**School-Based or School-Linked Mobile or Portable Dental Services Policy Statement**
**Association of State and Territorial Dental Directors (ASTDD)**
**Adopted: February 28, 2012**

## Problem

Dental disease in children in the U.S. remains a major public and personal health problem. [1,2] Disparities in oral health exist in every state. Untreated disease can result in pain, impairment, difficulty chewing and eating, difficulty concentrating and learning, poor appearance and low self-esteem. The solution requires primary prevention strategies, early detection and early intervention. [3,4]

Access to oral healthcare is a problem for many children and families. Many factors affect access to care, e.g., a maldistribution of general dentists and pediatric dentists, especially those willing to treat low-income or uninsured families; lack of parental awareness of oral health needs and the range of preventive measures available; lack of supportive services for helping families access care and competing daily priorities for families.

Parents often are cautious about taking time from work to seek healthcare for themselves or their family, especially in difficult economic times.[5] Likewise, some school administrators may discourage absences from school for routine healthcare because of concerns about academic performance and loss of income from per capita attendance reimbursement. Increasingly, preschools and K-12 schools are considering provision of oral health services on-site.

## Methods

Bringing health services to preschools and schools often is viewed as an efficient, cost-effective model to reach children and families, particularly for preventive services. In 2010, state supported or state-operated mobile or portable programs provided preventive care in at least 22 states and restorative care in 30 states.[6] Some programs provide initial screenings or exams for school entry and/or triage for establishing priorities for onsite care or referrals to care in the community. Dental services can be delivered in schools with stationary equipment, in a room in the school building using portable equipment, or in mobile vans that park at the schools. School dental services can be integrated into existing school-based health centers, operated as stand-alone dental services or linked to existing community-based dental services. Three common school-based dental service models include:

1. Dental sealant programs at selected grades to reach children for application on first and second permanent molars.
2. Dental preventive services, including teeth cleaning, fluoride treatments and/or sealants at any grade.
3. Basic preventive and restorative dental services at any grade.

These models usually include oral health education services. School-linked services use similar models, although services are provided by dental professionals in stationary community practices or health centers, or in mobile vans, with services coordinated by or linked to a school or district.

Targeting schools with a high percentage of children at high risk for dental disease is a practical approach for reaching those children with the greatest dental needs. Using the Free- and Reduced Price Meal Program enrollment as risk thresholds provides the ability to reach higher risk children.[7] Regardless of the model, the program must have the capacity to provide timely follow-up appointments and referrals to provide and complete treatment for problems found during the examination or screenings.

Information and research on the effectiveness of mobile or portable dental care delivery systems in various sites is limited.[8,9] Given the lack of such data, these services should be based on sound public health approaches. Services should be age appropriate and evidence-based. Based on limited studies and anecdotal information, school-based or linked mobile or portable services seem to be most successful when: 1) they are understood and supported at the outset by the participating schools and communities, including the local dental professionals; 2) they are coordinated with local public health and social service agencies and programs; 3) a diversified funding base is established for sustainability; 4) services and oral health outcomes are documented, tracked and evaluated for effectiveness and efficiency; and 5) services are available to all the children in the school regardless of insurance status or ability to pay.

Providing comprehensive services or linking children to a dental home for basic and continuing care on an ongoing basis is a crucial element which must occur no matter which model is used. It is critical that these programs are capable of having their services and/or an adequate and appropriate services network consistently and continually available in the community to ensure that these children obtain a dental home. Schools and communities should be encouraged to partner only with mobile and/or portable dental programs that offer either comprehensive care or provide effective referrals into the community leading to a dental home. Community outreach and case management services can be useful in attaining this goal.

Mobile and portable dental programs are financed in various ways through federal, state and local funding; corporate support; foundation grants; in-kind contributions; volunteerism; and reimbursements from Medicaid or CHIP. Federally Qualified Health Centers, State Oral Health Programs, hospitals, for-profit entities, non-profit groups and universities with dental and dental hygiene programs have also established mobile or portable dental services to increase their outreach to communities and schools. Staffing configurations use various combinations of dentists, dental hygienists and dental assistants aided by program coordinators, drivers, or other support staff, either as employees, contractors or volunteers.

School administrators and personnel are important team members and are directly involved in the program in numerous ways.

Each preschool and school setting has a unique set of challenges when designing school dental services, including addressing infection prevention and control. Also, various regulations, laws, practice acts and policies exist at the federal, state and local levels that govern mobile and/or portable programs as well as providers.

School-based or school-linked mobile or portable dental services can function as a safety net and as a gateway to a permanent dental home.

**Policy Statement**

The Association of State and Territorial Dental Directors (ASTDD) endorses and supports preschool and school-based or school-linked mobile and portable dental programs that provide comprehensive services or linkage to a dental home. Proponents of mobile and portable dental services should engage health care providers in communities to ensure access to care through a collaborative process and an effective referral system. Mobile-Portable programs should target services to schools with high percentages of children at high risk for dental disease regardless of the child's insurance status or ability to pay. Mobile and portable programs should also include plans to ensure quality of care and sustainability. Dental services must comply with all federal, state and community guidelines, laws and regulations.

Additional resources for mobile and portable programs include the Mobile Portable Dental Manual; Mobile and Portable Dental Services in Preschool and School Settings: Complex Issues; School-based Dental Services Guidelines for Mobile and Portable Programs. Information Toolkit; Site Assessment Checklist and Infection Control Checklist for Mobile and Portable Dental Programs; ASTDD Coordinated School Oral Health Policy Statement; and ASTDD Policy Statement on School Dental Sealant Programs.

---

[1] Dye BA, Tan S, Smith V, et al. Trends in oral health status: United States, 1988-1994 and 1999-2004. *Vital Health Stat 11*. April 2007; (248):1-92.

[2] Beltran-Aguilar ED, Barker LK, Canto, MT, et al. Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel fluorosis – United States, 1988-1994 and 1999-2002. In Surveillance Summaries, August 6, 2005. *MMWR* 2005;54(No.SS-3):1-44.

[3] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD.: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.

[4] Holt K, Barzel R. *Pain and Suffering Shouldn't Be an Option: School-Based and School-Linked Oral Health Services for Children and Adolescents*. Washington, DC: National Maternal and Child Oral Health Resource Center. 2010.

[5] California School Boards Association. Integrating Oral Health into School Health Programs and Policies. 2010. http://www.csba.org/EducationIssues/Education Issues/Wellness/OralHealth.asps. Accessed February 5, 2012.

[6] Association of State and Territorial Dental Directors. *Summary Report: Synopses of State Dental Public Health Programs; Data for FY 2009-2010*. June 2011. http://www.astdd.org/docs/State_Synopsis_Report_SUMMARY_2011.pdf. Accessed January 10, 2012.

[7] Siegal M, Detty A. Targeting school-based dental sealant programs: who is a "higher risk?" *J Public Health Dent.* Spring 2010;70(2):140-147.

[8] Arevalo O, Chattopadhyay A, Lester H, Skelton J. Mobile dental operations: Capital budgeting and long-term viability. *J Public Health Dent***.** 2010;70(1):28-34.
[9] Brooks C, Miller LC, Dane J, et al. Program evaluation of mobile dental services for children with special health care needs. *Spec Care Dent*. 2002;22(4):156-160.