

Chapter 5. Approaches to Screening, Referral and Case Management

Chapter Description

This chapter will describe ways to establish coordinated screening, referral and case management systems to help assure that children receive the oral health care they need in a timely and appropriate manner. Considerations for performing oral health screenings, and the differences between screenings, epidemiologic surveys and dental exams are discussed. Various referral and case management models are presented, including sample scopes of work, reimbursement issues, and ways to track and monitor care.

Chapter Overview

The fields of health and education include many types of screenings-developmental, hearing, vision, language. All are attempts to assess a child's development and identify those children with other than routine needs who should be referred for more in-depth examination and care.

Dental screenings are widely used for this purpose, to triage those children who have routine needs, those who are at high risk for developing problems, and those who have obvious disease that requires treatment. Children can then be referred for routine preventive care and regular examinations as well as restorative or other care. The process and data collection instruments for most health screenings are more standardized than those for dental screenings. Sometimes screenings or "oral health surveys" are done primarily to gain an overall understanding of the oral health status of a particular population for purposes of planning and allocation of resources. It is important to keep these two purposes in mind when determining how to conduct screenings.

Screenings are different than epidemiological surveys, such as the Basic Screening Survey, which require a sampling framework and other research-oriented considerations.

A dental screening is not the same as a clinical dental examination. Dental examinations are performed by dentists and should result in a diagnosis and an individualized plan for care.

Screenings are not effective and should not be undertaken unless there is a referral network of professionals to provide the needed care and there is a way to track which children received care.

A common complaint in many communities is that dental screenings are performed on a regular basis, but children with identified restorative needs may not be able to access care, resulting in the same needs being observed over a number of years.

This is where "case management" is valuable. Social workers, nurses and other health professionals have been providing case management in public health and school settings for over 70 years. Case management responsibilities are now performed by many different professionals in inpatient, outpatient, community and health insurer settings to coordinate resources. The population to be served, the type of services needed, and the available healthcare settings often determine what type of professional background a case manager needs. Highly specialized, complex care such as that provided for children with cleft lip/palate will require someone with more clinical expertise, while case management of families who do not speak English in a rural town and are not familiar with community services might best be provided by a bilingual lay advocate whom the families trust. Choosing the appropriate model and staff are crucial to the success of any screening, referral, and case management program.

Self-Assessment

Purpose

Determine what screening, referral and case management processes already exist in your community. Many of these may be informal processes that were created by a dedicated nurse from the local health

department or a Head Start Health Specialist. You may need to interview a number of people to find this information. Use the [Screening/Referral/Case Management Self-Assessment form](#) to help guide your search. After you complete the self-assessment, discuss the findings with your oral health coalition or other group to determine if a more formal system would enable more children to have a true "dental home."

Screening, Referral and Tracking

Screening provides a snapshot of a population at a particular point in time to identify oral health needs and ways to meet those needs. Let's look at the purposes in more detail.

1. Identify populations at high risk for dental problems because of:

- nutritional factors: inappropriate feeding practices, frequent use of snacks or beverages with high refined sugar content
- poor oral hygiene: infrequent tooth cleaning or brushing
- medical conditions: conditions that affect the immune system (e.g., HIV infection), craniofacial disorders (e.g., cleft lip/palate), or that require frequent hospitalizations or multiple medications (e.g., kidney problems)
- behaviors that interfere with home oral care or professional dental care or put the child at risk for child abuse: e.g., uncontrollable tantrums
- beginning stages of dental decay (white spot lesions) or gum tissue problems
 - o inability to access professional dental care for exams or treatment due to lack of finances, lack of providers, etc.
- poor overall coordination or hyperactivity resulting in frequent injuries

2. Triage to establish needs and priorities for allocation of resources, maybe using the following categories:

- need regular exams, anticipatory guidance and preventive care
- need further examination for definitive diagnosis and possible care other than preventive measures
- need further examination and treatment in a timely manner
- need immediate examination and care for advanced disease or other condition
- Differentiate between those with a dental home and those without
- Money for direct care vs. money for preventive supplies vs. money for supportive services such as transportation to appointments
- Type and level of effort of workforce, e.g., DDS and/or RDH, DA, case manager
- Analyze for gaps in resources or to advocate for more resources.

How and Where to Perform Screenings

Screenings can occur in most any setting as long as there is an adequate source of light and somewhere for the child to sit or recline, sometimes in a parent's lap. This includes Head Start programs, WIC sites, child care centers, health fairs, family resource centers, home visits, well child clinics or other medical clinics. Screenings can also be conducted for pregnant women seen in parenting classes, prenatal clinics or in other settings.

