

Dental Sealants: Proven to Prevent Tooth Decay

A Look at Issues Impacting
the Delivery of State and Local
School-Based Sealant Programs



May 2014

The **Children's Dental Health Project** (CDHP) extends deep thanks to all who provided information, data and technical review of this report, including state public health dental leaders, the Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Association of State and Territorial Dental Directors and the Health Resources and Services Administration.

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***Note:** Materials for this project were prepared by the Children's Dental Health Project and consultants. The report was supported by Centers for Disease Control and Prevention Cooperative Agreement No. 5U58DP002285-04 to the Children's Dental Health Project. Its contents are solely the responsibility of the authors and do not necessarily represent official CDC views.*



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School-based dental sealant delivery programs are an evidence-based public health strategy for preventing tooth decay among school-aged children, particularly those at highest risk.¹ Dental sealants are protective coatings, generally applied to children’s permanent teeth, which have been shown to reduce tooth decay by 60 percent.² The Community Preventive Services Task Force recommends school-based sealant delivery programs, reflecting evidence that these programs “increase the number of children who receive sealants ... and that dental sealants result in a large reduction in tooth decay among school-aged children (5 to 16 years of age).”³

This report provides an overview of the program design and key issues in school-based dental sealant programs in the U.S. It offers examples of factors that may facilitate or complicate program financing, reach, and sustainability. It considers features of five states—IL, NY, OH, SC, and WI—that have had longstanding school sealant programs and explores current and potential challenges for implementing such programs. Finally, the report provides recommendations for all who are engaged in promoting children’s oral health through school sealant programs (SSPs).

Information for this report was obtained between 2011 and 2013 and included surveys of state oral health officials and select SSP program officials, qualitative structured interviews, and in-depth case studies, all conducted under a cooperative agreement between the Children’s Dental Health Project and the Centers for Disease Control and Prevention.

METHODS

This project defined states with “sustained” school-based sealant programs as having one or more SSP operating each year for 10 years (2003—2012), as self-reported by states in the annual Association of State and Territorial Dental Directors (ASTDD) State Synopsis Reports (“Synopsis Reports”).⁴ To assess whether a state’s

SSPs reached a “substantial” number of children (approx. 10,000 each year), the state’s most recent Synopsis Reports data on children served (2011 or 2012) was divided by the number of school-aged children as reported by the US Census.* Based on these data, we contacted 13 State Oral Health Programs for more detailed information. Seven state officials agreed to complete a pre-tested 34-question questionnaire (Appendix A) and a 90-minute telephone interview with follow up. From these more detailed assessments, five states (IL, NY, OH, SC, and WI) were selected for case studies.

To capture sealant activities in the 37 states (and the District of Columbia) that did not meet the definition of having “substantial and sustained SSPs,” those State Oral Health Program Directors were queried through an e-mailed 15-question survey (Appendix B). Four listservs[†] were also queried for the identities of local SSPs that had either operated for 10 consecutive years *or* provided sealants to at least 10,000 children in one program year. To further build understanding of highly regarded SSPs at the local level, respondents were asked to identify one local program that “might be the best in the country.” These processes identified 36 local SSPs who were then emailed an 8-question survey (Appendix C), to which 27 local programs in 22 states responded. Their responses informed the findings in this report.

This report reflects the best available information as provided by key informants. However, sealant programs are in constant flux and reported information may not capture all factors that affect SSPs’ reach and sustainability. The report also builds on and complements significant reports and resources, including: a 2013 review by the Pew Children’s Dental Campaign of states’

* * Penetration was grossly estimated by dividing the number of children the respective SOHPs were able to document as having received sealants via SSPs for the most recent year for which they had complete data (2011-12 or 2010-11) by the number of school-aged children in the state according to the 2010 U.S. Census.

