


The Virtual Dental Home in Orange County: Building Best Practices into the Oral Health Care Delivery System for Children

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December 2020

Acknowledgments

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Introduction

While largely preventable, dental caries (tooth decay) is the number one chronic disease among children.[1] It is especially prevalent among low-income children, such as those enrolled in Medi-Cal, California's Medicaid program. One of the main reasons low-income children do not get needed dental care is that the traditional office-based dental care delivery system does not reach a large segment of the population, including children. Many families face significant systemic obstacles to accessing dental care, such as financial, transportation, language, and cultural barriers. This is in addition to the difficulty of finding dental offices that accept Medi-Cal.

These barriers hold true for children in Orange County. While having a dental visit is not a definitive indicator of complete or regular care, available data show that just over 54 percent of children enrolled in Medi-Cal in Orange County had a dental visit in 2018. Despite this being better than the state rate of 47.6 percent, these data mean that nearly half (46 percent) of Medi-Cal-enrolled children in Orange County did not have a dental visit that year.[2]

This is why First 5 Orange County chose to implement the Virtual Dental Home (VDH) as part of its Local Dental Pilot Project (LDPP). The aim of the LDPPs—which were part of the Dental Transformation Initiative (DTI) of California's Medi-Cal 2020 waiver—was to increase Medi-Cal-enrolled children's use of preventive, risk-based, and continuous dental care through innovative pilot projects, such as the VDH.

The VDH uses technology and innovations in workforce to bring safe, high-quality dental care to children where they already spend time, such as at schools and early learning sites.[3] With this pilot, four community health centers (CHCs) through one VDH team each, implemented the VDH in 12 schools and early learning sites. In addition, Healthy Smiles for Kids of Orange County (HSK), a private nonprofit dental provider, through eleven VDH teams, implemented the VDH in 92 additional community sites.

While data for HSK are included in this brief, this brief primarily focuses on the experience of the CHCs because HSK had already been implementing the VDH before the LDPP. As a result, they had streamlined their VDH processes and were not interviewed for this brief.

Notably, during the last year of the pilot, the providers were operating within the COVID-19 Public Health Emergency (PHE). Yet, some CHCs continued to serve as children's dental homes by using phone and videoconferencing to provide oral health education and support. And they are prepared to continue supporting children's oral health—whether on site or remotely—as community sites identify and continually modify how they will operate over the foreseeable future.

This issue brief provides background on the VDH, outlines how the VDH had been implemented by CHCs in Orange County as part of the LDPP, identifies lessons learned and best practices related to the deployment of the VDH, and provides recommendations for sustaining and integrating best practices into the oral health care delivery system throughout Orange County and the state.

[1] US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, Oral Health in America: A Report of the Surgeon General (Rockville, MD: US Department of Health and Human Services, 2000): 63; Dental Health Foundation, Mommy, It Hurts to Chew: The California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children (Oakland, CA: Dental Health Foundation, 2006).

[2] California Health and Human Services Open Data Portal https://data.chhs.ca.gov/dataset/242e5248-686f-4fdb-8c85-dc970de43d8f/resource/cbcdc262-5877-422e-8d2a-bd1459a90950/download/mdsd-utilization-and-sealants-by-county-cy-2013-to-2018.csv; https://data.chhs.ca.gov/dataset/f256b423-68ed-4958-ae79-9b2505e0578b/resource/ced1302b-0f32-426f-83d7-fb4c9e283444/download/mdsd-utilization-and-sealants-by-age-cy-2013-to-2018.csv

[3] While the project described in this document is geared toward children, the VDH serves all ages.

Overview of the Virtual Dental Home

Created by the Pacific Center for Special Care at the University of the Pacific School of Dentistry (UOP) and currently supported by Dr. Paul Glassman and his team at California Northstate University (CNU), the VDH is an evidence-based strategy for addressing barriers to accessing dental care by bringing that care to patients where they are—such as at schools, early learning sites, health clinics, and other sites in the community. Through the VDH, specially trained dental hygienists and assistants go to community sites to provide preventive and therapeutic dental care to patients. They start by collecting dental diagnostic information from patients, using portable x-ray machines, intra-oral cameras, cameras, and charting. They send that information electronically via a secure web-based system (called store-and-forward telehealth) to the collaborating dentist at a provider office. The dentist uses that information to establish a diagnosis and create a dental treatment plan for the hygienist or assistant to carry out. That plan can include activities such as providing preventive and therapeutic procedures—including sealants, cleanings, and interim therapeutic restorations (ITRs)[4] —education, and care coordination. The hygienists and assistants refer patients to dental offices in the community—more often than not, the collaborating dentist's office—for procedures that require the skills of a dentist.