[Performing dental screenings in dental offices is a waste of valuable resources and time. Dental office settings should primarily be used for diagnostic, treatment, and some preventive procedures.](#)

For screenings, examination gloves are optional, but should be used if there will be any contact with saliva. To gain access to the mouth, a small (not adult size) disposable tongue blade can be used or a small toothbrush that you give to the child after the screening (one with a rubber handle can be used to help prop open the mouth.) The latter is sometimes more helpful if there is food debris that obscures your view. Oral screenings on young children usually only take 1-3 minutes. Screening older children and adults takes a bit longer.

Consent Process

Consent must be obtained from parents/caretakers prior to performing an oral screening.

This can be accomplished by sending home a permission slip for signature (active consent) or by sending home a notice of the screening and asking those who don't consent to the process to send in a note stating so (passive consent). Examples of consent forms are included in the [Basic Screening Survey](#), and can be easily modified. Some include questions for parents to answer about access to dental care, home oral care practices, or feeding practices that might place a child at high risk for dental problems. After the screening, send a letter home noting the screening findings for each child, with an appropriate recommendation for seeking care and having a dental home. Emphasize in the letter that the screening does not take the place of a dental examination.

Incorporating Risk Assessment Questions

Asking a few key questions can help determine a child's risk for dental disease and other oral problems. Some high risk factors include: primary caregiver has active dental decay, child uses bottle that contains sweetened beverages, frequent between-meal snacks, medications that contain high amounts of sugar or that promote dry mouth, and inadequate oral hygiene. Examples of protective factors include appropriate use of fluorides, good oral hygiene, regular dental check-ups, primary caregiver has good oral health. Two examples of risk assessment questionnaires are at <http://www.cdafoundation.org/journal/jour0303/consensus.htm> and <http://www.aapd.org/members/referencemanual/pdfs/02-03/Caries%20Risk%20Assess.pdf>.

Recording Information

Collecting and recording the screening information in a consistent manner is important, especially if you are trying to categorize children to allocate resources and make appropriate referrals. If many agencies or individuals are performing screenings, then using the same form will allow aggregation or comparison of data. Again, there are examples in the Basic Screening Survey that can be modified. Make sure everyone is clear on the definitions of terms and categories. For example, if you intend to track children with suspected cases of Early Childhood Caries (versus any other pattern of decay that is evident), decide on a definition such as "obvious caries on at least one of the upper front teeth." Looking for and tracking oral injuries of the soft and hard tissues is important for anticipatory guidance with parents around oral injury prevention, or in cases of suspected child abuse.

Communicating with Parents

It is important that families understand the purpose and limitations of screening and what follow-up is recommended for further examination and care.

Most screening/referral programs provide a letter back to parents that describes what occurred at the screening and a general description of the child's oral health status (e.g., appears health, possible areas of dental decay) and what follow-up is recommended (e.g., routine examination and preventive care in dental office; needs dental treatment as soon as possible to reduce infection.) View [examples of letters from screenings](#) (need examples). Include contact information for questions, referrals or case management. This is also an opportunity to include oral health education information on specific topics.

Analyzing Results of Screenings

Analyze the screening data to see if they answer the questions that prompted your screening. For example, if you discover that most children in your preschool program don't have any immediate needs but could benefit from better oral hygiene care and preventive measures, you might decided to allocate resources to purchase toothbrushes and paste. Then you could schedule onsite fluoride varnish applications when parents can be present. Or if a number of children need dental treatment and parents don't have reliable transportation, you might allocate some funding to purchase transportation vouchers. Oral health screening data can be shared with other agencies in your community in a format that graphically displays the children's level of need; this helps document the need when advocating for additional funding.

Referral and Tracking

In many rural areas, an informal referral system exists because families and professionals in small towns know each other and interact on a more personal basis. Although this works well in some communities, it may not work where there are seasonal fluctuations in the population or where dental providers do not participate in public financing programs such as Medi-Cal or Healthy Families. Negotiations with providers and a definite process for referrals and tracking of care are needed. Incentives and community recognition often go far in sustaining provider participation.

Once a referral system is established, it usually requires frequent updating. The goal of a viable referral system is to have enough providers to meet anticipated needs in a timely manner and to establish "dental homes" for all children and their families. Dental homes should be accessible and provide continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective dental care and promote oral health. Waiting lists often are needed, so priorities based on level of urgency for the care are important to document.

