Oral Health Toolkit for Colorado School-Based Health Centers

October 2014 Edition

COLORADO ASSOCIATION FOR SCHOOL-BASED HEALTH CARE

Oral Health Toolkit for Colorado School-Based Health Centers

COLORADO ASSOCIATION FOR SCHOOL-BASED HEALTH CARE

Acknowledgements

Colorado Association or School-Based Health Care would like to acknowledge the following individuals who shared their time and expertise during the development of this toolkit:

Karen Callanan, DDS, General Dentistry, Wichita, Kansas

Deborah Costin, MA, Executive Director, Colorado Association for School-Based Health Care

Phyllis Hill, MN, MPH, FNP-C, Southwest Open School School-Based Health Center

Karen Savoie, RDH, BS, Associate Professor, University of Colorado Denver, School of Medicine

Shannon Wells, LPN, Clinic Coordinator, Southwest Open School School-Based Health Center

This toolkit was researched and written by Deidre Callanan, RDH, DC, MPH, director of clinical programs at the Colorado Association for School-Based Health Care.

Photographs courtesy of Cavity Free at Three, Metro Community Provider Network, Ohio Oral Health Pocket Guide for School Nurses, and Summit Community Care Clinic.

Oral Health Toolkit for Colorado School-Based Health Centers

School-based health centers (SBHCs) help improve the lives of Colorado's children by bringing essential services to students where they are—in school. SBHCs support student success because healthy students are better learners. The goal of this toolkit is to give school-based health care providers an easy-to-use oral health manual that shows options and resources for integrating oral health components into the school-based health center's policies and practices.

I. Introduction

Oral Health in America, the 2000 Surgeon General's report, emphasizes that oral health is essential to general health and well-being and can be obtained by all people (U.S. Dept. of Health and Human Services, 2000). Many people, however, for various reasons, cannot and do not experience optimum oral health. Over the past 50 years, there have been many advances in oral health, but dental disease continues to be a chronic problem among low-income and vulnerable populations. The United States General Accounting Office report on oral health found that poor children had five times more untreated dental caries (cavities) than children in higher-income families and poor adults were much more likely to have lost six or more teeth to decay and gum disease than higher-income adults (2000). Left untreated, dental decay has significant health, economic, educational, and social implications (Institute of Medicine, 2011).

Many studies show that prevention and early intervention of problems decrease disparities in dental health. However, getting the proper oral health care for children is not always easy. For example, although Colorado's Medicaid program allows reimbursement to dental professionals for preventative and restorative oral health procedures for children from birth to 19 years of age, the reimbursement rates are 51 percent of the national average charges in 2008 and more than nine percent lower than the average reimbursement rate for all states (Children's Dental Health Project, 2011). This may be directly related to the fact that only 20 percent of practicing Colorado dentists report accepting Medicaid patients in their practices (Colorado Health Institute, 2010).

School-based health centers are perfectly situated to help meet the oral health needs of at-risk children and adolescents. In SBHCs, primary care providers can provide oral health services such as oral evaluations and screenings, referral and case management, fluoride varnish, and oral health and nutritional education. By contracting with dental hygienists and dentists to come into the school-based health center or by partnering with dental professionals to provide services in the community, the SBHC can truly offer comprehensive dental care to its students.

The goal of this Oral Health Toolkit is to give school-based health centers the knowledge, tools, resources, and suggested processes that will help them effectively plan, understand, and institute the appropriate level and model of oral health services for their school-based center. The toolkit starts with basic oral health terminology and an explanation of how cavities are formed; from there, the toolkit describes the services that the primary care provider can deliver and the two models available for engaging dental professionals to ensure that comprehensive care is delivered. Suggestions and ideas for contracting or partnering with dental professionals are given, and the process of using Medicaid to pay for services is described.

II. Oral Health Terminology

Comprehensive services: The coordinated delivery of the total dental care required. Encompasses all levels of dental care, including diagnostic services, preventive services, and therapeutic (treatment) services

Demineralized white spots: White spots and lines typically beginning at the gingival margin that are the first clinical signs of demineralized enamel. If this process is not managed, these lesions will progress to cavities.

Dental assistant: An aide to the dentist or dental hygienist, whose services allow provision of more efficient dental care. Duties may include preparing patients, sterilizing instruments, managing instruments during treatment, processing dental radiographs, and making impressions.

Dental caries: The formation of cavities in the teeth by the action of bacteria; the disease of tooth decay

Dental hygienist: The professional who makes an oral health assessment and treatment plan and implements the plan. The treatment plan may include prophylaxis (cleaning), radiographs (x-rays), the application of sealants and fluoride, and referral to a dentist for further care. In Colorado, dental hygienists may work independently, without the supervision of a dentist.

Dental sealants: Composite or glass ionomer coatings applied to the surfaces of teeth with developmental pits and grooves (primarily chewing surfaces) to protect the tooth surfaces from collecting food, debris, and bacteria that promote the development of dental decay

Fluoride varnish: A highly concentrated form of fluoride that is applied to the surface of teeth by a dentist, dental hygienist, or a primary care provider. Due to its adherent nature fluoride varnish stays in contact with the tooth surface for several hours, enhancing its effect.

Hypoplasia or white spots: Spots on teeth formed during tooth development. If highly textured or pitted, these retain plaque, increasing the likelihood that a cavity will develop in these locations.

Oral health assessment: The initial step in the development of an oral health plan. An assessment establishes a step-by-step process to help moderate- to high-risk children receive oral health care and the necessary follow-up dental treatment. The oral health assessment can be performed by primary care providers.

Oral health case management: The process of planning and giving guidance to ensure that the oral health needs of the student are met. Following a case management protocol will provide outreach and coordination between the SBHC and the dental community.

Oral health: The word oral refers to the mouth, including the teeth, gums, jawbone, and supporting tissues. Poor oral health impacts a student's ability to concentrate in class; it affects self-image and causes pain and suffering.

Preventative services: Care that may include an oral health exam, prophylaxis, radiographs, and fluoride treatment

Restorative services: Services that include procedures to restore damaged teeth

III. Understanding Tooth Decay and Cavities

Tooth decay is nearly 100 percent preventable, and yet it is the most prevalent unmet health care need of children and adolescents in this country. Tooth decay is five times more common than hay fever. Poor and minority children are disporportionately affected by this disease. Left untreated, dental decay has immense health, economic, educational, and social implications. School-based health centers (SBHCs) can be instrumental in diminishing this burden.

When foods containing carbohydrates (sugars and starches), such as breads, crackers, cereals, milk, juice, soda, fruits, cakes, or candy, are in contact with the teeth for a period of time, the risk of developing tooth decay increases. Bacteria that live in the mouth digest these foods, producing acid as a byproduct. The bacteria, acid, food debris, and saliva combine to form plaque, which clings to the teeth. The acids in plaque dissolve the enamel surface of the teeth, creating hoels in the teeth called cavities, or caries.

IV. Chapter One: Program Planning

School-based health centers already provide medical and mental health services and are perfectly positioned to identify children in need of oral health care. By incorporating oral health services, SBHCs can directly reduce the proportion of children and adolescents who have untreated dental decay and increase the proportion of children and adolescents who receive fluoride varnish applications, dental sealants, and restorative care.

This section provides tools for understanding the oral health needs of the school-based health center's target population, an explanation of the services that the primary care provider can deliver, and a description of the different oral health care delivery models that are available to the SBHC for delivery comprehensive services. These models include direct oral health service delivery and collaborative oral health service delivery.

A. Oral Health Needs in the School-Based Health Center Population

The population of children enrolled at school-based health centers is the same population that shows a large oral health disparity. Many of the children enrolled in SBHCs are without dental insurance. These children are two and one-half times less likely to receive dental care than insured children. It should be noted that having dental insurance does not necessarily mean that children receive care. In Colorado, only 44 percent of Medicaid-enrolled children received dental services in 2009 (Trust, 2012), and only 20 percent of Colorado dentists accepted Medicaid patients (Colorado Health Institute, 2010). One of the strategies proposed in the report Filling in the Gap: Strategies for Improving Oral Health is to increase the proportion of SBHCs that have an oral health component by providing services in the center and by supporting linkages with dental partners in the community (Children's Dental Health Project, 2001).

B. Oral Health Services Provided by the Primary Care Provider

Regardless of the model used in delivering comprehensive dental services to children, the services that the primary care provider[1] (PCP) delivers remain the same. These services can be performed in the SBHC during the well-child visit or in the school along with mandatory hearing and vision screenings. By providing these oral health services to children, the SBHC broadens the scope of care it already offers.

The PCP can perform the oral evaluation or screening, apply fluoride varnish, and provide case management. If the primary care provider determines that follow-up care is needed, she/he refers the child to a dental hygienist or dentist with an established contract or partnership with the SBHC so that comprehensive care can be provided.

Costs Associated with PCP Oral Health Services

The cost of supplies to deliver preventive oral health services conducted by the PCP is low. These supplies include a good source of lighting, gloves, gauze, and a tongue depressor. These items may already be available in the clinic. The optional mouth mirror and the fluoride varnish application may be the only additional items that need to be purchased. Disposable mouth mirrors are suggested for SBHCs without access to an autoclave for sterilization.

Estimated costs for the supplies necessary for the oral screening and application of fluoride varnish are noted below. These costs can be lower, depending on vendor and volume purchased. Supplies such as exam gloves and gauze should be part of the materials found in the exam room.

Sample Supplies & Prices[2]

Fluoride Varnish		
Kolorz Clearshield Varnish Watermelon 35/box Item# 799501	$51.99/box	$1.48/ application
Enamel Pro Varnish Clear Bubblegum 35/box Item # 90007541	$65.99/box	$1.88/ application
Cavityshield 5% Varnish .25mL 32/box Item # 7378358	$36.99/box	$1.15/ application
Profluorid Varnish 50/box Item # 1269	$82.99/box	$1.65/ application
Disposable Mirror Mouth Medium White 60/Pk **Item # 1074205**	$23.49/box	$.39/ application

1 Primary care providers include physicians, physician assistants, and advance practice nurses in family practice, internal medicine, and pediatrics.

2 Sample items and prices are from: Henry Schein, 8591 Prairie Trail Dr. #C300, Englewood, CO 80112; 303-790-7745; www.henryschein.com

C. Oral Health Services Delivery Models

Two models provide a basic framework for integrating oral health services into school-based health centers. In both models, the PCP provides preventative services. The first model, Direct Oral Health Service, keeps all services either at the SBHC or on the school grounds. The second model, Collaborative Oral Health Services, describes a partnership with community-based dental providers. Each SBHC has its own setup and arrangement with the school and community and will determine which model provides the best approach to improving children's oral health.

1. Direct Oral Health Services

In the Direct Oral Health Service model, the SBHC employs or contracts with a dental hygienist and/or a dentist to provide cleaning, sealants, and restorative care within the SBHC or school. The PCP conducts an initial oral screening and, if necessary, applies fluoride varnish. If the PCP determines that follow-up care is needed, a referral is given to connect the child to a dental hygienist or dentist who has a contract with the SBHC to provide treatment there. Whether contracting with a hygienist or a dentist, the SBHC should outline the scope of services and who provides which equipment and/or supplies in a memorandum of understanding (MOU). (See page 10 for details.)

Costs Associated with Direct Oral Health Services:
When an SBHC contracts with a dental professional to provide services within the health center, additional equipment and supplies will be necessary. A contracted dental hygienist can administer sealants, fluoride applications, prophylaxis (cleaning), and radiographs and needs the supplies for these services. A contracted dentist may provide services ranging from minor restorations to more complex treatment. The supplies and equipment needed depend on the scope of services rendered. The costs can add up quickly.

The tables below include examples of some of the equipment that may be needed. Both portable and permanent equipment options are identified. Portable equipment can be stored in SBHCs with limited space and is more affordable than setting up a permanent dental unit and room. Equipment purchase prices are often negotiable. The possibility of donations, grants, etc. should be considered. Information about purchasing a mobile dental van and the use of portable dental equipment can be found in Mobile-Portable Dental Manual http://www.mobile-portabledentalmanual.com/index.html. The cost of dental supplies is variable and dependent on the number of procedures performed.

Table 1: Estimated Costs of Basic Portable Dental Equipment*

Equipment	Cost/Range
Operator Stool	$600-800
Assistant Chair	$750-950
Portable Patient Dental Chair	$3000-4000
Portable Dental Unit and Compressor	$6000-8000
Autoclave	$4000-5000
Ultrasonic Cleaner	$500-1200
Portable Intraoral X-Ray Unit	$5000-8000
Portable Operator Light	$1000-1500
Curing light	$900-1500

*Accessories, such as a carrying case, will add additional costs

Table 2: Estimated Costs of Basic Permanent Dental Equipment*

Equipment	Cost/Range
Operator Chair	$800
Assistant Chair	$700
Dental Unit with Compressor	$10,000-20,000
Autoclave	$4000-5000
Ultrasonic Cleaner	$500-1200
Intraoral X-Ray Unit	$5000-8000
Film Processor or Digital X-ray	$7500-100000
Curing light	$900-1500

*These estimates do not include the cost for equipment installation.

Table 3: Estimated Salary Expenses*

Salary Range Guidelines for SBHC Dental Staff			
Dental Staff	**Hourly Wage**	**Annual Salary**	**10-Month Salary**
Dental Hygienist	**$30-35**	**$57,000-67,000**	**$48,000-56,000**
Dentist	**$75-80**	**$144,000-153,600**	**$120,000-128,000**

*These salaries do not include benefits (which vary but may be estimated at an additional 26 percent of the salary) or malpractice insurance, which would be an additional cost for the providers. which would be an additional cost for the providers.

Services provided by contracted dentists and dental hygienists can be performed in the school-based health center either in a permanent operatory or through the use of portable dental equipment in a room in the health center or in the school. These procedures can also be provided through mobile dental vans.

Many SBHCs have limited space, and offering direct oral health services requires that the dentist or hygienist has room to work. This may seem daunting. Keep in mind that the room that is used for dental care must be accessible to water and electricity and be at least 100 square feet to accommodate portable equipment. The space must also have good ventilation, heating and cooling. One solution to limited space is to transform an existing exam room into an oral health room for the day, week, or month that the dental professional will be in the health center. This only requires removing the exam table and storing it elsewhere or moving it aside and covering it. Another option is to erect barriers that serve as room dividers in larger spaces. Once packed up, portable equipment does not need a lot of space for storage. SBHCs with limited space may need to think creatively when offering services through the Direct Oral Health Service model.

Services Provided by a Contracted Dental Hygienist

An SBHC can contract with a dental hygienist to provide these services to students: a dental hygiene assessment, creation of a treatment plan, taking of radiographs, placing sealants, providing prophylaxis (dental cleaning), and applying fluoride varnish. Dental hygienists who are Medicaid providers can bill for services rendered to enrolled children from birth to 21 years of age.

In Colorado, registered dental hygienists can work independently, providing oral health services and directly billing Medicaid and other insurance carriers.

Services Provided by a Contracted Dentist

A dentist can also be contracted by a SBHC to provide An SBHC can also contract with a dentist to provide services to students, including an examination, radiographs, diagnosis, restoration, and referrals to specialists. Dentists who are Medicaid providers can bill for services rendered to enrolled children.

