Dental Public Health Project/Activity Descriptive Report Form

Please provide a detailed description of your **successful dental public health project/activity** by fully completing this form. Expand the submission form as needed but within any limitations noted. Please return completed form to: lcofano@astdd.org

NOTE: Please use Arial 10 pt. font.

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SECTION I: ACTIVITY OVERVIEW

Title of the dental public health activity:

Improving Data Collection and Measurement to Support School-Based Oral Health Programs

Public Health Functions* and the 10 Essential Public Health Services to Promote Oral Health: Check one or more categories related to the activity.

"X"	Assessment
x	1. Assess oral health status and implement an oral health surveillance system.
	2. Analyze determinants of oral health and respond to health hazards in the community
	3. Assess public perceptions about oral health issues and educate/empower them to achieve and maintain optimal oral health
	Policy Development
x	4. Mobilize community partners to leverage resources and advocate for/act on oral health issues
x	5. Develop and implement policies and systematic plans that support state and community oral health efforts
	Assurance
	6. Review, educate about and enforce laws and regulations that promote oral health and ensure safe oral health practices
	7. Reduce barriers to care and assure utilization of personal and population-based oral health services
	8. Assure an adequate and competent public and private oral health workforce
x	9. Evaluate effectiveness, accessibility and quality of personal and population-based oral health promotion activities and oral health services
	10. Conduct and review research for new insights and innovative solutions to oral health problems

***ASTDD Guidelines for State and Territorial Oral Health Programs that includes 10 Essential Public Health Services to Promote Oral Health**

Healthy People 2030 Objectives: Please list HP 2030 objectives related to the activity described in this submission. If there are any state-level objectives the activity addresses, please include those as well.

HP 2030 objectives that are the focus of our work include:

1. Reduce the proportion of children and adolescents with active and untreated tooth decay OH-2
2. Increase the proportion of low-income youth who have a preventive dental visit OH 9

Our work aligns with The California Oral Health Plan 2018-28 in these areas:

Goal 1: Improve the oral health of Californians by addressing determinants of health and promoting healthy habits and population-based prevention interventions to attain healthier status in healthy communities.

Objective 1a. Reduce the proportion of children with dental caries experience and untreated caries.

Goal 2: Align dental health care delivery systems, payment systems, and community programs to support and sustain community-clinical linkages for increasing utilization of dental services.

Objective 2a. Increase the proportion of children who had a preventive dental visit in the past year and reduce disparities in utilization of preventive dental services.

Objective 2.b Increase the percentage of Medi-Cal enrolled children ages 1 to 20 who receive a preventive dental service.
Objective 2.e Increase the number of Medi-Cal beneficiaries under six years of age receiving in any 12-month period a dental disease prevention protocol by primary care medical providers that includes an oral health assessment, fluoride varnish application, and dental referral or assurance the patient has received examination by a dentist in the last 12 months.

Goal 5: Develop and implement a surveillance system to measure key indicators of oral health and identify key performance measures for tracking progress.

Objective
5.B Gather, analyze, and use data to guide oral health needs assessment, policy development, and assurance functions.

Provide 3-5 Key Words (e.g., fluoride, sealants, access to care, coalitions, policy, Medicaid, etc.) These will assist those looking for information on this topic:

Acquiring oral health data, Use of oral health data, Prevention, School-based oral health, Kindergarten screening, Oral Health Advisory Board, Oral health measurement

Executive Summary: Complete after Section II: Detailed Activity Description. Please limit to 300 words in one or two paragraphs.

Provide a brief description of the dental public health activity. Include information on: (1) what is being done; (2) who is doing it and why; (3) associated costs; (4) outcomes achieved (5) lessons learned, both positive and negative.

The L.A. Trust began its oral health work in 2012 with the aim to reduce dental caries in Los Angeles Unified School District (LAUSD) students by 25% over five years by Integrating oral health care into LAUSD's wellness strategy. This was accomplished in partnership with the district staff and community partners who have a shared understanding of the importance of preventing dental disease early so that children can thrive in school. While we were fortunate enough to have a formal evaluation, we needed a more efficient way to collect ongoing service data that could drive investments, improve quality, and support access to care.

