# How to Plan for Creating Community-Clinical Linkages Through Implementing School-Based/Linked Programs
# Frequently Asked Questions

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## Definition

**School-linked programs**: The purpose is to provide screening at the school, identify the need, link the child to a source of care, and establish a dental home.

**School-based programs**: The purpose is to provide preventive and treatment services (e.g., sealants) at the school.

## General Questions

1. **Does "target children" refer to the total # of children who were screened, total# of children who brought back permission slips, or total # of children in the school when looking at the sealant and fluoride percentages**.
   The goal is to increase the number of children in targeted schools. A program coordinator should think of creating measures to improve performance. Depending on the resources one can create one or more performance measures – number of targeted schools participating in a program, number of children participating in the program, percent of children receiving sealant, and percent of children linked to a source of dental care.

2. **What are strategies for getting more providers open to accepting Medi-Cal?**
   Generally, there are three reasons why dentists and dental hygienists do not participate in the Medicaid program: 1) low fees; 2) administrative burden; 3) no show rate. Every state Medicaid program tries to address these issues. In California, the Medi-Cal program has increased reimbursement and created incentive payments.

Smile, California is the Medi-Cal Dental Program's campaign to help members increase utilization of their dental benefits and increase provider participation in the program. There is a loan repayment program for dentists ($300,000) if they agree to participate in the program. Many administrative barriers have been addressed. The enrollment, prior approval process, and process of billing have been streamlined.

3. **Schools are not as willing to sacrifice class time/academics for OH. Would it be possible for OOH and CDE to send school districts and County Office of ED a co-authored letter encouraging schools to allow LOHP into schools?**
   Yes, OOH can work with CDE to send a letter encouraging schools to allow time for oral health education. However, decisions are made at the local level, so LOHPs need to advocate for oral health in their respective communities.

4. **Would it be possible for OOH and CDE to offer an incentive for school districts to work with LOHP? Any other ideas to help LOHPs overcome this challenge?**
   The 2021-22 budget will provide $93.7 billion in Proposition 98 funding to K-14 public education — the highest amount in state history. The budget creates the nation's first free breakfast and lunch program for all students, starting in 2022-23. Therefore, the incentive that CDPH/OOH could provide would not be large enough to make an impact.

5. **For children identified through a KOHA at a school-based screening with urgent or emergency needs (i.e., they should be seen in 24-48 hours), what guidance do you have about who should be the lead to ensure that child receives care - the PH Care Coordinator or the school (Nurse, social worker). Assume an MOU in place.**
   OOH does not want to dictate a specific solution, as every county has different resources and capacity.

6. **What do LOHPs do when the demand for dental care is much greater than the capacity for the limited dental professionals to provide services?**
   Start by reaching out to the local dental association or society to find dental hygienists and see whether they can take referrals from school programs. You can estimate by screening one grade what proportion of children will be in three buckets (emergency, urgent, needing some care in the next six months). Based on that, one can communicate the number of children who need a specific level of care.

   There are a couple of other steps one can take. First, reduce demand (improve home

care by brushing/flossing, reducing consumption of sugar-sweetened beverages). Second, increase capacity. California has a loan repayment option. One can recruit dentists to bring their practice to your county by reaching out to CDA and CDHA and marketing your county. Or one can go to your county or foundations and advocate for funds. One can also reach out to the media and bring attention to the extent of the problem in your county. Dentists may see or hear the story and want to set up their practice in your county. OOH is exploring ways to create a consortium of dental schools to create externship opportunities for students to work in rural counties. The hope is that these students may like the rural counties and use the loan repayment funds to set up their practices in those areas.

7. **Are Local Dental Pilot Projects independent programs outside of the LOHP?**
   Yes. Local Dental Pilot Projects were funded by DHCS Medi-Cal Dental Program. These programs have ended. LOHP is a public health program funded by CDPH. We intend to continue for another 5 years.

8. **What are some differences between rural and urban areas as far as opportunities and challenges for establishing these programs? How can LOHPs overcome them?**
   These areas are very different. In rural areas, the main challenges are around lack of providers (partners) or infrastructure (public health). Also, distance, geography, cultural sensitivity, and language needs contribute to access to care barriers and need to be considered carefully. For urban areas with large populations, it can be how to reach the impacted communities and challenges that come with inner city and urban environment. The answer in both cases is on a case-by-case basis, depending on what's needed. Having regional consortiums may be helpful to share promising practices at the local level.

9. **How does Covid-19 affect the school-based sealant programs?**
   Temporary delays:
   - as federal guidance is being updated
   - school re-opening and implementation of safety guidelines

     Note: As you approach schools, be mindful and communicate about their readiness.

