



# The Virtual Dental Home: Building Best Practices into California's Oral Health Care Delivery System for Children



# Acknowledgments

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# Introduction



Despite being largely preventable, dental caries— tooth decay—is the number one chronic disease among children.<sup>1</sup> 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 barriers to accessing dental care, including financial pressures, lack of transportation, language inaccessibility, and other systemic obstacles to care. Further, families with children enrolled in Medi-Cal face the additional difficulty of finding dental offices that accept Medi-Cal.

Because of this, four communities—across five counties—Orange, Riverside/San Bernardino, Sacramento, and San Joaquin—implemented the

Virtual Dental Home (VDH) as part of their Local Dental Pilot Projects (LDPPs). 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, early learning sites, and other sites in the community.<sup>2</sup> Through these pilots, 17 dental providers—fifteen of whom are community health centers (CHCs)—implemented the VDH at approximately 265 schools, early learning sites, medical clinics, and community-based organizations. This brief focuses on CHCs, but the analysis and recommendations are applicable to all dental providers.

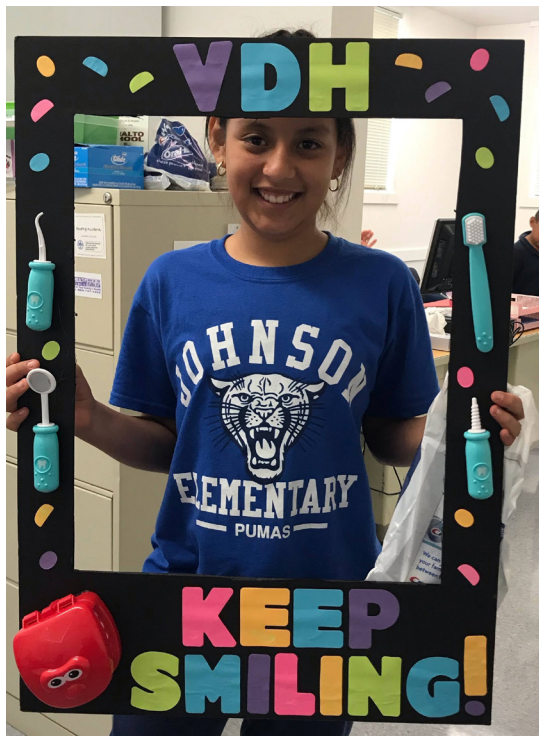
Notably, during the last year of these pilots, the CHCs were operating within the COVID-19 Public Health Emergency (PHE). Yet, many CHCs continued to serve as children’s dental homes by using phone and videoconferencing to provide oral health education and support. Moreover, because of CHCs’ adoption of telehealth through the VDH, many CHCs were better equipped to transition from on-site care to remote care when in-person care was limited. Finally, the CHCs now 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 in providing care in community settings during the pandemic.

This issue brief complements deeper analyses of each of the LDPP’s implementation of the VDH, found at <http://dentalmedicine.cnsu.edu/research-dti>. It provides background on the VDH, outlines how it was implemented as part of the LDPPs, identifies lessons learned and best practices, and provides recommendations for integrating the VDH into California’s oral health care delivery system. Importantly, this brief considers the impact of the COVID-19 pandemic on the implementation of the VDH.

<sup>1</sup> 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).

<sup>2</sup> While the projects described in this document are 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 centers, 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)<sup>3</sup>—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 community site 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 CHCs and private dental providers throughout five counties as part of four separate LDPPs.



<sup>3</sup> An Interim Therapeutic Restoration uses a fluoride-releasing glass ionomer – a dental restorative material – and without using local anesthetic and dental drill to prevent the progression of dental decay.

# The Virtual Dental Home Through the Local Dental Pilot Projects

## Support Structure

The lead agencies or subcontractors for each of the LDPPs provided administrative and data support to the VDH teams. These entities—which included county First 5 Commissions, a county department of health, nonprofit organizations, and consultants—helped coordinate regional efforts; purchased equipment and materials, as appropriate; and provided other operational support to the teams. 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 held regular phone calls with each of the teams.

