Expanding Oral Health Services in School-Based Health Centers

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WVSBHA
MISSION

Advancing comprehensive health services through responsive policies, practices, and partnerships
The West Virginia School-Based Health Assembly is working to promote health services in schools to help students be healthy learners.

- Statewide membership organization
- Formed in 1995
- Founding member of NASBHC
- 49 SBHCs serving 61 schools in 24 counties in WV
Tooth decay is the single most common chronic childhood disease
• 5 times more common than asthma
• 7 times more common than hay fever

More than 51 million school hours are lost each year due to dental related illness.

According to Surgeon Generals Report, 2000

50% of decay in low income children goes untreated.
Barriers in Access to Dental Health Services

- Lack of awareness of seriousness of oral health
- Lack of or insufficient dental insurance
- Lack of transportation
- Uncompensated time from work
- Limited income
- Low community-to-private provider ratio
- Dentist non-participation with Medicaid/CHIP
- Low Medicaid program reimbursement rates for dental services

Cost and Utilization of Dental Services

- $60,000 billion national dental expenditure for fiscal year 2000
- 500 million average number of dental visits in the U.S. annually
- 39 million number dental service beneficiaries through Medicaid and CHIP
- 19% percent of total Medicaid & CHIP beneficiaries who received preventive dental services

“One proven strategy for reaching children at high-risk for dental disease is providing oral and dental health services in school-based health centers… supporting linkages with health care professionals and other dental partners in the community”

School Based Oral/Dental Health Program Implementation

A Step-by-Step Process

Infrastructure Development
- Coalitions & Stakeholders
- Planning process
- Management structure

Prior to start of school year

Policy Context
- Flexibility
- Motivation
- Needs assessment
- Oral/dental service selection
- Resource considerations
- Staffing availability
- Equipment availability
- Supplies/electrical units
- Outcomes measures
- Quality assessment
- Referral networks
- Follow-up after referral

Outcomes/ Objectives
- State/Local priorities
- School priorities
- Goals/mission
- Short-term/long-term

Program Design
- Parent/Child education
- Staff training
- On-going needs assessment
- Local/ state regulations
- State licensure requirements
- Medicaid provisions
- Other dental insurance provisions

Program Implementation
- Parent/Child education
- Staff training
- On-going needs assessment

Evaluation
- Of goals
- Of mission
- Of outcomes
- Of clinical services
- Chart audits
- Program modification

Characteristics for success:
- Flexibility
- Motivation

Slide copied from “Considerations for Program Development”, Erica M. Allen May 2001
School-Based Health Centers, in Partnership with Community Dental Providers, Can:

- Enhance education
- Enhance dental service
- Eliminate barriers to dental care

A Proposed School-Based Oral/Dental Health Service Scheme

1. Risk Assessment
2. Establish Periodicity

Family + Child

3. Diagnosis/Treatment
4. Guidance/Referral
5. Education

- Individual/Parent
- Medical or Dental Professional
- EPSDT

Considerations in Implementing a School-Based Dental Program

✓ Staff recruitment and retention
✓ Sustainability – establishing a collaborative business plan
✓ Electrical capacity – “dedicated line” for dental equipment
✓ Potential use of portable equipment – (California and Oregon vendors)
✓ Temperature sensitive equipment, AC/fans required
✓ Availability of X-Ray machine – if unavailable, then referral service crucial
✓ Emphasis on skills training for long-term oral health maintenance
✓ Securing parent involvement for follow-up and family awareness
✓ Securing support from dental school and oral health organizations
✓ Securing support from local health providers involved in providing dental care to underserved populations
Encouraging Private Dentist Participation

- Emphasize that school-based dental programs are not competitive
- Involve private dental providers in planning for greater cooperation
- Analysis of community-to-private provider ratio:
  - Number of dental providers available to Medicaid & CHIP beneficiaries
  - Number/Percent offices open to new patients
- Private provider acknowledgement of inability to serve all children
  - Provides rationale/support for school-based services
  - More likely to support referrals for preventive/restorative care
- Capacity to follow-up in school-linked programs is crucial
  - Requires referral, annual check-up, and re-assessment

Adapted from text of: William Mercer Inc. (April, 2001). Geographic Managed Care Dental Program Evaluation: Executive Summary prepared for the Medi-Cal Policy Institute
“You cannot educate a child who is not healthy, and you cannot keep a child healthy who is not educated.”

~ Jocelyn Elders, Former US Surgeon General