The VDH teams often provide additional services to support the oral health of children and families at the community site. For example, they provide group oral health education to children and youth in classrooms and educate and engage parents and community site staff during meetings and school events.

The VDH started in 2008 as a pilot. In 2014, legislation was enacted to allow dental hygienists and certain dental assistants to perform two procedures that were currently not allowed under their licensure, ensuring these providers could provide comprehensive, preventive dental services in the community. The legislation also required Medi-Cal to pay for store-and-forward teledentistry, allowing dental providers to be paid for using the VDH to provide care to patients in community settings. The VDH has been implemented in dozens of communities, including by 17 dental providers throughout five counties as part of four separate LDPPs.

[4] An Interim Therapeutic Restoration uses a fluoride-releasing glass ionomer – a dental restorative material – and without using local anesthetic or dental drill to prevent the progression of dental decay.

The Virtual Dental Home in Orange County

Support Structure

First 5 Orange County provided administrative and data support to the VDH teams. The Coalition of Orange County Community Health Centers had the responsibility of convening the VDH teams and helping to coordinate efforts among the CHCs. California Northstate University provided comprehensive training and technical assistance to the VDH teams. They created an online toolkit, conducted in-person and online trainings, and conducted regular phone calls with each of the teams. The feedback on CNU's support and assistance was quite positive.

Numbers

Despite the challenges outlined below, such as slow start-up, 8,047 children received diagnostic, preventive, and early intervention dental services in community settings through this project.

- Healthy Smiles for Kids of Orange County—with 11 VDH teams and starting in July 2017—served 7,008 children.
- The four CHCs—with one team each and with one CHC starting in October 2018, two starting in 2019, and one starting in 2020—served 1,039 children.

Partners

As part of the Orange County LDPP, the following CHCs implemented the VDH in the corresponding sites.

Community Health Center	Community Sites
Central City Community Health Center	2 elementary schools
Families Together of Orange County Community Health Center	1 early learning site
Serve The People Community Health Center	2 early learning sites, 6 elementary schools
Vista Community Clinic	1 early learning site
Healthy Smiles for Kids of Orange County	81 schools, 6 medical clinics, 1 preventive dental clinic, 4 community-based organizations

Methods to Assess Implementation of the Virtual Dental Home in the Orange County

California Northstate University contracted with an independent consultant to interview First 5 Orange County, the CHCs, education leaders, and CNU to assess the implementation of the VDH in the County. The consultant used the information collected to develop this brief.

The Value of the Virtual Dental Home in Orange County

While it took time for the CHCs to start providing VDH services due to slow contracting processes and other start-up challenges, the program ultimately reaped many benefits for children, families, and communities. Even more important is the potential for the VDH to be integrated into the county's and California's oral health delivery systems to ensure every child has a dental home and good oral health.

Addressing Barriers to Dental Care for Children

The number one benefit of the VDH is that children get dental care that they most likely would not have received without the VDH. The VDH addresses families' barriers to bringing children to a dental office. Barriers include a lack of transportation, an inability to take time off of work, an inability to find a dentist that is open at times when parents can take their children, and an inability to find a dentist who will treat children enrolled in Medi-Cal. This is in addition to language and cultural barriers. Notably, at community sites where a significant number of families speak Spanish as their primary language, the VDH teams included at least one bilingual (Spanish/English) member, addressing language barriers.

Providing Oral Health Education

Just as important, the VDH addresses gaps in knowledge about oral health. The VDH teams can spend much more time educating children, parents, and community site staff than is possible in a dental office environment. Critically, they are able to provide incremental suggestions for behavior change over multiple encounters to better support the adoption of positive oral health behaviors. Not only did children and families learn about the importance of oral health, the education components of the VDH were also tremendously useful in helping children become familiarized with getting dental care as many VDH teams educated children and parents about what to expect during a dental visit.