## Impact

Despite the challenges outlined below, over the life of the pilots (through September 2020), 12,848 children received diagnostic, preventive, and early intervention dental services in community settings through the VDH. This number reflects the majority of CHCs implementing the VDH for about 18 months before the COVID-19 PHE as well as a limited number of VDH visits beginning in the fall of 2020.

It is important to note that each dental provider had anywhere from one to eleven VDH teams. The majority had one team. Most providers also implemented the VDH for varying lengths of times, ranging from just a couple of months to about 18 months.



One provider—which served more than 7,000 children—had 11 teams and was implementing the VDH before LDPP funding started, which meant that they were able to provide VDH services through the LDPP right away in 2017—not needing the start-up period other providers needed. This quantity was not typical. The other 16 providers served an average of 300 to 350 children through this project.

## VDH Community Sites

Type of Community Sites	Number of Sites
Schools	193
Early Learning Sites	51
Medical Clinics	12
Dental Clinics	1
Community-Based Organizations	8

# The Value of the Virtual Dental Home

While it took time for most of 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 California's oral health delivery system to ensure every child in California 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, addressing systemic barriers faced by families in accessing care at a dental office. 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.

## Advancing Oral Health Education and 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 children and



youth, 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. Finally, by being a presence at schools, early learning centers, medical clinics, and other sites, the VDH raises awareness around the need for oral health care, creating a culture of oral health.

## Addressing Language and Cultural Barriers to Care

The VDH plays a crucial role in addressing language and cultural barriers to care. At community sites where a significant number of families speak Spanish as their

“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, Neighborhood Healthcare, Riverside/San Bernardino County LDPP

“We are able to provide parents with information they didn't have before.”

– Andrea Rosas, Central City Community Health Center, Orange County LDPP

“One of my greatest concerns, during my 24 years as the principal of Walton Special Center, has been the lack of dental care for our student population—children with significant developmental and medical challenges.”

– Tom Whitesides,  
Walton Special Center,  
San Joaquin County LDPP

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.

## Acclimating Children to Dental Care

The VDH is instrumental in helping children become comfortable with dental care in a setting that is familiar and safe to them, such as their early learning center or school. 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 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—by 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. 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. Care coordinators also verified patients’

“Having the program physically there is a reminder to school personnel and families that dental care is important.”

– Christi Kagstrom, Twin Rivers Unified School District,  
Sacramento County LDPP

“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,  
Families Together of Orange  
County Community Health Center,  
Orange County LDPP

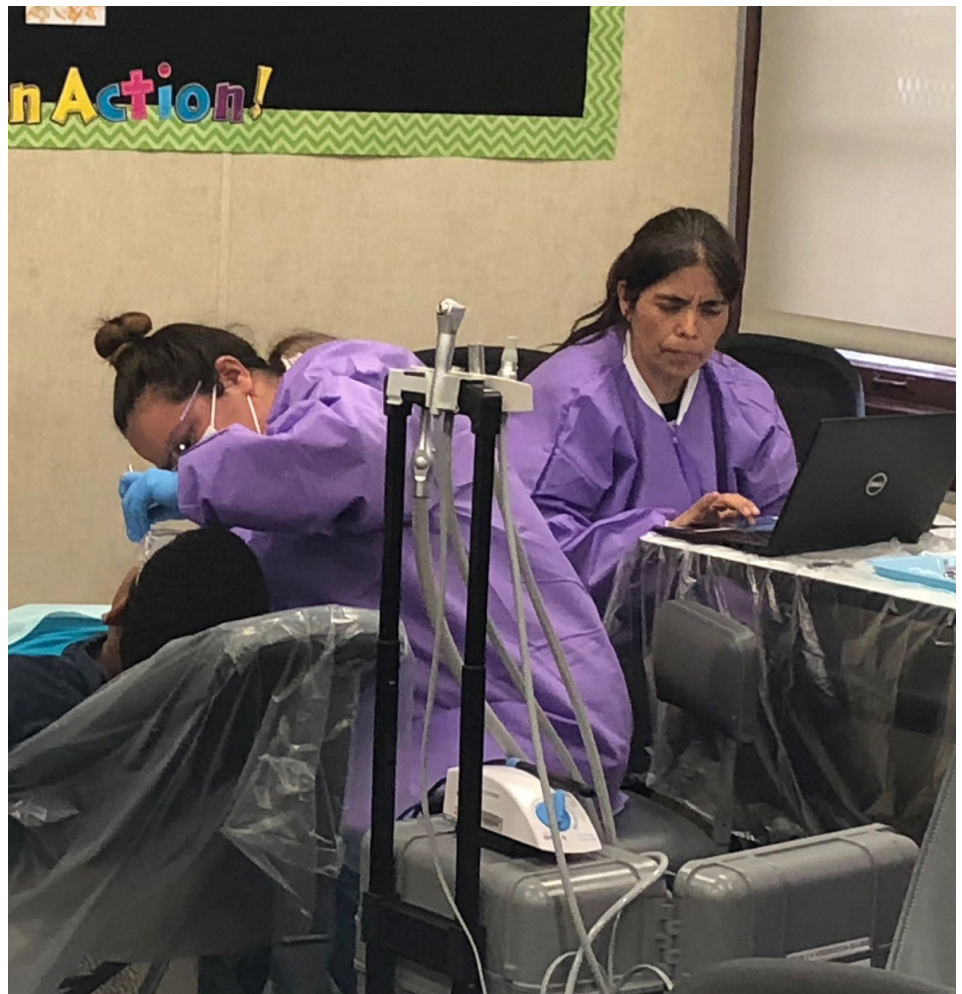
insurance status, helped families sign up for health coverage, tracked patients’ needs for recall visits, and connected them to other health and social support services.

