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

The Children's Partnership

CALIFORNIA NORTHSTATE UNIVERSITY
College of DENTAL MEDICINE

FIRST 5
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Acknowledgments

Introduction

Despite being largely preventable, dental caries—tooth decay—is the number one chronic disease among children.[1] It is especially prevalent among low-income children of color, 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. Low-income families and families of color face significant systemic barriers—related to the social determinants of health—in accessing dental care, such as financial pressures, lack of transportation, and language inaccessibility. Additionally, families with children enrolled in Medi-Cal face the additional difficulty of finding dental offices that accept Medi-Cal.

These barriers hold true for families in the Inland Empire (IE)—Riverside and San Bernardino counties—which is largely rural and where access to dental care is limited. While having a dental visit is not a definitive indicator of complete or regular care, available data demonstrate that in Riverside and San Bernardino counties, respectively, only 44.6 percent and 45.2 percent of children enrolled in Medi-Cal had a dental visit in 2018. These numbers are lower than the already low state rate of 47.6 percent.[2]

Because of this, First 5 Riverside and First 5 San Bernardino partnered as a region to implement the Virtual Dental Home (VDH) as part of the Local Dental Pilot Project-Inland Empire (LDPP-IE). The aim of the LDPPs, which were created as part of California's Medi-Cal 2020 waiver's Dental Transformation Initiative (DTI), was to increase Medi-Cal-enrolled children's use of preventive, risk-based, and continuous dental care through innovative strategies, 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] Through this pilot, eight community health centers (CHCs) implemented the VDH in more than 110 schools, early learning centers, and other community sites.

Despite the COVID-19 Public Health Emergency (PHE), in many cases, the VDH was able to continue to serve as children's dental homes by keeping connected to families to provide oral health education and support. In addition, the VDH helped pave the way for CHCs to adopt telehealth to respond to the PHE.

This issue brief provides background on the VDH, outlines how the VDH had been implemented in the IE, identifies lessons learned and best practices related to the deployment of VDH in the IE, and provides recommendations at the CHC and state levels for sustaining and integrating VDH best practices into the oral health care delivery system across the IE and statewide. Importantly, this brief considers the impact of the COVID-19 pandemic on both the implementation of the VDH and how the VDH can inform and help shape the provision of dental care in communities during a pandemic.

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[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, 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, enacted legislation (AB 1174) allowed dental hygienists and certain dental assistants to perform two procedures—place ITRs and decide which x-rays to take. These procedures were tested during the pilot but not previously allowed under their licensure. By allowing these providers to perform these duties, the legislation facilitated more comprehensive, preventive dental services to be provided 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 in community settings.

Since 2008, the VDH has been implemented in dozens of communities. Most recently, it has been deployed by 17 community health centers and private dental providers throughout five counties as part of four separate LDPPs.

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[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 the Inland Empire

Impact

Despite the challenges outlined below, such as slow start-up, over the course of approximately 18 months, 2,682 children received diagnostic, preventive, and early intervention dental services in community settings through the VDH. While the majority of these data reflect the period of time before the COVID-19 PHE, three CHCs resumed full VDH services in the late summer/fall of 2020.

Support Structure

First 5 Riverside and First 5 San Bernardino provided administrative and data support to the CHCs. First 5 Riverside also purchased the VDH equipment, oral hygiene kits, and other collateral items for the CHCs. First 5 Riverside convened the CHC teams on a regular basis, providing them with opportunities to receive updates and share best practices. The CHC teams found these convenings extremely helpful as an ongoing source of information and support.

Led by Dr. Paul Glassman, CNU provided comprehensive training and technical assistance to the CHC teams. They created an online toolkit, conducted in-person and online trainings, and held regular phone calls with each of the teams. The feedback on CNU's support and assistance was overwhelmingly positive. Community health centers found the online tools to be very helpful, appreciating the planning guides and "off-the-shelf"

templates. CNU was responsive to ongoing needs, including requests for training in specific areas, such as providing dental care to children with special health care needs and providing VDH services at community sites during the COVID-19 pandemic.

The Children's Partnership (TCP) helped facilitate a feedback process—querying CHCs through group discussions and individual meetings—to inform continuous improvement efforts. TCP also helped to lead convenings of the CHCs, advised on overall strategy, and was the primary researcher and author of this brief. Finally, the Center for Oral Health (COH) provided administrative and logistical support to the LDPP.

