



**School-Based Comprehensive Oral Health Services Grant Program  
FINAL REPORT**

**A. Project Identifier Information**

Grant Number: H47MC23170  
 Project Title: Children’s Oral Healthcare Access Program (COHAP)  
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**C. Progress**

- 1. Planning and Implementation**
  - a. Delivery System Design**

*See Appendix A page 1-2 for Project Logic Model as a reference for details below.*

**Inputs & Resources**

Our community advisory council, informally known as the project team, involved the following partners. Their roles and involvement throughout the funding period are described below:

***Solano Coalition for Better Health (Coalition)*** spearheaded the project and provided program promotion, reporting, fundraising, and fiscal oversight.

From 2011 to 2012, the project director was Doug Hayward, the executive director of the Coalition at the time. When Mr. Hayward stepped down from his role, Carl Thomas, the Coalition’s former chief financial officer and interim executive director of the Coalition from 2012 to 2013, filled his role. From 2013 to 2015, the project director role was appointed to Nikiyah Jones, the Community Programs Manager. Despite the significant turnover for this particular role, project coordination and clinic operations were not disrupted at any time during the funding period.

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*Vallejo City Unified School District (VCUSD)* provided the school-based health center (SBHC) facility and access to the Prognosis electronic health record system. The school district was also responsible for quality improvement and utilization reviews at the SBHC on a quarterly basis.

The SBHC's medical director from 2011 to 2014 was Dr. James E. Foy, a now retired osteopathic pediatrician and former chair of pediatrics at Touro University California, the local osteopathic medical school. Dr. Foy also led the Continuous Quality Improvement (CQI) Committee, making significant changes in the CQI committee's policies to include dental staff participation and dental interventions in the CQI committee's quality improvement and utilization reviews at the SBHC.

Throughout this project the Coalition worked closely with the Coordinator of Full Service Community Schools, a role that was initially filled by Kathleen Hahn, RN, MSN, CPNP, from 2011 to 2014. Mrs. Hahn's support of the integration at the SBHC was a significant factor in the success of the program. Her interest in the project and buy-in from the beginning allowed the Coalition and dental staff to participate in regularly scheduled clinic coordination meetings, where topics of integration were discussed among both medical and dental staff. She also approved the oral health curriculum and helped expedite the delivery of health education lessons in elementary school classrooms in the Vallejo City Unified School District. The Coalition shared its data collection methods with Mrs. Hahn, which she in her reports to the school district. Mrs. Hahn's role was filled by Rayito Farris in 2014 to 2015. Mrs. Farris has a background in education as an assistant principal in the Vacaville Unified School District. There was a slight lag in progress during the last grant year, largely in part from Mrs. Farris' restricted availability. However, she contributed to the negotiations and discussions in the months leading up to the warm transition to La Clínica de la Raza in October 2015.

From 2011 to 2015, the nurse practitioner role was filled by three providers - Meshia Darling, Beatriz Coll and Kathleen Hahn. Despite the significant turnover for this particular role, delivery of direct care services was not disrupted. Maria Theresa Leach was the medical assistant consistently from 2011 to 2015, and is still currently working at the SBHC with Mrs. Hahn.



**SBHC staff left to right: Maria Theresa Leach, MA; Maryluz Rodriguez, SBHC Care Coordinator; Janell Glouser, RDH; and Kathleen Hahn, RN, MSN, CPNP**

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*Touro University California (TU)* provided evaluation services at the Widenmann Student Health Center, producing reports analyzing preliminary baseline data, follow-up/recare data, and patient satisfaction surveys.

Dr. Annette Aalborg and Gayle Cummings led the evaluation team and were assisted by graduate students, who were trained as research assistants to conduct interviews and collect data on the demographic background and attitudes and behaviors of caregivers and pediatric patients. Dr. Aalborg and Ms. Cummings trained a new cohort of graduate students every



school year, as the students were available from the fall to spring quarters. The graduate students also contributed significantly to the classroom education activities in the project. A third faculty member, Garland Brinkley, was listed as a member of the evaluation team from

Above: Public Health graduate students who assisted with evaluation and education services in 2012-2013.

2011 to 2013, but he left the team shortly before leaving the Touro University California's faculty. The evaluation team was also temporarily assisted by Dr. Lucy Thairu, former assistant professor of Global Health at Touro University California.

**First 5 Solano** provided valuable resources and input at the quarterly project team meetings. First 5 Solano also contributed financial support in the health education and promotion of the project, specifically in the "First Tooth or First Birthday" campaign, which targeted parents/guardians of children who accessed dental services at the school-based health center and those who received education during outreach events at child development centers and pre-schools in Vallejo.

**The registered dental hygienist (RDH) and SBHC Care Coordinator** provided direct care services at the clinic. The RDH provided prophylaxis, fluoride application, sealant application, and oral health education services to patients at the clinic. The SBHC Care Coordinator was responsible for maintaining communication with patients; scheduling and tracking initial and follow-up appointments; inputting patient data into the electronic health record system; creating monthly direct service reports; and generally assisting the RDH. Both the RDH and Care Coordinator attended community events periodically to promote clinic services, recruit new patients, and deliver health education.

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**RDH and SBHC Care Coordinator promoting the SBHC at the Loma Vista Farm Day Festival, one of many community events they attended to provide education and promote services at the SBHC**

*Private practice dentists in the community, specifically Amy English, D.D.S. and Suzanne Clift, D.D.S., provided basic restorative treatment to patients that were referred to them on the criteria of age, insurance plan, and need for restorative care. Dr. English provided additional services of facilitating monthly “exam/x-ray days” at the clinic, with the help of two to three dental assistants from her private dental clinic. As a result of this additional service, she received a monthly stipend of \$2,500. From 2012 to 2015, Dr. English provided restorative*

services amounting to \$91,826, of which \$31,826 (approximately 35%) was donated as in-kind services. Patients were also referred to La Clínica Vallejo Dental, a local community dental clinic whose dentists also provided restorative services to referred patients from 2012 to 2015.



**Left: Dr. Amy English, DDS honored by the Solano County Board of Supervisors for her contributions to the demonstration project on May 4, 2013.**

*Select parents/caregivers of patients participated during quarterly community advisory council meetings (also known as project team meetings). The parents/caregivers were recruited by the SBHC Care Coordinator and compensated for their participation with gift cards to local grocery stores. The parents shared their experiences about how they learned about the program, how they felt about the quality of direct care delivery at the SBHC, and their recommendations for improvement of services. The parents informed the project team partners that “word of mouth, especially by other parents” was the best method of recruiting new patients. One of the parents expressed his concern about the termination of services at the end of the project funding period, but we reassured him that the Coalition was in discussion with the school district about available options to sustain services after September 2015.*

**Activities**

**Establishing oral health services**



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On March 1, 2012, the Widenmann SBHC offered oral health services for the first time since its grand opening in May 2010. The first patient was featured in an article that was printed in the local newspaper, the *Vallejo Times Herald*. She was one of 969 patients who received care the school-based health center from March 2012 to September 2015.

Cumulative encounters for preventive oral health services performed at the Widenmann SBHC include:

- 907 dental x-rays
- 907 comprehensive oral exams
- 1,485 prophylaxis
- 211 dental sealants
- 1,527 fluoride varnish applications
- 1,341 health education

The Coalition originally had an annual goal of 650 patient visits per year at two SBHCs in the Vallejo City Unified School District. After determining that the Annie Pennycook facility could not support additional dental services, the Coalition focused its efforts on the Elsa Widenmann site. Despite only having one site to provide direct care services, the dental staff reached or exceeded the goal of 650 patient visits per grant year, with the exception of the first grant year. This is not considered a failure because oral health services were established six months into the first grant year. With a total project goal of 2,600 patient visits, the SBHC staff recorded 2,619 cumulative patient visits.

### SBHC Protocol & Procedures

The SBHC has fully documented policies and procedures that guide primary care activities that easily expanded to accommodate oral health activities. The SBHC follows the standards of the federal CHDP program, which is based on authoritative medical organizations, including the American Association of Pediatrics and the Advisory Committee on Immunization Practices. The physician providers are board certified in pediatrics and nurse practitioners are nationally certified. The SBHC have standards that assure confidentiality of patient records, which are in compliance with HIPAA regulations. All SBHC employees receive HIPAA, OSHA and Blood Born pathogen training. Patient grievance, risk management, and incident policies are also in place. SBHC policies and procedures were updated to include dental protocols and procedures, which covered general policy, preventive services instructions, emergency cases, \ referrals for basic restorative treatment, OSHA/Personal Protective Equipment, sterilization, biological monitoring, environmental infection control, dental unit waterlines, and evacuation system cleaning. The updated policies and procedures were approved in September 2013 by the SBHC Medical Director Dr. James E. Foy; Coordinator of Full-Service Community Schools Kathleen Hahn; supervising dentist Dr. Amy English of Vallejo's Children Dentistry; and registered dental hygienist Janell Glouser.



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Oral health education

Oral health education was offered to patients at the SBHC during new, recare, and x-ray/exam day appointments. Education was also delivered by the dental hygienist and SBHC Care Coordinator at community events; exact numbers of contacts were not tracked at community events so the cumulative number of encounters of patient education for the overall program is an underestimated value. The Coalition also implemented a separate oral health education project in pre-school and elementary school classrooms within the Vallejo City Unified School District in the second, third, and fourth grant year.

Integration of services

Integration of dental services into the SBHC proved to be a challenge initially. In the first grant year, the Coalition and its partners focused on preparing and establishing dental services at the SBHC. In the second grant year, integration of services became the top priority. Though the Coalition attempted to introduce integration through different methods, only a few methods were successfully implemented at the SBHC.

|               | <b>New Integration Methods Attempted</b>         | <b>Description</b>  |
|---------------|--|---|
| <b>Year 1</b> | Co-location model of medical and dental services | <p>Extra medical exam room was renovated to serve as the dental exam room at the SBHC. Facilities were inspected prior to renovations and determined to be adequate supporting delivery of preventive oral health services. No significant changes were made to the infrastructure of the facility. However, big ticket equipment was purchased: a portable dental hygienist chair and portable NOMAD x-ray with supporting software which communicated with the SBHC's electronic medical records system Prognosis.</p> <p>The SBHC Care Coordinator shared an office with the nurse practitioner. The dental staff used Vallejo City Unified School District computers and also had access to the appointment scheduling program.</p> |
| <b>Year 2</b> | Updated SBHC policies and procedures, customized | <p><u>SBHC Policies &amp; Procedures</u><br/>The dental hygienist, who has a background in public health dentistry through past experience with a Solano County dental program, proposed oral health-focused additions to the existing SBHC policies and procedures. The SBHC medical director, nurse practitioner,</p>   |

