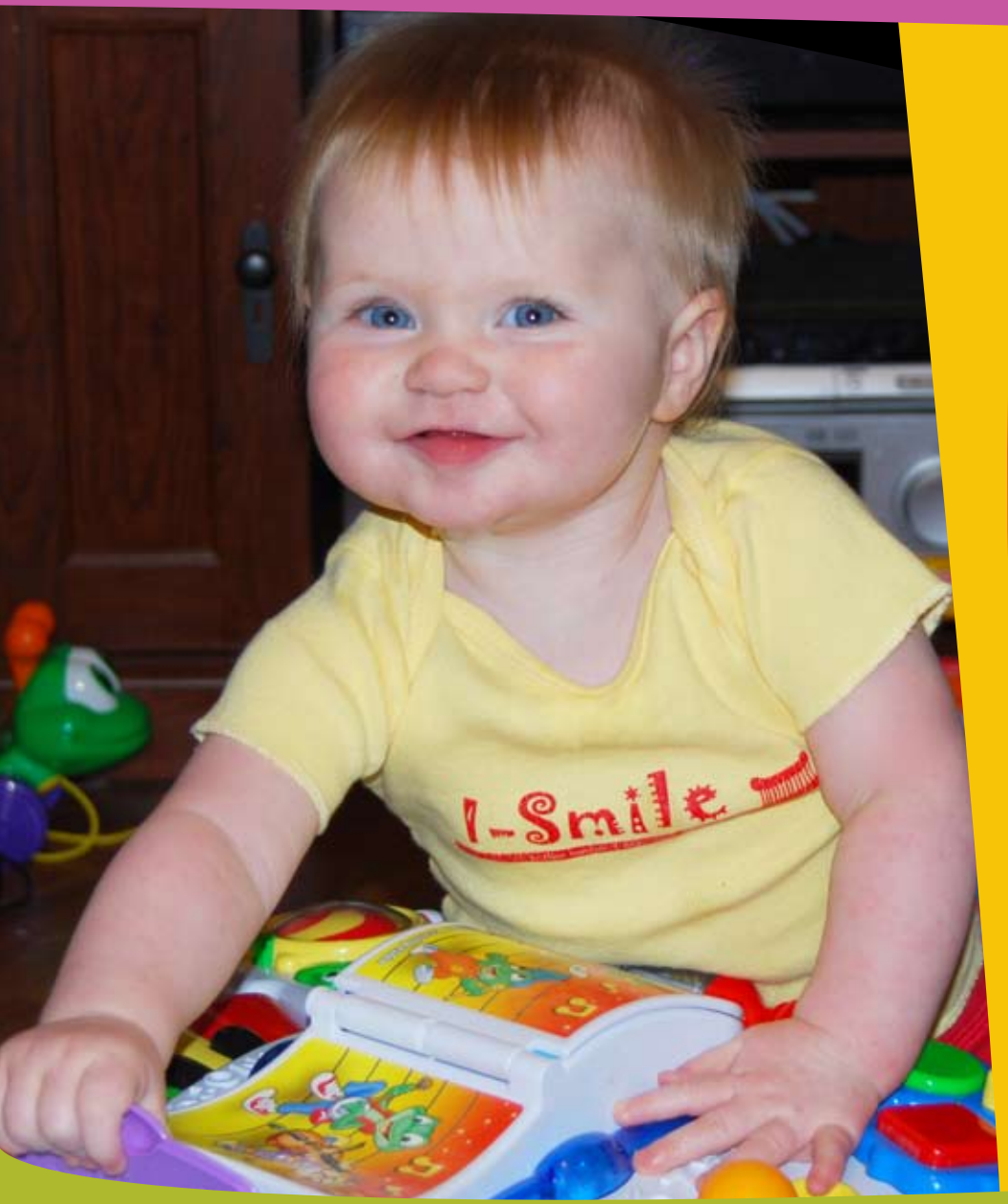

Inside I-Smile™ 2009

An Update on Iowa's Dental Home Initiative for Children

Iowa Department of Public Health - Oral Health Bureau

Inside I-Smile™ 2009

An Update on Iowa's Dental Home Initiative for Children

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Foreword by State Public Health Dental Director Bob Russell, DDS, MPH

This edition of ***Inside I-Smile™*** represents the second annual report on the I-Smile™ dental home project. We are pleased that the data contained within this report continues to further demonstrate the increasing benefits of public health infrastructure bridging the gap between at-risk families and the private practice health care system. While much has been done to improve oral health conditions for Iowans, much more is needed, and the obstacles and challenges facing underserved families are many.