> *"We are able to provide parents with information they didn't have before."*
>
> – Andrea Rosas, Dental Hygienist, Central City Community Health Center

Further, families with children not directly enrolled in the VDH benefit from the VDH oral health education. The VDH teams provided tailored, developmentally appropriate education to children. For example, they used stories, skits, costumes, and props to educate preschool children and more science-focused curriculum to educate older children. The teams also provided education to parents and community site staff at meetings and on-site events. Through this pilot, for both parents and children, the VDH teams used visuals to make the education as engaging as possible.

Acclimating Children to Dental Care

Another critical benefit of the VDH is helping children become comfortable with dental care in a setting that is familiar and safe to them, such as their early learning site or school. The VDH

> *"When we first started the program, we had children who didn't want to open their mouths or sit in the chair. Now they are excited to be seen. They feel comfortable and safe. They are with their peers, and they are used to seeing dental providers around."*
>
> – Erica Macias, Dental Hygienist, Families Together of Orange County Community Health Center

structure allows the on-site dental team to take more time with children, easing them into care. If a child is not comfortable with having all needed care done at once, the on-site dental team can complete the care during a subsequent visit so that the child can get used to dental care over time. Many traditional dental offices simply do not have the time or capacity to work with children to address their fears and concerns nor are they in an environment in which children feel comfortable.

Coordinating Care

Care coordination is a vital activity of the VDH. Having VDH team members support families' understanding of oral health and help them navigate the oral health care system made the difference in ensuring that children actually got care and that families began to adopt positive oral health behaviors. Through this pilot, the VDH care coordinators educated families about oral health and scheduled children for VDH visits at the community sites as well as for in-clinic appointments for patients who needed follow-up care, ensuring patients who needed emergency or urgent care got scheduled immediately. Care coordinators also verified patients' insurance status, helped families sign up for health coverage, and tracked patients' needs for recall visits.

Related, some providers used dental vans to bring restorative care to children at the community site. While mobile dental vans are expensive, they can be efficient when used to bring restorative care to patients.

> *"Children now run up to me when I am at the early learning center and tell me they brushed their teeth."*
>
> – Erica Macias, Dental Hygienist, Families Together of Orange County Community Health Center

Facilitating Continutity of Care

Another benefit of the VDH is that children receive ongoing care. Because care is provided at the community sites, children receive their six-month check-ups and other follow-up care prescribed by the dentist. Through this pilot, 3,757 children (3,469 through HSK and 288 through the CHCs) received their 6-month recall appointment at the community sites.

Creating a Culture of Oral Health

By being a presence at schools, early learning sites, and other community sites, the VDH helps to create awareness around the need for oral health care. As a result, the on-site VDH teams were seen as a vital component of the support services schools and early learning sites provided to enhance children's education, wellness, and development.

Improving Academic Outcomes

The VDH plays a key role in addressing barriers to academic achievement, particularly around reducing school absences and decreasing pain and associated health problems impacting children's ability to learn. Feedback from this pilot was that teachers appreciated that the students could leave class, get the oral health services they needed, and come back to class. The VDH also can keep children from missing days of school due to dental pain and infection. In addition, the oral health education students receive in the classroom and during dental appointments enhances their learning.

Facilitating Whole Body Care

The VDH facilitates the connection between overall health and oral health for families. The CHCs referred patients to behavioral health care services and medical services at their CHCs, as needed. One CHC also provided other supports to the

> *"Parents love having the program on campus. The VDH team members are bilingual, and the parents really appreciate them."*
>
> – Leticia Chacon, Principal, Abraham Lincoln Elementary School

> *"Dental health is so important; children cannot learn if they are in pain."*
>
> – Jerelyn Cowan, Center Director, Santa Ana College Early Childhood Education Center

community, such as food assistance, to which they connected VDH families. Finally, HSK provided preventive dental services at children's medical clinics, helping to bridge the medical-dental divide.

