Improving Oral Health through School-Based Health Centers

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National Assembly on School-Based Health Care

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- **Mission:** improve health status of children and youth by advancing/advocating for school-based health centers (SBHCs)
- **Strategy**: advocacy, technical assistance and training

What is a School-Based Health Center?

- "Doctors office in a school" created through a partnerships between a schools, health organizations, communities and families
- Sponsored by a health agency (community health center, local health department, hospital, or 501 C3 agency), or a school system
- provide on-site comprehensive primary care and mental health
- staffed by an interdisciplinary team of professionals

School-Based Health Centers, 2007-08

The Problem: Childhood Caries

- Dental caries prevalence data quantifies inequalities and to target high-risk groups.
- For children aged 2-5 (primary dentition):
  - ✓ **75% of dental caries is found in 8.1% of the population**
- For children 6 years and older (permanent dentition):
  - ✓ **75% of dental caries is found in 33% of the population**

Source: Maceck, M, et al, JPHD, V 64, Issue 1, p 20-25, March 2004

Lack of Access to Oral Health Services:

- Children are 2.6 times more likely to have medical coverage than dental coverage
- Only 20-30% of Medicaid-eligible children receive preventive health care
- Only 1/3 of 20 million children covered by Medicaid/ SCHIP received any dental care in 2007
- An estimated 6.5 million Medicaid-eligible children 2-18 years of age had untreated tooth decay and more than 5 percent had urgent conditions (fractures, chronic pain)
- 1.1 million children 2-18 years of age had conditions that warranted seeing a dentist within two weeks

Sad Reality

- 50% of tooth decay in low income children goes untreated
- 1 in 8 children never see the dentist
- >50% of children with private insurance received dental care in the preceding year (GAO 2007).
- Compared to those with private insurance, children on Medicaid/SCHIP were more than 4 times as likely to be in need of urgent dental care
- GAO estimated that in 2005, 724,000 2-18 year olds could not get needed dental care.

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Other Consequences of Tooth Decay

- Lost school days (51 X 10^6 hrs -1999)
- If in school with tooth decay and associated pain, poor school performance, disruptive behavior affecting other's learning
- Low income children missed 12 times more days than children from more affluent families
- Discrimination due to appearance of mouth (don't look as intelligent/don't trust) *(M. Willis, et. al, perceptual and Motor Skills 106 (2008).*
- Loss of wages and potential loss of job. 164 million hours of work missed/year because of dental issues. *(CDC Div of Oral Health 12/2006)*
- High cost of hospital outpatient surgery ($12,000/case)
- Emergency room visits in one year in Twin Cities (>10,000 ER visits for dental problems at a cost of > $4.7 million dollars (*E. Davis, A. Deinard, and E. Maiga, JPHD (Spring 2010): 1-6.)*
- Without care, oral infection can lead to death from sepsis

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Interdisciplinary Approach to Oral Health

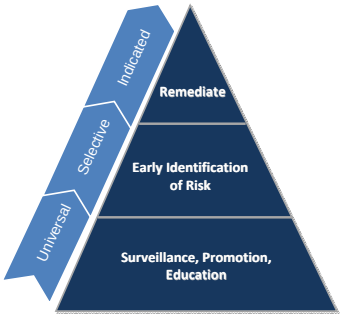
- Health care providers are first line of defense in preventing and treating dental disease
  - ✓ More contacts with kids and their families
  - ✓ Can provide anticipatory guidance, promote health literacy and good oral health habits, identify disease, counsel and provide fluoride varnish
  - ✓ Integrating oral health into SBHC is the opportunity to provide care to the whole child – including their mouth
- Must ensure that there is continuity of care
  - ✓ Need to be linked to dental providers in the community

Why Schools?

"Go where the money is…
and go there often."

