



# Dental Public Health Activity Descriptive Report

**Practice Number:** 19014  
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<b>SECTION I: PRACTICE OVERVIEW</b>		
<b>Name of the Dental Public Health Activity:</b> Kansas School Oral Health Programs		
<b>Public Health Functions:</b> Assessment: - Acquiring Data Assessment - Use of Data Policy Development – Collaboration and Partnership for Planning and Integration Policy Development – Oral Health Program Policies Policy Development – Use of State Oral Health Plan Policy Development – Oral Health Program Organizational Structure and Resources Assurance – Population-based Interventions Assurance – Oral Health Communications Assurance – Building Linkages and Partnerships for Interventions Assurance – Building State and Community Capacity for Interventions Assurance – Access to Care and Health System Interventions Assurance – Program Evaluation for Outcomes and Quality Management		
<b>Healthy People 2020 Objectives:</b> OH-1 Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth OH-2 Reduce the proportion of children and adolescents with untreated dental decay OH-7 Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year OH-8 Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year OH-11 Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers each year OH-12 Increase the proportion of children and adolescents who have received dental sealants on their molar teeth		
<b>State:</b> Kansas	<b>Federal Region:</b> Midwest Region VII	<b>Key Words for Searches:</b> School-based program, dental sealants, children’s oral health, prevention, access to oral health care, screening, acquiring oral health data
<b>Abstract:</b> Kansas has two school oral health programs, the Kansas School Screening Program and the Kansas School Sealant Program, that are administered by the Bureau of Oral Health (BOH). The state has a law that requires each child to have an annual “dental inspection.” This is an unfunded mandate, and until recently was largely overlooked by schools and administrators. In 2007 the Bureau of Oral Health received a state foundation grant to create a standardized screening protocol and an online data collection system. The protocol mimics the Basic Screening Survey and uses volunteer dental professional screeners to collect and input the screening data. The Screening Program provides the Bureau with school, county and statewide data on children K-12. In the 2011-2012 school year the Screening Program was in 46% of all Kansas public schools. A searchable database of the oral health data is publically available at the Bureau’s website.  In 2010 the Bureau of Oral Health received a grant from the Health Resources and Services Administration (HRSA) to provide preventive oral health services in schools. The Kansas School Sealant Program (KSSP) contracts with local safety net clinics, private dentists, and community based dental hygienists to provide sealants and other preventive oral health services (cleanings and		

fluoride varnish) to underserved children in a school based setting. KSSP targets schools with high numbers of children on Medicaid, and the Free and Reduced Lunch Program, as well as those schools whose school screening data indicates unmet dental needs. All providers participating in the KSSP do oral health screenings for all students in the participating schools. The screening data serves as a baseline to establish the oral health status of the students prior to the start of the School Sealant Program.

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**SECTION II: PRACTICE DESCRIPTION**

**History of the Practice:**

Kansas has a law that requires each child to have an annual “dental inspection.” This is an unfunded mandate, and until recently was largely ignored by schools and administrators. In 2007 the Bureau of Oral Health (BOH) received a state foundation grant to assist schools with complying with this law. The grant allowed BOH to develop a standardized screening protocol and online data collection system for the Kansas School Screening Program (a detailed description of this program is included under “Inputs, Activities, Outputs and Outcomes of the Activity”). This program allows the Bureau of Oral Health to quantify the burden of oral disease on K-12 children in the state and inform parents about the oral health of their child. The program has expanded every year since its inception, with 55,532 children screened during the 2008-2009 school year to 153,977 children screened during the 2012-2013 school year.

The Kansas School Screening Program facilitates the Kansas School Sealant Program (a detailed description of this program is included under “Inputs, Activities, Outputs and Outcomes of the Activity”). The Kansas School Sealant Program began in 2010, when BOH received a federal grant from the Health Resources and Services Administration (HRSA). This grant allowed BOH to contract with local dental providers to provide preventive oral health services to primarily high-risk children. The local dental providers use tools from the Kansas School Screening Program to conduct oral health screenings in schools before they provide services in those schools, which establishes a baseline measurement of the oral health of children in that school prior to providing services. This makes it possible for BOH and providers to measure the impact of the Kansas School Sealant Program on the oral health of K-12 children in the state.

Additionally, the Kansas School Sealant Program would not be able to be implemented to the extent that it is in Kansas without laws that created and expanded upon an Extended Care Permit (ECP), which allows dental hygienists who meet certain qualifications to provide oral health services to vulnerable populations in community-based settings. The first ECP law was passed in 2003, and two laws passed since then created ECP II and ECP III licenses which allow for a slightly greater scope of practice than the original ECP license. Since dental hygienists provide most of the in-school oral health services funded by the Kansas School Sealant Program, this legislation was crucial for the viability of the program.

