

# Issue BRIEF



## Engaging Schools to Support Better Oral Health for Low-Income Children

### In brief:

Inadequate access to oral health care and associated dental disease are significant problems for low-income children and adolescents. This technical assistance brief describes the role that school-based oral health programs can play in addressing this critical health challenge and outlines opportunities for state Medicaid agencies and public health programs to support school-based efforts to improve oral health among students.

**Background.** Our nation's schools represent an opportune channel for reaching children and their families with public health messaging, education, and services to advance oral health.<sup>1</sup> Incorporating oral health education and service delivery into the curricula and support services offered by schools—particularly those serving a large percentage of low-income children—can be a cost-effective way to improve children's oral health.<sup>2</sup>

The need for this is critical among children and adolescents from low-income families, who have more than twice as much untreated tooth decay (25 percent) than those from higher-income households (11 percent).<sup>3</sup> This disparity is linked to inadequate access to dental services, low rates of oral health literacy, and logistical challenges to visiting a dental office. Although the Medicaid benefit for children and adolescents (also known as the Early and Periodic Screening, Diagnostic and Treatment [EPSDT] benefit) fully covers comprehensive dental services, fewer than half of children ages 1 to 20 enrolled in Medicaid or the Children's Health Insurance Program (CHIP) received a preventive dental service in 2014. Further, only 16 percent of children ages 6 to 9 received a dental sealant on a permanent molar tooth, one of the most effective methods for reducing dental disease in children. Unfortunately, rates of dental sealant application are significantly lower for children and adolescents living below 200 percent of the poverty level than for those from higher-income families.<sup>4</sup>

To improve utilization of these covered oral health care services by low-income families, the Centers for Medicare & Medicaid Services (CMS) launched a national Oral Health Initiative (OHI) in 2010, asking each state to:

### CMS Oral Health Initiative Goals

1. Increase the proportion of children ages 1 to 20 enrolled in Medicaid or CHIP for at least 90 continuous days who receive any preventive dental service by 10 percentage points between federal fiscal year (FFY) 2011 and FFY 2015.
2. Increase the proportion of children ages 6 to 9 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a dental sealant on a permanent molar tooth by 10 percentage points (target date to be determined).



As part of the OHI, CMS requested that each state develop a State Oral Health Action Plan (SOHAP) describing its approach to meeting the OHI goals. Through its OHI Learning Collaborative (OHILC), CMS is providing technical assistance in a mutual learning environment to five state Medicaid agency and stakeholder teams (from Florida, Kansas, Michigan, Utah, and Washington, DC)—some of which include the state’s Department of Health—as they create these plans. As states consider how to achieve these goals (especially the second one), there has been renewed interest in exploring interventions that engage schools in improving children’s oral health.

This technical assistance brief discusses how states can pursue school-based strategies to improve the oral health of children, particularly those in low-income families. It describes (1) an overview of school-based oral health programs; (2) how to engage school decision makers and other key stakeholders in advancing school-based oral health; and (3) challenges and considerations of working to engage schools, students, and their families in oral health. The brief draws from the experiences of states across the country, including those participating in the CMS OHILC.

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## **I. OVERVIEW OF SCHOOL-BASED ORAL HEALTH PROGRAMS**

Schools are a convenient place to deliver oral, primary, and behavioral health care services, typically through school-based health centers (SBHCs) and occasionally through stand-alone programs. Nearly 2,000 SBHCs operate nationwide, serving approximately 2 million students annually;<sup>5</sup> up to 16 percent of SBHCs have oral health providers on site.<sup>6</sup>

In school-based oral health programs, dental services are delivered, billed, and funded in the same way they would be in a provider’s office or mobile site. These programs are often situated within SBHCs, or can stand on their own to serve a student population. Expanding these programs represents a promising opportunity: the Centers for Disease Control and Prevention (CDC) estimates that if half of the children at high risk for dental caries participated in school sealant programs, more than half of their tooth decay could be prevented.<sup>7</sup> Although about 60 percent of state Medicaid programs accept billing and reimburse for dental services in school-based programs, availability of these programs within and across states is inconsistent and inadequate.<sup>8,9</sup>

School-based oral health programs—whether stand-alone or embedded in SBHCs—may include the provision of:

- Oral health screening
- Dental sealants, often by dental hygienists or dental therapists
- Fluoride treatments
- Oral prophylaxis
- Dental treatment services
- Oral health education for students, either one-on-one in tandem with service delivery, or in a group setting such as a classroom or assembly
- Education for parents, such as during back-to-school night, at other school-based events, or via email, mail, or newsletters

The appropriate design of a school-based or school-linked oral health program will depend on a number of factors, including (1) the school community’s educational needs and learning preferences; (2) cultural considerations of enrolled families; (3) the content of the school’s existing classroom and health class curricula; (4) support available from the state Medicaid agency, department of health, dental or health plans, local community-based organizations, and other stakeholders; and (5) other state or local opportunities and barriers to oral health.



