California Department of Public Health

Request For Application

Children's Dental Disease Prevention Program (Equipment Support and Referral Management/Care Coordination Tools)

California Department of Public Health
Office of Oral Health
MS 7218
1616 Capitol Avenue, Suite 74.420
Sacramento, CA 95814
www.cdph.ca.gov/oralhealth

REQUEST FOR APPLICATION

Children's Dental Disease Prevention Program (Equipment Support and Referral Management/Care Coordination Tools)

Contents

BACKGROUND AND AUTHORIZING LEGISLATION 2

THE CALIFORNIA CHILDREN'S DENTAL DISEASE PREVENTION PROGRAM 2

COURSE OF ACTION 3

FUNDING 3

FORMULA FOR DISTRIBUTION OF FUNDS 6

KEY ACTION DATES 8

COMPONENTS 8

COMPONENT 1) SCHOOL-LINKED PROGRAM MODEL: REFERRAL MANAGEMENT AND CARE COORDINATION 8

PURPOSE 8

GOAL 9

ASSURANCES 9

REFERRAL MANAGEMENT TOOLS AND EQUIPMENT 11

GUIDELINES 12

COMPONENT 2) SCHOOL-BASED PROGRAM MODEL: EQUIPMENT SUPPORT 12

PURPOSE 12

GOAL 13

ASSURANCES 13

EQUIPMENT 17

GUIDELINES 20

EXPECTATIONS 21

APPLICATION INSTRUCTIONS 22

APPENDICES 24

APPLICATION DOCUMENTS 24

REQUEST FOR APPLICATION

Children's Dental Disease Prevention Program (Equipment Support and Referral Management/Care Coordination Tools)

BACKGROUND AND AUTHORIZING LEGISLATION

The California Office of Oral Health (OOH) was established in July 2014. The mission of the OOH program is to improve the oral health of all Californians through prevention, education, and organized community efforts. To achieve this, the OOH is providing strategic advice and leadership to oral health stakeholders throughout the state, building oral health workforce capacity and infrastructure, and implementing and evaluating evidence-based best practices in oral disease prevention. The Status of Oral Health in California: Oral Disease Burden Report, California Oral Health Plan (COHP), and an Oral Health Surveillance Plan were developed to build capacity and address the burden of oral disease. The COHP serves to identify priorities, goals, and objectives to address the burden of disease, increase access to oral health services for high-risk populations, and to increase the oral health status of all Californians.

In November 2016, California voters overwhelmingly approved the *California Healthcare, Research, and Prevention Tobacco Act of 2016,* Proposition 56 (Prop 56). Prop 56 added a $2.00 tax to each pack of cigarettes and an equivalent tax on other tobacco products, including electronic smoking devices.

The annual State Budget, California Health and Safety Code (HSC) Sections 104750-104765, 104770-104825, 104865 & 131085, and the Revenue and Taxation Code Section 30130.50-30130.58 (California Healthcare, Research and Prevention Tobacco Tax Act of 2016) provide OOH with the legislative authority to build capacity and infrastructure for the development, implementation, and evaluation of best practices and evidence-based programs in oral disease prevention. Under the leadership of the State Dental Director, OOH works to address the burden of oral disease, increase access to oral health services for high-risk populations, and improve the oral health status of all Californians.

THE 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 and sealants. 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 (FRLP) enrollment for each participating school.

REQUEST FOR APPLICATION

Children's Dental Disease Prevention Program (Equipment Support and Referral Management/Care Coordination Tools)

COURSE OF ACTION

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. The Centers for Disease Control and Prevention (CDC) recommends school sealant programs as a highly effective way to deliver sealants to children who are less likely to receive private dental care. These programs are generally targeted to children in 2nd and 3rd grade. Those who need dental treatment are referred to a source of dental care for ongoing services.

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 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 the free and reduced-price meals.

There are many advantages with the school-based programs; however, they are also resource intensive, have low participation rates, and require a greater degree of cooperation from the schools. 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. Such a program must have the capacity to provide timely referrals and follow-up appointments to arrange for sealants and treatment for problems found during the examination or screenings.

OOH has developed a methodology for promoting school-based and school-linked programs to address these challenges. The purpose of the new Children's Dental Disease Prevention Program is to expand evidence-based school-based and school-linked dental programs and best practice approaches that promote oral health. This funding will provide support for both school-based and/or school-linked programs. The school-based funding will support a one-time equipment purchase to increase sustainable community-clinical models. The school-linked funding will support an electronic referral management tool to improve care coordination and communication among medical providers, dental providers, and care management teams providing oral health services for children. Applicants may use a combination of these two approaches.

FUNDING

This <u>one-time</u> funding is for local health jurisdictions (LHJs) to support work plan activities to implement programs, gather outcome data from services and dental assessments, and serve as the coordinator for performance management and

evaluation. Data will help determine if these efforts are effective and identify if these efforts improved the dental health outcomes of children. Local Oral Health Programs (LOHPs) will engage dental practitioners in the community to provide direct clinical services and facilitate reimbursement from third party funding sources such as Medi-Cal Dental Services or leverage other sources of funding to support the program. This grant will support these efforts by providing 1) equipment; 2) materials/supplies support; 3) hardware and software for referral management; and 4) technical support. Funds for supporting the cost of materials is intended for the first year with the understanding the LOHP will develop a sustainability plan. Prop 56 funds may not be used to support the staff who deliver the clinical services.

This funding is not for the provision of direct services but to support start-up or expansion of children's preventive dental services.

The proposal request should:

- Demonstrate community need (e.g., high participation rate (minimum of 50%) in Free and Reduced-Price School Lunch Program, rural areas, dental deserts).
- Prioritize underserved areas and populations.
- Provide a long-term coverage plan to reach all targeted populations (build every year to increase the number of children being seen); and
- Include a program sustainability plan. The plan will include data collection, performance management, evaluation, sharing, and reporting, and leverage multiple funding sources.
- Demonstrate the ability to partner with dental providers.

The program's goals and objectives are linked to the state and/or national oral health goals and objectives.

a) This program will support Objective 6 of the current LOHP grant work plan with the addition of activities 6.4.0 and 6.5.0 to Objective 6 (See Exhibit A) to purchase equipment and, if needed, start-up materials per Request for Application (RFA) assurances and guidelines. The requirements for receiving funding are as follows:

    i) Detailed reporting will be submitted with each progress report including the added activity.
    ii) The State Fiscal Year 2021/2022 budgets must be revised.