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|  | <p>workflow based on facility layout, integrated promotion and marketing</p> | <p>supervising dentist, and registered dental hygienist approved and signed the updated language in the SBHC policies and procedures in early October 2013.</p> <p><u>Workflow:</u><br/>The medical and dental staff shared office space, access to the electronic health records and appointment scheduling program, and responsibilities of referring patients who required medical services, dental services, or assistance with health coverage enrollment.</p> <p>Patients checked in with the front office staff member, who typically was the multilingual English/Spanish/Tagalog speaking medical assistant. The front office staff informed the SBHC Care Coordinator, who worked in an office next to the dental exam room. The SBHC Care Coordinator would then call the patients’ names and guide them to the dental exam room, where the dental hygienist was prepared with her paper patient charts, electronic health record, and sterilized equipment. When the patient’s appointment was complete, the patient and their caregiver sat down with the SBHC Care Coordinator who informed them of whether they needed to schedule a recare appointment in six months or whether they would be added to the schedule for the next special x-ray/exam day for possible referral to a local dentist for basic restorative treatment. Patients received reminder cards in the mail and were contacted multiple times by phone by the SBHC Care Coordinator to ensure they were aware of their next appointment. If the dental patients did not have a medical home, the SBHC Care Coordinator referred them to the medical staff, who would create appointments for physical exams, immunizations, and other needs that fell under the scope of practice of the SBHC. After attending their medical appointment, the patients were referred to an external provider, where they established their medical home. If medical patients required dental services, the medical staff directly referred the patients to the dental staff. The SBHC Care Coordinator would create an appointment and send out an appointment reminder card and follow up with multiple phone calls, as a regular protocol for new and recare patients.</p> <p>Despite the significant difference in the medical and dental models within the SBHC, patients obtained access to necessary services either on-site or off-site. This workflow increased the medical staff’s patient visits and allowed for an environment in which the medical and dental staff could collaborate in the delivery of care as opposed to the traditional “siloeing” of medicine and dentistry. The regular contact</p> |
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|                          |  | <p>allowed the medical and dental staff to build team camaraderie and develop a mutual appreciation of the value attached to each others services. This relationship established grounds for further collaboration, which were practiced in the last two years of the project.</p> <p><u>Promotion &amp; Marketing</u><br/>An unexpected challenge in the first grant year was the visibility of the SBHC to the community. Though it shared the address of the elementary school on which it was located, patients and their families had difficulty finding the health center. To address this, the Coalition hired a contractor to design a banner which promoted both medical and dental services at the SBHC. The banner served two purposes: 1) To make the SBHC more easily visible to new patients navigating the school campus, and 2) To advertise all of the preventive services that the SBHC provided, which included the existing primary care services and new oral health services.</p> <p>This integrated design was also used in the promotional flyers which were distributed at elementary school sites within 10 miles of the health center and/or where classroom education events were facilitated. The flyers were also distributed at community events such as back-to-school nights, family resource nights, and local farm festivals. The flyers, available in English and Spanish, were uploaded onto social media accounts, including a Facebook page and Twitter account.</p> |
| <p><b>Year<br/>3</b></p> | <p>Integrated new patient intake form, integrated clinic website, clinic-wide “No Show” policy</p> | <p>In the first quarter, the Coalition presented the medical and dental team with a mock draft of an integrated patient intake form which incorporated all aspects of the medical and dental intake forms. The staff presented some hesitation with the form but after corrections it was implemented in the third and fourth grant year.</p> <p>In order to boost recruitment, the Coalition designed an integrated website for the medical and dental services at the SBHC. The website went live, but “word of mouth” among parents proved to be the most successful method of recruitment patients into the program.</p> <p>The dental hygienist brought up a concern regarding the high no-show rate for special x-ray/exam days, which is a protocol that was implemented to augment the lack of on-site restorative services. The regular care no-show rate was 20% while the x-ray/exam no-show rate was 38%. The no show rate for regular care was deemed acceptable for the patient population. However, the no show rate for x-ray/exam days required a quality intervention. This prompted the CQI Committee to</p>   |

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|                          |                                   |   |
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|                          |                                   | <p>establish a clinic-wide “No Show Policy” which aimed to increase the number of patients seen to at least 30 per x-ray/exam day and to reduce the no-show rate to 20%. The “No Show” policy was modeled after examples pulled from the Safety Net Dental Clinic Manual published by the National Maternal and Child Oral Health Resource Center; the Orangeburg-Calhoun Free Medical Clinic in South Carolina; and Erie County Community Health Center in Ohio. The policy was approved by members of the SBHC CQI Committee and implemented in January 2014. All new and recare patients were required to sign a dental agreement which defined the definition of a “no show” and listed the consequences of a “no show” appointment (three strike policy).</p> <p>In February 2014, approximately one month after establishing the “No Show Policy,” the SBHC staff recorded the lowest dental “no show” rate in grant history. However, the “no show policy” was only shown to maintain a “no show” rate at or below 20% for four months in the third grant year and two months in the fourth grant year after being implemented.</p> <p>SBHC data indicates that more patients were scheduled for x-ray/exam days in later grant years (Year 1: 24, Year 2: 33, Year 3: 33, Year 4: 35). However, the average number of patients actually seen remained about the same, with the exception from a significant increase from the first year to the second year. (Year 1: 15, Year 2: 25, Year 3: 25, Year 4: 24). Thus, the “no show” rate appeared greater in the last two years due to the increased number of patients scheduled to attend the monthly x-ray/exam appointments.</p> |
| <p><b>Year<br/>4</b></p> | <p>Community health education</p> | <p>The collaboration between the Coalition and SBHC medical and dental staff allowed implementation of two community health education campaigns – “ReThink Your Drink” and “Drink Vallejo Tap Water”. A visual display of sugar content in popular beverages was placed in the waiting room of the SBHC, where both medical and dental patients could be outreached. The display initiated conversations between patients and guardians/caregivers, which were later elaborated on by the nurse practitioner, dental hygienist, and dentist.</p> <p>The “Drink Vallejo Tap Water” campaign presented certificates and water bottles to patients who agreed to drink Vallejo’s fluoridated tap water. The water bottles promoted both medical and dental services at the SBHC.</p>   |

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Transportation vouchers

Though transportation vouchers were originally written in the grant, the majority of patients (99%) indicated that they were able to navigate public transportation or had access to a private vehicle.

Basic restorative services

Patients who presented with tooth decay were referred to special monthly x-ray/exam days where they were examined by Dr. Amy English, D.D.S. of Vallejo’s Children Dentistry. Dr. English ordered dental x-rays, performed comprehensive oral exams, and created treatment plans. Based on the severity of the tooth decay and need for restorative services, patients were either categorized as “regular care” patients or “restorative dental referral” patients. The referrals were then determined by the patient’s age and insurance status. The diagram below summarizes the referral protocol that was implemented in the second grant year and used up to the time of the “warm handoff” to the organization who took on the fiscal, coordination, and management responsibilities of the dental services at the SBHC.

*Restorative Care Referral Protocol*





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**b. Interdisciplinary Care**

Medical and dental services initially were delivered through a co-location model but became integrated as medical and dental staff participated in inter-departmental patient referrals, all staff clinic coordination meetings, and CQI activities. Preventative primary care services were delivered by the nurse practitioner while preventative dental services were delivered by a registered dental hygienist (RDH) under the general supervision of Dr. Amy English, D.D.S. of Vallejo’s Children Dentistry.

**c. Patient/Community Education**

Education was delivered in three different settings: the SBHC, classroom, and in the community. We tracked encounters in the SBHC and classroom settings.

| <b>YEAR</b>  | <b>SBHC</b>  | <b>Classroom</b>  | <b>TOTAL</b> |
|--------------|--|---|--------------|
| <b>1</b>     | Data collection methods initially did not track encounters for patient education at SBHC. This was added to the data collection methods in Year 2. | The classroom education curriculum was not approved by Vallejo City Unified School District until Year 2. | -            |
| <b>2</b>     | 422<br>(includes 44 knee-to-knee education, includes new and recare patients)  | 739<br>(All seventeen K-5 <sup>th</sup> grade classrooms at two schools)                                  | <b>1,161</b> |
| <b>3</b>     | 382<br>(includes 33 knee-to-knee education, new patients only)   | 905<br>(Most K-5 <sup>th</sup> grade classrooms at two schools)   | <b>1,287</b> |
| <b>4</b>     | 1,379<br>(includes 38 knee-to-knee education, new patients only)   | 1,374<br>(Select K, 3 <sup>rd</sup> , and 5 <sup>th</sup> grade classrooms at six schools)                | <b>2,753</b> |
| <b>TOTAL</b> | <b>2,183</b>   | <b>3,018</b>  | <b>5,201</b> |



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Feedback regarding classroom education project:

*Many students came up to me during recess showing me their teeth, (some of which were still purple from the tablets) with great enthusiasm. And with much detail, told me what they had learned from their Oral Health lesson. They smile and share even shared with friends for different class their experience with the lesson. It was clear to me our students benefit from this program because they now have the skills they need to care for one of their most precious resource... their teeth. While I did take time to thank each of the team members for the excellent job they did for us, please relay to them again our "**Widenmann Wildcat Pat on the Back of Thanks**" – Pamela Hatter, Principal at Elsa Widenmann Elementary School, 1/15/2013*

Vallejo Pre-School Dental Project

In the third and fourth grant year, the dental hygienist and two Vallejo City Unified School District school nurses collaborated on a pre-school project which aimed to increase the number of 0-5 year old patients accessing oral health services at Widenmann SBHC. With financial support from the Coalition and additional funding from First 5 Solano, the team achieved the following:

|   | <b>Year 3</b> | <b>Year 4</b> | <b>TOTAL</b> |
|---|---------------|---------------|--------------|
| Oral health education delivered by dental hygienist at pre-schools and child development centers  | 261           | 252           | <b>513</b>   |
| Oral health screenings performed by dental hygienist at pre-schools and child development centers | 261           | 247           | <b>508</b>   |
| Students with no fillings or visible tooth decay  | 173           | 163           | <b>336</b>   |
| Students with fillings but no visible decay   | 41            | 37            | <b>78</b>    |
| Students with visible decay   | 44            | 46            | <b>90</b>    |
| Students presented with urgent dental needs, indicated by pain, abscess, and extensive decay      | 3             | 1             | <b>4</b>     |
| Students with obvious need for dental cleaning  | 12            | 11            | <b>23</b>    |
| Students with broken tooth from injury  | 6             | 9             | <b>15</b>    |



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In the first grant year, the pre-Kindergarten population made up approximately 17% of the SBHC's dental visits. The pre-Kindergarten population improved to 26% in the second grant year. The dental hygienist brought this decreased utilization of services to the CQI Committee and proposed several methods of promotion targeting the 0-5 population in the Vallejo City Unified School District, some of which included attending community events geared towards pre-schoolers; promoting the SBHC on the school district website; meeting and greeting teachers and administrators of pre-schools and child development centers; offering dental screenings to 0-5 population in classroom settings; and conducting parent meetings for caregivers at all Head Start programs and child development centers in the Vallejo City Unified School District.

The dental hygienist ultimately proposed the Vallejo Pre-School Dental Project as an intervention. The dental hygienist worked with the Vallejo City Unified School District nurse to contact staff at pre-school and child development centers to schedule oral health education events where the dental hygienist also conducted oral health screenings and distributed integrated medical and dental promotional flyers for the Widenmann SBHC. The education and outreach efforts were delivered in the months of February to March in both 2014 and 2015. Following the outreach efforts, the Coalition noted an increase in the 0-5 patient population accessing oral health services from 32% (from October 2013 to January 2014) to 38% (from February 2014 to September 2014).

### ReThink Your Drink Campaign

In the third grant year, the Coalition incorporated aspects of the Rethink Your Drink campaign into the classroom education curriculum after attending Rethink Your Drink trainings conducted by representatives of the Solano County Department of Public Health. In addition, the SBHC staff approved a visual display in the SBHC waiting room which illustrated actual sugar content in popular beverages. In the fourth grant year, the Coalition improved upon its original ReThink Your Drink lesson by implementing a "Fruit Infused Spa Water" demonstration within elementary school classrooms.

