



Dental Public Health Activities & Practices

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SECTION I: PRACTICE OVERVIEW

Name of the Practice:

New Jersey "Save Our Smiles" Fluoride Mouthrinse Program

Public Health Functions:

Assessment – Acquiring Data
 Assessment – Use of Data
 Policy Development – Collaboration & Partnership for Planning and Integration
 Policy Development – Oral Health Program Policies
 Policy Development – Oral Health Program Organizational Structure and Resources
 Assurance – Population-based Interventions
 Assurance – Oral Health Communications
 Assurance – Building Linkages & Partnerships for Interventions
 Assurance – Building Community Capacity for Interventions
 Assurance – Access to Care and Health System Interventions
 Assurance – Program Evaluation for Outcomes and Quality Management

HP 2010 Objectives:

21-1 Reduce dental caries experience in children.
 21-12 Increase preventive dental services for low-income children and adolescents.

State:

New Jersey

Region:

Northeast
Region II

Key Words:

Fluoride mouthrinse program, school based programs, prevention, children services

Abstract:

The majority of New Jersey residents do not have the benefit of optimally fluoridated drinking water. The "Save Our Smiles" weekly fluoride mouthrinse program is funded by the New Jersey Department of Health and Senior Services (DHSS). Schools targeted for participation include "high-need" districts as determined by "Criteria for Eligibility in the Fluoride Mouthrinse Program," developed by a county health department. The program started in 1981 serving 20,000 children. In 2002, approximately 75,000 students in 350 schools were participating statewide.

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SECTION II: PRACTICE DESCRIPTION

History of the Practice:

The school-based fluoride mouthrinse (FMR) program "Save Our Smiles" was introduced in 1981 and initially served 20,000 children. When the Regional Preventive Oral Health Programs were established in 1985, the focus was to administer the fluoride mouthrinse program and increase the number of schools participating on a yearly basis. All schools were eligible for the program, regardless of socio-economic status. The only criterion for participation was a willingness on the part of the school nurse or administrator to implement the program. By 2002, approximately 75,000 students in 350 schools were participating statewide. The program had adopted new criteria for eligibility in 1997 to target high-risk children.

Justification of the Practice:

Approximately 17% of New Jersey residents have access to optimally fluoridated public water supplies. Minority and low-income children may suffer disproportionately from oral diseases. The Surgeon General's Report on Oral Health released in 2000 addresses the need and importance of fluoride in preventing tooth decay. Given the recommendations in this report, New Jersey's fluoride mouthrinse program continues to target high-risk children and expand into high-need areas throughout the state.

Administration, Operations, Services, Personnel, Expertise and Resources of the Practice:

The New Jersey "Save Our Smiles" Fluoride Mouthrinse Program targets "Abbott" or high-risk school districts with grades K-8 for participation. Regional Oral Health Program Coordinators initially contact a school's administrators to discuss the program and its benefits. If schools choose to participate, a contact person from the school, who will administer the program, is identified. The Regional Oral Health Coordinator then trains the individual to administer the FMR program. Training is accomplished on an individual or group basis. The fluoride mouthrinse program is administered through either the mix-and-pump or unit-dose method. A comprehensive coordinator's manual is provided to the school.

The Regional Oral Health Coordinators conduct an annual review of the program through a site visit or phone call. This is documented on the "Fluoride Mouthrinse Annual Monitoring Form." The Regional Oral Health Coordinators determine the quantity of supplies for shipment to each school. The supplier of fluoride, Medical Products, takes the order and ships supplies to each participating school by the third week of September each school year. Statewide annual statistics indicate a participation rate of 80%.

In December 1997, the New Jersey DHSS approved the "Criteria for Eligibility in the FMR Program" that was developed by the Bergen County Department of Health Geographic Information Systems Office. Factors taken into account include the median family income and poverty status. These criteria assured that the most "at-risk" school districts were initially targeted for the FMR program. In 1998, three tiers of FMR eligibility were established and the program emphasis was directed toward the 'Abbott' or high need districts, which would be Tier 1 or 2. Emphasis on high-need areas continues. The Regional Oral Health Program Coordinators continue to promote the FMR program. During the school year 2000-2001, over 70,000 children in 350 schools in New Jersey participated.