According to the U.S. Surgeon General, tooth decay is a "silent epidemic" and the most common chronic childhood disease. A recent report from the Centers for Disease Control and Prevention (CDC) indicates that childhood decay for children between ages 2 and 5 is increasing nationally. In Iowa, 2009 data indicates that 22 percent of third graders have untreated tooth decay – a significant increase from a rate of 13 percent in 2006. For low-income Iowa children, the data is even more alarming – with 27 percent having untreated decay in 2009. This "silent epidemic" is further evidenced by access to care data. In 2008, less than 49 percent of Iowa's Medicaid-enrolled children ages 1 to 20 received any type of dental service – and only 21 percent received dental treatment.

This report illustrates that while advances are being made closing the gaps in prevention and early detection, the gaps in access to dental care services are more difficult to bridge. More must be done to improve the ability for all Iowans to access necessary oral health services. We are determined to continue to seek remedies, both tried and new, that work to both build and sustain our vital oral health care delivery system. The data contained within this report will help focus our resources and efforts on those initiatives that work and to create new ones to replace those that don't.

"Insanity: doing the same thing over and over again and expecting different results" - Albert Einstein

Bob Russell DDS, MPH

Inside I-Smile™:

A Look at Iowa's Dental Home Initiative for Children

reported on the initial impact of the I-Smile™ project in 2008. This report is an update, reviewing results of activities from 2009.

Background

In Iowa, a dental home means a network of individualized care based on risk assessment. This includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services.

The I-Smile™ project was created to ensure that Medicaid-enrolled children have a dental home. Multiple health care providers play a role in providing the services within a dental home. Also, services are provided in locations or settings where at-risk families are found. This includes physician's offices during well-child exams, at WIC clinics, and in preschools. Dentists are relied upon to provide definitive diagnosis and restorative care as needed.

At the heart of I-Smile™ are 24 dental hygienists, working as regional I-Smile™ Coordinators within Title V child health agencies. The coordinators are responsible for building partnerships within communities; linking with local boards of health; providing education and training for health care providers about children's oral health; developing oral health protocols; ensuring care coordination services and assisting with referrals to dentists; and ensuring completion of screenings, risk assessments, and gap-filling preventive services.

Impact

The following report sections illustrate the impact of the I-Smile™ project on access to a dental home for Medicaid-enrolled children.

I-Smile™ Data and Discussion:
The data tables within this section correspond to those used in the original Inside I-Smile™ report from 2008. Baseline and previous measures are provided, as well as new data for comparison. Impact summaries follow each table, and brief discussions are included regarding the data.

Summary:
This section outlines the policy and program implications, based on the data results.

I-Smile™ Data and Discussion

Table 1 includes comparison data for Medicaid-enrolled children ages 0-5 receiving a dental service. CMS[1] 416 reports provide the utilization numbers. The baseline data is the last federal fiscal year[2] (FFY) before I-Smile™ began. The most recent available data for comparison is from FFY2008.

CMS 416 data includes services billed by dental offices and "screening centers", which refers to Title V child health agencies. Services provided within community health center dental clinics are not included in CMS 416 data.

Table 1: Number of Medicaid-enrolled children ages 0-5 receiving a dental service

Measure	Year	Number of children receiving a service	Total enrolled	Percent receiving a service (N/T)
Baseline	FFY2005*	28,806	93,311	30.9%
Previous	FFY2007	35,914	100,345	35.8%
Current	FFY2008	39,071	101,034	38.7%

* The original report used FFY2006 as the baseline for *Table 1*. For consistency with other report tables, the data from FFY2005 is used in this year's report for the baseline measure, to clearly reflect services prior to I-Smile™.

IMPROVEMENTS - more children are receiving early dental care
- 36% increase in children receiving services since implementation of I-Smile™
- 9% increase from 2007

Discussion of Table 1: The increases in the number of Medicaid-enrolled (ME) children ages 0-5 receiving dental services are particularly promising. Regular care at a very young age is an important way to prevent future disease and increased costs for dental treatment to the Medicaid program.