### Drink Vallejo Tap Water Campaign

The dental hygienist submitted quarterly reports to the Coalition staff, which included talking points for future patient/caregiver education. One of the concerning findings that the dental hygienist brought up to the Coalition staff was that the patient/caregiver population preferred to drink bottled water versus Vallejo's fluoridated tap water. When questioned why they did not drink tap water, the population cited personal and cultural beliefs – many of them come from countries where tap water is "not safe to drink". In order to promote the consumption of Vallejo's tap water and its benefits to oral health, the SBHC staff collaborated to implement the Drink Vallejo Tap Water Campaign. Patients scheduled for medical and/or dental appointments were given the opportunity to sign a pledge to drink Vallejo's tap water (see signed pledge on previous page). After signing their pledge, patients were given a special water bottle. The dental

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staff also participated in school and community events where non-SBHC patients were also given the opportunity to sign a pledge and were compensated with a water bottle. This campaign had an additional benefit of promoting SBHC services to these populations. The SBHC staff collected 100 pledges from May 2015 to September 2015.

## **2. Continuous Quality Improvement**

The Continuous Quality Improvement Committee met quarterly throughout the grant period, up until the last grant year. Dr. Foy, the SBHC Medical Director since the SBHC's establishment in 2010, retired in the third grant year. His role was taken over by Dr. Tami Hendrikz, who was unable to continue the Continuous Quality Improvement meetings due to her impacted schedule, though she attended some quarterly advisory council meetings.

CQI Interventions are summarized as followed:

- **Updated SBHC CQI Protocols and Procedures to include dental language**
- **Reward Program for X-ray/Exam Day (November 2013 – April 2014)**
  - Issue Addressed: High no-show rate at monthly x-ray/exam days (38%) vs. regular care appointments (20%, considered acceptable for patient population)
  - Goals: Decrease number of no shows; Encourage parents to take appointment day and time seriously; Reward parents who do bring their children
  - Intervention: The Coalition designed flyers and posters. The dental hygienist was given funds to purchase grocery gift cards. The flyers regarding the reward were explained and distributed to parents during the patients' initial screening appointment. Each parent is given one ticket per child brought to the appointment. Parents provide their name and phone number, which is later used to contact the winning family. The SBHC staff tracked the number of no shows for over 6 months and assessed whether there was a significant improvement in the no show rate.
  - Results: There was no significant improvement in the no show rate after 6 months of implementing the reward program. In addition, parents did not spread the word about the incentive and did not express any interest in the program.
- **“No Show” Policy (January 2014)**
  - Issue Addressed: High no show rate at monthly x-ray/exam days
  - Goals: 30 patients successfully attend their appointment with a no show rate of 20%
  - Intervention: The CQI Committee approved the implementation of a clinic-wide “no show” policy. The policy was implemented in January 2014. Families were

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notified at their initial screening and recare appointments. The policy was clearly posted on the bulletin board in the SBHC waiting room.

- Results: The policy temporarily met its goal of reducing the now show rate at or below 20% and increasing the number of students successfully attending their appointments. However, after five months, the no show rate returned to its baseline.
- **0-5 Population (January 2014 to March 2014, January 2015 to March 2015)**
  - Issue Addressed: Less than 1/3 of patients who use services are in the 0-5 population, who are at risk of developing early childhood caries
  - Goals: Increase the number of patients seen in the 0-5 age group and help them establish a dental home
  - Intervention: Promote services to the 0-5 population and their parents/caregivers through attendance at community events, and health education/oral health screenings conducted at pre-school sites and child development centers
  - Results: Health education and outreach to over 500 children over two years. In the third grant year, 36% of new patients were 5 years old or younger, indicating an improvement from 26% in Year 02. In the fourth grant year, 40% of new patients represented the 0-5 population, indicating a 23% improvement since Year 01 and a 14% improvement since Year 02.

### **3. Sustainability**

#### Challenges

##### *Technology: HL7 Bridge*

Sustainability became the Coalition's main priority in the third and fourth grant years. The Coalition attempted to create an integrated medical and dental electronic health record system through a HL7 bridge between the SBHC electronic health records system Prognosis and purchased dental software Dentrix. The bridge was necessary to create the billing infrastructure system that would have supported increased Medi-Cal and CHDP reimbursements. Dentrix representatives made several attempts to contact the Prognosis representatives, but due to differences in time zones and other unexpected challenges, the HL7 bridge was not created.

##### *Becoming a Medi-Cal/Denti-Cal Provider*

The Coalition submitted an application to become a Medi-Cal/Denti-Cal provider, but our application was put on hold due to a lack of a dental director at the SBHC. The Coalition staff reached out to several dentists, including those who accepted patient referrals from the SBHC and outside dentists, but no one agreed to take on the role. Being approved as a Medi-Cal/Denti-



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Cal provider would have increased the possible claims and reimbursements, as the SBHC patient population was largely insured under Medi-Cal and CHDP. However, we also would have needed the billing infrastructure to appropriately make these claims and receive these reimbursements.

### *Maintaining Integration*

Though the Coalition was able to find a third party to take over and improve upon services delivered at the SBHC, integration of medical and dental staff was not completely maintained. La Clínica de la Raza made significant changes, such as changing hours of operation to days when the medical staff are located at another SBHC site; changing the target population for dental services to children between the ages 0-12; and increasing the role of the Solano Kids Insurance Program health access specialist to include responsibilities once held by the SBHC Care Coordinator and medical assistant. The medical and dental services now currently work through a co-location model, though there is minimal interaction between the medical and dental staff. The Coalition is staying on at the SBHC to provide health enrollment assistance and health education. The Coalition staff meets monthly with La Clínica, but medical staff does not attend these meetings.

### Successes

#### *Establishment of On-Site Restorative Treatment*

Providing on-site restorative treatment was a major challenge for the Coalition during the funding period. In order to bypass the lack of restorative services, the dental hygienist and supervising dentist developed a model which allowed patients to be initially screened at the SBHC by the dental hygienist. Depending on presence or absence of tooth decay, patients were then referred to monthly x-ray/exam days where they were evaluated by Dr. Amy English, D.D.S. of Vallejo's Children Dentistry. Dr. English developed a treatment plan and the SBHC Care Coordinator determined which dental office the patients would be referred to. Dr. English took on uninsured patients while Dr. Suzanne Clift took on patients between 0-5 who were also insured under Medi-Cal. Overflow patients were then referred directly to La Clínica Vallejo Dental. All referred patients returned to the SBHC for recare appointments. At these follow-up appointments, the dental hygienist was able to track whether patients actually scheduled and followed through with their dental appointments. The Coalition reached out to actively practicing and retired dentists to provide restorative services on-site, but we were unsuccessful in recruiting a dentist for this purpose. The SBHC continues to provide preventive services.

## **D. Evaluation**

### Study Design

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The Touro University evaluation team used a quasi-experimental design which utilized a sampling strategy which included:

- 1) Baseline Parent Caregivers Surveys (259 caregivers of 482 children enrolled in COHAP);
- 2) Follow-Up/Recare Survey (50, matched to caregiver baseline surveys);
- 3) Key informant interviews of oral health service providers (n=12); and
- 4) Key informant focus groups of parents of children receiving services at the SBHC (n=13).

They analyzed a sample of data collected from these sources and concluded that “evaluation findings from this project demonstrates the project’s effectiveness in providing improved access and utilization of oral care and improved oral health behavior and practices in a low-income and ethnically diverse population in North Vallejo”. Furthermore, they stated, “The project successfully collaborated with elementary schools to provide oral health education and with project partners, ensured the sustainability of the project, including the addition of restorative oral health services to the services available in the school’s oral health clinic”.

### Data Analysis

Quantitative data was analyzed using STATA, version 13 and SPSS. Descriptive information and general associations between variables were analyzed using univariate analysis. Pearson’s chi-squared test was used to assess the presence of a relationship between dental insurance status and four oral health indicators: last dental visit (caregivers only), condition of mouth and teeth, times brushed, and confidence in cavity prevention. These tests were also used to measure the program’s impact based on baseline and follow-up surveys.

Qualitative data was analyzed using a thematic analysis technique which categorized recorded interview and focus group data into systemic reporting patterns.

### Data Collection Tools

- **Baseline Parent Caregiver Survey** administered to participating caregivers of children enrolled in and receiving dental health service from the SBHC during their initial clinic visit. The baseline survey assessed knowledge, attitudes, beliefs, and behaviors regarding the oral health of parent caregivers and their children who attended the Elsa Widenmann SBHC. Access and barriers to oral health services are also assessed in the survey.
- **Follow-Up/Recare Survey** administered to a sample of parent caregivers and their children, 12-15 months following the initial clinic visit;
- **Child Intake Survey** administered to children receiving dental health services at the SBHC during the initial clinic visit;

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- **Patient Satisfaction Survey** administered to parent caregivers following oral health services from the clinic;
- **Health Education Survey** administered to 3<sup>rd</sup> to 5<sup>th</sup> grade children at two Vallejo City Unified School District as part of a school-based oral health education intervention;
- **Key Informant Interviews** conducted among program collaborators who contributed to implementation of the program’s goals and objectives; and
- **Key Informant Focus Groups** conducted among parents of children receiving oral health services

Results**Baseline Parent Caregiver Survey Summary***Demographics*

The majority of families were low-income and ethnically diverse. The participants were primarily Hispanic/Latino (57%), Black/African American (16%), or Asian (13%). Nearly half were single parent households. 17% of respondents reported an annual family income as less than \$10,000 while 50% reported earning between \$10,000 and \$39,000. The mean age of participating children was 7.8 years of age. This information reflects SBHC dental patient intake data, which indicates that children between 6 and 12 years of age utilized the services more than any other age range.

*Access to Dental Health Care*

52% of caregivers who participated in the evaluation study reported that their child or children were covered by some form of dental insurance, including Denti-Cal. This subjective information is comparable to the range of all participants in the program who were covered by Medi-Cal/Denti-Cal, indicated as 40 to 55% from Year 1 to Year 4.

*Oral Health Status/Related Attitudes and Behaviors*

Only 1/3 of children self-reported to have fair/poor mouth and teeth conditions, though SBHC dental records indicated that 46 to 58% of program participants presented with tooth decay that required a referral to a dentist for basic restorative treatment. Nearly 40% of children also reported to brush their teeth less than twice daily. In addition, few caregivers (16.2%) and children (25.2%) reported confidence in cavity prevention.

The dental hygienist implemented incentive and reward programs at the SBHC which aimed to promote and acknowledge proper oral hygiene among SBHC dental patients. The programs include the monthly “No Cavity Club” and “Brushing Incentive Program”. These patients were



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acknowledged on the SBHC’s “Wall of Fame” and on the clinic’s Facebook account, with parental authorization.

**Follow-Up/Recare Survey**

*Summary*

- 78% reported having a regular dentist at follow-up compared at 29% at baseline;
- 67% of children had dental insurance at follow-up compared to 54% at baseline;
- Increase in children with government based insurance from baseline (57%) to follow-up (83%). Government insurance is more stable and provides a higher level of coverage for preventive and restorative services among the patient population

*Oral Health Status/Related Attitude and Behaviors*

Brushing twice daily and flossing daily were two primary measures used to assess oral health practices. Each child’s behavior was measured by caregivers’ reported number of times their child brushed and flossed during the last week. At baseline, 33% of children brushed once a day, 58% of children brushed twice a day, and 9% of children brushed three times a day. At follow-up, the children’s behavior was measured in terms of caregivers’ confidence that their children had brushed their teeth twice every day. There was an increase from 58% at baseline to 68% at follow-up of children who brushed their teeth twice a day. Results also show an increase from 35% to 44% of children who flossed once a day during the last week.