The evaluation of our screening programs demonstrated that 5 % of our children had emergent dental disease and 50% overall needed to see the dentist in one month. A study on the oral health of LAUSD students demonstrated that 2.2 days of school are missed due to dental pain. In our analysis, we concluded that untreated dental disease cost the district over $70 million in lost attendance revenues.

To streamline data collection and monitoring, The L.A. Trust developed a Data xChange that integrates student health data with academic and attendance measures. This system is unique in the nation in that it allows the district to monitor provider performance, target investment, support funding and policy advocacy, and offer keen insights for providers to improve quality and access to care. The Data xChange is unique at this moment to the LAUSD. Data collected includes primary care Heatlhcare Effectiveness Data and Information Set (HEDIS) standards and oral health indicators created through the National Network for Oral Health Access (NNOHA).

SECTION II: DETAILED ACTIVITY DESCRIPTION

Provide detailed narrative about the dental public health activity using the headings provided and answering the questions. Include specifics to help readers understand what you are doing and how it's being done. References and links to information may be included.

Complete using **Arial 10 pt.

Rationale and History of the Activity:

1. What were the key issues that led to the initiation of this activity?

The L.A. Trust's Oral Health Initiative (OHI) was established in 2012 with the goal of reducing dental caries in LAUSD students by 25% over five years. Within the first two years of the program, The L.A. Trust evaluated screening outcomes and noted that 5-7% of the children screened had level three concerns, (abscesses or broken teeth) and 50% had level two concerns, (caries experience). The University of Southern California (USC) conducted a study with LAUSD students that found that students with toothaches are almost 4 times more likely to have a low-grade point average and that 1 in 3 school absences was dental-related which amounts to, on average, 2.2 missed school days/student each year due to untreated dental disease. *Am. Journal of Public Health (2012) The impact of oral health on the academic performance of disadvantaged children:* https://pubmed.ncbi.nlm.nih.gov/22813093/

We calculated days lost to the district and monetized this showing 588,696 students were enrolled in the district and if 73% had untreated caries and missed 2.2 days of school that resulted in 945,446 missed days due to dental pain costing the district over $70 Million in revenues. This became the call to action.

To guide this work and advocate for action, The L.A. Trust established an Oral Health Advisory Board (OHAB), that includes dental providers, county public health staff, University of California, Los Angeles (UCLA) and USC dental programs, children's health advocates, school administrators, nurses, hygienists, policy makers, and promotora programs. Both the OHAB and the board of The L.A. Trust supported the development of a Districtwide Oral Health Initiative that would be based on a comprehensive public health approach and included a uniform data collection and monitoring methodology.

2. What rationale/evidence (may be anecdotal) did you use to support the implementation of this activity?

Based on the following information and research, The L.A. Trust developed a public and population health approach to meet the oral health care needs of students within LAUSD The design would include a comprehensive approach including: a) parent-informed prevention education for students, teachers, and parents b) improving access to care through primary prevention and early intervention via oral health screening and fluoride varnish based on the best practice model from Anderson Center for Dental Care at Rady Children's Hospital for universal screening and fluoride varnish application in schools c) regular communication and feedback from community advisors through an Oral Health Advisory Board d) using data to inform policy and financing to sustain oral health services.

There are remarkable disparities in dental disease by income.

- Low-income children suffer 2-5 x as many cavities as their more affluent peers, and their disease is more likely to be untreated.
- Low Income children spend nearly 12 x as many days suffering with limited ability to study, play, and interact socially, then children from higher-income families.

*Dental Disease Is a Chronic Problem Among Low-Income Populations.
HEHS-00-72: Published: Apr 12, 2000. Publicly Released: Apr 26, 2000.

