MINNESOTA DEPARTMENT OF HEALTH

Minnesota School-based Dental Sealant Program Manual

Oral Health Program

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This document is available to be used as a resource for new and existing school-based dental sealant programs and has been co-authored by staff from Children's Dental Services. Each organization can customize their program manual with information specific to their particular program.

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Introduction

The Minnesota Department of Health received funding from the Centers for Disease Control & Prevention and the Department of Health Resources and Services Administration to develop a state-wide School-Based Dental Sealant Program. The goal of the program is to improve the oral health of Minnesota school-aged children by improving access to preventive dental services. The desired outcome is to expand upon current community or school-based dental sealant programs with a focus on 2nd grade children who are at highest risk for dental disease.

From 1998 to 2004, only 11% of Minnesota children ages 6-12 years who were eligible for public health programs actually received dental sealants according to the 2006 Minnesota Department of Health, Minnesota Oral Health Data Book, Children and Youth. In 2011, CMS identified oral health strategies which require Medicaid agencies to increase preventive dental services. One of the specific goals noted is to increase the rate of children ages 6-9 enrolled in Medicaid who receive a dental sealant on a permanent tooth by 10 percentage points over a 5-year period. In FFY 2010, 16.74% of children ages 6-9 enrolled in Minnesota Health Care Programs had a dental sealant on a permanent tooth. The Minnesota Department of Health Oral Health Program is collaborating with the Minnesota Department of Human Services in an effort to increase the rate of children receiving dental sealants on a permanent molar tooth.

School-based sealant programs are highly recommended by the U.S. Task Force on Community Preventive Services and the Association of State and Territorial Dental Directors (ASTDD). The School-based Dental Sealant Program also aligns with the goals and objectives of Minnesota's first State Oral Health Plan. (Goal 2: *Strategies are implemented that reduce oral disease and mitigate risks*.)

Purpose

This manual provides technical assistance for programs who wish to start a school-based dental sealant program and for existing programs to standardize their policies and procedures. Entities who may be interested in starting a school-based dental sealant program include, but are not limited to, the following:

- Local public health departments
- Public schools/school nurses
- Community health center staff
- Safety net dental providers
- Dentistry and dental hygiene schools and faculty
- Non-profit organizations

Getting Started

A first step in program design and planning is to assess the needs of the target population. A Needs Assessment will not only provide an organization with valuable information, but will also make the case for political and financial support.

- Document the gap between the current and desired health outcome
- Discover the existing strengths in the community to build upon
- Describe the target population, e.g., age, barriers to care, number of schools, etc.
- Duplication – Are there existing programs that overlap the program area?
- Demand – Would participation rates be strong?

To document the gap between the current and desired health outcome, gather information about Minnesota oral health data. The first Basic Screening Survey (BSS) was conducted with third grade students attending Minnesota public schools in school year 2009-2010. To view the most current data visit the MDH Oral Health Program website: http://www.health.state.mn.us/oralhealth/data.html. Additionally, data may be collected by performing a BSS in the program's geographic area. Additional resources are available to assist in collecting data and other helpful tools:

http://www.astdd.org/basic-screening-survey-tool/

http://www.cdc.gov/nccdphp/dnpao/hwi/programdesign/needsassessment101.htm

http://www.astdd.org/oral-health-assessment-7-step-model/

Best Practices Approach

Nationally, many states have demonstrated the feasibility of operating efficient and effective programs targeting schools serving those children most at risk of the consequences of untreated tooth decay. See ASTDD Policy Statement:

http://www.astdd.org/school-based-dental-sealant-programs-introduction/

Another resource in getting started is Seal America: The Prevention Intervention. It is a manual that provides much of the same guidance you will find in this manual:

http://www.mchoralhealth.org/Seal/step10.html ;

Advisory Board

In planning any public health program, the needs, interests, and resources of the community should be considered. Establishing an advisory board early in planning will ensure that the needs of the community will be met. The board will also help establish key relationships that are vital for a sustainable program. Members may include:

- School principals and superintendents
- School health planning committees
- School nurses
- Parent-teacher association representatives
- Dental hygiene and dental society members
- Community health clinic providers

- Community leaders
- Local public health

School Selection Criteria

Sample guidelines for criteria for selection of schools include:

- General availability of dental care (e.g. population to dentist ratio)
- Percentage of population at or below Federal Poverty Guidelines
- Percentage of students eligible for Free/Reduced Lunch Program
- Community identified as high need based on results of oral health survey
- Communities with high percentage of immigrant, migrant worker, refugee, and/or other vulnerable and underserved populations

Agreements with Schools

Licensed dental hygienists working with a Limited Authorization Collaborative Agreement with a dentist must have a Memorandum of Understanding (MOU) with the school. This is an informal agreement that outlines the responsibilities of each party: the school authority and the collaborative dental hygienist and dentist. A copy of the Collaborative Practice Agreement must also be on file at the school with the MOU. (Appendix A – Sample Memorandum of Understanding)

For additional information, the Maternal and Child Health Resource Center of the Health and Human Resources Administration has a series of courses on-line that offers dental practitioners background and substantial guidance on establishing collaborative practice agreements. The courses are available at: http://www.mchoralhealth.org/mn/collaborative-practice/

Portable Equipment

Fixed-Site and Portable Clinics in School-Based Oral Health Programs

School-based dental sealant programs can offer preventive services (e.g., oral health education, oral prophylaxes, topical fluoride treatments, and dental sealants) utilizing dental hygienists with a Limited Authorization Collaborative Agreement.

School-based oral health programs can also efficiently provide students with access to comprehensive services (e.g., restorative care). Such services can be offered through fixed-site clinics, portable clinics, or a combination of the two. Dentists and dental therapists may be employed to provide this care.

Fixed-site clinics tend to offer comprehensive services to students, whereas portable clinics tend to provide preventive and basic diagnostic and restorative care (e.g., bitewing X-rays, restorations). The combination of portable clinics to conduct examinations and provide preventive care and fixed-site

clinics to provide advanced treatment can serve as an effective alternate dental home for students who do not have another dental home.

Mobile Dental Vans

Properly outfitted, mobile dental vans can provide comprehensive and ongoing oral health care to students living in geographic areas where fixed dental clinics may not be available (e.g., rural communities, inner cities). It is important for mobile dental van programs to identify a geographic area in which the program can meet the population's oral health care needs (e.g., provide routine preventive procedures, deliver restorative oral health care). Programs that serve overly large geographic areas (e.g., entire states, multiple counties) are generally not able to effectively serve as dental homes because there are times when the van is not accessible to those in need of care.

Regulatory Compliance

Minnesota Board of Dentistry

Minnesota Board of Dentistry (MBD) regulates the practice of dentistry, and sealant programs must operate within the rules and regulations in Minnesota Statute 150A. Dentists and hygienists involved in a sealant program must be licensed. Sealants may be applied by hygienists without a doctor being present if they enter into a collaborative practice agreement (Appendix B - MN Statute 150A.10).

Collaborative Practice Agreement in a school-based dental sealant program requirements include:

- Patients seen by dental hygienists in schools need a valid parent consent form.
- Pit and fissure sealants may be placed on the occlusal surfaces of permanent six molars, including over early (noncavitated) lesions (See "Evidence-based clinical recommendations for the use of pit-and-fissure sealants, a report of the American Dental Association Council on Scientific Affairs." JADA, Vol. 139, March 2008).
- A six month follow-up visit will allow assessment of the efficacy of pit and fissure sealants at a child's recall exam.

Occupational Safety and Health Administration (OSHA)

The portable nature of school-based dental sealant programs presents particular challenges for infection control (e.g., safe transport of sharps). This section provides guidance to programs, but should not be considered an exhaustive program manual. Each program should create their own unique OSHA manuals that meet state and federal requirements.

Several OSHA standards apply to oral health care workers and include the following:

1. Employees at-risk for exposure to bloodborne pathogens need to be trained in the following areas:

(1) Discuss job description; (2) job location; (3) key steps; (4) tools, machines and materials used; (5) actual and potential safety and health hazards associated with these key job steps; and (6) safe and healthful practices, apparel, and equipment required for each job step.

