

Integrating Oral Health into School Health Programs and Policies



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INTEGRATING ORAL HEALTH INTO SCHOOL HEALTH PROGRAMS AND POLICIES

Produced by

**California School Boards Association
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PREFACE

Good physical health, including oral health, is essential to our school children if they are to take full advantage of the educational services being offered. Unfortunately, large numbers of California's children have poor oral health, including untreated tooth decay, infection and pain.

The California School Boards Association (CSBA) and the Dental Health Foundation (DHF), with support provided by a grant from the Robert Wood Johnson Foundation, have entered into a partnership to develop a comprehensive approach to addressing oral health issues in schools. The primary objectives of the partnership are to:

- Educate school board members and communities on the link between oral health and student learning and achievement
- Develop a policy framework that supports local organization and solutions
- Share knowledge of best oral health practices in schools and examples of successes and challenges in California
- Encourage school-based oral health projects and partnerships in local communities.

Toward these goals, CSBA and DHF developed this guide to empower school board members and administrators to create an effective school-based oral health infrastructure. The guide provides background information, policy development tools and other strategies for addressing students' oral health needs. It is based on the recognition that a broad-based, collaborative effort involving local governmental agencies, community organizations, health professionals, parents, students and other stakeholders is the most cost-effective and efficient means of implementing effective programs. Except where otherwise noted, all references to school districts also include county offices of education.

CSBA is a nonprofit, member-driven organization representing virtually all of the state's more than 1,000 school districts and county offices of education. The association supports the governance team – school board members, superintendents and senior administrative staff – in its complex leadership role. On issues of student health, CSBA has been a leader for the past eight years in building and spreading awareness of the importance of student wellness and its impact on student learning and achievement. CSBA provides support to governance teams through publications, policy briefs, fact sheets, sample district policies, leadership development and other resources on such issues as nutrition, physical activity, oral health, indoor air quality, mental health, asthma management, pandemic flu and school health services.

DHF is one of the few organizations in the nation dedicated to the vision of “oral health for all.” DHF provides leadership in advocacy, education and public policy development; promotes community-based prevention strategies; encourages the integration of oral health into total health; and works to improve access to and the quality of oral health services. In a collaborative effort with the California Primary Care Association, it launched the Oral Health Access Council to work toward improving the oral health status of the state's traditionally underserved and vulnerable populations.

Special thanks are extended to Mark Cooper, DDS, a member of the Lake County Office of Education board of trustees, and Robert Isman, DDS, MPH from the California Department of Health Care Services, for their extensive review and input on the development of this guidebook.

The sample policies presented in this guide are copyrighted by CSBA. In addition, the Targeted Student Learning Project, a joint effort of CSBA and four other state school boards associations (Illinois, Maine, Pennsylvania and Washington), allowed its work on policy development to be adapted to create the policy development worksheet included in this guide.

The Association of State and Territorial Dental Directors gave permission for use of its Integrating Oral Health into Coordinated School Health Programs model, found on page 11.

This guide may be downloaded at no charge through the Oral Health link at www.csba.org/wellness.aspx or through DHF at www.dentalhealthfoundation.org.

I. INTRODUCTION

A critical, but often overlooked, impediment to student learning and achievement is poor oral health. Schools can be important partners in promoting good oral health practices and preventing oral disease among students. Students will be better prepared to learn and succeed if the school environment, policies and personnel are aligned to help them maintain their oral health.

This guidebook highlights:

- 1) the links between oral health, overall health and learning and ways that schools can reinforce those links;
- 2) risk factors for oral diseases and how schools can help reduce the risk factors;
- 3) how school boards, school districts, county offices of education (COEs) and school personnel can form community partnerships and develop policies to create environments that promote oral health;
- 4) national and other resources to help schools and communities accomplish oral health goals; and
- 5) case studies from California that highlight solutions and challenges to establishing and sustaining school-based and school-linked oral health programs.

Why be concerned about oral health?

Tooth decay is the most prevalent health problem and chronic disease of school-aged children in the United States.¹ In the most recent California statewide oral health survey (2004-05), more than 53% of California kindergarten children already showed signs of dental decay, with 28% having untreated decay. By the third grade, 71% of students had dental decay with almost 29% having untreated decay.

Impact of poor oral health on school attendance and student learning

Nationally more than 1.6 million days of school time are lost every year because of oral-related illnesses such as tooth decay or injury to the mouth.² In California, students miss an estimated 874,000 school days annually due to oral health problems.³ These illnesses cost districts funding based on average daily attendance calculations.

School absences for oral illness or treatment cost school districts approximately \$28.8 million per year.³

Children with severe untreated dental decay often are in pain, can't sleep at night, can't concentrate and get poor grades.⁴ Young children and children with special needs often are unable to communicate that they have an oral problem or pain. Teachers may notice a child having difficulty attending to tasks or demonstrating the effects of pain – anxiety, fatigue, irritability, depression and withdrawal from normal activities.⁵ Children who have a toothache when they take tests are unlikely to score as well as children who are not distracted by pain.⁶ When children's acute oral health problems are treated and they are not experiencing pain, their learning and school attendance records improve.⁷

Impact of poor oral health on physical, social and emotional health

Tooth decay is an infection caused by bacteria that are transmitted via saliva. Without proper care, the infection progresses to become a cavity and maybe an abscess, thus not just affecting the tooth but the rest of the mouth and even the rest of the body, leaving the child prone to many other childhood infections such as ear or sinus infections.¹

Oral injuries often occur during childhood and adolescence, and the teeth most frequently affected are the highly visible front teeth. Nearly 3% of children ages 6–8, 11% of children ages 9–11, 18% of adolescents ages 12–15, and 23% of adolescents ages 16–19 experience oral injuries.⁸

Children who have untreated oral diseases or injuries can suffer from inadequate nutritional intake, impaired growth and development, speech problems from missing teeth, or poor self-esteem.⁹

Emergency room admission studies reveal that more than 50% of oral injuries are the result of a fall.¹⁰ Trauma to the head and mouth can occur during school-sponsored physical activities, especially contact sports, as well as on the playground from accidents or fights. Studies indicate that about 33% of all dental injuries and about 19% of head and face injuries are sports related.¹¹

Loss of primary (baby) teeth from injuries or severe dental decay can result in permanent teeth that are crooked, trapped under other teeth or over-crowded, making them more susceptible to decay and periodontal (gum) disease. A single injury to a tooth may not heal completely and may create expensive, long-term problems.

Risk factors for poor oral health

A group of risk factors is common to many childhood diseases and conditions, including oral diseases. Most of these risk factors are preventable.¹²

Many schools and districts/COEs throughout California and the country are already playing a positive role in improving students' oral health through programs and policies around nutrition, physical education and sports, substance abuse and other risk factors. Addressing oral health issues as part of school programs and policies that tackle common risk factors for diseases is a key component to improving overall health for children.

Inadequate nutrition

Inadequate nutrition during childhood can have detrimental effects on children's cognitive, physical and oral development. Less than optimal intake of nutrients, including calcium and fluoride, make the teeth more susceptible to attack by the bacteria that cause tooth decay.

Schools can control targeted marketing and easy access to junk foods and beverages by establishing policies for foods served during meals and sold on school premises.¹³ In California, school districts already have policies in place with regard to beverages, in an effort to improve nutrition for students.

Many children do not meet the recommended intake for calcium. They also may develop eating disorders that involve frequent self-induced vomiting that not only leads to nutritional

deficiencies, but has devastating effects on the teeth and gum tissues.¹⁴ Students who frequently or excessively consume foods and beverages high in sugar are at increased risk for dental decay and obesity.¹⁵ About 25 percent of the food that adolescents eat is considered to be junk food, and soda consumption has almost doubled in the last 20 years.¹⁶ If water is not available via enough working water fountains or provision of bottled water, students may substitute other beverages such as sports drinks or sodas.

Lack of face/mouth protection in sports

Trauma to the head and mouth can occur during school-sponsored physical activities, especially contact sports. Most sports injuries can be prevented by wearing an inexpensive mouthguard.¹⁷ Athletic mouthguards have been the primary method for minimizing oral injuries sustained in sporting activities for decades. By 1962 all American high school football players were required to wear mouthguards during football games, which reduced the prevalence of oral trauma dramatically from 50% of all football injuries to 1%. In other contact sports that do not require use of mouthguards, 14-34% of injuries are in the mouth area.¹⁸

Use of tobacco, alcohol, and other substances

Tobacco products such as cigarettes and smokeless tobacco increase students' risk for periodontal (gum tissue and bone supporting the teeth) problems, precancerous conditions in the mouth, oral cancer, bad breath and staining of teeth. In 2008, 14.6% of high school students in California were current smokers, with 2.2% being daily smokers, and 6.8% of males and 1.5% of females being current smokeless tobacco users.²⁰

Studies have found that 60-78% of smokeless tobacco users have oral lesions.¹⁹ School policies that restrict use of all tobacco products and drugs, including smokeless tobacco, can help to prevent oral consequences.

Excessive use of alcohol dehydrates the body, creating a dry mouth and interfering with the protective effect of saliva on the teeth and tissues. It is also a risk factor for oral cancer.²¹ Individuals who become intoxicated experience more oral injuries. Additionally, rampant dental decay is associated with the use of methamphetamines.

Special health conditions

Children and teens with special health conditions usually have associated oral health needs.

The impact of oral disease on other health outcomes is clear in looking at teens who become pregnant, as they are also at risk for additional oral problems that affect them as well as the developing fetus. Changes in hormones can increase susceptibility to oral infections.²² Pregnant teens may not receive dental care during pregnancy because of misconceptions among some dentists and physicians that dental x-rays and dental care, even preventive services, will harm the fetus.²³⁻²⁴

Many children with developmental disabilities, mental health disorders, craniofacial syndromes or chronic diseases such as diabetes have associated oral conditions. Their oral health is

compromised by their conditions or by medications or therapies such as radiation therapy, chemotherapy or dialysis.²⁵ Oral complications (e.g., mouth lesions or pain) from immune deficiencies can have a devastating effect on a child's ability to eat, gain weight, speak, or socialize. Some children may have the stigma of facial disfigurement and exhibit low self-confidence.

Schools can work with families of children and teens with special health conditions to make sure oral conditions do not compromise their general health, learning, school attendance and social acceptance.

II. PROVIDING COMPREHENSIVE SCHOOL-BASED SUPPORT FOR ORAL HEALTH

School districts/COEs have a clear interest in promoting student health in order to enhance student learning. Although good oral health is a shared responsibility of parents, children, health professionals and health agencies, schools have access to children and can be strong partners in efforts to promote oral health.

Schools have a long history of integrating at least some aspect of oral health education and services into the K-12 curriculum. The profession of dental hygiene began as a result of their working in schools with children in the early 1900s.²⁶ Dental services such as fluoride mouthrinses, toothbrushing instruction and dental sealants have been a staple of clinical services in many schools across the nation. States, school districts, and COEs have developed a variety of oral health lesson plans, materials and curricula to integrate into all aspects of school curricula. February has been promoted as National Children's Dental Health Month by the American Dental Association and other groups for decades. Schools participate by focusing on dental health lesson plans and inviting dental professionals to provide classroom presentations and/or screenings.

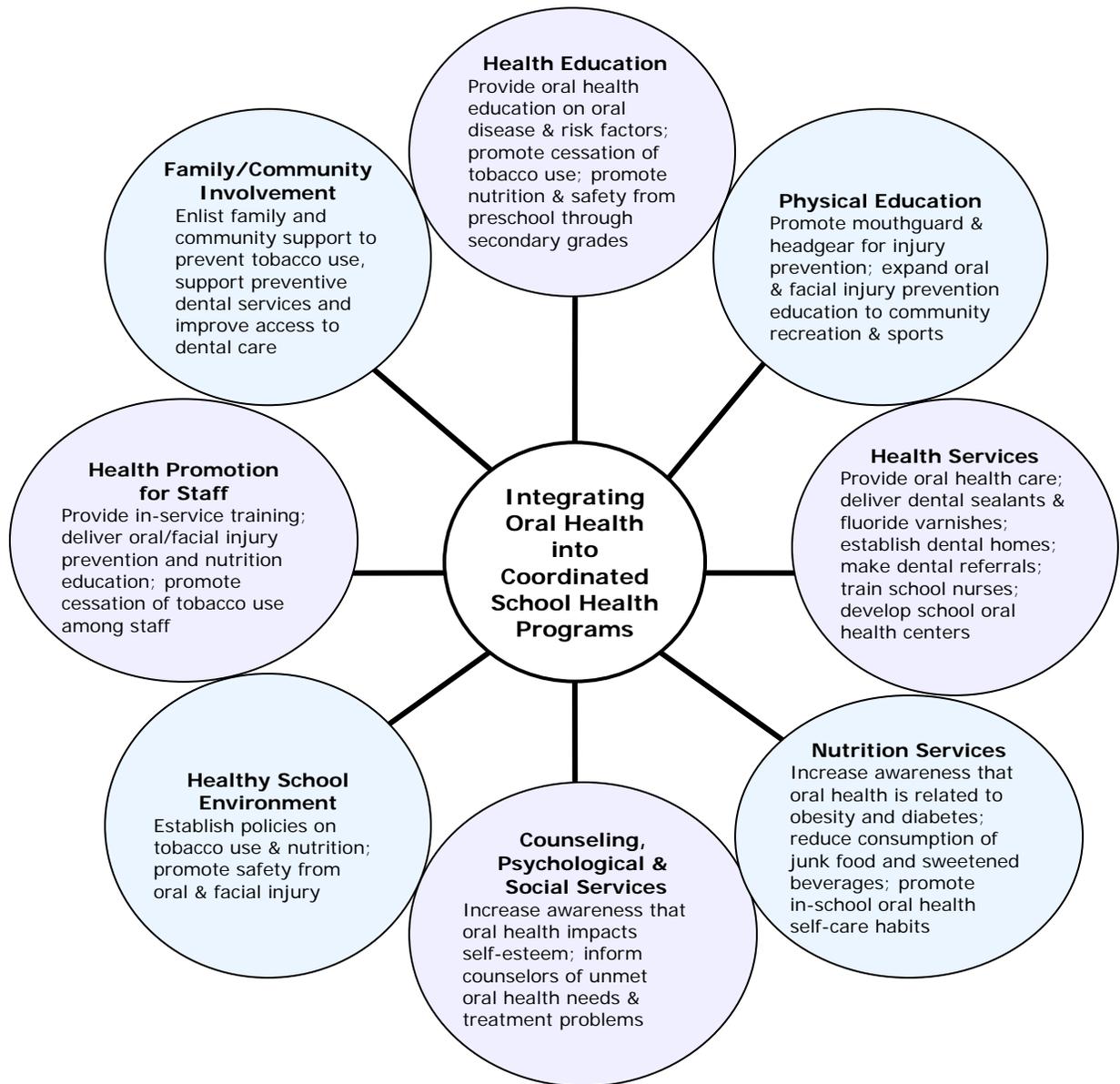
What can districts and county offices of education do?

In determining how the district/COE can be involved in oral health issues, the governance team should consider the following possible actions.

Through the establishment of the vision and goals, policies, budget priorities and communications to staff, the district/COE has an opportunity to set an expectation that promoting student oral health is an appropriate role for schools. The district/COE should involve school administrators, school nurses and school site staff to achieve buy-in from those responsible for implementing programs.

Integrating oral health into existing health and wellness practices, exemplified by models of coordinated school health programs, is an important part of not only preventing dental decay but also improving overall health and student success. In March 2010, the Association of State and Territorial Dental Directors (ASTDD) published an online Best Practice Approach Report on Improving Children's Oral Health Through Coordinated School Health Programs.²⁷ This first national school oral health model uses the eight components of the framework developed by the Centers for Disease Control and Prevention (CDC) for coordinated school health programs (CSHP).²⁸

Schools can play a key role in preventing or identifying children's oral problems before they become serious and helping families obtain dental care services that are accessible and affordable.



CSHP is a planned, organized set of health-related programs, policies and services coordinated to meet the health and safety needs of K-12 students at both the school district/COE and individual school levels. States use this funding to maximize efficiency and eliminate duplication in coordinating existing state and community initiatives. Success stories are reported on the Web site (<http://www.cdc.gov/HealthyYouth/CSHP/>).

The following recommendations highlight actions California districts/COEs can take and reference resources available to integrate oral health based on the eight components in the coordinated school health model.

1. *Ensure the provision of comprehensive oral health education.*

Instruction in the principles and practices of oral health should be part of a comprehensive, sequential, research-based health education program for grades K-12.

The grade levels and subject areas in which oral health will be addressed are at the discretion of the district/COE. Model content standards for health education, adopted by the State Board of Education in March 2008, are voluntary but provide useful guidance for selecting or developing health education curricula. Within these content standards, oral health is primarily addressed under the content area of personal and community health and is included in standards for kindergarten and grades 1, 4, 5, 6, 7/8 and high school. However, the standards publication encourages the addition of content areas for additional grades based on local health priorities.

Examples of curricula, guidelines and program manuals used by other states can be accessed via the National Maternal and Child Oral Health Resource Center listed in the Resources section of this guidebook. Other resources may be available from schools or county partners that have supported the California Children's Dental Disease Prevention Program (CCDDPP) or through partnerships with health professionals and agencies. In selecting, adapting or developing curriculum and instructional materials, the district/COE should use a process that involves health education teachers, administrators and health professionals and is based on evidence demonstrating the effectiveness of the curriculum.

2. *Encourage prevention and management of oral injuries at schools.*

Schools with recreation and sports programs can reduce oral and facial injuries by requiring students to use appropriate protective gear, including mouthguards for contact sports. Sports medicine societies and organizations recommend use of mouthguards for football, lacrosse, basketball, field hockey, soccer, ice hockey, wrestling and volleyball. The American Dental Association and the Academy of Sports Dentistry recommend that mouthguards be worn during at least 18 additional sports or recreational activities.²⁹ Studies show that voluntary use of mouthguards results in low compliance, and this statistic is one that districts should be aware of when adopting policies regarding participation in athletics.²⁹

School personnel can also be taught how to recognize and manage common oral emergencies that occur on the playground or during physical education classes, as well as oral manifestations of possible abuse and neglect, and assure that students receive appropriate professional care.