Twelve percent of children were unable to afford dental care in 2015. This ranged from 5%-20% by location with the highest rates of low income in the areas of Los Angeles that The L.A. Trust focused on.

* 2015 LA County Health Survey

A 2012 study of oral health needs in LAUSD found that students with toothaches are almost four times more likely to have a low-grade point average. One in three school absences was dental-related which amounts to, on average, 2.2 missed school days each year due to untreated dental disease resulting in over a $70 million dollar loss to the district.
*Mulligan R, et al. Dental carries in underprivileged children in Los Angeles. J Health Care Poor Underserved 22(2), 2011.:648-62.

Through our dental screenings we have discovered that, on average, 35.1% of children screened have no visible active oral disease. Of those with no active oral disease, 53% have fillings, indicating a history of cavities. 33.7% of students have early, reversible, signs of tooth decay. 25.9% of students have visible dental cavities (ranging in number from 1 to 10) and 5.2% of students have severe dental disease requiring emergency attention.

3. What month and year did the activity begin and what milestones have occurred along the way? (May include a timeline.)

In May of 2012, The L.A. Trust began its work to develop and Oral Health initiative. The program was designed based on oral health and behavioral health data that was gathered over the years. We understood the following elements were key to our strategy:

- develop our communication strategy with students and parents,
- develop multi-level partners through schools, provider community, and advocacy groups,
- develop a program that could universally be provided throughout the district,
- develop a way to measure impact and drive quality improvement

With input from the Oral Health Advisory Board (OHAB) and our school partners, we finalized and released our Oral Health Operations Manual outlining the program from providing the education curricula through the implementation of the universal screening program. The link to the manual is here: https://thelatrust.org/oralhealthtoolkit/

We learned about the immense importance of navigating local relationships, especially in public policy work, and in response, we have deepened our reputation as oral health experts within LAUSD and Los Angeles County. The L.A. Trust now has a seat at the proverbial table around children's oral health throughout Los Angeles County. The relationships led to stronger support for the OHI Model and for the pioneering Data xChange.

The L.A. Trust has stepped into a larger role advocating and finalizing standardized protocols and data collection across all sites. To accomplish this, we are spending the needed time working with the district and our stakeholders to develop a comprehensive policy strategy and finalize the ideal data collection process for school-based oral health.

The timeline for the start of the project is as follows:

2012 researched best practice models and the status of oral health in children in the US, California, and Los Angeles

2013 Established the Oral Health Advisory Board (OHAB); partnered with District Nursing to create a District Oral Health Nurse position to ensure alignment with policies and protocol for school based oral health screening and care; worked with partners, parents and school administrators to identify barriers to care and strategies for successful implementation of a school based oral health screening model and tested it within two schools; worked with LAUSD to include Oral Health in LAUSD's School Wellness policy.

2014 Developed health education programs based on parent, student and oral health partner input; refined Rady Children's Hospital's fluoride varnish screening program from parents applying to providers applying fluoride to make the program billable; conducted universal screening at 6 schools and developed a "principal friendly" oral health report card

2017 School board resolution passes to implement a Districtwide Oral Health Program including districtwide oral health education in February (Children's Oral Health Month) and expansion of kindergarten screening; began development of automated dental services reports through the *Data xChange*, (The L.A. Trust's data interface which collects care delivery data and integrates this with student academic and attendance records)

2019 Served at total of 136 schools cumulatively; finalized the Data xChange Dental reports with support from National Network for Oral Health Access (NNOHA)

2020 Succeeded in passing a school board resolution for opt-out consent for oral health screening; refined the dental data reports

The sections below follow a logic model format. For more information on logic models go to: W.K. Kellogg Foundation: Logic Model Development Guide

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	OUTCOMES

1. What resources were needed to carry out the activity? (e.g., staffing, volunteers, funding, partnerships, collaborations with various organizations, etc.)