For new funding: List items that cost $5,000 or less per item under the ***Other Costs*** line item. Items that cost $5,000 or more per item must be listed under the ***Equipment*** line item.

iii) Provide a detailed description including itemized list of all equipment, software (including licenses, training/onboarding), and materials/supplies including quantity, estimated purchase price, and justify the need for the proposed equipment, software (including licenses, training/onboarding), and material purchases on the justification tab of the budget.

iv) Incentives to support increased participation and return of consent forms, (highest participation by a class/school) will be considered. Incentives must follow guidelines for Behavior Modification Materials (BMM), Page 11.

v) Required data must be submitted biannually (twice per year) to the OOH. Program data should reflect the program's ability to reach its goals and objectives. Baseline data should be established to track progress towards program goals. Descriptive program data should include:
   - (a) An estimate of the number of all high-risk children in the jurisdiction who are eligible
   - (b) An estimate of the number and percentage of high-risk children in the jurisdiction who will receive sealants through the program.
   - (c) A list of participating schools.
   - (d) Number of consent forms returned.
   - (e) Rates of participation, number of children screened and number of children who received sealants, and number of sealants placed.
   - (f) Number of retention checks.

The funding supports LOHPs efforts for Objective 6 of the Work Plan to implement evidence-based programs to achieve COHP objectives. Materials, supplies, care referral management/ coordination software/hardware, and equipment may support Virtual Dental Home and tele-dentistry models.

FORMULA FOR DISTRIBUTION OF FUNDS

The California Department of Public Health (CDPH), OOH will allocate $2.5 million for an Equipment Support grant or a Referral Management and Care Coordination grant to be utilized from September 1, 2021 through June 30, 2022. LOHPs have the opportunity to apply for funding up to a maximum ceiling of $200,000. LOHPs can select school-linked or school-based or a combination of the models.

Funding is contingent on availability.

Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Grantee or to furnish any other considerations under this Agreement and Grantee shall not be obligated to fulfill any provisions of this Agreement.

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to either cancel this Agreement with no liability occurring to the State or offer an agreement amendment to Grantee to reflect the reduced amount.

LHJ Funding Tier
LOHPs are grouped into four funding tiers; **Table 1** lists each LHJ by tier.
Funding amounts have been determined using the estimated low-income population based on the 2015 American Community Survey Five-Year Estimates, which can be found at: https://data.census.gov/cedsci/map?vintage=2019&layer=VT_2019_050_00_PY_D1&palette=Teal&break=5&classification=Natural%20Breaks&mode=selection

Table 1. LHJ Funding Tier			
Tier 1	Tier 2	Tier 3	Tier 4
LHJs projected to receive $25,000	LHJs projected to receive $50,000	LHJs projected to receive $100,000	LHJ projected to receive $200,000
Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Nevada, Placer, Plumas, San Benito, San Luis Obispo, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba, City of Berkeley, City of Pasadena	Alameda, Butte, Contra Costa, Fresno, Imperial, Kern, Merced, Monterey, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, Yolo, City of Long Beach	Orange, Riverside, San Bernardino, San Diego	Los Angeles

KEY ACTION DATES

Project deadline, milestones and dates

Table 3. Key Activities and Dates

Activity	Action Date
CDPH to Release RFA	March 3, 2021
CDPH Information Session	March 10, 2021
LOHP's to reply with a Letter of Intent (LOI) 10 business days from release date	March 17, 2021
Deadline to Submit Application Respond to RFA with all required application contents from Document A Application Checklist.	April 21, 2021
Anticipated Award Date	September 1, 2021

COMPONENTS

COMPONENT 1) SCHOOL-LINKED PROGRAM MODEL: REFERRAL MANAGEMENT AND CARE COORDINATION

PURPOSE

Due to the COVID-19 pandemic, it may be necessary to delay school-based dental sealants programs until schools have adjusted to a regulated state of operations. However, delaying dental screenings is not recommended. Tooth decay is the most common chronic disease of childhood. In California, 54% of kindergarteners and 70% of third graders have experienced dental caries (tooth decay), and nearly one-third of children have untreated tooth decay. Left untreated, tooth decay can cause pain and serious oral infections that may compromise a child's ability to concentrate and learn. In the United States, approximately 16% of children and adolescents have untreated decay, rising to 20% in minority children and 23% among those living below 100% of the federal poverty threshold, reflecting profound ethnic and income disparities.

Because of recent reduced capacity due to new COVID-19 guidance, combined with parental fear, many children are not getting the dental care they need. This will likely increase the percentage of children with oral pain and/or a serious oral infection. This is more likely in high-risk or vulnerable populations which makes dental screenings with referral even more critical.

REQUEST FOR APPLICATION

Children's Dental Disease Prevention Program (Equipment Support and Referral Management/Care Coordination Tools)

GOAL

The goal of this program is to increase children receiving dental screenings and referrals. Creating or expanding school-linked dental programs to reduce the burden of oral diseases utilizing referral management tools and implementing care coordination will determine if these efforts will lead to better health outcomes.

School-linked health services or telehealth services are most appropriate when it is not feasible, or not the best use of resources, to bring clinical providers into the school. School-linked services exist when a local community health program, such as a community clinic, or a network of local dental professionals has a formalized, well-coordinated linkage to one or more schools.

This goal shall be achieved by providing funding to purchase hardware and software for the referral management tools, care coordination onboarding or technical support, and supplies for screening. Such a program should work with local Children's Health and Disability Prevention (CHDP) programs or other appropriate entities to establish a dental home.

ASSURANCES

To be eligible for an award the applicants must provide the following assurances:

1. Must be a currently funded local oral health program (or local health jurisdiction).
2. Submit a Program Plan from Document E template prior to software and hardware purchase. No longer than 10 pages and including the following elements:
    a) Staffing plans for managing and overseeing the project and activities. Description of organizational structure (particularly related to roles, responsibilities, and accountability for the project).
    b) Descriptive plans to identify and coordinate with new community partners. Applicant will identify anticipated support needed in establishing the collaboration and demonstrate willingness to identify potential community collaborators.
    c) Sustainability Plans, such as how this project will align with other funding streams, how it builds upon past work and supports future goals, and how enhanced LHD capability or new partnerships might be supported or leveraged beyond the funding period. The plan will include data collection, performance management, evaluation, leveraging of funds, institutionalizing services, sharing and reporting data.
    d) Provide long-term coverage plans to reach all targeted population (build every year to increase the number of children being seen); and

i. Plans to select schools based on demonstrated community need (e.g. high participation rate (minimum of 50%) in Free and Reduced School Lunch Program, rural areas, dental deserts). A clearly outlined methodology is needed (e.g., all schools meeting the criteria of >50% participation in FRLP, all Kindergarten, 2nd grade etc.). https://www.cde.ca.gov/ds/sh/cw/

3. The Program Plan should also take into consideration the following:
   a) 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.
   b) Develop referral criteria (e.g., all children needing dental sealants, having urgent or immediate care) and the protocol for linking children to a source of dental care.
   c) Create a network of dental care providers willing to accept referrals via case management/referral software.
   d) 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. the development of quality improvement strategies
   e) Establish performance measures and track progress in achieving targets. Consider quality improvement strategies.
   f) Required data must be submitted biannually (twice per year) to the OOH. Program data should reflect the program's ability to reach its goals and objectives.
4. Programs should select schools based on demonstrated need, as evidenced by high disease rates and/or unmet needs, and then obtain approval from the school administration and engage the clinicians early in the planning stage.