Promoting Workforce Development

The VDH is building a workforce of health providers who are gaining skills to both meet the oral health needs of communities and advance their careers. The on-site VDH teams were passionate about children getting the dental care they needed and recognized the significant benefit to bringing that care to them in community settings. Moreover, through the VDH, they built a unique set of skills in community-based care, care coordination, oral health education, and project management.

Increasing Patient Volume

The VDH demonstrated the potential to increase the total number of dental patients the CHC can see by keeping VDH patients healthy in the community. This can create appointment space for additional patients and those who need more extensive treatment as well as reduce wait times for all CHC patients.

> *"The program really minimizes disruption. Instead of students having to go off campus for a dental appointment, from which they often don't come back to campus that day, they can quickly get their oral health needs met within a short period of time."*
>
> – Leticia Chacon, Principal, Abraham Lincoln Elementary School

Supporting Oral Health in Crises

Building on the trusting relationships the VDH teams developed with families and education sites, the teams quickly were able to transition to support families' oral health in alternative ways during the COVID-19 PHE. The VDH teams called families to provide oral health education, identify if children were in pain, and schedule appointments for patients who needed urgent or emergency dental care. Some also connected families to other supports, such as food, housing, legal advice, and other resources.

We are still in a pandemic as of the writing of this brief. Yet, the VDH teams are well positioned to resume in-person care because of their expertise in being flexible, their relationships with community sites and families, and the training they received from CNU in providing care in community settings during the pandemic.

> *"The thing I love the most is that we are making a positive impact on the community. I am seeing first hand that we are helping children prevent dental problems down the line."*
>
> – Erica Macias, Dental Hygienist, Families Together of Orange County Community Health Center

Challenges in Implementing the Virtual Dental Home

Community Health Center Level Challenges

Throughout the LDPP, the VDH teams experienced challenges that over time they translated into lessons learned.

Leadership

Community health center leadership was involved at varying levels during VDH implementation; and when there was little engagement, the program suffered. For example, some VDH team members did not receive explicit direction and thus did not understand their roles, how their roles related to others' roles, or how to get support. In some instances, it was not clear where the VDH was situated in the overall CHC structure. This could have been the result of competing priorities among provider leadership, leading to a lack of guidance, project management, and coordination. Unfortunately, this led to obstacles throughout VDH implementation—from identifying and building trust with community sites to ensuring staff got the training and support they needed to execute VDH activities to maximize billable services.

Implementing the VDH as Intended

Another barrier was that some providers were not comfortable with the VDH model of centering the dental home in the community—a system in which patients receive as many services as possible in community settings to reduce their need to go to traditional dental offices for care. Further, some dentists were hesitant to perform a virtual examination or allow trained dental hygienists to place ITRs or order sealants due to being resistant to employ newer evidence-based strategies. This resulted in more families being told that their children needed to go to a dental office than was necessary, leaving them at risk of not getting that care at all, defeating the purpose of the VDH.

Identifying and Fostering Relationships with Community Sites

Identifying community sites—such as schools and early learning centers—and then building trusting relationships with the right staff at the sites were some of the biggest challenge CHCs faced. Community health centers often were surprised by the time and resources it took to develop supportive relationships. Without this trust and working protocols, the VDH teams could not move forward in identifying space, setting up the schedule, identifying community site staff's needs, conducting outreach and education, and implementing other elements of the VDH program.

Engaging Families

While the premise of the VDH is to bring care to where children are, relieving parents of the burden of unnecessarily bringing their children to the dental office, it is still imperative that parents and caregivers are involved in their children's oral health, especially since a primary aim of the VDH is to promote the adoption of healthy oral health behaviors. While the VDH teams overwhelmingly cite that the benefits of the VDH far outweigh the barriers, they struggled to help families sign up for the program, educate them about oral health, and help connect them to follow-up services when they needed care beyond what could be provided at the community site. In response, and though it took time, VDH teams tested various methods for engaging families and ultimately identified strategies—as described below—that worked well for the families, the community sites, and the VDH teams.