- Partnerships with dental providers, school nursing, school administrators and parents
- Funding to support staff time for the Data xChange from DentaQuest and Kaiser Permanente
- Guidance from the Oral Health Advisory Board
- Partnership with the California and LA County Oral Health programs
- Collaboration with UCLA and USC Schools of Dentistry and NNOHA
- Evaluation partners from UCLA Dept of Pediatrics
- Contract with Anton Consulting to build the dental database
- Other funders and investors

INPUTS	**PROGRAM ACTIVITIES**	OUTPUTS	OUTCOMES

2. Please provide a detailed description the key aspects of the activity, including the following aspects: administration, operations, and services.

Oral Health Advisory Board
Administration: Required executive director to recruit the OHAB and guide policy changes, executive assistant to coordinate meetings and take minutes, program staff to research new concerns, oversee the logic model progression, manage subcommittees, follow up on items requiring action, and manage speakers.
Operations: scheduling meeting rooms, ordering lunch, coordinating speaker presentations
Services: quarterly meetings to advance goals for increased oral health access to all children in LA county schools

Oral Health Data collection and evaluation
Administration: Required technical cloud frame for the collection of automated data, research partners to design and conduct the evaluation, Data Use and Business Associates agreements, legal review, students and parent recruitment for focus groups, communications staff to support promotion and dissemination
Operations: Required *a* cloud portal for data hosting and tableau reporting, coordination of focus groups, incentives for participants, coordination for event day data collection, follow up procedures for students with high needs, coordination with District Nursing
Services: Developed evaluation papers and publications to inform the oral health field on best practices and strategy. The L.A. Trust's Data xChange is now automating and reporting dental care data to improve practice, support policy change and sustain programs. Data is shared at Wellness Learning collaborative and Oral Health Advisory Board Meetings. We are working with LAUSD to gather the dental service data from all school-based oral health providers.

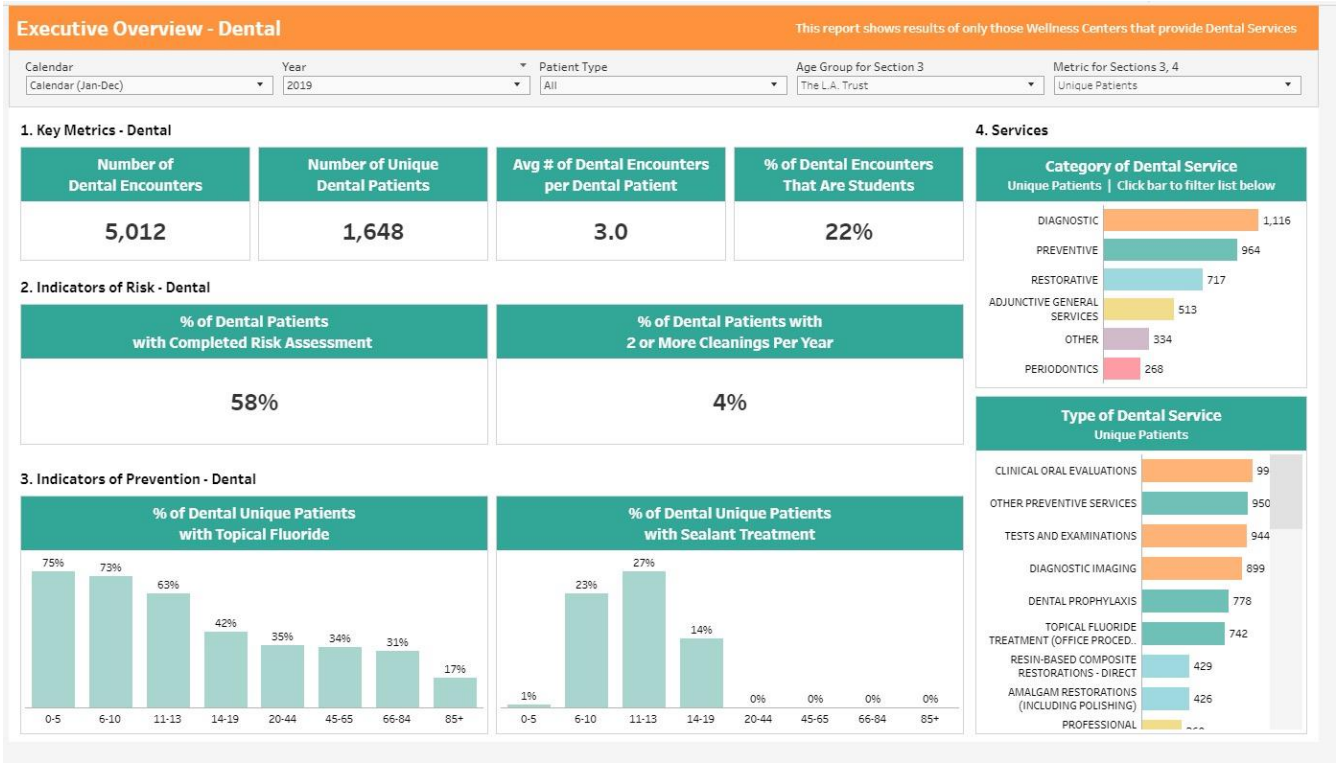
INPUTS	PROGRAM ACTIVITIES	**OUTPUTS**	OUTCOMES

