of Project
Ready, Set, Smile PA

Executive Summary (250-word limit))
Ready, Set, Smile (RSS) is a community school-based program that provides portable dental clinics and classroom oral health education on site at early childhood education centers, elementary and middle schools that enroll a high percentage of low-income children. About 20% of the children we serve are 5 years of age and younger. RSS was founded in 2013 to provide culturally rooted dental services, oral health education, and community outreach to low-income children who lack access to dental care. Emerging from a private dental practice, RSS is helping achieve the vision that every child has the opportunity to be free of dental disease. Our work builds on Minnesota's licensure of the mid-level dental practitioners and Community Health workers who represent the diverse population served. We will serve 43 schools in the Twin Cities Metro this coming school year. Many of the communities we serve experience significant trauma and children in these communities consider school a safe zone. Our non-invasive decay-control methods (interim therapeutic restorations and silver diamine fluoride) are performed without pain, needles, or drills. When further restorative care is necessary, we work to ensure children can receive that care in a dental clinic, with the loving support of parents/guardians: we refer children to our partner community clinics, which are culturally competent, accept Medicaid insurance, and have sliding-fee scale services for uninsured families and we follow up with families to ensure care has been accessed. By helping families establish a "dental home," we help ensure they will continue to receive affordable dental care in the future.

Name of Program or Organization Submitting Project
Ready, Set, Smile PA

Essential Public Health Services to Promote Health and Oral Health in the United States

Place an "X" in the box next to the Core Public Health Function(s) that apply to the project.

x	Assessment

	Policy development
	Assurance

http://www.astdd.org/state-guidelines/
Project submissions will be categorized by the Core Public Health Functions on the ASTDD website.

Healthy People 2030 Objectives

Reduce the proportion of children and adolescents with lifetime tooth decay. OH-01
Reduce the proportion of children and adolescents with active and untreated tooth decay. OH-02
Increase the proportion of low-income youth who have preventive dental visits. OH-09
Increase use of the oral health care system. OH-08
Increase the proportion of children and adolescents who have dental sealants on 1 or more molars. OH-10
Increase the proportion of people with dental insurance ASH-02

Keywords for sorting the project by topic.

Access to care, children, Silver Diamine Fluoride, Interim Therapeutic Restorations, Oral health literacy

Detailed Project Description

Project Overview
(750-word limit)

1. What problem does the project address? How was the problem identified?

Ready, Set, Smile (RSS) was founded by the women owners of a progressive private dental practice after they witnessed the devastating oral health needs of a local school that served a low-resource community. The health inequity between the children in this school and those who grew up in their practice was dramatic. They understood that there was a simple solution, access to preventive care and education. They boldly dove in to create the nonprofit, RSS.

This nonprofit was established by the principal of the founding private practice. As well as a dentist, she spent years as a social justice advocate and organizer and served on multiple Board of Directors for issues unrelated to dentistry. In 2006, the City of Minneapolis staff asked if as a dentist, she could develop a plan to bring a portable clinic into the convention center for dental services to the homeless as part of a new semi-annual event called Project Homeless Connect. She successfully did this for 4 years. Of the 30 services provided at these events, dental care was the #3 most requested service after housing and employment. Also, since 2002, her private practice participated in Give Kids A Smile (GKAS) by inviting a local principal to identify low-resourced children to receive comprehensive care. The children's oral health needs were overwhelming. These experiences brought her full circle in her advocacy work. She thought, "I am committed to social justice and nonprofit work. As a dental professional, I know there are solutions to this health disparity. I need to turn my skills to serve my community with my professional knowledge." A private practice dentist directly experienced the devastating

needs in her community, understood the issues that surround it and took action. She invited an array of diverse professionals to be on the Board of Directors. Together they built a nonprofit for the oral health needs of low-resourced children in their community.

While preventive visits can avert dental disease and identify problems before they become urgent, many low-income families do not access preventive care because they lack dental insurance; cannot afford to pay out-of-pocket for dental care; or have time, travel, or experience cultural and language barriers that hamper their efforts to find care. As a result, low-income children are far more likely than higher-income children to have tooth decay and serious dental problems.

Minnesota health statistical data confirm that we are reaching the population with the greatest needs. Our schools are chosen based on the percentage population for Free and Reduced Lunch (FRLP) and range from 58% to 98%, whereas the average FRLP populations in the two counties we serve are 21% and 55%. The average rate of dental uninsured in our population is 36%, whereas the average rate of uninsured in these two counties is about 20%, Third grade screenings conducted by the Minnesota Department of Health revealed a 30% rate of caries by patient count in schools with high FRLP populations, whereas this last school year our 3rd grade caries rate was 61%. That said, we have found a huge increase in decay rates by patients count since the pandemic. In general, at baseline of all first-time visits, our caries rate by patient count data over time fluctuates around 56%.