WILLIE SUTTON'S MAXIM

Oral Health in Schools: Prevention Model



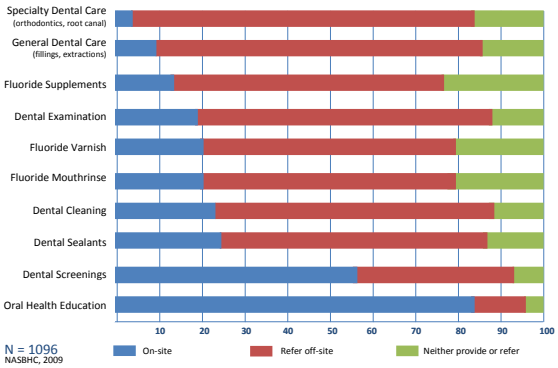
Oral Health in Schools

Universal	Selective	Indicated
School population	Subgroup with identified risk	Signs of early disease
• Surveillance/screening for risk • Oral health promotion in curriculum • School-wide oral health hygiene campaigns • Consumer education • Safety/injury prevention • Toothbrush/paste access	• Assessment • Anticipatory guidance • Counseling • Preventive services ✓ Sealants ✓ Fluoride applications • Case management and advocacy	• Refer for dx/tx • Ensure insurance coverage • Arrange transportation • Build provider network • Track/monitor referral • Engage in policy advocacy • On-site: fixed, portable, mobile

Oral Health in Schools

Universal	Selective	Indicated
School population	Subgroup with identified risk	Signs of early disease
• 75% of elementary schools taught dental/oral health in at least 1 class o 55% middle o 55% high • 40% of elementary schools conduct oral health screenings o 24% middle o 17% high	• 54% of schools identified/referred for oral health problems • 11% of schools provide fluoride rinses by health services • Another 8% by outside provider • 6% of schools provided dental sealants on site	• No data for US schools

Oral Health Services Provided in SBHCs



Considerations and Challenges

- School engagement
- Parent engagement/consent
- Dental community engagement
- Appropriate staffing/staff development
- Scope of Practice issues
- Coordinating with school around how/when to access services
- Finding/retro-fitting space for preventive and treatment services
- Specialized equipment and supplies
- Data management and sharing

Compounding the problem, physicians, nurses and other health care professionals generally have not been educated or trained in providing basic oral health care, including the ability to recognize oral diseases or teach patients about self care.

Institute of Medicine's Advancing Oral Health in America, April 2011

Reinforcing Oral Health in SBHCs: Practice

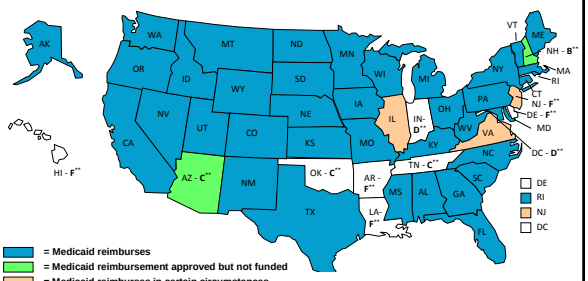
- Train SBHC primary care providers
- Focus on fluoride varnish- easy to apply and is reimbursed in some states
- Focus on strengthening the referral network for children with dental disease
- Interest at HRSA in supporting the provision of oral health services in SBHCs

Reinforcing Oral Health in SBHCs: Policy and Advocacy

- Support the Children's Dental Health Project and Pew Center for the States on policy and advocacy work
- Partner state SBHC associations with state-based oral health coalitions to strengthen oral health advocacy agenda
- Oral Health Opportunities for School Based Health Centers
  - ✓ http://www.cdhp.org/system/files/SBHC%20Issue%20Brief%20Final.pdf

Revised: 10/10

States With and Without MEDICAID Reimbursement for Primary Care Medical Providers to Perform Caries Prevention Services



= Medicaid reimburses
= Medicaid reimbursement approved but not funded
= Medicaid reimburses in certain circumstances
= Reimbursement not yet approved

** Indicates state grade from *The Cost of Delay: State Dental Policies Fail One in Five Children*, Pew Children's Dental Campaign

State Policy on Varnish

ST	Reimburse for age…	Amount reimbursed	Training required
CA	< 6 yrs	MD and NP get $18 from FFS; MCO is variable. Fluoride varnish only.	None required, but encouraged.
CO	< 5 yrs	Dental and medical providers get $15.37 for fluoride varnish; $20-$30 for oral exam.	Yes, for medical providers.
OH	< 3 yrs	MD and NP get $15. Fluoride varnish only.	Online training.
VA	< 3 yrs	MD, NP, PHN get $20.79. Fluoride varnish only.	
MD	9 mos to 3 yrs	MD and NP get $24.92. Fluoride varnish only.	Yes, training by Office of Oral Health.
OR	< 6 yrs	MD and NP get $13.65. Fluoride varnish only.	
WA	< 5 yrs for exam + varnish; < 20 yrs for varnish only	MD, DO, ARNP, PA, and PHN get $13.25 for fluoride varnish and $29.46 for oral exam.	Course
HI	No reimbursement		

Source: Children's Dental Health Project

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