**Justification of the Practice:**

Kansas periodically performs a Basic Screening Survey to evaluate the oral health of Kansas children. The most recent BSS, titled *Smiles Across Kansas 2012*, found that 48% of third graders had experienced dental decay, and 1 in 10 third graders at the time of the survey had untreated dental decay. The 5.7% of Kansas third graders have a sealant on at least one of their molars, but although Kansas exceeds Healthy People 2020 sealant targets, in a recently released Pew report card, Kansas only received a “C” in their use of sealants to prevent decay in children. Sealants are particularly absent in the rural southwestern part of Kansas and among African American children.

There is significant evidence for the efficacy/impact of these programs. The screening program uses a standardized protocol based on the Basic Screening Survey, and it has been observed by BOH and

sealant sites that schools that participate in the Kansas School Screening Program are more willing to participate in the Kansas School Sealant Program. School- based sealant programs have been shown to reduce dental decay for children, particularly for low-income and/or uninsured children. That is because these programs target children from low income families, as these children are likely to have financial barriers to dental care and/or be enrolled in the Medicaid program. School -based sealant programs are evidence- based strategies proven to reduce caries in high risk children, and they are recommended by the Centers for Disease Control and Prevention as a public health best practice.

### **Inputs, Activities, Outputs and Outcomes of the Practice:**

#### The Kansas School Screening Program

##### A. Detailed Description

The Kansas School Screening Program quantifies the burden of oral disease for K-12 children in the state and informs parents about the oral health status of their children. The program relies on screeners who travel to schools and examine children for a few key indicators of oral health status. These indicators include untreated decay, treated decay, and the presence of sealants. Screeners also record a treatment recommendation for each child, ranging from “No decay/problems” to “Urgent care needed.”

Screeners are required to be either dentists or dental hygienists. Some of these professionals work in private practice and volunteer their time to become screeners and perform screenings, while others work for safety-net clinics or other entities that contract with BOH for the Kansas School Sealant Program. Before these professionals can perform any screening they must take a calibration course, either online or in person, on the survey protocol. The calibration course does not teach individuals what decay is; rather, it teaches them how to classify the severity of the decay. The training course walks the screeners through the entire screening process and the paperwork associated with the screening.

After a dentist or dental hygienist completes the calibration course, BOH staff work with them and school nurses to help plan and implement the screenings. Calibrated screeners and/or schools who screen their children with calibrated screeners are eligible to receive gloves, tongue blades, and toothbrushes from BOH. The screeners collect the data and give it to the school nurse, who sends home results letters to parents. The screening data is aggregated and entered into the BOH online database by screeners, nurses, and/or BOH staff. Only registered users can enter data in the database, but a link to the part of the database that publishes reports is available to the public. These reports can be broken down to school-level, district-level, county-level, and state level data, and they can be isolated by data from a specific school year, starting with the 2008-2009 school year.

One other crucial element of this program is that the Kansas School Screening Program mostly utilizes passive consent. Parents are informed about an upcoming screening and told that their children are automatically opted-in to the screening, but they can fill out a form to opt their children out of the screening. A few schools choose to tell parents they must explicitly indicate their consent for their children to participate in the screening, but this is not the norm for the program.

##### B. Inputs

As mentioned above, the funding for the development of this program came from a state foundation grant offered to BOH in 2007. This funding allowed BOH to develop the screening protocol, calibration course, and database for school screening data. Funding from the 2010 HRSA grant provided support for the salaries of two .5 FTE dental hygienists at BOH to coordinate the screening program and perform associated activities. Additionally, funding from the Delta Dental Foundation of Kansas and the Centers for Disease Control and Prevention (CDC) allows BOH to buy screening supplies (gloves, tongue blades, and tooth brushes) to distribute to screeners and schools.

Screeners are either volunteers or required to perform school screenings as part of their Kansas School Sealant Program contract. They are either dentists or dental hygienists. School nurses, administrators, and other administrative personnel at schools also play a crucial role in the program as they are aware of the schedules of their children and must

inform teachers and students about an upcoming screening. Their cooperation is crucial for screenings to be performed efficiently and effectively.

In addition to the two .5 FTE dental hygienists who coordinate the school screening program, other staff at BOH assist in answering supply and screening requests from school nurses and other individuals.