[†] 1. * University of Pittsburgh. Pitt Dental Public Health Mailing List. Referenced at: <https://list.pitt.edu/mailman/listinfo/dental-public-health>; 2. Association of State and Territorial Dental Directors (ASTDD) ListServ. Referenced at: <http://www.astdd.org/membership-benefits/>; 3. National Network for Oral Health Access (NNOHA) Listserv. Referenced at: <http://www.nnoha.org/join/nnoha-listserv/>; 4. Community Oral Health Programs E-mail Discussion List. Referenced at: <http://lists.mchgroup.org/listinfo.cgi/cohp-mchgroup.org>.

performance on four sealant measures;[‡] earlier recommendations made by the collaborative Workshop on Guidelines for Sealant Use in 1994;⁵ the Community Task Force on Preventive Services in 2013;⁶ the American Dental Association’s Council on Scientific Affairs in 2008;⁷ and the CDC-sponsored expert work group in 2009;⁸ as well as materials provided by Seal America^{®9} and the National Maternal and Child Oral Health Resource Center.¹⁰ It seeks to complement information from ASTDD’s “Best Practice Approach Report on School-based Dental Sealant Programs” (available at www.astdd.org/school-based-dental-sealant-programs-introduction/) by providing a comprehensive assessment of SSPs and highlighting characteristics that support efficiency and effectiveness.



[‡] 1. The prevalence of programs in “high-need schools”; 2. Allowance of sealant placement by hygienists without a prior dentist examination of the child; 3. Compliance with data collection and reporting; and 4. Attainment of national sealant oral health objectives.

FINDINGS

Diversity of Models

Taken together, study informants identified more than 640 SSPs; most reportedly deliver sealants as part of a broader school-affiliated caries prevention program which may include dental screening, dental prophylaxis, topical application of fluorides, and oral health education. Information on SSP design was provided by 39 states and the District of Columbia. Of those, 27 states report that “all or most” SSPs were part of broader caries prevention programs and 13 report that “at least some” SSPs were part of such programs.

Roles of State Oral Health Programs (SOHPs)

Nearly all of the 40 SOHPs responding report involvement with SSPs, though they have varied roles in program design, operation, funding, oversight, and regulation. In general, SOHPs have greater input and closer partnerships when they provide direct funding to local SSPs.

Almost half (n=23)[§] of reporting states indicated that their SOHP provides funding to local entities to operate school sealant programs. Three states (MA, ND, NM) reported that SOHPs provide grants for SSPs in addition to operating their own SSPs. Four SOHPs (AR, CT, SC, UT) reported providing no direct funding for SSPs but support these programs through facilitation, coordination, regulatory action, and/or reporting.

SOHPs in 13 states were directly involved in the operation of SSPs: five (DC, DE, NC, OR, TX) by providing or contracting for SSP staff; five (GA, LA, MS, TN, VA) by funding and collaboratively operating local SSPs; and three (MA, ND, NM) by funding local SSPs and also operating their own SSPs.

Organizations that Manage SSPs

Among the 664 programs described by our informants, the types of organizations that manage local SSPs vary widely (Figure 1), with one-in-three

[§]AK, AZ, CO, FL, IA, ID, IL, IN, KS, KY, MD, ME, MI, MN, NH, NY, NV, OH, PA, SD, WA, WI, WV

programs delivered by local health departments; one-in-six delivered by either federally qualified health centers (FQHCs), non-profit or for-profit agencies; and smaller proportions by colleges/universities, school districts, and hospitals. While SOHPs are often engaged with SSPs, only 1% of programs were delivered directly by state oral health programs.

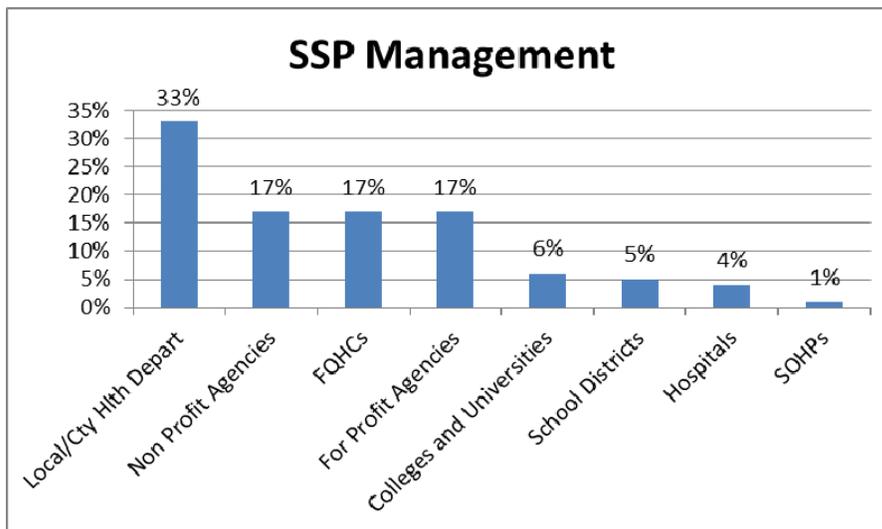


Figure 1 (N=664 programs)

Regional Patterns

Different types of organizations cluster regionally.