Assuring Patient Volume

While many CHCs understood that they did not have to provide as many billable visits as they would have to in the clinic, given that overhead costs of the VDH are lower and because of how efficiently the dentist can evaluate and develop a treatment plan, they initially struggled to make the program cost effective due to limited patient visits. For example, because the programs got off to a slower start than expected, they went for months without being able to bill for services. Also, some providers initially did not understand school and early learning site calendars and other scheduling issues, such as meal and nap times, in the case of early learning sites. These challenges led to providers not seeing as many children as they anticipated before the program started.

Technology Challenges

While technology is a key component of the VDH, many of the CHCs initially experienced glitches with the technology. For example, some CHCs had issues with connectivity, not realizing that they did not have access to the Internet at the community site.

Regional Coordination Challenges

There were times when providers were "competing" for the same community sites because they approached the same sites not knowing that another dental provider had just approached

that site. There was also confusion among schools and early learning sites because other dental providers—such as those providing more basic oral screening and referral programs—had developed relationships with the community sites to provide services, and the community sites did not realize that these services were not as comprehensive as the VDH. This resulted in frustration for the CHCs.

State Level Programmatic and Policy Challenges

Though this was a State-sponsored pilot program, CHCs faced barriers that, in hindsight, could have been addressed by State leadership and support.

Slow Start Up and Lack of Ongoing Support

While this was supposed to be a four-year pilot, due to slow contracting processes on behalf of the California Department of Health Care Services (DHCS), the Orange County LDPP started late. The CHCs had fewer than 18 months of implementation of their VDH projects, given that most VDH activities stopped in March 2020 due to the COVID-19 PHE.

Moreover, because of the COVID-19 pandemic, the LDPPs lost nearly a full year of implementation in the final year of the program—time the LDPPs could have used to hone best practices and develop sustainability plans. In response to the lost time experienced by other activities included in the Medi-Cal 2020 Section 1115 waiver, the State submitted a request to the federal government for an extension of the waiver through December 2021. Unfortunately, they excluded the LDPPs from this request, leaving the CHCs unable to fully demonstrate the potential impact of the VDH.

Lack of Start-Up Period

The Orange County LDPP lead agency

was told by DHCS that they had to start offering services on the first day of the program. This simply was not feasible. Had the LDPP been allowed a planning phase, they would have been more coordinated and thoughtful and could have had a more effective and efficient implementation in the long run.

Inconsistent Policy Direction

In the winter of 2019, DHCS provided guidance that Federally Qualified Health Centers/Rural Health Centers (FQHCs/RHCs) must "establish" an individual as a patient of the clinic through an in-person visit with a billable provider within the past three years before they can bill for telehealth services. This meant that patients either had to come to an FQHC or a billable provider had to go to the community site to establish the patient for the purposes of billing. This was after FQHCs had been establishing patients through store-and-forward teledentistry as part of the VDH for years as was the intent and understanding of previously enacted legislation.[5]

This new guidance was an unnecessary burden and added costs to FQHCs. They had to develop "work-arounds" to establish patients through VDH, which created an unnecessary burden on the dental providers, families, and community sites. Some FQHCs backed out of participating in the program because of this barrier. And some FQHCs reported that this additional burden caused productivity to drop and placed in jeopardy their ability to sustain the program after the DTI funding ends.

Fortunately, due to the PHE, the State has relaxed several regulations related to telehealth, including this requirement around FQHCs establishing patients in person before being able to bill for telehealth services. Policy reform will be needed to make this change permanent.

Complicated Process for Establishing Intermittent Clinics

In order for FQHCs to provide services in community settings, they need to establish the community site as an intermittent clinic. An intermittent clinic is an extension of the clinic that is operated off site in the community, offering services for a limited number of hours. Clinics noted that the process was burdensome and unclear, receiving varying and, sometimes, conflicting information from state and federal regulators–and even different information from different people within the same state and federal agencies. To address this barrier, some FQHCs utilized their already licensed mobile dental vans to serve as the VDH space, avoiding the need to establish an intermittent clinic at all.

[5] No RHCs have implemented the VDH.