3. *Develop partnerships to increase students’ access to preventive and restorative oral health care.*

Making oral health services available at or near school sites enables students to more easily access a broad range of services in a safe, familiar environment, usually at minimal or no cost to students and their families.

Fluoride mouthrinsing or use of fluoride tablets may be a reasonable procedure for groups of children age six or older who are at high risk for dental cavities, such as schools with a high percentage of low-income children. In the last decade, fluoride varnish, a film of fluoride that can be painted on teeth quickly 2-3 times a year, has supplanted mouthrinsing programs in some California classrooms. In 2009, AB 667 clarified existing law so that any person, including dental hygienists, dental assistants and non-health care personnel, with a prescription and protocol of a licensed dentist or physician, may apply topical fluoride varnish in public health and school-based settings.³⁰ Each state has a governmental oral health program or contact person who can link schools or the Department of Education to evidence-based resources; the contact for California is listed in the Resources section.

Increasing children’s access to dental sealants, a protective coating placed on the biting surfaces of teeth to seal the grooves, is another service that districts/COEs can provide to help reduce dental decay in school-age children. Sealants provided through school-based or linked programs have been associated with a 60% decrease in tooth decay in multiple studies.³¹

Recognizing that the provision of school oral health services is truly a collaborative effort, districts/COEs can identify potential partners in the community who are involved in oral health care or related service delivery and enter into a written contract or memorandum of understanding with each partner. Additional actions that boards can take to establish school health services are detailed in CSBA’s policy brief *Expanding Access to School Health Services: Policy Considerations for Governing Boards* in the Appendix.

In addition to or instead of establishing school-based services, districts/COEs might consider a system of referrals to existing services within the community. It may be especially useful to identify no-cost or low-cost oral health services for children such as those listed in the county specific table in the Appendix. School nurses and other staff can share this information with parents when they suspect a student has oral health problems.

4. *Ensure that the food services program supports good oral health.*

Schools play a significant role in feeding children and thus contribute to the acquisition of lifetime dietary habits. Because frequent exposure to foods and beverages high in sugar content increases the risk for and severity of tooth decay, districts/COEs can support good oral health by limiting students’ access to non-nutritious foods.

School meal programs and other food sales on campus and at school events (e.g., vending machines, school

Decreasing soda and junk food consumption is one of the most promising strategies for simultaneously preventing obesity and reducing tooth decay.

stores, snack bars, other venues) must meet federal and state nutrition standards. In California, school districts /COEs have already taken measures to improve nutrition for students. For example, Education Code 49431.5 specifies that fruit-based drinks, vegetable-based drinks and drinking water sold to students must have no added sweetener, and electrolyte replacement beverages sold to middle school, junior high or high school students must contain no more than 42 grams of added sweetener per 20 ounce serving. These beverages, plus milk, are the only beverages that may be sold to elementary students at any time of the day or to secondary students from one-half hour before the start of the school day to one-half hour after the end of the school day.

Readily available access to unhealthy foods conflicts with lessons taught in health, oral health and nutrition curricula. It is important to develop a district/COE policy that sets nutrition standards for all foods sold on campus. The American Academy of Pediatrics encourages school administrators to work with pediatricians and others in the community on ways to decrease the availability of foods and beverages with little nutritional value and to decrease dependence on vending machines, snack bars, and school stores for school revenue.

Districts/COEs can further support good oral health by discouraging the use of candy, soda or other unhealthy foods as a fundraiser, for classroom parties or as an incentive or reward for good behavior or academic performance. Non-food alternatives can be used instead.

For further suggestions on improving nutrition in the schools, see *Student Wellness: A Healthy Food and Physical Activity Policy Resource Guide*, a joint publication of CSBA and California Project LEAN (Leaders Encouraging Activity and Nutrition). This document can be found at www.csba.org/wellness.aspx.

5. Increase awareness of school psychologists and counselors about oral health issues.

School mental health and counseling professionals need to be aware of the issues discussed in Chapter I, particularly those that affect learning, self-esteem and social interactions. They can help recognize when oral health problems are affecting school performance and health and also help students who are self-conscious or bullied about their teeth or appearance. Meetings with families to discuss such issues would be helpful.

6. Support programs to deter use of tobacco, alcohol and other substances.

Because the use of tobacco, alcohol and other substances has been linked to oral health problems (see Chapter 1), programs that discourage students' use of these substances can positively impact their oral health. California is foremost among states for its multifaceted tobacco education and control efforts, including the Stop Tobacco Access to Kids Enforcement (STAKE) Act, which controls smokeless tobacco, one of the few laws that does.³² The Tobacco-Use Prevention Education (TUPE) program provides grant funding for tobacco-specific student instruction, reinforcement activities, special events, and intervention and cessation programs for students. Districts/COEs that have these funds should include oral health messages in their efforts.

Districts/COEs are in an important position to create policies that limit the use of smokeless tobacco, as well as cigarettes, on school campuses and at sporting events, and to include

smokeless tobacco prevention messages in health education curricula. Boards that want to develop policies in this area can refer to CSBA sample policies and administrative regulations BP/AR 3513.3 - Tobacco-Free Schools, BP/AR 5131.62 - Tobacco, and BP/AR 5131.6 - Alcohol and Other Drugs.

7. Provide professional development/in-service training for school staff on oral health issues.

Districts/COEs can work closely with the California Department of Public Health's Oral Health Program to identify new resources and information on school oral health to share with school staff. Dental professionals who are knowledgeable about school oral health can be invited as speakers for in-service sessions, education conferences or school nursing conferences. Incentive systems might be created for teachers who participate in such professional development, especially on a voluntary basis.

School personnel need to keep abreast of evidence-based recommendations for preventive oral health methods for school settings from national authorities.

School staff, especially school nurses, should be made aware of materials that they might share with parents and health care providers in the community. Some of these materials are listed in the Resources section of this guidebook, while others can be obtained from the CCDDPP in the state Department of Public Health, from districts that have supported these programs or from the California Dental Association.

8. Encourage involvement of parents.

Children's good oral health requires consistent reinforcement by parents. For example, California law (Education Code 49452.8) provides for children entering public school for the first time, in kindergarten or first grade, to have their oral health assessed by a dental professional. Districts/COEs have responsibilities to notify parents of the law, provide information on the importance of oral health to overall health and school readiness, provide information about government benefit programs such as Medi-Cal and Healthy Families, and collect and report data on compliance with this program. However, this program was included in the categorical flexibility granted by SBX3 4 and ABX4 2 (2009) and thus districts/COEs accepting the flexibility may choose to suspend this program's requirements through the 2012-13 fiscal year. In making decisions about whether to temporarily suspend any of the program's provisions, boards and superintendents are encouraged to consider the value of the notification in providing parents with useful information on oral health, the value of the assessment in identifying students' oral health needs, and the value of the assessment results in planning local programs and services to promote oral health. Parents should be encouraged to obtain an oral health exam for their child prior to school and on a regular basis thereafter, and to monitor their children's brushing and flossing at home.

What can school boards do?

The school board, working closely with the superintendent as a governance team, can promote the oral health of students through each of its major areas of responsibility: setting direction, establishing an effective structure for the school system, providing support to the superintendent and staff during program implementation, ensuring program accountability and providing community leadership.

Setting direction

The board sets direction for district/COE programs and services by establishing a long-term vision, goals and priorities. To help promote oral health, the board can:

- Develop an understanding among the governance team of the link between student health (including oral health) and academic achievement, and engage in discussions of this topic at board meetings to increase the community's understanding of the importance of oral health
- Use data on students' oral health practices, including results of the oral health assessment for school entry, any other local assessment of health conditions of children and information about services available in the community, as a basis for identifying unmet oral health needs
- Involve staff, parents, students, health professionals, local agencies and/or community members in establishing goals and priorities for district/COE efforts to promote oral health

Establishing an effective and efficient structure for the district/COE

The board must ensure that the district/COE has the resources and structures necessary to implement its vision. In carrying out this responsibility, the board can:

- Adopt policies that promote students' oral health, including policies related to each of the eight components of a coordinated school health program such as oral health assessment, school health services and health education (See Chapter III - Policy Development and Chapter IV - Sample Board Policies)
- Adopt curriculum for a comprehensive health education program that aligns with state content standards, including standards for instruction in the principles and practices of oral health at appropriate grade levels from elementary through high school
- Provide health teachers with opportunities for professional development to enhance the quality of standards-aligned oral health instruction

- Provide other school staff with opportunities for professional development to assist them in better understanding how to recognize poor oral health in their students and take appropriate action to reduce risk factors and refer students for professional care
- Adopt a budget that is aligned with established priorities for student health (including oral health) and maximizes use of community resources and other funding sources
- As appropriate, approve a written contract, memorandum of understanding or joint use agreement to formalize relationships with local agencies, organizations or individuals in the provision of oral health services on or near school sites

Providing support

After establishing effective and efficient structures that provide guidance in the area of oral health, the board has a responsibility to support the superintendent and staff as they carry out the direction of the board. The board can:

- Make decisions that support established goals, priorities and policies
- Integrate discussions and efforts to promote oral health with other school wellness efforts in order to provide a comprehensive, coordinated approach to student health
- Provide recognition to staff and community partners for outstanding efforts to promote oral health
- Be knowledgeable enough about the issues and district/COE programs to explain them to the public

Ensuring accountability

As community representatives, the board is accountable to the public for the performance of district/COE schools and progress toward the vision and goals. The board works with the superintendent to establish systems and processes to monitor and evaluate the effectiveness of programs, personnel and fiscal operations. The board can:

- Determine what measures and indicators will be used to assess program effectiveness, such as data from the oral health assessment for school entry, other data collected by the district/COE or another local agency, levels of participation in programs or services and/or feedback from students, parents and staff
- Schedule regular reports to the board from the superintendent or his/her designee to review and understand the data
- Communicate progress and, when needed, direct the superintendent to make program modifications

Acting as community leaders

As the only locally elected officials chosen solely to represent the interests of children, the board has a responsibility to advocate on behalf of those children – to speak out about their needs and the district/COE programs designed to serve them. Community leadership also requires involving the community in meaningful ways in efforts to promote children’s education and health. The board can:

- Work with the superintendent to develop a communications plan (including the appropriate role of board spokespersons) for promoting the importance of oral health and publicizing related programs and services
- Establish a districtwide health advisory council or committee to provide an opportunity to solicit community input on oral health and other health issues
- Help identify agencies, organizations, health professionals and businesses in the community that may be potential partners in community outreach, provision of no-cost or low-cost services through referrals or school-based programs, health education or other activities

III. POLICY DEVELOPMENT

Districts/COEs may have a policy specifically addressing oral health in schools or may incorporate oral health concepts into other student health policies on such issues as health education, nutrition, health screenings for school entry and school-based health services. Ideally, oral health policies will be considered as part of a comprehensive, coordinated school health system designed to support student health and learning.

It is recommended that districts/COEs review their existing policies on oral health to ensure that their policies are up to date and reflect the board's and community's priority on student health. Boards and administrators may find it useful to involve other stakeholders, such as school nurses, dental health professionals, city/county health agencies, school staff, parents, students and community members, in the policy development process.

This chapter provides information about the policy development process and includes a worksheet that may help guide the governance team as it reviews existing policies and/or develops new policy on oral health. The process described in the worksheet is resource intensive and thus provides the greatest opportunity for a full understanding of the issue and its impact on student learning. However, it is recognized that the policy development process varies. What is important is for districts/COEs to find what works for them and then to proceed accordingly.

The school board's role in policy

Many of the governance functions performed by the local school board are carried out through the development and adoption of documents that set policy. Policies are clear, concise, narrowly focused descriptions of the board's expectations for actions that will be taken in support of the district/COE vision. They express board philosophy, provide guidance to staff and can be used to hold the system accountable.

CSBA's publication *Maximizing School Board Leadership: Policy* lists some of the reasons that it is important for boards to provide direction through policies:

- Voting on a policy provides clear direction to the superintendent. Board members may not all agree, but the policy development and adoption process ensures a majority of the board comes to agreement, making it possible to provide coherent rather than fragmented policy messages to the staff.
- By creating policies, boards can initiate action or respond to stakeholders in an appropriate and systematic way.
- A policy manual provides a structural framework to guide and organize the school system, and helps clarify district/COE philosophy as well as the roles and responsibilities of the board, the superintendent and staff.

- Policy development, adoption and evaluation are the mechanisms by which district/COE operations remain stable through changes in board members, superintendent or staff.
- Development of sound policies through an effective process increases public confidence by showing that the district/COE is being governed and operated with a focus on student learning, within the parameters of law and in accordance with sound business practices.
- Policies help ensure that decisions are made thoughtfully. This process can help the district/COE avoid setting a precedent with individual decisions which may be hastily made without taking into consideration the long-term implications.

Setting policy direction and parameters can be done only by locally elected school boards that are vested with the authority to make decisions in the public policy arena on behalf of the community.

The policies that are in a district/COE policy manual are often developed and recommended to the board based on a directive from the board or superintendent, a mandate from a new law or a change in existing law. While staff usually drafts the policy language, the board has the responsibility to ensure that the language clearly reflects the board's policy intent, hear public input on the issue and then adopt the policy. Subsequently, the board should provide leadership in communicating and supporting the policies and should periodically review and revise policies as necessary to ensure their effectiveness.

It is the responsibility of the superintendent or assigned staff member to draft administrative regulations to carry out the intentions expressed in policy. The regulations describe specific practical and enforceable steps that are needed to make the policy succeed – how something is to be done, who is to do it, when it is to be done and sometimes requirements of pertinent laws. Regulations and policies are often adopted at the same time or located together so it is clear what actions will result from the adoption of the policy.

Oral health policy development worksheet

The following worksheet provides a guide to school boards, superintendents, district/COE staff and others to develop and review related board policies and administrative regulations.

Part I of the worksheet introduces the policy topic and provides a series of questions that will facilitate the board’s discussion and develop an understanding of this issue and its relationship with student learning and achievement.

Part II uses a series of questions to help boards, administrators, staff and others assess existing board policies and administrative regulations related to oral health in order to determine the need for the development or revision of current policies or regulations.

Part III suggests a policy development process to help school boards, administrators, staff and others determine the necessary actions and responsibilities for collecting data and for making recommendations on the relevant board policies and administrative regulations.

Part IV provides a format for completing policy revisions and developing new board policies and administrative regulations.

A workplan and timeline form is also provided to assist in the planning of the policy work and to establish deadlines.

Part I: Initial Discussion of Topic

Relationship to student learning: The following questions will focus the discussion on the relationship between oral health and student learning.

1. Why is oral health important to student learning?

2. What does your governance team see as the relationship between oral health and student learning in your district/COE?

3. How will policies on oral health contribute to improved student learning?

Policy topic components: Below are the basic components that a board should understand and/or address in policy on oral health. Some components are directly related to student learning, and others reflect legal compliance issues that are also important to include in policy or administrative regulations. Component statements are not intended to be policy language. Each component statement is a key concept related to the topic, but not the policy language itself. Each component will frame an issue or identify concerns and interests that your board would want to address in a policy on this topic. Under each component statement are questions that may help guide the board's discussion of the component.

1. The board recognizes that good oral health is necessary for maximizing the opportunity for a child to learn.

- What does research show about the relationship between oral health and student learning?

- What are your community's and board's expectations with regard to the responsibility of the district/COE to promote oral health?

- What are the board's goals for student health?

- Do students' needs for oral health information and services differ by age group, socioeconomic status or availability of community resources?

2. The curriculum includes instruction on oral health.

- What are the goals of the district/COE for oral health education?

- At what grade levels and in what courses are oral health principles and practices currently taught? Should these be expanded?

➤ How much time is spent on oral health education at each applicable grade level? Is this sufficient?

➤ Does the content of oral health instruction align with state standards for health education?

➤ How is oral health instruction linked to nutrition education and other health education topics?

➤ Is there a need for professional development to assist teachers in understanding state content standards for oral health education and implementing effective instructional methodologies?

3. The district/COE encourages completion of an oral health assessment prior to school entry.

- Has the district/COE chosen to continue implementation of the oral health assessment program? If so, how is the program being implemented ?

- What were the results of the most recent report of oral health assessments? How many students were unable to complete the assessment or failed to return the assessment form or waiver request?

- What steps can be taken to encourage completion of an oral health assessment at school entry?

- When parents indicate their child is unable to complete the oral health assessment, what steps should be taken to encourage participation or provide additional information or referrals?

4. The district/COE collaborates with health professionals and/or agencies to increase students' access to oral health services.

- Has the district/COE or community conducted a needs assessment to determine whether there is an unmet need for oral health services within the community? If so, what were the results of that needs assessment?

- Does the district/COE currently provide preventive or diagnostic oral health services or treatment through school health center(s) or mobile van(s)? If not, are these services that should be provided? Would access to oral health services at or near schools increase students' use of such services?

- What resources are available in the community that might partner with the district/COE to increase students' access to oral health services at or near schools?

- Are low-cost or no-cost oral health services available in the community to which students might be referred?

- What is the appropriate role of school nurses and other staff in making referrals or providing information about oral health?

5. The district/COE supports students' oral health by limiting non-nutritious foods and beverages and discouraging student use of tobacco, alcohol and other drugs.

- Does the food services program and other food sales (e.g., vending machines, student stores) meet federal and state nutrition standards? Do fundraisers and classroom parties also encourage healthy eating habits?

- Has the district/COE developed policies or administrative regulations prohibiting the use of tobacco, alcohol and other drugs on campus and at school activities? Are these policies consistently enforced? Does the district/COE also provide substance use prevention and/or intervention services?

6. Parents are provided information about the importance of oral health and the relationship between oral health and academic performance.