- Midwestern states (IA, IL, OH, WI) are home to 75% of SSPs managed by local or county health departments; Southern states (FL, GA, NC, TN, VA) are also characterized by having strong affiliations with health departments.
- FQHC-affiliated SSPs are strongly represented in the Northeast (CT, MA, NH, NY, RI) and a few Midwestern states (IL, KS, MI, WI) and in WV. Nine SOHPs reported five or more FQHCs operating SSPs in their states.
- For-profit SSP providers are reported to operate in 20 states; 12 states report having more than one for-profit SSP. Of the for-profit SSPs reported, 60% are found in three states: IL, MA, and WA. For-profit companies almost exclusively serve child Medicaid beneficiaries and some extend some service to uninsured children through affiliated foundations.

Financing Sources

Federal sources of financing that can be used to support SSPs include:

- State Oral Health Grants: competitive 5 year cooperative agreements with states from the Centers for Disease Control and Prevention Division of Oral Health through its *State-Based Oral Disease Prevention Program*;
- Funding to states from the *Title V Maternal and Child Health Services Block Grant Program* that states may allocate to oral health programs;
- Grants to states under the Health Resources and Services Administration (HRSA) Bureau of Health Profession's *State Oral Health Workforce Grants*; and
- Reimbursements from Medicaid through the state-administered *Early and Periodic Screening Diagnostic and Treatment (EPSDT)* pediatric dental benefit and the state's Children's Health Insurance Program (CHIP) (in states that maintain CHIP plans separately from Medicaid EPSDT).

In addition, states and locales may provide direct funding for SSPs through general revenues by way of grants, contracts, and cooperative agreements; also, foundations, professional associations, and other non-profits may provide charitable financing. Industry may provide discounts for dental materials and supplies to safety-net programs including SSPs. While not common, SSPs may also collect fees from commercial insurers when children served have private dental coverage.

Among federal programs, CDC's ***State-Based Oral Disease Prevention Program*** provides the most focused funding for SSPs. Twenty-one states receive this support** to "strengthen their oral health programs and improve the oral health of their residents."¹¹ Among targeted expenditures are:

- support for a state-wide sealant coordinator,

** CO, CT, GA, HI, ID, IA, KS, LA, MD, MI, MN, MS, NH, NY, ND, RI, SC, VT, VA, WV, WI. In 2010, Congress authorized the expansion of CDC program funding to all states through The Patient Protection and Affordable Care Act. Authorized expansions will require future Congressional appropriations.

- translating and disseminating the science supporting school-based sealant programs as an effective preventive intervention,
- monitoring data for program efficiency and reach,
- carrying out Basic Screening Surveys for 3rd graders, and
- funding for portable sealant equipment.

Twenty-one states receive CDC support for school-based sealant programs. This funding covers various needs, including state-wide sealant coordinators and data collection.

The *Title V Maternal and Child Health Services Block Grant Program* is a federal partnership with states that supports a wide range of public health, infrastructure, and clinical services targeting women and children with a focus on special needs populations.¹² Funds can complement Medicaid and CHIP fee-for-service payments by “providing gap-filling services to enrollees; assisting in the identification of potentially eligible beneficiaries; and creating an infrastructure in communities to ensure that the capacity exists to support the delivery of quality health care services for women and children.”¹³ The Maternal and Child Health Bureau (MCHB) also notes that “successful coordination of Title V with Medicaid/CHIP programs assists in maximizing Federal, State and local funds to meet the health care needs of low-income women and children.”¹⁴ Many states utilize Title V funding to support SOHP functions including the design, implementation, and monitoring of their SSPs. Examples include Illinois’ use of Title V funds to provide sealants to high-caries-risk children not eligible for Medicaid/CHIP and New York’s significant expansion of its SSP with Title V support in 1995.