2. Hazard Communication

- Material Safety Data Sheets (MSDS): reference them for the correct procedures to handle hazardous chemicals.
- Recognize hazards in the workplace.

3. Blood borne Pathogens Standard –

- Consider all occupational exposure to blood or other potentially infectious materials as hazardous.

4. Exposure Control Plan –

- Implement controls that isolate or remove the bloodborne pathogens hazard from the workplace.
- Occupational exposure protocol (Post Exposure Control & Management of Injuries – Appendix C – Post Exposure Protocol & Management of Injuries).

5. Engineering and Work Practice Controls –

- Implement controls that reduce the likelihood of exposure by altering the manner in which a task is performed.

6. Vaccinations

- Flu (recommended)
- The HBV vaccination series should be offered to all employees with potential occupational exposure to blood or other potentially infectious material (required).

7. Personal Protective Equipment (PPE)

- Wear appropriate PPE at appropriate times, including masks, protective eyewear, protective clothing, and gloves.
    - Change masks and gloves between each patient.
    - Use protective clothing that covers personal clothing and exposed skin.

8. Hand Hygiene

- Wash or sanitize before and after gloving, when hands are visibly soiled, after barehanded touching of objects potentially contaminated, and before and after treating each patient.

10. Handling of sharps

- Proper disposal of potentially sharp items, broken instruments, etc. in a puncture resistant container or a commercial grade sharps container.

11. Food/drink is only allowed in non-clinic areas

12. Proper use of hazardous waste containers (see under hazardous waste)

- Puncture-resistant containers with a biohazard label, located at the point of use.

13. Laundering of gowns

- All protective clothing should be removed when it is visibly soiled or at the end of a work day. Clothing must be laundered on site or via a laundry service and washed separately on the hot, heavy duty cycle, with a maximum of 8 gowns in each load.

14. Training – at least yearly on all safety issues or when new procedures affect the employee's occupational exposure.

15. Equipment maintenance

- Use single-use disposable items and equipment whenever possible.
- Consider items difficult to clean as single-use disposables and discard after one use.
- To minimize drying of tissues and body fluids on a device, keep the instrument moist until cleaned and decontaminated.
- Clean instruments thoroughly and steam-autoclave at 134°C for 18 minutes.

16. Infection Control Practices

- Spore tests are the most accepted method for monitoring the sterilization process. Correct functioning of sterilization cycles should be verified for each sterilizer by the periodic (at least weekly) use of Biological Indicators
- Instrument cleaning
    - Allow unwrapped and wrapped instruments to dry and cool in the sterilizer before they are handled to avoid contamination and thermal injury.
    - Examine wrapped packages of sterilized instruments before opening them to ensure the barrier wrap has not been compromised during storage. Recline, repack, and desterilize any instrument package that has been compromised.
    - Store sterile items and dental supplies in covered or closed cabinets, if possible.
- Use of an ultrasonic unit for automatic cleaning equipment does not require presoaking or scrubbing of instruments and can increase productivity, improve cleaning effectiveness, and decrease worker exposure to blood and body fluids.

HIPAA

Maintenance of Records, Data Management, and Confidentiality

Monitoring and maintaining records of work-related medical evaluations, screening tests, immunizations, exposures, and postexposure management records should be kept in accordance with all applicable state and federal laws. Examples of laws that might apply include the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR 160 and 164, and the OSHA Occupational Exposure to Bloodborne Pathogens; Final Rule 29 CFR 1910.1030(h)(1)(I--iv) (*34,13*).

The HIPAA Privacy Rule applies to covered entities, including certain defined health providers, health-care clearinghouses, and health plans. OSHA requires employers to ensure that certain information contained in employee medical records is 1) kept confidential; 2) not disclosed or reported without the employee's express written consent to any person within or outside the

workplace except as required by the OSHA standard; and 3) maintained by the employer for at least the duration of employment plus 30 years.

Specific and detailed information on the HIPAA privacy rule, OSHA guidelines and infection control policies can be found on the MBD website: (www.dentalboard.state.mn.us/StatutesRules/CurrentStatutesRules/tabid/136/Default.aspx).

Minnesota Rule 3100.9600 identifies the specific required components for dental record keeping: (https://www.revisor.mn.gov/rules/?id=3100.9600)

For services provided to Minnesota Health Care Program (MHCP) enrollees, provider requirements, including those related to recordkeeping are available in the Department of Human Services Provider Manual. MHCP includes both Medicaid and MinnesotaCare enrollees: (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008921)

Clinic Material and Methods

Sealant Material

A number of sealant materials are commercially available. No one product is clearly superior to the others. There are, however, considerations that narrow the choices of sealant materials that are acceptable for use in MDH-funded programs. Seal America: The Prevention Invention provides a useful overview of the attributes of sealant materials that are appropriate for use in school-based programs.

MDH-funded S-BSPs **must use** sealants that meet the following parameters:

- Resin-based material as opposed to glass ionomer
- Sealants must quickly self-adjust through normal occlusion; therefore, MDH-funded programs **may not use** sealant materials with more than 10 percent filler by weight.

Sealant Procedure

- Obtain consent from parent/legal custodian/guardian
- Conduct risk assessment of individual teeth (pit and fissure morphology, level of caries activity, caries pattern). Do not seal if:
  - The tooth cannot be isolated.
  - Proximal restoration involves pit and fissure surfaces
- Evaluate pit and fissure surfaces by visual assessment.
  - Do not use the explorer with pressure as this could introduce a pathway for caries progression. [1]
- Caries free seal in accordance with manufacturer directions if at risk based on:
  - Deep pits and fissure morphology
  - Sufficiently erupted to allow adequate isolation

[1] Kuhnisch J, Dietz W, Stosser L, Hickel R, Heinrich-Weltzien R. Effects of dental probing on occlusal surfaces: a scanning electron microscopy evaluation. Caries Res 2007; 41 (1):43-48.

    - Caries pattern
    - Questionable (stained)
    - Enamel caries (incipient with no evidence of undermining)
- Dentin caries (frank, overt with evidence of undermining) refer for restoration
- Inform parent/legal guardian of procedures and referral status
- Evaluate sealed teeth for sealant integrity, sealant retention and caries progression by sliding the explorer along the margins of the sealant.

Sealant application guidelines

Consistent with and subject to individual sealant material manufacturer direction:

Step 1: Review the medical history for contraindications (methyl acrylate allergy)
Step 2: Conduct risk assessment of individual, individual teeth and pits and fissure surfaces
Step 3: Prepare teeth by cleaning with pumice or Hydrogen peroxide.

- It is absolutely necessary to remove plaque and debris from the enamel and the pits and fissures of the tooth. Any debris that is not removed will interfere with the proper etching process and the sealant penetration into the fissures and pits.

Step 4: Isolate the teeth.

- For most sealant material, it is absolutely imperative to keep the tooth free from salivary contamination.

Step 5: Dry the surfaces
Step 6: Etch the surfaces

- The etchant should be applied to all the pits and fissures. In addition, it should be applied at least to a few millimeters beyond the final margin of the sealant and in accordance with manufacturer directions. Do not allow the etchant to come into contact with the soft tissue. If this occurs, rinse the soft tissue thoroughly.

Step 7: Rinse and dry the teeth

- Rinse all the etchant material from the tooth in accordance with manufacturer directions. The tooth is dried until it has a chalky, frosted appearance. If it does not, the tooth should be re-etched in accordance with manufacturer directions. It is imperative to avoid salivary contamination. There is agreement that moisture contamination at this stage of the process is the most common cause of sealant failure.

Step 8: Apply the material and evaluate for voids, marginal discrepancies or retention problems. If noted return to Step 1.

- Be careful not to incorporate air bubbles in the material
- Follow protocol for light cured or self-cure dental sealant material in accordance with manufacturer direction.
- After the sealant has set, the operator should wipe the sealed surface with a wet cotton pellet. This allows for the removal of the air-inhibited layer of the non-polymerized resin. Failure to perform this step may leave an objectionable taste in the individual's mouth.

