

# Implementation of School-based Pilot Program-Dental

(FY2018 Appropriation Act - Public Act 207 of 2018)

**October 1, 2018**

***Sec. 1230. By October 1 of the current fiscal year, the department shall provide a report to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, and the state budget office on estimated costs and timeline to implement a school-based pilot program for children up to grade 7 that may include, but is not limited to, oral health assessments, primary dental services, and referrals. The school-based pilot program shall track the number of children offered and receiving services at the school sites. Program goals shall include improving oral and physical health outcomes for children, improving rates of children receiving dental sealants, and reduction of rates of childhood tooth decay.***



# Legislative Report

## Section 1230 of Public Act 207 of 2018

### School-based Oral Health Services

#### **Background**

The Department of Health and Human Services' (DHHS) Oral Health Program convened a group of key stakeholders representing child and adolescent health, school health and wellness, dentistry and dental professionals, education, and other medical and dental professional organizations for a one-day meeting held on February 5, 2018 at Delta Dental in Okemos, Michigan. The day was facilitated by Michigan Public Health Institute. A pre-survey evaluation was sent to all invitees prior to the meeting to assist in planning and to maximize the overall outcome of the meeting. This report provides a brief summary of the work completed by the stakeholders that were in attendance.

Many of the attendees were experienced with a variety of models of school-based oral health programs. From the discussion, there are a number of different school-based oral health programs currently functioning in different areas across Michigan.

#### **Pilot Program Design**

There were three school based oral health models evaluated by the group. Each had pros and cons associated with their model. The models were: (1) a semi-permanent or fixed site, (2) portable equipment, and (3) mobile vans. All models mitigated access to care and transportation issues. All models report challenges in receiving parental consent forms and school administration valuing the out of classroom time needed to provide oral care service(s). Many pros and cons overlap with more than one model. Below is a brief summary of main findings that resulted from the group discussion.

#### **Semi-Permanent or Fixed Site**

- *Pros:* Permanent physical space is allocated, no equipment to move, provide more than just preventive care, can be implemented as part of the school-based health center model.
- *Cons:* Difficult to get services to other locations outside of the fixed site, cost of physical space remodel, and school administrator buy-in for fixed site.

#### **Portable Equipment**

- *Pros:* Inexpensive and least costly, efficient use of time, more flexible, and works well in existing spaces within schools.
- *Cons:* Physically transporting equipment, finding space at schools, and vehicle transportation to transport portable equipment.

### **Mobile Vans**

- *Pros:* Potential for larger impact with multiple sites, schools do not have to allocate internal space, and eliminates set up and tear down time.
- *Cons:* Cost and maintenance of vehicle, schedule coordination and time logistics, seasonal maintenance, and storage of vehicle.

### **Funding and Resources**

Different levels of funding and resources are needed for the three models. Fixed site funding will require larger upfront costs to build out a physical space with annual maintenance of required equipment. Mobile vans will require upfront costs to purchase as well as annual maintenance of equipment. There is a life expectancy of mobile vans as they need to be replaced on a regular basis. Portable equipment is least costly but does require annual maintenance. Equipment needs to be replaced on a regular basis, usually every three to five years. This may be cost-effective but needs regular, stable funds for the equipment.

Funding for personnel is required and will vary depending on the model and the type of services provided, such as preventive or comprehensive care.

In addition to licensed dental professionals to provide services, administrative support is needed within each model. For example, a dental coordinator to manage schedule and logistics may be necessary for both mobile vans and portable equipment. A driver with a CDL license may be required for a mobile van (depending on the size). Volunteers and/or parent participation for on-site assistance may also be required for all models.

Mobile vans and portable equipment models can offer relief to geographic locations that have a shortage of dental health professionals by the mobility of their staff to travel.

Below are rough estimates to start up each type of program design. The estimates are based on minimum staffing. For mobile programs, in order to reach more schools in a community, many will contract with more staff and that also means more equipment and mileage costs.