Title V, with a breadth of maternal and child health interests and collaborations, also provides a platform for SOHPs to promote oral health with partner groups and to highlight the importance of oral health and dental care with maternal and child communities of interest. For example, WI’s 2010 MCHB *Needs Assessment to Identify Priorities for 2011-2015* identified the SOHP as a “Primary Partner” in reaching the

MCHB National Performance Measure (#9) on the “percent of third-grade children who have received protective sealants on at least one permanent molar tooth.” Across states, SSPs contribute variably to the fulfillment of this measure’s state-specific annual goal.¹⁵ For the latest year available^{††}, the range of performance for this measure was 13.8% in Florida to 73.6% in Delaware, with an average across all states of 42.3%.

MCHB intermittently reformulates its set of required Title V Performance Measures and is expected to issue the next set in 2015. While the sealant measure has served SSPs well in highlighting the importance of dental sealants to children’s oral health and in tracking progress in reaching Healthy People oral health objectives, it—like all such measures—is subject to revision or elimination.

State Oral Health Workforce Grants administered by HRSA competitively fund 10 states to implement one or more of 13 designated activities that help states expand their oral health workforce in dental health professional shortage areas. Among allowable activities are “community-based prevention services such as ... dental sealant programs” and other activities that can support SSPs, including teledentistry, mobile dental programs in underserved areas, support of dental trainees, and “the development of a State dental officer position or the augmentation of a State dental office to coordinate oral health and access issues in the State.”¹⁶

In earlier funding cycles, 29 states have utilized grant funds to support community-based preventive services^{‡‡} including Ohio which used funding to expand its sealant network.

Medicaid and CHIP reimbursements are a critical revenue source for SSPs: 21 of 23 local programs responding to our survey report billing Medicaid. Although Medicaid is a sustainable funding source for children’s dental care that may be utilized by SSPs, states vary considerably in payment rates and in administrative rules, policies, and practices that impact SSPs’ access to this source of funding.

^{††} 2012 reports from all states except FL which reported 2011 data

^{‡‡} Analysis by Tener Huang and Burton Edelstein reported in a 2014 NOHC abstract

- *Billing:* As with all providers, SSPs that bill Medicaid are impacted by claims processing rules, numbers and timing of simultaneous claims by provider or location, claims review procedures, claims formats and submission processes, and timeliness of payment.
- *Allowable providers and service locations:* While most states allow hygienists to provide sealants in SSPs, programs are impacted by Medicaid interpretation of state licensure policies on levels of supervision of hygienists and scope of practice, provision of unique billing codes for hygienists, and disallowance of sealant billing in the absence of additional dental services, such as dental examinations and radiographs.
- *Services:* State Medicaid policies often proscribe the age of children eligible for sealant benefits or regulate the particular teeth that can be sealed as well as the frequency with which payment will be made for re-sealing teeth.
- *Program types:* State policies vary on the types of programs that can bill Medicaid, for example prohibiting claims from mobile dental program operators or school districts. As state Medicaid programs shift into managed care contracting for dental services, SSPs may be further impacted as non-network providers.
- *“Free Care Rule”:* Federal health insurance programs, including Medicaid and CHIP, prohibit healthcare providers from charging more for services delivered to public beneficiaries than are charged other payers, including commercial insurers and the uninsured. Since SSPs are typically designed to deliver sealant services to students without charge (i.e., “free care”), an SSP’s ability to bill for sealants delivered to Medicaid-eligible children is impacted



by their state’s interpretation of this policy. Significantly, on October 8, 2013 the U.S. Department of Health and Human Services Office of Inspector General (OIG) addressed its Medicaid enforcement policy by stating that free care provided to needy children who are uninsured or underinsured does not affect determination of customary charges

and allowable billable amounts for services provided to Medicaid beneficiaries.¹⁷ While written in response to a specific appeal, this OIG Opinion may help states implement the Medicaid free care policy more generally by clarifying that federal Medicaid enforcement policy is liberal with regards to free care for

financially vulnerable children—allowing both Medicaid billing and free care for targeted uninsured or underinsured children. The opinion, however, is limited with regard to requirements to bill non-governmental insurers. Clearly needed is a universal ruling by Medicaid that addresses the appropriateness of billing Medicaid, but not others, through SSPs.

- In addition to service-specific fees payable by Medicaid, the federal government supports states to administer Medicaid through an “Administrative Match” for which the federal government pays states one dollar for every state dollar committed to program management. Illinois has utilized this Administrative Match for its sealant program by having the SOHP provide quality assurance services to Medicaid. The SOHP reviews operations of all SSPs that bill Medicaid, conducts annual structured site visits of these programs, provides administrative services related to providing sealants to Medicaid beneficiaries, and provides information to Medicaid on evidence-based oral health services.