Step 9: Evaluate the sealant

- The sealant should be evaluated visually and tactically. Attempt to dislodge it with an explorer. If there are any deficiencies in the material, more sealant material should be applied

Step 10: Evaluate the occlusion

- Unfilled resins will wear down naturally and do not require occlusal adjustment

Step 11: Inform the parent/legal custodian/guardian of procedures that have been completed and the referral status.

Adverse Event Protocol

- Sealant contains methyl acrylates, which may be irritating to the skin and eyes. In case of contact with eyes, rinse immediately with plenty of water and seek medical attention. After contact with skin, wash immediately with plenty of soap and water. The product may cause sensitization by skin contact in susceptible persons. If skin sensitization occurs discontinue use.
- Sealant etchant contains phosphoric acid, which may cause burns. Avoid contact with oral tissues, eyes and skin. If accidental contact occurs, flush affected area with generous amounts of water. In case of contact with eyes, immediately rinse with plenty of water and seek medical attention.
- If a sealant is not retained it should be reapplied.

Safety Precautions

- Follow manufacturer's directions for application of pit and fissure sealants.
- Use the Center for Disease Control and Prevention (CDC) Guidelines for infection control.
- Sealant Precautions: A small percentage of the population of known to have an allergic response to acrylate resins. To reduce the risk of allergic reaction, minimize exposure to uncured resins. When resins are in prolonged contact with oral soft tissue, or in case of accidental prolonged exposure, flush with copious amounts of water. Wash skin with soap and water when skin contact occurs.
- Etchant Precautions: Conditioner (etch) contains phosphoric acid. Protective eyewear is recommended for both provider staff and individuals receiving services while using etchants. Contact with oral soft tissue, eyes and skin should be avoided. If accidental contact occurs, flush immediately with copious amounts of water. Wash skin with soap and water when skin contact occurs.
- Providers and individuals receiving services are required to wear safety glasses.
- Do not place dental sealants on individuals with a known allergy to components found in dental sealants (example: methyl acrylate).
- Sealant and sealant etchant should be tightly closed immediately after use. Keep out of direct sunlight, store at 40-70 degrees F, and use at room temperature.

Emergency Procedures

When working in the school setting, it is important to be prepared in case of an emergency. It is required for dental professionals to be certified in Cardiopulmonary Resuscitation (CPR). Best practices approach would also include training in first aid. Other considerations about the school and their protocols also need to be understood.

What is the emergency code/alarm that may be used in the event of a crisis situation?
Where is the primary fire exit/escape route?
Where is the secondary fire exit/escape route?

Where is the nearest fire extinguisher from your work area?
Where is the emergency kit/cart at your site?
Where is the CPR mask? Where is the AED located, if your school has one?
Where is the MSDS Manual?
Where is the emergency spill kit located?
Where is the eye wash kit located?
What should you do in the event of a tornado?
What should you do in the event of a bomb threat?
Who should you contact at the school if you have any questions or concerns?

Contraindications

- Dental sealants are contraindicated for individuals with a known allergy to components in dental sealant (example: methyl acrylate).
- Not to be used in case of frank (overt) dental caries.

Infection Control Protocols

The Organization for Safety, Asepsis and Prevention (OSAP) has a Public Health Page with news and resources to link programs to technical assistance, educational materials, information on policy development and other resources on infection prevention and safety. Examples include:

- OSAP Infection Control Considerations for Dental Services in Sites Using Portable Equipment or Mobile Vans - Site Analysis
- OSAP Infection Control Checklist for Dental Programs Using Mobile Vans or Portable Dental Equipment

Visit their website at: http://www.osap.org/?page=DentPH_IpAndSafety

Instrument Clean up and Instrument Processing

Contaminated instruments are to be handled carefully to prevent exposure to sharp instruments that can cause a percutaneous injury. Instruments are placed in an appropriate container in the treatment area to prevent injuries during transport to the instrument processing area. Clinic staff uses the patient tray in the transport of all instruments. Contaminated instruments are never carried by hand only, but always transported by plastic tray. Transport of contaminated instruments by tray is completed with gloved hands. Gloves, lab coat, mask and protective eyewear are worn throughout the instrument recycling process. Once in the sterilization area, the tray is placed on the counter in the receiving area of the sterilization center.

- Paper products and disposable items are discarded in the appropriate container.
- Sharps are placed in the red sharps container on the counter.
- The ultrasonic cleaner is checked for instruments prior to handling of instruments on the tray. If instruments are present in the ultrasonic cleaner, the basket is lifted and placed in the sink, carefully rinsed with cold water and then carefully tipped onto the large tray for sorting.

- Instruments are carefully rinsed with cold water prior to placing instruments into the ultrasonic basket. The cover is then securely placed on the ultrasonic cleaner and the dial is turned for 20 minutes. While the ultrasonic cleaner is running, no additional instruments are added, nor are the cover removed from the top of the cleaner.
- Instruments on the sorting tray are carefully sorted with gloved hands for specific instrument set-ups, and placed into the appropriately sized sterilization pouch. Prior to sealing the pouch, the strip from the sealing side is inserted into the pouch as it is a biological indicator.
- Once the appropriate instruments are bagged, they are placed into the clear tub or loaded into one of the sterilizers accordingly.

Once the instruments have been placed in the ultrasonic and/or bagged, the tray is wiped with a 4x4 gauze saturated with an approved disinfectant. The tray is then placed on the tray rack on the opposite counter to dry. Dry trays are re-circulated back into the clinic. Hands are then degloved, mask and eyewear removed and hands washed with soap and water, and towel-dried. Eyewear is disinfected or a new protective shield is inserted on the eyewear frame when visibly soiled.

Portable Dental Unit Water Quality

CDC recommends that water used for routine dental treatment meets Environmental Protection Agency (EPA) regulatory standards for drinking water. Some manufacturers of portable dental equipment advise that tap water, distilled, or purified water be used in the water-supply bottle. Programs should follow manufacturer's guidelines for appropriate methods and equipment to maintain and monitor dental-unit water quality. Dental water line cleaners should be used according to manufacturer's guidelines. Some recommend draining the water at the end of the day.

CDC recommends that water and air be flushed for a minimum of 20-30 seconds after each patient from any device connected to the dental water system that enters the patient's mouth (e.g., air/water syringe) to expel organisms that may have been drawn into the waterline.

Disinfecting Treatment Areas

After patient treatment, all surfaces not protected with disposable barriers are to be decontaminated with a disinfectant registered with the Environmental Protection Agency (EPA) as a hospital disinfectant. A known disinfectant approved by the EPA and with minimal environmental toxicity is Oxivir. This disinfectant remains in contact with the environmental surfaces for the period of time recommended by the disinfectant's manufacturer. Protective attire (gloves, eyewear, and clothing) is used when performing this procedure.

Clinic personnel who process treatment areas are required to adhere to the following protocol in disinfecting dental equipment:

- <u>Dental Lights, Handles, Chair, Controls, and Dental Delivery Units</u>:
  - Dental units, chairs, lights, and controls are wiped thoroughly with approved disinfectant after each patient unless these surfaces have been covered with a plastic or fluid resistant paper barrier, in which case the underlying surfaces must be wiped with a disinfectant at the beginning of each day. All hoses are also wiped. The operator chair as well as the assisting stool is also wiped.

- Portable dental equipment is treated in the same fashion as the stationary equipment found in our permanent dental clinic sites.

- Cotton Products: Cotton rolls and gauze are on a procedure tray for individual patient use. Gauze, cotton rolls and cotton pellets are stored in covered containers. Clean forceps are used for dispensing supplies for immediate use chairside if needed; otherwise these items are dispensed prior to treatment.

- Tray Setup**:** Think ahead when preparing for procedures. When possible, use tray setups so the entering of drawers and cabinets can be minimized. When cabinet drawers must be entered during a procedure to secure an instrument or supplies it must be accomplished with a sterile forceps or barrier to prevent contamination of the contents of the drawer.