Caregivers indicated changes in reasons for their children to seek dental care markedly from baseline to follow-up. At base line, 50% of caregivers listed preventive care (i.e. cleanings, checkups) as a reason to seek dental care. At follow-up, 70% of caregivers listed preventive care as a reason to seek dental care, indicating a significant shift in beliefs regarding reason for accessing oral health services. In addition, in the recare survey, only 3% of caregivers listed urgent care (for pain) as a reason for oral health visits, which is a significant decrease from 10% of caregivers at baseline.

**Key Informants Interviews**

| <b>Attitudinal and Knowledge Barriers</b>   | <b>Instrumental Barriers</b>  | <b>Provider Barriers</b>                                    |
|---|---|---|
| Decreased awareness of importance of early oral health care, brushing/flossing technique; | Limited access to oral health services, health insurance, language/cultural barriers; | Many dentists not interested/able to provide low cost care; |
|   | Limited accessibility to oral health  | Reimbursements from Medi-Cal                                |

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|   |   |  |
|---|---|--|
| <p>Low education and awareness levels of parents and misinformation among caregivers (i.e. importance of baby teeth, association between oral health and overall health, proper brushing/flossing technique, discontinuing of bottle feeding by age 1, and limited knowledge of available care);</p> <p>Oral health is not a priority among families and low motivation to seek oral health care, and</p> <p>Children’s fear to receive oral health services (when dental visits are not routine or do not happen at a young enough age).</p> | <p>because of few low cost/free oral health care clinics, limited hours, convenience of location, and accessibility via public transportation;</p> <p>Language barriers, cultural barriers, legal barriers (immigrant status), and</p> <p>Insurance/funding barriers, and paperwork (Medicare, etc.) can be overwhelming/complicated.</p> | <p>and Denti-Cal not adequate;</p> <p>Limitations of not providing full range of dental services, and</p> <p>Limited staffing and funding sources.</p> |
|---|---|--|

*Successes*

Three primary perspectives were discussed to highlight the factors that contributed to the overall success of COHAP. These include:

- **Strength of Collaborative Partnerships**
  - Community partners were highlighted as important collaborators, particularly in the early developmental stage of the intervention
  - It was critically important to have local dentists participate in the project as service providers providing restorative care
  - Many respondents stressed the convenient location of the SBHC at the school site and collaborative activities at the SBHC as an overall project success
- **Oral Health Education Integrated with School programs**
  - All participants discussed the “hugely successful integration” of oral health prevention education within the school program
  - The collaboration between the Coalition and Vallejo City Unified School District resulted in preventive oral health education systematically offered to large numbers of children during class time (n=3,814) and sealants provided (n=211) as part of the school program

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- 1,485 dental cleanings were delivered at the SBHC
- The SBHC recorded 969 COHAP enrollees and 2,840 clinic visits.
- Programs and services were seen as groundbreaking efforts to improve access to oral health services for low income students in the Vallejo City Unified School District who previously did not have access to oral health services
- **Success from Caregivers/Parent Perspective: Primary reasons for high level of satisfaction and participation**
  - Caregiver focus groups described their high level of satisfaction with the services provided at the clinic. All respondents touched on the high quality of interactions with staff, with particular attention to how well they were treated and educated
  - Reasons for their support for the program over the course of the intervention include:
    - Provision of all outreach and services in their family language (Spanish);
    - Patience of clinic staff and thorough explanation of the need for preventive care (regular exams) and detailed teaching of proper brushing and flossing technique;
    - High level of respect in how staff communicated with children and families;
    - Availability of free oral health services;
    - Convenient location at school site (could walk to clinic);
    - Children were not afraid of receiving services (secondary to the positive and “child friendly” approach of clinic staff; and
    - Opportunity to improve oral health behaviors for entire families.

*Challenges*

Three main factors were indicated as challenges by the program collaborators and service providers:

- Establishing a functional project data system. Stakeholders were concerned that this impeded data collection and reporting;
- Due to the involvement of large institutional partners, clear and constant communication was sometimes difficult, creating challenges to sharing information;
- Maintaining collaborative partners over time was a challenge. Active involvement of a range of community partners diminished over time (i.e. reduced attendance at regular team meetings);
- Staffing changes of some of the collaborative partners required time for new members to become fully oriented to the project, goals, and challenges;

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Additional concerns include: 1) Difficulty establishing a SBHC as a FQHC; 2) Identifying a dental director; and 3) Difficulty establishing a partnership with a Community Clinic with full dental services.

*Recommendations*

- Parents should be active partners in their child/children's oral health
- Incorporate oral health education into curriculum and into healthy food and beverage practices
- Increase commitments to improving access to oral health services
- Incorporate oral health education a wide variety of programs

**E. Resources and Capabilities**

*Necessary experience and leadership roles*

Prior experience working with the target population is important to properly addressing the target population's needs. The Widenmann SBHC operated for two years as a safety net health center providing preventive primary care services and referrals for dental services. In this time, the SBHC Medical Director and Coordinator of Full Service Community Schools were able to assess the needs of the population accessing services at the SBHC. In addition, County and city-level data was also available through community health assessments produced by prominent large medical groups in the local community and organizations such as First 5 Solano and the Solano County Department of Public Health.

The following personnel are determined as key to the success of a program like COHAP:

- SBHC Medical Director
  - Key stakeholder in the advisory council
  - Provides oversight and leadership of the Continuous Quality Improvement Committee
- Coordinator of Full Service Community Schools (Vallejo City Unified School District)
  - Key stakeholder in the advisory council
  - Direct representative of the school district
  - Helps expedite approval process for changes in the delivery of services at the SBHC
  - Monitor collection of SBHC dental patient data, included in reports to the school district
- SBHC Nurse Practitioners

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- Key stakeholder for implementation of integration practices during day-to-day operations of the SBHC
- Recommended to receive training to deliver fluoride varnish applications, especially for patients insured under Medi-Cal and CHDP
- SBHC Care Coordinator
  - Key personnel member for the distribution of information to patients, recruitment and maintenance of patient population, and collaboration with medical staff
  - Bilingual English and Spanish speaking is key (must cover the primary languages of majority of SBHC population)
  - Must be involved in clinic coordination meetings with the lead agency
  - Previous experience as a medical assistant or dental assistant is helpful
- Registered Dental Hygienist (RDH)
  - Must have previous experience in public health dentistry. Our RDH had previous experience in public health dentistry through the Solano County Smile in Style program, which allowed us to prepare and plan for establishment of services in a timely manner. Due to her experience, the RDH was key in establishing dental protocols and procedures, which were included in the SBHC's Procedures and Protocols
  - Must be comfortable and flexible with data collection methods. Over a span of four years, we changed the amount and type of data we collected from our patient population. The RDH must be able to produce the necessary reports to help the lead agency coordinate the overall program
  - Must be willing to collaborate with medical staff
  - Must take the initiative in identifying concerning issues with the patient population or delivery of services and bringing these concerns up to the lead agency, advisory council, and especially the Continuous Quality Improvement committee. Must be able to generate proposals for interventions and produce conclusions/results
  - Must be involved in clinic coordination meetings with the lead agency
- Community dentists
  - If restorative services cannot be provided on-site, generating protocols for patient referrals to local dentists in the community is imperative to the success of the program. If possible, recruit a dentist to provide on-site x-rays and comprehensive oral exams, generate treatment plans, and provide general supervision over activities of RDH (as determined by specific business codes and state legislation);
  - Prior involvement in public health dentistry programs is both a benefit and disadvantage. For example, one of our dentists was motivated to be a partner in the project because of personal childhood experiences receiving services at

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similar clinical settings. Another dentist participated as a dental provider in similar program prior to our project, but she unfortunately had a negative experience, and was hesitant and cautious to become involved in the program from the beginning

- Must be considered a partner in the program and receive regular correspondence and updates regarding the coordination of the program and delivery of dental services, especially if they are providing the general supervision which allows SBHC staff to carry out their responsibilities
- Principals, Academic Support Providers
  - Must be regularly informed of services delivered on their campuses
  - Key members in promoting clinic services to parents/caregivers
  - Key contact persons for implementation of oral health education in classroom settings
- Parents/Caregivers/Community members
  - Recommended to be included in advisory council meetings
  - Provide unique perspective which can be used to improve patient recruitment and delivery of services
  - Should receive compensation for their active participation (i.e. grocery gift cards)
  - SBHC Care Coordinator should recruit these individuals, make multiple phone calls to remind them about upcoming meetings they agreed to attend

### *Advisory Council Meetings*

Throughout the funding period, project partners regularly attended quarterly advisory council meetings. The composition of the advisory council changed in the third and fourth grant years when parents of children who received services at the SBHC attended the meetings and provided their input and perspective on the quality and type of services delivered at the SBHC. They shared the manner in which they heard about the SBHC and how they thought more parents could be successfully recruited to utilize the services at the SBHC. These parents also participated in the key informant focus groups.

All partners were involved in the evaluation of the project, but responsibilities were heavily shared among the Coalition, SBHC staff, and Touro University evaluation team. While both the Coalition and evaluation team provided overall program evaluation services, the evaluation team was able to collect preliminary baseline and follow-up recare survey data which was used to measure changes in attitudes, beliefs and behaviors of caregivers and children. The evaluation team used the data to general multiple studies whose abstracts were accepted at three American Public Health Association (APHA) conferences.



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### *Necessary Policies and Procedures*

In order to initiate the SBCOHS project, the following information must be collected or produced:

- 1) Current SBHC Protocols and Procedures, including new hire orientation and trainings; risk management, patient grievance, incident management, and patient confidentiality procedures;
- 2) Key Personnel Credentials, CV, and Responsibilities;
- 3) Dental protocol and procedures, including clinical standard of care following the American Dental Association; preventive direct care services; urgent/emergency patients; Occupational Safety and Health Administration/Personal Protective Equipment; sterilization; biological monitoring; environment infection control; dental unit waterlines; and evacuation system cleaning;
- 4) Promotional and marketing strategy to recruit new patients within the school district and community at large; and
- 5) Plans to establish a billing infrastructure which would contribute to sustainability of integrated services

### *Readiness to Initiate Project*

The Coalition established dental services at the Widenmann SBHC on March 1, 2011, exactly 6 months after the beginning of the grant period. The Coalition was able to do this for the following reasons:

- 1) Existing relationships and past experiences with project partners;
- 2) Proactive communication with prospective project partners and monthly planning meetings;
- 3) Creation, distribution, and completion of memorandums of understanding (MOUs) within the first three to four months;
- 4) Existing SBHC facilities had adequate infrastructure to deliver dental services; and
- 5) Hired culturally competent SBHC staff members who are multilingual and reflect the patient population (i.e. culturally and ethnically diverse staff members).