Medicaid and CHIP reimbursements are a critical revenue source for SSPs. Yet states vary widely in payment rates and in the rules, policies, and practices that impact SSPs’ access to this funding.



FEATURES OF 5 STATES WITH SUSTAINABLE AND SUBSTANTIAL SSPs

The lesson learned from comparing and contrasting five states that meet criteria for both sustainability and substantial reach is that there is no “one-size-fits-all” approach to SSP success. Across these states, variations exist in SOHP roles, funding sources, Medicaid policy on billing by non-dentist providers, and attendant state policies such as Medicaid managed care contracting, requirements for school-entry dental examinations, and presence of school-based health centers.

Illinois (SSP since 1986): Payments to SSPs are received for three-quarters of treated children either from Medicaid/CHIP or from state funds allocated to children who are eligible for subsidized school lunch programs but not enrolled in Medicaid /CHIP. The state allows grantees flexibility in program design and delivery to address local conditions and requires grantees to provide dental examinations consistent with a state mandatory school dental examination law passed in 2006. The SOHP conducts annual site visits of both grantee and non-grantee SSPs. Sealant programs predominate in Chicago where two-thirds of the state’s SSPs provide more sealants to children than any other locality or state in the nation. An

interagency agreement between the Chicago Department of Public Health and the Chicago Public Schools governs the program which is delivered by for-profit vendors that pay an administrative fee to participate.

New York (SSP since 1972): The state’s SOHP has legal authority to set standards for, approve, and monitor all oral health services provided in public schools. The state requires all oral health programs in schools to be affiliated with school-based health centers that provide primary dental care services. It provides funding through its Title V Block Grant. As the state with the longest-running SSP, New York has extensive experience in adapting to changing delivery and financing conditions. Respondents report that New York is currently challenged by three trends that exist to varying degrees in other states: (1) Medicaid’s increasing dependence on managed care that has required the state to seek “carve outs” allowing continued payments to SSPs for children receiving sealants in schools; (2) the integration of school sealant programs into dental prevention and treatment programs that began in 2006-7; and (3) changing concepts of the roles of localities in public health reflected in decreased provision of direct care complemented with increased provision of oral health promotion and public education.

Ohio (SSP since 1984): Ohio utilized Title V funding to operate 18 of 22 local health department SSPs which exclusively provide sealant services. SSPs bill Medicaid for sealant placements but not for dental examination, thus

To enhance efficiency, Ohio contracts with a small number of SSPs that each serves multiple schools.

allowing the examination to be performed and billed by providers who may see the child later to provide other dental services. To enhance efficiency, Ohio contracts with a small number of SSPs that each serves multiple schools. It has used a 2010 HRSA State Oral Health Workforce grant to develop a strategic plan supporting SSP expansions and refinements and has developed a widely-used state *Sealant Program Manual* (available at

<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/ohs/oral%20health/Dental%20Sealant%20Manual%202012.ashx>) and *Distance Learning Curriculum*

(available at <http://www.ohiodentalclinics.com/distancelearning.html>). The SOHP collects and utilizes data to manage and report on the program.

South Carolina (SSP since 2003): The state’s SOHP provides no funding for SSPs which rely instead on Medicaid billing for 96% of children served. The state has regulatory authority to approve dental hygienists as providers in schools under an arrangement called “public health supervision” governed by a memorandum of agreement (MOA). The SOHP maintains an “internal sealant management team” that provides support for and evaluation of SSPs. Six SSPs operate in the state, four under SOHP-hygienist MOAs, with one providing sealants to over 80% of South Carolina children served. The SOHP credits support and collaboration of the South Carolina Oral Health Coalition with its success in building school sealant program capacity.



Wisconsin (SSP since 1996): Since 2001, the state’s SOHP has partnered with the non-profit Children’s Health Alliance of Wisconsin to obtain and leverage multiple public and private funding sources and steadily expand SSPs’ reach to vulnerable children. Respondents report that state level administration provides centralized structure with room for local implementation, providing some flexibility to tailor the program to community circumstances. Partners report commitment to rigorous data collection and use of the data for program management and reporting. State policies allow hygienists to practice in public health settings, including schools, under a dentist’s general supervision and to place sealants without a requirement that a dentist first examine the child. Medicaid can be billed directly for both sealants and an oral health assessment provided in schools.