Methods to Assess Implementation of the Virtual Dental Home in the Inland Empire

The Children's Partnership contracted with an independent consultant to interview the CHCs and community sites, participate in meetings among the CHCs, and participate in site visits[5] at both CHC locations and community sites to understand how the VDH operated in the IE. The consultant also interviewed CNU about their experience in supporting the LDPP-IE's implementation of the VDH. The consultant, with support from CNU, used the information collected to develop this brief.

LDPP-IE VDH Partners

As part of the LDPP, the following community health centers implemented the VDH in the corresponding sites. Sites began implementation at different times, starting in Fall 2018, with most CHCs beginning services in 2019.

Community Health Center	Community Sites
Bear Valley Community Health District	1 Community Hospital
Borrego Community Health Foundation	4 early learning sites, 6 elementary schools, 1 K-8 school, 3 middle schools, 2 parent engagement/school enrollment centers, 2 community health centers, 2 community centers
Morongo Basin Healthcare District	10 elementary schools, 1 middle school, 1 high school
Neighborhood Healthcare	2 early learning sites, 2 middle schools, 1 7-12 school, 3 high schools
North County Health Services	10 early learning sites
ParkTree Community Health Center	8 elementary schools, 2 middle schools
SAC Health System	27 early learning sites, 10 elementary schools, 2 middle schools, 5 high schools
Vista Community Clinic	4 early learning sites, 4 elementary schools

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[5] Unfortunately, due to the COVID-19 pandemic, the team was able to visit only half of the VDH sites.

The Value of the Virtual Dental Home in the Inland Empire

Providing Oral Health Education/Creating a Culture of Oral Health

Just as important, the VDH addresses gaps in knowledge about oral health. The VDH teams can spend much more time educating students, 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.

Further, families with children not directly enrolled in the VDH benefit from the VDH oral health education. The VDH teams tailored the education to children's ages, such as integrating oral health into health and science classes for older children and using stories, costumes, and props to educate preschool children. The teams also provided education to parents and community site staff at meetings and on-site events.

By being a presence in the community,

While it took time for the VDH teams to get off the ground due to slow contracting processes and other start-up challenges, the programs ultimately reaped many benefits for children and families, the CHCs, and communities. Even more important is the potential for the VDH to be integrated into the counties' 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 systemic barriers faced by families in accessing care at a traditional dental office, such as a lack of transportation, inability to take time off of work, and financial pressures. In addition to bringing care to children where they are—addressing many of families' barriers to care—the VDH also addresses language and cultural barriers to care. At community sites where a significant number of families speak Spanish as their primary language, the CHCs included at least one bilingual (Spanish/English) member in their VDH teams. Also, many of the VDH team members are from the community they served or share similar backgrounds as many of the families they served.

Another benefit of the VDH is the ongoing care children receive. One CHC noted that they had a 95 to 98 percent recall rate because the care was brought to children at the site.

> " *Because we are bringing dental care to the students at the school sites, there is less opportunity for them to miss their next appointment six months later.*"
>
> – Astrid Forbito, Program Manager, Member Engagement, Neighborhood Healthcare

the VDH helps to raise awareness around oral health needs, thus creating a culture of oral health. As a result, in many instances, the on-site teams were seen as a vital component of the support services schools and early learning centers provided to advance children's education and development.

Acclimating Children to Dental Care

The VDH plays a critical role in helping children become comfortable with dental care in a setting that is familiar and safe to them—their school or early learning site—addressing fears children and families may have about seeking dental care. For example, many parents themselves may have had bad experiences with dental care, and they do not want to inflict that experience on their children. And many children have had traumatic experiences with dental care in the past. Finally, a significant number of children had never had dental care at all and, thus, can be apprehensive.

The VDH 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

> " *Parents trust schools more than they trust doctors. Being able to deliver care in the school setting lets you capture a significant number of children who do not have a dental home, who are not accessing dental care anywhere. Part of that is because of the trust parents and children have in the environment.* "

– David Kadar, DDS, Chief Executive Officer,
ParkTree Community Health Center

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 makes all the difference in ensuring that children actually get care and that families begin 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, tracked patients' needs for recall visits, and connected them to other health and social support services.