5. Programs should have an education and outreach component that involves children and parents, school administrators and staff, dental practitioners, and other influencers in the community. A partnership with a common goal of improving oral health and school attendance ensures success.

6. 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 (See School-Linked Dental Program: A Guide For Local Oral Health Programs).

REFERRAL MANAGEMENT TOOLS AND EQUIPMENT

Referral management includes referral tracking system to follow through to find out what happened after a referral is made, including:

- Referral acceptance: whether the receiving organization accepted the referral, or if not, why not.
- Patient contact: whether the receiving organization and the patient interacted, or if not, why not.
- Receipt of services: whether the patient received help from the organization; if yes, what kind; or if not, why not.
- Need resolution: whether the need that triggered the referral was resolved (or is in the process of being resolved), or if not, why not.

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. Applicants should obtain approval from Office of Oral Health before selecting a referral management system to purchase.

In California, the Department of Health Care Services has provided grant funding to develop the Los Angeles Dental Registry and Referral System (LADRRS).[i] 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 County[ii] 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.

Additionally, the Medical Dental Referral and Navigation (MDRAN) system currently utilized as a referral management system by Sacramento County may be modified for use by other jurisdictions for referral management and care coordination.

Other useful and affordable equipment to facilitate referrals and communicate dental care needs include intraoral cameras, software/hardware to support a teledentistry platform and is able to generate reports on specific criteria.

Following the award date, Office of Oral Health will host informational webinars and technical assistance sessions for LOHPs that apply for Component 1 funding prior to all software and hardware purchase deadlines.

GUIDELINES

Please refer to the following document from ASTDD for current guidelines.

https://www.astdd.org/docs/dental-screening-considerations-for-school-nurses-in-return-to-school.pdf

COMPONENT 2) SCHOOL-BASED PROGRAM MODEL: EQUIPMENT SUPPORT

PURPOSE

The purpose of the Children's Dental Disease Prevention Program (Equipment Support) is to expand evidence-based, school-based dental programs and best practice approaches that promote oral health by providing a one-time equipment purchase leading to sustainable community-clinical models. Evidence-based recommendations include school-based dental sealant delivery programs. School-based dental sealant programs are examples of a community-clinical linkage model where dental assessment, 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. According to research, programs that delivered sealants within school settings increased the proportion of students who received sealants and decreased occurrence of tooth decay.

Dental sealants are thin coatings that when painted on the chewing surfaces of the back teeth (molars) can prevent cavities (tooth decay) for many years. Sealants protect the chewing surfaces from cavities by covering them with a protective shield that blocks out germs and food. Once applied, sealants protect against 80% of cavities for 2 years and continue to protect against 50% of cavities for up to 4 years.[iii] Children aged 6 to 11 years without sealants have almost three times more first molar cavities than children with sealants. In addition, school sealant programs can be cost-saving within 2 years of placing sealants and delivering sealants to children at high risk for cavities can be cost-saving to the Medi-Cal Dental Program (Medicaid).[iv]

Sealants can be applied by a dentist, dental hygienist, or other qualified dental professional. This can be done in dental offices, mobile dental units or using portable dental equipment in community settings such as schools.

In addition, the number of children in grades Kindergarten through 6th grade receiving dental assessments will address the nature and extent of oral diseases in California. Oral health assessment activities provide a mechanism to routinely monitor state-specific oral health data and the impact of interventions within priority populations over time. These activities will improve the oral health of Californian children by decreasing dental caries experience, increasing the number of low-income children who received any preventive dental service during the past year, increase children (ages 6-9) with dental sealants, and improve the surveillance system at the jurisdiction level.

GOAL

The goal of this program is to increase access for children to receive dental sealants and other evidence-based preventive services by creating or expanding school-based dental programs to reduce the burden of oral diseases.

This goal shall be achieved by providing funding to purchase portable or mobile dental equipment and materials and supplies to start or expand on school-based dental programs.

The implementation of a School-based Program model should follow the protocol described in the manual *Seal America: The Prevention Invention*. This manual is designed to assist health professionals in launching and sustaining school-based dental sealant programs. In addition to offering a stepped approach for planning and implementing school-based dental sealant programs, this manual addresses issues related to referring students with unmet oral health needs to a dental clinic or office.

ASSURANCES

To be eligible for an award the applicants must provide the following assurances:

1. Must be a currently funded local oral health program
2. Submit a Program Plan from Document E template prior to completing equipment purchases. No longer than 10 pages and including the following elements:
   a) Staffing plans for managing and overseeing the project and activities. Description of organizational structure (particularly related to roles, responsibilities, and accountability for the project).
   b) Descriptive plans to identify and coordinate with new community partners. Applicant will identify anticipated support needed in establishing the

collaboration and demonstrate willingness to identify potential community collaborators.

c) Sustainability Plans, such as how this project will align with other funding streams, how it builds upon past work and supports future goals, and how enhanced LHD capability or new partnerships might be supported or leveraged beyond the funding period. The plan will include data collection, performance management, evaluation, leveraging of funds, institutionalizing services, sharing and reporting data.

d) Provide long-term coverage plans to reach all targeted population (build every year to increase the number of children being seen); and

   i. Plans to select schools based on demonstrated community need (e.g. high participation rate (minimum of 50%) in Free and Reduced School Lunch Program, rural areas, dental deserts). A clearly outlined methodology is needed (e.g., all schools meeting the criteria of >50% participation in FRLP, all Kindergarten, 2nd grade etc.). https://www.cde.ca.gov/ds/sh/cw/

3. The Program Plan should also take into consideration the following:
   a) 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.
   b) Develop referral criteria (e.g., all children needing dental sealants, having urgent or immediate care) and the protocol for linking children to a source of dental care.
   c) Establish performance measures and track progress in achieving targets. Consider quality improvement strategies.
   d) Required data must be submitted biannually (twice per year) to the OOH. Program data should reflect the program's ability to reach its goals and objectives.