Another option for partnership is retired Colorado dentists. Retired dentists holding a retired dental license (versus an inactive license) may volunteer to provide dental care on a limited basis (Colorado State Board of Dental Examiners, 2011)

Table 4: Direct and Collaborative Oral Health Services

Clinician	Services Delivered
Contracted Dental Hygienist	Dental hygiene assessment, treatment plan, radiographs, sealants, cleanings, fluoride application, referral to dentist
Contracted Dentist	All of the above plus examination, diagnosis, restoration, referral to specialist as needed

Considerations in the Use of Mobile/Portable Service

There are a few things to consider when using a mobile/portable service (California School Boards Association, 2010):

a. Any school or district entering into a contractual relationship should have legal counsel review the contract and/or memorandum of understanding before it is finalized.
b. Most mobile/portable services are businesses, which need to make money to operate. They may seek to serve children with government-sponsored insurance while largely ignoring uninsured children. Is this business privately funded or non-profit? How will the business ensure that all children have access to the care that they are offering? Is the business willing to treat uninsured children, and if so, how many? Does the business use case management to assure children receive care/needed treatment?
c. Can the business provide references?
d. Is the mobile/portable service going to provide comprehensive care (fillings, extractions, stainless steel crowns) or only preventive care (fluoride, sealants, cleanings)?
e. How often will the business return to provide services? What happens if a child seen by the mobile/portable provider develops problems while the provider is not

at the school? Who will the child be referred to?

f. How and in what language(s) will the provider communicate with parents to obtain permission, present a treatment plan, inform them of the services performed on a child, provide referral information, provide instructions for post operative care, etc.?
g. When a child has a regular dental provider what is done to assure the child is returned to the provider of record?
h. Request in writing the electronic reports that the portable service will provide to the SBHC, including, but not limited to:
   Individual Student Reports
   - Patient's treatment plan
   - Treatment completed
   - Any unmet treatment needs
   - Referral information if the child was referred to another dentist for any care, including the reason for the referral and contact information for the dentist to whom the child was referred

   Aggregate Reports
   - Number of children returning parental consent for services
   - Number of children served
   - Medical/dental insurance status of children served
   - List of each service provided and the number of students that received that service
   - Number of children referred and for what treatment
i. Emergency follow up:
   - Contact information of the mobile/portable dental care provider
   - Instructions for what to do in case of an emergency (including contact information for the local dental provider with which the mobile/portable care provider has an agreement)
j. When will the mobile/portable provider return to provide recall (routine cleaning and exams), follow-up, and new patient care?
k. How and where are services provided, e.g., in a mobile van in the parking lot, inside the school using portable equipment? What are the space, water and other needs?
l. How is quality of care determined, e.g., sealant retention, follow-up on extractions?
m. What are policies on photography and use of information for marketing?

2. Collaborative Oral Health Services

In this model, the PCP performs the oral screening or evaluation and, if necessary, the fluoride varnish application. The PCP refers students for further dental care through partnerships with community-based dental providers. Case-management is necessary to ensure that students receive comprehensive care when care cannot be provided directly in the SBHC. It is possible to combine both the direct and the collaborative models by providing sealants on-site through a dental sealant program and restorative care through community-based dentists.

A strong referral system is essential for offering comprehensive oral health services outside of the SBHC. Face-to-face, professional connections strengthen the relationship between the SBHC and community providers. Getting to know the dental community can be accomplished in the following three steps:

- **Conduct an inventory of dental resources**
  Research all local community dental providers. List direct access (independent) dental hygienists, private dental offices (pediatric and general), dental schools, and dental hygiene schools, and Federally Qualified Health Centers with dental services.

- **Understand the types of services provided and the insurance accepted**
  Different providers offer different services. For example, some general dentists may refer a patient to an endodontist for a root canal; others may perform this service themselves. Ask each provider which services are offered and which insurance, public and/or private, is accepted. Knowing the providers' scope of practice and their referral relationships will make collaborating within the community a smoother process.

- **Adapt for uninsured students**
  Some dentists and dental hygienists serve the uninsured, either by donating services or by offering a sliding fee scale. The dental provider may agree to provide services for a predetermined number of uninsured students.

SBHCs are part of the local community, and the PCP is positioned to reach out to the dental community to provide dental services to students. Connecting at the local level can be done through scheduled community events, parent-teacher associations, community or school health fairs, or various community boards. In addition, the SBHC can make direct contact with local dental professionals by inviting them into the SBHC, giving them tours and showing them first-hand the type of care that is given to students. The SBHC can also invite local dentists and hygienists to become members of the SBHC Community Advisory Committee or extend an invitation for them to speak or educate in classrooms or at health fairs.

Costs Associated with Collaborative Oral Health Services

School-based health centers can collaborate with oral health professionals in the community, including private dental practices, federally-qualified health centers, public health departments, and state and local dental associations. A formal partnership will facilitate a source of dental care and a solid referral system for students. In this model, other than the time to connect and partner with the dental community, there are no additional costs to the SBHC.

Service Delivery in the Collaborative Oral Health Service Model

In this model, dental care is performed outside the SBHC and within the school-based health center's community. By creating partnerships with local private dentists and dental hygienists or with dental providers at federally-qualified health centers, the primary care provider in the SBHC will create a medical-dental connection to ensure that students receive the necessary dental follow-up

Metropolitan Community Provider Network: Mobile Dentistry

In 2010, Metropolitan Community Provider Network (MCPN) was awarded a capital improvement grant to provide a mobile dental van and related services to students at schools in Jefferson County. The MCPN staff planned for two years, from the origin of the idea to the clinic's opening.

The van, which was specially built, is 36 feet long and 17.5 feet wide. It contains two full operatory chairs and can accommodate all procedures with the exception of those requiring significant sedation. MCPN held an art contest and selected several students' artwork to be displayed on the exterior of the van.

The mobile clinic is open Monday through Thursday from 8 a.m. to 4:30 p.m. It spends one day at Stein Elementary School, one day at Alameda High School, and one day at Jefferson High School. On the fourth day it rotates among other Jefferson County schools in need of services. The clinic is closed on the fifth day for restocking and cleaning.

care in a timely fashion. Working with the Colorado Department of Public Health and Environment (CDPHE) and contacting regional and state coalitions and local dental and dental hygienist societies can aid in providing connections for dental service referrals for SBHCs. (See **Tool F: Dental Referral Template**, page 45.)

Both the school-based health center and the students it cares for benefit from establishing and maintaining strong relationships with the oral health professionals in the community. When local oral health professionals understand that working with the SBHC is a mutually advantageous relationship, the needs of the children will be better met. Developing a memorandum of understanding (MOU) will outline and formalize the responsibilities of the school-based health center and the oral health provider. (See **Tool C: Sample Memorandum of Understanding**, page 39-41.)

Services Provided by a Community-Based Dental Hygienist

The school-based health center can partner with local dental hygienists to provide services to referred students. A dental hygienist can perform a dental assessment, create a treatment plan, and carry out radiographs, sealants, prophylaxis (dental cleanings), and fluoride applications. Services can be performed by an independent direct access dental hygienist who has an office or by a dental hygienist who is an employee in a community health center or a private dental office. If the hygienist ascertains that further care is needed, a referral to a dentist is given.

School-based health centers can connect with independent dental hygienists through an online search, contacting the Colorado Dental Hygienists Association, or talking to local health departments.

Services Provided by a Community-Based Dentist

School-based health centers can partner with local dentists in community health centers or private practice to provide care to students. Dentists can provide examinations, radiographs, diagnosis, restorations, and referrals to specialists.

Initiating contact with the community's local dentists can be done through local outreach or by contacting the Colorado Dental Association's Component Societies or the Community Health Network.

D. Informed Consent and Health Insurance Portability and Accountability Act (HIPAA)

Informed consent is a component of patient care that fosters trust and confidence between the provider and the student and parents. Students cannot be required to receive oral health services at the SBHC; individuals have the right to refuse care or to seek it elsewhere. Prior to any oral health treatment, proper consent must be obtained.

SBHCs require the parent or legal guardian to sign a consent form before their minor child may receive services in the SBHC. Once signed, the consent form becomes part of the child's medical record. Because SBHCs take the approach that the clinician, parents, and children should work together to resolve health problems, the staff should promote strong communication with parents.

1. Parental/Guardian Consent

A signed parental/guardian consent form for oral health services is an important record and is required for students to receive services within the SBHC. Ideally, consent forms should be signed at the time of school enrollment when all health center forms are processed. Changing the SBHC's current consent form to include preventive oral health services should be an easy adaptation. (See **Tool H: General Consent Form** (including dental services) on page 47-48 for a sample.)

The basic components of an effective consent form are:

- Use clear, concise, and ordinary language
- Avoid technical terms and complex sentences
- Use an 8th grade reading level
- Write in the second person, using you/your pronouns
- Make the form easy to read by avoiding small type and crowding

The SBHC may prefer to use a separate fluoride consent form. This form may include:

- The name of the SBHC
- A description of fluoride varnish; why it is being applied
- Name of child

8

Summit Community Care Clinic: A Creative Solution for Collaborative Care

Give Kids a Smile Day: Summit Community Care Clinic (SCCC) set aside a day for volunteer local dentists to provide exams, oral hygiene instruction, and treatment plans for students. Children who need further dental treatment are referred to the local dental community through the **Adopt a Student** program. In this program, community dentists agree to "adopt" an agreed upon number of uninsured students during the year. This agreement can include the number of students adopted as well as specific age requirements. Once a referral is given, it is the student's responsibility to make and keep the appointment.

This program took approximately a year of development, in order to make contacts and to determine each dentist's requirements. Since its start, Summit County dentists have found that the Give Kids a Smile Day and Adopt a Student Program are an easy way for them to collaborate in increased oral health service delivery.

- Signature of parent/guardian
- Date

A supplemental fluoride varnish information sheet should be given to the parent/guardian for further reading. Ideally, both the consent form and the fluoride information sheet should be available in the languages spoken by the students and families of the SBHC. (See **Tool A: Fluoride Varnish Parental Consent** and **Tool B: Fluoride Varnish Information Sheet** on pages 35-38 for a sample of each.)

2. Minor Consent to Services

SBHCs should be familiar with state laws regarding the ability of minors to consent to various types of treatment. Minors are youth under 18 years of age and are required to have parental/guardian consent for oral health services unless the minor is married or in Colorado's Youthful Offender System or is 15 years or older, living separate and apart from parents, and managing their own financial affairs.

3. Privacy and HIPAA

The U.S. Department of Health and Human Services implemented the Privacy Rule as part of the Health Insurance Portability and Accountability Act in 1996, addressing the use and disclosure of a person's health information. Its regulations guide the management and protection of personal health information in health records kept by the SBHC's medical sponsor and all sub-contracting medical providers. The parties agree that personal health information within medical records maintained by the medical sponsor in the SBHC will not be released to school personnel without required parental consent.

E. Memorandum of Understanding (MOU)

School-based health centers may enter into formal and informal agreements with dental personnel in the community or with mobile van services to provide dental care to students. An MOU is the perfect place to outline state minor consent laws, define services, and outline the scope of care provided. The key elements of an MOU are:

Purpose

An MOU should clearly articulate the desired outcome of entering the agreement. This outcome should result in tangible and reliable benefits to both organizations. This outcome should be clear to both parties. A third party should be able to clearly understand the commitments and promises in the MOU.

Mission Statements

An MOU should include a brief description of the respective organizations and their fundamental missions.

Activation Protocols

An MOU should clearly define the situations under which the MOU will be activated and the individuals with the authority to activate it.

Response Procedures and Obligations

An MOU that merely outlines the potential for cooperation can be beneficial, but a truly helpful MOU will oblige the respective parties to respond in a prescribed manner and answer some basic questions:

- What is going to be done?
- Who is going to do it?
- Under what conditions/when will it happen?
- Who pays for what?

Out Clause

There may be circumstances under which one of the parties is unable to meet the obligations outlined in the MOU. These circumstances should be recognized and included in the document.

Financial Relations

If the MOU includes a fee-for-service arrangement or other financial obligations, a method for determining financial payments should be clearly established. Any and all financial commitments should be spelled out clearly, with appropriate approvals and monitoring systems in place.

Annual Review

MOUs should be reviewed and updated at least annually, or as necessary, to account for staff turnover, etc.

Termination Clause

MOUs should allow for any party involved to terminate the agreement unilaterally with an agreed upon notification period.

Signature and Date

An MOU should always have signatures of the parties involved, and it should be dated.

Internal Review and Approval

Additionally, an MOU could include the existence of any actions or limitations on the practitioner's license, any required insurance, and requirements for record keeping in accordance with the clinic and state board regulations.

(See **Tool C: Memorandum Of Understanding Template**, page 39-41.)

V. Service Delivery by the Primary Care Provider

In this section, the oral health services delivered by the primary care provider are described. They include the following components:

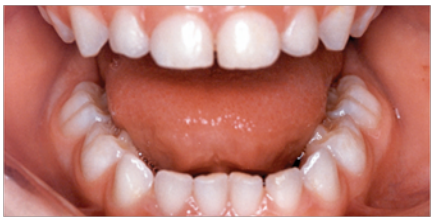
- performing the oral screening in the school-based health center
- addition of oral screening to the mandatory hearing and vision school screening event
- common behaviors/conditions that affect oral health
- oral health and children with special health needs
- oral hygiene instruction and nutrition counseling
- fluoride, application of fluoride varnish, supplementation and dosage information, and fluorosis
- case management and referral
- dental emergencies and prevention of mouth trauma
- medical-dental records

A. Performing the Oral Screening in the School-Based Health Center

The Colorado Association for School-Based Health Care (CASBHC) has developed an Oral Exam/ Assessment Form to guide the PCP through the oral health exam (see **Tool D**, page 42). Additionally, CASBHC was granted permission to use the Ohio Department of Health's Pocket Guide for School Nurses as a visual reference for performing the oral health exam. (See **Tool E: Oral Health Pocket Guide for School Nurses**, page 43-44.)

The purpose of the oral screening is to identify any problems that require treatment and to assess the risk of future problems. The screening should take less than two minutes to perform. Very little equipment is needed: a good lighting source, gloves, tongue depressor, gauze, and a mouth mirror. With the child lying back in the parent's arms or on the exam table, the provider performs a visual inspection of the gums/gingiva, plaque level, and the presence of white or discolored spots, abscesses, dental restorations, and dental sealants. After the screening is preformed, the PCP will determine the necessary case management steps.

Gingiva/gums: Healthy gums are usually described as pink, but their actual color varies according to an individual's complexion. Because the color of gingiva varies due to racial pigmentation, consistency of tone and texture is more important than the underlying color itself. Healthy gingiva often have a stippled (orange peel texture) appearance and are firm and resistant to movement. They are tight to the teeth, with a scalloped appearance around each tooth.

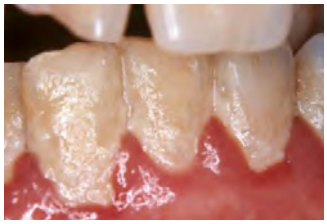


Healthy Gum Tissue

Gingivitis is inflammation of the gingiva (gums). It is the first sign of periodontal disease and is caused by plaque that has been undisturbed on the teeth for a period of time. The plaque releases toxins that irritate the gingiva and cause inflammation. The gingiva become swollen, red, and puffy and may bleed with brushing and flossing.

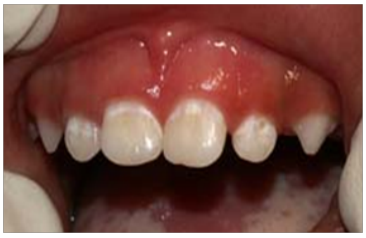
Gingivitis

Plaque: Bacteria, acid, food particles, and saliva combine in the mouth to form a sticky substance called plaque, which is constantly forming on all teeth. Plaque causes dental caries (tooth decay) and periodontal disease (gum disease). It is most common on the back molars, just above the gum line on all teeth, and at the edges of fillings. At first, plaque appears as a white/yellow, soft thin film on the tooth surface. As the plaque builds up and thickens, it becomes more visible.



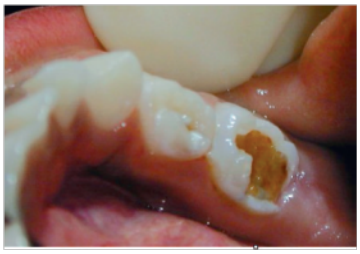
Plaque

White spots: The first sign of decay is a chalky-looking white spot, usually along the gingival margin. At this stage, the decay process can be reversed. As the decay process continues, the white spots become brown spots.



White spots

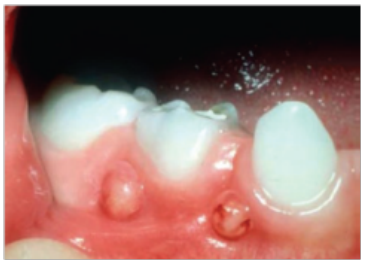
Carious lesions/cavities (caries): In addition to irritating the gingiva, the bacteria in the plaque produce acids that demineralize the enamel of the tooth. If the demineralization of the enamel is not stopped, cavities (holes in the tooth) are formed. An untreated cavity can cause an abscess.