- What information on oral health does the district/COE currently provide to parents, and at what grade levels? Should information be provided to parents of students at other grade levels?

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- What mechanisms can be used to conduct parent outreach on oral health (e.g., district or school newsletters, handouts, school Web sites, other communications)?

7. The district/COE shall regularly evaluate the effectiveness of its oral health policies and programs.

- What indicators will be used to measure the effectiveness of oral health policies and programs? In what ways can the board use the annual report on oral health assessment to evaluate whether efforts have been successful?
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➤ What types of reports does the board expect to receive, and how often?

➤ How will the board use assessment results to identify needs for program changes and/or needs for further education or communication with parents?

Part II: Assessment of Existing Policies

Review your current board policy and administrative regulations related to oral health based on the following questions. The assessment should determine whether your policies include all the policy components identified in Part I.

1. List your board policy or policies related to oral health.

2. Does the policy include a focus on student learning? How?

3. Are the administrative regulations consistent with the board policy?

4. Does district/COE practice comply with policy/administrative regulations?

5. Does the policy reflect current legal requirements?

6. As a result of the board discussion in Part I and assessment of policy just completed in Part II, in what areas does your board need to develop new policy, or delete or revise current policy?

Note: Items 7 and 8 will identify issues related to, but not directly part of, the policy topic under consideration. In addition, items 7 and 8 may identify issues that require further attention to ensure the alignment of policy, other key work of boards and other documents.

7. Has your board’s policy discussion and/or policy assessment raised any policy issues for future review or action?

8. Based on your discussion and assessment, do other documents require future review or revisions?

- Administrative regulations
- Budget
- Collective bargaining agreements
- Strategic plan
- Staff development plan
- Student handbook
- Parent handbook
- Other

Part III: Policy Development Process

As part of the policy development process, your governance team should determine the data needed to effectively address this policy topic. This includes determining where the data may be available, the appropriate allocation of resources for data collection and analysis, and the assignment of responsibility for data collection, analysis and recommendations. The process also should include opportunities for input from affected parties in the district/COE and the community.

1. What data do you need in order to develop policy related to oral health?

a. Internal data sources:

b. External data sources:

2. Who beyond the governance team should be involved in the policy development process (e.g., health teachers, school nurses, local dentists, public health agencies, school administrators, parents, students, interested community members)?

3. What are the recommendations from the individuals listed above?

4. What are the recommendations of staff based on an analysis of the data?

Part IV: Board Policy Content Directions

Content decisions: Your board should identify the content components of new or revised policy based on the discussion, assessment, analysis and input in Parts I through III and a review of the following questions:

1. Which of the policy components listed in Part I and those recommended by key stakeholders (identified in Part III) does the board want included in a new or revised policy?

2. Does the assessment of existing policy completed in Part II identify any additional content components the board wants in new or revised policy?

3. Has the board identified any content in existing policy that should not be included in new or revised policy?

4. Do the data and input developed in Part III reveal any additional (or new) content components the board wants in new or revised policy?

Review of draft policy: After the board has completed the process described previously, the superintendent, policy committee and/or other appropriate designees should prepare a draft policy, arrange for legal review of the policy, and bring it to the board for consideration at a public board meeting. The following questions should be used to guide the board's review of draft policy. If any significant revisions are required, some or all of the questions in Parts I through IV may need to be revisited before the policy is formally adopted.

5. Does the draft policy accurately reflect the board's intent? In what ways, if any, should the policy be revised to better communicate the board's direction?

6. Does public or staff input add any new issues that need to be addressed?

7. What criteria will the governance team use to determine whether this policy achieves the desired results?

8. What provisions does the draft policy include for periodic review and evaluation?

Note: Following adoption of the policy by the board, the superintendent should develop a plan for communicating the policy to interested parties, as well as a plan to implement the policy. The communications plan could include goals; key messages to be communicated; the individuals, groups and media organizations to receive the communication; and, when appropriate, strategies that tailor the messages for each of these groups so people receive the information of most use to them. Once a policy has been adopted, it is the board's responsibility to support it by providing the necessary funding when a budget is adopted, considering the policy implications of collective bargaining decisions and modeling the behavior called for in policy.

Oral health policy workplan and timeline

Activity	Person responsible	Deadline
Part I: Introduction of topic and initial board discussion of broad issues	_____	_____
Part II: Assessment of existing policy	_____	_____
Part III: Data collection and analysis	_____	_____
Professional staff analysis and recommendation	_____	_____
District/COE and community input	_____	_____
Part IV: Board content directions	_____	_____
Drafting of recommended policy	_____	_____
Legal review	_____	_____
First reading: board's initial opportunity for public input	_____	_____
Drafting of revised policy, if necessary	_____	_____
Legal review of revised policy	_____	_____
Second reading and adoption	_____	_____
Communication of new policy	_____	_____
Specifically: (list)	_____	_____
Implementation by superintendent and staff	_____	_____
Review and evaluation	_____	_____
Modify policy based on review and evaluation	_____	_____

IV. SAMPLE SCHOOL BOARD POLICIES

In California, the majority of districts use CSBA's sample policies as a starting point for developing their own local policies. CSBA recommends that staff reflect on the need for each sample policy provided, gather additional information as needed, make any necessary changes to the sample to reflect local circumstances and, finally, take the draft policies to the board for consideration, deliberation and adoption.

CSBA's policy manual addresses components of oral health in several sample board policies and administrative regulations which are included in this chapter:

AR 5141.32 - Health Screening for School Entry

BP/AR 5141.6 - School Health Services

BP/AR 6142.8 - Comprehensive Health Education

Other related policies may also be reviewed for alignment and to support oral health policies and practices, including but not limited to BP 5030 - Student Wellness, BP/AR 3550 - Food Services/Child Nutrition Program, BP/AR 3554 - Other Food Sales, BP 1020 - Youth Services, BP/AR 3513.3 - Tobacco-Free Schools, BP/AR 5131.62 - Tobacco, BP/AR 5131.6 - Alcohol and Other Drugs, AR 3515.6 - Criminal Background Checks for Contractors, AR 5148 - Child Care and Development, BP 5148.3 - Preschool/Early Childhood Education, and BP 4131 - Staff Development.

Note: CSBA's sample policies and administrative regulations are regularly reviewed and revised. Districts are encouraged to check with CSBA's Policy Services Department to ensure that they have the most recent version by calling (800) 266-3382 or e-mailing policy@csba.org. To learn more about CSBA's Policy Services, visit www.csba.org.

CSBA Sample Administrative Regulation

Students

AR 5141.32

HEALTH SCREENING FOR SCHOOL ENTRY

Cautionary Notice: As added and amended by SBX3 4 (Ch. 12, Third Extraordinary Session, Statutes of 2009) and ABX4 2 (Ch. 2, Fourth Extraordinary Session, Statutes of 2009), Education Code 42605 grants districts flexibility in "Tier 3" categorical programs and provides that districts are deemed in compliance with the program and funding requirements for these programs for the 2008-09 through 2012-13 fiscal years. As a result of this flexibility, the district may choose to temporarily suspend certain provisions of the following policy or administrative regulation that reflect those requirements. However, this flexibility does not affect or alter any existing contract or bargaining agreement that the district may have in place. Thus, districts should examine the terms of those contracts and agreements and consult with district legal counsel for additional guidance. Also see BP 2210 - Administrative Discretion Regarding Board Policy.

Note: The following **optional** regulation is for use by districts that offer grades K-1.

Comprehensive Health Screening for Grades K-1

Note: Health and Safety Code 124085 requires students to have a comprehensive health screening within 18 months prior to entry into first grade or within 90 days thereafter, as provided below. At their discretion, districts may revise the following paragraph to require proof of the health screening before the student is admitted to school (kindergarten or grade 1), as recommended by the Child Health and Disability Prevention (CHDP) office of the California Department of Health Services (DHS) in its CHDP School Handbook: School Entry Health Examination Requirements.

Pursuant to Health and Safety Code 124085, evidence of the comprehensive health screening must be provided on a form developed by the DHS. Districts may obtain the DHS "Report of Health Examination for School Entry" certification form through the CHDP program office at the local health department or on the CHDP web site.

The parent/guardian of a student in kindergarten or first grade shall submit to the Superintendent or designee a certification form developed by the California Department of Health Services (DHS) and signed by the student's health examiner certifying that the student has completed a comprehensive health screening within 18 months prior to entry into first grade or within 90 days thereafter. (Health and Safety Code 124040, 124085)

(cf. 5111 - Admission)

(cf. 5141.3 - Health Examinations)

Note: Pursuant to Health and Safety Code 124100, the notification described in the following paragraph must be provided in cooperation with the county's CHDP program established pursuant to Health and Safety Code 124025-124110. The CHDP program provides state-reimbursed health examinations at no cost to eligible students, including those who (1) are certified as eligible to receive Medi-Cal, (2) are not certified as eligible for Medi-Cal but have a family income at or below the level established annually by the DHS, or (3) are attending a Head Start or State Preschool program. Annual eligibility criteria for the CHDP program are available on the DHS web site and in its CHDP School Handbook: School Entry Health Examination Requirements.

The Superintendent or designee shall notify parents/guardians of all kindergarten students of the requirement to obtain a health screening and of the availability of the Child Health and Disability Prevention (CHDP) program established pursuant to Health and Safety Code 124025-124110 to assist eligible low-income families in obtaining the health screening. (Health and Safety Code 124100)

(cf. 5145.6 - Parental Notifications)

Note: The following optional paragraph reflects legislative intent in Health and Safety Code 124105 encouraging students to complete the health screening in conjunction with immunizations prior to enrolling in kindergarten. The CHDP School Handbook: School Entry Health Examination Requirements recommends that schools include the parent/guardian notice in the kindergarten registration packet because it has been found to be most effective to collect the certification forms at kindergarten entry.

The notice and certification form shall be included with the notification of immunization requirements provided to parents/guardians prior to their child's enrollment in kindergarten and shall encourage completion of the health screening simultaneously with immunizations. The notice shall also be provided to the parent/guardian of any student who is enrolling in first grade without having attended kindergarten in the district.

(cf. 5141.31 - Immunizations)

In lieu of the certification, the parent/guardian may submit a waiver on a form developed by DHS indicating that he/she does not want or is unable to obtain a health screening. If the waiver indicates that the parent/guardian was unable to obtain the services, the reasons should be included in the waiver. (Health and Safety Code 124085)

Note: The following **optional** paragraph may be revised to reflect district practice. The CHDP School Handbook: School Entry Health Examination Requirements recommends that the waiver form be provided to parents/guardians upon request rather than distributed with the notification of the health screening requirement.

The waiver form shall be provided to a parent/guardian upon request.

The completed certification form or the waiver shall be maintained in the student's health file or cumulative record. (5 CCR 432)

(cf. 5125 - Student Records)

During the first 90 days of the school year, the Superintendent or designee may contact any parent/guardian of a first-grade student who has not provided either the certification form or the waiver to ensure that the parent/guardian understands the health screening requirement and, if appropriate, his/her possible eligibility for the CHDP program.

The Superintendent or designee shall exclude from school, for not more than five school days, any first-grade student who does not present evidence of a health screening or a waiver on or before the 90th day after entering first grade. The exclusion shall begin on the 91st day after the

student's entrance into the first grade, or if school is not in session, then on the next succeeding school day. (Health and Safety Code 124105)

Note: Pursuant to Health and Safety Code 124105, the exemptions described in the following paragraph may not exceed five percent of the district's first-grade enrollment.

The Superintendent or designee may exempt a student from exclusion when his/her parents/guardians have been contacted at least twice between the first day and the 90th day after the student's enrollment in first grade and the parents/guardians refuse to provide either a certification form or a waiver. (Health and Safety Code 124105)

(*cf. 5112.2 - Exclusions from Attendance*)

Oral Health Assessment for Grades K-1

Note: The following **optional** section reflects Education Code 49452.8, as added by AB 1433 (Ch. 413, Statutes of 2006), which requires certification that a student enrolling in school for the first time, either in kindergarten or first grade, receives an oral health assessment. As required by Education Code 49452.8, the California Department of Education (CDE) has developed a standardized form, available on its web site, to be used by all districts to obtain the certification of the assessment.

No later than May 31 of the relevant school year, the parent/guardian of a kindergarten student, or first-grade student who was not previously enrolled in kindergarten in a public school, shall certify that the student has received an oral health assessment. The oral health assessment shall have been performed by a licensed dentist or other authorized dental health professional no earlier than 12 months prior to the date of the student's initial enrollment. The parent/guardian shall submit to the Superintendent or designee a California Department of Education standardized form which has been completed and signed by the dental health professional. (Education Code 49452.8)

Note: The CDE has developed a sample parent notification letter, available on its web site, which satisfies the following requirements of Education Code 49452.8.

The Superintendent or designee shall notify parents/guardians of the oral health assessment requirement. The notification shall, at a minimum, consist of a letter that includes all of the following: (Education Code 49452.8)

1. An explanation of the administrative requirements of the law
2. Information on the importance of primary teeth
3. Information on the importance of oral health to overall health and to learning
4. A toll-free telephone number to request an application for Healthy Families, Medi-Cal, or other government-subsidized health insurance programs
5. Contact information for county public health departments

6. A statement of privacy applicable under state and federal laws and regulations

Note: The following **optional** paragraph may be revised to reflect district practice.

The notification and certification form shall be provided to parents/guardians when they register their child for school.

Note: Pursuant to Education Code 49452.8, if parents/guardians are unable to obtain the oral health assessment for any of the reasons specified below, they must instead complete the section on the CDE's standardized form indicating why an assessment could not be completed.

The student may be excused from complying with the oral health assessment if his/her parent/guardian indicates on the standardized form that it could not be completed for any of the following reasons: (Education Code 49452.8)

1. Completion of an assessment poses an undue financial burden on the parent/guardian.
2. The parent/guardian lacks access to a licensed dentist or other dental health professional.
3. The parent/guardian does not consent to an assessment.

Note: The following paragraph is **optional**.

Students who are not assessed, or for whom the parents/guardians fail to return the standardized form, shall not be excluded from school attendance.

By December 31 of each year, the Superintendent or designee shall report data on oral health assessments to the county office of education in accordance with Education Code 49452.8.

The report shall also be provided to the Governing Board. The identity of any student shall not be included in the report.

Legal Reference:

EDUCATION CODE

48985 Notice to parents in language other than English

49060-49079 Pupil records

49452.8 Oral health assessment

HEALTH AND SAFETY CODE

104395 Child Health and Disability Prevention Program expansion

124025-124110 Child Health and Disability Prevention Program, especially:

124085 Certificate documenting health screening and evaluation services; waiver by parent/guardian

124100 Distribution of program information to parents/guardians of kindergarten children

124105 Exclusions and exemption; legislative intent of notification contents

CODE OF REGULATIONS, TITLE 5

432 Student records

CODE OF REGULATIONS, TITLE 17

6800-6874 Child Health and Disability Prevention Program

Management Resources:

CSBA PUBLICATIONS

Promoting Oral Health for California's Students: New Roles, New Opportunities for Schools, Governance and Policy Services, Policy Brief, February 2007

DEPARTMENT OF HEALTH SERVICES PUBLICATIONS

CHDP School Handbook: School Entry Health Examination Requirements, rev. January 2006

WEB SITES

CSBA: <http://www.csba.org>

California Department of Education, Health Services: <http://www.cde.ca.gov/ls/he/hn>

California Dental Association: <http://www.cda.org>

California Department of Health Services, Child Health and Disability Prevention Program:

<http://www.dhs.ca.gov/pcfh/cms/chdp>

California Healthy Kids Resource Center: <http://www.californiahealthykids.org>

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Policy Reference UPDATE Service

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CSBA Sample Board Policy

Students

BP 5141.6

SCHOOL HEALTH SERVICES

Note: The following **optional** policy should be revised to reflect district practice. This policy addresses the provision of health services at or near school sites, such as through a school-based or school-linked health center or mobile van. Districts maintaining or planning to establish school health services are encouraged to read CSBA's policy brief entitled [Expanding Access to School Health Services: Policy Considerations for Governing Boards](#).

Other CSBA sample policies and/or administrative regulations address specific health requirements and services for students, including, but not limited to, vision and hearing tests, scoliosis exams, oral health assessments, and medical and related services for students with disabilities. For example, see BP/AR 5141.21 - Administering Medication and Monitoring Health Conditions, AR 5141.24 - Specialized Health Care Services, BP/AR 5141.3 - Health Examinations, and AR 5141.32 - Health Screening for School Entry.

The Governing Board recognizes that good physical and mental health is critical to a student's ability to learn and believes that all students should have access to comprehensive health services. The district may provide access to health services at or near district schools through the establishment of a school health center and/or mobile van(s) that serve multiple campuses.

The Board and the Superintendent or designee shall collaborate with local and state agencies and health care providers to assess the health needs of students in district schools and the community. Based on this needs assessment and the availability of resources, the Superintendent or designee shall recommend for Board approval the types of health services to be provided by the district.

(cf. 5131.6 - Alcohol and Other Drugs)

(cf. 5131.61 - Drug Testing)

(cf. 5131.62 - Tobacco)

(cf. 5131.63 - Steroids)

(cf. 5141 - Health Care and Emergencies)

(cf. 5141.21 - Administering Medication and Monitoring Health Conditions)

(cf. 5141.22 - Infectious Diseases)

(cf. 5141.23 - Asthma Management)

(cf. 5141.24 - Specialized Health Care Services)

(cf. 5141.25 - Availability of Condoms)

(cf. 5141.26 - Tuberculosis Testing)

(cf. 5141.3 - Health Examinations)

(cf. 5141.31 - Immunizations)

(cf. 5141.32 - Health Screening for School Entry)

(cf. 5141.33 - Head Lice)

(cf. 5141.4 - Child Abuse Prevention and Reporting)

(cf. 5141.52 - Suicide Prevention)

(cf. 6145.2 - Athletic Competition)

(cf. 6159 - Individualized Education Program)

(cf. 6164.6 - Identification and Education Under Section 504)

The Board may employ or contract with health care professionals or partner with community health centers to provide the services under the terms of a written contract or memorandum of understanding.