- Contaminated Waste**:** Infectious refuse shall be separated from all other and placed into covered containers having red or orange plastic liners or liners clearly labeled as bio-hazard to alert personnel of possible danger.

  - The current State Environmental Improvement Divisions definition of infectious waste having dental implications is a limited class of substances that cause a probable risk of transmitting diseases to humans, including:
    - Pathological wastes and body parts (teeth and soft tissue);
    - Disposable equipment contaminated by highly contagious disease;
    - Blood and blood products;
    - Contaminated sharps and broken glass.

  - Limit materials that are red bagged to gauze and cotton balls soaked with blood, saliva and blood-stained paper goods, teeth or excised soft tissue. Sharps are to be tightly sealed in puncture resistant containers to preclude loss of contents.

  - All contaminated waste is collected from each container marked bio-hazardous materials at the end of each day. The dental personnel must wear gloves when performing this job. All bags are placed in a large red bag and taken to the designated holding areas within the clinic where it is deposited for removal by a contracted special waste hauler

  - Full sharps containers, which have been taped shut, are to be taken to the aforementioned holding area and deposited in infectious waste containers in a similar manner.

Spills of Chemical or Infectious Materials

Should any blood, infectious fluids or materials be spilled on the floor or any work surface, the spilled material should be wiped up using an absorbent material with gloved hands, and dispensed of in the appropriate waste container. The area should then be thoroughly wiped down with a hospital grade, high level disinfectant or a solution of 1:10 household bleach and water and allowed to remain wet for 30 seconds before wiping dry.

Retention Checks

A key indicator for measuring dental-sealant quality is retention rate. Sealant quality can be measured by checking short-term retention rates, 1-year retention rates, or both. Both measures serve important purposes. The following are recommendations by the National Maternal and Child Oral Health Resource Center's Seal America: The Prevention Invention (Seal America).

Short-Term Retention Checks

A sample of students who receive dental sealants as part of a school-based dental sealant program can be evaluated a few days, weeks, or months after sealant application to ensure that the dental sealants are intact, adequately cover the occlusal pits and fissures, and have marginal integrity. The proportion of students checked and the frequency with which they are checked varies from program to program. Conducting short-term retention checks can be an effective way to evaluate staff performance, identify needed protocol changes, and determine the adequacy of material and equipment used. Short-term retention checks offer an opportunity to correct problems with sealant-application techniques, material, and equipment. This type of retention checks can be especially useful in evaluating the performance of a new operator.

Yearly Retention Checks

Yearly retention checks can begin in the second year of the program and should occur yearly thereafter for as many students as possible. One-year retention rates of properly applied sealants should be high, averaging between 80 percent and 90 percent.

For programs that provide dental sealants for second- and sixth-grade students, retention checks typically involve checking third-grade students who received dental sealants the year before. Upon graduation from sixth grade, many students change schools, making retention checks difficult. If good tracking systems are in place, after the fourth year of a program sixth-grade students can also be checked, thus documenting 4-year retention rates of dental sealants that were placed when these students were in second grade.

To perform yearly retention checks, advance preparation is required. First, student records from the previous year need to be retrieved from storage. Using third-grade class lists, students who received dental sealants the previous year can be identified. New room numbers should be marked on student records before the program is next scheduled to operate in the school, and the records should be taken to the school when the program operates. If electronic records are being used, a list of third-grade students with room numbers will need to be generated.

As resources allow, retention checks should be completed on as many students as possible. A space should be available on the student record to indicate retention check results.

Lost vs. Partially Lost Dental Sealants

Some programs differentiate between lost and partially lost dental sealants while others do not. Both lost and partially lost sealants result from moisture contamination during application process. Program planners need to establish retention-check criteria that clearly define lost and partially lost dental sealants so both are recorded properly. Partially sealed teeth are also identified during retention

checks. (Teeth may be partially sealed, for example, when the sealant was applied before the occlusal surface of the tooth was fully erupted.) In these instances, an add-on sealant is indicated to protect the tooth. This tooth, however, should not be counted as a sealant because it was not completely sealed in the first place.

Program administrators must decide whether lost sealants will be reapplied. Some consent forms allow for reapplication of lost sealants that are detected during retention checks in subsequent years. In these instances, lost sealants are re-applied, and new sealants are applied to teeth that have erupted within the past year, if appropriate. An attorney familiar with consent can help determine how consent forms should be phrased to cover retention checks and additional dental sealant placement.

After all the retention-check information has been collected, the retention rate should be computed for each student and the total number of students in each school.[2] One year retention rates average between 80-90%. A 90% retention rate is expected for a sealant program; anything lower is indicative of a problem and should be addressed through an improvement plan.

Referral for Treatment

Many students treated in school-based dental sealant programs do not have a usual source of oral health care (dental home). School-based dental sealant programs can serve as stepping stones to the establishment of a dental home by linking students with oral health needs to the broader oral health care community. To accomplish this, programs need a plan for notifying parents about their child's oral health needs and for helping parents find a dentist for their child, if they don't already have one. The following strategies are recommended by Seal America:

Identifying Community Resources

The first step is to identify and cultivate relationships with referral sources in the community. The state dental society, the state office of oral health, community and migrant health centers, public health clinics, hospital dental programs, dental schools, comprehensive portable dental programs, and dentists in private practice may be able to aid in the establishment of a dental home. Program administrators may wish to prepare a list of dental-home-referral sources by neighborhood. The list should indicate which dentists and safety net dental clinics (e.g., community health centers, hospitals) accept Minnesota Health Care (MHCP). If dentists or safety net dental clinics do not accept MHCP, but are willing to treat students from families with low incomes, the list should clearly state the terms of payment.

It is also wise to develop a list of dentists or safety net dental clinics willing to provide emergency care to students with urgent problems (e.g., pain, swelling). These dentists or safety net dental clinics will not necessarily become the student's dental home; rather they treat urgent problems until a dental home can be established.

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[2] Carter NL, with the American Association for Community Dental Programs and the National Maternal and Child Oral Health Resource Center. 2011. Seal America: The Prevention Invention (2nd ed., rev.). Washington, DC: National Maternal and Child Oral Health Resource Center.

It is important to contact all dentists or safety net dental clinics to confirm that they accept MHCP and provide treatment to students who are participating in the school-based dental sealant program. In addition, it is a good idea to provide dentists and safety net dental clinics with a letter of agreement. The letter of agreement protects dentists or safety net dental clinics from expectations that they will provide services beyond those agreed upon and safeguard against undue disruption to dentists or clinics.

Working with Parents

Each student that participated in the school-based dental sealant program should bring a letter home informing their parents of how many dental sealants were placed, whether any obvious oral disease was identified, and whether the student needs treatment urgently (within 48 hours) or non-urgently (within 6 weeks). The letter should also emphasize the importance of regular dental visits and should provide a phone number that parents can call if they have questions.

Staff need to do their best to ensure that students receive necessary treatment. For students who have been referred for treatment, program administrators may choose to send the student's parents a follow-up letter or to contact them by phone. For students with pain or swelling, extra efforts should be made to ensure that appropriate care is provided.

Involving School Nurses

If a school nurse is available, program staff can provide the nurse with a list of students with oral health needs. The nurse is likely to be in contact with parents about students' health problems. In addition, students experiencing oral pain at school will be sent to the nurse's office. It can be helpful for school-based dental sealant program administrators to provide the school nurse with a list of dentists or safety net dental clinics that are willing to provide emergency care, as well as a list of dental-home-referral sources, as mentioned previously.

Strong leadership is the cornerstone of a successful school oral health program. The school nurse is best positioned to coordinate and integrate a successful oral health program which provides students and parents with the knowledge and tools they need to make good oral health decisions.

Tracking Referral Effectiveness

School-based dental sealant program administrators should consider developing a system to track the effectiveness of the program's referral component. Most school-based dental sealant programs re-assess as many students as possible 1 year after sealant application to determine whether the sealants have been retained. At that time, the status of oral health needs can be monitored, and the effectiveness of follow-up methods can be determined.