4. Partner with providers to facilitate the delivery of sealants to a significant number of high-risk children with susceptible permanent molar teeth.[v]
   a) Identify appropriately licensed and registered clinician(s) who are willing to partner with the local oral health program to assume the responsibility for delivering dental sealants using a nationally accepted protocol.

   b) The program should serve a geographic area that has a high concentration of children at increased risk for tooth decay who meet its eligibility criteria. Such areas could include urban neighborhoods or rural counties.

c) The goal of the program is to reach children who would be considered high-risk based on their socioeconomic status and limited access to dental services. Generally, eligibility for the Free and Reduced-Cost School Lunch Program from the U.S. Department of Agriculture's National School Lunch Program has been used as a proxy for income and increased risk of untreated decay. Data has shown that children from low-income families are less likely to receive dental care than are children whose families do not meet the meal program criteria.

   i. Targeting schools based on the proportion of children who are eligible for the free or reduced-cost lunch program, is generally an acceptable approach. A minimum of 50% of students eligible for the free and reduced-cost meals is a common benchmark for school eligibility.
   ii. Obtain a high rate of signed parental consent forms. This is a critical component of successful school-based sealant programs. In general, signed consent form return rates are between 40 to 60%. Some of the reasons why parents may not sign consent forms are: a) failure of the child to bring the consent form home and give it to the parents, b) parent's lack of knowledge about the benefits of dental sealants, c) other health, social, cultural or family factors. To develop an effective program, the program administrators should try to reduce barriers and develop strategies to gain parental consent for students to receive dental sealants.

d) Prioritize underserved areas and populations.
   i. To increase impact and effectiveness, the program delivers services to proportionately large numbers of high-risk children with susceptible permanent molar teeth.
   ii. The program maintains a quality improvement system that includes technical quality (the sealants placed have a high rate of retention) and appropriateness (the children receiving sealants are at high risk for caries (tooth decay)).

5. Implement a referral management system to ensure needed dental treatment care is completed.
6. Re-screen children within approximately one year of initial sealant placement.
   a) Sealant retention and integrity should be checked, and newly erupted teeth can be sealed during the following school year if the child has not moved and if consent is received. Typically, children who received sealants in second grade are re-screened in third grade. Best practices

guidelines recommend sealant retention checks to be performed approximately one year from initial sealant placement.

b) One-year retention rates of sealants should be high, averaging at least 90%. See sample Sealant Retention Data Recording Form- Appendix 2.

c) A minimum of 10% sample of children who received sealants during the previous year need to be re-evaluated to ensure sealants are still intact and adequately cover the occlusal surfaces. See Random Sampling Instructions- Appendix 3.

7. Provide a long-term coverage plan to maximize the number of children served (build each year to increase the number of children served).
8. Include a sustainability plan.
   a) The program's sustainability can be demonstrated by having an ongoing plan for covering program expenses. This may include a mechanism for collecting Medi-Cal Dental (Medicaid) reimbursements, or recurring grant funding. Some programs may enter into creative partnerships with community groups or funders to sustain the program. For more information on sustainable school sealant programs refer to the Children's Dental Health Project (CDHP) "Dental Sealants: Proven to Prevent Tooth Decay" Report, pages 14-16.[vi] https://www.cdhp.org/resources/314-dental-sealants-proven-to-prevent-tooth-decay
   b) Collaborative partnerships are established to administer and sustain the program.

EQUIPMENT

Portable Equipment resources: see Appendix 4

Allowable equipment list:

- Dental unit

  The dental unit should contain high-speed evacuation and an air-and-water syringe with a self-contained water source and waste system. Many dental units also come equipped with an air compressor. Hand pieces are not necessary for school-based dental sealant programs since usage of unfilled dental sealants and toothbrush prophylaxes are supported by current evidence-based recommendations.[vii] Consideration should be given to the unit's weight, cost, ease of mobility, ease of use, ergonomic compatibility, maintenance requirements, and whether it has a stand. A tripod stand will prevent the unit from wobbling on uneven floors.

- Air compressor (if not included in the dental unit)

  If the dental unit purchased does not include an air compressor, a separate unit will need to be purchased. Dry, oil-free air is important for all dental procedures and is essential for the successful application and retention of dental sealants. Most compressors used in dental offices have dryers to ensure that the air used for dental procedures is free of moisture and oil.

  Some portable compressors use oil, and others are non-oil. Non-oil compressors are light and easy to move, but they can be noisy. It is best to place them as far away from the operatory as possible to reduce the noise level while the compressor is running. When possible, compressors can be located in an adjacent room (extra-long hoses that attach the compressor to the unit can be ordered).

- Dental chair

  The dental chair should be durable, stable, light, easily foldable, and adjustable in seat height and chair back tilt. It should also have a carrying case. School-based dental sealant program directors should check the chair's seat

height to make sure it could be adjusted to a level that allows staff to work comfortably. It may be necessary to purchase a heavier chair to obtain one that is ergonomically appropriate. The chair should also allow operators to work from either side, depending upon whether the individual is left- or right-handed. Adjustable headrests can be helpful.

- Dental light

  Bright dental lights are important for school-based dental sealant programs, because the lighting in the room where the program is located may be poor. The intensity of dental lights can be assessed by comparing the foot-candles of light they produce (a unit of measure of the intensity of light falling on a surface). Operator acceptance, cost, weight, adjustability, ease of bulb replacement, and cost of bulbs are also important considerations. The heat generated from the light is a consideration as well, since school-based dental sealant programs often are located in spaces without air conditioning.

  Three commonly used dental lights in school based-dental sealant programs are halogen, fiber optic, and light-emitting diode (LED).

- Sterilizer

  If a school-based dental sealant program decides to use reusable instruments, the program should use only sterilizers manufactured for medical or dental instruments and supplies to ensure proper sterilization. These can be acquired from dental-equipment suppliers. Different types of sterilizers are available: steam under pressure (also called autoclaves) and dry heat.

- Ultrasonic cleaner (if not using disposable instruments)

  All dental instruments should be decontaminated before they are sterilized. The ultrasonic cleaner is an effective tool for removing blood, saliva, and debris from dental materials before sterilization. Size, weight, and cost are all considerations in selecting an ultrasonic cleaner.

- Operator stools

  A seat usually without arms that has back and lumbar support. Four legs and canister wheels support the stool.

- Intra oral camera

Digital cameras that fit comfortably in the mouth and enable the dentist to show the patient an enlarged image of an individual tooth or an entire smile on a computer screen. The camera is located in the tip of the intraoral wand and transmits real-time video for the patient and dentist to review. The wand is covered with a disposable plastic sheath, similar to an electronic thermometer, to keep the procedure sterile and comfortable. Not only does this allow observation of what is really happening inside the mouth, it also allows the documentation of anything that is seen, and photos can be uploaded to a computer. Information can then be printed out to provide a hard copy picture for your records or for procedure verification by an insurance company. In addition, these photos can be retrieved at subsequent patient visits and used to compare the current state of their oral health to that which existed previously.