[If you recommend that a child be seen for care, make sure that you have a tracking system to follow up on that recommendation, both with the parents and with the dental provider who sees the child.](#)

This means documenting when appointments are scheduled, if appointments are kept, reasons why appointments are not kept, if the child's care is completed, and what the recall interval is. Some programs have developed standard referral [forms that include a portion to return after care is provided](#). This sends a clear message to the dental provider that a response is expected, and promotes two-way communication. Any problems that occur around missed appointments, other specialty referrals, etc. can also be shared via this mechanism.

Tracking systems vary in their sophistication. They can include color-coded cards, reminder stickers on patient records, spreadsheets, or computerized databases. Some automated tracking systems generate patient reminders, letters, and topical information. Situations that create gaps in these systems include missed appointments, delays in pre-authorizing care, specialty referrals where paperwork is lost or the results of the care are not sent to the referring provider, or families move and don't notify the office. Effective tracking systems should have cross-checks, tickler files or alerts to prevent or manage these situations.

Case Management

Case management is a process used by a health professional or care coordinator to manage health care needs of families. Case managers make sure that families get needed services, and track their use of facilities and resources. They try to identify individuals at high risk for problems and assess opportunities to coordinate care to optimize health outcomes.

Benefits

Case managers can provide a variety of valuable services:

- implementing an active outreach system to underserved populations
- handling requests for screening or care from community-based groups such as Head Start
- explaining benefits and services to providers
- responding to provider problems with families, paperwork or reimbursement
- establishing a family's eligibility for services or funding
- providing information, answering questions and helping people make decisions about services
- helping families complete paperwork to obtain services
- making and following up on referrals to dental providers
- finding additional funding for individual cases if needed; interfacing with other agencies
- helping families find interpreters
- determining potential barriers for parents and problem-solving to reduce the barriers
- arranging for transportation or child care assistance or payment during dental appointments
- scheduling appointments and coordinating with other health or social service appointments if possible
- explaining the importance of oral health and answering some common oral health questions
- reviewing responsibilities and rights of patients and of dental providers
- managing paperwork so that everyone has what they need
- coordinating with families to facilitate follow-up on recommendations and routine care

- checking with families and providers to determine if there were any problems
- helping to prioritize and allocate resources
- generating reports to providers or agencies

In essence, case managers act as ombudsmen-playing an advocacy role, as well as a coordinator of care and a liaison between families, providers, and funders.

View a scope of work for a comprehensive care coordinator position in a regional center program in the program examples section. Where funding and staff are limited, case management services that address oral health in an integrated way with other health services are probably most cost-effective and help assure that health needs are being addressed in a comprehensive, coordinated way. If this is not an option because of dedicated grant funds for oral health or because of large potential dental caseloads, then a separate case management system may be warranted.

Some potential beneficial outcomes from case management include: 1) lower missed appointment rates, 2) increased future self-reliance and confidence of families, 3) increased knowledge of oral health, dental benefits and services available, 4) improved provider understanding and respect of families and young children, 5) improved timeliness of referrals and receipt of care, 6) increased adherence to recommendations and follow-up care, 7) reduced barriers to care, 8) increased numbers of dental professionals providing care to young children and pregnant women, 9) decreased prevalence of dental diseases, especially at advanced levels requiring urgent care, 10) reduced costs for dental care over the long run.

Examples of Programs

- Spokane Regional Health District received funding from the March of Dimes to provide oral screenings for low-income pregnant women seen by public health nurses. They have created a referral system with Eastern Washington University Dental Hygiene Program, focusing on care for periodontal disease. Contact: Oral Health Program Supervisor, 509-324-1550.
- Hawaii's Medicaid program contracts with a local private sector case management service to work with dentists and Medicaid recipients to help them understand Medicaid benefits and how to utilize them appropriately. They also coordinate specialty appointments, transportation and translators (when needed) and help place people with dentists when they have difficulty finding accessible/willing Medicaid providers. Contact: Dr. Mark Greer, 808-832-5700.
- Red River Valley Dental Access Project is a collaborative effort with public, private and philanthropic groups to improve access to dental care. It offers case management to a referral network of dentists in 25 counties in eastern North Dakota and western Minnesota. Social service and housing agencies identify clients in need of service. The project offers oral health screenings and education to programs that serve low-income families, such as Head Start. Multiple funding sources are used. Contact 701-364-5364; view website at <http://www.rrdentalaccess.com>.
- Plumas County conducted a dental case management program in 2001 through a Rural Health Services Small Grants Program. View the [case study](#). Twenty-four of the 105 individuals served were ages 0-5.
- Lassen Oral Health Task Force began a case management and tracking system using volunteer coordinators and providers. As the caseload increased and the need for a toll-free number, office space and record storage became crucial, they documented the effectiveness of the system and successfully acquired funding for a case manager and donated office space from a community health center.
- Anderson Center for Dental Care in San Diego initiated a Healthy Smiles for Children with Disabilities program to help families improve and maintain oral health for their children ages 0-3 with autism or other disabilities. The program is funded by the California State Council on Developmental Disabilities. A [program overview](#) and an example of an [oral health assessment](#) and plan provide more details and contact information. Anderson Center also received grant funding from First 5 Commission of San Diego to implement "[Welcome Baby Teeth.](#)" Physicians and staff receive in-office training, parent education materials, referral resources, and care coordination services to incorporate oral health screening into regular check-ups. Screenings also are conducted at Head Start and State-funded preschools. This curriculum will be adapted for the statewide First 5 Oral Health Education and Training Project, administered