(cf. 1020 - Youth Services)
(cf. 3312 - Contracts)

Note: According to the California School Health Centers Association, school health centers generally are funded by a combination of insurance reimbursements; state, federal, and county grants; district funds; subsidies from community clinics or hospitals; and/or private donations. In some cases, the provision of school health services has been supported by grants provided through the state's Healthy Start program (Education Code 8800-8807) although districts are expected to sustain programs and services after the grant period expires.

Board approval shall be required for any proposed use of district resources and facilities to support school health services. The Superintendent or designee shall identify funding opportunities available through grant programs, private foundations, and partnerships with local agencies and organizations.

(cf. 1260 - Educational Foundation)
(cf. 3100 - Budget)
(cf. 7000 - Facilities Master Plan)

Note: The following **optional** paragraph may be revised to reflect district practice. The California Department of Education's Health Framework for California Public Schools recommends a coordinated school health approach which integrates health services, health education, physical education, parent/community involvement, nutrition services, psychological and counseling services, a safe and healthy school environment, and health promotion for staff.

The Superintendent or designee shall coordinate the provision of school health services with other student wellness initiatives, including health education, programs that address nutrition and physical fitness, and other activities designed to create a healthy school environment. The Superintendent or designee shall encourage joint planning and regular communications among health services staff, district administrators, teachers, counselors, other staff, and parents/guardians.

(cf. 3550 - Food Service/Child Nutrition Program)
(cf. 5030 - Student Wellness)
(cf. 6142.7 - Physical Education)
(cf. 6142.8 - Comprehensive Health Education)
(cf. 6164.2 - Counseling/Guidance Services)

Consent and Confidentiality

The Superintendent or designee shall obtain written parent/guardian consent prior to providing services to a student, except when the student is authorized to consent to the service pursuant to Family Code 6920-6929 or other applicable laws.

Note: The Health Insurance Portability and Accountability Act (HIPAA) (45 CFR 164.500-164.534) mandates actions that "covered entities" must take to protect the privacy of an individual's health information. Generally, entities covered by HIPAA may release or receive "protected health information" about an individual only if that individual gives permission or the Act expressly permits its release. Districts with questions about the applicability of HIPAA should consult legal counsel as appropriate.

In addition, 22 CCR 51270 requires districts serving as Medi-Cal providers (see section entitled "Payment/Reimbursement for Services" below) to comply with confidentiality requirements specified in 42 USC 1320c-9, 42 CFR 431.300, Welfare and Institutions Code 14100.2, Education Code 49073-49079, and 22 CCR 51009.

The Superintendent or designee shall maintain the confidentiality of student health records in accordance with law.

(cf. 5125 - Student Records)

Payment/Reimbursement for Services

Note: Some school health services, such as medical and related services specified in an individualized education program for students with disabilities, must be provided free of charge. For other services, districts may charge a fee and are entitled to seek third-party reimbursement from students' private insurance and state or federal programs such as Medi-Cal, the low-cost Healthy Families insurance program, and the Child Health and Disability Prevention program. See the accompanying administrative regulation.

The Board desires that costs not be a barrier to student access to services. Services may be provided free of charge or on a sliding scale in accordance with law.

The Superintendent or designee shall establish procedures for billing public and private insurance programs and other applicable programs for reimbursement of services as appropriate.

(cf. 5143 - Insurance)

Note: The following optional paragraph is for use by districts that have received approval from the California Department of Health Care Services to serve as Medi-Cal providers. A program that receives funding through the Healthy Start program is required by Education Code 8804 to seek designation as a Medi-Cal provider.

Pursuant to Welfare and Institutions Code 14132.06 and 22 CCR 51051 and 51190.1, to the extent that federal funding is available, local educational agencies (LEAs) may receive partial Medi-Cal reimbursement through the LEA Medi-Cal Billing Option for health services provided to an enrolled student under age 22 who is certified for Medi-Cal and/or an eligible member of his/her family. In addition, pursuant to Welfare and Institutions Code 14132.47, LEAs may be reimbursed through the Medi-Cal Administrative Activities (MAA) program for some of their administrative costs associated with school-based health and outreach activities that are not claimable under the LEA Medi-Cal Billing Option or other programs. See the accompanying administrative regulation. Districts may receive assistance with Medi-Cal and Medicaid billing through CSBA's PractiCal program; see CSBA's web site for further information.

The district shall serve as a Medi-Cal provider to the extent feasible, comply with all related legal requirements, and seek reimbursement of costs to the extent allowed by law.

Note: The following **optional** paragraph is for use by districts that choose to engage in outreach and enrollment efforts to encourage eligible students' participation in no-cost or low-cost health coverage programs. See E 5141.6 for a related sample board resolution.

Education Code 49557.2 authorizes the district to include on the application for free and reduced-price meals information about the Medi-Cal program and a student's potential eligibility. Pursuant to Education Code 49558, districts may release information on the free and reduced-price meals application to the local agency that determines eligibility under the Medi-Cal program, provided that the student is approved for free meals and the parent/guardian consents to the sharing of information. See BP/AR 3553 - Free and Reduced Price Meals.

Students who do not qualify for Medi-Cal may be eligible for low-cost insurance through the state Healthy Families program, a part of the federal State Children's Health Insurance Program (SCHIP)(42 USC 1397aa-1397jj), which provides coverage for a variety of health, dental, and vision services, with the exception of early and periodic screening, diagnosis, and treatment services.

To further encourage student access to health care services, the Superintendent or designee shall develop and implement strategies to assist in outreach and enrollment of eligible students from low- to moderate-income families in affordable, comprehensive state or federal health coverage programs and local health initiatives. Such strategies may include, but not be limited to, providing information about the Medi-Cal program on the application for free and reduced-price meals in accordance with law and providing students and parents/guardians with information about the low-cost Healthy Families insurance program.

(cf. 3553 - Free and Reduced Price Meals)

Program Evaluation

In order to continuously improve school health services, the Board shall evaluate the effectiveness of such services and the extent to which they continue to meet student needs.

The Superintendent or designee shall provide the Board with periodic reports that may include, but not necessarily be limited to, rates of participation in school health services; changes in student outcomes such as school attendance or achievement; feedback from staff and participants regarding program accessibility and operations, including accessibility to low-income and linguistically and culturally diverse students and families; and program costs and revenues.

(cf. 0500 - Accountability)

Legal Reference:

EDUCATION CODE

8800-8807 *Healthy Start support services for children*

49073-49079 *Privacy of student records*

49423.5 *Specialized physical health care services*

49557.2-49558 *Eligibility for free and reduced-price meals; sharing information with Medi-Cal*

FAMILY CODE

6920-6929 *Consent by minor for medical treatment*

GOVERNMENT CODE

95020 *Individualized family service plan*

HEALTH AND SAFETY CODE

121020 HIV/AIDS testing and treatment; parental consent for minor under age 12

123110 Minor's right to access health records

123115 Limitation on parent/guardian access to minor's health records

123800-123995 California Children's Services Act

124025-124110 Child Health and Disability Prevention Program

124172-124174.5 Public School Health Center Support Program

130300-130317 Health Insurance Portability and Accountability Act (HIPAA)

WELFARE AND INSTITUTIONS CODE

14059.5 Definition of "medically necessary"

14100.2 Confidentiality of Medi-Cal information

14115 Medi-Cal claims process

14124.90 Third-party health coverage

14132.06 Covered benefits; health services provided by local educational agencies

14132.47 Administrative claiming process and targeted case management

CODE OF REGULATIONS, TITLE 10

2699.6500-2699.6905 Healthy Families Program

CODE OF REGULATIONS, TITLE 17

2951 Testing standards for hearing tests

6800-6874 Child Health and Disability Prevention Program

CODE OF REGULATIONS, TITLE 22

51009 Confidentiality

51050-51192 Definitions of Medi-Cal providers and services

51200 Requirements for providers

51231.2 Wheelchair van requirements

51270 Local educational agency provider; conditions for participation

51304 Limitations on specified benefits

51309 Psychology, physical therapy, occupational therapy, speech pathology, audiological services

51323 Medical transportation services

51351 Targeted case management services

51360 Local educational agency; types of services

51491 Local educational agency eligibility for payment

51535.5 Reimbursement to local educational agency providers

UNITED STATES CODE, TITLE 20

1232g Family Educational and Privacy Rights Act (FERPA)

UNITED STATES CODE, TITLE 42

1320c-9 Prohibition against disclosure of records

1397aa-1397jj State Children's Health Insurance Program

CODE OF FEDERAL REGULATIONS, TITLE 42

431.300 Use and disclosure of information on Medicaid applicants and recipients

CODE OF FEDERAL REGULATIONS, TITLE 45

164.500-164.534 Health Insurance Portability and Accountability Act (HIPAA)

Management Resources:

CSBA PUBLICATIONS

Expanding Access to School Health Services: Policy Considerations for Governing Boards, Policy Brief, November 2008

Promoting Oral Health for California's Student: New Role, New Opportunities for Schools, Policy Brief, November 2008

Providing School Health Services in California: Perceptions, Challenges and Needs of District Leadership Teams, 2008

DEPARTMENT OF HEALTH SERVICES PUBLICATIONS

LEA Medi-Cal Provider Manual

California School-Based Medi-Cal Administrative Activities Manual

DEPARTMENT OF HEALTH SERVICES POLICY LETTERS

00-06 Managed Care Plan Relationships with Local Education Agency Providers, December 11, 2000

NATIONAL ASSEMBLY ON SCHOOL-BASED HEALTH CARE PUBLICATIONS

A Guidebook for Evaluating School-Based Health Centers

NATIONAL CENTER FOR YOUTH LAW PUBLICATIONS

Minor Consent, Confidentiality, and Child Abuse Reporting in California, October 2006

WEB SITES

CSBA: <http://www.csba.org>

CSBA, PractiCal Program: <http://www.csba.org/Services/Services/DistrictServices/PractiCal.aspx>

California County Superintendents Educational Services Association: <http://www.ccsesa.org>

California Department of Education, Health Services and School Nursing: <http://www.cde.ca.gov/ls/he/hn>

California Department of Health Care Services: <http://www.dhcs.ca.gov>

California Department of Public Health: <http://www.cdph.ca.gov>

California School Health Centers Association: <http://www.schoolhealthcenters.org>

California School Nurses Organization: <http://www.csno.org>

Center for Health and Health Care in Schools: <http://www.healthinschools.org>

Centers for Disease Control and Prevention, School Health Policies and Programs (SHPPS) Study:

<http://www.cdc.gov/HealthyYouth/shpps>

Centers for Medicare and Medicaid Services: <http://www.cms.hhs.gov>

Healthy Families Program: <http://www.healthyfamilies.ca.gov>

National Assembly on School-Based Health Care: <http://www.nasbhc.org>

National Center for Youth Law: <http://www.youthlaw.org>

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CSBA Sample Administrative Regulation

Students

AR 5141.6

SCHOOL HEALTH SERVICES

Program Components

Note: The following **optional** section may be revised to reflect district practice. Health and Safety Code 124174.6, as added by SB 564 (Ch. 381, Statutes of 2008), establishes a grant program within the Public School Health Center Support Program to award funds, if and when funds are appropriated in the State Budget, to school health centers that meet or have a plan to meet the requirements described below. The program will be administered by the California Department of Public Health in cooperation with the California Department of Education. The district may be subject to additional requirements specified in Health and Safety Code 124174.6 depending on whether it is applying for a planning grant, facilities and start-up grant, or sustainability grant.

Preference for grant funding shall be given to (1) schools in areas designated as federally medically underserved areas or in areas with medically underserved populations; (2) schools with a high percentage of low-income and uninsured children and youth; (3) schools with large numbers of limited-English-proficient students; (4) schools in areas with a shortage of health professionals; and (5) schools with Academic Performance Index (API) rankings in deciles 1-3.

The district's school health services program shall meet, or have a plan to meet, the following requirements: (Health and Safety Code 124174.6)

1. Strive to provide a comprehensive set of services including medical, oral health, mental health, health education, and related services in response to community needs
2. Provide primary and other health care services, provided or supervised by a licensed professional, which may include all of the following:
 - a. Physical examinations, immunizations, and other preventive medical services

(cf. 5141.26 - Tuberculosis Testing)

(cf. 5141.3 - Health Examinations)

(cf. 5141.31 - Immunizations)

(cf. 5141.32 - Health Screening for School Entry)

- b. Diagnosis and treatment of minor injuries and acute medical conditions
- c. Management of chronic medical conditions

(cf. 5141.23 - Asthma Management)

- d. Basic laboratory tests

- e. Referrals to and follow-up for specialty care
- f. Reproductive health services

(cf. 5141.25 - Availability of Condoms)

- g. Nutrition services

(cf. 3550 - Food Service/Child Nutrition Program)

(cf. 5030 - Student Wellness)

- h. Mental health services, provided or supervised by an appropriately licensed mental health professional, which may include assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs

The Superintendent or designee shall collaborate with the county mental health department in planning and service delivery.

(cf. 1020 - Youth Services)

(cf. 5131.6 - Alcohol and Other Drugs)

(cf. 5141.52 - Suicide Prevention)

(cf. 6164.2 - Counseling/Guidance Services)

- i. Oral health services that may include preventive services, basic restorative services, and referral to specialty services

Note: Health and Safety Code 124174.6 requires school health centers, as a condition of grant funding, to work with the school nurse to provide the services listed in item #3 below. A school health center may receive grant funding if it does not employ a school nurse, although it is the Legislature's intent that a school health center not serve as a substitute for employment of a school nurse.
--

- 3. Work in partnership with the school nurse, if one is employed by the school or district, to provide:

- a. Individual and family health education
- b. School or districtwide health promotion
- c. First aid and administration of medications

(cf. 5141.21 - Administering Medication and Monitoring Health Conditions)

- d. Facilitation of student enrollment in health insurance programs

- e. Screening of students to identify the need for physical, mental, and oral health services
- f. Emergency response procedures

(cf. 5141 - Health Care and Emergencies)

- 4. Have a written contract or memorandum of understanding between the district and the health care provider or any other community provider that ensures coordination of services, confidentiality of health information consistent with applicable federal and state laws, and integration of services into the school environment

(cf. 3312 - Contracts)

- 5. Serve all students in the school regardless of ability to pay
- 6. Be open during all normal school hours, except that services may be provided on a more limited basis if resources are not available or on a more expansive basis if dictated by community needs and resources are available
- 7. Establish protocols for referring students to outside services when the school health center is closed
- 8. Facilitate transportation between the school and the health center if the health center is not located on school or district property

Medi-Cal Billing

Note: The following **optional** section is for use by districts that have contracted with the California Department of Health Care Services (DHCS) in order to provide services as a Medi-Cal provider as authorized by Welfare and Institutions Code 14132.06; see the accompanying Board policy.

In order to provide services as a Medi-Cal provider, the district shall enter into and maintain a contract with the California Department of Health Care Services (DHCS). (Welfare and Institutions Code 14132.06; 22 CCR 51051, 51270)

Note: Pursuant to Welfare and Institutions Code 14132.06 and 22 CCR 51535.5, reimbursement under Medi-Cal is limited to the services specified in 22 CCR 51190.4 and 51360. Also, Medi-Cal will not reimburse providers for services given to Medi-Cal beneficiaries if the same services are offered for free to non-Medi-Cal beneficiaries.

Welfare and Institutions Code 14132.06 and 22 CCR 51360 provide that targeted case management services and off-campus nursing or school health aide services will be reimbursable when specified in an individualized education program (IEP), individualized family service plan (IFSP), or individualized health and support plan (IHSP); however, the DHCS discontinued reimbursement for IHSP-linked services

effective July 1, 2001. Its action was based on a decision by the Centers for Medicare and Medicaid Services (CMS) that IHSP services are not covered by the federal Medicaid program. Thus, such services must be specified in an IEP or IFSP to be reimbursable.

The district may apply for Medi-Cal reimbursement for medical transportation services for students with or without an IEP or IFSP pursuant to 22 CCR 51323. On December 28, 2007, the CMS finalized a rule (CMS-2287) that would eliminate federal Medicaid reimbursements for transportation services for students with disabilities. However, P.L. 110-252 (War Supplemental Funding Bill, Title VII) established a moratorium on any new Medicaid-related regulations until April 1, 2009.

The Superintendent or designee shall submit a claim for Medi-Cal reimbursement whenever the district provides a covered preventive, diagnostic, therapeutic, or rehabilitative service specified in 22 CCR 51190.4 or 51360 to a Medi-Cal-eligible student under age 22 and/or a member of his/her family. (Welfare and Institutions Code 14132.06; 22 CCR 51096, 51098, 51190.1, 51190.4, 51309, 51360, 51535.5)

(cf. 5141.24 - Specialized Health Care Services)
(cf. 6159 - Individualized Education Program)

The district shall maintain records including, but not limited to, records of the type and extent of services provided to a Medi-Cal beneficiary in accordance with law. (22 CCR 51270)

(cf. 3580 - District Records)
(cf. 5125 - Student Records)

Note: With the exception of health care aides who provide specialized physical health care services pursuant to Education Code 49423.5, any practitioner whom the district employs or with whom it contracts must be credentialed to practice as a physician, registered nurse, psychologist, school counselor or one of 17 other professions listed in 22 CCR 51190.3 in order for the district to receive Medi-Cal reimbursement.

The Superintendent or designee shall ensure that all practitioners employed by or under contract with the district possess the appropriate license, certification, registration, or credential and provide only those services that are within their scope of practice. (22 CCR 51190.3, 51270, 51491)

Note: 22 CCR 51270 requires federal reimbursements to be reinvested in health and social services for students and their families, as provided below. This requirement does not apply to reimbursements received under the Medi-Cal Administrative Activities (MAA) program described in the following section.