Carious lesion (cavity)

Abscess: An abscess can be the result of trauma (chipped or broken tooth) or tooth decay. In either case, an immediate dental visit is required to treat it. Bacteria enter the tooth through the opening (caused by fracture or decay) and can infect the pulp (inside) of the tooth. The infection can spread to the gums and bone, and an abscess may develop. In addition to pain, swelling, and pus drainage (purulent exudates), complications of an untreated abscess include (Tooth Abscess, 2012):

- Loss of the tooth
- Blood infection (sepsis)
- Spread of infection to soft tissue
- Spread of infection to the jaw bone
- Spread of infection to other areas of the body resulting in brain abscess, endocarditis, pneumonia, or other complications

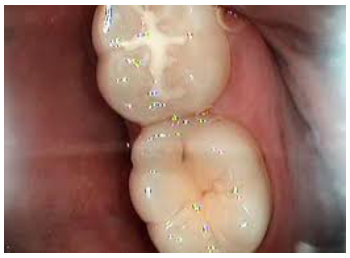


Abscess

A longstanding untreated abscess may develop a drainage path (fistula) through the bone and gingiva, allowing pus produced by the abscess to continuously drain into the mouth.

Dental restorations/fillings: Restorations, or fillings, replace or restore the tooth structure. The most commonly used materials are silver amalgam or a tooth-colored plastic or glass composite resin.

Dental sealants: Dental sealants are white, clear, or colored material placed on the chewing surface of teeth, most commonly on molars. The material adheres to the pits and grooves of the tooth surfaces and protects them from decay.



Sealant (top tooth)

To determine whether or not a tooth has a sealant, the PCP will need to rely on both visual and tactile techniques. If a tooth has been sealed using a white or colored material, visual inspection is all that is necessary. If the tooth was sealed using a clear material, a tactile technique will be necessary. The PCP can use a dental explorer (disposable or autoclavable), if available, to detect the sealant. Hold the explorer, tip toward the tooth, and run it over the biting surface of the tooth. If the surface feels glass-like and no pits or grooves are felt, a sealant has been placed on the tooth.

As with any contaminated instruments, the used explorer is to be handled carefully to prevent exposure to sharp instruments that can cause a percutaneous injury. If using an autoclavable explorer, bag and sterilize it. If using a disposable explorer, place it in a sharps container.

Oral health screening performed by the PCP can occur during any non-urgent visit in the SBHC or in the school during mandatory healing and vision screening.

B. Adding the Oral Screening to the Mandatory Hearing and Vision School Screening Event

Currently in Colorado, vision and hearing screening is mandatory for students in grades K-3, 5, 7, and 9. The addition of an oral screening station to the school's vision and hearing screening event requires little space and only a short increase in the time each student is out of class. During this screening, the application of fluoride varnish could also be performed by the PCP (see fluoride application page 11). In discussions with school administrators and decision makers, address the importance of good oral health and the advantages of expanding the existing vision and hearing screening events to include the oral screening and fluoride varnish. Stress that including the oral health services at the same time as the other screenings will be minimally intrusive and well worth the effort.

The SBHC primary care provider, in collaboration with the school nurse, should take the lead and organize the oral health screening. This includes gathering consent forms, finding volunteers and reviewing their roles, applying the fluoride varnish (if performed), and contacting the parents/guardian of the students who are identified as in need of further dental care. A tally of findings will show administrators how important the addition of an oral health screening can be. Follow-up phone calls should be made to parents of those students who need further care. Offer a list of local dental providers for children without a dental home.

Here are the steps to take once approval is obtained:

Consent

Obtaining parental consent to perform an oral screening and fluoride varnish during mandatory screenings can be done by either adding the services to the overall screening consent form or as a separate consent form. It is important to keep the consent consistent with school standards for other health screenings (i.e., positive vs. negative consent).

Prior to the screening event, review the screening process and the screening form with the volunteers. Two oral screening forms are located in the Tool section of this toolkit (see Tool J: Oral Health Screening Form (CDPHE), and **Tool K: Oral Health Screening Form (abbreviated)**. If possible, use a pre-printed label with information such as the student's name and date of birth to reduce the time required. The basic screening form asks the volunteer to answer Yes or No to three categories: untreated decay, caries experience (the presence of dental fillings), and sealants (which may be difficult to detect, see page 12). The fourth category, Urgency, asks the screener to identify the immediacy of the need for a dental visit – no obvious problem, seek early care (see dentist soon for diagnosis), or urgent (same or next day).

A form should be completed for each student. After all screenings are performed, an Oral Health Screening Tracking Form can be used, in spreadsheet form, to help summarize the results (see **Tool G: Oral Health Screening Tracking Form**). This tracking form will also help the PCP to organize the calls to parents of children who have been categorized as in need a dental appointment.

Volunteers

Recruiting volunteers to help with the screening will help the event run more smoothly. The screening performed during the mandatory hearing and vision screening is different than the oral screening that is performed during the well-child or sports physical exam by the PCP in the SBHC. The value of the addition to the school screening event is to quickly identify whether or not a child needs to been seen by a dentist. Volunteers can be trained to perform this quick visual check.

Identify Volunteers: Look for potential volunteers among

- Parents/guardians
- Parents who may work in the dental field and may be interested in participating in the screen ing. Ask if they have other staff that would help out.
- School staff
- Teachers, teacher's aides, school nurse
- Local dental offices
- Community dental offices
- Local and state public health department that may have access to area dental coalitions and dental providers
- Parent Teacher Association members

Screening Supplies include

- Gloves *
- Tongue blades/depressors*
- Flashlights or penlights
- Masks*
- Hand sanitizer
- Antimicrobial wipes
- Paper towels
- A sturdy table – to hold supplies and to fill out forms
- Chairs – for volunteers and students
- Trash can – to discard gloves, masks, and tongue blades/depressors
- Pens
- Toothbrushes and/or toothpaste – for students

* During a routine oral screening there is NO anticipated screener contact with mucous membranes, blood, and/or saliva. However, universal precaution recommendations should be followed, and gloves, masks, and tongue depressors should be used and disposed of after each student exam. Flashlights and penlights should be wiped with antimicrobial cloths in between students.

C. Common Behaviors and Conditions that Affect Oral Health

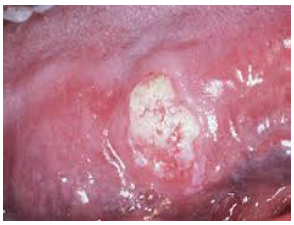
1. Tobacco Use

According to the American Lung Association, "Every day, almost 3,900 children under 18 years of age try their first cigarette, and more than 950 of them will become new, regular daily smokers. Half of them will ultimately die from their habit." (Centers for Disease Control, 2011)

Tobacco, whether in cigarettes or in smokeless form, can cause severe health effects. Not only are users at a higher risk for lung, throat, mouth, and pharyngeal cancer, as well as other diseases, tobacco users have a higher rate of gum disease and tooth loss (American Dental Association, Tobacco Control, n.d.).

Tobacco can cause many changes in the oral cavity. Some are harmless mucosal changes, such as increased tissue pigmentation, but others may be life threatening, such as oral cancer. Oral lesions should be evaluated by a dentist or an oral surgeon. If they cannot be clinically diagnosed as benign, biopsy may be indicated.

Leukoplakia is an often-seen precancerous change to mucosa. It results in white or grey patches that are a result of irritations, including the use of tobacco.



Leukoplakia

Motivational Interviewing (MI) is a counseling technique that helps people explore their uncertainties about changing a behavior. It encourages self-belief in change rather than using an aggressive or confrontational approach to change. MI was first used in the treatment of alcohol abuse to help understand and modify a patient's ambivalence about change, but the technique has been shown to have positive results with tobacco cessation in adolescents (Heckman, Egleston, and Hofmann, 2010; Lai, Cahill, Qin, and Tang, 2010). An example of a brief motivational intervention is provided below. The technique is described in more detail in relation to changing eating habits below.

<table>
<tr><th colspan="3">Smoking Cessation
Flash Card for a Motivational-Based Intervention</th></tr>
<tr><td colspan="3">Ask: "Do you smoke?"
"Yes"</td></tr>
<tr><td colspan="3">Ask: "Do you want to quit?"</td></tr>
<tr><td colspan="2">"Yes"
(Motivated)</td><td>"No"
(Not motivated)</td></tr>
<tr><td colspan="2">Ask: "What do you think of quitting in the next month?"</td><td rowspan="3">Ask: "What do you know about the benefits of quitting smoking?"

Provide: "Because of the benefits you mentioned (and/or other), I strongly urge you to stop smoking as soon as possible. What do you think of this?"

Act: Answer patient's questions and give information if he/she accepts.</td></tr>
<tr><td>"I am ready to quit."</td><td>"I am not ready to quit."
(i.e. "not right now.")</td></tr>
<tr><td>Act:
1. Offer appropriate pharmacotherapy.
2. Refer to community smoking cessation program.</td><td>Act:
1. Offer "Reduce-to-Quit" strategy
2. Refer to community smoking cessation program for further motivational counseling.</td></tr>
</table>

The American Lung Association has many resources for primary care providers to use to help children and adolescents quit smoking (How to Quit Smoking, 2012). The Center for Tobacco Cessation offers free webinars on how PCPs can help children and teens stop the use of tobacco (www.centerforcessation.org). More information about MI and its use in smoking cessation can be found at http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf

2. Cannabis Use

There are three main forms of cannabis: marijuana, hash, and hash oil. All contain delta-9-tetrahydrocannbenol (THC), a psychoactive or psychotropic chemical substance that crosses the blood-brain barrier and causes alterations in perception, mood, consciousness, cognition, and behavior. All three forms can be smoked or added to foods (Darling, 2006).

Cannabis smoke is carcinogenic and is associated with dysplastic and pre-malignant changes in the oral cavity. Cannabis users have an increased risk of xerostomia (dry mouth), which may increase the occurrence of caries and periodontal disease. Users also have an increased risk for severe gingivitis and may experience complications with administration of adrenaline-containing local anesthetic.

3. Electronic Cigarettes/Vaporizers

Electronic nicotine-delivery systems (ENDS), also called e-cigarettes or vaping, deliver nicotine without the toxins associated with tobacco or smoke. Their use is rising in popularity. At this time, because the use of ENDS is relatively new, there is little research into the complications in relation to oral health.

However, the clinician in the SBHC should remain up-to-date on ENDS use and its effects. Certainly, medical histories should include questions about tobacco and marijuana use, and providers may have to prompt the student to ascertain ENDS use.

E-cigarettes have the look and feel of tobacco and are sold over the counter. They consist of a cartridge filled with liquid nicotine, which is often flavored and available in varying strengths. Upon inhalation, heat vaporizes the liquid, bringing a mist to the user. The mist, while it does not contain carbon monoxide found in traditional cigarettes, does contain a "small amount of diethylene glycol (approximately 1%), a known carcinogen. There is no current data on the toxins exhaled" (Palazzolo, 2014).

Marijuana can be sold and consumed in vaporizers that work in a similar fashion as e-cigarettes, with marijuana oil, concentrate, or powdered leaves in the cartridge or chamber. Vaporizers are sold in a wide variety of sizes. Small devices, known as "vape pens," are sometimes sold pre-loaded with a highly concentrated marijuana.

One major public health concern about e-cigarettes and vaporizers is that as advertising and sales increase, the normalcy of cigarette and marijuana smoking may undermine the public health efforts to decrease tobacco and marijuana use (McGill, 2013).

4. Hookah/Bong

A hookah is a waterpipe, usually made out of glass, which is used to smoke tobacco. Many believe that because the tobacco smoke goes through water, it is harmless. Many also believe that smoking nicotine in a water pipe is less addictive than smoking cigarettes, though this is not the case. In fact, the water cools the smoke and allows the user to inhale more smoke, which contains the same carbon monoxide and heavy metals as cigarettes (Dais, 2013). Not only does the shared pipe lead to health concerns, smoking tobacco from a hookah has been linked to cancers, including oral, and to respiratory disease and low birth weight babies.

Hookahs are also used to smoke marijuana and other drugs. A bong, commonly used to smoke marijuana, works the same way as a hookah, with lit marijuana leaves or hash inhaled through a water chamber. Bongs are commonly shared, leading to health concerns.

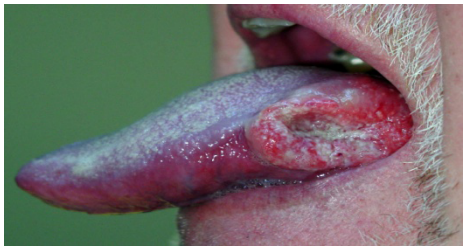
5. Human Papillomavirus Virus

The genital human papillomavirus (HPV) is the most common sexually transmitted infection (CDC, 2012). It can be passed through genital contact, and it can also be passed through oral sex. HPV infection is a common cause of oral cancer, particularly tongue and tonsillar cancer, and the primary care provider should be aware of the associated oral changes. In the past, the two major risk factors for oral cancer have been the use of tobacco and the consumption of alcohol. Oral HPV infection is now considered a high risk factor, even in the absence of alcohol and tobacco use.

While performing the oral exam/assessment, the PCP should check the mouth and throat for red or white patches, lumps, and swelling, looking carefully at the roof of the mouth, back of the throat, and insides of the cheeks and lips. Using gauze, the practitioner should hold the tongue so it can be checked on the sides and underneath and so the floor of the mouth can be examined. A biopsy is the only sure way to know if an

abnormal area is cancerous.

Early stage cancer



Later stage cancer

6. Oral Piercings

Oral and peri-oral piercings are very popular among adolescents. Primary care providers should be aware of the risks and know how to educate children about the care of piercings. Complications can come from the procedure itself or from the jewelry inside and around the mouth. The American Dental Association lists the following risks (American Dental Association, 2001).

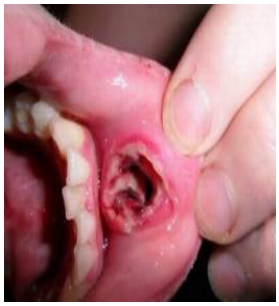
Infection is a possibility with any opening in skin or oral tissues. Given that the mouth is teeming with bacteria, oral piercing carries a high potential for infection at the site of the piercing. Handling the jewelry once it has been placed also increases the chances of developing an infection.

Prolonged bleeding can result from damage to the tongue's blood vessels and can cause serious blood loss.

Swelling and possible nerve damage is a common symptom experienced after oral piercing. Unlike an earlobe that is pierced, the tongue is in constant motion, which can slow and complicate the healing process. There have been some reports of swelling subsequent to tongue piercing that has been serious enough to block the airway.

Blood borne disease transmission (hepatitis B, C, D and G) has been identified by the National Institutes of Health as a possible risk of oral piercing. Although no cases of tetanus or tuberculosis transmission have been reported in connection with oral piercing, both have been documented in association with ear piercing.

Endocarditis, a serious inflammation of the heart valves or tissues, is a risk of oral piercing. The wound created during oral piercing provides an opportunity for oral bacteria to enter the bloodstream, where they can travel to the heart. This presents a risk for people who have cardiac abnormalities, on which the bacteria can colonize.



Infected piercing site

Regardless of the complications associated with oral and peri-oral piercings, children and adults continue to get them. The PCP can give a few educational reminders to the patient (Janssen and Cooper, 2008):

- Use clean fingers when adjusting or touching the jewelry
- Remove the tongue stud while eating
- Use acrylic ends when possible to reduce trauma to teeth and restorations
- With lip or cheek piercings, avoid opening too wide: jewelry may cause trauma if tissue is stretched
- After the piercing, use a new toothbrush to prevent contamination from the old brush
- Lightly brush jewelry around a new piercing site, brush normally around a healed piercing site
- Clean jewelry after every meal
- Get immediate care at signs of redness, swelling, heat, or discharge

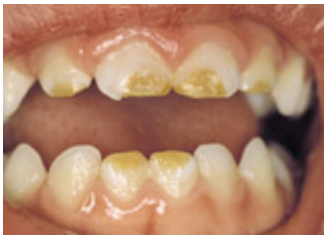
D. Oral Health and Children with Special Health Needs

The primary care provider should be aware of the oral health issues of children with special health care needs. Not only may some of these children have difficulty performing daily oral care for themselves, certain conditions also predispose to oral health problems. Children who were preterm or low birth weight have a higher rate of enamel defects and are at an increased risk of developing caries. Children with congenital heart disease are at risk of systemic infection from untreated oral disease (National Institute of Dental and Craniofacial Research, 2012).