by the Dental Health Foundation. For more information on the Welcome Baby Project, contact Jan Ferree, Program Coordinator at 858-576-1700 x 4802.

- The Center for Oral Health for People with Special Needs at the University of the Pacific School of Dentistry has developed a community-based system for oral health care for persons with developmental disabilities. One component of this program includes dental coordinator positions at eight or more state-contracted regional centers to provide case management, education and training. For more details see <http://www.pacificspecialcare.org/factSheet.htm> and a [position description](#).
- Donated Dental Services Program. In this program, volunteer dentists agree to accept a certain number of needy patients each year who are disabled, medically compromised or elderly to treat in their offices where they can work more efficiently with their own equipment, supplies, and staff. Although the focus generally is on older patients, this could be a resource for young children with special health care needs. In each state, at least one program coordinator is responsible for determining that applicants are eligible and have no other way of paying for dental care. Communicating between offices and patients is also a major responsibility. The coordinators play a case management role, verifying patients have reliable transportation, reminding them of appointments, and resolving problems that may arise. Coordinators also arrange for specialists and laboratory services when necessary. To find further information about the DDS program in a specific state, go to <http://www.nfdh.org/DDS.html>.
- El Dorado California Care Program/ East and West Slope Offices: Case management and dental care is offered through the county public health department; http://www.sacdhhs.com/cms/download/pdfs/pub/pub_source_eldorado.pdf
- Alameda County Health Department received funding for a national demonstration program called Healthy Kids, Healthy Teeth (HKHT): Case Management and Care Integration for children ages 0-5. Modeled after the Washington ABCD program, the program assists families in accessing dental care, provides education about dental visits, removes some barriers to care, tracks children's progress through the dental system, encourages appropriate use of dental services, and provides linkages to other health programs such as health insurance, well child exams and WIC. There are four program components: 1) recruitment, enrollment and case management, 2) dental and medical provider training, 3) provider incentives for participation, and 4) outcome evaluation. For information, contact Dr. Jared Fine at jared.fine@acgov.org.

Evaluating Effectiveness

What are some ways to determine if your screening, referral, tracking, and case management systems are effective? Consider the following methods and outcome measures.

- Examples of methods: family satisfaction surveys, provider interviews, case manager interviews, time and effort analyses, cost analysis, oral health data analysis
- Some outcome measures: improved oral health status of individuals/groups one year after screening, % of children who have a dental home, % of children completing recommended care, % of providers participating in referral system, in-kind efforts or donations such as transportation, # of case management hours spent/child or family, % of families who kept scheduled appointments, families reporting high level of satisfaction with care and with case management process.

Use evaluation information to improve your program and to justify its continuation or expansion.

General Resources

- Summers S et al. Practical infection control in oral health surveys and screenings. JADA. 125:1213-17, 1994. Available as an appendix to the Basic Screening Survey at http://www.astdd.org/docs/BSS_Manual_Appendix.pdf.
- Case Management Basics: <http://www.cyberchalk.com/nurse/courses/nurseweek/nw2210/c1/>. This course covers eight chapters. Although not focused on oral health, it does provide a good overview of the goals and strategies of case management. The course includes references, review questions and a posttest.
- ADA. State Innovations to Improve Dental Access for Low-Income Children: A Compendium, <http://www.prnewswire.com/mnr/ada/11207/#>; this a compilation of data drawn from each state's Medicaid and State Children's Health Insurance Program. Some examples of case management are given.

Evaluation

What did you learn or accomplish as a result of reading this chapter? Did it help you to organize your thoughts about what types of screening, referral and case management systems would be appropriate in your community? Were the resources and examples helpful? Go to the feedback form for Chapter 5 ([link to chapter 5 feedback form](#)) and tell us what was useful or not useful for you.