Any federal funds received by the district as reimbursement for the costs of services under the Medi-Cal billing option shall be reinvested in services for students and their families as specified in Education Code 8804(g). The Superintendent or designee shall consult with a local school-linked services collaborative group, such as that defined in Education Code 8806, regarding decisions on reinvestment of federal funds. (22 CCR 51270)

Medi-Cal Administrative Activities

Note: The following **optional** section is for use by districts that participate in the MAA program administered by the DHCS pursuant to Welfare and Institutions Code 14132.47. Under this program, districts providing Medi-Cal-covered health services may be reimbursed for some of their administrative and outreach costs. School staff is required to complete a time survey indicating the time spent on specified MAA activities. This section reflects program requirements described in the California School-Based Medi-Cal Administrative Activities Manual and time survey forms published by DHCS.

Districts may receive assistance with Medi-Cal and Medicaid administrative billing through CSBA's PractiCal program; see CSBA's web site for further information.

Designated school staff shall document, on a time survey form, the amount of time spent on activities identified by DHCS which are related to the administration of the Medi-Cal program. Such activities include, but are not be limited to:

1. Outreach
2. Referral of health and mental health services
3. Translation services
4. Facilitation of applications
5. Scheduling and arranging emergency and medical transportation of eligible individuals
6. Contracting for services
7. Program planning and policy development
8. Claims administration
9. General administration

Note: The district must submit claims through either a local educational agency consortium (i.e., one of the service regions of the California County Superintendent Educational Services Association) or a local governmental agency (i.e., county or chartered city) that has contracted with DHCS. The district may modify the following paragraph to reflect the appropriate entity or agency.

The Superintendent or designee shall, on a quarterly basis, submit an invoice to the local educational consortium or local governmental agency through which the district has contracted to receive reimbursement.

Note: The program requires the local educational consortium or local governmental agency to provide training to participating districts prior to the time survey. District staff to be included in the time survey must participate in training as described in the following paragraph.

Staff responsible for completing the time survey shall annually participate in training regarding eligible activities and the time survey methodology, and shall receive additional training whenever there are changes or updates in administrative claiming categories and activities. New or reassigned staff shall receive training before beginning their duties completing time surveys.

The Superintendent or designee shall maintain an audit file containing original time survey documentation and other records specified by DHCS. Such documentation shall be kept for three years after the end of the quarter in which expenditures were incurred or, if an audit is in progress, until the completion of the audit.

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CSBA Sample Board Policy

Instruction

BP 6142.8

COMPREHENSIVE HEALTH EDUCATION

Note: The following **optional** policy may be revised to reflect district practice.

The Governing Board believes that health education should foster the knowledge, skills, and attitudes that students need in order to lead healthy lives and avoid high-risk behaviors. The district's health education program shall be part of a coordinated school health system which supports the well-being of students and is linked to district and community services and resources.

(cf. 1020 - Youth Services)
(cf. 3513.3 - Tobacco-Free Schools)
(cf. 3514 - Environmental Safety)
(cf. 3550 - Food Service/Child Nutrition Program)
(cf. 3554 - Other Food Sales)
(cf. 5131.6 - Alcohol and Other Drugs)
(cf. 5131.63 - Steroids)
(cf. 5141.22 - Infectious Diseases)
(cf. 5141.23 - Asthma Management)
(cf. 5141.3 - Health Examinations)
(cf. 5141.32 - Health Screening for School Entry)
(cf. 5141.4 - Child Abuse Prevention and Reporting)
(cf. 5141.6 - School Health Services)
(cf. 5141.7 - Sun Safety)
(cf. 5142 - Safety)
(cf. 5146 - Married/Pregnant/Parenting Students)
(cf. 6164.2 - Guidance/Counseling Services)

Note: The federal Child Nutrition and Women, Infants and Children (WIC) Reauthorization Act of 2004 (42 USC 1751 Note) requires each district participating in the National School Lunch program (42 USC 1751-1769) or any program in the Child Nutrition Act of 1966, including the School Breakfast Program (42 USC 1771-1791), to adopt a districtwide school wellness policy which includes goals for nutrition education and physical education. See BP 5030 - Student Wellness for language fulfilling this mandate.

Goals for the district's health education program shall be designed to promote student wellness and shall include, but not be limited to, goals for nutrition education and physical activity.

(cf. 0200 - Goals for the School District)
(cf. 5030 - Student Wellness)
(cf. 6142.7 - Physical Education)

Note: The following **optional** paragraph should be revised as necessary to reflect grade levels offered by the district. Education Code 51210 requires that the adopted course of study for grades 1-6 include instruction in health, including instruction in the principles and practices of individual, family, and community health.

Education Code 51202 requires that certain health-related topics be addressed at the appropriate elementary and secondary grade levels and in appropriate subject areas, as determined by the district. Education Code 51934 requires that students be provided HIV/AIDS prevention instruction at least once in middle school or junior high school and at least once in high school. See AR 6143 - Courses of Study and BP/AR 6142.1 - Sexual Health and HIV/AIDS Prevention Instruction.

In March 2008, the State Board of Education adopted voluntary content standards for health education as required by Education Code 51210.8; see the accompanying administrative regulation. The state's Health Framework for California Public Schools.

The district shall provide a planned, sequential, research-based, and developmentally appropriate health education curriculum for students in grades K-12 which is aligned with the state's content standards and curriculum framework. The Superintendent or designee shall determine the grade levels and subject areas in which health-related topics will be addressed, in accordance with law, Board policy, and administrative regulation.

(cf. 6011 - Academic Standards)
(cf. 6141 - Curriculum Development and Evaluation)
(cf. 6142.1 - Sexual Health and HIV/AIDS Prevention Instruction)
(cf. 6143 - Courses of Study)

Note: The following **optional** paragraph may be revised to reflect district practice. Education Code 51890 defines a "comprehensive health education program" as one that includes community participation in the classroom. Education Code 51891 defines "community participation" as including participation by parents/guardians, practicing health care and public safety personnel, and public and private health care and service agencies in the planning, implementation, and evaluation of the program.

As appropriate, the Superintendent or designee shall involve school administrators, teachers, school nurses, health professionals representing various fields of health care, parents/guardians, community-based organizations, and other community members in the development, implementation, and evaluation of the district's health education program. Health and safety professionals may be invited to provide related instruction in the classroom, school assemblies, and other instructional settings.

(cf. 1220 - Citizen Advisory Committees)
(cf. 1240 - Volunteer Assistance)
(cf. 1400 - Relations Between Other Governmental Agencies and the Schools)
(cf. 1700 - Relations Between Private Industry and the Schools)
(cf. 6020 - Parent Involvement)
(cf. 6145.8 - Assemblies and Special Events)
(cf. 6162.8 - Research)

The Superintendent or designee shall provide professional development as needed to ensure that health education teachers are knowledgeable about academic content standards and effective instructional methodologies.

(cf. 4131 - Staff Development)

Note: The following **optional** paragraph should be revised to reflect indicators agreed upon by the Governing Board and Superintendent for evaluating the district's health education program.

The Superintendent or designee shall provide periodic reports to the Board regarding the implementation and effectiveness of the district's health education program which may include, but not be limited to, a description of the district's program and the extent to which it is aligned with the state's content standards and curriculum framework, the amount of time allotted for health instruction at each grade level, and student achievement of district standards for health education.

(cf. 0500 - Accountability)

(cf. 6190 - Evaluation of the Instructional Program)

Legal Reference:

EDUCATION CODE

8850.5 Family relationships and parenting education

35183.5 Sun protection

49413 First aid training

49430-49436 Pupil Nutrition, Health and Achievement Act of 2001

49490-49494 School breakfast and lunch programs

49500-49505 School meals

51202 Instruction in personal and public health and safety

51203 Instruction on alcohol, narcotics and dangerous drugs

51210 Areas of study

51210.8 State content standards for health education

51220.5 Parenting skills; areas of instruction

51260-51269 Drug education

51513 Personal beliefs

51880-51881.5 Health education, legislative findings and intent

51890-51891 Comprehensive health education programs

51913 District health education plan

51920 Inservice training, health education

51930-51939 Comprehensive sexual health and HIV/AIDS prevention education

CALIFORNIA CODE OF REGULATIONS, TITLE 5

11800-11801 District health education plan

Management Resources:

CSBA PUBLICATIONS

Asthma Management in the Schools, Policy Brief, March 2008

Monitoring for Success: Student Wellness Policy Implementation Monitoring Report and Guide, 2007

Physical Education and California Schools, Policy Brief, rev. October 2007

Promoting Oral Health for California's Students: New Roles, New Opportunities for Schools, Policy Brief, March 2007

Sun Safety in Schools, Policy Brief, July 2006

Student Wellness: A Healthy Food and Physical Activity Policy Resource Guide, rev. April 2006

AMERICAN ASSOCIATION FOR HEALTH EDUCATION PUBLICATIONS

National Health Education Standards: Achieving Excellence, 2007

CALIFORNIA DEPARTMENT OF EDUCATION PUBLICATIONS

Health Education Content Standards for California Public Schools, Kindergarten Through Grade Twelve, 2008

Health Framework for California Public Schools: Kindergarten Through Grade Twelve, 2003

WEB SITES

CSBA: <http://www.csba.org>

American Association for Health Education: <http://www.aahperd.org>

American School Health Association: <http://www.ashaweb.org>
California Association of School Health Educators: <http://www.cashe.org>
California Department of Education, Health Education: <http://www.cde.ca.gov/ci/he>
California Department of Public Health: <http://www.cdph.ca.gov>
California Healthy Kids Resource Center: <http://www.californiahealthykids.org>
California Subject Matter Project, Physical Education-Health Project: <http://csmp.ucop.edu/cpehp>
Center for Injury Prevention Policy and Practice: <http://www.cipp.org>
Centers for Disease Control and Prevention: <http://www.cdc.gov>
National Center for Health Education: <http://www.nche.org>
National Hearing Conservation Association: <http://www.hearingconservation.org>

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CSBA Sample Administrative Regulation

Instruction

AR 6142.8

COMPREHENSIVE HEALTH EDUCATION

Content of Instruction

Note: Items #1-6 below reflect six content areas delineated in the voluntary content standards for health education adopted by the State Board of Education in March 2008. The district may revise the following list to reflect the topics to be addressed in the district's program.

The district's health education program shall include instruction at the appropriate grade levels in the following content areas:

1. Alcohol, tobacco, and other drugs

(cf. 3513.3 - Tobacco-Free Schools)
(cf. 5131.6 - Alcohol and Other Drugs)
(cf. 5131.63 - Steroids)

2. Human growth, development, and sexual health

(cf. 6142.1 - Sexual Health and HIV/AIDS Prevention Education)

Note: The **optional** paragraph under item #3 below includes examples of topics that are addressed in the state content standards within the content area of injury prevention and safety. In addition, pursuant to Education Code 51940, districts may, on a voluntary basis, use curricula distributed by the California Healthy Kids Resource Center that focuses on prevention of brain and spinal cord injuries.

3. Injury prevention and safety

Instruction related to injury prevention and safety may include, but is not limited to, first aid, protective equipment such as helmets, prevention of brain and spinal cord injuries, violence prevention, topics related to bullying and harassment, and Internet safety.

(cf. 0450 - Comprehensive Safety Plan)
(cf. 3543 - Transportation Safety and Emergencies)
(cf. 5131 - Conduct)
(cf. 5138 - Conflict Resolution/Peer Mediation)
(cf. 5142 - Safety)
(cf. 5145.3 - Nondiscrimination/Harassment)
(cf. 5145.7 - Sexual Harassment)
(cf. 5145.9 - Hate-Motivated Behavior)
(cf. 6163.4 - Student Use of Technology)

4. Mental, emotional, and social health

(cf. 5137 - Positive School Climate)

(cf. 5141.52 - Suicide Prevention)

(cf. 5149 - At-Risk Students)

5. Nutrition and physical activity

(cf. 3550 - Food Service/Child Nutrition Program)

(cf. 5030 - Student Wellness)

(cf. 6142.7 - Physical Education)

Note: The optional paragraph under item #6 below includes examples of topics that are addressed in the state content standards within the content area of personal and community health.

6. Personal and community health

Instruction in personal and community health may include, but is not limited to, oral health, personal hygiene, sun safety, hearing protection, transmission of germs and communicable diseases, symptoms of common health problems and chronic diseases such as asthma and diabetes, emergency procedures, and the effect of behavior on the environment.

(cf. 3516 - Emergencies and Disaster Preparedness Plan)

(cf. 5141 - Health Care and Emergencies)

(cf. 5141.21 - Administering Medication and Monitoring Health Conditions)

(cf. 5141.22 - Infectious Diseases)

(cf. 5141.23 - Asthma Management)

(cf. 5141.7 - Sun Safety)

(cf. 5146 - Married/Pregnant/Parenting Students)

(cf. 6142.5 - Environmental Education)

Note: Items #1-6 below combine eight "overarching standards" described in the state content standards as essential concepts and skills to be taught to students.
--

Within each of the above content areas, instruction shall be designed to assist students in developing:

1. An understanding of essential concepts related to enhancing health
2. The ability to analyze internal and external influences that affect health
3. The ability to access and analyze health information, products, and services

(cf. 5141.6 - School Health Services)

4. The ability to use interpersonal communication skills, decision-making skills, and goal-setting skills to enhance health

5. The ability to practice behaviors that reduce risk and promote health
6. The ability to promote and support personal, family, and community health

Exemption from Health Instruction

Note: Pursuant to Education Code 51513, districts may not administer exams, surveys, or questionnaires containing questions about a student's or his/her family's personal beliefs or practices in sex, family life, morality, and religion unless the student's parent/guardian has provided prior written consent. See AR 5022 - Student and Family Privacy Rights.

Upon written request from a parent/guardian, a student shall be excused from any part of health instruction that conflicts with his/her religious training and beliefs, including personal moral convictions. (Education Code 51240)

(cf. 5020 - Parent Rights and Responsibilities)
(cf. 5022 - Student and Family Privacy Rights)
(cf. 6141.2 - Recognition of Religious Beliefs and Customs)
(cf. 6145.8 - Assemblies and Special Events)

Students so excused shall be given an alternative educational activity.

Involvement of Health Professionals

Health care professionals, health care service plans, health care providers, and other entities participating in a voluntary initiative with the district are prohibited from communicating about a product or service in a way that is intended to encourage persons to purchase or use the product or service. However, the following activities may be allowed: (Education Code 51890)

1. Health care or health education information provided in a brochure or pamphlet that contains the logo or name of a health care service plan or health care organization, if provided in coordination with the voluntary initiative
2. Outreach, application assistance, and enrollment activities relating to federal, state, or county-sponsored health care insurance programs

(cf. 1325 - Advertising and Promotion)

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VI. CASE STUDIES

Promoting oral health services in schools is hard work but the rewards are immense. In the case studies presented in this chapter the coordinators of several successful school-based oral health programs share their enthusiasm and experiences.

There are some notable differences among the programs highlighted in these case studies. The most obvious difference is the type of organization that administers the program. Many programs are managed by nonprofit organizations, while others are managed from within a county public health department or office of education. Each type of administration comes with a set of distinguishable strengths and limitations.

Staffing is another element that differs among programs. Available funding and the size of the community served are factors that influence the number and type of staff. Volunteers are the heroes of these programs, and each program finds volunteers from different sources.

There are also similarities among the programs, which provide valuable lessons about what works. Most importantly, every program is rooted in the belief that children will achieve greater academic success and live healthier lives through enhanced oral health outcomes. Most of the programs make oral health education and prevention services a cornerstone of their work. Parent education and involvement, collaboration between schools and health service providers, staff development, and referrals or other efforts to help children find a dental home are other common program components.

Following the case studies is a summary of the lessons learned through these sample programs, including potential barriers and keys to success.

San Diego County — *San Diego SMILES*

- Providing school-based coordination, preventive dental care and dental referrals through a program in the San Diego County Office of Education (SDCOE) in collaboration with Share the Care, an initiative of the county Department of Health and Human Services, county dental society and county dental health coalition.

Demographics

In San Diego County, the majority of low-income communities consist of Latino immigrants who have crossed the California-Mexico border. Among the county's 47 school districts, 34% qualify for free or reduced-price meals. Poverty is particularly concentrated along border cities such as Imperial Beach, San Ysidro and National City. Many of these communities are linguistically isolated and, as a consequence, non-English-speaking parents have trouble interacting with teachers, health care providers and agencies providing social services.

The need

The San Diego County Report Card on Children and Families contains a series of reports providing a snapshot of the overall health and well-being of San Diego County's children and families. In the most recent 2007 report, oral health is featured as a top priority demanding attention, with the next two areas being school attendance and school achievement. Although the report does not make the correlation, dental disease is the number one cause of school absenteeism and hinders academic performance. The fact that one out of every eight San Diego County children aged 2-11 have never visited a dentist underscores the need to enhance access to dental care.

The solution

The link between oral health and child well-being was recognized by the San Diego County Parent Teachers Association Board when it first encouraged SDCOE to apply for funding from the state's newly developed CCDDPP in 1980. Since then, SDCOE has provided school-based oral health services and education to children throughout the county. Its SMILES program specifically targets schools with over 50% of children qualified for free and reduced-price meals. Children in preschool through grade 6 are eligible for services, and special education classes up to grade 8 can also participate in the program.

The majority of funding came from CCDDPP in 2007-08 (\$257,370); occasionally grants from school districts, the San Diego Foundation, First 5, and Delta Dental are able to supplement the budget. Funding is constantly an issue that limits the scope and sustainability of the program. A larger budget would increase services provided by a registered dental hygienist (RDH), such as fluoride varnish and dental sealants, to more children. Cutbacks to schools also impact the program, since both teachers and school nurses are integral to enhancing oral health through SMILES.

Program staff includes a full-time coordinator, two part-time dental hygienists and two part-time health profession students. SMILES depends on teachers to incorporate oral health into classroom activities, not an easy task for the current exam-driven school environment. The program coordinator works with teachers at SMILES program orientations and is always present at SDCOE school nurse meetings to emphasize looking at the whole child, weaving together oral health and educational performance.