10. **With the recent resurgence of Coronavirus cases this may impact our outreach efforts. Is there some guidance on this?**
    If Covid is ongoing, promote a campaign like *Back Tooth School* to encourage parents to

seek dental care before starting school. As we look forward to the COVID challenge diminishing, be prepared to reassure school districts that we are following the most updated guidelines.

11. **What about COVID precautions? NEW**
    Hopefully, the COVID pandemic will become like influenza by 2022. We are recommending you start with a few schools and gradually expand over the years. Between now and June 2022, you can test your approaches.

12. **What should we do if a student does not have insurance in a school-based program?**
    Connect students and family to eligibility workers in your jurisdiction. Encourage enrollment in the Medi-Cal Dental or Covered CA program. Parents / guardians can apply online on CoveredCA.com. This single application will let parents know if they qualify for coverage through Covered California or Medi-Cal. Parents can also apply in person at your local county human services agency or by phone by calling Covered California at (800) 300-1506 or use one ofthe certified enrollers.

13. **Can you cover the essential components of a school-based/-linked OH program? I'm wondering if some audience members might need that background first. Screenings at the minimum? Other preventive services?**
    It will depend on the goal and the provider. If the goal is a school-based sealant program, then the minimum would be an oral health assessment/dental screening and sealant placement. The dental screening will identify kids who may have cavities or other dental problems; therefore, the school-based program must have a referral plan in place. The screening will also detect first and second molars thatneed sealants. Keep in mind that first molars erupt around 6 years of age. Yes, that is correct; your first adult molar erupts about age 6. These chewing teeth in the back often go undetected by parents as you do not lose a tooth in order for the molar to erupt. It erupts behind the row of baby teeth. The molar can be susceptible to decay because of the large chewing surface with many deep fissures and grooves which are hard to keep clean by children just gaining fine motor skills. Six years old is the average age and kids can have early or delayed eruption patterns. A school-based sealant program will typically work with second graders. Second molars tend to erupt about 12 years of age, depending on the goal of the program and resources, school-based sealant programs may include this age group. School-based programs can include other preventive services suchas prophylaxis (dental cleaning), and fluoride varnish application.

Here are great resources to become familiar with: Welcome | Seal America (mchoralhealth.org); Seal America (mchoralhealth.org), School-Based Dental Sealant Programs (mchoralhealth.org)

For a school-linked program the minimum would be an oral health assessment / dental screening and referral. School-linked programs screen the children in school and refer them to private dental practices or public dental clinics that place the sealants, provide other preventive and treatment services. Many students treated in school-based or school-linked dental programs do not have a primary or regular source of oral health care (dental home). School-based and school-linked dental programs can serve as steppingstones to the establishment of a dental home by linking students with oral health needs to the broader oral health care community. To accomplish this, programs need a plan for notifying parents about their child's oral health needs and for helping parents find a dentist for their child, if they don't already have one.

Here are some additional references: SCHOOL LINKED DENTAL PROGRAM A GUIDE FOR LOCAL ORAL HEALTH PROGRAMS.pdf (ucsf.edu)
School-Based and School-Linked Dental Sealant Programs | PreventiveInterventions | State-Based Programs | Division of Oral Health | CDC

14. **What are the deciding factors for choosing one model over the other (school-based vs school-linked)?**
Some things to consider are school and community support, resources, capacity,and sustainability. In general, school-based programs require more commitments and support from the schools. It will require space to set up a temporary clinical facility. Because only about 10-12 children can be provided preventive services by aprovider per day, it takes more time to see all children in a school. On the other hand, a school-linked program is less resource-intensive. A provider can screen 50-75 children in one session. This is ideal if a sufficient number of providers in the community are available to accept the referral from a school-linked program to establish a dental home. If not, providing sealant or preventive services to the school helps overcome barriers to care.

Another consideration is that school screenings may be performed using passive consent if it is permitted by the school. Providing preventive services in a school-based program will require active consent.

15. **Could Riverside County provide more information regarding their relationship with the GeriSmiles program? Is Prop 56 funding some of his work? NEW**
In 2020, we (Riverside County) did fund part of his work. We got permission from OOH

to pilot the virtual screenings. In 2022, we'll be working with him to do a stipend. The organization will get a stipend for children screened for KOHA. His business model is, he does the screenings, and we (Riverside LOHP) do the other billable services, such as fluoride varnish. We support GeriSmiles going in and doing follow up, but we use community partners for anything that is a billable service, since we can't spend Prop 56 funds on services that can be billed. He has the contract with the schools and then we have a separate contract with GeriSmiles. We're mentioned in his contract with the state that it's a partnership between GeriSmiles and the state, so we're allowed to go with him to the various sites. We don't have a separate contract with the school district. We let our community partners establish the contracts with the individual school district. Then we create an MOU with the community partners.