3. What outputs or direct products resulted from program activities? (e.g., number of clients served, number of services units delivered, products developed, accomplishments, etc.)

Oral Health Report Card 2013-2019

	Overall
Total number of children screened	**17075**
Abnormal exam	68%
Caries experience	66%
Visible decay	32%
Number with urgent/emergent dental needs	3384

- Authored an Issue Brief, *"*Building on Momentum Paving the Way for a System of Oral Health Care in Los Angeles Unified School District*"*
- Published a journal article: *A school-based public health model to reduce oral health disparities* in the Journal of Public Health Dentistry
- Worked to pass two school board resolutions to develop a district wide oral health initiative and another to allow opt out consent for screening
- Created automated dental care reports



INPUTS	PROGRAM ACTIVITIES	OUTPUTS	**OUTCOMES**

4. What outcomes did the program achieve? (e.g., health statuses, knowledge, behavior, care delivery system, impact on target population, etc.) Please include the following aspects:
    a. How outcomes are measured
    b. How often they are/were measured
    c. Data sources used
    d. Whether intended to be short-term (attainable within 1-3 years), intermediate (achievable within 4-6 years), or long-term (impact achieved in 7-10 years)

Our original long-term aim was to reduce dental caries in children by 25% from baseline. We did not have a formal longitudinal study to assess this, nor did we have any consistent or automated data from the partners or providers, however, the UCLA Pediatrics Research Team, Dr, Rebecca Dudovitz, has been our evaluation partner in the Oral Health Initiative (OHI) since its inception. The team collected data for each oral health event and compiled it annually. Eighty-eight percent of students served were Latinx, 8 % Black and 57% come from Spanish monolingual families. Students screened ranged from ages 2-18 years of age. Over 80% served were elementary school children. 17,075 screenings were conducted across 136 schools. In assessing our needs, formal evaluation was necessary to establish the value of the program, but we needed a consistent and seamless way to collect the data.

Our oral health report card spanning 2013 through 2018 demonstrated that 32% of the children brushed their teeth less that twice/day; 40% had no dental visit in the last six months; 33% drank fluoridated water in the last 7 days; 46% drank soda in the last 7 days; and 88% drank sugar sweetened beverages in the last 7 days; 73% had an abnormal health exam; 63% had caries experience; and 36% had visible decay. Further screening results showed, that 40% of the students screened had visible gingivitis (83% among adolescents); 34% of adolescents reported gum bleeding with toothbrushing or flossing: 5% of all children had emergent disease of which 36% had abscesses, 30% had severe decay, 15% had other infections; 6% had pain, 5% had broken teeth; and 15% other.