### **Semi-Permanent or Fixed Site Estimated Start-up Costs per school site**

Construction costs to build out/renovate a site (includes build out, plumbing, electrical)	<b>\$200,000</b>
Dental operatory & equipment (dental chair, patient chair, compressor, lights, x-ray machines, autoclaves)	<b>\$100,000</b>
Supplies and materials	<b>\$ 40,000</b>
Salary/fringes for minimum of two staff (dental hygienist & dental assistant)	<b>\$130,000</b>
Miscellaneous (insurance, communications, computers)	<b>\$ 30,000</b>
<b>Total estimated minimum costs</b>	<b>\$500,000</b>

**Portable Equipment Estimated Start-up Costs per each community site**

Van purchase to transport equipment	\$ 30,000
Purchase of mobile equipment	\$ 30,000
Maintenance/insurance of van	\$ 2,500
Salary/fringes of staff (minimum 2 staff-dental hygienist/assistant)	\$130,000
Mileage Urban	\$ 2,000
Mileage Rural	\$ 25,000
Miscellaneous (insurance, communications, computers/laptops)	\$ 30,000
<b>Total estimated minimum costs</b>	<b>\$249,500</b>

**Mobile Vans Estimated Start-up Costs per each community site**

Mobile vans range in size so quotes vary (does not include dental equipment)	\$500,500 to \$650,000
Gas/oil change/Vehicle maintenance/repairs	\$ 12,000
Vehicle insurance	\$ 1,500
Mileage (urban vs. rural)	\$ 2,500 to \$ 10,000
Garage Rental	\$ 2,400
Dental Operatory equipment plus installation	\$125,000
Salary/fringes of staff and driver with CDL operator permit (minimum of three staff for mobile van)	\$165,000
Miscellaneous (insurance, communications, computers/laptops)	\$ 30,000
<b>Total estimated minimum costs</b>	<b>\$838,900 to \$995,900</b>

**School Participation**

Establishment and maintenance of partnerships among schools and school-based oral health programs is essential to the success of the school-based oral health program. Strong working relationships between teachers, school administrators, school health staff, and the school oral health program is necessary for success. Parental involvement and support is also necessary for a successful program. It is important to provide oral health education to teachers, school administrators, school nurses, and parents regarding the importance of oral health care. Including an oral health education component into the school health education curriculum may also be an effective strategy to garner school administrator and teacher support and buy-in.

**Consideration for a Pilot Program**

Since there are already three main school based oral health models in existence in Michigan, the group did not recommend just one model to pilot. Instead, the group of stakeholders recommended that all three models be evaluated to demonstrate the successes and challenges of each. The pilot locations would be underserved communities, for fixed sites, and schools with a Child and Adolescent Health Center that

does not have existing oral health services. Schools targeted for a school-based oral health pilot should have at least 50 percent of students utilizing free and reduced lunch programs and/or subpopulations that face barriers to oral health care (e.g. migrant communities).

Other considerations that need to be factored into the pilot program include:

- **Appropriate Budget:** Determining a budget with the cost to support programs is a crucial first step in consideration of the pilot models. The budget should include the type of model, staffing requirements, equipment, supplies, mileage, travel expenses, etc. Depending on the model, budgets can range from approximately \$250,000 to \$1,000,000 dollars.
- **Location and personnel:** Personnel may vary depending on model. Locations will be based on unmet need and factors such as percentage of students that qualify for free and reduced lunch.
- **Buy-in from school administrators, teachers, and parents.**
- **Evaluate to determine cost effectiveness, quality of care, school and parent support, and other outcomes should be included in any pilot process.**

### **Outcomes**

The workgroup described elements of a successful school-based oral health pilot program. The elements included determining the overall program design based on the unmet needs of children; establish clear goals with measurable outcomes; have a clear education plan; and ensure access by providing care coordination. To support the elements, each of the pilot programs will be charged with developing a data base that will track the number of children screened, the type of services received such as cleanings, sealants, fluoride, fillings, etc., and the information provided to the department on a quarterly basis. The programs will also track the referrals to dental providers in the community for further follow up care if they are not able to provide the services at the school program. In addition, the pilot programs will develop a plan to demonstrate activities that will help achieve the goals of improving oral health outcomes for children, improving rates of children receiving dental sealants, and decreasing the rates of dental decay.

The full report of the February 5, 2018 meeting can be found at the following link: [www.michigan.gov/Oralhealth](http://www.michigan.gov/Oralhealth).