At a minimum, it appears that there is improved access to preventive services for ME children ages 0-5 in public health settings. It also appears that traditional barriers of limited acceptance of Medicaid patients by dental offices and waiting to see children until they are 3 or older are lessening.

[1] Centers for Medicare and Medicaid Services
[2] Federal fiscal year is October 1 through September 30.

Table 2 includes data from the Child and Adolescent Reporting System (CAReS), which documents dental services provided to children ages 0-20 served by the state's Title V child health agencies. Services are provided in a variety of public health settings, including WIC clinics and Head Start centers. Most services are provided by dental hygienists; some are provided by registered nurses or nurse practitioners.

Discussion of Table 2: I-Smile™ allows Title V agencies the ability to provide more preventive care for underserved children. Although it appears there were fewer education/oral health counseling services provided during the past year, the decrease is likely due to changes in protocols for recording those services within the Child and Adolescent Recording System (CAReS). Oral Health Bureau (OHB) staff made minor policy changes for Title V agencies regarding CAReS documentation, intended to ensure consistency and improve standardization of the data reported.

Many dental hygienists within Title V agencies also provide education for groups, a common public health practice. However, these population-based education services are not captured within the CAReS database, so the number of families impacted by that is unknown.

Table 2: Services provided to Title V child health clients

Service	Year	Total provided
Fluoride varnish application	FFY2005	10,090
	FFY2008	34,320
	FFY2009	40,628
Oral screening	FFY2005	14,437
	FFY2008	43,490
	FFY2009	48,703
Education/Oral health counseling	FFY2005	12,603
	FFY2008	29,868
	FFY2009	22,166

IMPROVEMENTS – more at-risk children, including low-income, uninsured, and Medicaid-enrolled, are receiving preventive dental services from Title V staff

- Four times as many fluoride varnish applications since prior to I-Smile™
- Three times as many screenings since prior to I-Smile™
- 76% increase in education/counseling services since implementation of I-Smile™

Table 3: Examples of I-Smile™ activities during FFY2009

Description	Total
Dental hygienists working as I-Smile™ Coordinators	24
Medical practices receiving training on oral screenings/fluoride varnish application	27
Outreach contracts to medical providers	633
Title V agency staff receiving oral health training	113
I-Smile™ reports given to local boards of health	195
I-Smile™ presentations given to local boards of health	86
Dentists accepting referrals from I-Smile™ for uninsured, low-income children	346
Dentists accepting referrals from I-Smile™ for Medicaid-enrolled children	415
Outreach contacts to dentists	1,889
Oral health care coordination services	18,963

Discussion of Table 3: I-Smile™ Coordinators continue to build partnerships and promote children's oral health. Although fewer medical practices received training on oral screenings and fluoride application this year (49 less than in 2008), coordinators provided several outreach contacts with medical practices. By doing so, the coordinators are strengthening existing and building new relationships, and becoming a valuable resource to assist with dental referrals. Oral health promotion also occurred through the number of written reports and oral presentations given to local boards of health in each county.

In addition to medical offices, coordinators had numerous outreach contacts with dental offices. This is a particular strength of the I-Smile™ project. These contacts are building referral systems and enhancing public-private partnerships to ensure at-risk children receive all of the services within a dental home. Coordinators reported on the number of dental offices that accept referrals – not only for children enrolled on Medicaid, but also for low-income children with no payment source for care. There may be others that will occasionally see Medicaid-enrolled (ME) and uninsured children, but the numbers reported by coordinators reflect those dentists they know they can rely upon to see the at-risk children. As I-Smile™ Coordinators and their roles become more familiar to dental office staff, we hope to see the number accepting referrals grow.

A large number of families receive assistance in accessing dental care, as seen through the number of care coordination services. While it appears that care coordination services were lower this year (41,354 in 2008), the decreases are most likely the result of the OHB's new policies for how agencies record services within CAReS. The changes were made to ensure consistency and standardization of the data reported, as well as to ensure accuracy for a new billing process.

More at-risk children

are receiving preventive dental services from Title V staff.

Tables 4 through 9 include data from paid Medicaid claims, provided to the OHB from Iowa Medicaid Enterprise. Baseline data is from state fiscal year (SFY) 2005, prior to the implementation of I-Smile™. The most recent available data for comparison is from SFY2009. Data includes services billed by dental offices and "screening centers", which refers to Title V child health agencies. Services provided through community health center dental clinics are not included in these tables.