## Improving Academic Outcomes

The VDH can play a 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.

## 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 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-



“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, Abraham Lincoln Elementary School,  
Orange County LDPP

based care, care coordination, oral health education, and project management.

## Supporting Oral Health in Crises

The VDH system—especially the trusting relationships the VDH teams developed with families and community sites—proved to be invaluable in supporting families during the COVID-19 pandemic.

Because of the VDH teams’ relationships with families, they quickly were able to transition to reaching out to families via phone and videoconference to provide preventive oral health education and connect them to urgent and emergency care, as needed. Many also addressed additional needs resulting from the PHE, connecting families to food, housing, legal services, and other supports.



# Challenges in Implementing the Virtual Dental Home

## Community Health Center Level Challenges

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

“Dental health is so important; children cannot learn if they are in pain.”

– Jerelyn Cowan,  
Santa Ana College Early  
Childhood Education Center,  
Orange County LDPP

### Leadership

Community health center leadership was engaged in VDH implementation at varying levels. Where 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 CHC leadership, leading to a lack of guidance, project management, and coordination.

### 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. In addition, some dentists were hesitant to perform virtual examinations 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 needed care, 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 challenges providers faced. Providers often were surprised by the time and resources it took to develop supportive relationships.

### Engaging Families

Providers struggled with identifying the best way to engage families, given that they did not always have immediate and direct contact with them.

### Technology Challenges

While technology is a key component of the VDH, many of the CHCs initially experienced glitches with the technology, such as lacking access to the Internet and equipment not working as expected.

### Lack of Regional Coordination

In some regions, a lack of coordination resulted in providers “competing” for the same community sites because they approached the same sites not knowing that another CHC 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. Finally, in some communities, several CHCs felt that a coordinated outreach strategy and uniform branding would have eased the relationship-building process with community 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), many of the CHCs had fewer than two years to implement their VDH projects.

Moreover, because of the COVID-19 pandemic, the LDPPs lost nearly a full year of implementation in the final year of the pilots—time the LDPPs could have used to hone best practices and develop sustainability plans. In response to the lost time experienced by other activities

“*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, Vista Community Clinic, Riverside/San Bernardino County LDPP

included in the Medi-Cal 2020 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 pilot projects unable to fully demonstrate the potential impact of the VDH.

### 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).<sup>5</sup>

This new guidance was an unnecessary onus 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 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.

“*If we didn't bring the services, they would not get them. It's really hard for families to get to the dentist.*”

– Felicia Estrada, Community Medical Centers, San Joaquin County LDPP

<sup>5</sup> This issue did not pertain to the one RHC that participated in the LDPPs, and no RHCs had implemented the VDH previously.

# Recommendations



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 pilots, we have 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 through the LDPPs. These recommendations also apply to dental providers that are not CHCs.