Strategies

Ensuring that students receive needed oral health care is challenging. A panel of experts was convened on May 11–12, 2006, in Washington, DC, to discuss strategies to overcoming barriers to accessing oral health care. The report from that panel, titled "**Improving the Oral Health of School-Aged Children: Strengthening School-Based Dental Sealant Program Linkages with**

Medicaid/SCHIP and Dental Homes," provides useful information. Following is a list of the types of strategies discussed at the meeting:

Case Management

Case management is a process whereby families receive help with finding and using oral health care services, including establishing dental homes. The process, overseen by a case manager, addresses any need or circumstance that may prevent students from receiving needed oral health services. Case managers must understand students' oral health care needs and must act to ensure that these needs are met. Activities undertaken by case managers include

- Engaging parents in obtaining needed oral health care for their children
- Enrolling students and their families in insurance plans (e.g., MHCP)
- Helping families use their insurance coverage (e.g., filling out forms, following insurance-coverage policies)
- Identifying dentists in the community who will accept students enrolled in MHCP
- Setting up appointments
- Educating students and their families on how to be good patients (e.g., arriving on time for appointments, appropriate waiting room behavior)
- Arranging transportation
- Obtaining translation services
- Following up to ensure that needed oral health care was received

It is important to establish approaches for providing services based on the needs of the community in which the school-based dental sealant program operates. Case managers can include health and social service professionals (e.g., dental hygienists, dental assistants, school nurses, and social workers), administrative staff, or volunteers. Case-management services and case managers' level of effort vary depending on the geographic and sociodemographic needs of the community as well as each individual case manager's level of expertise.

Safety Net Dental Clinics

Creating links with local safety net dental clinics is another approach for establishing dental homes for students participating in school-based dental sealant programs. Safety-net dental clinics can provide comprehensive and ongoing oral health care to children from families with low incomes and to other underserved populations.

Safety net dental clinics are usually staffed by community-based oral health professionals and are generally located in areas that serve populations that face various access barriers, often including limited ability to pay for care. These clinics are frequently located in community settings such as public schools, community health centers, Indian Health Service clinics, public health departments, dental schools, hospitals, and private not-for-profit service agencies (e.g., social service agencies).

Other strategies include

- Advocating, in collaboration with community coalitions, for competitive or market-based MHCP reimbursement rates and policies that allow for easier administration of the program.
- Helping families complete applications for MHCP, so that children have dental insurance.
- Encouraging and mobilizing parents to take their child to the dentist; understanding the barriers faced by parents whose children are treated in school-based dental sealant programs (e.g., transportation, keeping appointments).
- Addressing the communication and information needs of families from various cultural backgrounds who speak a primary language other than English.
- Recruiting new dentists to participate in MCHP and encouraging those already participating to treat children.
- Compiling lists of referral sources by neighborhood that have agreed to provide treatment to students participating in the school-based dental sealant program.
- Partnering or collaborating with pediatric physicians or departments who have shown a disposition for recognizing the importance of oral health for overall health.

School-based dental sealant programs that wish to offer MCHP outreach activities may be able to obtain additional funding through the Medicaid administrative match process. The Medicaid administrative match can provide additional funding for Medicaid outreach activities that may include care coordination and referrals to other health professionals (medical or dental), provide eligibility applications to parents and children, and assist families in the MCHP application process.[3]

Billing

Reimbursement

Reimbursement for dental services provided may be sought either through a third party payor or directly from the service recipient. Given the target population for school-based dental sealant programs, a large portion of children at schools with sealant programs are expected to be Minnesota Health Care Program (MHCP) enrollees. Providers should make all reasonable efforts to identify which children they serve may be MHCP enrollees and submit claims for services rendered to the

[3] Carter NL, with the American Association for Community Dental Programs and the National Maternal and Child Oral Health Resource Center. 2011. Seal America: The Prevention Invention (2nd ed., rev.). Washington, DC: National Maternal and Child Oral Health Resource Center.

appropriate payer. It is a goal of the Minnesota Department of Human Services (DHS) to increase the number of children who receive a dental sealant on at least one permanent molar.

Provider Enrollment (provided by DHS)

- All providers delivering services to enrollees of Minnesota Health Care Programs (MHCP) must complete an enrollment application form and provider agreement. Federal regulations require a signed agreement with every person, organization or business. Provider agreements must be signed personally by the individual applying for the provider number. An officer, administrator, manager, director or person with similar authority must sign a provider agreement for an organization or business.
- MHCP uses electronic funds transfer (EFT) to pay providers for services rendered to MHCP recipients.
- To receive MHCP payment, enrolled organizations and sole practice individuals must register for a vendor number and EFT activations available from the Minnesota Management & Budget's (MMB) Vendor Payment Website. After MMB notifies providers of their vendor number and EFT activation, the provider must report it to MHCP Provider Enrollment using the EFT Vendor Number Notification Form (DHS-3725) which is located on the MHCP Enrolled Provider website.

MHCP Provider Enrollment and NPI contact information:

- MHCP Provider Call Center: 651-431-2700 or 1-800-366-5411 (Press option 5 for enrollment questions)
- MHCP fax number for completed enrollment forms: 651-431-7462
- National Provider Identifier (NPI) toll free number: 1-800-465-3203

Filing Claims

General Billing Requirements (provided by DHS)

MHCP providers who render or supervise services are responsible for claims submitted to MHCP as follows:

- Submit claims only after services are provided of one or more MHCP-covered service
- Bill only for dates of service when services were provided
- Bill the provider's usual and customary charge
- Bill only one calendar month of service per claim
- Submit claims electronically

Timely Billing

- Submit claims correctly, including TPL claims, so that MHCP receives them no later than 12 months from the date of service

- Submit replacement claims so that MHCP receives them within 6 months of the date of incorrect payment, or within 12 months from the date of service, whichever is greater
- Resubmit claims MHCP denied erroneously (due to system error or incorrect information from county) within 12 months of the date of service or up to 6 months from date of county correction, whichever is greater
- Submit claims over one year old with appropriate, dated documentation. See Electronic Claim Attachments for instructions. MHCP will review documentation, but does not guarantee payment.[4]

Quality Assurance

A quality sealant program will assure confidentiality and treat children and families respectfully. Two primary elements of quality assurance are:

1. Assuring technical quality of the sealants applied. Technical quality generally refers to a high rate of retention for sealants placed and can be assessed through analyzing sealant retention data from follow-up screenings. Also, retention may be assessed on a short-term basis by returning to a sample of schools within 1-2 months of sealant placement or during the next school year and re-checking a small number of children (e.g., 10-15 children).

2. Assuring appropriateness of the program. Appropriateness can be evaluated by analyzing program participation to ensure children and schools in the program meet its eligibility criteria. Additionally, programs should assure compliance with applicable laws and professional standards and guidelines, including infection control.

Data

Provide information about the region where the program is providing preventive oral health care in schools. Specific information about the number of schools and the counties in which they preside is helpful information for those interested in learning more about the program.

Individual sealant programs are encouraged to collect data such as numbers of children treated and number of sealants provided. The Sealant Efficiency Assessment for Locals and States (SEALS) created by the Centers for Disease Control and Prevention (CDC) is a helpful tool for tabulating such data. Sample reports can be viewed at:
http://www.cdc.gov/oralhealth/state_programs/infrastructure/seals.htm

The Minnesota Department of Health (MDH) has various data resources available on their website:
http://www.health.state.mn.us/oralhealth/data.html

- In 2009, MDH conducted the first state-wide baseline assessment of the oral health and sealant rates for third graders. The assessment was conducted with the assistance of

[4] *MHCP Provider Manual*, Provider Basics section, billing policy information is subject to change. For current, updated information check online Provider Manual, review MHCP Provider News and Updates.

Children's Dental Services' specially trained screening team and included a random sample of third graders across all regions of the state.
- "At-a-Glance" Oral Health Indicators highlights twelve county-level oral health indicators. The indicators' data sources and years collected vary.

Funding and Sustainability

In addition to fee-for-service reimbursements, grant funds are often utilized to support a dental sealant program.