Tooth eruption may be delayed, accelerated, or inconsistent in children with growth disturbances. Gums may appear red or bluish-purple before erupting teeth break through into the mouth. Eruption depends on genetics, growth of the jaw, muscular action, and other factors. Children with Down syndrome may show delays of up to two years.

Malocclusion, a poor fit between the upper and lower teeth, and crowding of teeth occur frequently in people with developmental disabilities. Nearly 25 percent of the more than 80 craniofacial anomalies that can affect oral development are associated with intellectual disability. Muscle dysfunction contributes to malocclusion, particularly in people with cerebral palsy. Teeth that are crowded or out of alignment are more difficult to keep clean, contributing to periodontal disease and dental caries.

Developmental defects appear as pits, lines, or discoloration in the teeth. Very high fever or certain medications can disturb tooth formation and result in defects. Many teeth with defects are prone to dental caries, are difficult to keep clean, and may compromise appearance.



Developmental defects

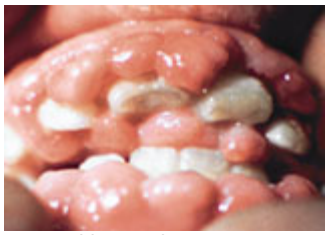
Tooth anomalies are variations in the number, size, and shape of teeth. People with Down syndrome, oral clefts, ectodermal dysplasias, or other conditions may experience congenitally missing, extra, or malformed teeth.

Effects of medications on teeth and gums Xerostomia, or dry mouth syndrome, accelerates the rate that plaque and tarter build up on the teeth and increases the possibility of periodontal disease and dental caries. There are many drugs that cause dry mouth. The following website lists common drugs that cause dry mouth: www.laclede.com/learn/medlist.asp.

There is an increased risk of dental caries and periodontal disease when children take sugary liquid medicines. This is complicated by several conditions that make it difficult to swallow and/or clear the mouth out properly. The strategies below may be helpful in such cases.

- Rinse the child's mouth with water after giving medicines that contain sugar
- Brush frequently if the child takes sugary medicines several times each day
- Combine medicines with water in a cup to dilute the sugar
- Speak to a pharmacist about getting sugar-free versions of medicines

Gingival hyperplasia, commonly called gingival overgrowth, is the over growth of the gingiva. This can be caused by medications such as anticonvulsants, immunosuppressants, and calcium channel blockers. Treatment includes good oral hygiene, regular dental visits, cleanings, and in some cases surgical repair (Oklahoma Association of Community Action Agencies, 2008).



Gingival hyperplasia

E. Oral Health Instruction and Nutrition Counseling

Providing health education during oral health exams is a successful method for teaching children about the importance of oral hygiene and the impact of good nutrition. Parents and children should be given oral health education and information on how and when to brush and floss during the exam and to take home.

1. Brushing: Proper brushing is essential for cleaning teeth and gums effectively. Use a toothbrush with soft, nylon, round-ended bristles that will not scratch and

irritate teeth or damage gums.

Children's teeth should be brushed at least two times a day: in the morning and before bed. The American Academy of Pediatric Dentistry suggests that parents/guardians brush their child's teeth until they can write in cursive, about second or third grade (American Academy of Pediatric Dentistry, 2011).

Use the following steps, provided by the American Dental Hygienists Association (Proper Brushing, n.d.), to ensure proper brushing technique:

1. Place bristles along the gum line at a 45-degree angle. Bristles should contact both the tooth surface and the gum line.
2. Gently brush the outer tooth surfaces of 2-3 teeth using a vibrating back and forth rolling motion. Move brush to the next group of 2-3 teeth and repeat.
3. Maintain a 45-degree angle with bristles contacting the tooth surface and gum line. Gently brush using back, forth, and rolling motion along all of the inner tooth surfaces.
4. Tilt brush vertically behind the front teeth. Make several up and down strokes using the front half of the brush.
5. Place the brush against the biting surface of the teeth and use a gentle back and forth scrubbing motion. Brush the tongue from back to front to remove odor-producing bacteria.

2. Flossing: Flossing not only removes food debris, it also removes plaque, which causes decay and gingival inflammation. In general, parents/guardians should start flossing a child's teeth as soon as teeth touch one another. As the child develops manual dexterity, the child should be encouraged and trained to floss their teeth. Adolescence can be a critical period in developing caries and periodontal disease; the importance of flossing as a preventive measure is an important topic to include for this age group. Use the following steps, provided by the American Dental Hygienists Association (Proper Flossing, n.d.), to ensure proper flossing technique:

1. Wind 18" of floss around middle fingers of each hand. Pinch floss between thumbs and index fingers, leaving a 1" - 2" length in between. Use thumbs to direct floss between upper teeth.
2. Keep a 1"- 2" length of floss taut between fingers. Use index fingers to guide floss between contacts of the lower teeth.
3. Gently guide floss between the teeth by using a zigzag motion. DO NOT SNAP FLOSS BETWEEN TEETH. Contour floss around the side of the tooth.

Slide floss up and down against the tooth surface and under the gum line. Floss each tooth thoroughly with a clean section of floss.

3. Nutrition Counseling

The bacteria in the mouth rely on the sugars that are eaten to produce the acids that cause dental decay. Primary care providers should encourage students to reduce sugary foods and drinks. The American Dental Association provides the following recommendations (American Dental Association, Nutrition, n.d.):

1. Get a balanced diet by eating a variety of foods. Choose foods from each of the five major food groups:

- breads, cereals, and other grain products
- fruits
- vegetables
- meat, poultry, and fish
- milk, cheese, and yogurt

2. Limit the number of snacks eaten. Each time food that contains sugars is eaten, the teeth are attacked by acids for 20 minutes or more.

3. If snacks are eaten, choose nutritious foods, such as cheese, raw vegetables, plain yogurt, or fresh fruit.

4. Foods that are eaten as part of a meal cause less harm. More saliva is released during meals, which helps wash foods from the mouth and helps lessen the effects of acids.

For many children and adolescents poor food choices are the norm (Mancino, Todd, Guthrie, and Lin 2010). Helping children make more nutritious choices may seem like a daunting task, but PCPs in school-based health centers are positioned to educate. The use of Motivational Interviewing techniques to make behavioral changes that encourage more nutritious food choices has shown positive effects (U.S. Dept. of Agriculture, 2011). In Motivational Interviewing, the acronym **OARS** is used to guide the clinician:

Open-Ended Questions: "What kinds of things have you done to try to eat healthier?"

Affirmations: Positive reinforcements such as, "You are a very resourceful person" or "You are very brave to reveal this."

Reflective Listening: Rephrase and repeat with statements such as, "So you feel …." "It sounds like you…."

Simple Reflection or **S**ummary: "This is what I heard you say …." "Let me see if I understand you …."

For more information about Motivational Interviewing, go to http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf or http://www.eatsmartmovemorenc.com/MotivationalInterviewing/MotivationalInterviewing.html

F. Fluoride, Application of Fluoride Varnish, Supplementation and Dosage Information and Fluorosis

Fluoride occurs naturally in water but not always at optimum levels to prevent decay. To reach optimal levels, fluoride is added to or removed from the community's water source. The most effective way to prevent and even reverse early dental decay is fluoridation of the water supply. Fluoridation has been shown to reduce dental caries in primary teeth 40-50 percent and in permanent teeth 50-60 percent (U.S. Dept. of Health and Human Services, 2012). Fluoridation also decreases cavities in adults. With low rates of dental coverage and no Medicaid coverage for adults, prevention of tooth decay is critical for both adults and children.

Unfortunately, parents may hear mixed and often incorrect information about community water fluoridation. To help answer parents' questions about fluoride, and for further information about addressing water fluoridation concerns, the Campaign for Dental Health has developed FAQs. Information can be found at www.ilikemyteeth.org/wp-content/uploads/2012/05/What_Opponents_Say__March_2012_.pdf.

The per capita cost of fluoridation over a lifetime is less than the cost of a single filling (American Dental Association, Fluoride and Fluoridation, 2012), and yet in Colorado, about 30 percent of the population lives in communities without an optimally fluoridated water supply (U.S. Dept. of Health and Human Services, 2011). For school-aged children living in these communities, there is good evidence to support the use of fluoride dietary supplements in preventing dental caries. The body of evidence for prescribing supplementation for children younger than six years of age is less well established.

1. Fluoride Varnish: The benefit of applying varnishes every six months has been well established for children and adolescents at moderate to high risk for caries. Fluoride varnish can be applied up to three times a year to a high-risk child enrolled in Medicaid. The American Academy of Pediatrics states that children in one of the following risk groups are determined to be at moderate to high risk (2009):

- Children with special health care needs
- Children of mothers with a high caries rate
- Children with demonstrable caries, plaque, demineralization, and/or staining
- Children who sleep with a bottle or breastfeed throughout the night
- Later-order offspring
- Children in families of low socioeconomic status

The varnish enables a high concentration of fluoride to remain in close contact with the teeth for several hours. This strengthens tooth enamel, preventing the initiation of disease and even reversing early dental decay. Fluoride varnishes are inexpensive and safe. The risk of fluorosis (see below) with varnish application is minimal. Varnishes are well tolerated, without an offensive taste. There is no waiting period for eating and drinking after the application. Varnishes do not require special preparation of the teeth, and application is quick and easy, taking less than five minutes. Minimal equipment is needed and may include: toothbrush and toothpaste; fluoride varnish; disposable applicator (included with the product); gauze sponges; disposable tongue depressor or mouth mirrors (optional); gloves; and a good light source. The cost of fluoride varnish ranges between $1 and $3 per application. Information about Colorado Medicaid billing for varnish treatment by PCPs is found in the section titled Colorado Medicaid Reimbursement**.** (For further information see **Tool A: Fluoride Varnish Consent**, page 35-36, **Tool B: Information for Fluoride Varnish**, page 37-38, and **Tool G: Fluoride Varnish Product List**, page 46)

a. Contraindications for fluoride varnish application
Known sensitivity to colophony, or colophonium, or to other product ingredients, which include:

- Ethyl alcohol anhydrous USP 38.58%
- Shellac powder 16.92%
- Rosin USP 29.61%

- Copal
- Sodium Fluoride 4.23%
- Sodium Saccharin USP 0.04%
- Flavorings
- Cetostearyl alcohol

b. Fluoride Varnish Application

Below are steps to applying fluoride varnish (Kansas Dept. of Health and Environment, n.d.):

- Place the child on the exam table or in a chair, or a position that works best. Work from over head.
- Dry the teeth either by wiping with gauze or having the patient swallow and clear the mouth as much as possible.
- Apply a thin layer of varnish to all surfaces of every tooth. Don't worry about saliva contamination, the varnish will set quickly.
- Instruct parent or patient:
  - Eat a soft non-abrasive diet for the rest of the day
  - Do not brush or floss until the next morning
  - Give written follow-up instruction (see **Tool B: Fluoride Varnish Information for Parent or Guardian**, page 37-38.)

    For a video demonstration of the application of fluoride varnish, go to: http://www.youtube.com/watch?v=cV5OmL7C8K4

2. Fluoride Supplementation

The American Academy of Pediatric Dentistry (2011) suggests the following clinical guidelines for fluoride supplements:

Fluoride supplements should be considered for all children drinking fluoride-deficient (<0.6 ppm) water. Systemic fluoride should be prescribed only if the child's water source is known to contain less than 0.6 (or less than or equal to 0.6 -depending on the information source used) ppm of fluoride. After determining the fluoride level of the water supply or supplies (either through contacting the municipal or rural district water department or private water company), evaluating other dietary sources of fluoride, and assessing the child's caries risk, the daily fluoride supplement dosage can be determined using the Dietary Fluoride Supplementation Schedule below. Well water levels of fluoride can vary significantly, even in the same geographic area. Well water fluoride levels should be tested so that an accurate fluoride supplementation dose can be determined. To optimize the topical benefits of systemic fluoride supplements, the child should be encouraged to chew or suck fluoride tablets.

3. Fluoride prescription and dosage information

Write the appropriate prescription and instruct the parent that the tablets should be chewed and swished before swallowing when possible. Drops may be used instead of tablets for infants. Be sure to inquire as to whether there are other young children in the home and use this opportunity to prescribe the appropriate dose for each child.

Counsel the parents on the importance of systemic supplementation. The parents are much more likely to comply if they thoroughly understand the significance of the prescription. It will also increase compliance to help the parents arrange the best time to fit this new habit into their daily routine. On return visits, check for compliance and further counsel the parents if there is noncompliance. Document each counseling session in the chart.

Table 5: Fluoride Supplementation

Approved by the American Dental Association, American Academy of Pediatrics, and American Academy of Pediatric Dentistry

Age	Fluoride ion level in drinking water (ppm)*		
	Less than 0.3 ppm	0.3-0.6 ppm	Greather than 0.6 ppm
Birth-6 months	None	None	None
6 months-3 years	0.25 mg/day**	None	None
3-6 years	0.50 mg/day**	0.25 mg/day	None
6-16 years	1.0 mg/day	0.50 mg/day	None
*0.1 part per million (ppm) = 1 milligram/liter (mg/L)			
**2.2 mg sodium fluoride contains 1 mg fluoride ion			

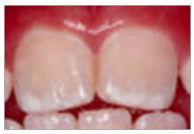
Systemic Fluorides: Dosage Information[3]

Generic Name	Brand Name(s)	Usual Child Dosage **	Maximum Child Dosage
Sodium Fluoride, tablets & lozenges - 0.25 mg/ml fluoride	**Tablets:** Fluor-A-Day*, Fluoritab*, Luride Lozi-Tabs*, Luride SF Lozi-Tabs* **Lozenges:** Fluor-A-Day*	1 tablet or lozenge per day taken with water or juice, dissolved in mouth or chewed	Prescribe no more than 480 tablets or lozenges
Sodium Fluoride, tablets & lozenges - 0.5 mg/ml fluoride	**Tablets:** Fluor-A-Day*, Fluoritab*, Luride Lozi-Tabs* **Lozenges:** Fluor-A-Day*	1 tablet or lozenge per day taken with water or juice, dissolved in mouth or chewed	Prescribe no more than 240 tablets or lozenges
Sodium Fluoride, tablets & lozenges - 1 mg/ml fluoride	**Tablets:** Fluor-A-Day*, Fluoritab*, Luride Lozi-Tabs* **Lozenges:** Fluor-A-Day*	1 tablet or lozenge per day taken with water or juice, dissolved in mouth or chewed	Prescribe no more than 120 tablets or lozenges
Sodium Fluoride, drops - 0.5 mg/ml fluoride	**Drops:** Luride*, Pediaflor	1/2 dropperful = 0.25 mg 1 dropperful = 0.5 mg 2 droppersful = 1 mg	Prescribe no more than 200 ml
Sodium Fluoride, drops - 2 mg/ml fluoride	**Drops:** Karidium*	2 drops = 0.25 mg 4 drops = 0.5 mg 8 drops = 1 mg	Prescribe no more than 30 ml
Sodium Fluoride, drops - 2.5 mg/ml fluoride	**Drops:** Fluor-A-Day*	2 drops = 0.25 mg 4 drops = 0.5 mg 8 drops = 1 mg	Prescribe no more than 30 ml
Sodium Fluoride, drops - 5 mg/ml fluoride	**Drops:** Fluoritab*	1 drops = 0.25 mg 2 drops = 0.5 mg 4 drops = 1 mg	Prescribe no more than 23 ml
Sodium Fluoride, rinse - 0.2 mg/ml fluoride	**Rinses:** Phos-Flur*	1 mg fluoride/teaspoonful (0.2 mg fluoride/ml) swished for 1 minute, then expectorated	Prescribe no more than 500 ml
*Indicates a product bearing the ADA Seal of Approval			
**These supplements are for children only. There is no dose for adult or geriatric patients.			

