



SCHOOL-LINKED DENTAL PROGRAM: A GUIDE FOR LOCAL ORAL HEALTH PROGRAMS



Office of Oral Health, California Department of Public Health

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Community Clinical Linkage Program in Schools

Introduction

The California Oral Health Plan 2018-2028 is a call to action to a broad range of stakeholders to collaborate at the community level to assess oral health status and needs, identify health priorities, and plan and implement strategies for oral health improvement.¹ Improved oral health of California children and reduction in oral health disparities by emphasizing prevention are key goals. The plan also highlights the significance of oral health and identifies a goal of reducing tooth decay in children.

The Local Oral Health Program grant to Local Health Jurisdictions is a funding opportunity to implement a key strategy by establishing linkages between schools and clinicians to promote clinical preventive services and healthy lifestyles.² According to the Centers for Disease Control and Prevention (CDC), community-clinical linkages are collaborations between health care practitioners in clinical settings and programs in the community—both working to improve the health of people and the communities in which they live.³ Developing strong community-clinical linkages connects health care providers, community organizations, and public health agencies so they can collectively improve access to preventive and treatment services. School-based and school-linked dental sealant programs are examples of a community-clinical linkage model where

California Oral Health Plan Goals and Objectives

GOAL 2: Align dental health care delivery systems, payment systems, and community programs to support and sustain community-clinical linkages for increasing utilization of dental services.

OBJECTIVE 2.A

Increase the proportion of children who had a preventive dental visit in the past year, and reduce disparities in utilization of preventive dental services.

OBJECTIVE 2.B

Increase the percentage of Medi-Cal enrolled children, ages 1 to 20, who receive a preventive dental service.

OBJECTIVE 2.C

Increase the percentage of children, ages six to nine years, who have received dental sealants on one or more of their permanent first molar teeth.

STRATEGY 2.2: Identify, maintain, and expand community-clinical linkage programs in targeted sites such as WIC programs, Early Head Start/Head Start, preschools, and schools.

screening, counseling, provision of topical fluoride and sealants, referral, and follow-up

occur in a school setting. Children are linked to a source of dental care where they can receive ongoing clinical services. Programs such as the Virtual Dental Home model are another method to expand the reach of the dental home to a variety of community settings.⁴

California Children's Dental Disease Prevention Program

The California Children's Dental Disease Prevention Program (CCDDPP) (Health and Safety Code 104770-104825) was established in 1979 to provide funds to local agencies for comprehensive dental disease prevention efforts. The mission of the CCDDPP was to assure, promote, and protect the oral health of California's school-aged children by increasing their oral health awareness, knowledge, and self-responsibility by developing positive, life-long oral health behaviors and by providing an opportunity for access to primary preventive services such as topical fluoride. The program was targeted to children who were otherwise unlikely to receive preventive services. The criterion was based on the proportion of Free and Reduced-Price School Lunch Program enrollment for each participating school.

Since the enactment of the CCDDPP, several developments have occurred: 1) the expansion of the dental insurance coverage; 2) the increase of fluoride availability because of community water fluoridation; 3) a lack of available supplies for school fluoride rinse programs; 4) improvement in the utilization of the Medi-Cal Dental Program; 5) availability of care coordination platforms to improve linkage; 6) increased focus on dental sealants and silver diamine fluoride; 7) an increase in the cost of administering the program; and 8) the need to reduce aerosol generating procedures during the COVID-19 pandemic, which is limiting and affecting the delivery of clinical services in schools.

There are several models of care in schools: 1) school-based preventive programs; 2) school-linked programs; 3) Virtual Dental Home; and 4) preventive and treatment programs using portable, mobile van, or fixed equipment.^{5,6,7} The CDC recommends school sealant programs as a highly effective way to deliver sealants to children who are less likely to receive private dental care. Programs that deliver sealants to children at high risk for tooth decay also save money. Each tooth sealed saves more than \$11 in dental treatment costs. Applying sealants in schools to the nearly 7 million low-income children who don't have them could prevent more than 3 million cavities and save up to \$300 million in dental treatment costs.^{8,9} These programs are generally targeted to children in 2nd and 3rd grade. Those who need dental care are referred to a source for ongoing care.

While school-based programs provide on-site services in schools, school-linked programs identify children who need services and then coordinate the services and the

referral to a provider in the community. Targeting schools and children at high risk for dental disease is a practical approach for reaching those children with the greatest dental needs. Using enrollment in the Free and Reduced-Price Lunch Program (FRLP) as a risk threshold provides the ability to reach higher-risk schools and children. A common targeting methodology for eligibility is rural schools or urban schools with greater than 50 percent student enrollment eligible for free and reduced-price meals.

While there are many advantages with the school-based programs, they are resource intensive, have low participation rates, and require a greater degree of cooperation from schools.^{10, 11} With the disruption caused by the COVID-19 pandemic and the difficulty in providing clinical services in off-site locations, programs may explore school-linked options. While a school-linked program may already be in place in many communities, these programs have not been thoroughly evaluated despite their obvious potential. Such a program must have the capacity to provide timely referrals and follow-up appointments to provide treatment for problems found during the examination or screenings. With this in mind, the Office of Oral Health has developed a methodology for promoting school-linked programs.