Resources for grants and grant writing in Minnesota include the following:

- Management Assistance Program for Nonprofits www.mapfornonprofits.org
- Minnesota Council on Foundations www.mcf.org/
- Minnesota Council of Non-Profits www.minnesotanonprofits.org/
- Minnesota Department of Health http://www.health.state.mn.us/grants/index.html

Here is a sample sustainability plan:

SUSTAINABILITY PLAN OUTLINE

I. Executive Summary
   a. Organizational and/or program history
   b. Definition of sustainability
   c. Description of who was involved
   d. Summary of efforts for which sustainability
   e. Goals, needs, and costs for efforts being continued

II. Situational Analysis
   a. Organizational strengths as they relate to positioning
   b. Current picture/pending items

III. Criteria to Determine Program Value-Added Benefits
   a. Identify what elements will be used to determine criteria (e.g., population reached, evidence of effectiveness, broad support)

IV. Sustainability Planning Goal(s)
   a. Efforts to continue
   b. Efforts to revise and continue
   c. Efforts to ask another organization to continue

V. Sustainability Strategies
   a. Describe any organizational or structure changes
   b. Recruit program champions and partners
   c. Marketing and public relations
   d. Funding
   e. Communication of justification matrix (for every policy strategy, there is an activity associated with it and a suggested financial strategy)

VI. Action Plan by Strategy

a. Develop SMART (Specific, Measureable, Achievable, Relevant, Time-bound) objectives for organizational and policy efforts
b. Develop action plan and timetable for strategies

Other Resources:

- Work Group for Community Health and Development, University of Kansas: http://ctb.ku.edu/en/dothework/index.aspx
- Sample Plan: http://www.nationalserviceresources.org/files/legacy/filemanager/download/online/sustainability_plan.pdf
- Centers for Disease Control and Prevention Sustainability Guide: http://www.cdc.gov/healthycommunitiesprogram/pdf/sustainability_guide.pdf

Sample Forms

Report of Dental Assessment

Children's Dental Health Services
Report of Dental Assessment

To the parent/guardian of_____Date_____
Your child had a dental assessment today. Our observations for your child are listed below.

- Your child has a need for immediate dental care. It is recommended that a dentist be consulted as soon as possible to initiate treatment.

- Your child has a need for dental care. It is recommended that a dentist be consulted at an early date to initiate treatment.

- Your child has no obvious need for dental treatment at this time; however, we suggest that your child visit a dentist at least once a year for a complete dental examination.

If you have any question, please call our office at (507) 529-0436. Thank you Children's Dental Health Services.

Recommendations

- Help your child brush teeth or check brushing daily.
- Limit sugary snacks (pop and candy).
- Have your child brush teeth, gums, and tongue daily.
- Limit juice to 1 glass a day.

Comments:

Consent Form

Community Dental Care's School Based Sealant Program

Dear Parent,

A dental sealant program is being offered in your child's school. This program helps prevent tooth decay by placing a thin plastic coating, called a sealant, on the chewing surfaces of the teeth. A collaborative dental hygienist will complete a dental screening to see if your child needs dental sealants. Dental cleaning and fluoride may also be provided to participating students. We will send a report home with your child describing screening results, the number of sealants provided and dental referral if needed. Sealants may be evaluated 2 months to 1 year after application and reapplied if necessary. This screening is *not* intended to take the place of a comprehensive dental examination. Your child should receive a complete dental exam from his or her dentist at least once a year.

Please indicate below if you would like your child to participate and return this form to your child's teacher today! (Please check yes or no below)

☐**YES** I want my child to receive preventive services including SEALANTS! *If you would like your child to participate: please complete entire form (front and back), sign and return to your child's teacher.*

☐**NO**, I do not want my child to receive preventive services or SEALANTS. *If you do not want your child to participate: Please fill in student name only, sign reverse side of form, and return.*
Child's name: _____

Please complete the following if your child will be participating in the dental sealant program:

CHILD'S NAME_____

BIRTHDATE____/_____/_____**MALE**____ **FEMALE**____

SCHOOL_____ **TEACHER**_____

GRADE_____

HOME ADDRESS:_____**HOME**

PHONE_____

HEALTH HISTORY: (Please circle yes or no)

- Is your child currently under a physician's care for a specific problem or illness? **YES / NO**

If **YES**, please explain_____

- Is your child currently taking any medications? **YES / NO**

If **YES**, please list medications

_____

- Has your child ever had any serious health problems? **YES / NO**

If **YES**, please explain_____

- Does your child have any allergies? (Please circle) **YES /NO**

If **YES,** please list

_____

- Does your child have a regular dentist? **YES/NO**
- Has your child been to a dentist within the last year? **YES/NO**

RACE/ ETHNICITY: (Please check all that apply for your child)

☐African American ☐Hmong ☐Karenni ☐Other

☐African ☐Other Asian ☐Caucasian

☐Hispanic/Latino ☐Karen ☐Multi Ethnic

Did you receive the Notice of Privacy Practices? (Please circle) **YES /NO** If yes, **initial** here _____

Payment from Minnesota heath care and other insurance helps to cover the costs of this sealant program. If your child is covered by a Minnesota health care program, *please circle* the name of his/her insurance program and fill in the ID numbers, *or check appropriate boxes below.*

☐**My child is covered by Minnesota Health Care Programs:**

BluePlus MEDICA METROPOLITAN MHP HEALTH PLAN HealthPartners UCare (MHCP)

ID # /Member # _____ PMI#(Health Partners/DentaQuest/UCare _____

☐**My child is covered by another plan not listed above:** plan name and member/ID #_____

☐**My child has no insurance. I would like the sealant cost to be covered by scholarships/mini grants.**

Emergency Contact Information:

please provide name and phone number of person to contact in case of an emergency

Contact Name: _____ Phone number: _____

Relationship to student: _____

Name of parent/guardian: (please print) _____

- **SIGNATURE** of parent or guardian

_____DATE_____

(Funding for this sealant program is provided by grants from the Otto Bremer Foundation, Boston Scientific, Delta Dental and an oral health workforce grant from the USDH/HRSA to the MDH.)

SEALS Data Form

SEALS Child-Level Data Collection Form

1. Program Name: _____ 2. Event/Site Name: _____

3. Patient Name: First _____ Last _____

4. ID #♦: NOT OPEN DENTAL ID_____ ♦Each child's ID # must be unique for that event; do not use duplicate ID #'s at any one event.

5. Sex: _____ (0 = Male, 1 = Female) 6. Grade: _____ (0 = Kindergarten) 7. DOB _____ 8. Age: _____

9. Race/ethnicity (Check all that apply): ____White ____Black/African American ____Asian ____Hispanic
____American Indian/Alaska Native ____Native Hawaiian/Pacific Islander ____Other

10. Special health care needs: _____ (0 = No, 1 = Yes) 11. Medicaid/SCHIP status _____ (0=Medicaid, 1=SCHIP, 2=neither, 99=unknown)

I. Screening – D = decay, F = filled, M = missing, S = sealant present, PS = prescribe sealant,
RS = recommend reseal, **no mark** = no treatment recommended

1	2	3	4	5	12	13	14	15	16	Sealant Prescriber's Signature _____ Date Fluoride Prescriber's Signature _____ Date
32	31	30	29	28	21	20	19	18	17	

Comments:

12: INCLUDE ANY CAVITIES IN ANY TEETH 13: TREATED OR UNTREATED IN ANY TEETH

12. Untreated Cavities: 0 = No untreated cavities 1 = Untreated cavities present		13. Caries Experience: 0 = No caries experience 1 = Caries experience		14. Sealants Present: 0 = No sealants 1 = Sealants present	
15. Treatment Urgency: 0 = No obvious problem 1 = Early dental care 2 = Urgent care		16. Referred for treatment: 0 = No 1 = Yes		17. Decayed or filled teeth: a. 1st molars b. 2nd molars	

II. Preventive Services - Mark the teeth where sealants were placed with an **S**.

1	2	3	4	5	12	13	14	15	16	Provider's Signature _____ Date _____
32	31	30	29	28	21	20	19	18	17	

Comments:

18. Number of teeth sealed among: a. 1st molars b. 2nd molars c. other				19. Fluoride treatment received: 0 = none 1 = varnish 2 = gel/foam/rinse	

Seals Data Form Continued

III. Follow-Up - Mark teeth where sealants were retained with an **R**.

1	2	3	4	5	12	13	14	15	16	Evaluator's Signature
										Date _____
32	31	30	29	28	21	20	19	18	17	

Comments:

20. Number of teeth retaining a program sealant:		21. Subsequent visit for restorative treatment: 0 = No 1 = Yes 99 = Unknown, no follow-up performed by program	

20: ONLY THE # OF RETAINED SEALANTS PLACED BY OUR PROGRAM

Take Home Letter to Care-giver

Northern Dental Access Center

Community Based Oral Health Program

To the Parent/Guardian(s) of: _____ Date: _____

Your child received preventive dental care by Northern Dental Access Center to help prevent cavities. It is important to remember this care **does NOT replace the need for an exam at a dental office.**

Your child should see a dentist:

_____ **IMMEDIATELY because of probable cavities and/or infection**

_____ **Soon because of possible cavities**

_____ **Within the next six months**

Northern Dental Access Center is a nonprofit community dental clinic in Bemidji, Minnesota serving those who are uninsured and/or enrolled in Minnesota Health Care Programs.
Please call Northern Dental Access Center if you have any questions or concerns.
(218) 444-9646 or Toll Free: (888) 678-3033

_____Your child had his/her teeth cleaned today
_____Your child received a fluoride treatment
_____Your child had sealants placed today
_____Your child did not have sealants placed on some teeth because:

- _____ Sealants are already present
- _____ Teeth have not completely grown in
- _____ Teeth have fillings
- _____ Possible cavities
- _____ A sealant could not be safely placed because of child's behavior

Sealants act as a barrier, protecting the teeth against decay-causing bacteria and are usually applied to the chewing surfaces of the back teeth where decay occurs most often.

Fluoride varnish helps keep teeth strong and prevents cavities. We have asked your child not to brush off the fluoride varnish until bedtime. He/she may eat and drink as usual.

Comments:
_____
_____

Referral for Care

www.justkidsdentaline.org

DDS REFERRAL
from
JUST KIDS DENTAL

Lake Superior Community Health Center Duluth
4325 Grand Avenue
Duluth, MN 55807
Phone: 218.628.7035
Hours: Monday and Friday 8-5
Tuesday thru Thursday 7:30-5

Eversmiles
4419 Air Base Road
Duluth, MN 55811
Phone: 218.728.2117
Hours: Monday thru Thursday 8-4

Lake Superior Community Health Center Superior
3600 Tower Avenue
Superior, WI 54880
Phone: 715.394.5411
Hours: Monday thru Friday 7:30-5

Dr. Bussa
324 W. Superior Street #628
Duluth, MN 55802
Phone: 218.722.7271
Hours: Monday thru Thursday 8-4:30

Child Last Name: _____

Child First Name: _____

DOB: _____

Date of School Visit: _____

Parent Name: _____

Parent Phone #: _____

Insurance Provider & ID #: _____

REASON FOR REFERRAL: _____

_____

_____

DATE OF REFERRAL: _____

1	2	3	4 or A	5 or B	12 or I	13 or J	14	15	16
32	31	30	29 or T	28 or S	21 or L	20 or K	19	18	17

Phone 218.206.4327 Like Us!

Apple Tree Dental

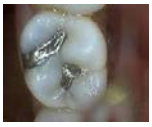
Madelia Smiles
Restorative Consent

Apple Tree Dental
115 Drew Ave SE Ste 202
Madelia, MN 56062

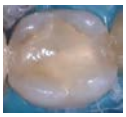
owing explanations of dental services that may be r
for your child. Sign below if you want Apple Tree Dental to perform the services as needed and diagnosed by our dentist.

☐ **Exam/x-rays**

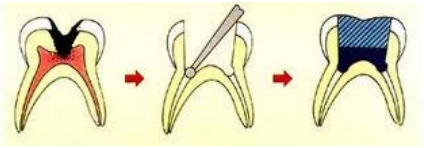
☐ **Filling(s):** Amalgam (silver colored fillings), glass ionomer (tooth colored fillings), and/or composite resin (tooth colored fillings) for cavities. The dentist will choose the filling for each tooth that will last longer.


Amalgam

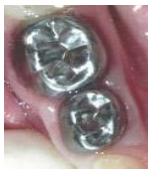

Glass Ionomer

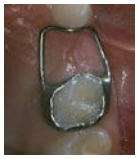

Composite Resin

☐ **Pulpotomy:** This procedure is like a root canal on a baby tooth. The dentist will make this choice when decay has gone into the pulp of the tooth. A tooth with a pulpotomy always has a crown on it.



☐ **Crown(s):** This is a silver crown, which is mainly used on baby teeth when the tooth cannot be fixed with a filling.


Crown


Space Maintainer

☐ **Space Maintainer:** The dentist places this to hold space for the adult tooth after a baby tooth has been pulled. It will need to be taken out when the adult tooth starts to come in.

☐ **Extraction(s):** Only on baby teeth or "milk" teeth. The dentist will pull (extract) the tooth to prevent an infection, only if the tooth cannot be saved with a filling or a crown.

I authorize Apple Tree Dental to provide the treatments marked above.

Signature: _____ **Date:** _____

Patient Representative/ Guardian

☐ I will schedule and bring my child to their dental appointment

☐ I want the Madelia Smiles program to schedule and bring my child to their dental appointment

☐ **I DO NOT** authorize dental treatment. Reason:

_____

Signature: _____ **Date:** _____

Patient Representative/ Guardian

School Satisfaction Survey

Review Completed By:_____
Date :_____

Community Based Oral Health Program Review

1. What was the impact of this program in your school?

2. Do you have any suggestions or recommendations to help this program in the future?

3. Have you received any feedback from the children at your school regarding the program's appearance?

4. Are there any perceived gaps in the services we provided?

5. Did you feel there was adequate communication between our partnership?

6. One of the biggest barriers was parent contact. Do you have any suggestions regarding this matter?

7. We have applied a fee schedule for those that are not insured and would like to take advantage of this program, how do you think this has been received by parents/guardians? (Currently there is a flat fee of $45 for children age 12 and younger and a flat fee of $65 for children above age 12 for a screening, cleaning, oral health instruction, sealants (if needed), and a fluoride treatment.)

8. Are you interested in continuing this program at your school in the upcoming years?

Parent Satisfaction Survey

MADELIA SMILES PARENT SURVEY

The Madelia Smiles Program wants to know what you think about the dental program your child is receiving at the Madelia Public Schools. Please complete this survey and return it to your child's teacher.

1. How satisfied have you been with the services provided by the Madelia Smiles Program?

   Very satisfied *Somewhat satisfied* *Not satisfied*

2. Did your child receive protective sealants on their teeth?

   Yes *No*

3. How important to you is having dental screenings and preventive care available at school?

   Very important *Somewhat important* *Not important*

4. Will you sign your child up for the Madelia Smiles Program next year?

   Yes *No (reason* _____ *)*

5. What could the Madelia Smiles Program do to improve its services?

Thank you for completing our survey.

Appendix

Appendix A-Sample Memorandum of Understanding

Agreement Between
<Organization> And <Name>School, District

This agreement is made on June 1, 2011, by and between **<Name> School, located at <street address>, <city>, <state>, <zip>** and <**Organization**> to provide on-site oral health services.

Background:
<**Organization**> is a community dental clinic providing dental care to low income children and families in Minnesota. New resources allow the Center to provide preventive care off-site at community-based locations in order to improve the health of people in its service area. With the support of host agencies, Organization can provide oral screening, prophylaxes (cleanings), fluoride treatment, sealants, oral health instruction, and data collection. Information and referrals will also be provided to assist parents in finding dental homes for their children, to promote long term oral health. Should additional treatment, including but not limited to restorative care, be deemed necessary or appropriate, the examining oral health provider will so advise the patient (parent/guardian) and provide a referral to an appropriate community based dental provider or to . In addition, as parents encounter barriers to obtaining the needed follow up services prescribed, staff will work with the families to address such barriers.