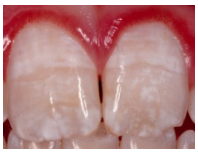
3 American Dental Association, *Guide to Dental Therapeutics*, First Edition, Chicago: author, 1998

4. Fluorosis

Dental fluorosis results from consuming too much fluoride while teeth are forming (approximately age 8 and younger). It affects the appearance of the tooth's enamel. These changes range from mild, which is more common, to severe and are dependent on the duration and the amount of fluoride consumed. These enamel changes are of esthetic concern only and do not affect general health. All sources of fluoride can contribute to fluorosis, including fluoride in drinking water, fluoride toothpaste—especially if swallowed by young children, and dietary prescription supplements in tablets or drops (particularly if prescribed to children already drinking fluoridated water).



Mild fluorisis



Moderate fluorisis

Severe fluorisis

G. Case Management and Referral

Once the PCP has performed the oral screening, fluoride varnish, hygiene instruction, and nutritional guidance, case management should follow. Case management includes referrals for further dental care and the follow-up to ensure that appointments are made and kept.

Referral to a dental hygienist or dentist should be treated like any other referral to a health professional. It should involve a call to the dentist's office when possible and a written referral to the parent or guardian that includes the name and contact number of the dental professional. It is also important to follow-up with parents and/or students to be sure the appointment was kept and to document all referrals and interactions.

H. Dental Emergencies and Preventing Mouth Trauma

A dental emergency is an acute departure from oral health that requires the immediate attention of a health care provider. This can range from an infection in a tooth to trauma from accidents or sports. The primary care provider should be prepared to triage these emergencies. Having a separate dental first aid kit in the SBHC will help the provider act quickly if and when dental emergencies occur.

Dental First Aid Kit

- Contact information for local dentists and dental clinics
- Exam gloves
- Topical anesthetic
- Temporary filling material
- Dental floss
- Soft mouth prop
- Flashlight or penlight
- Dental (Paraffin) wax or chapstick
- Disposable mouth mirror
- Emory board
- Gauze squares
- Hemostat
- Toothbrushes
- Disposable spatula
- Small containers with lids or small envelopes

The American Dental Association offers these tips for handling the following dental emergencies (Dental Emergencies, n.d.):

Bitten lip or tongue: Clean the area gently with a cloth and apply cold compresses to reduce any swelling. If the bleeding doesn't stop, go to a hospital emergency room immediately.

Irritations caused by ortho wire: Discomfort caused by newly placed orthodontic bands/wires is normal. Cover the protruding wire with wax or a piece of gauze. Do not attempt to remove any wire that is embedded in the cheek, gum, or tongue. Contact the child's orthodontist immediately (CDPHE).

Broken tooth: Rinse the mouth with warm water to clean the area. Use cold compresses to cheek or lip next to the injured tooth to keep any swelling down. If the broken tooth has created a sharp edge, it may be covered in wax to prevent laceration. Call a dentist immediately.

Jaw possibly broken or dislocated: Immobilize the jaw by placing a scarf or towel under the chin and tying the ends on top of the child's head. Apply cold compresses to control swelling. Go to a dentist or a hospital emergency department immediately.

Knocked-out tooth: Baby teeth that have been knocked out cannot be replaced. If an entire permanent tooth has been knocked out and is found, hold the tooth by the crown and rinse off the root of the tooth in clean or sterile water if it's dirty. Do not scrub it or remove any attached tissue fragments. If possible, gently insert and hold the tooth in its socket. If that isn't possible, put the tooth in a cup of milk and go to a dentist, with the tooth, as quickly as possible.

Objects caught between teeth: Try to gently remove the object with dental floss; avoid cutting the gums. Never use a sharp instrument to remove any object that is stuck between the teeth. If the object can't be dislodged using dental floss, contact a dentist.

Toothache: Rinse the mouth with warm water to clean it out. Gently use dental floss or an inter-dental cleaner to ensure that there is no food or other debris caught between the teeth. Never put aspirin or any other painkiller against the gums near the aching tooth because it may burn the gum tissue. If the pain persists, contact a dentist.

An additional resource for dental emergencies, "Dental First Aid," is available from the Colorado Association for School-Based Health Care.

Preventing Mouth Trauma

Mouth injuries and maxillofacial trauma from playing sports are common (American Association of Oral and Maxillofacial Surgeons, 2005-2012) and can range from a chipped or cracked tooth to a fracture of facial bones. Avoiding injury is the best practice. The use of helmets, faceguards, and mouth guards reduces the possibility of trauma caused by sports injury. Primary care providers should be aware of the sports involvement of the child and recommend protection as needed.

According to the American Academy of Oral and Maxillofacial Surgeons (ASOMS, 2005-2012), there are five criteria to consider when fitting for mouth guards. The device should be:

- fitted so that it does not misalign the jaw and throw off the bite
- lightweight
- strong
- easy to clean and
- should cover the upper and/or lower teeth and gums

Mouth guards can be custom-made by a dentist, or the "boil and bite" type of mouth guard can be purchased inexpensively from sporting goods stores. Both can provide adequate protection.

I. Medical-Dental Records

Oral health is related to overall health. Diseases that begin in the mouth can become systemic, and systemic diseases can create oral health problems. The burden that untreated oral diseases place on the body's defenses can also contribute to the worsening of unrelated systemic diseases. Over 120 systemic diseases begin in the mouth (Rudman, Hart-Hester, Jones, Caputo, and Madison, 2009). The primary care provider improves patient care by documenting oral findings, patient/provider communication, and subsequent treatment and/or referral in the school-based health center medical record.

Maintaining records is essential and contributes to providing the best possible care for the patient. Good records contain the information that enables any provider, regardless of prior knowledge of the patient, to understand the patient's treatment history. The Oral Health Assessment form and the referral form provided by CASBHC can be easily incorporated into electronic or paper-based records (See **Tool D: Oral Exam/Assessment Form** and **Tool F: Dental Referral Template**)

Dental professionals working in the SBHC or on the school grounds will, most likely, have a separate and distinct electronic dental record that does not integrate with the SBHC electronic medical record. The advantages of integrating medical and dental records are increased communication between providers, improved clinical decision making, and improved patient outcomes through prevention (Rudman, et al. 2010). However,

EHR vendors have only recently worked toward this development.

Until seamless integration of medical and dental records is widely available, it is important that providers and staff communicate both formally and informally about patient care through meetings, in-services, and other staff events. Sharing information about appointments, referrals, medication, and follow-up are crucial for quality patient care.

VI. Financing Oral Health Services

In this section, financing oral health services in the school-based health center is discussed, including the following components:

- Start-up costs
- Cost of ongoing operations
- Length of time for oral health procedures by provider type
- Cost of supplies
- Comparing costs and billing amounts
- Billing procedures for medical providers
- Billing procedures for dental providers
- Reimbursement per visit by provider type, patient age, and payment source
- Financial feasibility of services performed by the PCP and RDH

A. Start up Costs

In an ideal world, each school-based health center would have a dental unit with the dental staff to provide the needed preventative and restorative care for children and adolescents. While a few SBHCs have this capacity, for most, it is not a possibility due to the lack of funding, high start-up costs for permanent or portable dental units, and lack of space. Providing an oral screening, fluoride varnish, and further care either in the SBHC or in collaboration with the local dental community is an effective alternative.

Integrating oral health services into the SBHC's model of care requires funding for development. If an SBHC would like to follow the Direct Oral Health Service model, offering comprehensive services within the health center or school, a larger investment will be needed. A smaller budget may be required if the SBHC is adopting the Collaborative Oral Health Services model. Regardless of the model, seed money for construction and equipment may be needed to start the process.

Typically, start-up costs are financed through grants or fundraising campaigns. Grants can come from local, state, or federal sources, either public or private. Traditional and nontraditional fundraising opportunities should be investigated and identified by the local community and the SBHC. Alternately, the SBHC may choose to develop a citizen advisory development committee to pursue local and regional funding.

Other potential sources for start-up and construction costs are charitable naming rights for corporate sponsorships, citizen groups, and private benefactors that desire public recognition.. Donations, monetary or in-kind, and funding from dental or medical equipment companies are other options.

B. Ongoing Operations

School-based health centers provide care to all enrolled students, regardless of health insurance status. Maintaining oral health services in the SBHC may require revenue from diversified funding from sources including public and private grants, in-kind support, and insurance billing.

An example of ongoing operational costs, showing the costs and possible income, of providing an oral screening, fluoride varnish application, hygiene and nutrition counseling, and case management is outlined below. This example looks at the expense and revenue of providing these services when performed by the PCP and compares the costs of the same services when provided by the dental hygienist.

C. Length of Time for Oral Health Procedures by Provider Type

The length of time that it takes for either the PCP or the registered dental hygienist (RDH) to perform the individual tasks of the oral health visit will vary with each situation. The provider's experience and level of expertise in performing the task, as well as the level of the student's hygiene and decay, will affect the timing. In this section, each procedure is broken down into the length of time in minutes that it may take for each provider to perform each task. These are estimates only.

1. Oral Screening

The PCP performs an oral screening that will quickly detect the need for further care, taking approximately two minutes. The dental hygienist may perform an exam that

is more comprehensive and assesses the entire oral cavity, as well as the head and neck, therefore taking requiring five minutes.

2. Fluoride Varnish Application

It takes about two minutes to apply fluoride varnish from the time the provider picks up and opens the varnish container until the application is complete. If there is heavy plaque or debris on the teeth, the provider should take the time to use gauze to remove it prior to the varnish placement.

3. Hygiene and Nutritional Instruction

These activities take approximately two minutes each when performed by the PCP or the dental hygienist. It should be noted that discussing nutritional information or explaining proper oral hygiene can be done while performing another task, such as applying the fluoride varnish.

4. Case Management

An average time of two minutes is allocated for the PCP or the dental hygienists to perform case management. Although not all students will require referrals for further treatment, the two-minute average is provided for each student.

5. Patient/Room Turnover Time

For the PCP, performing preventive oral health services will most likely be part of the well-child visit. While there is cleaning and set-up needed after the well-child exam, no additional time is required when preventive oral health services are included. For the RDH, additional time for cleaning and reset between students is required and therefore allotted in the table below.

The following two tables estimate procedure time by provider type and cost per visit by provider type illustrating that a primary care provider could potentially need less time (10 minutes) and money ($8.47) per student visit than a dental hygienist, who would spend 18 minutes per student visit at a cost of $13.14.

Table 6: Procedure Time by Provider Type

Preventive Oral Health Services	**Time (Minutes)**	
	PCP	**RDH**
Oral Exam/Risk Assessment	2	5
Fl2 Varnish Application	2	2
Hygiene Instructions	2	2
Nutritional Counseling	2	2
Case Management	2	2
Patient/Room Turnover Time	0	5
Total	10	18

D. Cost of Supplies

Operating expenses also include the cost of supplies. The chart below breaks down the cost of supplies that are specific to performing the oral screening and the fluoride varnish application. Other supplies that are part of the stocked exam room, such as gloves and gauze, are not included in this assessment.

Table 7: Costs per Visit by Provider Type

	PCP	RDH
Fluoride Varnish Application	$1.25	$1.25
Disposable Mouth Mirror	$0.39	$0.39**
Hygiene Kit	$1.00	$1.00
Provider Time*	$5.83	$10.50
Total	$8.47	$13.14

***Costs are based on $35/hour for both provider types**
****The RDH may use a mouth mirror that can be autoclaved, this may alter the costs**

E. Comparing Costs and Billing Amounts

When considering to what extent it will provide oral health services, the SBHC should compare costs with income from billing insurers for services. Even though a dental hygienist (RDH) would cost the SBHC more in terms of time spent performing the oral screening and fluoride varnish, the RDH is reimbursed by some private insurance and can perform other reimbursable services, such as sealants, that a medical provider cannot. Therefore, paying a dental hygienist to provide services may be more financially feasible. Each SBHC should be sure to understand the current reimbursement rates for all pay sources and provider types.

Colorado Medicaid Reimbursement

Colorado Medicaid provides **reimbursement** for an oral evaluation or screening and the application of fluoride varnish to children **birth through twenty years of age** (until the day before the 21st birthday) by a trained primary care provider. These providers include MDs, DOs, nurse

practitioners, and physician assistants, as well as medical personnel employed through qualified physician's offices or clinics that have completed on-site training.

There are two ways in which a PCP can receive the training required by Medicaid in order to be authorized to bill for oral health services to children. The medical provider who cares for children under twelve years of age can participate in an on-site training from Cavity Free at Three or complete modules 2 (Oral Health) and 6 (Fluoride Varnish) of the Smiles for Life curriculum. Providers who treat children over age twelve must complete Module 3 (Adult Oral Health) and Module 6 (Fluoride Varnish) in the Smiles for Life curriculum. Medical personnel must save training documentation in the event of an audit.

F. Billing Procedures for Medical Providers

The Medicaid codes for dental procedures for children in different age groups, along with the accepted frequency of administration, are described below.

• **For children ages birth through 2 years** (until the day before the third birthday):

D0145 - oral evaluation for a patient under three years of age and counseling with primary caregiver. Frequency: Two per 12 months, unless the patient is high risk,* then three per 12 months.

D1206 - topical fluoride varnish. Frequency: Two per 12 months, unless the child is high risk,* then three per 12 months. This service must be done in conjunction with the oral evaluation and must be billed electronically as an 837P (professional) transaction.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): D1206 and D0145 must be itemized on the claim form; reimbursement will be at the current encounter rate. For both private practices and FQHCs: The diagnosis V72.2 (dental examination) should be used as a secondary diagnosis to the well-child code. Billing is done electronically as an 837I (institutional) transaction.

• **For children ages 3 through 4 years** (from the third birthday to the day before the 5th birthday):

D0190 - dental screening. Frequency: Two per 12 months, unless the patient is high risk,* then three per 12 months.

D1206 - topical fluoride varnish. Frequency: Two per 12 months, unless the child is high risk,* then three per 12 months. This service must be done in conjunction with the oral screening, and must be billed electronically as an 837P (professional) transaction.

FQHCs and RHCs: D1206 and D0190 must be itemized on the claim with a well-child visit; reimbursement will be at the current encounter rate. The diagnosis V72.2 (dental examination) should be used as a secondary diagnosis. Billing is done electronically as an 837I transaction.

*High risk is defined based on the caries risk assessment form found at cavityfreeatthree.org

• **For children ages 5 through 20 years** (from the 5th birthday until the day before the 21st birthday)

D0190 - dental screening Frequency: Three per 12 months

D1206 -topical fluoride varnish Frequency: Three per 12 months

School-based health centers should pursue third-party reimbursement from both public and private insurance in order to secure continuous funding and sustainability of the SBHC. SBHCs that are designated as Federally Qualified Health Centers (FQHC) receive cost-based (enhanced) Medicaid reimbursement. Variances in utilization, payer mix, and reimbursement rates can all affect the financial health of an SBHC program.

To bill Colorado Medicaid, a claim form, along with a required risk assessment form, if necessary, must be submitted. The assessment and claim forms may be found in the Provider Services Forms section of the Colorado Department of Health Care Policy and Financing Web site: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696550

• **Colorado Child Health Plan Plus (CHP+)**: Child Health Plan Plus (CHP+) is a low-cost health insurance program for uninsured Colorado children ages 18 and under whose families earn too much to qualify for Medicaid but cannot afford private insurance. There is a maximum allowable amount for dental costs of $1000.00 per child per calendar year (January 1-December 31), and families with higher income may be required to pay a small fee when they receive services.

Under CHP+, when a medical provider performs an oral evaluation and applies varnish for children under 5 years, it is considered a medical service; when a dental hygienist or dentist performs an oral evaluation and applies varnish, it is considered a dental service. Billing for medical services and dental services are distinct. In addition, CHP+ enrollees receive care either through a contracted managed care plan or through the state's managed care network, depending on where they live. For managed

care network members, fluoride varnish application is built into the capitation rate (monthly per member amount) received by primary care providers; therefore, there is no additional reimbursement for rendering that service.