Data is also included within *Tables 4 and 7* for services provided by medical practitioners – physicians, nurse practitioners, and physician assistants.

Table 4: Number of dentists and medical practitioners billing Medicaid for dental services provided to children ages 0-12*

Measure	Year	Dentists who billed	Physicians or nurse practitioners who billed
Baseline	SFY2005	1,092	3
Previous	SFY2008	1,144	23
Current	SFY2009	1,147	25

* Medical practitioners are limited to billing Medicaid for fluoride varnish applications to children younger than 3.

MIXED RESULTS – overall, more health care professionals are providing dental services to children, however only slight changes in the past year

- 5% increase in dentists providing dental services since implementation of I-Smile™; no significant improvement in past year
- Eight times as many medical practitioners provide preventive dental services since implementation of I-Smile™; no significant improvement in past year

Table 5: Number of Medicaid-enrolled children 0-12 receiving a dental service by provider type

Measure	Year	Provider	Number of children receiving a service	Total enrolled	Percent receiving a service (N/T)
Baseline	SFY2005	Dentist	59,390	189,484	31.3%
Previous	SFY2008	Dentist	64,327	201,619	31.9%
Current	SFY2009	Dentist	81,118	214,252	37.9%
Baseline	SFY2005	Screening Center	7,861	189,484	4.1%
Previous	SFY2008	Screening Center	17,039	201,619	8.5%
Current	SFY2009	Screening Center	23,483	214,252	11.0%

IMPROVEMENTS – more children are receiving dental services

- 37% increase in children receiving services from dentists since implementation of I-Smile™; 26% increase since last year
- Three times as many children receive services from Title V staff since implementation of I-Smile™; 38% increase since last year

Table 6: Number of Medicaid-enrolled children ages 0-12 receiving preventive dental services* and provider type

Measure	Year	Provider	Number of children receiving a preventive service	Total enrolled	Percent receiving a service (N/T)
Baseline	SFY2005	Dentist	51,411	189,484	27.1%
Previous	SFY2008	Dentist	56,524	201,619	28.0%
Current	SFY2009	Dentist	71,258	214,252	33.3%
Baseline	SFY2005	Screening Center	6,019	189,484	3.2%
Previous	SFY2008	Screening Center	14,145	201,619	7.0%
Current	SFY2009	Screening Center	21,054	214,252	9.8%

* Preventive dental services includes prophylaxes, sealant and fluoride applications

IMPROVEMENTS – more children are receiving preventive dental care

- 39% increase in children receiving preventive care from dentists since prior to I-Smile™; 26% increase since last year
- 3 ½ times as many children receiving preventive care from Title V staff since prior to I-Smile™; 49% increase since last year

Table 7: Number of Medicaid-enrolled children ages 0-2 receiving a fluoride varnish application from a medical practitioner

Measure	Year	Provider	Number of children receiving a service
Baseline	SFY2005	Physician or Nurse Practitioner	13
Previous	SFY2008	Physician or Nurse Practitioner	167
Current	SFY2009	Physician or Nurse Practitioner	72

MIXED RESULTS – although more children are receiving preventive fluoride applications from medical practitioners, fewer children received those services in the past year

- More than 5 times as many children receive preventive dental care from medical practitioners since implementation of I-Smile™; however a 57% decrease since last year

Discussion of Tables 4-7: There was little change in the number of dentists billing Medicaid for services provided to children ages 0-12. However, there was an increase in the number of children ages 0-12 receiving a service from a dentist in 2009. This likely reflects that dentists willing to treat Medicaid-enrolled (ME) children as patients are seeing more cases - perhaps due to care coordination by I-Smile™ Coordinators. Raising Medicaid reimbursement for dental procedures may be necessary to see increases in the number of dentists providing care for ME children.

The number of medical practitioners that billed Medicaid for fluoride varnish applications in the past year rose by just two. And although the number of children benefiting from the applications from medical practitioners was still 5 ½ times greater than prior to I-Smile™, the large decrease during the past year is of concern. Because dental services may be considered to be outside of the medical providers' standard of care, policy changes to allow additional reimbursement may impact these numbers in the future.