- Curing light

  A dental curing light is a piece of dental equipment that is used for polymerization of light cured resin-based composites. It can be used on different dental materials that are curable by light. The light used falls under the visible blue light spectrum. This light is delivered over a range of wavelengths and varies for each type of device. There are four basic types of dental curing light sources: tungsten halogen, LEDs, plasma arcs, and lasers. The two most common are halogen and LEDs.

GUIDELINES

Guidelines and Recommendations: In 2009, the Centers for Disease Control and Prevention (CDC) and a workgroup of recognized experts in sealant research, practice, and policy, and experts in caries assessment, prevention, and treatment published guidelines for sealant usage in school-based programs. These guidelines are based on current scientific evidence and provide guidance in planning, implementing, and evaluating school-based sealant programs (Table 2).

Table 2: Recommendations for School-based Sealant Programs

Topic	Recommendation
Indications for sealant placement	Seal sound and non-cavitated pit and fissure surfaces of posterior teeth, with first and second permanent molars receiving highest priority.
Tooth surface assessment	Differentiate cavitated and non-cavitated lesions. □ Unaided visual assessment is appropriate and adequate. □ Dry teeth prior to assessment with cotton rolls, gauze, or, when available, compressed air. □ An explorer may be used to "gently" confirm cavitation (i.e., breaks in the continuity of the surface); do not use a sharp explorer under force. □ Radiographs are unnecessary solely for sealant placement. □ Other diagnostic technologies are not required.
Sealant placement and evaluation	Clean the tooth surface. □ Toothbrush prophylaxis can be used. □ Additional surface preparation methods, such as air abrasion or enameloplasty, are not recommended. □ Use a fourhanded technique, when resources allow. □ Seal teeth of children even if follow-up cannot be ensured. □ Evaluate sealant retention within one year.

EXPECTATIONS

- Current, valid professional license for dental health professionals providing services.
- Best practice approaches. https://www.astdd.org/bestpractices/bpar-sealants-update-08-20-2014.pdf
- OSHA Bloodborne Pathogens Standard and Infection control standards. OSHA regulations are found at www.osha.gov.
- OSHA regulations and interpretations are available at: https://www.osha.gov/SLTC/dentistry/index.html and https://www.osha.gov/SLTC/bloodbornepathogens/index.html
- Centers for Disease Control and Prevention. Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health; March 2016. https://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care2.pdf
- Organization for Safety, Asepsis and Prevention (OSAP) Fact Sheet and Infection Control Checklist for Dental Settings Using Mobile Vans or Portable Dental Equipment from
  - https://cdn.ymaws.com/www.osap.org/resource/resmgr/checklists_new/2019osap_portable_mobile_che.pdf
  - https://phpa.health.maryland.gov/oralhealth/Documents/OSAPFACTSHEET.pdf

REQUEST FOR APPLICATION

Children's Dental Disease Prevention Program (Equipment Support and Referral Management/Care Coordination Tools)

APPLICATION INSTRUCTIONS

Applications for funding Components 1 and 2 must include:

A. Grantee Information Form (Document B)

B. An Optional Non-Binding Letter of Intent (LOI). The LOI is optional and not binding and those submitting a LOI are not obligated to submit an application. Due to timeline and approval constraints, entities may elect to not submit an LOI prior to submitting an application. OOH staff will be available for LOI technical assistance requests. All LOI submissions and technical assistance requests must be sent to DentalDirector@cdph.ca.gov. The LOI must include the following elements:

1. Completed LOI template on CDPH letterhead from Document D.
2. Signature by an authorized agency signatory or their official agent.
3. The name and number of the RFA under which the application will be submitted (i.e., Request for Application #21-10037).
4. Which funding Component the entity is applying for (Component 1: Referral Management/Care Coordination software, or Component 2: Equipment Support).

C. SCOPE OF WORK AND DELIVERABLES

The CDPH OHP shall grant additional funds to LHJ from Prop 56 for the purpose and goal of expanding evidence-based, school-based/school-linked dental programs and best practice approaches to promote oral health by providing a one-time equipment and/or software purchase leading to sustainable community-clinical models. The Equipment Support funding supports Local Oral Health Program (LOHP) efforts to address Objective 6 of the Work Plan and to implement evidence-based programs to achieve California Oral Health Plan Objectives. The funds will not be used for direct services.

LHJs shall establish or expand upon existing LOHP to include the following program activities related to oral health in their communities: A one-time portable dental equipment purchase to increase sustainable community-clinical models and/or execute the use of an electronic referral management tool to improve care coordination and communication among medical providers, dental providers, and care management teams providing oral health services for children.

To complete this portion of the grant application, LHJs will use Document F, Scope of Work and Deliverables document, to select the SOW Objectives and Deliverables for their LOHP by checking all the corresponding "Selected Deliverables" boxes for

each component they are applying for. The LHJ will select Component One (Objective 6.4) and/or Component Two (Objective 6.5). For example, if the LHJ is opting to apply for Component One, Objective 6.4, review and check each box corresponding with the deliverables of 6.4. If the LHJ is selecting both Components One and Two, please check all corresponding deliverable boxes for both components.

D. Submit a Budget Revision

i. The State Fiscal Year 2021/2022 budgets must be revised. **For new funding**: List items that $5,000 or less per item under the ***Other Costs*** line item. Items that cost $5,000 or more per item must be listed under the ***Equipment*** line item.

ii. Provide a detailed description including itemized list of all equipment, software (including licenses, training/onboarding) ,and materials/supplies with quantity, estimated purchase price, and justify the need for the proposed equipment, software (including licenses, training/onboarding) and material purchases on the justification tab of the budget.

iii. Incentives to support increased participation and return of consent forms, (highest participation by a class/school) will be considered. Incentives must follow guidelines for Behavior Modification Materials (BMM), Page 11.