Recommendations

This pilot has had the advantage of funding and support associated with starting up the program, training, care coordination, administration, equipment, and supplies. Importantly, these investments have allowed Orange County stakeholders to test and identify the best strategies for implementing the VDH in the most efficient way, while ensuring children receive the highest quality dental services. By implementing the following recommendations—at the CHC, regional, and state levels—we can reap the benefits of the pilot to integrate the VDH into Orange County and state systems of care. And while it is disappointing that the State did not include the LDPPs in its request to extend the Medi-Cal 2020 waiver for another year, with the right commitment and by building on the lessons learned and best practices of the pilot, there is an opportunity to continue to integrate the VDH into community systems of care through the following recommendations.

Recommendations for Community Health Centers

The following recommendations are guidance based on the lessons learned and best practices from implementation of the VDH in Orange County. As providers look to implement the VDH in their communities, there is a growing group of experienced practitioners who can supplement formal training with strategies for how they customized the following guidance.

Demonstrate Leadership and Institutionalize the VDH Within CHCs.

Once a dental provider has decided to adopt the VDH model, it is important that all staff members—from senior staff to the on-site team to administrative staff—commit to and champion the model so the VDH can get the support and attention it needs. This leadership should be demonstrated in several ways.

- ***Implement the VDH as intended.*** In order for the VDH to truly serve as a comprehensive system of care that benefits families, providers, and communities alike, provider leadership needs to support the goal of keeping as many children as possible healthy in the community as opposed the traditional goal of using community activities to screen and refer patients to dental offices. In addition, provider leadership should be comfortable with evidence-based dental procedures, such as virtual examinations, ITRs, and allowing dental hygienists to order sealants.
- ***Invest in effective project management.*** The VDH impacts multiple sectors of CHC operations, including clinical services, community engagement and outreach, IT, billing, and other administration. Strong project management is essential to ensure the right people understand their roles, have autonomy to make decisions within those roles, collaborate as the VDH team, and get the training and support they need.
- ***Identify staffing structure needs.*** Another area that requires strong leadership is around staffing needs—both in terms of function and where staff are located. Community health centers should

do a thorough assessment of needed activities—including, but not limited to, start-up activities, project management, training, clinical care, care coordination, outreach and relationship building with communities and families, billing and other administrative tasks, and IT support—to identify how to provide the highest quality care, while providing and as many billable visits as possible. California Northstate University initially provided guidance as to potential team members' job descriptions. However, based on feedback from Orange County CHCs, to better support CHCs' need for flexibility around which team member performs which task, CNU recreated their guidance to focus on the specific activities that need to be accomplished, rather than on who performs those duties.

> *"Developing a good team is very important. That is how you are going to succeed."*
>
> – Erica Macias, Dental Hygienist, Families Together of Orange County Community Health Center

- ***Invest in training.*** Community health center leadership should ensure all staff participate in available VDH training, such as the training provided by CNU. Dentists and dental hygienists need training in the latest evidence-based, minimally invasive dental procedures. Dental hygienists and assistants need training in providing dental care in community settings. Information technology staff need training in the technology aspects of the VDH and how to support the clinical staff. And the nondental team members, such as the care coordinators and administrative staff, need training in the basics of oral health. Releasing staff from their day-to-day activities and investing in this training will help ensure the VDH runs smoothly, saving the provider time and resources in the long run.

Engage and Nurture Relationships with Community Sites.

The VDH is a partnership between the community site and dental provider to pursue the collective goal of improving the oral health of children. The design of the program should reflect that partnership, with mutually agreed upon decisions, clear expectations on behalf of all partners, and clear and ongoing communication among the partners.

- ***Ensure a champion at the community site.*** Having a champion as a partner at the community site can make the difference in whether or not the program is successful. Once a leader, such as a school principal or an early learning site director, sees how the VDH benefits children, they often will impart the importance of the program to other staff. They also support the VDH teams by helping them identify clinic space, facilitate conversations with parents and community site staff, help develop systems to get children enrolled in the program, assist with scheduling, and support other aspects of the project.
- ***Allow ample time and resources to build relationships with community sites.*** It is critical for providers to recognize that it takes time for community sites to understand the VDH, get to know the dental provider, and work with the provider to develop a working relationship. Schools, school districts, and early learning sites are busy, have competing priorities, and are approached frequently by outside groups offering to provide services to students. Even when trust is built, community site staff may need to wait for certain leadership meetings to get approval to engage in the project and/or get the proper legal documents, such as a memorandum of understanding (MOU), signed. Providers need to take this into account, start early, and be patient.
- ***Develop and communicate clear expectations for both CHC teams and community site staff.*** It is important to remember that implementing the VDH requires work on behalf of the community site. While many sites are willing to put in the extra effort to support the program, they will be much more engaged if expectations are clear.