More ME children received preventive services in the past year – there was a 26 percent increase from dentists as well as a 49 percent increase from Title V program staff (Table 6). *Tables 5 and 6* both show the large increases in ME children receiving services from Title V staff. Three and a half times as many children are receiving preventive services within the Title V program than prior to implementation of I-Smile™.

Table 8: Number of Medicaid-enrolled children receiving a dental service at or by the age of 1 and provider type

Measure	Year	Provider	Number of children receiving a service	Total enrolled	Percent receiving a service (N/T)
Baseline	SFY2005	Dentist	1,726	54,300	3.2%
Previous	SFY2008	Dentist	3,040	60,294	5.0%
Current	SFY2009	Dentist	3,945	62,679	6.3%
Baseline	SFY2005	Screening Center	2,493	54,300	4.6%
Previous	SFY2008	Screening Center	6,758	60,294	11.2%
Current	SFY2009	Screening Center	7,216	62,679	11.5%

IMPROVEMENTS – more children are receiving dental services at or before the age of 1

- More than twice as many children receive care from a dentist before they are 2 years old than prior to I-Smile™; 30% increase since last year
- Nearly 3 times as many children receive care from Title V staff before they are 2 years old than prior to I-Smile™; 7% increase since last year
- Public health programs see 83% more children before their second birthday than dentists

Table 9: Number of Medicaid-enrolled children receiving an initial exam (dentist) or initial screening (screening center) before the age of 1

Measure	Year	Provider	Number of children receiving a service	Total enrolled	Percent receiving a service (N/T)
Baseline	SFY2005	Dentist	131	38,102	0.3%
Previous	SFY2008	Dentist	182	42,466	0.4%
Current	SFY2009	Dentist	211	43,411	0.5%
Baseline	SFY2005	Screening Center	974	38,102	2.6%
Previous	SFY2008	Screening Center	2,289	42,466	5.4%
Current	SFY2009	Screening Center	3,012	43,411	6.9%

IMPROVEMENTS – more children receive a dental exam or screening before their 1st birthday

- 61% more children receive exams from dentists than prior to I-Smile™; 16% increase since last year
- Three times more children receive screenings from Title V staff since prior to I-Smile™; 32% increase since last year
- Public health programs see 14 times as many children for screenings before the age of 1 than dentists

Discussion of Tables 8 and 9: Both the American Dental Association and the American Academy of Pediatric Dentistry recommend that children need to receive care within 6 months of the first tooth erupting or by their first birthday. Yet, baseline data prior to I-Smile™ shows that very few ME children received an exam prior to turning 1, or any services prior to age 2. Current data shows little change in the number of ME children seen by dentists prior to age 1 (last year, just 211 received an exam) and minor improvement in the number seen prior to the age of 2. Perhaps more promising is that during the past year, 3,012 children received a screening within public health settings before the age of 1, and 7,216 received a service prior to the age of 2.

I-Smile™

is improving access to dental care for children.

Summary

I-Smile™ is improving access to dental care for children.

Preventing tooth decay before it begins is an important premise of the I-Smile™ initiative. Iowa's public health programs see 14 times as many children for screenings before the age of 1 than dentists see for exams, and 83 percent more children receive care from public health programs than dentists prior to the age of 2. The differences between the number of very young children receiving care from dentists and public health practitioners illustrates the importance of public-private collaborations as part of I-Smile™ in improving the availability of recommended early care to prevent and reduce dental disease.

In order to ensure Iowa children receive the evidence-based standard of care recommended by national dental organizations, we will pursue ways to enhance early entry into the I-Smile™ dental home within public health programs. The differences in children receiving services within public health settings compared to dental offices underscores the difficulty for some families to access traditional systems of dental care. Although the number of children seen at or before age 1 continues to rise, there are still many

more yet to be reached. Partnerships with Early Childhood Iowa and programs such as Head Start will be expanded in order to achieve even more improvements in the number of children receiving early preventive care.

I-Smile™ Coordinators are responsible for creating local referral networks with dental offices, and these networks appear to be working to improve availability of care for some families. Dentists who accept ME children are providing more services, but the number of Medicaid providers is not changing. Relationships between I-Smile™ Coordinators, the children they serve, and dental office staff are critical to ensure that dental care is not only sought but treatment plans are completed as needed. Future I-Smile™ strategies will expand on these successful linkages to try to build the dentist referral network statewide, including exploring ways to increase dental provider willingness to see children at the age of 1 and potentially raising Medicaid reimbursement for dental services.