#### C. Activities

BOH recruits screeners for the Kansas School Screening Program by advertising the program at a variety of events and venues for dental professionals. The bureau created postcards that allow screeners to write down their contact information; BOH screening coordinators collect those postcards and contact individuals with more information about the program. BOH screening coordinators inform potential volunteers about the required calibration course, and they periodically travel to sites to teach the calibration course in person. Most often these trainings are conducted at local dental and dental hygiene schools.

BOH coordinators keep a list of calibrated screeners and what area they are from in order to assist school nurses and other school officials when they request a school screening. The bureau identifies volunteer screeners near the school and assists schools with connecting with those screeners and scheduling a screening on a date that works for the school and the screeners. BOH staff sometimes performs screenings if no volunteer screeners are in the area and/or if they cannot recruit screeners for that school for some reason.

Once a screening is completed, BOH staff assists nurses and screeners with entering data, any issues they may have with the forms associated with the school screening program, and a number of other miscellaneous issues. The bureau identifies and responds to any technical issues with the database and collaborates with the IT department at the Kansas Department of Health and Environment to resolve those issues.

#### D. Outputs

The Kansas School Screening Program has expanded every year since its inception, with 55,532 children screened during the 2008-2009 school year to 153,977 children screened during the 2012-2013 school year. During the 2011-2012 school year the program was in 46% of all public schools in Kansas. As a result of the program, the screening database maintained by BOH is accessible by the public, who can pull reports about the oral health of schools, counties, and the state.

#### E. Outcomes

There has been a marked decrease in oral health problems among K-12 school children in the state over the past decade. In 2004, 55% of 3<sup>rd</sup> graders had experienced dental decay and 25.1% of 3<sup>rd</sup> graders had untreated decay, but in 2012 48% of 3<sup>rd</sup> graders had experienced dental decay and 9.4% of 3<sup>rd</sup> graders had untreated decay. While these changes are not wholly attributable to one program, the referrals that screeners make for children with obvious dental problems may have contributed to that decrease. Additionally, the Kansas School Screening Program has created a much larger body of data for the Bureau of Oral Health and other entities to monitor the oral health of children in Kansas.

### The Kansas School Sealant Program

#### A. Detailed Description

The Kansas School Sealant Program (KSSP) contracts with local safety net clinics, private dentists, and community based dental hygienists to provide sealants and other preventive oral health services (cleanings and fluoride varnish) to underserved children in high risk schools. KSSP targets schools with high numbers of children on Medicaid, and the Free and Reduced Lunch Program (FRL), as well as those schools whose school screening data indicates unmet dental needs. For the most part, in urban areas schools with more than 50% of students on FRL are considered high risk, while most schools in rural areas are considered high risk because of the lack of dental providers in those areas, and most of those schools tend to have a high proportion of Medicaid-insured children and/or children on FRL.

All providers participating in the KSSP do oral health screenings for students in the participating schools. The screening data serves as a baseline to establish the oral health status of the students prior to the start of the School Sealant Program. Contracted providers then work with schools to schedule times for the providers to come to the school and provide oral health services (sealants, cleanings, fluoride varnish) to mostly high risk children whose parents have given consent for them to be seen. As the providers see children, they fill out a standardized form that indicates what services that child has received. These forms are sent to BOH, and data from the forms is entered into the Sealant Efficiency Assessment for Locals and States (SEALS). Providers also go back to schools after a while to perform sealant retention checks on children.

KSSP is staffed by the Children's Oral Health Program Manager (1 FTE – RDH), who is assisted by 2 (.5 FTE – RDH) Public Health Educators. In year one of the program, the Program Manager staff approached dental safety net clinics located in areas of highest needs and asked them to partner in KSSP. In areas without dental clinics, private practitioners were recruited. KSSP also works with two dental hygiene schools to implement the program. In the first year, 8 contracted providers were in 118 K-12 schools. The Program Manager created standardized forms and educational materials and provided technical assistance to the local programs. All providers were required to enter screening data into the School Screening Program data base as well as provide data about any services (sealants, fluoride varnish) they were providing. In year two of the program (2011-12 school year) KSSP expanded to include 16 contracted providers. Each provider was funded based on a targeted number of children sealed. After year two, a mid-program evaluation was conducted of each provider. Struggling programs were offered technical assistance. Before the start of year three, targets and funding levels were revised to reflect the performance of each individual provider. KSSP now includes 16 contracted providers.