To facilitate claims processing, CHP+ contracted providers must abide by Colorado Access's claims filing procedures. Claims for professional services can be billed on a CMS1500. Claims for facility services can be billed on a UB04. All services are reimbursed using the current CHP+ Fee Schedule.

CHP+ dental coverage is available at www.deltadentalco.com. The frequency of patient services is on a rolling 12-month schedule (from occurrence date to occurrence date) rather than the calendar year.

G. Billing Procedures for Dental Providers

The Colorado Department of Health Care Policy and Financing (HCPF) has contracted with DentaQuest to be its Administrative Services Organization (ASO). The ASO manages the benefits and provides a customer service center for Medicaid dental questions. All Medicaid dental claims, for both adults and children, are processed through DentaQuest.

H. Reimbursement per Visit by Provider Type, Patient Age, and Payment Service

The table below describes the reimbursement rates for each payment source for the oral services provided for different age groups by a PCP and by an RDH. The dental hygienist is reimbursed by Medicaid and, in some cases, by private insurance, for services performed on children from birth through 19 years of age. The dental hygienist is reimbursed by CHP+ for services for children until the age of 18 years. The PCP is reimbursed for oral health services to children from age 0 through 20 years by Medicaid and for age 0 through age four by CHP+. The reimbursement fees below are examples only; Medicaid and CHP+ reimbursements can change often, so as each SBHC begins to understand its own needs, it is important to review the current reimbursements for all services.

*Reimbursement estimates are approximate and are based on information available at the time of publication. Use current data when calculating results.

Table 8: Reimbursement per Visit by Provider Type, Patient Age, and Payment Source*

		Medicaid	CHP+	Private Insurance	Uninsured/Self-Pay	Uninsured/No Fee
PCP Age 0 through 2 (until day before 3rd birthday)	Oral Evaluation	$30.28	$30.28	0	Adjust this amount to SBHCs sliding fee scale	0
	Fl2 Varnish	$15.94	$15.94	0		0
PCP Age 3 through 20 (until day before 21st birthday)	Oral Evaluation	$15.18	$15.18	0		0
	Fl2 Varnish	$15.94	$15.94	0		0
RDH Age 0 through 2 (until day before 3rd birthday)	Oral Evaluation	$30.28	30.28	$40.00		0
	Fl2 Varnish	$15.94	15.94	$30.00		0
RDH Age 3 through 18 (until day before 19th birthday)	Oral Evaluation	$15.18	$15.18	$40.00		0
	Fl2 Varnish	$15.94	$15.94	$30.00		0
RDH Age 19 through 20 (until day before 21st birthday)	Oral Evaluation	$15.18	0	$40.00		0
	Fl2 Varnish	$15.94	0	0		0

*Reimbursement estimates are approximate and are based on information available at the time of publication. Use current data when calculating results.

Income & Expenses per Visit by Provider Type, Student Age, and Payer Source

In the examples shown in Table 9 on the following page, the income is reimbursement for the combined fee for oral screening and fluoride varnish (see table above), minus the cost of provider time and supplies, (in this case, PCP $8.47 and RDH $13.14; see Table xx).

I. The Financial Feasibility of Services

The amount by which a reimbursements fall short of total expenses is called the shortfall. The SBHC should compare the expense (or cost) of providing services to the possible income from billing different payer sources. Because dental hygienists are reimbursed for services other than exam and fluoride varnish, having a dental hygienist provide services may be more financially feasible, even though the costs per visit with a dental hygienist are more than the cost with a primary care provider.

Table 10 shows the net income for providing oral health services to 100 students, using the estimated reimbursements from the table above and a projection of the distribution of payer sources.

School-based health centers that are integrating comprehensive oral health services should perform their own financial analyses to fully understand sustainability through billing Medicaid, CHP+, and private insurance.

An interactive table is available at www.CASBHC.org.

Table 9: Difference Between Income & Expense per Visit by Provider Type, Student Age, and Payer Source

Student Age	Provider Type	Medicaid	CHP+	Private Ins	Uninsured/Self Pay	Uninsured/No Fee
0 through 2 (until day before 3rd birthday)	PCP	$37.75	$37.75	($8.47)	Adjust this amount to SBHCs sliding fee scale	($8.47)
	RDH	$33.08	$33.08	$56.86		($13.14)
3 through 4 (until day before 5th birthday)	PCP	$22.65	$22.65	($8.47)		($8.47)
	RDH	$17.98	$17.98	$56.86		($13.14)
5 through 18 (until day before 19th birthday)	PCP	$22.65	($8.47)	($8.47)		($8.47)
	RDH	$17.98	$27.09	$56.86		($13.14)
19 through 20 (until day before 21st birthday)	PCP	$22.65	($8.47)	($8.47)		($8.47)
	RDH	$17.98	($13.14)	($13.14)		($13.14)

*Reimbursement estimates are approximate and are based on information available at the time of publication. Use current data when calculating results

** Each insurance plan may vary

Table 10: Net Income for Preventive Oral Health Services Rendered to 100 Students by Age, Payment Source, and Provider Type

Age 0 through 2 years

		Primary Care Provider					Registered Dental Hygienist				
Coverage	# of Students	Reimbursement Amount	Total Payment	Cost Per Student	Total Cost	Net Income	Reimbursement Amount	Total Payment	Cost Per Student	Total Cost	Net Income
Medicaid	28	$46.22	$1,294.16	$8.47	$237.16	$1,057.00	$46.22	$1,294.16	$13.14	$367.92	$926.24
CHP+	6	$46.22	$277.32	$8.47	$50.82	$226.50	$46.22	$277.32	$13.14	$78.84	$198.48
Private Insurance	11	$0.00	$0.00	$8.47	$93.17	-$93.17	$70.00	$770.00	$13.14	$144.54	$625.46
Other Government	5	$0.00	$0.00	$8.47	$42.35	-$42.35	$70.00	$350.00	$13.14	$65.70	$284.30
Uninsured	50	$0.00	$0.00	$8.47	$423.50	-$423.50	$0.00	$0.00	$13.14	$657.00	-$657.00

Total Net Income for 100 Students Age Birth through 2 — $724.48 — $1,377.48

Age 3 through 4

		Primary Care Provider					Registered Dental Hygienist				
Coverage	# of Students	Reimbursement Amount	Total Payment	Cost Per Student	Total Cost	Net Income	Reimbursement Amount	Total Payment	Cost Per Student	Total Cost	Net Income
Medicaid	28	$31.12	$871.36	$8.47	$237.16	$634.20	$31.12	$871.36	$13.14	$367.92	$503.44
CHP+	6	$31.12	$186.72	$8.47	$50.82	$135.90	$31.12	$186.72	$13.14	$78.84	$107.88
Private Insurance	11	$0.00	$0.00	$8.47	$93.17	-$93.17	$70.00	$770.00	$13.14	$144.54	$625.46
Other Government	5	$0.00	$0.00	$8.47	$42.35	-$42.35	$70.00	$350.00	$13.14	$65.70	$284.30
Uninsured	50	$0.00	$0.00	$8.47	$423.50	-$423.50	$0.00	$0.00	$13.14	$657.00	-$657.00

Total Net Income for 100 Students Age 3 through 4 — $211.08 — $864.08

Age 5 through 18

		Primary Care Provider					Registered Dental Hygienist				
Coverage	# of Students	Reimbursement Amount	Total Payment	Cost Per Student	Total Cost	Net Income	Reimbursement Amount	Total Payment	Cost Per Student	Total Cost	Net Income
Medicaid	28	$31.12	$871.36	$8.47	$237.16	$634.20	$31.12	$871.36	$13.14	$367.92	$503.44
CHP+	6	$0.00	$0.00	$8.47	$50.82	-$50.82	$31.12	$186.72	$13.14	$78.84	$107.88
Private Insurance	11	$0.00	$0.00	$8.47	$93.17	-$93.17	$70.00	$770.00	$13.14	$144.54	$625.46
Other Government	5	$0.00	$0.00	$8.47	$42.35	-$42.35	$70.00	$350.00	$13.14	$65.70	$284.30
Uninsured	50	$0.00	$0.00	$8.47	$423.50	-$423.50	$0.00	$0.00	$13.14	$657.00	-$657.00

Total Net Income for 100 Students Age 5 through 18 — $24.36 — $864.08

Age 19 through 20

		Primary Care Provider					Registered Dental Hygienist				
Coverage	# of Students	Reimbursement Amount	Total Payment	Cost Per Student	Total Cost	Net Income	Reimbursement Amount	Total Payment	Cost Per Student	Total Cost	Net Income
Medicaid	28	$31.12	$871.36	$8.47	$237.16	$634.20	$31.12	$871.36	$13.14	$367.92	$503.44
CHP+	6	$0.00	$0.00	$8.47	$50.82	-$50.82	$0.00	$0.00	$13.14	$78.84	-$78.84
Private Insurance	11	$0.00	$0.00	$8.47	$93.17	-$93.17	$40.00	$440.00	$13.14	$144.54	$295.46
Other Government	5	$0.00	$0.00	$8.47	$42.35	-$42.35	$40.00	$200.00	$13.14	$65.70	$134.30
Uninsured	50	$0.00	$0.00	$8.47	$423.50	-$423.50	$0.00	$0.00	$13.14	$657.00	-$657.00

Total Net Income for 100 Students Age 19 through 20 — -$24.36 — $197.36

VII. Conclusion

Good oral health is related to general health; it is more than having a pretty smile. It is about the absence of disease and the ability to access care. There are many disparities and inequalities in the ability of children and youth to obtain optimal oral health, and the challenges to providing dental health care to all children may seem daunting to providers in school-based health centers. The goal of this toolkit is to offer resources and tips and to provide a general understanding of the options that are available for the primary care provider to offer oral health services in the school-based health center.

School-based health centers are perfectly situated to offer oral health services as part of the comprehensive care that they already provide. The oral screening, application of fluoride varnish, and anticipatory guidance can and should be incorporated into the routine well-child visit. Follow-up care, whether provided in the SBHC or in the community, is also crucial for all children.

Providers in school-based health centers deliver services to prevent illnesses and intervene early when problems arise so that children are better able to learn. They can offer integrated care and provide comprehensive services that include physical, behavioral health and oral health services. In this way, school-based health centers can become a true health home for the children they serve.

Web-Based Resources

American Academy of Pediatrics

Fluoride Tools for Health Professionals and Parents

http://www.ilikemyteeth.org/tools-health-professionals-parents/

Academy of Pediatric Dentistry

http://www.aapd.org

Cavity Free at Three

http://www.cavityfreeatthree.org

Colorado Community Health Network.

www.cchn.org

Colorado Dental Association

http://cdaonline.org/index.php?option=com_content&view=article&id=50&Itemid=101

Colorado Dental Hygienist Association

http://www.codha.org

Colorado Department of Public Health and Environment Oral Health

http://www.cdphe.state.co.us/pp/oralhealth/OralHealth.html

Colorado Medicaid Fluoride Varnish Form

http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251714350281&ssbinary=true

Medicaid

http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696550

Smiles for Life

http://www.smilesforlifeoralhealth.org

Surgeon General's Report on Oral Health

http://www.surgeongeneral.gov/library/calls/oralhealth/index.html

Bibliography

American Association for Pediatric Dentistry. (2011). *A Dental Grade on Children's Teeth*. Retrieved from http://www.aapd.org/a_dental_grade_on_children%E2%80%99s_teeth/?F_All=y

American Academy of Pediatrics. (n.d.). *Oral Health Risk Assessment Timing and Establishment of the Dental Home*. Retrieved from http://pediatrics.aappublications.org/content/111/5/1113.full

American Association of Oral and Maxillofacial Surgeons. (2012). *Treating and Preventing Facial Injury*. Retrieved from http://www.aaoms.org/facial_injury.php

American Dental Association. (2001). *Oral Piercings and Health*. *JADA*, 127. Retrieved from http://www.ada.org/sections/scienceAndResearch/pdfs/patient_04.pdf

American Dental Association. (2012). *Fluoride and Fluoridation*. Retrieved from http://www.ada.org/fluoride.aspx

American Dental Association. (n.d.). *Tobacco Control*. Retrieved from http://www.ada.org/2788.aspx

American Dental Association. (n.d.). *Dental Emergencies*. Retrieved from http://www.mouthhealthy.org/az-topics/d/dental-emergencies.aspx

American Dental Association. (n.d.). *Nutrition*. Retrieved from http://www.mouthhealthy.org/en/adults-under-40/nutrition.aspx

American Dental Association. (n.d.). *Proper Brushing*. Retrieved from http://www.adha.org/resources-docs/7221_Proper_Brushing.pdf

American Dental Association. (n.d.). *Proper Flossing*. Retrieved from http://www.adha.org/resources-docs/7222_Proper_Flossing.pdf

American Lung Association. (2012). *How To Quit Smoking*. Retrieved from http://www.lung.org/stop-smoking/how-to-quit/

California School Boards Association. (2010). *Oral health.* Retrieved from California School Boards Association: http://www.csba.org/~/link.aspx?_id=8E1F5E4FE5C44A67B621B556F29090BF&_z=z

Center for Cessation. (n.d.). *Tobacco Center Resource Center*. Retrieved from http://www.centerforcessation.org/

Centers for Disease Control. (2011). *Smoking & Tobacco Use*. Retrieved from http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/sections/index.htm

Centers for Disease Control. (2012, March). *Human Papillomavirus (HPV)*. Retrieved from http://www.cdc.gov/hpv/whatishpv.html

Children's Dental Health Project. (2010). *Filling the Gap: Strategies for Improving Oral Health.* Retrieved from http://www.cdhp.org/resource/filling_gap_strategies_improving_oral_health

Colorado Department of Public Health & Environment. (n.d.). *Dental First Aid*. Retrieved from CDPHE: https://www.colorado.gov/pacific/sites/default/files/PW_OH_Emergency-Dental-Flip-Chart.pdf merican Dental Association. (2001). Oral Piercings and Health. *JADA*, 127. Retrieved from http://www.ada.org/sections/scienceAndResearch/pdfs/patient_04.pdf

Colorado Health Institute. (2010, 3). *The Practice of Dentistry in Colorado*. Retrieved from http://www.coloradohealthinstitute.org/uploads/downloads/UrbanRuralDentist.pdf

Colorado State Board of Dental Examiners. (2011, December). Division of Registrations Board of Dental Examiners. Retrieved from http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251632085632

Dais, J. (2013, November). *Straight Talk About Hookah Smoking.* Retrieved from Dimensions in Dental Hygiene:http://www.dimensionsofdentalhygiene.com/2013/11_November/Features/Straight_Talk_About_Hookah_Smoking.aspx

Darling, M. R. (2006, May). *Effects of Cannabis Smoking on Oral Soft Tissues.* Retrieved from Wiley Online Library: http://onlinelibrary.wiley.com/doi/10.1111/j.1600-0528.1993.tb00725.x/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=false

Dear Doctor Inc. (2009). *A Field-Side Guide for Dental Injuries*. Retrieved from http://www.deardoctor.com/dental-injuries/dental-injuries-guide1.pdf

Heckman, C. J., B. L. Egleston, and M. T.Hofmann. (2010). *Efficacy of motivational interviewing for smoking cessation: a systematic review and meta-analysis. Tobacco Control*. Retrieved from http://tobaccocontrol.bmj.com/content/early/2010/07/30/tc.2009.033175.abstract

Institute of Medicine. (2011). *Advancing Oral Health*

in America. Retrieved from http://www.iom.edu/Reports/2011/Advancing-Oral-Health-in-America.aspx

Janssen, K. C. (2008). *Oral Piercing: An Overview. Internet Journal of Health Sciences and Practices.* Retrieved from http://ijahsp.nova.edu/articles/vol6num3/pdf/cooper.pdf

Kansas Department of Health and Environment. (n.d.). *Steps for Fluoride Varnish Applications*. Retrieved from http://www.kdheks.gov/ohi/download/fluoride_varnish/Steps_for_Fluoride_Varnish_Applications.pdf

King County Government. (n.d.). *Partnering for Strength: MOUs Getting Your Relationships in Print.* Retrieved from http://hurricanes.ii.fsu.edu/docs/mou_workshop.pdf