16. **What type of nurse can do dental screenings? NEW**

Nurses can perform a dental screening if they are concerned that a child is suffering or may have an infection and inform the parents the need to visit a dentist. School nurses have historically been the ones to receive a child in pain, determine the source of the discomfort, render care as appropriate and make the necessary referral. We have heard from many school nurses that their number 1 problem is untreated dental disease. The role of school nurses will not change with this requirement.

The requirement is intended to identify dental problems earlier, thereby reducing the number of children's visits to the school nurse for undiagnosed dental disease. The requirement is also expected to provide added support for the dental referrals that nurses make, in that the school nurse cannot "sign off" on a child's oral health. By requiring that a dental professional do this assessment, the State is emphasizing to parents that their child's oral health must be cared for by dental professionals and reinforces the referrals that school nurses make for children with dental disease. Kindergarten Oral Health Requirement: Information for Schools (cda.org)

17. **Can nurses perform the dental screening for KOHA? NEW**

No, the law states it must be completed by a "dental professional." The goal of this law is to connect children with a regular source of dental care. The law requires schools to educate parents about the importance of oral health to overall health and readiness for school and encourages parents to locate a source of dental care, be that a private dentist or a community clinic, for this dental evaluation. Additionally, information to support enrolling children in Medi-Cal is also provided to parents. This law serves as the impetus to make a connection that is ideally not a one-time event but can become a regular source of care.

An ongoing challenge for school nurses who provide basic assessments (i.e., screenings) for children at school is follow through on referrals made. This law provides another tool to back up a recommendation to see a dentist for comprehensive evaluation and care. What's more, this law also measures the specific barriers encountered when the parent does not follow through on that recommendation. Kindergarten Oral Health Requirement: Information for Schools (cda.org)

18. **Are we just doing screenings and referral and no fluoride varnish? NEW**
The evidence for a single application of fluoride varnish is weak. You must do at least three or four applications to see any impact. If you are screening and connecting a child to a source of dental care with the hope of getting the child into a dental home, then there is no need to do fluoride varnish. The second reason is you must obtain active consent for fluoride varnish. The screening can be done with passive consent. Participation rates drop dramatically when active consent is needed. In school sealant programs, research has shown that those who need it the most, don't participate. We encourage you to focus on passive consent and screening. Screening will not help as much unless you have a robust referral management system in place. Focus on building the referral management system.

19. **How much staff supports screening 100 children in an 8-hour workday? How many minutes per child should it take to do 1 screening? NEW**
With dental screenings, it's a quick look. You shouldn't need to touch the child if you have a penlight. Ask them to open and tip their head back. The less you touch the child, the fewer infection control steps need to happen, which makes it so much faster. If you have a screener or assistant to help with charting, you can screen the child in a matter of minutes. One person can do the screening and write down the information. It still should take 1-3 minutes. Schools end early and they have breaks, so work with the school to coordinate times. Even on a short day, you should be able to see 50 – 80 kids for a screening. Good coordination with the school will make the process very quick. RDHs and RDHAPs are familiar with this process. Ask them how many they could screen in a day.

Danika Ng in Marin County stated "*At one of our dental screening events we were able to screen an entire school (571 students) in a few hours (~4-5). It was a very quick process for us.*"
Laura McEwen stated, *"Be sure to include the travel time to the school. Very important for rural communities where schools are 1.5 hours away one-way."*

20. **How many times in a school year should we screen a single school? NEW**
    Only once.

21. **How many days did it take to recruit schools? NEW**
    Recruiting will differ for each area. Here are some resources: KOHA Toolkit Working with Schools.pdf (ucsf.edu). We encourage you to find local champions to partner with schools. Teachers, school nurses, principals, parents, and other active community members can make great champions. Check to see if schools will be holding Back to School events or meetings, parent nights, or other events such as coffee socials, fall or spring festivals, etc. that are open to the community and may promote health. By attending school social activities, you can be present and possibly recruit someone to lead the effort.

22. **Can you share an example screening form so we can see what priority info is collected? NEW**
    There are several examples of screening forms on COHTAC. One example is Prop 10 Patient Information Form (ucsf.edu).

    Other examples can be found on the following pages: School Program Resources | California Oral Health Technical Assistance Center (ucsf.edu), KOHA Toolkit | California Oral Health Technical Assistance Center (ucsf.edu).