School-Linked Program Model

According to CDC, school-based and school-linked dental sealant programs are highly effective strategies for preventing tooth decay in children.¹² School-based sealant programs provide pit and fissure sealants to children in a school setting, and school-linked programs screen the children in school and refer them to private dental practices or public dental clinics for sealant placement. The implementation of a school-linked program model consists of several steps:

1. Programs should select schools based on demonstrated need, as evidenced by high disease rates and/or unmet needs, then obtain approval from the school administration and engage the clinicians early in the planning stage.
2. Programs should have an education and outreach component that involves children and parents, school administrators and staff, dental providers, and other influencers in the community. A partnership with a common goal of improving oral health and school attendance ensures success.
3. The planning should also take into consideration the following:
 - Consider the resources needed to screen, refer, and coordinate care for all children in selected schools or focus on certain grades when the resources are limited.
 - Determine the type of consent for screening and referral. As the clinical procedure is limited to a non-invasive assessment of dental problems in the mouth, pursue approval to use a passive consent. However, the program must ensure privacy of the information.

- Develop referral criteria and the protocol for linking children to a source of dental care.
 - Create a network of dental care providers willing to accept referrals.
 - Use a referral management and care-coordination platform for connecting with parents and linking children to a source of dental care. This will allow the following:
 - i. efficient communication with parents/guardians and clinicians
 - ii. tracking the success of referrals
 - iii. data metrics to communicate findings to school administrators, stakeholders, and funding agencies
 - iv. development of quality improvement strategies
 - Establish performance measures and track progress in achieving targets. Consider quality improvement strategies.
4. A school-linked dental program should develop a protocol to implement assessment, counseling, and linkage to providers, as well as care coordination using the 5A's strategies for addressing oral health problems in pre-school and school-aged children. These include the following:

Ask - Ask the child and/or the parent/guardian about any dental problem he/she may be experiencing during the encounter and document the response along with the findings of an open mouth screening. If an in-person clinical assessment is not possible, explore a teledentistry option.

Advise – Advise* the child/parent/guardian in a clear, personalized manner about the screening findings and the importance of routine dental care. If not already achieved, contact the parent/guardian to report the screening findings. Consider using text and email as options.

Assess - Assess the readiness to visit a dentist as well as the barriers encountered by parents/guardians (i.e., dental insurance coverage, accessibility to a source of dental care, language, and transportation issues) in obtaining dental care. Also review the extent to which the parents/guardian may require assistance in making an appointment and a dental visit.

Assist - Assist the child/parent/guardian in overcoming barriers and to set up an appointment for follow-up dental care. Provide them with appropriate oral hygiene instructions and relevant health-promoting educational materials, as well as a toothbrush and toothpaste kit.

Arrange - Arrange an appointment for a dental visit and/or to follow up with the child/parent/guardian within the first few weeks, either in person or by phone or email, and take appropriate action to assist them.

For those children/parents/guardians who are not ready to improve their routine dental care, clinicians should use a brief intervention to promote good home care and routine dental care. Content areas that should be addressed are captured by the 5R's:

Relevance - Encourage the child/parent/guardian by stating why routine dental care is relevant to them. Be as specific as possible including how it may affect school attendance and the need for advanced care.

Risks - Ask the child/parent/guardian to identify potential negative consequences of their lack of routine dental care, including acute and long-term risks.

Rewards - Ask the child/parent/guardian to identify potential benefits, such as improved health, self-perception, and cost savings.

Roadblocks - Ask the child/parent/guardian to identify barriers (e.g., fear of dentist, transportation, language, cost, etc.) and provide assistance and resources to address them.

Repetition – Repeat the motivational intervention every time the child/parent/guardian is seen.

**Note: The target for intervention is often the parent/guardian and not the child patient.*

Benefits

The 5A's and the 5R's of the *School-Linked Program in Schools* are adapted from the 5A's and 5R's of tobacco-cessation counseling, which are effective in improving tobacco cessation rates among adults and has been recommended by the U.S. Public Health Service for adolescents.^{13, 14} Through the 5A's and 5R's intervention techniques, clinicians can tailor the messages and strategies to cater to the individual needs of the children. Further, since these techniques are not time-consuming, they can easily be employed by providers. Providers can also reach more children since the linkage program involves quick intervention techniques and does not require space for clinical set up.

Referral Management and Care Coordination

To successfully link children to a source of dental care and improve performance, it is essential to create an electronic platform. However, there are only a handful of such tools. In California, the Department of Health Care Services has provided grant funding to develop the Los Angeles Dental Registry and Referral System (LADRRS).¹⁵ This was created to improve care coordination and communication among medical providers, dental providers, and care management teams providing oral health services for children with Medi-Cal coverage in Los Angeles County. A referral management tool for children's oral health such as LADRRS enables medical providers to send referrals directly to dental providers. The tool assists in scheduling children's dental appointments while facilitating communication, effective information sharing, and care management among providers and delivery systems. This system could be modified to include referrals from other settings such as Head Start centers and schools.

The Healthier Kids Foundation of Santa Clara County¹⁶ uses an electronic platform to implement the DentalFirst program which screens children 6 months to 18 years old for undetected dental issues and assists them with accessing follow-up dental care.

Evaluation

To build an evidence base, we must determine whether the program is meeting its purpose and objectives. Therefore, we must ensure a robust data collection system and measurement efforts. Every step of the 5A's and 5R's (if appropriate) for every child should be measured and tracked. Through rigorous methods and evaluation of the assessment, counseling, and linkage approaches, we can determine the level of success and the impact of the program.

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