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**Appendix A – SUPPORTING DOCUMENTS**

**Project Logic Model**

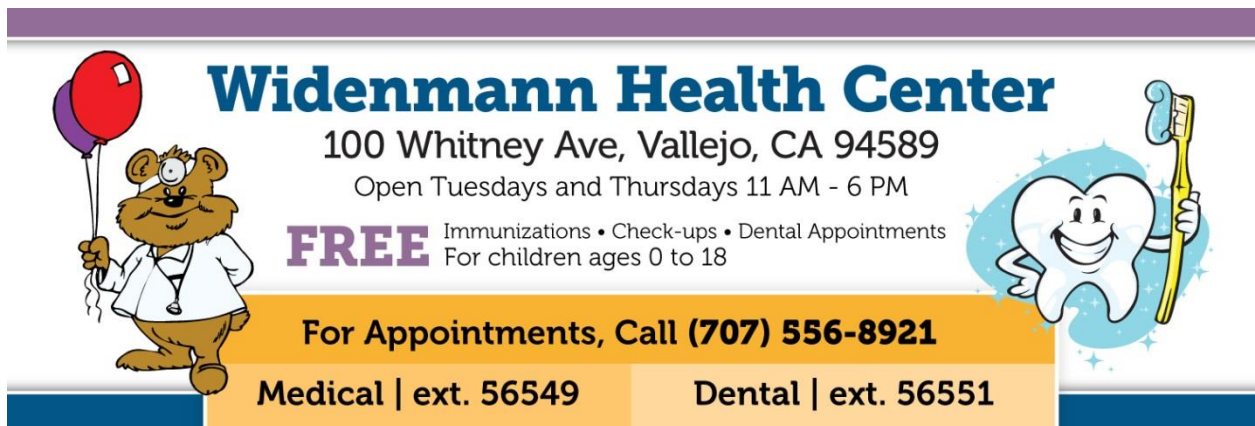
| <b>Inputs/Resources</b>  | <b>Activities</b>  | <b>Outputs</b>  | <b>Short-Term &amp; Long-Term Outcomes</b>  |
|--|--|---|---|
| <ul style="list-style-type: none"> <li>• Vallejo City Unified School District</li> <li>• Touro University researchers/evaluation team</li> <li>• SBHC infrastructure</li> <li>• Community Advisory Council</li> <li>• Foundation, State, and Local funders</li> <li>• Children and Families</li> </ul> | <ul style="list-style-type: none"> <li>• Offer oral health services at current Widenmann SBHC</li> <li>• Add sealants and varnishes to the SBHC Policies and Procedures</li> <li>• Oral health education</li> <li>• Integrate dental health services into SBHC</li> <li>• Dental treatment referrals for basic restorative services</li> <li>• Provide off-site transportation vouchers</li> </ul> | <ul style="list-style-type: none"> <li>• Approximately 650 visits per year at two oral health clinics</li> <li>• More resources and staff trained to provide oral health</li> <li>• Service providers and users (parents and children) receive oral health education annually in clinic, classroom, and afterschool</li> <li>• Add on-site oral health education and preventive services</li> <li>• Dental training and services provision by primary care providers</li> <li>• Develop a tracking and billing mechanism</li> <li>• Primary care tracking system will remind all patients for oral health visits</li> </ul> | <ul style="list-style-type: none"> <li>• Increase access to quality oral health care</li> <li>• Increase dental cleanings</li> <li>• Improve the quality of life for all children in Vallejo</li> <li>• Increase number of decayed teeth with sealant</li> <li>• Reduce rate of tooth decay, untreated teeth</li> <li>• Increased awareness and positive attitudes toward oral health prevention and practices</li> <li>• Primary care providers add varnishes and sealants to their menu of primary care services</li> <li>• Increase understanding about factors associated with high risk of oral</li> </ul> |

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|  |  |  |   |
|--|--|--|---|
|  |  | <ul style="list-style-type: none"> <li>• Purchase taxi vouchers for families experiencing transportation challenges</li> </ul> | <p>health disease and prevention</p> <ul style="list-style-type: none"> <li>• Sustained integration of primary care and dental services</li> <li>• Increase insurance coverage for oral health</li> <li>• Higher enrollment by low-income, uninsured children</li> <li>• Increase client compliance with treatment plans and referrals</li> <li>• Increased visits by low-income families at school-based clinic and offsite</li> </ul> |
|--|--|--|---|

**Marketing Tools**

Integrated SBHC Banner Design (located on fence of SBHC’s parking lot)



**Widenmann Health Center**  
 100 Whitney Ave, Vallejo, CA 94589  
 Open Tuesdays and Thursdays 11 AM - 6 PM

**FREE** Immunizations • Check-ups • Dental Appointments  
 For children ages 0 to 18

**For Appointments, Call (707) 556-8921**

Medical | ext. 56549      Dental | ext. 56551



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## Integrated Promotional Flyers

**Widenmann Student Health Center**  
100 Whitney Ave, Vallejo CA, 94589  
Open Tuesdays and Thursdays 10AM - 6PM

Serving Vallejo children 1-18 years old

**FREE** Immunizations • Check-ups • Vision & Hearing Screening • Dental Exam • Dental Cleaning • Fluoride Varnish • Sealants • Dental X-rays

For appointments, call (707) 556-8740  
Medical | ext. 7  
Dental | ext. 5

Uninsured? No problem! We'll help you and your family enroll into free or low-cost health insurance.

**Widenmann Student Health Center**  
100 Whitney Ave, Vallejo CA, 94589  
Abierto los Martes y Jueves de 10:00 AM a 6:00PM

Servicios para los niños de Vallejo

**Servicios gratuitos para** Vacunas • Exámenes físicos • Exámenes de la vision y de audicion • Exámenes dentales• Limpieza • Barnices de fluorororo • Sealladores • Rayos X

Para hacer una cita favor de llamar al  
(707) 556-8740  
Servicio Medico | ext. 7  
Servicio Dental | ext. 5

¿No tiene aseguranza? ¡No hay problema! Nosotros le ayudaremos para obtener aseguranza de salud a bajo costo ó no costo, para usted y su familia.

## Drink Vallejo Tap Water Pledge & Water Bottle

**Drink Vallejo Tap Water Pledge**

Date: 5/26/15

I pledge to:

- Choose Vallejo tap water over bottled whenever possible;
- Fill my reusable bottle with tap water; and
- Support and encourage good oral health by drinking Vallejo tap water

Name: NATHALIE

Phone: [REDACTED]

Address: [REDACTED]

City/State/ZIP: VALLEJO

Thank you for choosing Vallejo Tap Water!

Solano Coalition for Better Health In partnership with...





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### Classroom Education Materials

Announcement to Principals

---



July 16, 2014

Heather Tapacio  
Dan Mini Elementary School  
1530 Lorenzo Drive  
Vallejo, CA 94589

Dear Principal Tapacio,

Solano Coalition for Better Health aims to deliver oral health education within classrooms at select elementary schools in the Vallejo City Unified School District during the 2014-2015 school year. The lessons will introduce the chain of tooth decay and proper brushing and flossing technique, and explore the association between sugary beverages and oral disease. We are interested in including your Kindergarten, third grade, and fifth grade students in the oral health education program for the 2014-2015 school year.

Poor oral health has been shown to have a detrimental impact on children's quality of life, performance at school, and success later in life (Kwan, Pine, and Borutta, 2005). The U.S. Department of Health and Human Services reported in 2000 that the daily reality for children with poorer oral health includes persistent dental pain, endurance of dental abscesses, inability to chew foods well, embarrassment about discolored and damaged teeth, and distraction from play and learning. Missing school as a result of oral pain or infection also negatively affects children's school performance (Jackston et al., 2011).

Fortunately, oral disease is preventable. While the dental clinic at the Widenmann Student Health Center (located on 100 Whitney Ave.) provides preventative dental services for those who access it, we feel it is important to also incorporate an education program in order to reach as many students as possible.

Solano Coalition for Better Health will cover all expenses for the curriculum supplies and equipment as well as training for health educators. We only ask that you provide a confirmation response regarding the delivery of oral health education in your classrooms, and an enrollment report that provides the number of students per classroom so that we can order the appropriate amount of supplies. We will work with you to create a schedule that works for both your teachers and for the health educators.

If you are interested, please contact Nikiyah Jones, Community Programs Manager, at (707) 803-1658 or [njones@solanocoalition.org](mailto:njones@solanocoalition.org).

Thank you.

A handwritten signature in black ink, appearing to read "Nikiyah Jones", is written over a light blue and green gradient background.

Nikiyah Jones  
Community Programs Manager  
Solano Coalition for Better Health

## **Vallejo City Unified School District Performance Improvement Committee Definition**

**Initial Approval:** July 1, 2011

**Revision Dates:** Sept. 10, 2013

### **Purpose**

The Vallejo City Unified School District (VCUSD) Performance Improvement Committee (the Committee) is responsible for Peer Review and the assessment and improvement of the medical **and dental care** provided at the clinical practice sites that are managed by the VCUSD. The Committee will seek continuous quality improvement and identify opportunities for improvement. After initial assessment, the Committee will make recommendations concerning interventions and will then reevaluate the outcomes of the interventions, using the methods of the classical quality improvement loop. The Committee will also assess clinic utilization to assure that services are provided in the appropriate setting, and in an efficient manner. The VCUSD has delegated the responsibilities for Quality Improvement (QI) and Utilization Review (UR) to this Committee.

### **Committee Composition**

The Committee shall be chaired by the VCUSD Coordinator of Student Health Services. Other members shall include the VCUSD nurse practitioner staff, **dental staff**, medical assistant staff and administrative staff. The VCUSD Medical Advisor serves as an ex-officio member of the Committee.

### **Function**

The Committee shall meet at least **twice a year quarterly**. Meetings shall be announced at least 10 days in advance of the meeting. Attendance by three members of the Committee shall constitute a quorum. Minutes shall be kept for all meetings. The Committee will be responsible for the development and monitoring of QI and UR programs at the VCUSD Student Health Centers **and Dental Clinic**, assessing quality and utilization data from a variety of sources, including: 1) CHDP billing data; 2) VCUSD Student Health Center production reports; 3) **Widenmann Dental Clinic Quarterly Grant Reports**; 4) electronic medical record data; 5) National Committee for Quality Assurance recommendations; 6) California School Health Center Association recommendations; and 7) recommendations from other national and regional medical societies.

The Committee will assess clinic function, and then develop interventions and programs to improve quality and utilization, utilizing standard methods, to include the Quality Loop. The Committee may form subcommittees, either standing or ad hoc, to deal with specific issues.

This Committee reports to the VCUSD Student Health Centers Governing Body. The Governing Body is composed of the VCUSD Medical Director and Coordinator of Student Health Services.

# Vallejo City Unified School District Student Health Centers Performance Improvement Plan

**Initial Approval: July 1, 2011**

**Revision Dates: Sept. 10, 2013**

## Introduction

The ultimate responsibility for the quality of medical **and dental** care at the Vallejo City Unified School District (VCUSD) Student Health Centers and **Dental Clinic** is maintained by the VCUSD Coordinator of Student Health Services and the VCUSD Medical Advisor. These individuals serve as the Governing Body for the VCUSD Performance Improvement Committee (the Committee), and as such, delegate the oversight of quality improvement and utilization review to the Committee.

## Performance Improvement Committee

The VCUSD Student Health Centers Description is included herein by reference. The Committee's primary responsibilities concern the review and assessment of processes and systems that impact quality, including, but not limited to:

- Peer review
- Program development
- Communication
- Monitoring and evaluation of clinical care

The Committee will then implement the quality improvement loop, recommending interventions and changes, with subsequent reevaluation, in an effort to continuously seek quality improvement. The Committee will also evaluate medical utilization, to assure that services are delivered in the proper setting, and in an efficient manner.

## Methods

In its evaluative processes, the Committee will use both internal and external data bases and sources. The Committee will promote collaboration in the pursuit of quality goals. The evaluation of clinical care will be objective, outcome oriented and data driven. This process will also assure compliance with Medical **and Dental** Standards and State Law.

The Committee will oversee evaluation of:

- Complaints and grievances
- Unexpected outcomes

- Periodic medical record reviews
- Performance Improvement Plan development and activities

In defining the focus of the Performance Improvement Plan, the Committee will concentrate on high volume and high risk aspects of care. Evaluation of Unexpected Outcomes or Individual Provider performance shall held in Confidence, not to be discussed outside of the Committee meeting for Performance Improvement purposes.