2. Who is the target population?

Children from low-resourced/low-income families. Our program accepts schools with high populations of children who qualify for free and reduced lunch programs, an indicator of poverty. At our partner schools, from 58% to 98% of children are low-income. Of the children we served last year, 96% were of color (39% Black, 36% Latino, 18% Asian, and 3% American Indian), over half were from immigrant families, and 36% were uninsured. Many of the children we serve are undocumented and cannot qualify for Medicaid.

3. Provide relevant background information.

On-site dental clinics are offered every 6 months. During a clinic visit, our team of licensed dental professionals conducts a simplified Caries Risk Assessment (CRA), which is based on clinical findings and health history, not a family interview nor the socioeconomic status of the child. Children are categorized into one of two levels: high or low.

Services provided every six months include routine preventive care: cleanings, sealants, fluoride varnish application, and oral hygiene instruction. In addition, silver diamine fluoride (SDF) is placed on all caries lesions to arrest or delay the decay progress. When clinically possible, Silver Modified Atraumatic Restorative Therapy (SMART technique) is provided. This is a noninvasive temporary restorative treatment for carious teeth. Atraumatic restorative treatment uses manual excavation and restoration of dental caries, eliminating the need for anesthesia and for large, expensive, and noisy dental equipment, making treatment highly portable and far less intimidating.

Based on a child's CRA, children identified as "high risk" receive an additional fluoride treatment between their 6-month clinic visits. This simple treatment is delivered by CHW's outside the child's classrooms. The additional fluoride varnish application delivered by a CHW is billed for

through the medical code established for this procedure (99188). The product used for both sealants and SMART are glass ionomers based.

We bill Medicaid and dental insurance providers for services provided to the insured. Our services are at NO COST TO FAMILIES.

Equally as important to our mission as our onsite dental services is our oral health literacy program brought into our schools' classrooms by Community Health Workers (CHW). Through our oral health curriculum, we integrate science and lifestyle habits into lessons that are hands-on and age appropriate. Our education focuses not only on the importance of brushing and flossing, but on the science behind dental disease and the impact of fluoridated water, nutrition, and sugar consumption on health. For children in the older grades, we teach lessons on vaping, tobacco use and the HPV vaccine.

CHWs attend after-school events such as back-to-school nights, health fairs, and conference days to register families and interface with families. Parents and guardians become familiarized with our program through their presence. Typically, CHWs will set up a table with our banner and healthy snacks to attract families. We have simple games for kids to play. This builds trust with families, students, and our school staff who recognize our commitment to be their oral health resource.

4. Describe the project goals.

- To be upstream to the dental disease process with preventive services
- Reduce the number of children with active decay.
- Increase the oral health literacy of the community served: school staff, children, parents, caregivers
- Empower children to care for themselves
- Connect families with dental homes through a network of collaborative partnerships

Resources, Data, Impact, and Outcomes
(750-word limit)

1. What resources were/are necessary to support the project?

Staffing includes a full-time leadership team of 3 staff, five full-time community health workers who work in all aspects of our program and a part-time licensed clinical team of an advanced dental therapist, a collaborative dental hygienist, and a licensed dental assistant. On clinic days, our CHWs work as unlicensed dental assistants. A team of volunteers supports the navigation of children from classrooms to clinics. Volunteer dental professionals participate in our program. We are designed not to be dependent on volunteers who we consider supplemental.

The simplest portable equipment is used with a process to transport equipment to school sites. We do not use a portable compressor or vacuum. We have light-weight portable patient chairs, provider chairs, and trays all purchased from Aseptico. Supplies and instruments are kept in large portable toolboxes on wheels. Instruments and individual supplies are prepared in the office by bundling into "burritos" with the patient napkin as the wrap. A reliable moving service transports our equipment.

We have collaborative partnerships with multiple organizations, including four higher education programs who do intern outreach in our program. Our most important collaborators are our referral network of community clinics who see the children that we diagnosed with needs

beyond the scope of our school-based program. These clinics include FQHC's, private dental practices and community clinics. We have built these relationships. Some clinics provide special phone contacts for our families for what we call a warm, respectful referral.

These partnerships are built through relationship building. Initially we share our mission and present an ask for partnership. We request a specific phone line for our families to call and a specific liaison care coordinator to schedule our families when they call and identify themselves an RSS parent or guardian. Private practices will sponsor a local school or donate time to see a few children each year. Two pediatric dentists donate sedation dentistry visits. One pediatric practice has a contract with a health care insurance provider and will see those insured children only for us. Commitments are flexible and varied. We are amid a pilot to expand and formalize this dental home safety net model which we are seeking funding for with a new affiliate of RSS, Apple Tree Dental.

2. (a) What process measure data are being collected (e.g., sealants placed, people hired, etc.)?

RSS collects comprehensive data on the children we serve, the number and type of services they receive (child and tooth count), the oral health education we provide, and specific dental health so that we can effectively determine the impact of our services. We use software designed by New England Survey Systems (NESS) for school-based dental clinic programs. The data collecting program was developed by Dr. Richard Neiderman for school-based programs and clinical trials. The tablet-based software does not require Wi-Fi – an asset when providing onsite services at schools where firewalls make internet access difficult to impossible. The software has stringent record security, HIPAA compliance and is simple to use. Services or outcomes can be tracked at multiple levels, including child, classroom, school, or population.