## Example of a School-Based Sealant Program: SEAL! Michigan<sup>10</sup>

Michigan, a participant in the OHILC, has offered its school-based oral health program, SEAL! Michigan, since 2007. The program provides dental sealants, fluoride varnish, and oral health education to students in Michigan schools. During the 2012–2013 school year, the program served 138 schools, screened 4,700 students, provided 16,700 sealants, and delivered 4,200 fluoride applications. Surveys in 2006 and 2010 showed that the percentage of 3rd grade children with dental sealants rose from 23.3 to 26.4 percent during that period, approaching the Healthy People 2020 target of 28.1 percent.

Two key factors enabled SEAL! Michigan to grow. First, passage of the Public Acts of 2006 (Act No. 161) allowed dental hygienists to provide preventive dental hygiene services, including dental sealants, to underserved patients without a dentist on site. Second, Michigan received a cooperative agreement from the CDC Division of Oral Health,<sup>11</sup> providing grant funding to build infrastructure for preventive programs, including SEAL! Michigan.

To be eligible to be a SEAL! Michigan site, more than half of a school's population must participate in the free and reduced-price lunch program, which is considered a proxy for low-income status. SEAL! Michigan programs serve all 1st, 2nd, 6th, and 7th grade students who return a completed parental permission slip. Services are provided at no charge to the family, though if the child has dental insurance (including Medicaid/CHIP), the programs must bill for services (providing funding for the programs).

### SEAL! MICHIGAN

#### Other key elements include:<sup>12</sup>

- **Providing** a small incentive to students (such as tooth-shaped silly bands or a spinning toothbrush) to return permission slips, and to teachers (such as a \$10 gift card) for encouraging students to do so. The state reports that these incentives have drastically improved student participation.
- **Helping** each student establish a dental home to provide ongoing and comprehensive dental care<sup>13</sup> within 20 miles of the school.
- **Following up** with the parents, school, teacher, school nurse, and/or student if the student needs urgent dental care, until the needed restorative care is received.
- **Checking** retention on 20 percent of the students who receive sealants, ideally 6 to 12 months after service delivery, and providing any needed replacements or repairs.
- **Submitting** tracking data to the Michigan Department of Community Health (MDCH).
- **Educating** parents and students about oral health (such as group or one-on-one education when a child is screened); many programs give students pre- and post-tests of knowledge to monitor whether this education is effective.

Once a school begins its SEAL! Michigan program, MDCH's statewide dental sealant coordinator helps school-based program staff with technology, materials development, and problem solving, and leads workshops to provide program updates and training, and encourage peer-to-peer networking. The coordinator visits each site quarterly when students are receiving dental sealants, to review the program's successes and concerns, program data, work plans, and budget.



Early program lessons identified by the MDCH include:

- Cost-effectiveness typically does not occur until a program's second year because a new program needs time to address its unique challenges.
- Incentivizing teachers to urge students to participate is crucial to program success.
- Program staff benefit from networking opportunities to share experiences and lessons.
- Programs should be evaluated regularly to help make adjustments to better meet the needs of schools, teachers, parents, and students.
- Operating a sealant program booth at back-to-school nights can facilitate collecting signed permission slips from parents and reduce the need to send slips home with students.

## II. ENGAGING SCHOOL DECISION MAKERS AND OTHER STAKEHOLDERS TO ADVANCE SCHOOL-BASED ORAL HEALTH

States considering the development or expansion of school-based oral health programs should engage a wide range of stakeholders. To identify relevant individuals or organizations, it is helpful to ask:<sup>14</sup>

- **What are the objectives of stakeholder engagement?** The targets of engagement will depend on what the state is trying to achieve (for example, organizational buy-in, political will, resource commitments, or community support). There often will be multiple objectives, requiring the engagement of a variety of stakeholders with diverse areas of expertise such as knowledge of (1) the community's cultural needs and nuances, (2) health promotion programs or strategies that have worked or failed previously in the particular school setting, and (3) particular oral health care access challenges in the local community.
- **What is each stakeholder's level of influence, potential contribution(s), and necessity of involvement in the program objectives?** Answers to these questions can help determine how much time and effort to spend engaging each stakeholder, to maximize the use of resources and the likelihood of success.

Commonly identified stakeholders to advance school-based oral health programs include school superintendents, school nurses, classroom and health teachers, local primary care and oral health providers, parent liaisons in schools, community-based organizations, state and local agencies that serve or support low-income populations, state legislators, and health and dental plans.