Improving Academic Outcomes

The VDH plays a role in addressing barriers to academic achievement, particularly around reducing school absences and decreasing pain and

associated health problems that impact children's ability to learn. Through this pilot, teachers were appreciative that children were taken out of class for only 30 minutes through the VDH, instead of an entire day, for a dental appointment or dental emergency. In addition, the oral health education CHCs provided in classrooms enhanced students' learning.

Keeping Care Local

Many of the staff at the schools and early learning sites appreciated that the VDH staff were part of the local health care systems and connected families to needed follow-up care locally. Further, since many of the providers were part of the community, families began to recognize them at the CHC, helping to build trust and integrate oral health into overall health and wellness.

Facilitating Whole Body Care

The VDH facilitates the connection between oral health and overall health for families in at least two important ways. First, the VDH providers in the IE referred dental patients to behavioral health care services and medical services at their CHCs, as needed. Second, by embedding the VDH into a clinical setting, one CHC ensured children received dental care at the same place that they received medical care.

Promoting Workforce Development

The VDH is building a workforce of health providers who are gaining skills to both advance their careers and meet the oral health needs of their own communities as many of the providers come from the communities they served. The on-site VDH teams were passionate about children getting the care they needed and recognized the significant benefit to bringing

> **"** *I wish I had a program like this growing up. I was raised by a single mom. I do this because I care."*
>
> – Dean-Paul Bao, Mobile Dental Services Manager, Vista Community Clinic

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.

Supporting Oral Health and Wellbeing During Crises

The VDH system—especially the trusting relationships the VDH teams developed with families and community sites as well as the technology components of the VDH— proved to be invaluable in supporting families during the COVID-19 pandemic. Because of the VDH teams' relationships with families, they were able to quickly transition to reaching out to their patients via phone and videoconference to provide preventive oral health education; assess if they or their families had urgent or emergency dental care needs; and connect them to needed dental care, including dental care provided via telehealth. In addition, they connected

families to other health and social supports, such as food, legal advice, financial resources, and other services. And many of the CHCs worked with schools and other community programs to hand out oral hygiene kits and educational materials during meal distribution.

Since schools resumed online in late summer/fall of 2020, three CHCs began to provide VDH services at the community sites by scheduling children to come to the school site and employing measures to ensure the health and safety of both staff and patients. One CHC provided services in a school conference room, and two used their dental vans to provide services. Others partnered with schools to provide oral health education via videoconferencing during classes, either live or through pre-recorded videos. Finally, some CHCs provided oral health education in groups and individually to their patients, mailing incentives and tools to families after the sessions. Moreover, the CHCs' use of telehealth for the VDH primed them for using telehealth to serve their wider patient base during the PHE when in-person contact was limited.

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.

Challenges in Implementing the Virtual Dental Home

Community Health Center Level Challenges

Throughout the LDPP, the VDH teams implementing VDH 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 provider organization 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 more 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, struggling more with K-12 schools than early learning sites. Without this trust and working protocols, the VDH teams could not move forward in identifying space, setting up the schedule, identifying teachers' 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 can be provided at

the community site. In response, as described in the recommendations below, the VDH teams tested various methods for engaging families and ultimately identified strategies that worked well for families, the schools, and VDH staff.

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 CHCs initially did not understand school and early learning site calendars. 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 or they were in a geographic area that lacked internet access. In addition, some CHCs did not have established protocols for their Information Technology (IT) and VDH teams to work together, resulting in the VDH teams not getting the IT support they needed.

Lack of Regional Coordination

There were times when CHCs 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.

Several CHCs also noted that they struggled when conducting outreach because they were not known to the community. They had to build relationships with community sites from the ground up and felt that a coordinated strategy and uniform branding—that leant the credibility of the First 5s and the group of participating CHCs—would have eased the relationship-building process with community sites. Finally, they felt that the First 5s could have helped facilitate relationships with early learning sites.

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 LDPP-IE started quite late. Being one of the last LDPPs to sign a contract with the State and after First 5 Riverside purchased the equipment and signed individual contracts with the CHCs, the CHCs had only about 18 months to fully implement their VDH projects. This takes into account the fact that all VDH activities stopped in March 2020 due to the COVID-19 PHE. Though three CHCs slowly resumed VDH services in late summer/fall 2020.