#### B. Inputs

Funding for the Kansas School Sealant Program has come from a variety of sources over the years. HRSA funding paid the bulk of the cost of KSSP for the first three years, but that finding has since expired. Currently money from CDC, three state foundations, and state Medicaid dollars are being used to maintain contracts with contracted dental providers, and money from the Delta Dental Foundation of Kansas is being used to buy supplies (gloves, masks, tongue blades, toothbrushes) for those providers.

BOH has a Children's Oral Health Program Manager who manages the Kansas School Sealant Program. She maintains relationships with the contracted providers, who include community health centers, FQHCs, community based dental hygienists, and private dentists/dental hygienists. These providers establish relationships with school nurses and/or other school staff; schools are not always willing to allow these contracted providers to come into schools and provide services, so a significant amount of time and effort can be required to gain the trust of a school and their cooperation to schedule a visit from the provider.

The forms associated with the Kansas School Sealant Program are essential for its success. The consent forms for parents make it clear that if a child has a dental home, they should continue to see their regular dentist and not see the contracted provider when they are at school. This prevents conflicts with local dentists who may feel that the KSSP providers are stealing their patients. Additionally, the forms that the providers fill out when they see each child allow BOH to enter a large amount of data into SEALS. SEALS enables BOH to run reports about the efficiency of each provider and a number of other indicators.

#### C. Activities

Most of the activities performed by BOH for the Kansas School Sealant Program are enumerated in the "Detailed Description", but an additional activity that should be mentioned is the annual sealant meeting hosted by BOH. This meeting allows BOH to convene all contracted providers to go over things that went correctly with the program, and things that could be improved. Additionally, data from the program is shared, and usually one or two contracted providers give a presentation about the lessons they learned from their program.

#### D. Outputs

The Kansas School Sealant Program has continued to grow over the years since its inception. During the 2010-2011 school year, 6,222 sealants were placed on children in 114 schools. During the 2012-2013 school year, 16 KSSP contracted providers placed 21,914 sealants on children in 355 Kansas schools. Retention checks can be completed from 6months-18months from original placement date. There were 1,885 retention checks done on those children who received a sealant during the 2011-12 school year with a retention rate of 86.5%. In addition to sealants, 12,072 cleanings and 17,332 fluoride varnish applications were performed during that year.

E. Outcomes

As noted in the section about the Kansas School Screening Program, there has been a marked decrease in oral health problems among K-12 school children in the state over the past decade. In 2004, 55% of 3rd graders had experienced dental decay and 25.1% of 3rd graders had untreated decay, but in 2012 48% of 3rd graders had experienced dental decay and 9.4% of 3rd graders had untreated decay. While these changes are not wholly attributable to one program, the referrals that screeners make for children with obvious dental problems may have contributed to that decrease. Additionally, the Kansas School Screening Program has created a much larger body of data for the Bureau of Oral Health and other entities to monitor the oral health of children in Kansas.

**Budget Estimates and Formulas of the Practice:**

The budget for the Kansas School Screening Program, because the standardized protocol and database have been set up, is almost exclusively the salaries of BOH staff that help run the program. HRSA funds allowed BOH to employ 2 .5FTE who helped recruit screeners state wide, manage supplies and maintain and update the database and reporting system. The only other significant cost of the program is the supplies (gloves, tongue blade, toothbrushes) for which primary support has been through \$25,000 in renewable grant funding from Delta Dental Foundation of Kansas, as well as HRSA grant funding.

Current contracts with local partners vary from \$5,000 to \$70,000 depending on the size of the program. These dollars come from the Bureau’s federal grants from HRSA and CDC. Each provider is expected to bill Medicaid if possible for services. From the outset of the program the providers were made aware that the each program would need to be self-sustaining after the three year period.

The 2011-12 school year was the first year that many of these programs had ever been in schools. New equipment costs and the time associated with going into a school for the first time accounts for the average of \$140.62 cost per child sealed/screened. In Kansas many of the programs have significant distances to travel and this travel is directly reflected in their costs. When looking at individual programs, the cost per child varies greatly between more highly populated cities and rural communities. Without grant funds and Medicaid reimbursement, many of these programs might not exist or the reach of the program would stay in the larger cities.