APPENDICES

Appendix 1 RFA Sealant Funding Tiers
Appendix 2 Sample Sealant Retention Data Recording Form
Appendix 3 Random Sampling Instructions
Appendix 4 Sample Equipment Resources
Appendix 5 Infection Control Checklist
Appendix 6 Additional Resources
Appendix 7 References

APPLICATION DOCUMENTS

Exhibit A Scope of Work and Deliverables
Document A Application Checklist
Document B Grantee Information Form
Document C Detailed Budget Template
Document D Letter of Intent Template
Document F Scope of Work and Deliverables

Children's Dental Disease Prevention Program (Equipment Support and Referral Management/Care Coordination Tools) Funding Tiers

Local Oral Health Program	Tier	Contract / Grant No.	Total Based on Tier*
Alameda	2	17-10681	$ 50,000
Alpine	1	17-10682	$ 25,000
Amador	1	17-10448	$ 25,000
Berkeley, City of	1	17-10683	$ 25,000
Butte	2	17-10684	$ 50,000
Calaveras	1	17-10685	$ 25,000
Colusa	1	17-10686	$ 25,000
Contra Costa	2	17-10687	$ 50,000
Del Norte	1	17-10688	$ 25,000
El Dorado	1	17-10689	$ 25,000
Fresno	2	17-10690	$ 50,000
Glenn	1	17-10691	$ 25,000
Humboldt	1	17-10692	$ 25,000
Imperial	2	17-10693	$ 50,000
Kern	2	17-10695	$ 50,000
Kings	1	18-10213	$ 25,000
Lake	1	17-10696	$ 25,000
Lassen	1	17-10697	$ 25,000
Long Beach, City of	2	17-10699	$ 50,000
Los Angeles	4	17-10698	$ 200,000
Madera	1	17-10701	$ 25,000
Marin	1	17-10702	$ 25,000
Mariposa	1	17-10703	$ 25,000
Mendocino	1	17-10704	$ 25,000
Merced	2	17-10705	$ 50,000
Modoc	1	17-10706	$ 25,000
Mono	1	17-10707	$ 25,000
Monterey	2	17-10708	$ 50,000
Nevada	1	17-10710	$ 25,000
Orange	3	17-10711	$ 100,000
Pasadena, City of	1	17-10700	$ 25,000
Placer	1	17-10712	$ 25,000
Plumas	1	17-10713	$ 25,000
Riverside	3	17-10714	$ 100,000
Sacramento	2	17-10715	$ 50,000
San Benito	1	17-10716	$ 25,000
San Bernardino	3	17-10717	$ 100,000
San Diego	3	17-10718	$ 100,000
San Francisco	2	17-10719	$ 50,000
San Joaquin	2	17-10720	$ 50,000
San Luis Obispo	1	17-10721	$ 25,000
San Mateo	2	17-10722	$ 50,000
Santa Barbara	2	17-10723	$ 50,000
Santa Clara	2	17-10724	$ 50,000

Santa Cruz	2	17-10725	$ 50,000
Shasta	1	17-10726	$ 25,000
Sierra	1	18-10233	$ 25,000
Siskiyou	1	17-10728	$ 25,000
Solano	2	17-10729	$ 50,000
Sonoma	2	17-10730	$ 50,000
Stanislaus	2	17-10731	$ 50,000
Sutter	1	17-10732	$ 25,000
Tehama	1	17-10733	$ 25,000
Trinity	1	17-10734	$ 25,000
Tulare	2	17-10735	$ 50,000
Tuolumne	1	17-10737	$ 25,000
Ventura	2	17-10738	$ 50,000
Yolo	2	17-10739	$ 50,000
Yuba	1	17-10740	$ 25,000
			$ 2,500,000

*The award amount per program may increase depending on the number that apply. If one or more LOHP does not apply, those funds will be evenly distributed to accepted applicants with the total not to exceed $2.5 million.

Sample Sealant Retention Data Recording Form

SEALANT RETENTION DATA RECORDING FORM									
School Type:		**Retention Per Tooth:**							
1 for Elementary		1 Sealant intact, does not need replacement							
2 for Middle/ Junior High		2 Sealant partially retained, needs to be replaced							
		3 Sealant not intact, needs to be replaced							
		4 Tooth not sealed in program							
		TOOTH NUMBER							
School Type	**Student ID**	**2**	**3**	**14**	**15**	**18**	**19**	**30**	**31**

Random Sampling Instructions

Random sampling helps to accurately determine the retention rate. A random sample gives each student an equal chance to be selected, regardless of their characteristics, such as which school they go to or which provider served them.

Microsoft Excel can be used to generate a random sample, following these steps. If your sample will include both elementary school students and middle/junior high students, repeat the process for each school type separately.

1. Determine the list of all students eligible for retention checks. This list should broadly represent the students served, though for practical reasons, it may not be from all schools. For example, if your program is not returning to a school this year, you may exclude that school.

2. Put each eligible student ID number or develop a unique student ID number in column A of an Excel spreadsheet, in any order (alphabetical, by student number, etc.).

3. In column B, type =RAND() into the first cell.

4. Click, hold and drag the first cell to copy it down to every student. This produces a random number for each student.

5. Use the sort option to sort on column B. Use this sorted list to determine your student sample.

Sample Equipment Resources:

- https://dntlworks.com/
- https://aseptico.com/product-category/portable-dentistry/
- https://www.mchoralhealth.org/seal/PDFs/Step4_EquipmentCostWorksheet.pdf

Infection Control Checklist for Dental Settings Using Mobile Vans or Portable Dental Equipment

Infection Control Checklist from OSAP ©2010-2011
P.O. Box 6297 Annapolis, MD 21401
P: 410-571-0003
F: 410-571-0028
office@OSAP.org www.OSAP.org
https://c.ymcdn.com/sites/www.osap.org/resource/resmgr/Checklists/OSAP.checklist.portabledenta.pdf

Levels of Anticipated Contact between the dental health care professional (DHCP) or volunteer and the patient's mucous membranes, blood or saliva visibly contaminated with blood to determine the suggested elements for the infection control program. This checklist is designed to provide information for 3 levels of programs:

I. Anticipated contact with the patient's mucous membranes, blood or saliva visibly contaminated with blood.

II. Anticipated contact with the patient's mucous membranes but not with blood or saliva visibly contaminated with blood.

III. No anticipated contact with the patient's mucous membranes, blood, or saliva visibly contaminated with blood.

IMPORTANT DISCLAIMER: Although the Organization for Safety, Asepsis and Prevention (OSAP) believes that the information contained herein in accurate, it necessarily reflects OSAP's interpretation of CDC guidelines. Moreover, inadvertent errors may occur. Accordingly, OSAP makes no representations of any kind that its interpretations are always correct, complete or up-to-date and expressly disclaims any representation that this checklist satisfies any applicable standard of care. Users of this checklist are encouraged to read the Centers for Disease Control and Prevention guidelines and reach their own conclusions regarding any matter subject to interpretation. OSAP shall not be liable for any direct, indirect, incidental, special or consequential damages resulting from the user's reliance upon the material contained herein.