## **Summary**

The Committee serves as the main body for Peer Review at the VCUSD Student Health Centers **and Dental Clinic**. The Committee is responsible for oversight of Quality Improvement and Utilization Review at VCUSD clinical care sites. The Committee assures compliance with recognized medical **and dental** standards and State Law.

Through the above processes, the Committee not only oversees and assures quality of medical **and dental** care, but also assures the safeguarding and the promotion of the VCUSD's reputation as a leader in the community in both the clinical and educational fields.

**Widenmann Student Health Center**

100 Whitney Ave, Vallejo Located At Elsa Widenmann Elementary School  
Medical Clinic 707 556- 8740 ext 7  
Dental Clinic 707 556-8740 ext 5

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**NO SHOW Appointment Policy**

**Purpose:**

Due to the number of people who make appointments but fail to show up for them or fail to give adequate advance notice when canceling them, it has become necessary to have a policy on appointment responsibility. Broken and no show appointments waste the clinic's limited time and hinder the medical and dental program's efforts to improve the health status of the children that we serve.

**Policy:**

Widenmann Student Health Center will allow only 3 missed appointments per 12 month period.

Patients who wish to cancel appointments must do so with a minimum of 24 hours notice in advance of their scheduled appointment.

The staff understands that sometimes situations arise that require rescheduling your child's appointment. If you need to reschedule please call the Widenmann Student Health Center as soon as you know your child will not be able to make the appointment.

An appointment is considered missed or a NO SHOW if any of the following occur-

- \*the patient fails to show up for the appointment
- \*the responsible party [parent, guardian, grandmother, etc] for the patient fails to cancel the appointment 24 hours in advance either by phone call, in person or on answering machine

**Procedure:**

When a patient accumulates 3 no show appointments at either the medical or the dental clinic they will not be allowed to schedule any further appointments in that clinic for a period of 12 months following the 3<sup>rd</sup> no show appointment.

DATE: \_\_\_\_\_ Child's name: \_\_\_\_\_

Parent or guardian signature: \_\_\_\_\_

**Widenmann Student Health Center**

100 Whitney Ave, Vallejo Located At Elsa Widenmann Elementary School  
Medical Clinic 707 556- 8740 ext 7  
Dental Clinic 707 556-8740 ext 5

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**APPOINTMENT AGREEMENT**

It is important for patients to keep their appointments at the health center because no show appointments result in lost time that could have been used to treat other patients.

**Rescheduling appointments:**

The staff understands that sometimes situations arise that require rescheduling your child's appointment. If you need to reschedule please call the Widenmann Student Health Center as soon as you know your child will not be able to make the appointment. You can do this by calling the clinic, stopping by in person or by leaving a message on the voice mail.

**No show appointments:**

A no show appointment is a failure to come to your appointment or to let the health center know you are not coming 24 hours in advance. If your child misses a scheduled appointment with the health center it will be recorded in their chart.

If you have 3 no show appointments in a 12 month period you will not be able to bring your child to the health center for a period of 6 months following the 3<sup>rd</sup> no show appointment.

I understand the Appointment Agreement and agree to follow the terms of the no show policy.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## CQI Quality Improvement Project Widenmann Dental Clinic

Analysis and improvement in the number of 0-5 year old patients seen at Widenmann Dental Clinic.

GOAL: Increase the number of patients seen in the 0-5 age group and help them establish a dental home.

A dental home is the ongoing relationship between the dental services and the patient, inclusive of all aspects of oral health care, delivered in a comprehensive; continuously accessible, coordinated and family center way.

Note: While there is no data to back this up it feels like in the age range 0-5 yrs we currently see mostly ages 4-5 yrs. We should consider making the improvement project about the 0-3 yrs age group and start tracking this age group.

New data points are going to be set for grant year three starting October 1<sup>st</sup>. We currently do age break down for *patient visits* only – 0-5 yrs, 6-12 yrs and 13-18 yrs. It has been proposed to collect age break downs for *new patients* AND *patient visits* and we could consider changing the break down to 0-3 yrs, 4-5yrs, 6-12 yrs, and 13-18yrs.

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**DATA:**

Grant year 1 – age break down was 0-4 years

Period- 44 clinic days

Total patient visits: 352

Total patients age 0-4 yrs: 59

**17% grant year 1 / 0-4 yrs**

Grant year 2 – age break down is 0-5 years

Period [to date]-76 clinic days

Total patient visits: 686

Total patients age 0-5 yrs: 177

**26% grant year 2 [to date] 0-5 years**

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### Background

Oral health is an integral part of the overall health of children. Dental caries is a common and chronic disease process with significant consequences. Dental caries remains the most prevalent chronic childhood disease in the US, five times more common than asthma and seven times more common than hay fever.

This disease, known as early childhood caries (ECC) [formerly termed *nursing bottle caries* or *baby bottle decay*] is currently defined as the presence of one or more decayed, missing [due to caries] or filled surfaces in any primary tooth in a child age 6 or younger.

ECC is prevalent among young children, particularly in underserved populations and racial/ethnic minorities. Approximately 75% of ECC is found in approximately

8% of children between the ages of 2 and 5. Compared to other age groups, where caries rates remain unchanged, the caries rate among preschoolers has increased to 28%.

[Caries risk assessment, prevention and management in pediatric dental care. Ramos-Gomez F, Crystal YO, Ng MW, Tinanoff N, Featherstone JD, J Academy General Dentistry, November/December 2010 505-517]

It is well documented that caries is a transmissible infectious disease in which pathogenic risk factors prevail over protective factors, producing demineralization of tooth structure. If the disease is allowed to progress, surface cavitation and dental tissue destruction will result.

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#### Things to consider when promoting the WDC for the 0-5 age group:

We do not want to duplicate services or cause potential problems by contacting groups that are already served by another organization in the community, such as Solano County.

Is the WDC really a 'dental home'? The grant ends in 2 years and we do not provide restorative or emergency dentistry on site.

How much money is available in the grant for staff to do activities for this improvement project? Nikiyah Jones, Solano Coalition for Better Health, is the manager of the Oral Health Project and the person who approves expenditures from the federal grant.

#### Where to promote WDC for patients age 0-5 years

\*Attend community events to promote WDC service; find events that are geared for preschoolers

\*Put a spot – button on the Vallejo City Unified School District web page where parents could find information about WDC

\*Find out if Head Start has a newsletter and possible do an article for the publication

\*Contact Napa Solano Head Start and find out if they are in need of dental services 707 252 8931 ext 2013 or 2019  
4 centers in Vallejo, educated guess at 200 children

\*Contact VCUSD Child Development Centers, Pre-K School Nurse and Special Education Director to open discussion about what dental services we could offer the infant and preschool programs the school district currently operates.

Manuela Miller, Coordinator School Development Centers 556-8921 ext 50205  
7 centers in Vallejo elementary schools, 315 children, infant & preschool ages  
George Anich, Director Special Education

Exceptional Tots program 0-3 yrs , approx 50-80 children + Special Day class  
preschool age 4-5 yrs, approx 60-80 children  
Sara Mai, PreK School Nurse 707 249 7247  
Willing to help coordinate dental activities

### Ideas for promotion

**Hand out WDC flyers** at day care centers, Head Start Centers, other children's Centers in Vallejo

cost : very minimal

**Janell meet & greet with teachers & administrators** [short, drop by or make apt] to put a face to the name to promote the clinic and give WDC flyers to pass out, explain services

Cost: minimal, estimate less than \$200

**Visual dental screening for children in childcare** - Children would be screened [and varnished ?] and a 'Report of Screening' would be sent home to all parents with the results and WDC contact info, data would be kept on number of children with decay and urgent care needs, info would be given to administrators

Cost: significant, many hours to schedule, get permission slips, prepare rosters, perform screenings, write out ROS, compile data, fluoride varnish cost 75 cents each, takes approximately 3 hours per class of work for RDH

**Parent meetings** – offer to do parent meetings for all the Head Starts and VCUSD Child Development Centers, would be providing educational information and promoting the WDC, would need laptop and projector for power point

Cost: would need translator with dental knowledge such as WDC Care Coordinator, hours would include arranging dates & times, preparation of power point, 'give aways' for parents such as toothbrushes, floss, etc, rough estimate would be \$50 per presentation for 'give aways' and 2 hours each for RDH and Care Coordinator once supplies have been purchased and presentation is prepared, (purchase of projector ?)

**SBCOHS Minimal Set of Process and Outcome Data Elements**

**Children's Oral Healthcare Access Program**  
*Solano Coalition for Better Health*

| Process                 | Measurement of Planned Program  | 1st Year   | 2nd Year   | 3rd Year   | 4th Year  |
|-------------------------|---|--|--|--|---|
| <b>Informed Consent</b> | Number of forms distributed   | <p>Data collected in the first grant year was tracked by <b>patient visits</b>, not new patients. Informed consent forms were distributed to <u>all</u> new clients once, at the time of their enrollment in the program.</p> <p align="center">Patient visits: 352<br/>New patients: 223</p>  | <p>Data collected in the second grant year was tracked by <b>patient visit</b>, not new patients. Informed consent forms were distributed to <u>all</u> new clients once, at the time of their enrollment in the program.</p> <p align="center">Patient visits: 434<br/>New patients: 347</p>  | <p>Data collection method was changed to track new enrollments by <u>patients</u> and not patient visits.</p> <p align="center">New patients: 240</p>  | <p>No changes in data collection method since third grant year.</p> <p align="center">New patients: 159</p>   |
|                         | % forms returned  | 100%   | 100%   | 100%   | 100%  |
| <b>Enrollment</b>       | Number of children enrolled in the program by age, grade level, and insurance coverage (Medicaid, CHIP and third party insurance) | <p>Data collected in the first grant year was tracked by <b>patient visit</b>, not new patients. Data collection methods were limited in first grant year, though some demographic information was captured.</p> <p align="center">Patient visits by <b>AGE</b><br/>0 to 4: 59 (17%)<br/>5 to 6: 75 (21%)<br/>7 to 12: 137 (39%)<br/>13 to 18: 81 (23%)</p> <p align="center">Patient visits by <b>INSURANCE</b><br/>Data collection to support a detailed breakdown of enrolled by insurance coverage (Medi-Cal, CHDP, and third party) was not implemented in the first grant year. However, data collection reports indicated that the majority of children were insured primarily under Medi-Cal or CHDP (64%).</p> <p align="center">Patient visits by <b>GRADE</b><br/>Approximately 38% of the children enrolled in the program were either not enrolled in school, enrolled in Pre-K, or were enrolled in Kindergarten.</p> <p align="center">39% were enrolled in 1st to 7th grade.<br/>23% were enrolled in 8th grade to 12th grade.</p> | <p>Data collected in the second grant year was tracked by <b>patient visit</b>, not new patients. Changes to data collection methods included tracking enrollments by insurance status, and change in age categories compared to first grant year.</p> <p align="center">Patient visits by <b>AGE</b><br/>0 to 1: 4 (1%)<br/>1 to 2: 34 (8%)<br/>3 to 5: 101 (23%)<br/>6 to 12: 216 (50%)<br/>13 to 18: 79 (18%)</p> <p align="center">Patient visits by <b>INSURANCE</b><br/>MC: 175 (40%)<br/>CHDP: 1 (0%)<br/>Third Party: 47 (11%)<br/>Uninsured: 211 (49%)</p> <p align="center">Patient visits by <b>GRADE</b><br/>32% were either not enrolled in classes, enrolled in Pre-K, or were enrolled in Kindergarten.</p> <p align="center">50% were enrolled in 1st to 7th grade.<br/>18% were enrolled in 8th grade to 12th grade</p> | <p>Data collection method was changed to track new enrollments by <u>patients</u> and not <u>patient visits</u>. Changes to data collection methods included tracking enrollments by grade level, and change in age categories compared to second grant year.</p> <p align="center">Patients by <b>AGE</b><br/>0 to 3: 38 (16%)<br/>4 to 5: 49 (20%)<br/>6 to 12: 115 (48%)<br/>13 to 18: 38 (16%)</p> <p align="center">Patients by <b>INSURANCE</b><br/>MC: 105 (44%)<br/>CHDP: 3 (1%)<br/>Third Party: 30 (12.5%)<br/>Uninsured: 102 (42.5%)</p> <p align="center">Patients by <b>GRADE</b><br/>Not enrolled: 46 (19%)<br/>Pre-K: 23 (10%)<br/>K to 5: 111 (46%)<br/>6 to 8: 33 (14%)<br/>9 to 12: 27 (11%)</p> | <p>No changes in data collection method since third grant year.</p> <p align="center">Patients by <b>AGE</b><br/>0 to 3: 33 (21%)<br/>4 to 5: 30 (19%)<br/>6 to 12: 72 (45%)<br/>13 to 18: 24 (15%)</p> <p align="center">Patients by <b>INSURANCE</b><br/>MC: 88 (55%)<br/>CHDP: 4 (3%)<br/>Third Party: 27 (17%)<br/>Uninsured: 40 (25%)</p> <p align="center">Patients by <b>GRADE</b><br/>Not enrolled: 46 (29%)<br/>Pre-K: 11 (7%)<br/>K to 5: 75 (47%)<br/>6 to 8: 13 (8%)<br/>9 to 12: 14 (9%)</p> |