Lai, D.T.C., K. Cahill, Y. Qin, and J.L. Tang. (2010). *Motivational interviewing for smoking cessation.* Retrieved from http://www.thecochranelibrary.com/userfiles/ccoch/file/World%20No%20Tobacco%20Day/CD006936.pdf

McGill, N. (2013, July). *Research on E-cigarettes Examining Health Effects: Regulations Due*. Retrieved from APHA Publications: http://thenationshealth.aphapublications.org/content/43/5/1.2.full=

National Institute of Dental and Craniofacial Research. (2012, July). *Oral Conditions in Children with Special Needs: A Guide for Health Care Providers*. Retrieved from http://www.nidcr.nih.gov/OralHealth/OralHealthInformation/ChildrensOralHealth/OralConditionsChildrenSpecialNeeds.htm

Oklahoma Association of Community Action Agencies. (2008, August). *Oral Health Care for Children with Special Health Care Needs*. Retrieved from http://www.okacaa.org/8.5%20x%2011%20Oral%20Health%20Care%20for%20Children%20with%20Special%20Health%20Care%20Needs.pdf

Palazzolo, D. (2014, November). *Electronic Cigarettes and Vaping: A New Challenge in Clinical Medicine and Public Helath*. *A Literature Review*. Retrieved from National Library of Medicine: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3859972/

The Pew Charitable Trusts (2011, 4). *Expanding the Dental Workforce*. Retrieved from The Pew Charitble Trust: http://www.pewtrusts.org/en/topics/state-policy

D. Robertson and A.J. Smith. "The Microbiology of the AcuteDental Abcess." Journal od Medical Microbiology, 2009

U.S. Dept. of Health and Human Services. (2012). P*roposed HHS Recommendation for Fluoride Concentration in Drinking Water for Prevention of Dental Caries*. Retrieved from http://aspe.hhs.gov/oash/floridation.shtml

U. S. General Accounting Office (2000, April). GAO/HEHS-00-72 *Oral Health in Low-Income Populations*. Retrieved from http://www.gao.gov/new.items/he00072.pdf.U.S. National Library of Medicine, PubMed Health. (2012, Feburary 22). "Tooth Abscess". Retrieved from NIH.gov: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002055/

U.S. Surgeon General. (2000, May). *Oral Health in America*. Retrieved from http://www.surgeongeneral.gov/library/reports/oralhealth/

Tools

A: Fluoride Varnish Parental Consent Form

English and Spanish

B: Information for Parent or Guardian on Fluoride Varnish

English and Spanish

C: Sample Memorandum Of Understanding

D: Oral Exam/Assessment Form

E: Oral Health Pocket Guide for School Nurses (Ohio)

F: Dental Referral Template

G: Oral Health Screening Tracking Form

H: Fluoride Varnish Product List

I: General Consent Form (including dental services)

J: School Oral Health Screening Form - CDPHE

K: School Oral Health Screening Form - Abbreviated

A. Fluoride Varnish Parental Consent Form (English and Spanish)

Fluoride Varnish Parental Consent Form

Dear parent or guardian,

As a preventative dental service, _____, is offering the application of a temporary coating called *fluoride varnish* to your child's teeth to help protect against cavities. See attached sheet for more information.

Please indicate below whether you give permission for your child to receive the application of fluoride varnish.

YES, I give permission for my child to receive the fluoride varnish application. I have read the information sheet about fluoride varnish, and will allow a health professional to apply the varnish to my child's teeth. I understand that this is a painless procedure that will take only a few minutes. **(Please sign below)**

NO, I do not give permission for my child to receive this preventative fluoride varnish application.

Name of child: _____

Date of birth: _____

Signature of parent or guardian: _____

Name of parent or guardian (please print clearly): _____
_____

Date: _____

Formulario de consentimiento para los padres sobre el barniz de flúor

Estimado padre o tutor:

Como un servicio dental preventivo, _____, le ofrece la aplicación de una capa temporal llamada *barniz de flúor* en los dientes de su hijo a fin de protegerlo contra las caries. Consulte la hoja adjunta para obtener más información.

Indique a continuación si da autorización para que su hijo reciba la aplicación del barniz de flúor.

Sí, doy mi autorización para que mi hijo reciba la aplicación del barniz de flúor. He leído la hoja de información acerca del barniz de flúor y autorizaré que un profesional de la salud aplique el barniz en los dientes de mi hijo. Comprendo que este es un procedimiento indoloro que solamente tomará algunos minutos. **(Firme a continuación)**

No, no doy mi autorización para que mi hijo reciba la aplicación del barniz de flúor preventivo.

Nombre del niño: _____

Fecha de nacimiento: _____

Firma del padre o tutor: _____

Nombre del padre o tutor (letra imprenta clara): _____
_____

Fecha: _____

B. Information for Parent or Guardian on Fluoride Varnish (English and Spanish)

Information for Parent or Guardian
Regarding Fluoride Varnish

Why do we recommend putting fluoride varnish on children's teeth?
Tooth decay is one of the most common diseases in children today. Children as young as 10 months can get cavities (holes in teeth). Cavities can cause pain and may prevent children from being able to eat, speak, and learn properly. To prevent cavities, the application of fluoride varnish three times a year is recommended for children aged 6 months to 19 years.

What is fluoride varnish?
Fluoride varnish is a temporary coating that is painted on teeth and strengthens tooth enamel to prevent new cavities and to stop cavities that have already started.

Is fluoride varnish safe?
Yes! Fluoride varnish can be used on babies from the time they have their first tooth (about six months of age). Fluoride varnish has been used to prevent cavities in children for more than 25 years, and is supported by the American Dental Association.

How is fluoride varnish put on my child's teeth?
The varnish is painted on the teeth with a disposable applicator. It is quick and easy and does not have a bad taste. There is no pain. Your child's teeth may seem a little bit yellow, but this is temporary.

What do I do after the varnish is put on my child's teeth?
Your child should not brush his or her teeth for 4-6 hours not eat hard or sticky food for 2-4 hours.

Información para los padres o el tutor
Barniz de flúor

¿Por qué recomendamos aplicar barniz de flúor en los dientes de los niños?
Actualmente, las caries son una de las enfermedades más comunes en los niños. Los niños tan pequeños como 10 meses pueden presentar caries (agujeros en los dientes). Las caries pueden causar dolor y evitar que los niños puedan comer, hablar y aprender correctamente. Para evitar las caries, se recomienda la aplicación de barniz de flúor dos veces al año para niños de 6 meses hasta 19 años. Los niños no debieran perder normalmente todos sus dientes de leche hasta que lleguen a los 11 ó 12 años.

¿Qué es el barniz de flúor?
El barniz de flúor es una capa temporal que se pinta en los dientes y fortalece el esmalte dental para ayudar a evitar que se produzcan nuevas caries y para detener las caries que ya se produjeron.

¿Es seguro el barniz de flúor?
¡Sí! El barniz de flúor se puede usar en bebés desde el momento en que aparece el primer diente (alrededor de los 6 meses de vida). El barniz de flúor se ha usado para evitar caries en niños en Europa por más de 25 años y cuenta con el respaldo de la American Dental Association.

¿Cómo se aplica el barniz de flúor en los dientes de mi hijo?
Un profesional de la salud aplica el barniz que se pinta en los dientes con un aplicador desechable. Es rápido y fácil de aplicar y no tiene un mal sabor. No hay dolor alguno. Los dientes de su hijo pueden parecer un poco amarillos luego de aplicar el barniz, pero esto es solo temporal.

¿Qué hago luego de la aplicación de barniz en los dientes de mi hijo?
Su hijo no debe cepillarse los dientes por 4 a 6 horas. Tampoco debe comer alimentos duros ni pegajosos por 2 a 4 horas.

C. Sample Memorandum Of Understanding

SAMPLE MEMORANDUM OF UNDERSTANDING

THIS AGREEMENT is executed by and between _____ (hereinafter referred to as "School-Based Health Center or SBHC") and _____ (hereinafter referred to as "Provider") for the purpose of providing needed dental services to students (hereinafter referred to as the "Program").

WHEREAS, it is the intention of the Parties to participate in the Program for the purpose of providing students (hereinafter referred to as "Students" or "Participants") with the opportunity to receive needed dental services provided by Provider and/or their community partners.

NOW, THEREFORE, in consideration of the mutual covenants hereinafter contained, the Parties hereto agree as follows:

I. Scope of Agreement

A. This Agreement forms the basis of mutual understanding and respective responsibilities between the School-Based Health Center and the Provider for providing needed dental services to students.

B. This Agreement will be for a period of one year, with review for continuation of the Program at yearly intervals. Renewal of this Agreement and continuation of the Program will be subject to each Party signing a renewal agreement.

C. School-Based Health Center agrees:

1. To the extent SBHC is able, provide Students with a safe setting to receive dental care. SBHC shall provide sufficient oversight of the Program to ensure that it meets the needs of Students.

2. To provide a mutually acceptable place to set up portable equipment or park a mobile facility to provide students with needed dental care.

3. To provide access to toilet facilities and potable water, including hot water.

4. To comply with all applicable laws relating to nondiscrimination.

D. Provider Agrees:

1. To provide all Students who provide written consent of their parent or guardian with the opportunity to receive needed dental care.

2. To ensure parents are informed and consent to the proposed treatment plan.

3. To provide or arrange for the provision of necessary dental services, including preventive, diagnostic and restorative care, to all students with identified need.

4. To provide needed care to at least (#) ____uninsured children each _____(day, week, month, visit).

5. To inform the SBHC in writing of any limitations in the services the Provider is able to provide.

6. To provide the SBHC with proof of a written contract between Provider and a community-based dentist or dental facility where Students may receive follow-up and/or emergency care when the Provider is out of the area or otherwise unavailable.

7. To provide parents and the SBHC with an information sheet within 48 hours after each Student's dental visit to include:

a. A list of completed dental procedures and their corresponding dental procedure (CDT) codes

b. A list of any unmet treatment needs

c. Contact information for Provider, including contact information during non-business hours

d. What to do in case of an emergency (including contact information for the local dental provider/clinic with which the Provider has a contract)

e. Referral information if the child was referred to another dentist/clinic for any care – to include the reason for the referral and contact information for the dentist/clinic where the child was referred

8. To provide SBHC with an electronic report at the conclusion of Provider visit or at least monthly, whichever is sooner, to include:

a. Number of Students returning signed permission slips

b. Number of Students screened for oral health problems

c. Number of Students receiving any services

d. A list of services that were provided and how many times each service was provided

e. Number of Students that received each service

f. Insurance status of each Student screened and/or receiving services

9. To provide SBHC a report that will validate contractual agreements have been met.

10. To comply with all applicable laws relating to nondiscrimination.

II. Term of Agreement

A. This Agreement may be terminated by SBHC or Provider at any time by giving at least seven (7) days written notice.

B. This Agreement shall be effective from _____(date) to _____(date).

C. This Agreement may be modified at any time by written consent of both Parties.

D. This Agreement constitutes the entire Agreement between the Parties. There is no express or implied Agreement except as stated in this Agreement.

E. All provisions of this Agreement are separate and divisible, and if any part is held invalid, the remaining provisions shall continue in full force and effect.

III. Insurance and Liability

A. SBHC and Provider shall secure and maintain comprehensive general liability insurance in the amount of $_____ (write number and then write out words) per occurrence with coverage for incidental contracts. SBHC shall name Provider and Provider shall name SBHC by endorsement as an additional insured under its respective policy(s). Further, the Certificate of Insurance shall provide that insurance may not be canceled, nonrenewed, or the subject of material change in coverage or available limits of coverage, except on 30 days' prior written notice. Provider must also provide proof

of professional liability insurance coverage.

B. School-Based Health Center agrees to defend, hold harmless, and indemnify Provider and its directors, officers, employees, and agents against and from any and all loss, liability, damage, claim, cost, charge, demand, or expense (including any direct, indirect or consequential loss, liability, damage, claim, cost, charge, demand, or expense, including without limitation, attorneys fees) for injury or death to persons, including employees or other agents of Provider, and damage to property including property of SBHC, caused by the negligent acts or omissions of SBHC in the performance of the Agreement. SBHC's duty to indemnify Provider under this Agreement shall not extend to loss, liability, damage, claim, cost, charge, demand, or expense resulting from Provider's negligence or willful misconduct.

C. Provider agrees to defend, hold harmless, and indemnify SBHC and its directors, primary care providers, employees, and agents against and from any and all loss, liability, damage, claim, cost, charge, demand, or expense (including any direct, indirect or consequential loss, liability, damage, claim, cost, charge, demand, or expense, including without limitation, attorneys fees) for injury or death to persons, including employees of SBHC, and damage to property including property of Provider, caused by the negligent acts or omissions of Provider in the performance of the Agreement. Provider's duty to indemnify SBHC under this Agreement shall not extend to loss, liability, damage, claim, cost, charge, demand, or expense resulting from SBHC's negligence or willful misconduct.

D. School-Based Health Center's insurance obligations set forth in section A of this Paragraph III are independent of School-Based Health Center indemnification and other obligations under this Agreement and shall not be construed or interpreted in any way to restrict, limit, or modify SBHC's indemnification or other obligations or to limit SBHC's liability under this Agreement. Provider's insurance obligations set forth in section A of this Paragraph III are independent of Provider's indemnification and other obligations under this Agreement and shall not be construed or interpreted in any way to restrict, limit, or modify Provider's indemnification or other obligations or to limit Provider's liability under this Agreement.

IV. Independent Contractor

Provider is, for all purposes, an independent contractor and shall not be deemed an employee of the SBHC. Provider specifically acknowledges that it controls the manner and means by which the Program is accomplished, agrees to hold itself out as an independent contractor, and waives any rights to claim that it is an employee of SBHC under the common law agency test, the economic realities test, or any other legal test.

School-Based Health Center OFFICIAL	PROVIDER
By: _____	By:_____
Name	Name
Title	Title
Address	Address
Date:_____	Date:_____

D. Oral Exam/Assessment Form

ORAL SCREENING FORM

Patient Name: _____ Date of Service: _____
Age: ___ Provider Initials: _____

Have you had a dental exam in the past year?	Yes	No		
How often do you brush your teeth?	2X/day	1X/day	Less	Never
How often do you floss your teeth?	1X/day	at least 1X/week	Less	Never

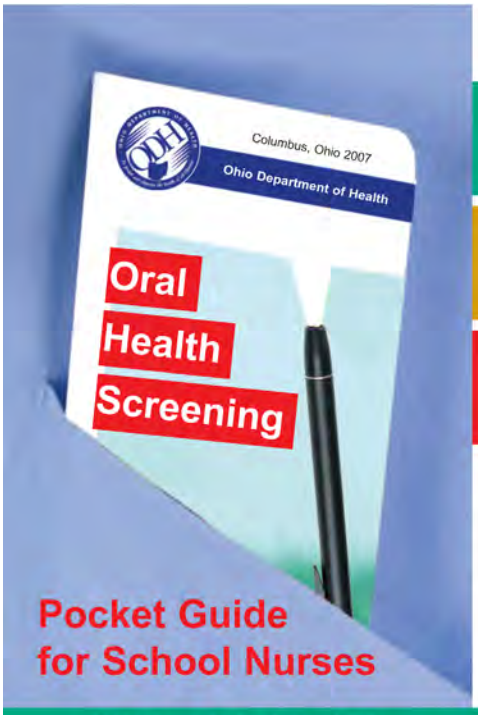
Mark all of the findings below and circle the highest score found. Mark services you performed today and follow the next steps applicable to the patient's score.