It is important for states to consider what approaches to engagement are likely to be most effective for each stakeholder group, entity, or individual. The following are potential activities, including examples from states in the OHILC:

- Communicate through annual meetings, newsletters, or other forums of state or national associations serving school superintendents, teachers, or nurses. For example, Kansas is planning workshops on opportunities to participate in school-based preventive programs at meetings of the Kansas School Nurse Association and the Kansas Association of Local Health Departments.
- Provide schools with educational materials to share with teachers and families, and hold webinars for superintendents and school nurses on the value of having a school-based oral health program.
- Equip community-based organizations or state or local agencies that support low-income families with standardized school-based services permission forms to ease participation, as Kansas has done. Many school districts and national dental service programs have examples of such forms available online.<sup>15</sup>
- Provide email or newsletter updates to low-income families through Medicaid health and dental plans to educate them on the importance of oral health. Florida is pursuing this approach.



- Meet with state legislators to secure support for expanded scope of practice and/or mobile dentistry laws that will increase the number of oral health providers eligible to deliver services in school-based settings.
- Conduct a “town hall” or other group meetings to share the benefits of the program with the community and answer questions in an open forum.

### III. CHALLENGES AND CONSIDERATIONS IN WORKING TO ENGAGE SCHOOLS, STUDENTS, AND FAMILIES IN ORAL HEALTH

Anticipating potential challenges at the outset of planning a school-based oral health program can help states and program leaders address issues proactively. Common challenges that can arise, and corresponding options to explore, include:<sup>16</sup>

- **Obtaining parental consent.** Consider ways to facilitate the process, who can implement them, and whether to adopt incentives.
- **Providing follow-up for students with urgent or acute oral health needs.** Explore available staff resources and local dental practices willing to accept students with urgent or acute oral health needs identified by programs. (Ohio found that typically 30 to 50 percent of those screened have such needs.)<sup>17</sup>
- **Overcoming limitations in scope of practice laws that prevent registered dental hygienists and other licensed and qualified dental practitioners from providing services in school-based settings without either a dentist on site or a dentist’s prior exam.** Consider the legislative climate around the dental workforce, and which stakeholders might help secure changes in the law.
- **Reluctance to contract with school-based oral health entities.** Managed care organizations (MCOs) are not required to enroll all qualified providers, but instead limit their provider networks. Accordingly, it is important to educate MCOs about the benefits of including school-based dental programs in their networks.
- **Difficulty of contracting with multiple MCOs.** If multiple plan choices exist, school-based programs will have to contract with multiple MCOs in order to bill for services rendered to all children. To facilitate this, approach plans when setting up a school-based program to explore how the program can join managed care networks, and communicate the process to the participating schools at the outset.
- **Engaging support from local schools and school districts that favor “local control” and may be wary of state-level interventions.** Consider developing messages and a program design that reinforce the school’s control over a proposed intervention, and that are tailored to the nuances of the district’s education system.
- **Securing Medicaid reimbursement for school-based service delivery.** Understand current limitations, and whether there are opportunities for improvements that may affect provider participation, the volume of oral health services delivered, and program sustainability. Factors driving this challenge vary by state, and among others may include (1) a requirement that a dentist examine a child before a community- or school-based program can be reimbursed for services, (2) state laws preventing dental hygienists from billing Medicaid, (3) a requirement that parents be present for any dental services delivered as a condition of reimbursement.<sup>18</sup>

It is also important to keep in mind that school-based oral health or dental sealant programs are not dental homes. Although the services students receive in these programs advance their oral health, a dental home is best positioned to provide ongoing, continuous care for a child’s evolving oral health needs.<sup>19</sup>



## IV. CONCLUSION

School-based oral health efforts have tremendous potential to improve oral health care access—and the subsequent oral health—of low-income children. By providing education, service delivery, and care referrals in a site that families already frequent, and often trust, school-based oral health programs meet children and families “where they are.” These school-based efforts can reach a large number of children at high risk for dental disease and in need of dental care, and put them on the path to lifelong oral health.