In one longitudinal study across six elementary schools over two years, 22.7% or 631 students participated in the oral health program both years. Repeat participants were significantly more likely to report a dental problem (17.7% vs. 14.1%, p=0.03) and less likely to have an emergent dental need (3.7%

vs. 6.2%, p=0.02). At follow up, 56% of the repeat participants had fewer or no cavities, 27% were unchanged, and 17% had more cavities.

An assessment of program cost benefit was conducted and showed the cost of unreimbursed care ranged from $0-$3944/school due to lost attendance dollars. The application of fluoride varnish in the populations could prevent 0.74 cavities per child. The cost of filling the cavities costs $369 per child versus $70 per child to run the program. Preventing caries could save 1.6 school days per child at a rate of $79/day in ADA (Average Daily Attendance) funding for the district.

We are now collecting oral health services data at six sites through the Data xChange. The L.A. Trust can report seamlessly as indicated above. In the 2019-20 school year, oral health services were provided to 1648 unique patients with an average number of 3 encounters per year. 22% were students. 58% of all patients received a comprehensive risk assessment. Over 70% of the 0–13-year-olds received fluoride varnish and approximately 25% of the 6–13-year-olds received sealants.

A pilot study was conducted to implement a behavior change program increasing twice daily brushing and dental visits with kindergarten students. Behavior change theories, tangible incentives and social cognitive influence were drawn upon. Data on the effectiveness of brushing and seeing a dentist were presented as motivating factors and qualitative interviews with parents suggested that children resisted brushing and visiting the dentist was not routine. Students received oral health education and toothbrush/toothpaste at the beginning of the program. Parents received a letter explaining the study and their role. Students completed weekly dental charts tracking brushing and charts were turned in for sticker prizes. Students received larger prizes for visiting a dentist, (coloring books and markers). Oral health messages were reinforced throughout. Points were publicly displayed on posters. The class with the most points won a “bubble party” after four weeks and the interclass competition encourage positive peer support. The program was piloted at three schools/15 classrooms. 263 students participated; 588 brushing charts were returned, (an average of 2.2 charts per student); 27 students turned in dental certificates. Teachers were interviewed and focus groups with English and Spanish were conducted at all sites with 28 participants.

Students were excited to brush their teeth and go to the dentist.
Suggestions for improvement included integrating the program into the regular classroom practices, beginning earlier in the school year, and greater parent engagement.
Most teachers felt they could sustain the program if provided with the materials and a system for accountability.

Comments from teachers and parents were:

Teacher – “The kids see their progress, see the points, see who brought it in, and who’s ‘oh, hey, you don’t have any stars.’ ‘Also, “U-oh’ I don’t want any of my friends asking me, ‘Hey, are you brushing?” ---

Parent - “I think it helped that it didn’t come from me…When their teachers tell them and all of their little friends participate too, that also kind of hypes them up.

Teacher - “And the thing was, just the parents all of a sudden started taking their kids to the dentist.”

We hope to expand this to all school-based dental providers in LAUSD and beyond.

Budgetary Information:
NOTE: Charts and tables may be used to provide clarity.

1. What is the annual budget for this activity?

   For fiscal year 2021-22, the annual budget for Oral Health activities is $32,635.

Below are the pre and post COVID oral health program costs. Funds were cut off on 3/13/2020 when the President declared COVID-19 a national emergency.

Pre COVID costs	3/14/2019 – 3/13/2020	$223K. $50,000 was for the Data xChange
During COVID costs	3/14/2020 – 3/13/2021	$143K. $20,000 was for the Data xChange

The oral health program costs were reduced/cut by 36% during the Pandemic due to contracts being suspended or limited to administrative and virtual learning costs.