Moreover, because of the COVID-19 pandemic, the LDPPs lost nearly a full year of implementation during the last year of the project—time the LDPP-IE 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 waiver, the State requested an extension of the waiver through December 2021. Unfortunately, they excluded the LDPPs from this request, leaving the pilot projects unable to fulfill their potential.

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 FQHC/RHC through an in-person visit with a billable provider within the past three years before they can bill for telehealth services, requiring either patients to come to an FQHC/RHC or a billable provider 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 (AB 1174).[6]

This new guidance was an unnecessary burden and added costs to FQHCs. They had to develop "work-arounds" to establish patients through the VDH, which created an unnecessary burden on the dental providers, families, and community sites. 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 pursuant to state and federal regulations. 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.

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[6] This issue did not pertain to one RHC that participated in the LDPP in the IE, and no RHCs had implemented the VDH previously.

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 IE 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. 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 the IE. As CHCs 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. Moreover, these recommendations can apply to dental providers that are not CHCs.

Demonstrate Leadership and Institutionalize the VDH Within CHCs.

Once a CHC 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—have bought in 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, CHC leadership needs to support the goal of keeping as many children as possible healthy in the community as opposed to the traditional goal of using community activities to screen and refer patients to dental offices. In addition, leadership should be comfortable with and deploy 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 at the CHC 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. Providers should do a thorough assessment of needed activities—including, but not limited to, start-up activities, project management, training, clinical care, care coordination, relationship building with communities and families, billing
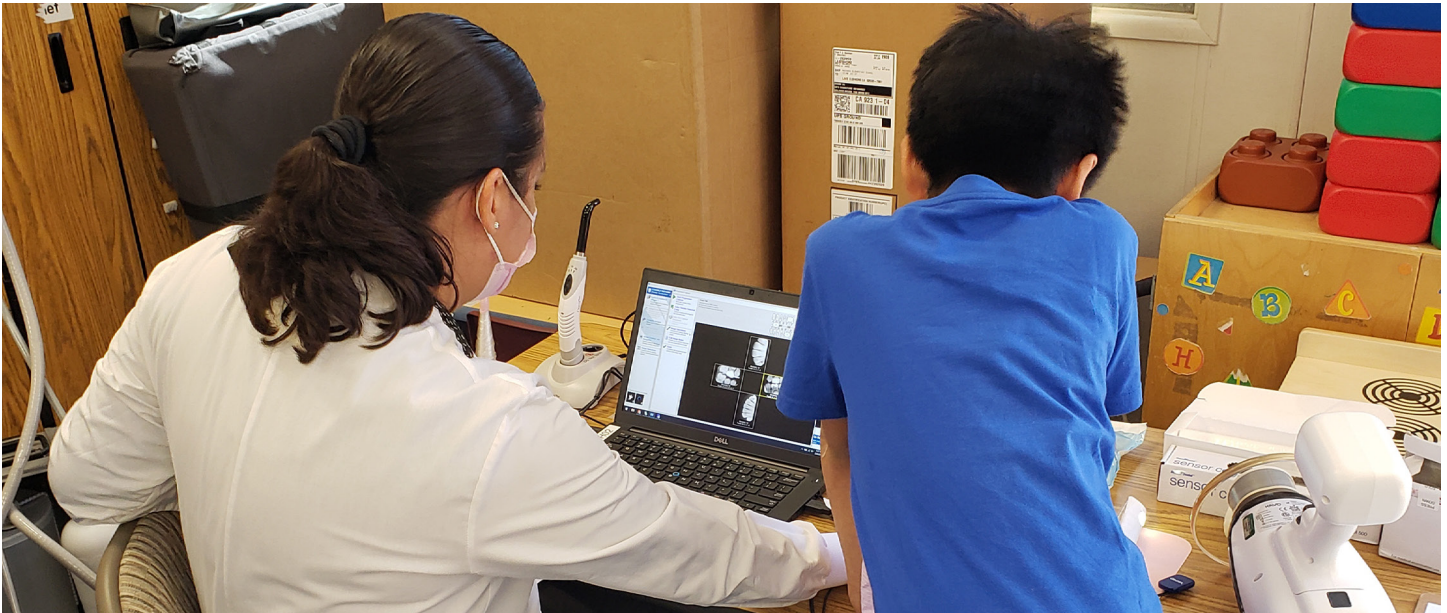
and other administrative tasks, and IT support—to identify how to provide the highest quality care, while providing and as many billable visits as possible.