## ENDNOTES

- <sup>1</sup> National Center for Education Statistics. “Schools and Staffing Survey: Average Number of Hours in the School Day and Average Number of Days in the School Year for Public Schools, by State: 2007–08.” Available at: [https://nces.ed.gov/surveys/sass/tables/sass0708\\_035\\_s1s.asp](https://nces.ed.gov/surveys/sass/tables/sass0708_035_s1s.asp).
- <sup>2</sup> Association of State and Territorial Dental Directors (ASTDD). “School Dental Sealant Programs Policy Statement.” December 15, 2010. Available at: <http://www.astdd.org/school-and-adolescent-oral-health-committee/>.
- <sup>3</sup> B.A. Dye, L. Xianfen, and E.D. Beltrán-Aguilar. “Selected Oral Health Indicators in the United States 2005–2008.” NCHS Data Brief, no. 96. Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control and Prevention, 2012.
- <sup>4</sup> Ibid.
- <sup>5</sup> B.L. Smith. “Expanding School-Based Care.” *American Psychological Association*, vol. 44, no. 8, September 2013. Available at: <http://www.apa.org/monitor/2013/09/school-care.aspx>.
- <sup>6</sup> School-Based Health Alliance. “National Census of School-Based Health Centers: 2010–11 Census Report of School-Based Health Centers.” Available at: <http://www.sbh4all.org/school-health-care/national-census-of-school-based-health-centers/>.
- <sup>7</sup> U.S. Department of Health and Human Services, CDC. “Data 2010: Healthy People 2010 Database.” Atlanta, GA: CDC, 2009. Available at: <http://wonder.cdc.gov/data2010/focus.htm>.
- <sup>8</sup> R. Feild and M. Dellapenna. “State Medicaid and CHIP Program Support of Sustainable Oral Health Care Delivery Models in Schools and Community-Based Settings.” Based on Centers for Medicare & Medicaid Services and Medicaid CHIP State Dental Association Learning Lab Series, May 14, 2014 (slide 11). Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/learninglabslides7.pdf>.
- <sup>9</sup> Of those states that reimburse for dental services in a school-based or school-linked setting, 73 percent reimburse *dentists*, 43 percent reimburse *hygienists*, and 18 percent reimburse “*others*” for dental service delivery at these sites. Ibid. (slide 13).
- <sup>10</sup> Adapted from Association of State and Territorial Dental Directors (ASTDD). “SEAL! Michigan School-Based Dental Sealant Program.” Available at: <http://www.astdd.org/state-activities-descriptive-summaries/?id=245>.
- <sup>11</sup> Centers for Disease Control and Prevention. “CDC Funded States: Cooperative Agreements.” Available at: [http://www.cdc.gov/oralhealth/state\\_programs/cooperative\\_agreements/](http://www.cdc.gov/oralhealth/state_programs/cooperative_agreements/).
- <sup>12</sup> Not all of the items listed, including student financial incentives and parent/student education can be billed to Medicaid. They must be supported by state-only funds, grant funds, or other sources.
- <sup>13</sup> A dental home is the “ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.” American Academy of Pediatric Dentistry. Available at: [http://www.aapd.org/media/Policies\\_Guidelines/D\\_DentalHome.pdf](http://www.aapd.org/media/Policies_Guidelines/D_DentalHome.pdf).



- <sup>14</sup> Adapted from Business for Social Responsibility. “Back to Basics: How to Make Stakeholder Engagement Meaningful for Your Company.” 2012. Available at: [http://www.bsr.org/reports/BSR\\_Five-Step\\_Guide\\_to\\_Stakeholder\\_Engagement.pdf](http://www.bsr.org/reports/BSR_Five-Step_Guide_to_Stakeholder_Engagement.pdf).
- <sup>15</sup> For an example of a parental permission form that encompasses a range of medical and oral health care services, see: <http://www.cttech.org/cheneyschoolnurse/documents/Medical.Dental.EnrollmentForm.pdf>. For examples of permission forms for school-based dental services only, visit: <http://mchoralhealth.org/seal/step6.html#consent>, or [http://www.pdc.k12.wi.us/cms\\_files/resources/Dental%20Permission%20Form.pdf](http://www.pdc.k12.wi.us/cms_files/resources/Dental%20Permission%20Form.pdf).
- <sup>16</sup> Taken in part from D. Behrens, School-Based Health Alliance. “Integrating Oral Health into Schools.” Presentation to CMS Oral Health Initiative Learning Collaborative, May 7, 2015.
- <sup>17</sup> Ohio Dental Clinics. “School-Based Dental Sealant Programs: Training Module.” Available at: [http://ohiodentalclinics.com/curricula/sealant/mod1\\_1\\_1.html](http://ohiodentalclinics.com/curricula/sealant/mod1_1_1.html).
- <sup>18</sup> The Pew Charitable Trusts. “States Stalled on Dental Sealant Programs.” April 2015. Available at: [http://www.pewtrusts.org/~media/Assets/2015/04/Dental\\_SealantReport\\_Final.pdf](http://www.pewtrusts.org/~media/Assets/2015/04/Dental_SealantReport_Final.pdf).
- <sup>19</sup> Taken in part from D. Behrens, *op cit*.

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