The I-Smile™ dental home includes services provided by non-dental health care providers (ie - nurses, physicians, and physician assistants). Current Medicaid policy allows medical practitioners to bill for fluoride varnish applications provided to children younger than 3 when done in conjunction with well-child exams. I-Smile™ Coordinators have been somewhat successful in working with local medical offices to provide training and assistance in the billing process.

Although there has been a rise in the number of medical practitioners billing for fluoride varnish applications since I-Smile™ began, there was little change in the past year. Health care workforce issues may be playing a role. Many medical practitioners voice their interest in participating in the I-Smile™ dental home and their concern for children's oral health, but anecdotally, I-Smile™ Coordinators are often told that schedules do not allow any additional service during the well-child exam. A significant change in the number of medical providers willing to include preventive dental services is unlikely without a separate fee structure for oral screenings. Because medical practitioners have so many contacts with very young children, it is important to seek ways to improve the likelihood that they play a role within the I-Smile™ dental home. The Oral Health Bureau will continue to seek policy changes that may provide additional incentive, such as the ability to bill for a screening as well as fluoride varnish application.

As more families receive preventive services within public health and medical settings and more treatment needs are identified, there is an increased demand for dental services. In order to further assure availability of both preventive and restorative dental care, it may be necessary for Iowa policy-makers to explore alternatives to workforce issues. This is particularly true if there continues to be no improvement in the number of dentists and medical practitioners willing to provide dental services for at-risk children. This may include increased training opportunities, scope of practice changes, and introduction of new provider types.

Because I-Smile™ is working to improve the number of at-risk children receiving dental services, sustaining funding for the project is crucial. As indicated by the growing number of children enrolled on Medicaid, more and more Iowa families are being impacted by the country's economic issues. Maintaining services provided through I-Smile™ will be integral to ensure children in Iowa have a dental home and good oral health.

I-Smile™ Stories from the Field

Reported by I-Smile™ Coordinators

Northwest Iowa

The I-Smile™ activities this year have gone above and beyond offering screenings at the schools. We were able to reach out to children that were being home-schooled, those living in rural areas, and low-income children unable to afford dental care or transportation to their dental appointments. Correctionville Medical Clinic staff recounted a story of a child whose mother would bring her in all the time if there were problems with her child's teeth. She didn't know that there were dental providers who were accepting Medicaid. Once the medical clinic staff had the oral health training and heard the I-Smile™ Coordinator's presentation, they connected her to the family where she was able to guide the mother in the right direction by helping her make an appointment with a private dentist who was accepting Medicaid.

The efforts put into the new school screening mandate have really impacted this community. It is brought to light all the time and has been great leverage now into linking with dental offices, medical clinics, schools and other agencies. The community wants to know more about it and take it serious as they would with getting their child's vaccinations up to date.

Southeast Iowa

Many low-income children receiving Medicaid benefits have a difficult time finding a dentist in our area. Our programs enable many children to receive preventive oral health services they may not otherwise have been able to receive. When prevention is not enough, the I-Smile™ Coordinator provides care coordination to see that follow-up care is received.

Recently, a mother was very grateful for all of the help she received for her eight- year-old daughter. The child was seen in the school-based dental sealant program. The hygienist found six areas of suspected decay, and the child reported that her "teeth kinda hurt." The I-Smile™ Coordinator called right away and helped the mother schedule an appointment at the Community Health Center (CHC) dental clinic, about a half hour's drive, for the following day. The mother voiced some concern about gas money, but knew she could make it work. The I-Smile™ Coordinator explained Medicaid could reimburse her for the travel. The mother was very interested and surprised she had not already known that.

The mother then reported the child had x-rays taken not too long ago at a different dental office, about a half hour's drive in the opposite direction, and feared she would be charged if new x-rays were taken. That office was not currently an option, as the dentist was out for personal reasons. The I-Smile™ Coordinator offered to pick up a copy of the x-rays on her way to work the next day. The mother agreed that would work out great, and she could pick them up before leaving town for the appointment. The I-Smile™ Coordinator also gave her a few copies of the travel reimbursement form while she was there. She also showed her how to complete it and explained where to send it. The child was seen by the dentist at CHC that day and is now in the process of completing her treatment plan.