Services include:

- **Oral health education:** Two half-hour oral health presentations are given by the SMILES staff to every participating classroom. In addition, SMILES supplies poems and books (in both English and Spanish) dedicated to oral health to encourage young students to read, a graph charting the class's tooth loss as a math activity, and word games and puzzles. Oral health education is incorporated into school health fairs and special sessions for parents of preschool children held before or after class.
- **Fluoride:** Children receive both fluoride varnish and a weekly fluoride rinse. Once trained by the SMILES staff, teachers can lead the class in the rinse once a week whereas an RDH must travel to schools to apply fluoride varnish. Daily brushing with fluoride toothpaste is also a component led by teachers, with flossing an option for upper grades. Teachers and volunteers who participate in SMILES attend one mandatory orientation to the program on how to facilitate and monitor fluoride rinse programs, basic dental health concepts and oral health educational tools to incorporate into their teaching curriculum and class activities.
- **Screening and sealants:** Screenings are provided upon request to schools based on demonstrated need, a high percentage of students with financial hardship, and backing from school staff. Since too many schools meet the first two criteria, support from school administration is often the deciding factor. Assistance from school staff, from the principal to the office coordinator, allows SMILES to run a sealant program successfully.

A successful partnership has emerged between SMILES, school nurses, and Share the Care, the dental health initiative of San Diego. Share the Care was established in 1994 as a public-private partnership between the County of San Diego Health and Human Services Agency, the San Diego County Dental Society, and the San Diego County Dental Health Coalition. Share the Care provides free emergency treatment for children ages 5-18 in severe need but without the resources to obtain care. Services are provided by a volunteer dentist and arranged on a single child basis. Share the Care works with SMILES to promote the program to public health nurses and school nurses, who are many children's gateway into dental care. They learn about eligibility criteria and what information is needed to make the referral to Share the Care. If a child does not qualify, Share the Care maintains a list of community clinics offering low-cost dental services and other resources. In addition, the program reinforces the educational concepts taught in the school program with families during community events.

Results

Each year the SMILES program is delivered to approximately 30,000 students in school settings. Many of the parents in this community have several hurdles when accessing care for their children: language, money, taking off time from work and transportation. Usually these parents are new to the United States and can be fearful and mistrusting of agencies inquiring about their children. Strong relationships that focus on support must develop between the parent and agency to ensure cooperation. The SMILES program, with its partner Share the Care, helps parents overcome these hurdles.

SMILES has one chief advantage over many other school-based oral health programs: acting as a division within SDCOE. The direct association with SDCOE cements a high level of buy-in from schools. This support and enthusiasm from school administration is necessary to make high student participation a reality. For example, when the opportunity for free dental sealants, fluoride varnish and dental screening was a possibility for one school, its principal was determined to get all qualified students involved. A man on a mission, he made personal calls to encourage parents to sign consent forms for the services. If a phone call was not enough, the principal could be found knocking on parents' doors. In short time, all permission slips were signed and every eligible child received free dental services.

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San Bernardino County – *Smile in Style*

- A continuum of services and dental safety net for infants through sixth grade using multiple workforce models and partners

Demographics

San Bernardino is geographically the largest county in California, containing more square miles than nine of the smallest U.S. states. It is unique in geographic size and diversity. Condensed cities such as San Bernardino are contrasted by sparsely populated cities like Needles bordering Nevada. In 2007, 20% of the county's children were living in poverty. More than half of the county's public school districts had over 50% of students qualifying for free or reduced-price meal programs in the 2007-08 school year. San Bernardino City Unified School District, the largest in the county, reported 81% of children qualifying for free or reduced-price meals.

The need

San Bernardino County contains 20 geographical Dental Health Professional Shortage Areas defined by the Health Resources and Services Administration (HRSA) as areas of great need. High gas prices place an additional burden on families in outlying areas where many miles separate children from a source of care. The result is that many children in San Bernardino County suffer from two major threats affecting access to dental care: ability to pay and limited availability of dental providers in some areas.

The solution

In 1978, Arlene Glube, currently the supervisor of dental health programs for the county, began the pilot program for San Bernardino's CCDDPP program, which built the framework for the state program legislated in 1980. The first years of the San Bernardino CCDDPP were so successful in San Bernardino County that Fontana Unified School District (FUSD) initiated an expansion of the program. In 1985, FUSD became the first school district in California to hire a dedicated dental hygienist. However, dwindling financial resources in the district could not sustain that position.

The current program, Smile in Style, is based in the San Bernardino County Department of Public Health and offers a full range of prevention, education and case management services for children attending public schools.

Three major funders have contributed to the program: the California Department of Health's CCDDPP, First 5, and a large project grant administered through the Dental Health Foundation. All the resources combined make the Smile in Style program the dental safety net for thousands of children in San Bernardino County.

Smile with Style has used funding (\$20,200) from CCDDPP for staff salaries, oral health education and clinical preventive services for students in kindergarten through sixth grade. The

services are targeted to schools where over 50% of students qualify for the free and reduced-price school meals program. Services include:

- Oral health education: Presentations on oral health and nutrition are made in a multi-purpose room accommodating students from several classes. The presentation is offered once a year per school. Parent education is also offered at back-to-school nights, either by a dental hygienist or a school nurse.
- Dental screening: A consent form for screenings and other preventive services is sent home to parents to allow screening by a dental hygienist or dental assistant for students whose teeth could benefit from sealants and those with decay needing treatment. If a child is found with decay, a case manager is notified.
- Fluoride varnish: A dental hygienist applies fluoride varnish twice a year per child. This mode of prevention is extremely effective and time efficient; 25 children can be given fluoride varnish in under 25 minutes. Teachers show a strong preference for varnish over tablets or rinses, which are administered more frequently, take more class time and teacher involvement, and require storage.
- Dental sealants: Dental sealants are applied by a dental hygienist on children's decay-free permanent molars in school settings using portable equipment. Sealants require a retention check two weeks after application to ensure that the sealant remains intact.

Space issues in older schools present an obstacle to in-school services. Fluoride varnish and sealant applications require ample space and a working sink, which are not available at all schools. A barrier particular to San Bernardino County is the year-round school track system that increases costs by having to make multiple visits to schools throughout the year to reach all students.

Linked to the Smile with Style program is the Continuum of Care Demonstration Project (COCD), funded (\$450,000) through the Dental Health Foundation through 2010 for children ages 0-5 and students in grades K-5 in the county. COCD funds have been used to pay for staff, provide clinical services and build a strong dental community in schools that did not have the services. This additional funding allowed Glube to train 67 school nurses to apply fluoride varnish in the three largest school districts. They fax an order to Glube's office for the varnish, which they then apply to students in entire classrooms at a session. The nurses also perform outreach by identifying children with dental pain or other problems. In addition, 50 bachelors-level nursing students from California State University San Bernardino have been trained to apply fluoride varnish for schools of the Rialto Unified School District as well as conducting home visits and other general outreach activities. In the field, teams of nurses are supplied with work-kits that include all necessary materials, forms, maps and directions to program school sites to complete the scheduled activities for a given day.

Partnerships have also been established with Loma Linda University School of Dentistry, three local schools of dental hygiene, San Bernardino Assistance League, and the California Child Health and Disabilities Prevention (CHDP) program. Training sessions for case managers in the

Black Infant Health Program and Pregnant Minor Program were established to educate prospective parents and promote early intervention for good oral health.

Case management is provided by five staff members and three bilingual community health outreach workers (CHOWs). Sophistication is supplied to case management with an electronic application developed by the Dental Health Foundation. CHOWs use the software to systematically follow best practices in case management and digitally keep track of oral health outcomes for children. Case managers contact parents to enroll all their children (not just the child with tooth decay) in Medi-Cal or Healthy Families. Parents are informed of their child's needs, and the case manager will book a dental appointment at the most convenient location.

Glube and her staff have established a referral base of 300 Denti-Cal providers in the county. Information collected on practitioners includes languages spoken in the office, ages of children they agree to see and location. Children are matched with the best-suited provider in hopes of securing a dental home for the entire family. Case managers continue to work with the parents beyond scheduling dental services, educating on oral health, sending reminders for future appointments, and following up to make certain the care was received. Bilingual CHOWs who linguistically and culturally relate to parents establish a foundation of trust, assuaging the fears of the many newly immigrated parents who use the service. Although case management staff are very successful in finding dental care, sometimes service for undocumented children is difficult to secure. The larger challenge is to find care for children who don't qualify for any insurance or other public assistance programs.

To ensure a healthy start for children in the county to prevent oral health problems before school entry, funding (\$55,000) from First 5 for 2006-09 was used for administration and providing education, screening and fluoride varnish to children age 5 and younger at state-sponsored preschools. Parent education is offered after classes when children are picked up by their parents. San Bernardino is also the recipient of a small grant from the Dental Health Foundation that places staff at a local WIC clinic for about six hours a week. Children are screened and receive two applications of fluoride varnish, while parents are educated and receive anticipatory guidance. All families are directly referred for dental care. Parents and WIC staff love this program and staff are seeking funding to expand the program to five more sites.

Results

Through the multiple resources administered by Smile in Style, the program has achieved great success in reaching children throughout the county. In 2007 the program accomplished 60,000 fluoride varnish applications for 30,000 children, 1,645 dental sealants for 1,457 children, and placed 340 children in case management.

As of August 2009, however, the oral health landscape vastly changed. Budget cuts at the state level eliminated funding for the entire CCDDPP that supported these classroom-based services for the past 30 years. The shrinking dollars at the county level also resulted in a loss of \$50,000 that was contributed by San Bernardino Department of Public Health in support of dental programs. This has left a few small private grants (First 5 and a new grant via the Kaiser Foundation) to fund fluoride varnish programs for the four largest school districts. Targeted at

state-funded preschool students, these grants allow continued services to nearly 7,000 preschool students and kindergarten students less than 6 years of age. In the demonstration project, budget constraints resulted in loss of two staff members and an increased workload for all. Shrinking dollars have caused schools to reconsider participating in the dental program as well. With the reduction of school nursing staff, principals are reluctant to burden teachers with services that are not mandated.

In 2010 San Bernardino County has ceased funding the Treatment Service Program that assisted case managers with funding for students with no resources. This has caused much difficulty, especially for undocumented children in need or uninsured children who simply do not have the money to cover costly care. Many children who are case managed cannot receive the necessary services or their families cannot pay the sliding fees at the two Federally Qualified Health Centers (FQHCs) in the area. FQHCs are community-based organizations that provide health care, including medical, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay.

Over the 30 years of operation, Glube has tirelessly promoted oral health programs at school board and staff meetings, with assistance from multiple levels of school leadership and prominent school nurses. The most challenging task, however, is selling the effectiveness of the program to schools and districts that have never incorporated oral health in their classrooms and to the county, which is experiencing severe budget shortfalls. Glube spreads the message that poor oral health is the chief reason for school absenteeism, and children in pain are at too great a disadvantage to learn.

Participation from both school nurses and nursing students has numerous advantages for the families and for schools. Schools see less absenteeism due to early identification and referral of problems. In addition, involving nurses represents a much-needed shift to include oral health services in overall health care. In helping their community, the nurses-in-training learn that oral health is an integral component of general health.

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Lake County – *Tough Teeth & Healthy Start*

- Dental initiative that partners with Healthy Start and AmeriCorps and blends many funding sources and dental care through community health clinics, a dental van, and volunteers.

Demographics

Lake County is quintessential rural California with 65,000 people surrounded by pear and walnut orchards, an increasing number of vineyards, and the natural beauty of Clear Lake. In 2007 26% of families with children lived below the poverty level. In the 2007-2008 school year, 63.5% of children enrolled in Lake County schools participated in free and reduced-price meal programs compared to 50.9% statewide. There is a large portion of immigrant Latino parents in Lake County contending with language barriers.

The need

Although a substantial percentage of children in Lake County are poor and in desperate need of dental services, the area does not attract enough dentists to serve this population. Major obstacles are the absence of dentists participating in Medi-Cal and the absence of a dental program in community health clinics. For young children with complex needs or advanced decay who require anesthesia procedures, there were no services in the county; some families had to travel five hours one-way to receive dental care. Much of Lake County's population is highly mobile or are agricultural workers moving to where there is work. The challenge is to keep track of children and their needs. Since Medi-Cal uses an encounter-rate system, where one quadrant of the mouth is treated at a time, children with serious dental disease usually need at least four visits to complete their treatment plan. Fulfilling all appointments is nearly impossible for the children who move out of the Lake County system.

The solution

Increasing access to preventive services and dental care has hinged on creating partnerships to integrate existing resources and to generate new resources. Lake County's school-based oral health program, Tough Teeth, began in 1980 with funds from the state-funded CCDDPP, only enough for one staff. The program coordinator, Marta Fuller, has been the leader of the program from the program's inception. Although trained as a nurse, Fuller had extensive experience in oral health care working as a dental assistant for several years before making the switch to public health. In 1996, when Fuller learned that the Lake County Office of Education was preparing a grant application to form a Healthy Start program, she quickly advocated for integration of oral health.

Healthy Start programs are the product of California legislation in 1991 to provide funding for K-12 school-based programs that emphasize community and collaboration. Building partnerships with community organizations and agencies to streamline and integrate services is the hallmark of Healthy Start. Once initiated, programs can achieve sustainability by applying for other grants

and by billing for both clinical and administrative Medi-Cal activities that take place at school sites.

A core requirement for Healthy Start funding is the demonstration of an authentic community needs assessment, where parents and educators are surveyed to identify the specific roadblocks that prevent children from being healthy and able to learn. During focus groups parents revealed that access to health care was a huge issue. In Lake County access meant the availability of insurance, but also the ability to make it to appointments. The community showed a lack of interest in dental care, however. For parents, oral health was not considered a part of general health; with tight budgets, dental care was a low priority on a long list of competing needs.

Despite this lack of community interest, a natural partnership emerged between Healthy Start and Tough Teeth. Since 1996 the two programs have worked together with defined roles, creating a division of labor key to the program's success. Fuller provides the dental knowledge, acts as a dental advocate and identifies need. Healthy Start is responsible for the legwork. Each school that participates in the Healthy Start program has a coordinator on site to assist with classroom setup and data collection for screenings. The coordinators also work with families to case-manage dental care. This includes enrolling children into Medi-Cal or Healthy Families, setting up appointments and making sure that the appointments are kept. Since the 2009 CCDDPP budget cuts, multiple funding sources continue to support a .25FTE coordinator.

Healthy Start has a blended mix of funding sources. Money comes from individual school districts, grants (a First 5 oral health grant is used solely for dental care), and California Department of Education funds to assist homeless students. Another funding source for Healthy Start unique to Lake County is the Redbud Health Care District, a tax district that reinvests tax revenue into community health services. Prior to 2009, the state CCDDPP funded dental health coordination and preventive services.

Services include:

- Oral health education: Elementary school children receive oral health education in the classroom once a year using curriculum created by Fuller. Fuller also trains AmeriCorps members who are on staff with the Lake County Office of Education to lead oral health education for preschoolers. AmeriCorps reserves at least three of its weekly sessions for oral health topics. Additionally, parents of preschoolers receive education on oral health during monthly parent meetings or at the annual Health Fair at preschools. (The project was expanded into Mendocino County as well, with three more AmeriCorps workers stationed in Ukiah and Willits.)
- Screening: Healthy Start coordinators act as liaisons to schools and as administrative staff for Fuller. When Fuller performs screenings, the Healthy Start coordinator attends to consent forms, sends results home to parents, manages data collection and initiates case management for those children needing emergency care. For cases where insurance is not an option or emergency care is needed, Healthy Start coordinators can use CHDP funds to get children into a care setting.

- Fluoride: Community water fluoridation is not available in Lake County, which makes fluoride application an important component of a school-based oral health program. Multiple strategies are used to reach all children for fluoride varnish applications twice a year: in individual classrooms, during screenings, or during varnish clinics for several classes. At sealant clinics, every child receives a fluoride varnish application. Healthy Start coordinators keep track of consent forms, facilitate scheduling and record who receives the care.
- Sealants: A list is kept of the students deemed eligible for dental sealants during screening, and a sealant clinic is organized for the school site. Dentists from local community dental clinics volunteer to apply sealants and create more coordinated clinic referrals for additional care.
- Case management: Like any other rural area, getting from one place to another is a challenge for many residents, including those with cars, as dental clinics are dispersed throughout the county. For parents dependent on the limited public transportation in Lake County, taking their child to the dentist can be an all-day affair, which means a full day off work. Case management that includes transportation arrangements has been ideal for maintaining a steady stream of patients at clinics so “no-shows” are nonexistent. At the Clearlake Family Dental Clinic, an FQHC accepting MediCal, two afternoons every week are reserved for children referred by the Healthy Start program. The children are driven directly from school and brought back after their appointments so the school does not need to count an absence and still receives ADA money. The majority of children case-managed are in elementary school but Healthy Start can serve children in the entire school system through grade 12. Give Kids a Smile Day, a national volunteer program in February, serves children in both Lake and Mendocino counties through the Mendocino Community Health Clinic. One rural dental clinic in Potter Valley, however, recently has been lost as a result of state budget cuts.
- Dental van: A mobile dental van plays an important part in Lake County’s oral health program in areas where transportation and insurance status are obstacles difficult to overcome. Funding for the van comes from grants and donations, such as First 5 Oral Health and ACCESS Dental, a dental insurance provider. Depending on funds, dental van clinics occur two to four times a year. The van is parked at a school site for one week and children attend daily until their treatment plan is finished. For children who do not go to that school but are close by and in need of care, transportation is provided to the van. The van schedule and location are determined by the dental need identified by screenings and the insurance options for the community. Currently it serves three school sites and is used during Cinco de Mayo. Occasionally uninsured parents receive services from the dental van as well. The dental van is not meant to be a substitute for a dental home.