<u>Summary of efficiency of input usage</u>	<u>Total outlays</u>	<u>Direct state funds**</u>	<u>State \$ + Medicaid**</u>
1. Total cost	\$711,561.90	\$352,500.00	\$581,352.00
2. Cost per child screened	\$140.62	\$69.66	\$114.89
3. Cost per child sealed	\$140.62	\$69.66	\$114.89
4. Cost per tooth sealed	\$32.23	\$15.97	\$26.33
5. Cost per cavity averted	\$122.78	\$60.83	\$100.32
6. Number of children screened per chair hour*		3.81	
7. Number of children sealed per chair hour*		3.28	
8. Number of children checked for sealant retention per chair hour*		0.06	
9. Number of labor hours per chair hour during screening*		0.45	
10. Number of labor hours per chair hour during		1.93	

sealing*	
11. Number of labor hours per chair hour during retention check*	0.04
12. Administrative time (including organization, setup, and breakdown) per child screened (in hours)*	0.22

**Lessons Learned and/or Plans for Improvement:**

One of the most significant problems faced by BOH in the implementation of the Kansas School Sealant Program has been the incorrect reporting of data on forms. This problem was addressed by personal visits or contact through email/phone to address issues, and consistent errors are brought up at the annual sealant meeting hosted by BOH. Another problem has been contracted providers that are in the same general area and providing services in schools in those areas; an example is the three safety net clinics located in Wichita, KS. The county health department mediated a discussion between those clinics and a tentative solution was reached, though there have still been some minor problems.

A significant problem faced by both the Kansas School Screening Program and the Kansas School Sealant Program has been the resistance of some schools to providers coming in and offering services to underserved children (it should be noted here that this resistance was for a variety of reasons). At the 2012 sealant meeting, advice was offered to contracted providers on how to establish relationships with schools and move forward with providing services in those schools. For the Kansas School Screening Program, BOH staff makes every effort to communicate effectively with schools, school districts, and screeners to ensure good relationships between all entities.

When contracting with safety net clinics for sealant program implementation, it is imperative that the clinic have good staff and the support of the clinic administration to be successful. Clinics cannot make a single hygienist responsible for the entire project. Many times a clinic puts the full program on the back of a single hygienist. Programs that utilize clinic staff to help make contacts with schools, make the schedule, do the follow up phone calls and enter the data are able to utilize the hygienist primarily for her clinical skills. These programs are more successful than those who have one person running the program.

The Sealant Program and the School Screening Program are supportive of each other. Schools that participate in the Screening Program are more receptive to in-school services. Providers that do the Sealant Program also compile the data for the Screening Program. The Screening data can be used to evaluate the Sealant Program.

**Available Information Resources:**

A toolkit and the forms used for the Kansas School Screening Program and Kansas School Sealant Program can be found on the Kansas Bureau of Oral Health website ([www.kdheks.gov/ohi](http://www.kdheks.gov/ohi)). This site also includes links to the Kansas School Screening Database, allows users to pull reports from that database, and includes brochures and other materials related to these programs.

**SECTION III: PRACTICE EVALUATION INFORMATION**

**Impact/Effectiveness**

*How has the practice demonstrated impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence, outcomes of the practice and/or evaluation results)?*

There has been a marked decrease in oral health problems among K-12 school children in the state over the past decade. In 2004, 55% of 3rd graders had experienced dental decay and 25.1% of 3rd graders had untreated decay, but in 2012 48% of 3rd graders had experienced dental decay and 9.4% of 3rd graders had untreated decay. While these changes are not wholly attributable to the Kansas School Screening and School Sealant programs, it is clear that since the inception of these programs more underserved children have been referred for treatment and received preventive oral

health services that have been proven to reduce rates of dental decay in children. As a result of these programs, during the 2012-2013 school year, 16 KSSP contracted providers placed 21,914 sealants on children in 355 Kansas schools, and 12,072 cleanings and fluoride varnish applications were performed during that year. Additionally, 153,977 children were screened during the 2012-2013 school year.

### **Efficiency**

*How has the practice demonstrated cost and resource efficiency where expenses are appropriate to benefits? How has the practice demonstrated realistic and reasonable staffing and time requirements? Provide unit cost analysis or cost-benefit analysis if appropriate.*

The Kansas School Screening Program was created to assist schools in complying with a state mandate. They have the entire school year to be able to conduct the screenings and submit data. With school nurse turnover it is common for BOH to be educating on how to do a screening, how to get volunteers and how to submit data. It is possible for a school of 600 students to be completed in less than 3 hours if there are knowledgeable staff and volunteers, with changeover some schools feel like they are always starting over and screenings are not as efficient as they could be. The continued source of data is what allows program implementation and evaluation in other aspects of oral health such as the Sealant Program. It is necessary to continue to push outside non-government entities to utilize the data that is available at State, County, School District, and School Building levels.