  Utilizing the guidance and checklists provided by CNU, creating protocols that work for both the CHCs and community sites will help ensure the program runs smoothly and minimizes disruption to the daily activities of the community site. Examples include identifying appropriate space at the community

> *"With any program, I have to sell it to the to the teachers and staff, and they have to support it. Otherwise, it is not going to be successful."*
>
> – Leticia Chacon, Principal, Abraham Lincoln Elementary School

site that works for the VDH team but also does not disrupt the day-to-day operations of the site; planning for early learning site requirements related to nap and meal times, child-staff ratios, and other conditions; understanding and planning for school schedules, such as summer breaks, mid-year breaks, and shortened school days; identifying the best times to take students out of class; and protocols for working with teachers and other community site staff. The CHCs and community sites should tailor protocols to meet the unique needs of their programs.

- ***Engage all levels of community site personnel.*** It is critical to develop relationships and partner with staff at all levels of the community site. For example, at schools, key partners may include school nurses, front office staff, janitorial staff, teachers, and other school personnel. These staff play a role in the VDH partnership and should be a part of the VDH planning process at their sites.
- ***Pay special attention to community sites' needs, and exercise flexibility.*** Providers need to recognize that each community site has different needs and requirements to meet the site's program objectives. For example, as mentioned above, some early learning sites have certain mandates, such as nap and meal schedule requirements as well as teacher-child ratios. Moreover, CHCs that partnered with schools learned to place a specific focus on teachers' needs. Some teachers did not want students to be taken out of class, especially older children, during particular instruction times. It is vital that CHCs respect each community site's unique needs and work with the community site to develop the program around those needs.

  In addition, identifying space—such as a classroom or other site—to provide VDH services at a community site can be difficult. Therefore, some providers utilized their mobile dental vans to provide VDH services.
- ***Engage families in decisions about program design.*** While each family has unique needs as discussed below, they collectively know what works for them as a community. It is critical to give them a voice in how the VDH is implemented at their school or early learning site.
- ***Provide consistency.*** Providers found that it was easier to build trust with both community site staff and families when the staff who conducted upfront outreach and built relationships with the community site were the same staff (i.e., dental hygienist, assistant/coordinator) who provided services.
- ***Recognize when a site may not be a good match.*** While most community sites, like early learning sites and schools, want the best for the children and families they serve, they sometimes struggle to bring in additional support services. It is important to acknowledge when they simply may not be ready to partner or do not have the capacity to engage.

Invest the Time and Resources Needed to Engage and Support Families.

Partnering with families and understanding their unique needs are critical elements of a successful VDH program. Importantly, each VDH team needs to devise tailored strategies that work best for the families they serve.

- ***Develop trusting relationships with families.*** The VDH on-site teams quickly realized the importance of spending ample time with families to develop trusting relationships with them so that they would be more open to engaging in discussions about their children's oral health. For example, to educate families about the importance of oral health and urge them to enroll in the VDH, the teams showed up when and where they knew they would see parents, such as at school and early learning site drop-off and pick-up and at events like health fairs, back-to-school events, parent meetings, and other gatherings. The VDH teams should seeks families' advice around strategies that work best for them and recruit parents and other families members to serve as champions of the program.
- ***Support program enrollment.*** To help families enroll in the program, providers developed creative strategies, such as developing one-page interest forms to spark families' interest in the VDH, helping them fill out the complete application at a later time. They also made phone calls to families from the community

site as parents are more likely to answer a call from their child's school. Finally, they recruited school staff to help follow up and/or echo the VDH team's messages.

- ***Engage in creative care coordination strategies.*** To support families in helping their children get recommended care beyond what could be provided at the community site, the VDH teams identified various methods. For example, the teams found that families often responded better to texting over phone calls. And some programs used their mobile dental vans to provide follow-up treatment to children. Care coordinators understood that this work requires multiple communications with families, persistence, and empathy.