KEYS TO SUCCESS FOR SUSTAINABLE & SUBSTANTIAL SSPs

- 1. Financing:** While financing is central to all programs' success, the surveys and case studies reveal that a variety of financing approaches can support effective SSPs. Examples range from public-private financing partnerships, to market-driven models, to exclusively Medicaid-financed.

Seen as critically important is the capacity of SSPs to bill Medicaid/CHIP when providing services to enrolled children. SOHPs must work collaboratively with state Medicaid programs to facilitate SSP operations by reducing cited administrative barriers and by addressing impediments created by some states' interpretations of the federal "free care" rule. Featured states were also notably effective in securing state support for their sealant programs through allocation of federal Title V block grant funds and in securing competitive funding through CDC-sponsored cooperative agreements to support State Oral Health Programs and in HRSA-sponsored Oral Health Workforce Grants.

- 2. Partnerships and collaborations:** In addition to having partnerships with state Medicaid authorities, successful SOHPs were leaders and facilitators that

arranged partnership agreements and formalized contracts for quality control and administrative support of local SSPs. States also leveraged data as in Wisconsin, which created persuasive arguments for state and private financing. Featured SOHPs are substantially involved in supporting administrative structures and accountability.

- 3. Efficiencies:** Supporting the cost efficiency and reach of SSPs, three of the five states profiled have practice acts that permit dental hygienists to practice in public health settings under general supervision. Efficient programs also maintained effective administrative structures and tracked accountability. One state (WI) refined its data collection and data analyses to demonstrate efficiencies and program cost-effectiveness, thereby attracting significant funding from the private sector.^{§§}
- 4. Adaptability:** Featured programs recognize and respond creatively to the ever-changing political, policy, and administrative contexts within which they deliver sealant services. Among these are changing state practice acts that govern the availability and conditions under which allied dental professionals can participate in SSPs and the evolution of Medicaid managed care through which contracted vendors become significant players in determining the composition of provider networks. The Affordable Care Act will likely impact SSPs by authorizing expansions of school-based health centers, by pegging dental benefits for children to “benchmark dental plans” that almost universally include coverage for dental sealants to age 16, and by determining that the only preventive services that must be provided at no cost to the beneficiary are those receiving an A or B recommendation from the United States Preventive Services

Successful states like Wisconsin used data to create persuasive arguments for state and private financing of SSPs.

^{§§} Wisconsin’s model for collecting and reporting data is being adapted by three states in 2014 through the CDC’s Cooperative Agreement with the Children’s Dental Health Project.

Task Force (USPSTF). The USPSTF does not make recommendations for services delivered by dental personnel.**

Clearly evident from these four keys to success is that SOHP leadership is essential in leveraging opportunities and creatively responding to local circumstances in designing, implementing, monitoring, and sustaining SSPs.

Effective leadership involves:

- working closely with others to mutually build capacity based on shared goals;
- measurement based on relevant metrics;
- mutually reinforcing and complementary activities; and
- ongoing communication that builds stakeholder investment.

Substantial reach and sustainability of state SSPs also requires that SOHPs leverage multiple funding approaches to maximize financial support for their programs from both governmental and non-governmental sources.



TRANSLATING LESSONS LEARNED TO PRACTICE

Translating lessons gleaned from this report and from additional sources into greater availability of sealants to high-risk US children in schools will require active collaboration and commitment to SSPs among multiple players including sealant experts, public health leaders, the dental professional community, school officials, Medicaid officials, and state and federal policymakers.

First, the nearly 20-year-old guidelines for sealant use in community programs need to be updated. From there, strong and persistent promotion of revised guidelines by federal, state and local authorities with influence over sealant programs will be essential.

Suggested steps include:

1. Convene an expert **SSP Sustainability Work Group** to collaboratively review available information and recommend or develop new strategies for inclusion in ASTDD **Best Practice Approaches** and new resources, as appropriate, in existing authoritative **Program Guidance** (e.g., through the American Association of Community Dental Programs' [AACDP] *Seal America* manual). This Work Group may begin by considering the following needs that have emerged from SSPs:
 - business planning template (addressing funding sources, staffing, etc.);
 - protocol for analyzing and improving sealant-related program policies;
 - resources to assist in assessing and addressing barriers to participation (e.g., parental consent, cooperation of older children and middle school personnel);
 - systems for easily acquiring patient identification numbers needed for Medicaid reimbursement;
 - protocols for collecting, presenting and using data to gain new resources and maintain current funding; and

The nearly 20-year-old guidelines for sealant use in community programs need to be updated. Then these revised guidelines must be promoted by federal, state and local officials who oversee sealant programs.