    Also, review the KOHA Handbook examples on School Oral Health Programs | California Oral Health Technical Assistance Center (ucsf.edu)

23. **How does your team manage logistics and bandwidth to promote and support KOHA in all the kindergarten classrooms in Riverside County? NEW**
    Riverside County manages bandwidth by not going to each individual school. They start at the district level. They advise if you can get buy-in at the district level, it saves a lot of steps and communication.

24. **Do the schools agree to use staff time to manage KOHA care coordination? Santa Cruz schools are varied in which ones have the capacity to follow up with KOHA forms, let alone follow-up with forms that are waived or can't find a dentist. Do you have suggestions on how to encourage the school to engage in the KOHA follow up? NEW**
    In Riverside County, there's an expectation that children are going to get identified and get into care and to establish who's going to be the responsible party. We're getting more involved with our CHDP program and, at drive-thru events, having the opportunity

to speak with parents. We also found it effective to print out some Smile, CA cards. It's putting that onus on adults/parents/caregivers to contact Smile, CA to get a local referral of dentists in the area as well as resources for other providers. We also make sure the schools know about those resources as well.

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## Funding, Billing, and Budget

1. **Can we use LOHP funds for honoraria for screenings, who receives them, for what tasks and for what approved amount?**
   We can allow for honorariums (i.e., stipends) for licensed dental providers to provide screenings for children because screenings are not reimbursable. This may offset the cost of taking time off from their regular clinical hours. Fluoride varnishes are billable to Medicaid. We will need a proposal from the LOHP listing how many events and providers and what the cost (stipend) would be, and how many children would be served?

2. **For the budget revision due at the end of September, how should we allocate the RFA funding if we plan to use the state-selected referral management program?**
   It will be a subscription, so you can include it under 'Other' for now and adjust later if something changes.

3. **Can you provide some clarification about the state-sponsored referral management system? Does this mean LOHPs will not have to pay for the system?**
   Correct. OOH is working to procure a referral management system software. The procurement process will take about a year and is expected to be complete by mid-summer 2022. Each LOHP will have the option to subscribe to the basic system, and the OOH will cover the cost of the licenses. However, each LOHP canpurchase additional features as needed. If your LOHP is planning a school-based program or a Virtual Dental Home model, then you may want to explore a different system like clinical management software.

4. **Will the new referral management system be available to us soon? (NEW)**
   OOH is still waiting for approval from the Department to procure a system. This should not deter one from starting a screening program because one can start with a paper-based system.

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5. **Will the care-coordination system be decided upon before budget revisions are due on Sept 30th? If not, how should we write that into the budget revision?**
   The referral software will not be decided upon by the Sept. 30, 2021 budget revision due date. Please contact your GM for details.

6. **Does Medi-Cal allow billing for Dental Services via teledentistry or in person at the schools?**
   Yes, dental programs are operating in schools and billing Medicaid for services. For teledentistry specifically, OOH would need to know which specific service would be provided. If it is in the context of a virtual dental home, it would be allowable.

   However, many dental services are in-person procedures, which teledentistry could not provide. For details regarding the Medi-Cal teledentistry policy, please refer to Medi-Cal Provider Bulletin.

## Advocacy

1. **Our schools seem overwhelmed since the pandemic and are more reluctant toallow services on their sites. Is there advocacy from a state level to school districts and superintendents to support SBSPs? We are reaching out at a local level, but I am hoping there may also be outreach from a state level.**
   Support from the state level to schools and superintendents does exist. The best way to gain support for SB/SL programs is at the local level. Identifying a local champion will help reinforce support from the state level is key.

2. **In terms of advocacy for the new PH Infrastructure funds, could the State OOHplease present to both CCLHO and CHEAC at the State level to inform them ofstatewide successes and the need for concerted funding in the LHD's for Oral Health funding? That way our local advocacy has a platform and some uniformity of need upon which to build.**
   OOH will follow up on this.

3. **Will there be an opportunity to advocate for inclusion of dental care coordination in CalAIM?**
   Please visit the CalAIM website to provide input.

## Five-year Grant, Planning Activities

1. **Has the RFA been released?**
   Not yet. Expect a special funding announcement in early October 2021. Wecannot discuss the details until all the documents have been approved.

2. **Are we going to shift to planning activities in FY5? Will the new RFA include present activities?**
   We want to encourage everyone to take the next year to plan goals for the next cycle and look at the step-by-step process. We're still focused on the same things and in the next cycle evidence-based and school-linked/based programs will be a priority.