Results

In a small community like Lake County, connectivity and collaboration are vital components of making programs work. The Healthy Start and Tough Teeth collaboration is widely accepted by school administration and teachers. In an environment where school programs come and go,

Tough Teeth has built a reputation for being an established and sustainable program. Since Healthy Start is operated by the county office of education, teachers and administrators view Healthy Start as *part of their schools*, making buy-in an innate feature.

Parents also have buy-in with Healthy Start. Healthy Start coordinators reach parents on issues ranging from domestic violence to nutrition education. Many opportunities to form trust with parents leave lots of time to talk about their children's oral health.

Fortunately, five-hour trips for sedated dentistry are no longer the case. The opening of Pediatric Dental Initiative (PDI) in nearby Sonoma County has made dental sedation accessible for Lake County children. PDI is a nonprofit formed in 2001 from a collaboration of health providers, child advocates, and social service and public health programs from Lake, Sonoma and Mendocino counties. With financial support from both private and public sectors, PDI opened a surgical center in 2007.

Data from screenings and sealant clinics was a powerful tool in securing referral resources for children. Letting the numbers speak for themselves has been an effective way of creating buy-in and drawing resources for the program. Currently the dental director of the Clearlake Family Adventist Dental Clinic is serving on the State Board of Education's School Board Oral Health and Health Subcommittees and is trying to establish a clinic in one of the high schools. The dental director of Mendocino Community Health Clinic is a member of the state Oral Health Advisory Council and will represent the dental care needs of the two counties to the California Primary Care Association.

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Orange County – *Seals on Wheels*

- Collaboration and buy-in to provide preventive and comprehensive dental care through dental care coordinators to children in preschool through sixth grade

Demographics

Orange County is filled with fun destinations for children: Disneyland, Knott's Berry Farm and miles of coastline. There is certainly plenty to do and see in California's third most populous county. But something is lacking in Orange County: dental care for underserved populations, especially children.

The need

For every child without health coverage in Orange County, two do not have dental coverage, which translates to more than 150,000 children without dental insurance. Overall, 33% of children in Orange County have untreated decay, 5% higher than the state average. Nearly 35% of kindergarteners in Orange County required some type of dental care in 2007 compared to 20% statewide. Dental clinics that provide low-cost care are crucial to meeting the needs of this population, but only 11 dental clinics operate regularly in Orange County.

The solution

The Seals on Wheels program, a school-based oral health program for preschool children through sixth grade, seeks to bridge this gap for uninsured children in Orange County. Formed in 1999, Seals on Wheels helped 299 children that first year receive dental sealants at two school sites.

The majority of Seals on Wheels funds came from the state-funded CCDDPP (\$200,000 of the \$350,000 budget). A small portion of the budget is earned revenue from Denti-Cal for reimbursement of fluoride varnish applications. Grants from private foundations make up the rest of the operating budget.

Seals on Wheels is committed to providing an in-service education program for teachers. During a 45-minute session, teachers learn about clinical prevention strategies, how oral health is related to general health and learning, and what Seals on Wheels offers students. Teachers are crucial for overall buy-in. If teachers feel that their students will benefit from oral health services, they are willing to free up class time.

The program provides a number of services:

- Oral health and nutrition education: RDHs and registered dental assistants (RDAs) teach two half-hour age-appropriate oral health and nutrition education presentations to participating schools. The curriculum has been crafted by Seals on Wheels staff to incorporate California health education standards. Students are given a pre- and post-test on oral health, and teachers are given an evaluation form to assess the curriculum and

individual educator. Parent education is also provided. Lessons are presented in both English and Spanish at open house nights, school health fairs, or special sessions held before or after school.

- Fluoride varnish: Children attending Head Start centers or state-funded preschools, except those with private insurance, are screened and receive fluoride varnish applications and cleaning of their teeth by an RDH. This program bills Medi-Cal for the varnish treatments. The earned revenue contributes only a small fraction to the overall budget, but is a crucial part of program sustainability.
- Dental sealants and screening: A full-time RDA, the Seals on Wheels coordinator, checks for signed consent forms and organizes the efforts of four part-time RDHs and an occasional volunteer dentist who provide screening and dental sealants to children in kindergarten and grades 2, 5 and 6 in hopes of sealing newly erupted molars. Screening and dental sealants are done at school sites using portable equipment. If obvious advanced decay is present on tooth surfaces, then sealants are not placed and the child is referred for restorative care. Two weeks after the sealants are applied, the RDH returns to perform retention checks to make sure that sealants are intact. The retention check helps in collecting data, which is used primarily for grant writing and program evaluation.
- Referral for treatment: A team of dental care coordinators is charged with helping children access dental treatment. A list of students needing care is generated during screenings and given to the school nurse, with a copy to the dental care coordinator. The coordinators contact parents with referral sources, trying to accommodate the parent's needs (e.g., ability to pay, location, language) and scheduling an appointment if requested. Regular sources of care are local community clinics and a few private dentists.

Results

Early on the program was difficult to implement, with resistance from teachers and administrators, lack of funding, and the complex logistics of bringing services into schools. Seals on Wheels staff maintained the patience and dedication to establish a base of trust with several schools. School nurses are valuable advocates for oral health programs; their relationship with the principal can be instrumental in securing buy-in. Supportive principals can help to recruit teachers; teachers previously involved can help to recruit new teachers. Mastering the art of knowing *who to talk to when* helped raise the number of schools served from two in 1999 to 45 in 2007.

Collaboration plays a major role in expanding capacity. Working with community clinics and participating in health fairs not only increases the reach of Seals on Wheels, but helps to form relationships within the community. In addition, 17 volunteer dentists from the Orange County Dental Society provide pro-bono care to children who are unable to afford care. Trying to get children dental care and trying to connect families with a dental home persistently pose challenges for the program. In 2007, Seals on Wheels embarked on the biggest partnership to date – merging as a division of Healthy Smiles for Kids of Orange County (HSK). HSK is a nonprofit that formed in 2003 out of a need to strengthen the dental safety net for children in

Orange County. HSK is a comprehensive organization combining prevention, education, treatment and advocacy to positively affect children's oral health. With similar missions, a partnership between the Seals on Wheels and HSK was inevitable. The complete merge mutually benefits both organizations and more children are able to receive valuable services. An advantage of teaming with HSK has been the assistance from a team of grant writers and managers on staff.

In 2007, Seals on Wheels served more than 35,000 children, providing oral health education, sealants, fluoride varnish, and referral services. Unfortunately, with suspension of funding for the state CCDDPP in June 2009, funding for many of the preventive and program services has been lost. The organization maintains a strong commitment to the provision of prevention services to children and a continuation of the delivery of these services at locations that facilitate access for the children and the families. A redesign of the structure of the program included a reduction in staff positions, including that of the executive director and some of the prevention clinical staff. Negotiations are in process for partnering with a local Federally Qualified Health Center to continue the delivery of services in the community, and with the local school systems for new contractual agreements.

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Los Angeles County – Pasadena Young and Healthy

- An example of integrated oral health and other health services under one nonprofit organization, relying on volunteers and grants but no state or federal funding to provide school-based oral health services.

Demographics

Pasadena, the sixth largest city in Los Angeles County, is nationally known for the Rose Bowl and Rose Parade. However, it's not all roses for the city. Although the city has affluent communities and 30% of the city's children attend private schools, the Pasadena Unified School District (PUSD) educates significant numbers of low-income, disproportionately African American and Latino communities. According to the 2007 American Communities Survey, 34% of families served by the district live below the poverty level. In the 2007 school year, 67.7% of PUSD students qualified for free or reduced-price lunch.

The need

In 1988 a community needs assessment, *The Health of Pasadena's Children*, explored inequities in health care access. The report uncovered that nearly 30% of children in Pasadena were without health insurance. No dental statistics were available. A newly released 2010 report by The Children's Dental Health Project of Los Angeles County, *The Oral Health Baseline Needs Assessment of Underprivileged Children*, includes low-income preschool and school children in Pasadena. Overall findings for Los Angeles County indicated:

- On average, 44% of the 2,313 children examined have dental decay, but 90% of white-Hispanic elementary school children have decay.
- 72% of the children needed dental care, with another 9% needing immediate dental care.
- 21% have no dental insurance, 43% are covered by Denti-Cal and 14% by Healthy Families.
- Only 6% drink tap water as their main water source, even though it has been fluoridated since 2003.
- One-half of 5,790 dental offices and clinics contacted did not serve children covered by Denti-Cal.

The solution

Dr. Don Thomas, a family and emergency room physician in Pasadena, realized that many of the sick children he treated arrived at the emergency room in lieu of accessing primary care. Thomas organized a group of local physicians to donate a portion of their time to treat uninsured children. By 1990 the nonprofit Pasadena Young and Healthy was born. Young and Healthy started by offering free medical services to children. After the first few months it became apparent these children were in desperate need of dental care. A staff member recruited her personal dentist to provide free dental services, creating the start of a range of dental programs now offered by Young and Healthy.

Young and Healthy has well-established relationships within the community. In addition to a special connection with PUSD, Young and Healthy collaborates with the Pasadena Public Health Department, local hospitals, health providers, community leaders and a dedicated group of volunteers. After 20 years of serving the children of Pasadena, Young and Healthy offers an integrative approach to healthcare. Local volunteer physicians, dentists, optometrists, therapists and other healthcare providers create a network of resources for uninsured school children.

Young and Healthy's financial resources come primarily from grants from public and private organizations, local foundations such as the Patron Saints Foundation, QueensCare Charitable Division, Rose Hills Foundation, and the S. Mark Taper Foundation. Young and Healthy currently does not operate with state or federal money. Donations and a high degree of volunteerism from health providers and community members drastically increase capacity.

The program offers an array of school-based oral health programs to children in PUSD:

- Kindergarten screening initiative: To meet the AB1433 requirements for an oral health assessment for children entering their first year of public school, the program uses local dentists from the San Gabriel Valley Dental Society to adopt a school and work with the school nurse on logistics. A form is faxed to each school outlining all the necessary steps and supplies needed to perform the assessment. Children found to have dental disease requiring follow up are placed with one of three case managers at Young and Healthy. The case manager works with the parents to determine the best source for dental care, either a dental clinic within the family's area or services from a volunteer dentist.
- First grade dental education program: Developed in 1994 with a budget of \$6,500, the educational program for first graders trains a group of volunteer retired teachers, retired dental hygienists, community members, and dental hygiene students from Pasadena City College. Dental hygiene students volunteering in the program are motivated to contribute by receiving credits toward their degree. Volunteers aim to provide a 20-25 minute session designed by Young and Healthy once a month during the school year (9-10 times total). Each teacher designates times for volunteers to come to the classroom. The oral health lesson plans include several printouts for the children and materials for parents. Teachers are asked to evaluate the effectiveness of the lesson plan through a form provided by Young and Healthy.
- Mobile dental clinic: In partnership with the University of Southern California (USC) School of Dentistry, and with a budget of \$47,000, Young and Healthy arranges free dental care to 120 students ages 7-18 throughout PUSD. Dental students and faculty provide acute care services from a mobile dental clinic. Dental teams work in four converted recreational vehicles. Young and Healthy coordinates training for school nurses to learn the basics of oral assessments from USC faculty. The nurses then routinely screen students to identify those who need care. Parents are notified by the school nurse to determine if they are eligible (without dental coverage and unable to access care) and would like to participate in the mobile clinic. The mobile clinic takes place for seven days at a centrally located school that has enough space for the four trailers. Children served by the clinic receive x-rays and a plan of treatment for the week,

all under the supervision of licensed pediatric and general dentists. Parents must be present when their children are seen. While the children are receiving care, parents receive oral health information that will benefit their entire family.

Results

There is a high learning curve to make programs work effectively and efficiently. In the beginning of the kindergarten screening initiative, it was unclear how to recruit volunteer dentists and how to facilitate coordination between Young and Healthy, school nurses and volunteer dentists. Over the years, Young and Healthy has engaged almost 50 volunteer dentists available on a rotational basis to provide acute dental services to children in their offices after the annual screenings.

It took time to refine the first-grade oral health curriculum and training enough that a volunteer and teacher could work independently. The first-grade education program is well liked by teachers and students, and schools are eager to continue participating. In 20 PUSD elementary schools, 65 first grade classrooms participate in the program.

Since its inception, the mobile clinic has served more than 93,000 children and has become the flagship of USC School of Dentistry's Community Outreach Programs. At the end of the event, an estimated \$190,000 worth of dental services are provided free to the children.

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Lessons Learned

The experiences of the case study programs reveal a number of challenges that face school districts and their partners that are interested in establishing school-based oral health programs. However, they also reveal characteristics and components that can increase program effectiveness and likelihood of success.

Barriers

Improving children's knowledge base, academic performance, and problem-solving skills is clearly the mission of schools, which sometimes allows **little time for non-academic services**. Nearly all of the programs acknowledged the difficulty of convincing principals and educators to spare time for oral health programs that were not part of the educational curriculum. A common theme was the "vicious cycle" where the lowest performing schools demonstrated the greatest need for oral health services, yet these were the hardest ones from which to gain support.

Inadequate funding is an issue for every program, especially since the suspension of the state CCDDPP funding. A common complaint was the need to chase after grant funding to sustain programs. Program coordinators constantly keep an eye open for different opportunities from various sources: local, state and federal.

California is the most diverse state in the country, with new residents coming from all parts of the globe. Programs mentioned the difficulty that comes with working with newly immigrated parents. Fear is the most likely response to a phone call from a school nurse or case manager saying that their child is sick and needs to see a dentist. **Lack of cultural competency** requires programs to address parents' understanding of the local community and to use bilingual/bicultural staff. The crucial step in eliminating fear is to develop trust with parents, an act of both patience and understanding.

All these barriers demonstrate a **lack of recognition for the importance of oral health**. Oral health has always received low priority despite the high rate of dental disease in the United States, and may be considered a "neglected epidemic." Without an appreciation for oral health from a broad audience, there will always be challenges.

Solutions

A number of initiatives and practices are identified which help to boost the effectiveness of school-based oral health programs.

One of the most important elements is **establishing "buy-in"** from the school system. The first step that most programs used in establishing buy-in was to gain support from the superintendent or school board. Demonstrating the academic benefits of good oral health (see Chapter I) as well as the financial benefits of increasing school attendance and academic achievement helped persuade the superintendent and board that involvement in oral health programs is an appropriate role for schools and is worthy of valuable class time. **Staff development** is another important part of creating buy-in. As school personnel developed trust in the programs, word of mouth

became a powerful tool for promotion. Buy-in is a process built over time and is labor-intensive: lots of pitching the program to multiple groups (school boards, teachers, principals, teachers, school nurses) and developing allies, who were often school nurses. Communication and sharing a common language is crucial, as educational terms are often unfamiliar to dental professionals and dental terms are unfamiliar to educators and the general public.

Once schools are convinced of the value of oral health activities, **collaboration** will help ensure the program's success and sustainability and enable the program to expand capacity. Collaboration with clinics, dental professionals, nonprofit organizations and other local agencies was an essential facet of reaching more children and offering comprehensive services. To make collaborations and partnerships work, the programs had to demonstrate flexibility and compatibility.

Expanding capacity may also be accomplished by involving school nurses and using **non-dental personnel** for a variety of roles. Previous experience in the dental field should not be a prerequisite for volunteers, who can be retired teachers, health profession students, parents and other community members. All of the volunteers need to be publically acknowledged.

Parent involvement was a component of all the school-based oral health programs. Either before or after school hours, or during back-to-school nights, classrooms accommodate parents for lessons on oral health care to support what their children are learning in school. Parents should also be involved in the initial conversation with school personnel about the desire and need for a school-based oral health program. This would introduce a bottom-up or grassroots approach to creating buy-in.

Knowledge about proven best prevention practices and community engagement is another major factor for successful programs. Understanding the community is a big part of creating a thriving program. The community includes not only the children and parents, but the culture of a particular school as well.

All the programs keep records of services rendered, such as how many sealants are placed or the number of fluoride varnish applications, but there is little study **assessing the final impact of services**. For example, what is the percent decline in new tooth decay or absenteeism due to dental problems or appointments? These statistics require re-screenings or better documentation of completed care, parent surveys, and reports from schools. This information would help increase the appreciation for oral health and prevention services.

