Access to Oral Health in Schools

KEY TO IMPROVED ORAL HEALTH AMONG YOUNG CHILDREN

The COVID-19 pandemic has brought many new challenges to school-based oral health programs (SBOHPs). Schools nationwide have closed for safety, further reducing access to dental care for children who may not receive dental services elsewhere. Thousands of children, in particular those from low-income families or those in rural areas, already suffer from higher rates of untreated decay, and this suspension of SBOHPs increases risk for poor oral health.[1] This number is projected to increase if the current pandemic continues.

The DentaQuest Partnership for Oral Health Advancement recently conducted a study to examine the continued impact of SBOHPs among children ages birth to 20 years from 2012 to 2018. The study used administrative claims data from the IBM Watson Market Scan Medicaid Database, a nationally representative sample of 13 state Medicaid programs, to identify all dental services offered in SBOHPs paid by those states' Medicaid programs. Findings from this study show why it is crucial to preserve school-based dental services for children, especially during this time.

KEY FINDINGS

Schools provide direct access to oral care.

54,658 Medicaid-enrolled children received a dental service in a school-based setting during the study period.

The most common dental procedures provided in 2018 were

- **diagnostic,**
- **imaging,** and
- **preventive services** including fluoride treatments.

Schools are an important access point for preventive care.

Of children who had a school-based dental service:

- **78%** received a fluoride varnish application
- **75%** received a comprehensive dental examination
- **60%** had x-rays or intraoral images taken
- **51%** had sealants placed*

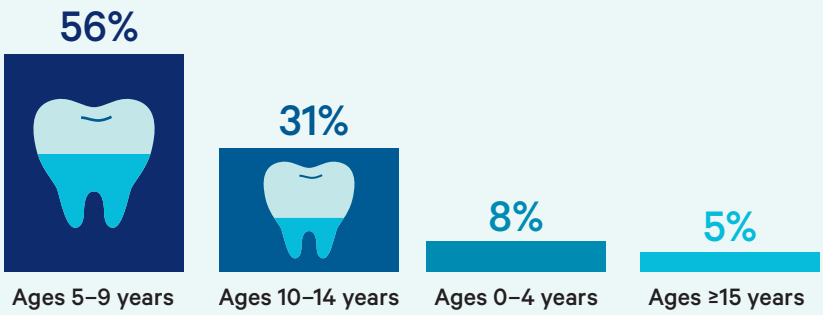
*There is substantial evidence that dental sealants prevent most pit and fissure caries in children (CDC, 2020). Therefore, the percentage of sealant placement should be higher. See https://www.cdc.gov/vitalsigns/dental-sealants/index.html#:~:text=Sealants%20are%20a%20quick%2C%20easy,for%20up%20to%204%20years.

WHY FLUORIDE VARNISH IS IMPORTANT.

Fluoride varnish is important because it can **strengthen enamel and help prevent tooth decay**, slow it down, and/or stop it from getting it worse.[2]

SBOHPs reach young children the most.

Elementary-aged children (ages 5–9 years) **were the most likely to have received a school-based dental service** in 2018 (making up **56%** of the school-based claims), followed by **middle school students** ages 10–14 years (**31%**), **preschool-aged children** ages 0–4 years (**8%**) and then **high school students ages ≥15 years** (5%).



SBOHPs can lead to further care.

Among children continuously enrolled in Medicaid and who received school-based dental services in 2017,

66% had never received dental care

36% of those children without prior dental care went on to receive care in an office setting

SBOHPs can reduce racial and ethnic disparities in oral health care.

From 2012 to 2018, program utilization rates significantly increased across all racial and ethnic groups as follows:

White children	from 1,078	**to 8,787**	**715% increase**
Black children	from 674	**to 4,406**	**554% increase**
Hispanic children	from 37	**to 782**	**2014% increase**
Children identified as **"other"**	from 112	**to 628**	**461% increase**

WHY REACHING OUT TO THE YOUNGEST CHILDREN IS IMPORTANT.

Tooth decay is one of the most common chronic diseases in children. **About 1 of 5 children aged 5 to 11 years will have at least one untreated decayed tooth.** Furthermore, children from low-income families are twice as likely to have cavities compared to higher-income families.[3] Previous studies have shown that caries left untreated can lead to poor oral health outcomes, especially as children get older. Therefore, it is essential to prevent caries in young children.

LOW UTILIZATION RATES

Many school-based programs have funding sources other than Medicaid reimbursement and are not universally tracked.[4] In addition, most SBOHPs report the schools they are in or the number of children they serve to the state dental board, state health department, or the Board of Education. This makes the tracking of delivery of school-based services difficult and means that the total number of children who received school based dental services is likely underrepresented here.

Because research indicates that tooth pain may disrupt learning and have a harmful impact on school performance, oral health services for children are critical for lifelong health and wellness. SBOHPs continue to be an effective strategy to prevent tooth decay, promote oral health education, and increase access to oral health care. Since care provided within the school environment has been suspended in many regions due to the COVID-19 pandemic, alternative outreach models should be implemented so at-risk children can receive the oral health services they need. For example, SBOHPs can incorporate virtual oral health education sessions for children into their curriculum, develop fact sheets about the safety of dental-related activities for children during the pandemic, or provide oral health care services through different means such as teledentistry.[5-6]

There are two modes of teledentistry:[7]

Live video (synchronous)
A synchronous visit is a "live" two-way interaction between a dental provider and patient.

Store and forward (asynchronous)
An asynchronous visit is when a patient's photographs, X-rays or other recorded health information is sent via a secure electronic system to a dental provider, who later reviews this information to evaluate a patient's condition and/or update their treatment plan without real-time interaction.

SUGGESTED CITATION:

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