|   |  |   |   |   |  |
|---|--|---|---|---|--|
|   | Wait time for 1st appointment from time of enrollment  | There is no wait time for the 1st appointment from time of enrollment. Patients are seen immediately after initial enrollment. Wait times only exist for follow-up/recare appointments.   |   |   |  |
|   |  |   |   |   |  |
| <b>Reimbursements</b>   | Number of claims eligible for Medicaid and CHIP; % claims billed, % claims paid  | No claims eligible because we did not have the billing infrastructure to support reimbursements. 0% claims billed; 0% claims paid.  |   |   |  |
|   | Number of claims eligible for other 3rd party reimbursement; % claims billed, % of claims paid   | No claims eligible because we did not have the billing infrastructure to support reimbursements. 0% claims billed; 0% claims paid.  |   |   |  |
|   |  |   |   |   |  |
| <b>Preventive Dental Services</b><br><br>-Oral exam<br>- X-rays<br>- Oral Prophylaxis<br>- Fluoride<br>- Sealant<br>- Education | % of enrolled children who received preventative services  | 100%  | 100%  | 100%  | 100%   |
|   | For each type of preventive service, the distribution of children by age, grade level, and insurance coverage (Medicaid, CHIP and third party insurance) | <b>Data collection to support a detailed breakdown of preventive dental services by age, grade level, and insurance status was not implemented in the first grant year.</b><br><br>Prophlyaxis: 215<br>Fluoride Varnish: 242<br>Knee-to-knee: 28<br>X-rays: 61<br>Comprehensive Exams: 61<br>Education: 248 | <b>Oral Exam:</b><br>Patients by <b>AGE</b><br>0 to 1: 1 (0%)<br>1 to 2: 2 (1%)<br>3 to 5: 22 (11%)<br>6 to 12: 136 (65%)<br><u>13 to 18: 48 (23%)</u><br>Total: 209<br><br>Patients by <b>GRADE</b><br>Not enrolled: 3 (1%)<br>Pre-K/K: 22 (11%)<br>1st to 7th: 136 (65%)<br><u>8th to 12th: 48 (23%)</u><br>Total: 209<br><br>Patients by <b>INSURANCE</b><br>Medi-Cal: 175 (40%)<br>CHDP: 1 (0%)<br>Third Party: 47 (11%)<br><u>Uninsured: 211 (49%)</u><br>Total: 209 | <b>Oral Exam</b><br>Patients by <b>AGE</b><br>0-3: 8 (3%)<br>4-5: 50 (20%)<br>6-12: 138 (56%)<br><u>13-18: 52 (21%)</u><br>Total: 248<br><br>Patients by <b>GRADE</b><br>Not enrolled: 14 (6%)<br>Pre-K: 21 (8%)<br>K to 5: 141 (57%)<br>6 to 8: 32 (13%)<br><u>9 to 12: 40 (16%)</u><br>Total: 248<br><br>Patients by <b>INSURANCE</b><br>Medi-Cal: 152 (61%)<br>CHDP: 1 (0.5%)<br>Third Party: 31 (12.5%)<br><u>Uninsured: 64 (26%)</u><br>Total: 248 | <b>Oral Exam</b><br>Patients by <b>AGE</b><br>0-3: 18 (7.6%)<br>4-5: 38 (16%)<br>6-12: 145 (61.2%)<br><u>13-18: 36 (15.2%)</u><br>Total: 237<br><br>Patients by <b>GRADE</b><br>Not enrolled: 22 (9.3%)<br>Pre-K: 16 (6.7%)<br>K to 5: 138 (58.2%)<br>6 to 8: 39 (16.5%)<br><u>9 to 12: 22 (9.3%)</u><br>Total: 237<br><br>Patients by <b>INSURANCE</b><br>Medi-Cal: 164 (69.2%)<br>CHDP: 9 (3.8%)<br>Third Party: 48 (20.3%)<br><u>Uninsured: 16 (6.7%)</u><br>Total: 237 |

|  |  |   |
|--|--|---|
| <p align="center"><b><u>X-rays</u></b></p> <p>Patients by <b>AGE</b><br/> 0 to 1: 1 (0%)<br/> 1 to 2: 1 (0%)<br/> 3 to 5: 21 (10%)<br/> 6 to 12: 138 (66%)<br/> <u>13 to 18: 47 (23%)</u><br/> Total: 208</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 2 (0%)<br/> Pre-K/K: 21 (10%)<br/> 1st to 7th: 138 (66%)<br/> <u>8th to 12th: 48 (23%)</u><br/> Total: 208</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 77 (37%)<br/> CHDP: 0 (0%)<br/> Third Party: 24 (12%)<br/> <u>Uninsured: 107 (51%)</u><br/> Total: 208</p>              | <p align="center"><b><u>X-rays</u></b></p> <p>Patients by <b>AGE</b><br/> 0-3: 8 (3%)<br/> 4-5: 49 (20%)<br/> 6-12: 138 (56%)<br/> <u>13-18: 52 (21%)</u><br/> Total: 247</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 13 (5.3%)<br/> Pre-K: 21 (8.5%)<br/> K to 5: 141 (57.1%)<br/> 6 to 8: 32 (13%)<br/> <u>9 to 12: 40 (16.1%)</u><br/> Total: 247</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 151 (61.1%)<br/> CHDP: 1 (0.5%)<br/> Third Party: 31 (12.5%)<br/> <u>Uninsured: 16 (25.9%)</u><br/> Total: 247</p>      | <p align="center"><b><u>X-rays</u></b></p> <p>Patients by <b>AGE</b><br/> 0-3: 13 (5.6%)<br/> 4-5: 36 (15.7%)<br/> 6-12: 145 (63%)<br/> <u>13-18: 36 (15.7%)</u><br/> Total: 230</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 18 (7.8%)<br/> Pre-K: 16 (7%)<br/> K to 5: 129 (56%)<br/> 6 to 8: 42 (18.3%)<br/> <u>9 to 12: 25 (10.9%)</u><br/> Total: 230</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 157 (68%)<br/> CHDP: 9 (4%)<br/> Third Party: 48 (21%)<br/> <u>Uninsured: 16 (7%)</u><br/> Total: 230</p>                         |
| <p align="center"><b><u>Oral Prophylaxis</u></b></p> <p>Patients by <b>AGE</b><br/> 0 to 1: 3 (1%)<br/> 1 to 2: 30 (8%)<br/> 3 to 5: 92 (23%)<br/> 6 to 12: 199 (50%)<br/> <u>13 to 18: 71 (18%)</u><br/> Total: 395</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 33 (9%)<br/> Pre-K/K: 92 (23%)<br/> 1st to 7th: 199 (50%)<br/> <u>8th to 12th: 71 (18%)</u><br/> Total: 395</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 160 (41%)<br/> CHDP: 1 (0%)<br/> Third Party: 43 (11%)<br/> <u>Uninsured: 191 (48%)</u><br/> Total: 395</p> | <p align="center"><b><u>Oral Prophylaxis</u></b></p> <p>Patients by <b>AGE</b><br/> 0-3: 72 (14%)<br/> 4-5: 104 (20.5%)<br/> 6-12: 259 (51%)<br/> <u>13-18: 76 (15%)</u><br/> Total: 509</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 81 (16%)<br/> Pre-K: 46 (9%)<br/> K to 5: 255 (50%)<br/> 6 to 8: 67 (13%)<br/> <u>9 to 12: 62 (12%)</u><br/> Total: 509</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 274 (53.5%)<br/> CHDP: 7 (1.5%)<br/> Third Party: 65 (13%)<br/> <u>Uninsured: 163 (32%)</u><br/> Total: 509</p> | <p align="center"><b><u>Oral Prophylaxis</u></b></p> <p>Patients by <b>AGE</b><br/> 0-3: 80 (15.9%)<br/> 4-5: 80 (15.9%)<br/> 6-12: 270 (53.5%)<br/> <u>13-18: 74 (14.7%)</u><br/> Total: 504</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 92 (18.3%)<br/> Pre-K: 46 (9.1%)<br/> K to 5: 261 (51.8%)<br/> 6 to 8: 60 (11.9%)<br/> <u>9 to 12: 45 (8.9%)</u><br/> Total: 504</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 360 (71.4%)<br/> CHDP: 5 (1%)<br/> Third Party: 78 (15.5%)<br/> <u>Uninsured: 61 (12.1%)</u><br/> Total: 504</p> |