Regarding services rendered by **Organization** to students participating in the **Community Based Oral Health Program**, it is agreed that:

Responsibilities of Organization and its dental providers:

a. On a date mutually agreeable to Agency administration and the Provider, the Provider will implement oral health services which will be delivered to students by a registered dental hygienist.
b. Provider will provide services at Agency on mutually agreeable days of the week when Agency is in session. Provider will bill insurance programs for services to students covered by insurance providers. Provider will seek reimbursement from student's parents or guardians, upon determination of eligibility.
c. All students who fit the eligibility guidelines will be patients, provided they have parental consent for this participation if they are under the age of 18 years of age. Agency will provide parental consent forms for this purpose and shall require a completed form from each minor student who is treated by the Provider.
d. Provider will obtain a health history and treatment consent forms from the parent/guardian of each student seeking treatment. Provider shall then conduct a dental assessment and screening of the student and apply tooth sealant or fluoride treatment, as appropriate. If such examination reflects that further treatment is necessary, Provider will assist in providing the student with dental agencies who can assist in the student receiving the appropriate dental treatments.
e. Provider shall bear the cost of all dental equipment, including protective garments and supplies, utilized in conjunction with the "project" and shall be responsible for the sterilization of all equipment and supplies.

f. Provider shall maintain during the term of this Agreement, Professional Liability Insurance. Provider shall assume all risk of loss or damage to Provider's property and waives all claims with respect thereto against Agency, unless such loss or damage is directly attributable to the negligence of Agency.

Responsibilities of Agency:

a. Agency shall make appropriate space available to Provider at no cost to Provider for the oral services provided, and shall inform students of the services available and shall encourage, students for appropriate appointment times so as not to interfere with their educational program schedules.

b. Agency, through its personnel, shall assist Provider in distributing parental consent forms to potential student patients.

Term:

The term of this Agreement shall commence as of the date indicated above and shall continue for one year with the option to extend this Agreement for additional one year periods of time based on mutual written consent of all parties to extend the Agreement.

Termination:

Either party may terminate this Agreement at any time, with or without cause, by providing thirty (30) days written notice to the other party. Provider retains the right to remove all of its oral health equipment and supplies from Agency upon termination of this Agreement, and Agency shall grant Provider access to the Agency premises for such purpose during the normal Agency hours of operation.

Modifications:

No modification, expansion or amendment of this Agreement shall be of any force or effect unless it shall be in writing and signed by the parties hereto. All additions and future program developments and curriculum design must be approved by all parties and reviewed by the appropriate administration to ensure the safety, security and protection of the students and the Agency district.

IN WITNESS WHEREOF, the parties have signed this Agreement.

Organization

By: _____

Project Manager

Date Signed: _____

<Name> School District

By: _____

Print: _____

Title: _____

Date Signed: _____

Appendix B-Minnesota Statute 150A.10

Minnesota Statute 150A.10
Limited authorization for dental hygienists.

(a) Notwithstanding subdivision 1, a dental hygienist licensed under this chapter may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services described under paragraph

(b) without the patient first being examined by a licensed dentist if the dental hygienist:

(1) has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years;

(2) has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist;

(3) has documented participation in courses in infection control and medical emergencies within each continuing education cycle; and

(4) maintains current CPR certification from completion of the American Heart Association healthcare provider course, the American Red Cross professional rescuer course, or an equivalent entity.

(b) The dental hygiene services authorized to be performed by a dental hygienist under this subdivision are limited to:

(1) oral health promotion and disease prevention education;

(2) removal of deposits and stains from the surfaces of the teeth;

(3) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;

(4) polishing and smoothing restorations;

(5) removal of marginal overhangs;

(6) performance of preliminary charting;

(7) taking of radiographs; and

(8) performance of scaling and root planing.

The dental hygienist may administer injections of local anesthetic agents or nitrous oxide inhalation analgesia as specifically delegated in the collaborative agreement with a licensed dentist. The dentist need not first examine the patient or be present. If the patient is considered medically compromised, the collaborative dentist shall review the patient record, including the medical history, prior to the provision of these services. Collaborating dental hygienists may work with unlicensed and licensed dental assistants who may only perform duties for which licensure is not required. The performance of dental hygiene services in a health care facility, program, or nonprofit organization as authorized under this subdivision is limited to patients, students, and residents of the facility, program, or organization.

(c) A collaborating dentist must be licensed under this chapter and may enter into a collaborative agreement with no more than four dental hygienists unless otherwise authorized by the board. The board shall develop parameters and a process for obtaining authorization to collaborate with more than four dental hygienists. The collaborative agreement must include:

(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene services;

(2) age- and procedure-specific standard collaborative practice protocols, including recommended intervals for the performance of dental hygiene services and a period of time in which an examination by a dentist should occur;

(3) copies of consent to treatment form provided to the patient by the dental hygienist;

(4) specific protocols for the placement of pit and fissure sealants and requirements for follow-up care to assure the efficacy of the sealants after application; and

(5) a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist. This procedure must specify where these records are to be located.

The collaborative agreement must be signed and maintained by the dentist, the dental hygienist, and the facility, program, or organization; must be reviewed annually by the collaborating dentist and dental hygienist; and must be made available to the board upon request.

(d) Before performing any services authorized under this subdivision, a dental hygienist must provide the patient with consent to treatment form which must include a statement advising the patient that the dental hygiene services provided are not a substitute for a dental examination by a licensed dentist. If the dental hygienist makes any referrals to the patient for further dental procedures, the dental hygienist must fill out a referral form and provide a copy of the form to the collaborating dentist.

(e) For the purposes of this subdivision, a "health care facility, program, or nonprofit organization" is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated facility licensed by the commissioner of human services or the commissioner of corrections; and federal, state, or local public health facility, community clinic, tribal clinic, school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.

(f) For purposes of this subdivision, a "collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services authorized under this subdivision and the collaborative agreement may be performed without the presence of a licensed dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Appendix C-Post Exposure Protocol & Management of Injuries

Post Exposure Protocol & Management of Injuries

After an occupational blood exposure, first aid is administered as necessary. Puncture wounds and other injuries to the skin are washed with soap and water; mucous membranes are flushed with water.

Exposed employees are to immediately report the exposure to the exposure control officer or the designated person who completes the necessary reports. The employee may seek treatment at the clinic of their choice or the medical center, which is equipped to handle exposure incidents.

Because multiple factors contribute to the risk of infection after an occupational exposure to blood or other infectious materials, the following information is included in the exposure report, recorded in the exposed employee's confidential medical record, and provided to the qualified health-care professional:

- Date and time of exposure.
- Details of the procedure being performed including:
    - where and how the exposure occurred
    - whether the exposure involved a sharp device, the type and brand of device, and how and when during its handling the exposure occurred
- Details of the exposure, including:
    - exposure severity
    - type and amount of fluid or material
      For a percutaneous injury, severity might be measured by the depth of the wound, gauge of the needle, and whether fluid was injected.
    - the estimated volume of material, duration of contact, and the condition of the Skin (e.g., chapped, abraded, or intact) is noted.
- Details regarding whether the source material was known to contain HIV or other blood borne pathogens, and, if the source was infected with HIV, the stage of disease, history of antiretroviral therapy, and viral load, if known.
- Details regarding the exposed person (hepatitis B vaccination and vaccine-response status).
- Details regarding counseling, post exposure management, and follow-up.
  Each occupational exposure is to be evaluated individually for its potential to transmit HBV, HCV, and HIV, based on the following:
    - The type and amount of body substance involved.
    - The type of exposure (percutaneous injury, mucous membrane or non-intact skin exposure, or bites resulting in blood exposure to either person involved).

- The infection status of the source.
- The susceptibility of the exposed person.

All of these factors are considered in assessing the risk for infection and the need for further follow-up (Post exposure protocol).

All injuries, regardless of size, are to be reported to the office manager or OSHA coordinator.