Northeast Iowa

We had a very good experience while doing dental screenings through the Empowerment Preschool Screening Program. While doing the screening, a mom was there watching and asked the dental hygienist some questions. Her little girl had brittle bone disease, and the mom wasn't sure if she should let the hygienist look in the girl's mouth. She did consent, and the screening went very well. Mom stated she was very happy for her little girl to have the experience and even felt she would now look into taking her to the dentist. Mom also didn't know she was eligible for WIC, even though she had Medicaid. Now, the hygienist can continue to monitor the child at her WIC appointments also. This would not have happened without the preschool screening program and the partnership with Empowerment.

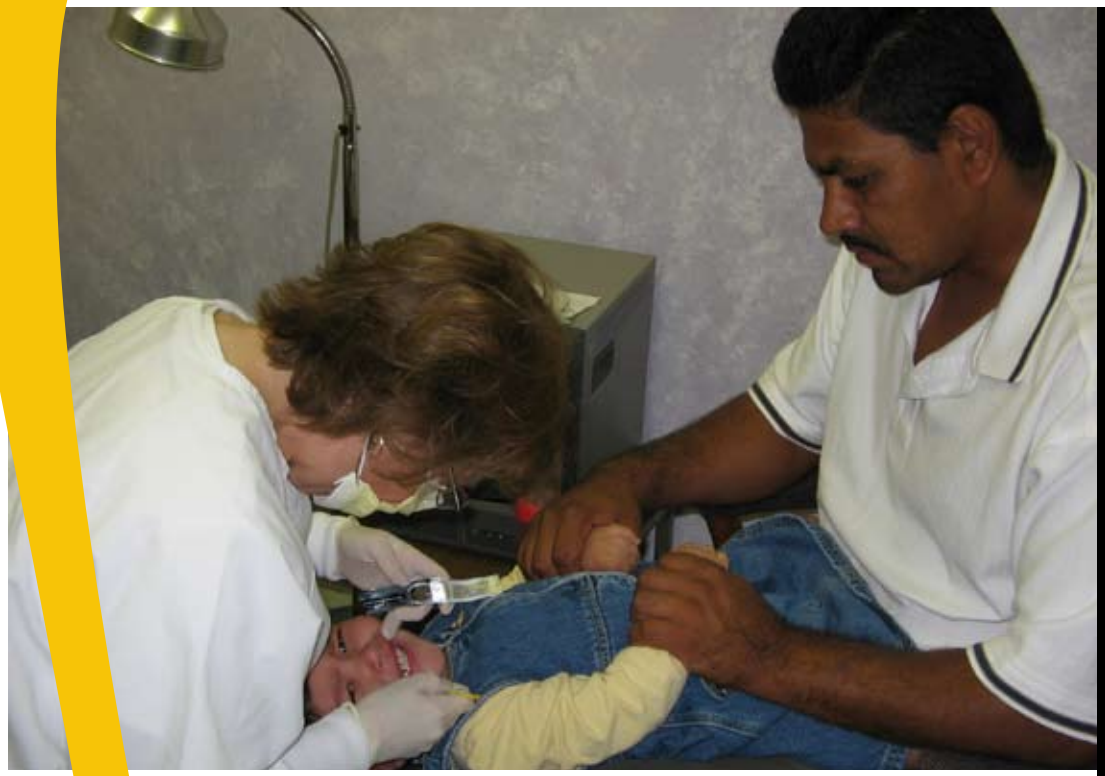
Another mother was referred by an agency case manager with oral health concerns for her family. Three children live in the home, ages 20, 16, and 8. The family has no dental insurance, and the mother will not drop the health insurance to apply for ***hawk-i*** - for which they meet the eligibility guidelines. The 16-year-old daughter has complained of mouth pain, but the mother delayed care due to lack of funds. She is now is the process of receiving root canal therapy for which the dentist has graciously agreed to accept payments. The 8-year-old (with cardiac issues) has never seen a dentist. The 20-year-old also needs a dental exam. Mom requested information on payment options for dental care. We discussed the MCH Title V Referral Program for which mom is completing paperwork. Mom was extremely appreciative of whatever assistance we could provide. This family will probably benefit from the new changes to ***hawk-i*** which will allow them to enroll for the dental-only option and keep their existing medical coverage.