Infection Control Checklist for Dental Settings Using Mobile Vans or Portable Dental Equipment
Infection Control Checklist from OSAP ©2010-2011

ALL PROGRAMS SHOULD MEET THE MINIMUM REQUIREMENTS BASED ON THE CENTERS FOR DISEASE CONTROL AND PREVENTION'S (CDC) GUIDING PRINCIPLES OF INFECTION CONTROL

Level I	Level II	Level III	INFECTION CONTROL PRACTICE	Yes	No	Comments
X	X	X	**Infection Control Program Operating Procedures**			
			Is there a written infection control program?			
			Is there a designated person(s) responsible for program oversight?			
			Are there methods for monitoring and evaluating the program?			
			Is there a training program for dental health-care personnel (DHCP) (initial and ongoing) in infection control policies and practices?			
X	X	X	**Immunizations**			
			Are DHCP adequately immunized against vaccine-preventable diseases? Immunizations should meet or exceed federal, state and local guidelines. (May not be necessary for screenings)			
			Hepatitis B			
			Annual Influenza			
			Additional immunizations needed for program:			
X	X	X	**Hand Hygiene**			
			Are sinks available close to the area where care is provided?			
			If not, are alcohol-based hand sanitizers available?			
			Is staff properly trained in the use of alcohol hand rub products?			
X	X		**Personal Protective Equipment (PPE) (e.g., gloves, masks, protective eyewear, protective clothing)**			
			Is there a protocol that outlines what PPE are worn for which procedures?			
			Is PPE storage available and close to care?			
			Are facilities available to disinfect PPE (DHCP eyewear, patient eyewear, heavy duty utility gloves)?			
X	X	As necessary	**Environmental Surfaces: Clinical Contact Surfaces (e.g., light handles and countertops)**			
			Is there a list of what surfaces will be cleaned, disinfected or barrier protected and the process and products to be used?			
			If chemical disinfectants are used, is there a protocol for how they are managed, stored and disposed?			
X	X		**Housekeeping Surfaces (e.g., floors, walls)**			
			Is there a list of which housekeeping surfaces will need to be cleaned and disinfected and how often?			

Infection Control Checklist for Dental Settings Using Mobile Vans or Portable Dental Equipment
Infection Control Checklist from OSAP ©2010-2011

ALL PROGRAMS SHOULD MEET THE MINIMUM REQUIREMENTS BASED ON THE CENTERS FOR DISEASE CONTROL AND PREVENTION'S (CDC) GUIDING PRINCIPLES OF INFECTION CONTROL

Level I	Level II	Level III	INFECTION CONTROL PRACTICE	Yes	No	Comments
X	X		**Safe Handling of Sharp Instruments and Devices**			
			Are DHCP trained in the safe handling and management of sharps?			
			Are sharps containers safely located as close as possible to the user?			
			Is there a written protocol for transporting and disposing of sharps and sharps containers?			
X	X		**Management and Follow-Up of Occupational Exposures**			
			Is there a written procedures manual for post-exposure management?			
			Is there a designated person responsible for post-exposure management?			
			Is there a mechanism to document the exposure incident?			
			Where is the closest medical facility for wound care and post-exposure management?			
			Is there a mechanism to refer the source and DHCP for testing and follow-up?			
			Is there a mechanism for expert consultation by phone?			
			Are post-exposure prophylaxis medications readily available onsite, at an emergent care facility or nearby pharmacy?			
			Who is the responsible party for post-exposure care costs?			
			Does Workers' Compensation apply?			
			Have DHCP been trained in post-exposure management procedures?			
X	X	If used	**Reusable Patient Items**			
			Are reusable patient items processed onsite?			
			IF YES:			
			Is there a protocol for how and where contaminated instruments are cleaned and processed?			
X	X	If used	**Reusable Patient Items, continued**			
			Is there adequate space for the processing area to be divided into clean and dirty areas?			
			Has the person who is performing the processing been adequately trained?			
			Is the sterilizer(s) spore tested at least weekly?			
			Are protocols in place to handle positive tests?			
			Can dental equipment and patient items be safely stored and secured if left on site?			
			IF NO:			
			Is there an adequate inventory of instruments for the number of patients to be treated?			
			Are containers for holding or transporting contaminated instruments puncture-proof, secured, & labeled as a biohazard?			

Infection Control Checklist for Dental Settings Using Mobile Vans or Portable Dental Equipment
Infection Control Checklist from OSAP ©2010-2011

ALL PROGRAMS SHOULD MEET THE MINIMUM REQUIREMENTS BASED ON THE CENTERS FOR DISEASE CONTROL AND PREVENTION'S (CDC) GUIDING PRINCIPLES OF INFECTION CONTROL

Level I	Level II	Level III	INFECTION CONTROL PRACTICE	Yes	No	Comments
X	X	X	**Single-Use (Disposable) Items and Devices**			
			Is there a protocol for which single-use, disposable items will be used and how they will be disposed? (e.g., gloves, tongue depressors)			
			Are disposable items unit-dosed for each patient?			
			Are syringes that deliver sealant and composite material barrier-protected if they aren't single-use, disposable syringes?			
X	X	X	**Management of Dental Unit Water Quality**			
			Is there a protocol for how dental unit water quality will be maintained and monitored?			
X	X	X	**Management of Regulated and Non-Regulated Medical Waste**			
			Is there a protocol and designated person responsible for proper disposal of regulated waste (e.g., sharps containers, extracted teeth) and non-regulated waste (regular trash)?			

ADDITIONAL RESOURCES

1. Seal America https://www.mchoralhealth.org/seal/
2. CDC School-Based Dental Sealant Programs https://www.cdc.gov/OralHealth/dental_sealant_program/
3. NIDCR- Sealants https://www.nidcr.nih.gov/health-info/sealants
4. Maryland - Guidelines & Operations Manual https://phpa.health.maryland.gov/oralhealth/Documents/DentalSealantGuidelinesOperationsManual.pdf
5. Confidentiality in School-Based Health Services: Understanding HIPAA & FERPA http://www.nasbhc.org/atf/cf/%7BCD9949F2-2761-42FB-BC7A-CEE165C701D9%7D/HIPAA-FERPA%201.25.11.pdf
6. DHHS & Dept. of Education: FERPA & HIPAA https://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf
7. ADA- Pit-and-Fissure Sealants https://www.ada.org/en/member-center/oral-health-topics/dental-sealants
8. CDHP- Dental Sealants: Proven to Prevent Tooth Decay https://www.cdhp.org/resources/314-dental-sealants-proven-to-prevent-tooth-decay
9. Glossary of Dental Clinical and Administrative Terms from American Dental Association (ADA). https://www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-ter
10. When considering incentives, follow the guidelines in the Detailed Budget and Budget Justification Instructions, G. OTHER COSTS, Behavior Modification Materials (BMM), Page 11. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/Appendix%206-DetailedBudgetJustifInst92017_ADA.pdf

References

COMPONENT 1 REFERENCES

California Department of Public Health. California Oral Health Plan 2018-2028. Oral Health Program. www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/FINAL%20REDESIGNED%20COHP-Oral-Health-Plan-ADA.pdf. Accessed August 2020.