2. What are the costs associated with the activity? (Including staffing, materials, equipment, etc.)

The current annual costs are listed below:

Category	**Amount**
Personnel	$23,931
Printing and copying	$1,600
Supplies	$493
Telephone	$106
Misc. Expenses	$170
Memberships	$400
Meeting Expenses	$3,000
Conference	$1,120
Travel	$450
Website Services	$1,365
TOTAL	$32,635

3. How is the activity funded?

The following entities have funded this initiative over the past 10 years: DentaQuest Foundation, Dignity Health, Queenscare, Kaiser Permanente Community Benefits, University of California Los Angeles's Dental Transformation Initiative (DTI) grant, Big Smiles, Delta Dental, America's Tooth fairy, Oral Health America, Liberty Dental, and Patterson Dental.

Data xChange funding has been awarded from Kaiser Permanente and the DentaQuest Foundation.

4. What is the plan for sustainability?

This year, The L.A. Trust is securing county contracts to maintain oral health education in schools and support the reporting of kindergarten mandated data. In addition, The L.A. Trust is contracting with private dental providers to support their outreach and enrollment for school-based oral health programs which will include fees to support the data reporting to LAUSD.

Lessons Learned and/or Plans for Addressing Challenges:

1. What important lessons were learned that would be useful for others looking to implement a similar activity? Was there anything you would do differently?

We have learned more about the immense importance of navigating local relationships, especially in public policy work, and in response, we have deepened our reputation as oral health experts within LAUSD and Los Angeles County. The L.A. Trust now has a seat at the proverbial table around children's oral health throughout Los Angeles County. The relationships lead to stronger support for the OHI Model and for the pioneering Data xChange. In an infamously laborious bureaucratic system, it is advantageous to have partners who can expedite our aims.

The L.A. Trust's engagement with our network partners (LAUSD, staff, community-based oral health providers) has shaped our role as the facilitator of oral health care for LAUSD children, their families, and the surrounding community. It is precisely these partnerships that we will continue to leverage to develop and distribute our public policy strategy for the OHI model throughout LAUSD.

The L.A. Trust uses a collective impact model to advance the school health centers movement in Los Angeles County. A condition for the success of the model is shared measurement. To that end, the establishment of the Data xChange is essential. With it, The L.A. Trust can work with clinic partners to promote quality improvement efforts, share best practices, and demonstrate the impact of oral health services on reducing dental disease in children and supporting their academic success.

We will begin organizing a clear public policy advocacy strategy to achieve our goal of standardizing our model throughout the district. This strategy will require substantial planning with our partners. To inform our strategy, we will continue to bring together our Oral Health Advisory Board, LAUSD, UCLA, Los Angeles County Departments, dental insurance providers, local health plans, and academic institutions to gather information, discuss feasibility (especially in terms of navigating administrative and legislative guidelines), and develop additional needed partnerships. Because we will need the buy-in of LAUSD to implement the model, we will work closely with their new leadership and align with new statewide and county initiatives. The Oral Health Resolution of January 2017 will be the basis for advocating for standard operations, data collection, and more thorough policy implementation. In addition, the State Dental Director has created a statewide work group to focus on the Kindergarten Mandate as a core priority in his State Dental Plan and we contribute as an advisory member. This statewide work group includes the Dental Director from California Department of Public Health to support progress toward our goals including the use of standardized data reporting.

In the next year, we will advocate to LAUSD to modify general operating forms such that dental providers have standardized operating agreements. This will also include provisions for data collection and education components for students, teachers and parents and caregivers. Currently, not all providers have the same operating agreement and not all provide data in a standardized way to LAUSD. The Data xChange will be crucial in how we aim to streamline and rectify this process.

We will work with key informants (the National Alliance, NNOHA, dental providers, LAUSD nurses, and dental thought leaders at UCLA) to help develop specific performance metrics to use in the Data xChange. There is no standardized oral health performance measure recorded through the National School-Based Health Alliance. Once we know the national school-based program standards, we will create sample reports in Tableau and review them with our partners. Once approved, we will convert these reports into the Data xChange and merge the extracted data from the Wellness Centers into the platform.