### 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—have bought in to and champion the model so that the model 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 to 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 provider operations, including clinical services, community engagement and outreach, IT, billing, and other

“Developing a good team is very important. That is how you are going to succeed.”

– Erica Macias,  
Families Together of Orange  
County, Orange County  
LDPP

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.

- ▶ **Invest in training.** Provider leadership should ensure all staff—including dental and nondental personnel—participate in available VDH training, such as the training provided by CNU.

### Engage and Nurture Relationships with Community Sites.

The VDH is a partnership between the community site and the 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 for

“As a principal, with any program, I have to sell it to the teachers and staff and they have to support it. Otherwise, it is not going to be successful.”

– Leticia Chacon, Abraham Lincoln Elementary School, Orange County LDPP

both the dental provider and the site. Once a leader, such as a school principal, sees how the VDH benefits children, they often will impart the importance of the program to other staff and support the implementation of the program.

- ▶ **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 and have competing priorities. Providers need to take this into account, start early, and be patient.

- ▶ **Pay special attention to community sites' needs, and exercise flexibility.** Providers need to recognize that each



“The teachers really appreciated being surveyed; they feel valued, and now they are more engaged in the program.”

– Debra Payne, Sacramento County Public Health, Sacramento County LDPP

community site has different needs and requirements to meet the site's program objectives. Early learning sites, for example, may have requirements around nap and meal times. Some teachers may not want students to be taken out of class during particular instruction times. These and other factors should be taken into account as providers work with community sites to design their VDH programs.

- ▶ **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.
- ▶ **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. They simply may not be ready to partner or do not have the capacity to engage.

#### **Engage Families: Education about the VDH, VDH Enrollment, and Care Coordination.**

Partnering with families and understanding their unique needs are critical elements of a successful VDH



“The collaboration piece was the number one thing that helped us get through; without that collaboration, we would have never gotten off the ground.”

– Michael Failla, Western Dental,  
Sacramento County LDPP

relationships with them and ease the process for them. The VDH teams learned to show up when they knew they would see parents, such as when they drop off and pick up their children from school and early learning sites and at community site events, such as health fairs, back-to-school events, parent-teacher meetings, and other community site gatherings.

► **Engage in creative care coordination strategies.** The VDH teams identified various methods for educating families and helping families get care beyond

what could be provided at the community site. Some providers made calls from the school or early learning site since families recognized and trusted phone calls from their child’s educational entity. Some recruited community site staff to help follow up and/or echo the VDH teams’ messages. And some providers found that texting families to remind them of appointments worked better than phone calls. Care coordinators understood that this work requires multiple communications with families, persistence, and empathy.

**Support Regional Coordination.**

Following the example of the Sacramento

LDPP, in which the lead entity—Sacramento County Public Health—convened stakeholders and facilitated coordination across VDH activities, local leaders—such as county local oral health programs, local oral health coalitions, health center associations, or other entities—should coordinate a regional oral health strategy. This would entail a process to identify the oral health needs of communities, identify gaps in care, and coordinate VDH and other oral health services within the community. 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 oral health stakeholders to share lessons learned and best practices and collaborate.

**State-Level Programmatic and Policy Recommendations**

While this was a State-endorsed pilot program, there are several areas in which the State could better support the VDH.

**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-and-forward telehealth, Governor Newsom vetoed the bill. As mentioned, the State DHCS has temporarily allowed FQHCs/RHCs to use telehealth to establish patients during the current PHE. It is critical to make these changes permanent.

“Any event where we know parents will be present, we try to attend.”

– Andrea Rosas, Central City  
Community Health Center,  
Orange County LDPP

program. Importantly, each VDH team needs to devise tailored strategies that work best for the families they serve.

► **Invest the time and resources needed to educate families and enroll them in the program.** It is critical to spend ample time with families to develop trusting

## 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



“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, Families Together of Orange County Community Health Center, Orange County LDPP

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 state.

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- Sacramento Native American Health Center
- San Bernardino City Unified School District
- San Joaquin General Hospital
- Santa Ana College Early Childhood Education Center
- Serve the People Community Health Center Santa Ana
- Social Action Community Health System
- The Children’s Partnership
- Twin Rivers Unified School District
- Vista Community Clinic
- Walton Special Center, Stockton Unified School District
- WellSpace Health
- Western Dental



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