|   |   |  |
|---|---|--|
| <p><b><u>Fluoride Varnish</u></b><br/> Patients by <b>AGE</b><br/> 0 to 1: 4 (1%)<br/> 1 to 2: 30 (7%)<br/> 3 to 5: 100 (25%)<br/> 6 to 12: 199 (50%)<br/> <u>13 to 18: 69 (17%)</u><br/> Total: 402</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 43 (8%)<br/> Pre-K/K: 100 (25%)<br/> 1st to 7th: 199 (50%)<br/> <u>8th to 12th: 69 (17%)</u><br/> Total: 402</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 164 (41%)<br/> CHDP: 0 (0%)<br/> Third Party: 46 (11%)<br/> <u>Uninsured: 192 (48%)</u><br/> Total: 402</p> | <p><b><u>Fluoride Varnish</u></b><br/> Patients by <b>AGE</b><br/> 0-3: 77 (15%)<br/> 4-5: 103 (20%)<br/> 6-12: 258 (51%)<br/> 13-18: 71 (14%)</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 88 (17%)<br/> Pre-K: 43 (8%)<br/> K to 5: 257 (51%)<br/> 6 to 8: 61 (12%)<br/> 9 to 12: 60 (12%)</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 275 (54%)<br/> CHDP: 7 (1.4%)<br/> Third Party: 63 (12.4%)<br/> Uninsured: 164 (32.2%)</p>  | <p><b><u>Fluoride Varnish</u></b><br/> Patients by <b>AGE</b><br/> 0-3: 82 (16.6%)<br/> 4-5: 78 (15.8%)<br/> 6-12: 262 (52.9%)<br/> <u>13-18: 73 (14.7%)</u><br/> Total: 495</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 90 (18.2%)<br/> Pre-K: 35 (7.1%)<br/> K to 5: 264 (53.3%)<br/> 6 to 8: 65 (13.1%)<br/> <u>9 to 12: 41 (8.3%)</u><br/> Total: 495</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 353 (71.3%)<br/> CHDP: 4 (0.8%)<br/> Third Party: 76 (15.4%)<br/> <u>Uninsured: 62 (12.5%)</u><br/> Total: 495</p> |
| <p><b><u>Dental Sealants</u></b><br/> Patients by <b>AGE</b><br/> 0 to 1: 1 (1%)<br/> 1 to 2: 0 (0%)<br/> 3 to 5: 0 (0%)<br/> 6 to 12: 44 (69%)<br/> <u>13 to 18: 19 (30%)</u><br/> Total: 64</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 1 (1%)<br/> Pre-K/K: 0 (0%)<br/> 1st to 7th: 44 (69%)<br/> <u>8th to 12th: 19 (30%)</u><br/> Total: 64</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 25 (39%)<br/> CHDP: 0 (0%)<br/> Third Party: 6 (9%)<br/> <u>Uninsured: 33 (52%)</u><br/> Total: 64</p>                   | <p><b><u>Dental Sealants</u></b><br/> Patients by <b>AGE</b><br/> 0-3: 0 (0%)<br/> 4-5: 0<br/> 6-12: 47 (80%)<br/> <u>13-18: 12 (20%)</u><br/> Total: 59</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 0 (0%)<br/> Pre-K: 1 (1.7%)<br/> K to 5: 41 (69.5%)<br/> 6 to 8: 8 (13.5%)<br/> <u>9 to 12: 9 (15.3%)</u><br/> Total: 59</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 32 (54.2%)<br/> CHDP: 0 (0%)<br/> Third Party: 8 (13.6%)<br/> <u>Uninsured: 19 (32.2%)</u><br/> Total: 59</p> | <p><b><u>Dental Sealants</u></b><br/> Patients by <b>AGE</b><br/> 0-3: 0 (0%)<br/> 4-5: 2 (3.1%)<br/> 6-12: 51 (81%)<br/> <u>13-18: 10 (15.9%)</u><br/> Total: 63</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 0<br/> Pre-K: 0 (0%)<br/> K to 5: 44 (69.8%)<br/> 6 to 8: 14 (22.2%)<br/> <u>9 to 12: 5 (8%)</u><br/> Total: 63</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 52 (82.5%)<br/> CHDP: 1 (1.6%)<br/> Third Party: 5 (7.9%)<br/> <u>Uninsured: 5 (7.9%)</u><br/> Total: 63</p>                                   |

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|  |  |  | <p><b>Health Education</b><br/> Patients by <b>AGE</b><br/> 0 to 1: 4 (1%)<br/> 1 to 2: 34 (8%)<br/> 3 to 5: 101 (23%)<br/> 6 to 12: 216 (50%)<br/> <u>13 to 18: 79 (18%)</u><br/> Total: 434</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 38 (9%)<br/> Pre-K/K: 101 (23%)<br/> 1st to 7th: 216 (50%)<br/> <u>8th to 12th: 79 (18%)</u><br/> Total: 434</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 175 (40%)<br/> CHDP: 1 (0%)<br/> Third Party: 47 (11%)<br/> <u>Uninsured: 211 (49%)</u><br/> Total: 434</p> | <p><b>Health Education</b><br/> Patients by <b>AGE</b><br/> 0-3: 64 (18.3%)<br/> 4-5: 68 (19.5%)<br/> 6-12: 174 (50%)<br/> <u>13-18: 43 (12.3%)</u><br/> Total: 349</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 71 (20.3%)<br/> Pre-K: 35 (10%)<br/> K to 5: 164 (47%)<br/> 6 to 8: 46 (13.2%)<br/> <u>9 to 12: 33 (9.5%)</u><br/> Total: 349</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 167 (48%)<br/> CHDP: 4 (1%)<br/> Third Party: 46 (13.2%)<br/> <u>Uninsured: 132 (37.8%)</u><br/> Total: 349</p> | <p><b>Health Education</b><br/> Patients by <b>AGE</b><br/> 0-3: 36 (16%)<br/> 4-5: 40 (17.9%)<br/> 6-12: 114 (50.9%)<br/> <u>13-18: 34 (15.2%)</u><br/> Total: 224</p> <p>Patients by <b>GRADE</b><br/> Not enrolled: 48 (21.4%)<br/> Pre-K: 14 (6.3%)<br/> K to 5: 104 (46.4%)<br/> 6 to 8: 37 (16.5%)<br/> <u>9 to 12: 21 (9.4%)</u><br/> Total: 224</p> <p>Patients by <b>INSURANCE</b><br/> Medi-Cal: 140 (62.5%)<br/> CHDP: 4 (1.8%)<br/> Third Party: 38 (16.9%)<br/> <u>Uninsured: 42 (18.8%)</u><br/> Total: 224</p> |
|  |  |  |  |   |   |
|  | % of enrolled children who received treatment services | <p><b>39%</b><br/> (87/223 new patients)</p> <p>Determined by number of new patients who were referred to dentist in community for treatment services.</p> | <p><b>40%</b><br/> (138/347 new patients)</p> <p>Determined by number of new patients who were referred to dentist in community for treatment services.</p>  | <p><b>67%</b><br/> (160/240 new patients)</p> <p>Determined by number of new patients who were referred to dentist in community for treatment services.</p>   | <p><b>77%</b><br/> (123/159 new patients)</p> <p>Determined by number of new patients who were referred to dentist in community for treatment services.</p>   |

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| <b>Treatment Services</b><br>- Restoration<br>- Extractions<br>- Other (specify) | For each tye of treatment service, the distribution of children by age, grade level, and insurance coverage (Medicaid, CHIP and third party insurance) | Data collection did not include a breakdown of services by age, grade level, and insurance coverage during this grant year.<br><br>Restorative services provided by partner/community dentist Amy English, D.D.S. were not tracked in the first grant year.<br><br><b>Additional services were provided by Dr. Suzanne Clift, D.D.S., and community dental clinic dentists at La Clinica Vallejo Dental.</b> | Data collection did not include a breakdown of services by age, grade level, and insurance coverage during this grant year.<br><br>Restorative services provided by partner/community dentist Amy English, D.D.S. of <u>Vallejo Children Dentistry</u> :<br><br>Amalgam - 1 surface: 10<br>Amalgam - 2 surfaces: 45<br>Amalgam - 3 surfaces: 4<br>Amalgam - 4+ surfaces: 2<br>Extraction, Erupted Tooth or Exposed Root: 12<br>Prefab Stainless Steel Crown: 13<br>Resin Composite - 1 surface: 1<br>Resin Composite - 2 surfaces: 0<br>Resin Composite - 3 surfaces: 3<br>Therapeutic Pulpotomy: 4<br><br><b>Additional services were provided by Dr. Suzanne Clift, D.D.S., and community dental clinic dentists at La Clinica Vallejo Dental.</b> | Data collection did not include a breakdown of services by age, grade level, and insurance coverage during this grant year.<br><br>Restorative services provided by partner/community dentist Amy English, D.D.S. of <u>Vallejo Children Dentistry</u> :<br><br>Amalgam - 1 surface: 16<br>Amalgam - 2 surfaces: 104<br>Amalgam - 3 surfaces: 5<br>Amalgam - 4+ surfaces: 1<br>Extraction, Erupted Tooth or Exposed Root: 28<br>Prefab Stainless Steel Crown: 31<br>Resin Composite - 1 surface: 6<br>Resin Composite - 2 surfaces: 3<br>Resin Composite - 3 surfaces: 0<br>Therapeutic Pulpotomy: 16<br>Surgical Removal of Erupted Tooth: 1<br><br><b>Additional services were provided by Dr. Suzanne Clift, D.D.S., and community dental clinic dentists at La Clinica Vallejo Dental.</b> | Data collection did not include a breakdown of services by age, grade level, and insurance coverage during this grant year.<br><br>Restorative services provided by partner/community dentist Amy English, D.D.S. of <u>Vallejo Children Dentistry</u> :<br><br>Amalgam - 1 surface: 16<br>Amalgam - 2 surfaces: 77<br>Amalgam - 3 surfaces: 8<br>Amalgam - 4+ surfaces: 0<br>Extraction, Erupted Tooth or Exposed Root: 40<br>Prefab Stainless Steel Crown: 33<br>Resin Composite - 1 surface: 4<br>Resin Composite - 2 surfaces: 3<br>Resin Composite - 3 surfaces: 2<br>Therapeutic Pulpotomy: 30<br>Surgical Removal of Erupted Tooth: 3<br>Space Maintainer - Fixed - Unilateral: 3<br>Partial pulpotomy for partial apexogenesis: 1<br>Composite/Incisal/Angle/ or 4+ Surfaces: 1<br><br><b>Additional services were provided by Dr. Suzanne Clift, D.D.S., and community dental clinic dentists at La Clinica Vallejo Dental.</b> |
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| Outcome/Impact                               | Measurement of Program Success   | 1st Year  | 2nd Year   | 3rd Year   | 4th Year   |
|--|--|---|--|--|--|
| <b>Dental Caries</b>                         | Prevalence of dental caries among students who were recruited into the program | 28% of 223 recruited students attended special x-ray/exam days with a community dentist from March 2012 to Sept 2012.<br><br>Of the 61 patients examined, 48% showed evidence of dental caries. | 73% of 347 recruited students attended special on-site x-ray/exam days with a community dentist from Oct 2012 to Sept 2013.<br><br>Of the 253 patients examined, 58% showed evidence of dental caries. | 248 new and recare patients attended special on-site x-ray/exam days with a community dentist from Oct 2013 to Sept 2014.<br><br>Of the 248 patients examined, 52% showed evidence of dental caries. | 237 new and recare patients attended special on-site x-ray/exam days with a community dentist from Oct 2014 to Sept 2015.<br><br>Of the 237 patients examined, 46% showed evidence of dental caries. |
|  | % of children having annual diagnostic dental examination                      | 28%   | 73%  | 45%  | 42%  |
| % children having teeth cleaned in past year | 96%  | 82%   | 99%  | 85%  |  |

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| <p><b>Utilization of Dental Services</b><br/> <b>- For students enrolled in the program:</b></p> | <p>% of all children having completion of treatment plan in one year</p> | <p>Data collection did not track this data in the first grant year. Process was established in October 2013.</p> | <p>Data collection did not track this data in the first grant year. Process was established in October 2013.</p> | <p>Data collection tracked treatment plan completion at Dr. Amy English's private office. Dr. English is a partner in the project and accepts the majority of patient referrals, with the exception of children below age of 5 who are insured under Medi-Cal. When the maximum number of referrals to Dr. English were met, overflow patients were referred to La Clinica Vallejo Dental. The primary documents tracking the completion status for patient treatment plans was misplaced during the warm hand-off transition.</p> | <p>Data collection tracked treatment plan completion at Dr. Amy English's private office. Dr. English is a partner in the project and accepts the majority of patient referrals, with the exception of children below age of 5 who are insured under Medi-Cal. When the maximum number of referrals to Dr. English were met, overflow patients were referred to La Clinica Vallejo Dental. The primary documents tracking the completion status for patient treatment plans was misplaced during the warm hand-off transition.</p> |
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