California Department of Public Health. Office of Oral Health. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/OralHealthProgram/LOHPs.aspx

Centers for Disease Control and Prevention. Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2016.

University of the Pacific Arthur Dugoni School of Dentistry. Virtual Dental Home System of Care. https://dental.pacific.edu/departments-and-groups/pacific-center-for-special-care/projects/virtual-dental-home-system-of-care

Barzel R, Holt K, eds. 2019. Promoting Oral Health in Schools: A Resource Guide (4th ed.). Washington, DC: National Maternal and Child Oral Health Resource Center.

ASTDD. Best Practice Approach. Improving Children's Oral Health through the Whole School, Whole Community, Whole Child (WSCC) Model. https://www.astdd.org/bestpractices/wscc-bpar-final-3-2017.pdf

ASTDD. School and Adolescent Oral Health Committee. https://www.astdd.org/school-and-adolescent-oral-health-committee/.

Centers for Disease Prevention and Control. Vital signs: dental sealant use and untreated tooth decay among U.S. school-aged children. MMWR. 2016;65(41):1141–1145. https://www.cdc.gov/mmwr/volumes/65/wr/mm6541e1.htm?s_cid=mm6541e1 w. Accessed August 2020.

Centers for Disease Control and Prevention. Dental Sealants Prevent Cavities—Vital Signs website. https://www.cdc.gov/vitalsigns/pdf/2016-10-vitalsigns.pdf [PDF – 2.37 MB]. Accessed August 2020.

Pew Charitable Trusts. States Stalled on Dental Sealant Programs, June 2015, 7-8, http://www.pewtrusts.org/~/media/assets/2015/04/dental_sealantreport_final.pdf.

Children's Dental Health Project. Report of the Sealant Work Group Recommendations & Products. April 2017. https://s3.amazonaws.com/cdhp/sealants/SWG+Report.pdf

Centers for Disease Control and Prevention. School-Based and School-Linked Dental Sealant Programs. https://www.cdc.gov/oralhealth/funded_programs/infrastructure/school.htm. Accessed January August 2020.

Fiore MC, Bailey WC, Cohen SJ. et al. *Treating Tobacco Use and Dependence*. A Clinical Practice Guideline. Rockville, Md: US Dept of Health and Human Services; 2000. AHRQ publication No. 00-0032.

Consensus Statement. A Clinical Practice Guideline for Treating Tobacco Use and Dependence A US Public Health Service Report. The Tobacco Use and Dependence Clinical Practice Guideline Panel, Staff, and Consortium Representatives. JAMA. 2000;283(24):3244-3254. doi:10.1001/jama.283.24.3244

More LA Smiles. A UCLA-led consortium funded by CA DHCS through the California Medi Cal 2020 Dental Transformation Initiative. https://ladrrs.org/

Healthier Kids Foundation. DentalFirst Program. https://hkidsf.org/our-programs/dentalfirst/

Centers for Disease Control and Prevention. (2019). Oral health surveillance report: Trends in dental caries and sealants, tooth retention, and edentulism, United States, 1999–2004 to 2011–2016. https://www.cdc.gov/oralhealth/publications/OHSR-2019-index.html

Barzel R, Holt K, eds. 2019. Promoting Oral Health in Schools: A Resource Guide (4th ed.). Washington, DC: National Maternal and Child Oral Health Resource Center.

COMPONENT 2 REFERENCES

Barzel R, Holt K, eds. 2019. Promoting Oral Health in Schools: A Resource Guide (4th ed.). Washington, DC: National Maternal and Child Oral Health Resource Center.

ASTDD. Best Practice Approach. Improving Children's Oral Health through the Whole School, Whole Community, Whole Child (WSCC) Model. https://www.astdd.org/bestpractices/wscc-bpar-final-3-2017.pdf

ASTDD. School and Adolescent Oral Health Committee. https://www.astdd.org/school-and-adolescent-oral-health-committee/.

Pew Charitable Trusts. States Stalled on Dental Sealant Programs, June 2015, 7-8, http://www.pewtrusts.org/~/media/assets/2015/04/dental_sealantreport_final.pdf.

Children’s Dental Health Project. Report of the Sealant Work Group Recommendations & Products. April 2017. https://s3.amazonaws.com/cdhp/sealants/SWG+Report.pdf

More LA Smiles. A UCLA-led consortium funded by CA DHCS through the California Medi Cal 2020 Dental Transformation Initiative. https://ladrrs.org/

Healthier Kids Foundation. DentalFirst Program. https://hkidsf.org/our-programs/dentalfirst/

Community Preventive Services Task Force. Preventing Dental Caries: School-Based Dental Sealant Delivery Programs website. www.thecommunityguide.org/oral/schoolsealants.htmlexternal icon. Accessed October 12, 2016.

Griffin SO, Naavaal S, Scherrer CR, Patel M, Chattopadhyay S. Evaluation of school-based dental sealant programs: an updated Community Guide systematic economic review. Am J Prev Med. 2017;52(3):407-415.

ASTDD Best Practices Committee. Best practice approach: school-based dental sealant programs [monograph on the Internet]. Reno, NV: Association of State and Territorial Dental Directors; 2014 August 18.16p. Available from: http://www.astdd.org.

Children's Dental Health Project. Dental Sealants: Proven to Prevent Tooth Decay. A Look at Issues Impacting the Delivery of State and Local School-Based Sealant Programs May 2014. Available from: https://www.cdhp.org/resources/314-dental-sealants-proven-to-prevent-tooth-decay

Wright JT, Tampi MP, Graham L, Estrich C, Crall, JJ, Fontana M, Gillette EJ, Novy BB, Dhar V, Donly K, Hewlett ER, Quinonez RB, Chaffin J, Crespin M, Iafolla T, Siegal MD, Carrasco-Labra A. 2016. Evidence-based clinical practice guidelines for the use of pit-and-fissure sealants: A report of the American Dental Association and the American Academy of Pediatric Dentistry. **Journal of the American Dental Association** 147(8):672–682.Gooch, BF, et al. Nov. 2009. Preventing dental caries through school-based sealant programs: Updated recommendations and reviews of evidence. **Journal of the American Dental Association** 140(11):1356-1365.