Dental Public Health Activity Descriptive Summary

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Georgia's State School-based Dental Sealant Program

The Georgia dental sealant program is a school-based program designed to provide eligible students with dental sealants on their first and second permanent molars to prevent tooth decay. The Georgia Third Grade Oral Health BSS, in 2011, found 52% of 3rd grade children in Georgia have a history of tooth decay; 19% have untreated tooth decay; only 37% of 3rd grade children in GA have protective sealants on their 1st permanent molars.

The Georgia Oral Health Prevention Program (GOHPP) provides funds to support the School-Based Sealant Program (S-BSP) targeting high-risk schools, those with large proportions of students from families with low-income. In 2009, 45 of the state's sealant programs were funded by the GOHPP and approximately 3000 sealants were placed on schoolchildren. The GOHPP funds originated from the Maternal and Child Health Block (MCHB) grant as well as state general funds. Findings from the GOHPP's 2011 oral health survey of schoolchildren indicate that the school-based sealant program, targeting groups at high risk for dental caries, and least likely receiving regular dental care, has substantially increased sealant prevalence and reduced disparity in schools reached by the program. The prevalence of sealants among third grade students in schools with dental sealant programs is approximately five times greater than for students in schools without sealant programs.

The GOHPP's Dental Sealant Program targets schools where at least 50% of the students are eligible for the Federal Free-and-Reduced Lunch Program. In participating schools, all 2nd graders, with parental permission, receive a screening, sealants when appropriate, and fluoride varnish. For small schools, additional grades are included; 1st-5th graders. The programs provide referrals for restorative treatment and other dental needs, and follow-up as needed with both school nurses and parents.

The school-based programs are scheduled for a site visit with the sealant coordinator on a yearly basis, to review processes, provider procedures, and for a full assessment of the program. The program has an evaluation process approved by an advisory committee of dentists and hygienists in our district programs. Processes for infection control and clinical procedures are updated as best practice policies for public health to adapt to more effective services. The sealant staff meets with the district state dental team quarterly for training; any changes in processes can be part of the quarterly training module. The targeted schools are visited every year, and often twice a year, and at return visits the retention rate of the sealants is assessed. Practitioners are encouraged to report retention rate concerns as soon as determined, allowing for immediate assessment of product, equipment or other lapse in reaching sealant quality retention goals. If concern about retention rate arises, then an immediate site visit is scheduled.

Georgia currently has more than 50 S-BSP's operating in nine districts. Some programs are 100% funded by the state and operate utilizing portable equipment owned by the state; others are funded by individual counties. At this time Georgia has one county supporting the activities for the county school-based sealant program in the metro Atlanta area. For the last 3 years, school-based sealant programs have provided more than 16,000 sealants on second grade children with at least one molar sealant; 99% of the children participating in the free and reduced lunch program received at least one molar sealant.

The dental sealant team consists of a dentist, dental hygienist or dental assistant and uses 4-handed technique to apply sealants. One or two teams are assigned to a school for each clinic day. The lead

hygienist for a school is responsible for scheduling clinical days, transporting equipment, setting up equipment, placing sealants, and managing and submitting the paperwork. The dental hygienist usually spends the summer break and other school holiday breaks scheduling schools visits, ordering supplies, filing charts from previous school visits and managing the program. Annual training is required for all providers in order to calibrate screening criteria, improve clinical techniques, and review infection control. Staff is required to perform retention checks on 10% of the students sealed within each school within a six month time frame and replace/repair any missing sealants. A 90% retention rate is expected. (see comments back few paragraphs)

All school-based sealant programs are required to track their sealant data in CDC's Sealant Efficiency Assessment for Locals and States (SEALS) software, and provide the data information to GOHPP at the end of the event.
The GOHPP dental sealant coordinator assists the districts throughout the year with their programs. This includes technological support, assistance with the creation of forms or documents, proposing solutions to barriers, providing additional supplemental information which will strengthen their programs (i.e. free posters, literature, brochures, grant opportunities). The coordinator conducts quarterly site visits with each district. A comprehensive site visit is done every three years.

The GOHPP's Dental Sealant Program has experienced significant growth over the past three years. During the school year (2009-10), the program served 45 schools and provided 2616 screenings and 3297 sealants. By the 2011-12 school year, the program had expanded to include 71 schools; providing 5337 screenings and 7461 sealants.

In FY 2012-13, the program was challenged due to state budgetary constraints; instead of expanding the number of schools, the program focused on improving quality and increasing the number of children served within each school. This included an emphasis on increasing the percentage of parent permission forms returned, streamlining administrative processes, retention checks and more training for the staff.

The GOHPP continues to increase oral health awareness among children, their families, and the schools.

Lessons Learned:

It appears states vary in their approach to school-based/linked oral health prevention programs. Georgia has an oral health presence in the public health districts, but even our programs are varied from district to district. Lessons are learned by sharing on committees and listening to school-based oral health program webinars presented by other states. Georgia has expanded programs, adopted a more uniform retention rate check system, tried new approaches to increase parental consent rates, and has begun a process of approaching Georgia Medicaid (CMS) for reimbursement for dental hygiene services in public health under general supervision (presently CMS only reimburses when the dental hygienist works under direct supervision). This would assist with sustainability for the program.

- New programs take several years to become cost effective;
- Partner with Head Start, local business organizations, school administrators; school nurses; WIC; perinatal and other partners
- Good marketing of programs within schools to build trust;
- Schedule the school to be served one year out for the following year's visit;
- Improvement needed:

- Need for sustainability of dental sealant programs;
- Need for ongoing source of funding;
- Need to increase positive consent forms returned from parents;
- Need access to schools and populations with difficult barriers; and
- Need to assure that urgent follow-up care is received by all children with a stronger case management program. Previously, there was often a dependence on the school nurse or counselor for follow-up on referrals. There has been a decrease in the number of Medicaid dentists in Georgia limiting our referral database. DPH began to be concerned parents were being told to call a dentist on a list that was outdated. Many dentists still maintain their provider number although they haven't scheduled a Medicaid patient in years. The change came from a proactive approach requesting all of our districts have a consistent case management protocol. Our approach is, get the child into a dental home. In some of our districts we have a DPH dentist, but not in all counties. We don't want a child to suffer because there wasn't follow-up.

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