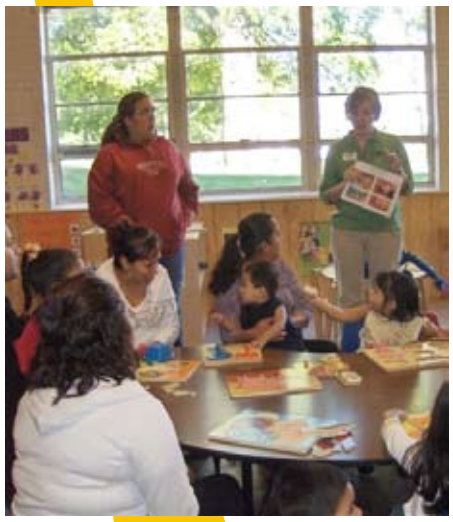
"Our programs **enable many children to receive preventive oral health services they may not otherwise have been able to receive."**

Central Iowa

Sometimes the I-Smile™ Coordinator can coordinate a dental appointment for a child with one simple phone call, and sometimes there is much more involved. This story starts when the I-Smile™ Coordinator was about to screen a child at a WIC Clinic. She put on her gloves and took her flashlight out. Andrew, a rambunctious four year old boy, started screaming and yelling at the top of his lungs, "OWIE, OWIE!" The I-Smile™ Coordinator had yet to even touch him, but already she could see large areas of decay. Mom was near her breaking point and about in tears. She explained the family moved to Iowa and was currently living with in-laws while looking for work. Andrew had Medicaid in South Carolina and was able to see a dentist while there. However, Andrew would not cooperate for that dentist and was referred to a pediatric dentist. In the mean time, the family moved to Iowa.

Mom was overwhelmed with the move and had not yet applied for Medicaid in Iowa. The I-Smile™ Coordinator gave her the forms to sign up, but then discovered that Mom was not able to read. This led to a call to a volunteer from the Income Tax Prep Program. He met with the mom later that same day at the library to help her complete the application forms. Within ten days, Andrew had Medicaid coverage. The I-Smile™ Coordinator then made an appointment with a pediatric dentist that accepted Medicaid and told the staff that mom may need a little extra help with paperwork. She also gave a map to mom with pictures and landmarks as directions to the dental office. Mom was very thankful and could not believe the help and caring of strangers in Iowa. This was a good lesson that barriers are not always just about money.





Southwest Iowa

Last February, the staff at a local elementary school alerted the principal they had concerns regarding 4-year-old Megan's oral health. The principal called the I-Smile™ Coordinator for suggestions as to what to do and where to go with this child. With about two and a half hours worth of phone calls and emails between the school and the dentist, an appointment was made with a pediatric dentist in Des Moines for March. The principal drove the child herself as the family did not have the means. The I-Smile™ Coordinator encouraged the principal to use Medicaid transportation forms the round trip would be about 180 miles.

Megan had four extractions, replaced with a "kiddie" partial. She also had four crowns placed on molars and then additional restorations and sealants. The principal also took Megan back for a follow-up appointment about a week later. She stated Megan was a little teary but liked her new pretty teeth. That was on a Tuesday. By Friday, the cook at school noticed that Megan finished all of her breakfast for the first time. In May, the I-Smile™ Coordinator contacted the school to see how Megan was doing because the phone had been disconnected at Megan's home. She found out that the principal had taken her back to the dentist in Des Moines. The partial had become loose since the swelling went down and was re-adjusted. In October, the I-Smile™ Coordinator saw Megan at preschool and applied fluoride varnish for additional prevention. She noted that Megan was brushing sometimes three times a day!

Another school nurse also called the I-Smile™ Coordinator to get help for a little girl whose family had just moved from out of state. Lydia had gone to the school nurse in pain. The nurse suspected an abscess. The family had Medicaid when they lived in another state. However, they had not yet applied in Iowa. After calls to two different dentists, the I-Smile™ Coordinator was able to get her in for an appointment with one of them that day. She supplied payment assistance for that visit, a Medicaid application, and transportation forms for future visits. Because there is no dentist in this town, the round trip was forty-six miles for the family. The dentist was able to help control the pain until a root canal was performed later in the month.

Oral Health Bureau
Iowa Dept. of Public Health

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