- sample partnership agreements.
2. Convene an expert **SSP Design and Operations Work Group**, primarily to update program planning guidelines from the 1994 Workshop on Guidelines for Sealant Use that were not addressed in the CDC’s 2009 “Updated Recommendations and Reviews of Evidence” and have not been revisited since. Using the *Worksheet for Determining the Need for Community Sealant Programs and Designing a Direct Service Community Sealant Program* (<http://www.dentalcare.com/media/en-US/education/ce128/WorkshopGuidelinesSealantUse.pdf>), sections 1 through 6, this work group could begin by considering the following items that have emerged from this study and from discussions with those who operate SSPs:
- strategies for identifying and reaching appropriate high-risk or vulnerable populations;
 - strategies for providing appropriate services under the conditions of school-based/linked programs (e.g., relying on evidence to determine which—if any—services add value for particular children receiving sealants, and tooth selection guidance that targets hard-to-reach populations such as middle-school children with 2nd molar development);
 - strategies for connecting children with sources of dental care while maintaining adequate personnel time to maximize the primary program objective of sealant placement;
 - protocols for short- and long-term sealant retention rate checks and other clinical quality assessments; and
 - protocols to monitor program operations for quality improvement purposes (e.g., data on rate of consent return, number of children receiving various levels of service).
3. Convene an expert **SSP Facilitators and Barriers Work Group** to review and analyze federal and state policies that may facilitate or act as barriers to SSPs, with input from oral health, public health, and public finance policy experts. This

third Work Group should make specific recommendations, including model policies, to promote expansion of cost-effective and efficient SSPs.

Once these Work Groups have completed their reports, the combined influence of public health agencies at all levels and of their organizational partners will be critical both for disseminating new guidance and ensuring success in incorporating the updated recommendations into practice. Determinative organizational actors include:

- Federal agencies—with capacity to draw on inter-agency collaboration and partner organization support—to influence implementation;
- State Oral Health Programs to influence and/or implement; and
- Local and state-operated SSPs to influence and implement.

Federal and state oral health officials have significant options and resources to exercise such leadership. The Association of State and Territorial Dental Directors' Best Practice Approach report on dental sealants is a rich resource that is regularly updated. Findings of this report point states to a variety of financing and delivery options, partnerships and collaborations, and efficiencies for sustainable and substantial programs. Further, the survey instruments developed for this report (see Appendices A, B, C) can be readily adapted by states to closely examine their sealant activities.



Technical assistance is available through CDC and HRSA resources and their grantees. Consultation with SOHP Directors who have successfully prioritized SSPs

in their states can further assist all who are committed to improving children's oral health and equity through SSPs.

CONCLUSION

The cost of preventing tooth decay by placing dental sealants through SSPs is much less than the cost of treating tooth decay that was not prevented. By expanding the reach and effectiveness of SSPs, state agencies and their partners can prevent the most common cavities in the permanent teeth of school-age children. Prevention is a powerful tool for potential cost savings and for measurable improvements in the health and wellbeing of children who are at greatest risk for the significant consequences of unaddressed tooth decay. The lessons highlighted in this report are offered to help provide focus and to assist in meeting those goals.

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- ¹² <http://www.hrsa.gov/about/pdf/mchb.PDF>
- ¹³ <http://www.mchb.hrsa.gov/programs/collaboration/>
- ¹⁴ <http://www.mchb.hrsa.gov/programs/collaboration/>
- ¹⁵ <https://mchdata.hrsa.gov/tvisreports/MeasurementData/NationalMeasures/NationalMeasuresMenu.aspx>
- ¹⁶ <http://www.hrsa.gov/about/news/pressreleases/131030oralhealth.html>
- ¹⁷ Office of the Inspector General Advisory Opinion OIG #13-13 available at <http://oig.hhs.gov/fraud/docs/advisoryopinions/2013/AdvOpn13-13.pdf>