V. RESOURCES

American Dental Association divides its Web site into information for dental professionals, the public and dentist members. Most full journal articles, reports and other items that are considered member benefits are restricted to member viewing by a password. Journal abstracts can be viewed along with information on a number of oral health related topics. School personnel can, however, benefit from the many resources listed on the public portion of the Web site, including oral health modules for preschool through grade eight.

www.ada.org/public/education/teachers/smilesarts/index.asp

Association of State and Territorial Dental Directors (ASTDD) represents state governmental oral health programs. Through cooperative agreements with the CDC and Health Resources and Services Administration it provides resources and technical assistance to states and partners with more than 25 national organizations. A number of resources are posted on the Web site, including a section devoted to school and adolescent oral health that includes the oral health integration model included in this guidebook. Navigate via the A-Z tab. www.astdd.org

California Department of Education, Oral Health Assessment reviews the provisions of the assessment program and provides sample letters and forms.

www.cde.ca.gov/ls/he/hn/oralhealth.asp

California Department of Public Health, California Children’s Dental Disease Prevention Program provides an overview of this program, program materials and links to other organizations that have resources. Information for school personnel and parents is available on topics such as sealants, first aid for dental emergencies, toothbrushing, and oral injury prevention. www.cdph.ca.gov/programs/Pages/CCDDPP.aspx

California School Boards Association provides policy services, publications, policy briefs, fact sheets, leadership development and other resources on a variety of student health issues, including nutrition, oral health and school health services. In partnership with California Project LEAN, it published *Student Wellness: A Healthy Food and Physical Activity Policy Resource Guide* to provide school governance leaders with a step-by-step approach to enhance the school environment so students can develop and practice healthy eating habits. CSBA also offers the Practi-Cal program which simplifies the complicated billing process of filing reimbursement claims for health services provided to eligible students in the school setting as well as Medi-Cal Administrative Activities outreach activities. www.csba.org

California School Health Centers Association provides information and monthly updates on potential funding for school-based and school-linked health programs as well as resources related to health center policies and operations, communications and advocacy.

www.schoolhealthcenters.org

Center for Health and Health Care in Schools has collected and developed a number of materials on school health, including a dental health section. Categories of materials include background on oral health, clinical operations and management, financing issues, state and local dental health policies and programs, and Caring for Kids grant program summaries, with additional resources and links.

www.healthinschools.org/Health-in-Schools/Health-Services/School-Based-Dental-Health.aspx

Centers for Disease Control and Prevention (CDC) houses a number of divisions and programs that provide resources on oral health and on school health for the public and for professionals. www.cdc.gov

- *Youth Risk Behavior Surveillance – United States, 2007*
www.cdc.gov/mmwr/preview/mmwrhtml/ss5704a1.htm
- *School Health Programs. Improving the Health of Our Nation’s Youth, 2009*
www.cdc.gov/nccdphp/publications/aag/pdf/dash.pdf
- Fluoride Recommendations Work Group, Recommendations for using fluoride to prevent and control dental caries in the United States, *Morbidity and Mortality Weekly Report*, August 17, 2001, 50(RR14): 1-42.
www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm
- National Center for Chronic Disease Prevention and Health Promotion, *Healthy Youth! Coordinated School Health Program*. www.cdc.gov/HealthyYouth/CSHP
- National Oral Health Surveillance System www.cdc.gov/nohss
- Task Force on Community Preventive Services, Promoting oral health: Interventions for preventing dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries, *Morbidity and Mortality Weekly Report*, November 30, 2001, 50(RR21): 1-13.
www.cdc.gov/mmwr/preview/mmwrhtml/rr5021a1.htm
- CDC Division of Oral Health posts information for the public and professionals on a variety of topics. www.cdc.gov/OralHealth

Centers for Medicare and Medicaid Services (CMS) Medicaid School-Based Administrative Claiming Guide is intended to help schools and other interested parties better understand when Medicaid reimbursement can be obtained for the administrative costs of school-based health services and how to prepare and submit appropriate claims for federal financial participation (FFP).

www.cms.hhs.gov/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf

Children's Dental Health Project in Washington, D.C. serves as the federal Maternal and Child Health Bureau's National Oral Health Policy Center. It provides fact sheets, issue briefs, policy briefs and other resources in addition to advocacy related to children's oral health and financing programs. www.cdhp.org

- *Cost Effectiveness of Preventive Dental Services*, 2005
- *The Policy Tool Guidebook: Steps for Creating a Successful Oral Health Policy Tool Session*, 2009

Dental Health Foundation works through community partnerships to advance the public's oral health interests by providing advocacy and policy development, services and education and oral health research. A number of California and national reports are posted on the Web site. www.dentalhealthfoundation.org

Missouri Department of Health and Senior Services provides downloadable oral health education PowerPoint presentations designed specifically for kindergarten through high school in English, Spanish and a Native American version. www.dhss.mo.gov/oralhealth/OralHealthEducation.html

National Maternal and Child Oral Health Resource Center at Georgetown University houses a number of local, state and national resources on various aspects of oral health and school health, many of which are available online. Examples of oral health curricula for schools are also included in its library. The Center works with national partners to produce materials. www.mchoralhealth.org

- *Promoting Oral Health in Schools: A Resource Guide*, 2009, contains examples of educational curricula, guidelines, program manuals and other materials from states or organizations
- *Dental Sealant Resource Guide*, 2006
- *Improving the Oral Health of School-Aged Children: Strengthening School-based Dental Sealant Program Linkages with Medicaid/SCHIP and Dental Homes*, Summary of expert meeting, 2006
- *Pain and Suffering Shouldn't Be an Option: Oral Health in School-Age Children and Adolescents*
- *Seal America. The Prevention Invention*, Manual, 2007
- *Oral Health and Learning*, Fact Sheet, 2003

National School Boards Association maintains an online district policy database for members and searchable databases on school health and promising district practices, as well as links to a variety of resources. www.nsba.org

Ohio Department of Health Bureau of Oral Health Services has created a comprehensive curriculum for grades K-6, a teaching module on the dangers of using smokeless tobacco, and a dental first aid chart. www.odh.ohio.gov/odhPrograms/ohs/oral/oraledumat/schlprogs.aspx

San Diego Share the Care Program includes a wealth of information for schools and parents. Available for downloading are oral health curriculum modules for ages 4 through 14, a separate teen dental health training curriculum, an oral health assessment toolkit related to accomplishing the dental evaluation for school entry, a children's booklist on the topics of dental health and nutrition, a manual on using arts and crafts to teach the importance of good oral health, and various short information sheets related to prevention and handling of oral injuries and creating healthy lifestyles through nutrition and physical activity. www.sharethecaredental.org

U.S. Department of Health and Human Services publishes a number of documents that serve as background or guidelines for oral health and school health programs, including the Healthy People 2010 objectives for improving health. www.hhs.gov

Health Resources and Services Administration of the U.S. Department of Health and Human Services is the primary federal agency for improving access to health care services for uninsured, underserved and special needs populations. The agency administers grant funding for the Federal Health Center Program (migrant health centers, community health centers, health care for the homeless and public housing primary care centers) and provides information on oral health and the *National Survey of Children's Health*. www.hrsa.gov

Virginia Department of Health has developed a number of downloadable curriculum materials for schools. www.vahealth.org/dental/oralhealtheducation/training.htm

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APPENDIX A

RATIONALE FOR SCHOOL-BASED ORAL HEALTH SERVICES

Global and national recognition of the need for a focus on oral health in schools

The World Health Organization promotes school health programs as a strategic means to prevent important health risks.¹³ *Oral Health in America: A Report of the Surgeon General*, published a decade ago, called for continued emphasis on education and programs in schools to prevent children’s use of tobacco products and to prevent tooth decay using dental sealants and fluorides.²¹

Integration of oral health in school health is promoted globally as well as in the U.S.

and programs in schools to prevent children’s use of tobacco products and to prevent tooth decay using dental sealants and fluorides.²¹

A subsequent report, *A National Call to Action to Promote Oral Health*, calls for four actions to improve public perceptions about oral health: (1) enhance oral health literacy, (2) develop messages that are culturally sensitive and linguistically competent, (3) enhance knowledge of the value of regular, professional oral health care, and (4) increase understanding of how the signs and symptoms of oral infections indicate general health status and act as markers for other diseases.³³ Schools can play an important role in all four actions.

One of the developmental objectives in the Healthy People 2010 Objectives for the Nation addressed the need for school-based oral health services as part of school-based health centers (see Figure 1).²⁹ The same objective has been proposed for Healthy People 2020, with more specifics about the focus of the programs. A national oral health workgroup has recommended adding oral health to the list of focus areas proposed in another Healthy People 2020 objective, “Increase the proportion of elementary, middle and senior high schools that provide comprehensive school health education to prevent health problems in the following areas...”³⁴

Figure 1.
Healthy People 2010 Objectives

“Increase the proportion of school-based health centers with an oral health component.”	2001-02 Baseline	2010 Target
21.13a. Dental sealants	12%	15%
21.13b. Dental care	9%	11%

Data source: School-Based Health Care Census, National Assembly of School-Based Health Care⁵

A new question for the 2007-2008 National Assembly on School-Based Health Care (NASBHC) Census will permit tracking of trends in key oral health indicators.^{27,35} The new question asks: “Indicate which of the following oral health services are provided onsite: Oral health education, Dental screenings, Dental examination (by a dentist), Dental sealants, Fluoride mouthrinse, Fluoride varnish, Fluoride supplements (tablets), Dental cleaning, General dental care (fillings, extractions), Specialty dental care (orthodontics, root canal).” If not provided onsite, respondents indicate which services are provided offsite by referral, or not provided or referred. The new question will permit trend reporting for HP2010, the ASTDD State Synopsis and the National School-Based Health Care Census.

Extent of oral health problems in children

More than half of all children in the nation have dental decay by second grade; by the time they graduate, about 80% will have experienced dental decay.¹ The California Smile Survey, a sample of 21,399 kindergarten and third-grade students in 186 schools in 2004-05, demonstrated alarming statistics.³⁶ Seventeen percent of kindergarteners and almost six percent of third graders had never been to a dentist. Schools can help find care for these children.

The California Smile Survey also found oral health disparities among children who are eligible for the federal free/reduced price lunch program compared to their higher income classmates (see Figure 2). Latinos and other minorities have higher tooth decay rates than their White classmates, as do families who don't have dental insurance.

When the California findings are compared to the Healthy People 2010 objectives, California is woefully short of the goals (see Figure 3).³⁶ According to the National Survey of Children's Health, only Arizona, Mississippi, Nevada and Washington D.C. have higher percentages of children with oral health problems overall.³⁷ Despite all the evidence for their effectiveness, the 2004-05 statewide survey of California children noted that more than 70% of those children surveyed did not have any dental sealants.

Figure 2.
Healthy People 2010 Objectives

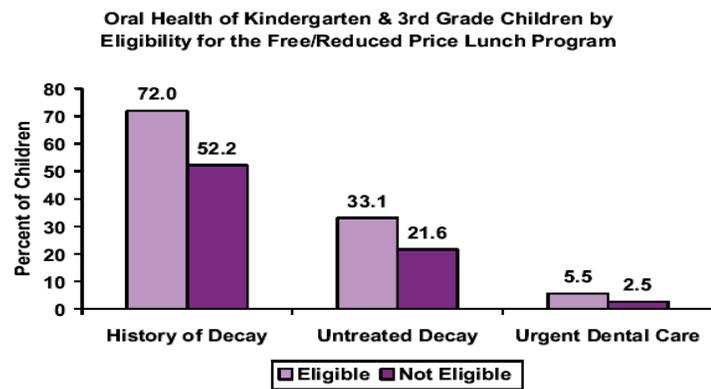
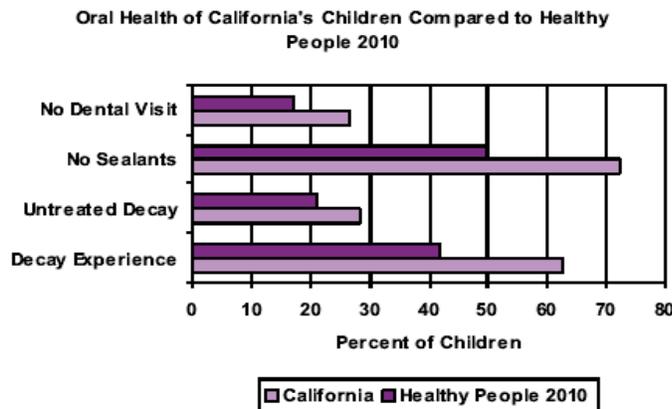


Figure 3.
Healthy People 2010 Objectives



For most children and adolescents with special health care needs, oral health care is the greatest unmet need compared with all other health care services, including mental health. Unmet oral health care needs affect 78% more children and adolescents with special health care needs than unmet mental health care needs.³⁹

It is important for schools to include special needs students in surveys and in school-based oral health services.

Despite the discouraging findings from the 2004-05 Smile Survey, it does appear that there have been significant improvements in the oral health of California's children over the last decade. Between 1993-94 and 2004-05, the percentage of third-grade children with untreated decay decreased from 57% to 29%, while the percentage with dental sealants increased from 12% to 28%, although sampling differences preclude direct comparisons between the two surveys.³⁹ Some of the increases in sealants are probably due to their increased placement in school-based sealant programs. Recent national surveys, however, show that tooth decay rates are on the rise in children younger than age five for the first time in 40 years. This means that more children entering school in future years will already be at an oral health disadvantage unless they start receiving preventive services earlier, preferable as infants and preschoolers.

Oral injuries continue to be a problem for children and young adults. Most injuries that were observed in hospital emergency rooms were to the lips and soft tissues, while 22% of the injuries were to the teeth and bones. Some of these may have occurred in school, during school-sponsored sporting events or on the playground. Other oral injuries may be the result of abuse, including bruises, burns, bite marks, scarring or lacerations of any parts of the face or mouth; teeth with fractures, dislocations or completely knocked out; or bone and jaw fractures. Although oral sex is common in sexual abuse, visible oral injuries or symptoms of transmitted diseases are often difficult to detect.⁴⁰ A single injury to a tooth may not heal completely and may create expensive, long-term problems. Initial management of oral injuries in schools is estimated to be more than \$1,000 per student, which doesn't include follow up.¹⁷

Unfortunately, no national dental injury surveillance system exists. Some states, such as Massachusetts, are considering legislation to conduct comprehensive studies of oral injuries in school sports.

In 2001, the U.S. Task Force on Community Preventive Services noted that oral injuries had decreased in sports such as football and ice hockey since use of helmets, facemasks and mouthguards became mandatory.¹¹ Baseball and biking are associated with high rates of oral injuries. Research shows that face guards, eye protection and mouthguards significantly reduce the risk of injury in youth baseball. An epidemiologic study of soccer injuries in U.S. high schools noted 13.7% were to the head and face.⁴¹ A study comparing oral-facial injuries in basketball showed a seven times higher rate of injury in those players not wearing mouthguards.

Dental care utilization and costs

Despite attempts to get children into care, use of professional dental care by Medicaid-eligible children in California is very low. Figure 4 shows a detailed breakdown by age.

Figure 4. Medi-Cal Users, Eligibles, Utilization Rates and Expenditures by Age Group, 2008⁴³

Age Group	Users	Eligible	Utilization Rate (%)	Expenditures
0-5	412,565	1,949,840	21.2	\$119,074,437
6-8	294,420	793,322	37.1	89,961,346
9-11	238,423	742,241	32.1	58,108,168
12-14	213,509	744,707	28.7	57,883,990
15-18	247,431	1,006,9881	24.6	83,380,107

Costs for dental care of children covered by Medicaid in California are significant despite low utilization and reimbursement rates. In California, payment levels are substantially below dentists' charges.⁴⁴ Families who do not have dental insurance or a regular source of dental care often seek relief of pain in a hospital emergency room. This is costly and still requires follow-up dental care.

Some barriers to utilization include low provider reimbursement resulting in dentists not participating in the program; long waiting lists for those dentists or clinics who do accept Medi-Cal or Healthy Families or who treat the uninsured; dentists who feel inadequately trained or uncomfortable treating children and pregnant females; high no-show rates for appointments in low-income families; families unaware of their dental benefits or who go on and off Medi-Cal; and family obstacles such as taking time from work or school or lack of transportation.

Inclusion of dental services in school-based health centers or care coordination by schools with local clinics or private practitioners could alleviate some of these barriers.

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.⁴⁵ In 2008 there were CCDDPP coordinators in 31 counties in California serving preschool through sixth grade in 1,112 schools.⁴⁶ Schools participating in the program were required to have at least 50% National School Lunch Program participation. Due to funding limitations, only 12% (300,000) of eligible children were reached at an annual cost to the state of \$3.2 million, or \$10 per child per year.^{48, 47} CCDDPP has five required program components: (1) fluoride supplementation: 2-3 annual varnish applications, weekly mouth rinse or daily tablet, (2) dental sealants in molar teeth, (3) plaque control via toothbrushing and flossing, (4) oral health education and (5) an active community oral health advisory committee.⁴⁶ In a typical year 15,000 children received dental

sealants and 200,000 children participated in a fluoride program, while more than 6,000 students were referred by the program for urgent dental care.

As the case studies in Chapter V of this guidebook demonstrate, the state CCDDPP funds leveraged other local and county funds and a huge amount of in-kind donations and volunteer services from schools and professionals in the community. Despite this demonstrated commitment, in 2009 the governor suspended the entire program due to budget deficits. The 2009-10 state budget significantly decreases the availability of preventive health care to California's children and will further widen health disparities for low-income children and children of color.

Those schools that have benefited from this funding and these programs in the past are encouraged to enlist partners to work on a sustainability plan through 1) advocating for a reinstatement of the state funding for such a cost-effective program; 2) advocating for use of federal Title V Maternal and Child Health Block Grant funds given to the state (one of the performance measures that states are required to report is the percentage of third grade students who have received dental sealants); and 3) forming or working with a local oral health coalition to identify other resources for staffing or purchasing supplies.

APPENDIX B

COMMUNITY DENTAL RESOURCES BY COUNTY

This document, prepared by the Dental Health Foundation, highlights specific community dental resources for each county in California. It includes the name of the organization, contact information, services provided and who is eligible, and the payment options available.

In order to access this alphabetical listing by county, click [here](#) and scroll down to the desired county.

If you have any questions about this resource, please contact Joel Cohen, Policy and Community Education Director at the Dental Health Foundation, jcohen@tdhf.org.

APPENDIX C

MOBILE/PORTABLE DENTAL CARE PROVIDERS

Many school districts throughout California have been solicited by mobile/portable dental care providers offering to provide school-based dental services for students. For most school districts, talking and negotiating with such providers is new. Some have expressed a need for assistance in deciding whether and under what conditions to contract with these private providers.

In an effort to assist school districts approached by mobile/portable dental care providers, a statewide group of dental and education professionals, led by the Dental Health Foundation and the California Dental Association, developed the documents below, which include a one-page overview of issues to consider, a more detailed set of guidelines, and a sample memorandum of understanding. This information kit is not intended to lead school districts to a particular decision; rather, it is intended to give decision-makers some tools and ideas to help make the best choice for a particular situation.

For more information about mobile dental care providers, please contact the California Dental Association at 800-CDA-SMILE, ext. 5305 or the Dental Health Foundation at 510-663-3727.

These resources can be found by clicking on the links below:

- [Cover memo](#)
- [Things to Consider](#): This document highlights twelve items for school districts to discuss when considering entering into a contract with a mobile/dental care provider.
- [Mobile Provider Guidelines for School Districts](#): This spreadsheet outlines in more detail items and issues for school districts to discuss when considering contracting with a mobile/dental care provider.
- [Sample Memorandum of Understanding \(MOU\)](#): This sample MOU is an example for school districts to use and tailor to fit their specific needs.