▶ *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 CHC 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.

▶ *Allow ample time and resources to build relationships with community sites.* It is critical for CHCs 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. The VDH teams need to take these and other factors 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.

> **"** *The greatest success is when we collaborate with the school site, especially at the preschool, because the health clerk has a trusting relationship with the families. That has made our efforts easier in understanding the family and why they may not be responding to us. It is great to have the school's support in addressing barriers to access to care."*
>
> – Astrid Forbito, Program Manager, Member Engagement, Neighborhood Healthcare

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 minimize disruption to the daily activities of the community site. Examples include identifying appropriate space at the community site that works for the VDH team but also does not disrupt the day-to-day operations of the site; 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 or an early learning site activity; and protocols for working with community staff. The CHCs and community sites should tailor protocols to meet the unique needs of their programs.

▶ *Engage all levels of school 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 teachers' needs.* Community health centers need to recognize that each community site—particularly schools—has different needs and requirements. For example, in the IE, 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 the unique needs at each community site and work with the community site to develop the program around those needs.

▶ *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.* Community health centers 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 community site were the same staff—the on-site team—who provided services.

▶ *Start small to build trust.* While not necessary in all cases, where it was difficult to build trust, several CHCs brought in less comprehensive dental care to community sites as a way to introduce the CHCs and the VDH to the schools and/or early learning sites. For example, a few CHCs began by providing oral health screenings and sealants to students at school sites. This facilitated the school in trusting the CHC and eventually engaging in a partnership with them to implement the VDH.

▶ *Communicate progress with community sites.* By sharing the results of the VDH with the

community site, CHCs acknowledge the partnership with the community site and the community site feels a sense of ownership of the program. For example, at the end of the school year, one CHC provided a graphically designed report to the partnering school district that highlighted how many students were served with what services at which sites.

▶ *Recognize when a site may not be a good match.* While all educational institutions—both early learning sites and schools—want the best for their students, 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 as well as 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 pre-filled out enrollment forms as much as possible. They made phone calls to families from school sites as parents are more likely to answer a call from their child's school. Finally, they recruited community site 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 can be provided at the community site, VDH teams employed various methods, such as scheduling same-day appointments, given that they had the parents' attention at the moment, and calling and texting families multiple times before appointments. In addition, they recruited school staff to help follow up and/or echo the VDH's teams' messages. 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.

Address Technology Challenges

Community health centers should test both equipment and the internet connection at the community site before seeing patients. To resolve connectivity issues, many CHCs used portable Wi-Fi devices or powered Wi-Fi antennas, such as Plum Cases or Cradle Point devices. CHCs should ensure IT staff understand the VDH technology needs and work with the CHC teams to test equipment and create protocols for IT and VDH teams to work together.

Coordinate Regionally

Local leaders—such as the county local oral health programs, the local oral health coalition, CHC associations, or another relevant coalition—should create a system to identify oral health needs among communities, identify gaps in care, and coordinate VDH and other oral health services within the IE. Such a regional approach would reduce duplication and competition among CHCs, 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 the IE.

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 (AB 2164) 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. It is critical to make these changes permanent.

Simplify and Clarify the Process for Establishing Intermittent Clinics.

Decisionmakers at the state level 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 and Maintain Community-Based Oral Health Programs.

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 innovative, community-based models of care could be integrated into California's oral health care system and be sustained over time. Moreover, supporting programs, such as the VDH, would help the State meet its obligation to provide care to children enrolled in Medi-Cal. Pertaining to

VDH, this should involve the following components.

▶ *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 decisionmakers, 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 the IE and the state.

Sources
- Bear Valley Health District
- Borrego Community Health Foundation
- California Northstate University
- Family Services Association Hemlock Child Development Center
- First 5 Riverside
- First 5 San Bernardino
- Morongo Basin Community Health Center
- Morongo Unified School District
- Neighborhood Healthcare
- North County Health Services/TrueCare
- ParkTree Community Health Center
- San Bernardino City Unified School District
- Social Action Community Health System
- The Children's Partnership
- Vista Community Clinic