> *"Any event where we know parents will be present, we try to attend."*
>
> – Andrea Rosas, Dental Hygienist, Central City Community Health Center

Regional Recommendations

Local leaders—such as the county local oral health program, health center associations, or other coalitions—should create a system to identify oral health needs among communities, identify gaps in care, and coordinate VDH and other oral health services within Orange County. Such a regional approach would reduce duplication and competition among oral health care providers, simplify and streamline processes for community sites, facilitate coordinated outreach, and provide an avenue for CHCs and other oral health providers and stakeholders to share lessons learned and best practices and collaborate. In turn, this would strengthen care for all under-resourced communities in Orange County.

State-Level Programmatic and Policy Recommendations

While this was a State-endorsed pilot program, there were several areas in which the State could have better supported the VDH programs of the LDPPs. And based on the learnings of this pilot, there are several areas in which the State should maximize its investment in this pilot by supporting the integration of the VDH's best practices into statewide systems of care.

Allow FQHCs to use Telehealth to Establish Patients.

While the Legislature passed a bill in 2020 to allow FQHCs/RHCs to establish a patient at a community site through store store-and-forward telehealth, Governor Newsom vetoed the bill. As mentioned, the State has temporarily allowed FQHCs/RHCs to use telehealth to establish patients during the current PHE. Work will need to be done to make these changes permanent.

Simplify and Clarify the Process for Establishing Intermittent Clinics.

The State should work with the federal government to simplify the process, clarify instructions, and provide consistent assistance to clinics in establishing intermittent clinics.

Create a Statewide Program to Support the Start-up Costs and Sustain the VDH.

Because the VDH is such a different system of care than the traditional office-based delivery system, establishing the VDH takes time and resources. However, this pilot proved that the costs are worth the investment, given that children get the preventive care they need. By creating a supportive policy and payment environment, a statewide program—housed at either the California Department of Public Health (DPH) or DHCS—would ensure that the VDH could be integrated into California's oral health care system and be sustained over time. Moreover, supporting the VDH would help the State meet its obligation to provide care to children enrolled in Medi-Cal.

- ***Invest in VDH equipment.*** The State generously allowed the LDPP providers to keep the equipment purchased as part of the pilot. This made the difference for dental providers in terms of whether they would be able to continue implementing the VDH past the pilot. The State should create a pool of funds to support providers' purchase of equipment for the VDH.
- ***Support Care Coordination.*** Care coordination is such a critical component of the VDH, truly ensuring children get the services they need to improve their oral health. Providers need upfront and ongoing support for this activity. Such support could come from multiple mechanisms, such as a grant program, systems to draw down Medi-Cal dollars, or other creative strategies.
- ***Support training and technical assistance.*** Once a supportive policy environment is in place, the State should play a role in developing and supporting systems of training, technical assistance, and materials development—such as template forms, checklists, and other documents—along the lines of the support provided by CNU. In addition, such programs should support experienced VDH providers in advising the development and implementation of new VDH programs. Finally, the State should identify ways to support VDH communities in coming together to learn from each other to further streamline best practices.

The Next Era of the Virtual Dental Home

While there were challenges—such as slow start up and the COVID-19 pandemic—in implementing the VDH through the LDPPs, this pilot demonstrated that there is a clear path for the VDH to successfully bring dental care to children who most likely would not get that care otherwise. The VDH's community-based approach not only addresses families' socioeconomic barriers to care, but it also facilitates dental team members to work at the top of their credentials; supports more efficient provider operations; and supports schools, early learning sites, and other community sites in fulfilling their objectives around advancing the wellbeing of children and families. Therefore, it behooves our decision makers, health leaders, communities, and other stakeholders to ensure that we reap the benefits of the VDH and find ways to sustain and expand it throughout Orange County and the state.

Sources

- Anaheim Elementary School District
- California Northstate University
- Central City Community Health Center
- Families Together of Orange County Community Health Center
- First 5 Orange County
- Santa Ana College Early Childhood Education Center
- Serve the People Community Health Center Santa Ana
- Vista Community Clinic: The Gary Center

http://dentalmedicine.cnsu.edu/