The source of funds for the New Jersey "Save Our Smiles" Fluoride Mouthrinse Program is the Maternal Child Health Block Grant. Funding has remained constant. Schools are encouraged to provide in-kind resources, if possible.

Budget Estimates and Formulas of the Practice:

- Funds for the administration of the FMR Program are allocated by the DHSS at approximately \$45,000/year.
- The Regional Oral Health Coordinators allocate ¼ of their time to administer the program.

Lessons Learned and/or Plans for Improvement:

1. Unit dose, which increases compliance with the FMR Program, is more popular with teachers and school nurses due to decreased preparation time. However, the unit-dose system is currently used only in a limited number of school districts. These districts are responsible for the cost difference over the mix-and-pump method.

2. Barriers perceived by the administration, school nurse and teachers must be overcome for successful implementation of the FMR Program.
3. If funding would be eliminated, schools state they would probably eliminate the program.

Available Resources - Models, Tools and Guidelines Relevant to the Practice:

1. "Save Our Smiles" Fluoride Mouthrinse Coordinator's Manual
2. "Save Our Smiles" Fluoride Mouthrinse Application
3. Standard Operating Procedures for the FMR
4. Unit Dose Funding Worksheet
5. Fluoride Mouthrinse Monitoring Form

SECTION III: PRACTICE EVALUATION INFORMATION

Impact/Effectiveness

Does the practice demonstrate impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence and outcomes of the practice)?

Studies by the National Institute of Health and the National Institute of Dental Research in the 1970's indicate that fluoride mouthrinse programs can reduce tooth decay by 35%. In one review, the average caries reduction in non-fluoridated communities was 31%.¹ The Centers for Disease Control (CDC) states that the quality of evidence for fluoride rinses is Grade 1. It is considered a reasonable procedure for persons at high risk for caries, but the cost effectiveness as a universal population-wide strategy in the modern era of ubiquitous fluoride exposure is questionable.

Reference: ¹Centers for Disease Control and Prevention. Recommendation for using fluoride to prevent and control dental caries in the United States. MMWR2001;50(No. RR-14):[p15].

Efficiency

Does the practice demonstrate cost and resource efficiency where expenses are appropriate to benefits? Are staffing and time requirements realistic and reasonable?

New Jersey's three-tier eligibility system was developed utilizing GIS (Geographic Information System) to ensure efficiency. Factors taken into account include the median family income and poverty status. The FMR is provided to school districts in communities that fall into the highest three tiers of need as determined by the GIS selection criteria as priority.

Demonstrated Sustainability

Does the practice show sustainable benefits and/or is the practice sustainable within populations/communities and between states/territories?

The FMR program, initiated in 1981, still remains viable today. School districts are encouraged to allocate funds for the program's administration. In addition, PTO's are encouraged to develop creative strategies to provide funds to the existing program and make it self-sustaining. Program efforts are directed to the "Abbott" or high-risk school districts.

Collaboration/Integration

Does the practice build effective partnerships/coalitions among various organizations and integrate oral health with other health projects and issues?

Schools that select the unit-dose method are responsible for partial funding of the program. Private industry, such as pharmaceutical companies, insurance plans and local businesses have donated funds for the FMR's administration in their community. Additionally, a link between the Preventive Oral Health Program staff and schools is established, which is mutually beneficial.

Objectives/Rationale

Does the practice address HP 2010 objectives, the Surgeon General's Report on Oral Health, and/or build basic infrastructure and capacity for state/territorial oral health programs?

The FMR program addresses the Healthy People 2010 Objective 21.1 of reducing dental caries experience in children. The program also addresses the Surgeon General's Report on Oral Health by targeting minority and low-income individuals, who are at higher risk for dental/oral disease.

Extent of Use Among States

Is the practice or aspects of the practice used in other states?

Forty-nine states currently have established fluoride mouthrinse programs.