Score 1.0	Score 2.0	Score 3.0	Score 4.0	Score 5.0
No evidence of plaque	Evidence of mild plaque		Pain and/or swelling	Pain and/or swelling
Gums pink/healthy	Gums show slight redness	Gums show slight redness	Gums show inflammation	Gums show inflammation
No white or discolored spots	No white or discolored spots	White spots noted	Brown spots noted and/or mild decay noted	Obvious decay noted
No erupted permanent molars				
There **is** clear evidence of sealants on molars	There is **no** clear evidence of sealants on molars			
Fewer than two restorations	Two or more restorations			
Services Performed Today				
☐ Oral Screening ☐ Fl2 Varnish	☐ Oral Screening ☐ Fl2 Varnish ☐ Hygiene Instr	☐ Oral Screening ☐ Fl2 Varnish ☐ Hygiene Instr ☐ Nutrition Cnsl	☐ Oral Screening ☐ Fl2 Varnish ☐ Hygiene Instr ☐ Nutrition Cnsl ☐ Fl2 Supplement Rx	☐ Oral Screening ☐ Fl2 Varnish ☐ Hygiene Instr ☐ Nutrition Cnsl ☐ Fl2 Supplement Rx
Next Steps				
F/U in 12 months	F/U in 6 months Re-apply Fl2 varnish Repeat hygiene instructions	Refer for sealants F/U in 6 months Re-apply Fl2 varnish Repeat hygiene instructions Provide nutrition counseling	Refer for cleaning Refer for sealants Refer for minor restoration F/U in 2 months Re-apply Fl2 varnish Repeat hygiene instructions Provide nutrition counseling	Refer to dentist F/U in 2 months Re-apply Fl2 varnish Repeat hygiene instructions Provide nutrition counseling

☐ Supplies given ☐ Referred to dentist/dental home

Additional comments:

E. Oral Health Pocket Guide for School Nurses (Ohio)



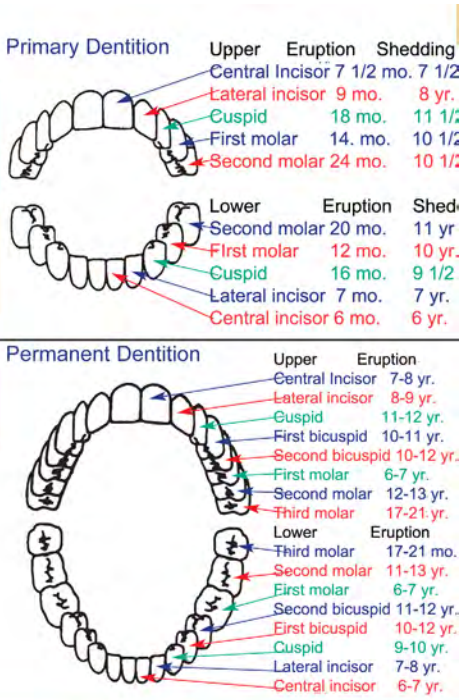
Categories of Need for Treatment:

No obvious dental problems/routine dental visit recommended.

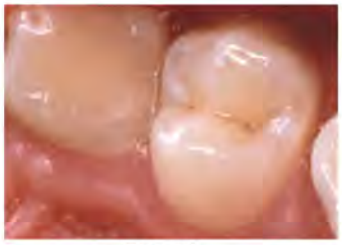
Early dental visit due to teeth that appear to be decayed or have other problems.

Immediate dental visit due to a reported toothache or signs of infection.

Document screening results in the student health record as well as the parent/guardian letter that goes home. Remember, if in doubt refer to dentist sooner rather than later

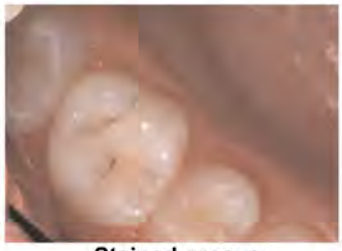


No obvious dental problems



Sound

No obvious dental problem



Stained groove

No obvious dental problems

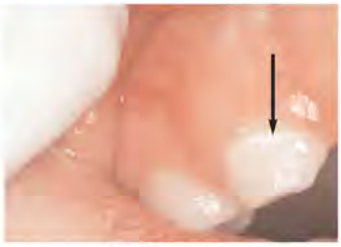
Stainless steel crown Amalgam filling

No obvious dental problems

Sealant - Clear

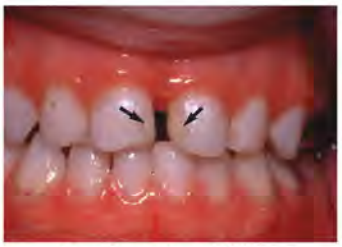
Sealant - Opaque

No obvious dental problems



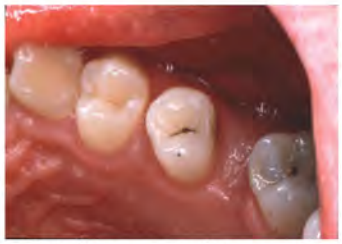
White spot

No obvious dental problems



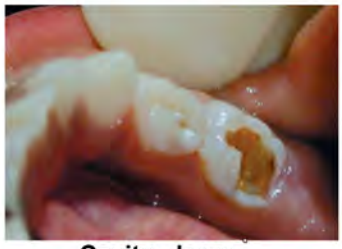
Tooth-colored filling

Early dental visit needed



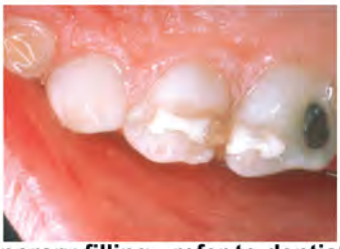
Pit & fissure cavity - small

Early dental visit needed



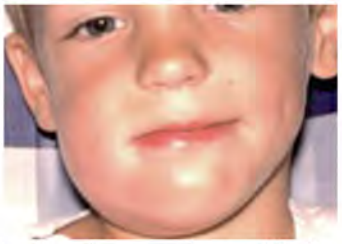
Cavity - large

Early dental visit needed



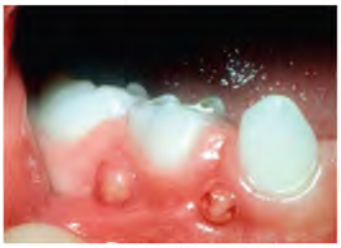
Temporary filling - refer to dentist if there is no follow-up scheduled

Immediate dental visit needed



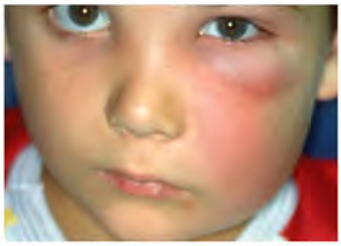
Swollen face - submandibular

Immediate dental visit needed



Parulus (abcess)

Immediate dental visit needed

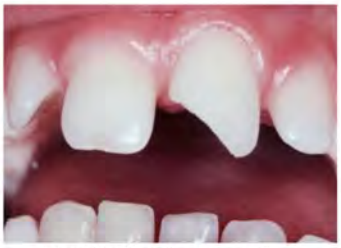


Swollen face - Periorbital

Other oral observations

Gingivitis - discuss toothbrushing 2-3 times a day and recheck in a couple weeks

Other oral observations



Tooth fracture - refer

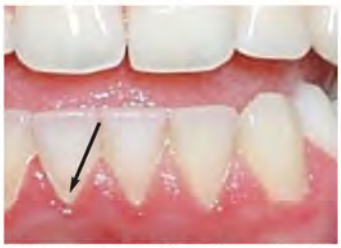
Other oral observations

Apthous Ulcer - refer to dentist if it doesn't heal in 7-10 days

Other oral observations

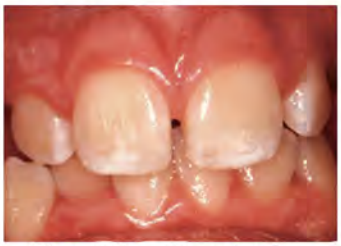
Herpes - refer to dentist if it doesn't heal in 7-10 days

Other oral observations



Plaque on teeth - do not refer

Other oral observations



Fluorosis - do not refer

F. Dental Referral Template

Pediatric Dentists

Name	Telephone Number	Insurance Plans Accepted	Medicaid/CHIP Accepted (Y/N)	Accepts Children Ages	Other Info
Dr Joe Smile	847-422-6323	BC/BS, Cigna, United Healthcare	Y	0 and 21	Located conveniently in the local shopping center, friendly staff
ADD ROWS AS NEEDED					

Family Dentists

Name	Telephone Number	Insurance Plans Accepted	Medicaid/CHIP Accepted (Y/N)	Accepts Children Ages	Other Info
Dr Frank Family	847-422-5896	BC/BS	Y	0 and 21	Loves infants and toddlers!
ADD ROWS AS NEEDED					

Public Health Dental Clinics, Charity/Donated Time Programs, Other

Name (Contact Person)	Telephone Number	Insurance Plans Accepted	Medicaid/CHIP Accepted (Y/N)	Accepts Children Ages	Other Info
Kids Smiles (Linda Smith)	847-456-8695	N/A	N/A	0 and 21	Monthly clinic, accepts adults as well as kids
ADD ROWS AS NEEDED					

Oral Screening Tracking Form

Treatment Urgency: **No** obvious problem/routine dental visits recommended
Early dental care due to teeth that appear decayed or other problems
Urgent (same or next day appointment needed)

Screening Date	Student Name	Grade	Teacher Name	Tx Urgency	Referral Date	Follow-up	Outcome

H. Fluoride Varnish Product List

Fluoride Varnish Product List

Fluoride Name	Unit Dose	Fluoride %	Manufacturer	Supplier/Distributor
AllSolutions/NUPRO	0.25 ml	5 % NaF	Dentsply Professional 800-989-8825 www.dentsply.com	Patterson Dental www.Pattersondental.com
Cavity Shield	0.25 ml 0.40 ml	5 % NaF	Omni/3M 800-634-2249	Pearson Dental www.pearsondental.com
Clear Shield	0.40 ml	5 % NaF	DMG America 800-662-6383	DMG America www.dmg-amercia.com
Duraflor	0.25 ml 0.40 ml 10 ml tube	5 % NaF	Medicom 800-361-2862	Patterson Dental www.Pattersondental.com Henry Schein www.henryscheinmedical.com
Duraphat & PreviDent	no	5 % NaF	Colgate Oral Pharmaceuticals 800- 226-5428	Henry Schein www.henryscheinmedical.com
Enamel Pro	0.25 ml 0.40 ml	5 % NaF	Premier Products 800-670-6100	Practicon www.practicon.com
Flor-Opal Varnish White	0.50 ml	5 % NaF	Ultradent Products 888-230-1420	Ultradent Products www.ultradent.com
Fluor Protector	0.40 ml	0.1 % difluo-rosilane	Ivoclar North America Vivadent 800-533-6825	Pearson Dental www.pearsondental.com
PreviDent Varnish	0.40 ml	5 % NaF	Colgate Oral Pharmaceuticals 800- 226-5428	Colgate www.colgateprofessional.com

Topex DuraShield	0.40 ml	5 % NaF	Sultan Healthcare 800-637-8582	Pearson Dental www.pearsondental.com
Vanish Varnish	0.50 ml (can be used as 0.25 ml and 0.40 ml)	5 % NaF	Omni/3M 800-634-2249	Patterson Dental www.Pattersondental.com
VarnishAmerica	0.25 ml 0.40 ml	5 % NaF	Medical Product Laboratories 800-523-0191	Direct sales

I. General Consent Form (including dental services)

Consent to Medical Treatment
at [*insert name of school health clinic or provider*]

Please read this form carefully and provide all the requested information to allow your child to receive health services at school.

Student/Patient Information
Name:_____ Date of birth:_____ Grade:_____
Address:_____
Cell Phone:_____ Email:_____

1. **I GIVE PERMISSION FOR [*INSERT NAME OF HEALTH CARE SERVICES PROVIDER OR CLINIC*]** to provide any of the health and mental health care services listed below to my child during the coming year, when advised or recommended by [*insert name of health care services provider or clinic*] staff.

TYPE OF SERVICES:
Diagnosis/treatment of minor and acute illnesses, including first aid for minor injuries
Assistance with chronic (on-going) illnesses
Routine physical examinations, including exams for sports or pre-employment clearance
Immunizations
Routine laboratory services
Dental screening and application of fluoride varnish
Vision and hearing screenings
Over-the-counter and basic prescription medications
Health and wellness education
Mental health services, including screening, assessment, and counseling
Referrals for health services that cannot be provided at this clinic

2. **I UNDERSTAND THAT I CAN CHANGE MY MIND LATER** on and decide I do not want my child to get services at [*insert name of health services provider or clinic*]. If I change my mind, I will let [*insert name of health services provider or clinic*] know in writing by sending a letter to the following address:[*insert name and address of health care services provider or clinic*].

3. I understand that this consent form remains valid for one year, until the following expiration date _____, or until the clinic receives a written revocation from me.

4. **I UNDERSTAND THAT** [*insert name of health care services provider or clinic*] needs to cover its expenses. I agree to allow [*insert name of health care services provider or clinic*] to bill any applicable health insurer. I will provide my insurance information below. If I do not have insurance, I agree to discuss my family's eligibility for available public insurance programs or sliding-scale fee options with [*insert name of health services provider or clinic*].

Signature of Parent/Legal Guardian:_____ **Date:**_____

Print Name of Parent/Legal Guardian:_____

Parent/ Legal Guardian Contact Information
Address:_____
Home Phone:_____Cell:_____Work:_____
Email:_____

Insurance Information:

Name of Health Insurance: _____
Health Insurance Address: _____
Health Insurance Phone: _____

Policy #/Medicaid # (if applicable):_____ Insurance Effective Date:_____

Name of Insured:_____

Race (mark all that apply): ___White
___Black or African American
___American Indian/Alaska Native
___Asian/Pacific Islander

Ethnicity (check one): _____Hispanic/Latino _____Non-Hispanic/Non-Latino

Number of People in Family: _____ Family Income: _____

Primary Language Spoken at Home:_____

J. School Oral Health Screening Form - CDPHE

Colorado Oral Health Survey/ Body Mass Index Screening Form

Screen Date: __ __ / __ __ / __ __ __ __	School Code: ___ ___ ___ ____	Grade: ☐ Kindergarten ☐ 3rd Grade	
Birth month and Birth Year:	Gender: 1=Male 2=Female		
Race/Ethnicity: 1=White 2=Black/African American 3=Hispanic/Latino 4=Asian 5=American Indian/Alaska Native 6=Native Hawaiian/Pacific Islander 7=Multi-racial 8=Other 9=Unknown or Missing		Number of Quadrants with Untreated Decay: 0=No untreated decay 1=One quadrant only 2=Two quadrants 3=Three quadrants 4=All four quadrants	
		Caries Experience: 0=No caries experience 1=Caries experience ***NOTE: if Untreated Decay > 0 then Caries Experience=1***	
Sealants on Permanent Molars: 0=No sealants 1=Sealants		Treatment Urgency: 0=No obvious problem 1=Early dental care 2=Urgent care	
Comments:			
		Height:	Weight:

Colorado Oral Health Survey/ Body Mass Index Screening Form

Screen Date: __ __ / __ __ / __ __ __ __	School Code: ___ ___ ___ ____	Grade: ☐ Kindergarten ☐ 3rd Grade	
Birth month and Birth Year:	Gender: 1=Male 2=Female		
Race/Ethnicity: 1=White 2=Black/African American 3=Hispanic/Latino 4=Asian 5=American Indian/Alaska Native 6=Native Hawaiian/Pacific Islander 7=Multi-racial 8=Other 9=Unknown or Missing		Number of Quadrants with Untreated Decay: 0=No untreated decay 1=One quadrant only 2=Two quadrants 3=Three quadrants 4=All four quadrants	
		Caries Experience: 0=No caries experience 1=Caries experience ***NOTE: if Untreated Decay > 0 then Caries Experience=1***	
Sealants on Permanent Molars: 0=No sealants 1=Sealants		Treatment Urgency: 0=No obvious problem 1=Early dental care 2=Urgent care	
Comments:			
		Height:	Weight:

K. School Oral Health Screening Form - Abbreviated

Oral Health Screening

Name

Gender

DOB

Untreated Decay

0= No Decay

1= yes- Untreated

Caries Experience

0= No Previous Restorations

1= Previous Restorations

Sealants

0= No

1=Yes

Urgency

0= 6 month recall

1= 1 month recall

2= Urgent (same of next day)

Colorado Association for School-Based Health Care
1801 Williams Street, Suite 400
Denver, CO 80218
303-399-6380
www.casbhc.org

COLORADO ASSOCIATION FOR
SCHOOL-BASED HEALTH CARE