(b) What outcome measure data are being collected (e.g., improvement in health)?

We assess impact by tracking changes over time in the percentage of children with active decay and with urgent needs. We have not done individual longitudinal outcomes since the pandemic. We track all treatment by individual child and tooth (including the number of teeth that had active decay arrested by SDF) and analyze these changes at the school and population levels.

More intensive analysis of longitudinal data conducted prior to the pandemic showed that with four consecutive visits (over two years), the number of children with active decay decreased by 25%. We will not be doing this in-depth analysis due to the expense.

(c) How frequently are data collected?

Through NESS iPad software, we collect data with every dental visit. We can look at our data in the NESS online portal at any time. It aggregates the number of procedures performed and gives us a basic updated analysis of our data, such as the percentage of children with active decay and urgent needs weekly.

3. How are the results shared?

Our data is shared individually and annually with each school during our end-of-year assessment meeting. Other stakeholders, including donors, foundations and Minnesota health agencies receive data regularly through annual letters, reports, and communications. At all times, data are used to inform planning and continuous improvement.

Budget and Sustainability
(500-word limit)

Note: Charts and tables may be used.

1. **What is/was the budget for the project?**

Our fiscal is a July 1 start. In 2022/2023, with a budget of $644,309, we treated 1520 children in 34 schools with 2290 visits excluding the additional fluoride varnish applications. We doubled the number of children seen over the previous year. This current fiscal year budget is $825,952 and we are adding an additional five schools. We are aiming for a 15% increase in the total number of children served.

2. **How is the project funded (e.g., federal, national, state, local, private funding)?**

Our project is funding as follows:

- 50% - Earned revenue for services provided
- 35% - Foundation Funding
- 15% - Donations from individuals and corporations

We have a Sponsor A School program for local dentists to provide a generous annual sustaining gift.

4. **What is the sustainability plan for the project?**

We hope with time to increase the revenue earned, especially for services provided by our CHWs. In the last two years, we have ended our year with a substantial surplus. We have created a 7-month reserve fund. We have been working with a skeleton staff. We are adding more employees and we recently added benefits and increased wages to retain our staff. This includes health, dental benefits, and a 401K.

Lessons Learned
(750-word limit))

(a) What lessons were learned that would be useful for others seeking to implement a similar project?

A key to our success is to address the culturally specific needs of children and families served. A core feature of our team-based dental services and education delivery model is the employment of culturally rooted Community Health Workers who help address the cultural barriers to access and help reduce the disparities in dental health outcomes for low-income children and families from diverse racial, cultural, and linguistic backgrounds. They touch every aspect of our program and are critical to the building of trust with our families. They have lived the experiences of our families and are committed to serving their communities.

To become a CHW, one receives a one-year certificate from a higher education program. Most programs are in the evening and online. Typically, CHWS are young adults from immigrant families. Although they receive education on specific diseases, nothing is given to oral health education. Onboarding a CHW requires a full year of intensive on-the-job training, which includes job shadowing, mentorship, and cohort training.

As our reputation grows, schools have begun to initiate the request for our program as they recognize that the oral health needs of their students are neglected and create learning issues for their students. Wrap-around school-based health service is a growing trend in public schools, even globally. RSS answers this call for dental services in school seeking wrap around services. More programs are needed. Public health agencies setting up calibration options for

programs with recommendations for how to provide services could be an answer to this health disparity.

Data from prior to the pandemic shows that the longer we serve a school, the lower the percentage of children with active decay and urgent needs. During the pandemic we were unable to provide services because schools were closed. Post-pandemic, we experienced an expected decline in improvement, and this was greatest in the early childhood programs.

(b) Any unanticipated outcomes?

Although there are billing opportunities for the work of CHWs, they are most difficult to get through the insurance industry for payment. They create an environment where it is not worth the effort to bill. We should receive compensation for CHWs' classroom education, but it is a constant struggle. We need to advocate for a breakthrough on behalf of the CHW profession. We have not given up.

We do not find push-back from parents who decline our consent for SDF because they read about the staining. Once we call to explain what the product does for their child, they most often accept the staining of the decayed areas of teeth because of the potential to arrest it.

(c) Is there anything you would have done differently?

We started our program with dental software that we were accustomed to in our private practice. The program is not user-friendly for a school-based program. We are currently converting to Open Dental, an open-source system that allows the writing of your own queries.

A dream would be to have Open Dental integrated with NESS, our software iPad system that does not require Wi-Fi. We do not know if that is possible. Right now, we have the cumbersome process of using both. One for billing and one for record keeping. We should have done this differently.

Resources

List resources developed by this project that may be useful to others (e.g., guidelines, infographics, policies, educational materials). Include links if available.
Our educational materials can be found on our website: www.readysetssmile.org

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