The Kansas School Sealant Program utilizes the Kansas School Screening Reports to know what areas of the state that should be targeted based on the higher percentages of untreated decay and treated decay coupled with the lower percentages of no sealants present. BOH has structured the program to allow for individual control of how they run their programs, but complete evaluation of each site on a yearly basis which directly impacts the target number of children set as a goal tied to a monetary value.

### **Demonstrated Sustainability**

*How has the practice showed sustainable benefits and/or how has the practice been sustainable within populations/communities and between states/territories? What mechanisms have been built into the practice to assure sustainability?*

The Kansas School Screening Program, because it is heavily dependent on volunteers, does not require a lot of financial investment from the Bureau of Oral Health. As long as BOH is staffed, the program should be able to continue in some capacity. In fact, some school districts that have been participating in the school screening program for years schedule their own screenings now, and only contact BOH for screening supplies. The number of districts and schools becoming sustainable in this respect has increased since the beginning of the program.

There are a few mechanisms in place that contribute to the sustainability of the Kansas School Sealant Program. All of the contracted programs are required to bill for the services they provide in the schools if there is a payment source. All sealant contractors are Medicaid providers and do their own Medicaid billing. The Bureau of Oral Health does not bill for the sealant programs, but provides the contractors with technical assistance on billing through their sealant program consultant. In addition to sealants, most of the programs also offer fluoride application and cleanings to increase the program's revenue. Services are also offered to all grades at a participating school, not just those in the

Additionally, many of the contractors are Federally Qualified Health Centers (FQHCs) that are provided federal funds to treat underserved patients. These FQHCs receive cost based reimbursement for their work in schools which helps with program sustainability. For the community health centers that are not FQHCs who participate in the sealant program, many also receive state primary care grant funds and private foundation dollars that subsidize staff salaries and travel.

### **Collaboration/Integration**

*How has the practice built effective partnerships/collaborations among various organizations and integrated oral health with other health projects and issues? What are the traditional, non-traditional, public and private partnerships/collaborations established by the practice for integration, effectiveness, efficiency and sustainability?*

The Kansas School Screening Program has allowed BOH to be more responsive to requests about the oral health status of Kansas children. This has strengthened partnerships between the Bureau

and other sections of KDHE, such as the Bureau of Health Promotion (BHP) which addresses chronic disease issues. BHP is interested in health screenings at schools, and has collaborated with the Kansas School Screening Program as part of that interest.

The Kansas School Sealant Program is characterized by partnerships between a number of organizations, including safety net clinics, private practitioners, schools, and other entities. The partnerships with the dental providers are fairly traditional, but the effectiveness of the strong collaborations between providers and school nurses and other officials has been particularly important.

### **Objectives/Rationale**

*How has the practice addressed HP 2020 objectives, met the National Call to Action to Promote Oral Health, and/or built basic infrastructure and capacity for state/territorial/community oral health programs?*

The Surgeon General's Report on Oral Health emphasizes the importance of oral health to overall health and the prevalence of oral disease, particularly among children. The report notes that there are striking disparities in oral health among children of different incomes, and that "safe and effective disease prevention measures exist that everyone can adopt to improve oral health and prevent disease."

The Kansas School Screening and School Sealant Programs address the HP 2020 objectives and the Surgeon General's Report on Oral Health by quantifying the burden of dental caries on K-12 children, referring children in need of care for treatment, and providing sealants and other preventive oral health services to primarily low-income children who are unlikely to receive that care another way. These programs reflect the vision cited in the National Call to Action to Promote Oral Health, which is to "to advance the general health and well-being of all Americans by creating critical partnerships at all levels of society to engage in programs to promote oral health and prevent disease." The public-private partnerships that are characteristic of these programs, between safety net clinics, schools, private practitioners, and other entities, have been critical to advancing the oral health of Kansas children, particularly those that are underserved and at high risk for oral disease. By creating a database, forms relevant for the programs, and establishing a network of partnerships throughout the state, the Kansas School Screening and Sealant Programs have created infrastructure that can be built on for years to come.

### **Extent of Use Among States**

*Describe the extent of the practice or aspects of the practice used in other states?*

School based sealant programs are a public health best practice that are actively promoted by various health organizations, including the CDC and HRSA. States that receive oral health grants from CDC often implement school based sealant programs with that funding. There are 21 states currently engaged in a cooperative agreement with CDC. However, other states that are not funded by CDC or HRSA could have a school based sealant program. Additionally, many other states have oral health screenings programs, though the features of these programs can vary widely.