Through the Data xChange, we will have the capacity to gather and report on all dental care activities provided, from school-based dental clinics to screening events. Such information represents a value proposition for both school administrators and dental care providers. LAUSD can use this information to inform policy decisions related to healthcare investments, while providers can use the information as a basis for Quality Improvement. Both parties will be able to track student oral health and academic outcomes over time, leading to more robust and informed partnerships. The Data xChange's improved integration of disparate data sets will also help improve our referral network and advance care. By drawing clear connections between oral health and academic outcomes, we can continue to advocate for policy decisions that further integrate oral health into the education system, from the primary level through high school. This directly aligns with Goal 2 and the following drivers: (1) School district policy (School committee/board/taxpayer support) and (2) School administration and staff engagement (value proposition).

We have learned and reinforced three important lessons: (1) data is a powerful tool if illustrated and discussed with appropriate context; (2) cultivating partnerships is built on trust; and (3) the adoption of new technology takes time. These lessons learned are important as we reflect on our successes and our challenges in developing this data system. For example, the process of creating the shared data use agreement with LAUSD took much longer than anticipated. In extending that process, however, we deepened the trust between partners and brought new insight into the project.

We have also learned that in-school services need constant innovation and construction of a robust infrastructure to ensure care. In addition to hosting oral health education workshops and screening events, The L.A. Trust advocated to LAUSD for systemic changes to increase access to these non-invasive dental screenings. In a singular advancement of the OHI agenda, the LAUSD Board of Education passed a resolution to adopt passive consent on March 10, 2020. This is a major accomplishment that happened much quicker than anticipated. It reinforced our understanding that

partnerships are crucial, and we rely on a wide community to advance change for our students. While this resolution would have approved implementation in the fall, with the COVID-19 crisis, passive consent implementation may be delayed. The pandemic creates a series of yet unanswered questions for the future of in-school screenings, but we remain confident in our ability to innovate and continue this needed oral health work in our communities.

2. What challenges did the activity encounter and how were those addressed?

The L.A. Trust has built out the first steps of our oral health data integration into the Data xChange. In uploading and using the available oral health data from four Wellness Center sites, we created four reports: (1) dental executive overview; (2) dental clinic comparisons; (3) dental clinic-specific; and (4) oral health services by Wellness Center. These reports succeeded as a first step and illuminated future challenges for us to contend with. Firstly, our current reports are simple and represent a small data sample. As we move forward, we will need to integrate additional data sources from our partners and continue to increase the number of available report types. In addition, we currently lack standardized oral health metrics across partners. In the future and with our new partnership with National Network for Oral Health Access (NNOHA), we need to create a standardized oral health metric set to use across the Data xChange.

We have begun the process of adapting the 'Data Helper'(our unique application for de-identifying data) to extract zip code and month of service for new reports. Unfortunately, due to the COVID-19 crisis, we placed our Data xChange contractors on hiatus. We expect to resume this work later in the year and continue moving forward on the remaining activities.

The L.A Trust's Oral Health Initiative had great success, pre-COVID-19. When LAUSD schools closed on March 13th, we had to cancel scheduled screening events and education workshops at a series of schools. Given the uncertain nature of when schools will open, we have begun looking into alternative options to continue this work. For example, we are exploring teledentistry to see if it is a viable option to satisfy the Kindergarten Oral Health Mandate. In addition, we have developed virtual oral health education and outreach materials.

Available Information Resources:

Share any models, tools, and/or guidelines developed by the program specifically for this activity that may be useful to others seeking additional information. Hyperlink resources if possible.

The Oral Health Toolkit
LA Trust Issue Brief
Journal of Public Health Dentistry article
Oral Health Initiative
Oral Health Initiative Strategy

TO BE COMPLETED BY ASTDD	
Descriptive Report Number:	06009
Associated BPAR:	Dissemination of Data from State-Based Surveillance Systems
Submitted by:	The Los Angeles Trust for Children's Health
Submission filename:	DES06009CA-data-collection-measurement-2021
Submission date:	August 2021
Last reviewed:	August 2021
Last updated:	August 2021