Dental Public Health Activity Descriptive Summary

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Maine School Oral Health Program (SOHP)

The Maine School Oral Health Program (SOHP) is an activity of the Oral Health Program (OHP) within the Division of Population Health in the Maine Center for Disease Control and Prevention (MCDC), an Office of the Maine Department of Health and Human Services (DHHS). School based oral health education has been supported by DHHS since the mid-1970s. The purpose of the SOHP is to improve the oral health of Maine's citizens by promoting oral health and preventing dental disease in children. Between 2009 and 2012, most of the funding for the SOHP was shifted from the state's General Fund and allocations from the MCDC's federal block grants to the Fund for a Healthy Maine (FHM), the name for funding in Maine deriving from state tobacco settlement revenue. Maine has been one of increasingly few states to direct these dollars to public health, with a primary focus on programs designed to prevent disease and promote improved health behaviors and outcomes.

The OHP awards small grants to public school administrative units and to community agencies representing groups of schools to implement and maintain their local school oral health programs. Community organizations and health agencies are considered for funding when school personnel are not available to administer the program. SOHPs are locally designed to provide education to students in grades K-6 and to offer preventive interventions (e.g., fluorides, dental sealants, brushing, dental screenings). The education component of the SOHP conveys information and skills to prevent the disease process. The OHP provides coordination, training, technical assistance, oral health curricula and other educational tools.

Eligibility for SOHP funding is based on a formula that evaluates each school. It includes the proportions of students eligible for the Free & Reduced Lunch Program (FRL) and for MaineCare (Maine's Medicaid program), and the proportions of the community with fluoridated public water and whose family income is at the federal poverty level. Exposure to fluoridated water is weighted in the eligibility formula, and participating schools generally have high FRL rates. The SOHP is thus directed toward schools where children are more likely to have difficulty accessing dental services. A cut-off score is determined and schools are funded using an allocation methodology related to student enrollment. Funding is intended to support the educational component of the program; that is, grant funds must be used for oral health education materials, for stipends or honoraria for dental professionals to make presentations, and for certain limited administrative costs.

In 1998, the OHP began awarding additional funds to existing SOHPs to implement school-based and school-linked dental sealant programs for second-graders, starting with 22 schools, again within the limits of available funding and based on an allocation methodology. Since schools must be part of the SOHP to be funded, this program component meets the same eligibility screen. About half of participating schools have these supplemental grants. The dental sealant program was developed as part of efforts to target schools in underserved areas and to provide preventive services to children without a dental home. Funds may be used to purchase supplies and to contract with licensed dental hygienists or dentists to provide the sealants.

In 2007, there were 79 grants for oral health programs operating in 242 schools with a total student population of 45,146 students in kindergarten through sixth grade. About two-thirds of the students in these schools participated in a weekly fluoride mouth rinse program. In that year 125 schools participated in the dental sealant program, providing sealants to about 1,400 children.

Since 2008, the number of children served by the SOHP has declined, for differing yet related reasons. Reductions in allocations from the state's General Fund and then a shift to the Fund for a Healthy

Maine (FHM) for the majority of the SOHP's support resulted in at least a 40% cut to the SOHP's total funding between 2009 and 2012. Changes in school enrollment and school district reorganization, along with fine-tuning program requirements and auditing program reports, also resulted in changes in the program and further trimming of grant awards. Preventive interventions within the program, other than classroom education, are limited to grades K-4. With the shift to the FHM, other state resources for the OHP and SOHP have been eliminated, and the allocation from the FHM has been reduced from year to year. The changes in funding have resulted in reducing funding for the SOHP from close to $330,000 at one time from various sources to $198,000 in state FY13. The OHP cannot fund all interested and eligible schools; there is a waiting list for the SOHP and a waiting list for schools that want to add the sealant component. At the end of the 2010-11 school year, these schools represented an estimated 8,464 children overall and among them, an estimated 5,890 second-graders who could receive dental sealants.

Lessons Learned:

Maine has mandatory school health education and the Maine OHP has strongly supported the inclusion of oral health in this initiative. Recognizing that school districts often do not have the money or personnel for oral health education, fluorides and professional initiatives, the OHP remains committed to the continuation of financial and technical assistance, particularly for small schools in rural areas, which also tend to be underserved for oral health services. One identified strength of the Maine SOHP has been that it is locally designed and implemented within the state OHP's guidelines. School-based services are provided, for the most part, by dental hygienists working under Public Health Supervision (PHS) status, a practice status (www.mainedental.org) in Maine that allows them to provide services in public health settings. Some are contracted individually by schools; some work for private organizations that make arrangements with schools; some, but not all of these, work in concert with the state's SOHP. One distinction to be noted is that the state SOHP will provide or facilitate services at smaller and more rural schools that other organizations may not find it cost-effective to serve.

To help assure the health and safety of all Maine students who may receive services provided in a school-based setting, and to better assure that such services are coordinated and documented, the Maine OHP developed "Guidelines for Mobile/Portable Dental Care Programs Working in School Administrative Units," (www.maine.gov/dhhs/mecdc/population-health/odh/documents/Guidelines-Mobile-providers.pdf) a document that may be used by school personnel to evaluate proposals from dental services providers. Developed in collaboration with the Maine Department of Education, it was also reviewed by a group of dental professionals. The guidelines do not regulate school-based or linked activities; rather, they are intended to help the interested parties by providing guiding principles, based in best practices, by which schools may implement and evaluate activities that are proposed by dental services providers for their students. Broadly written, they are meant to encompass services (such as dental screenings, preventive dental care, restorative services or a combination of these) offered by organizations or entities on site at schools during school hours.

In the fall of 2010 the Maine OHP initiated a pilot project to provide additional field support and resources to its SOHPs. The District Oral Health Coordinator (DOHC) pilot provided small amounts of funding for six existing local oral health directors to develop the role of district-wide coordinators for their areas (Maine has nine public health districts). These individuals already had a history with the OHP and were located in organizations with county-wide responsibilities, or in one case, in a large municipality. The purpose of the project was to enhance the presence and resources of the OHP at both the school and community levels, with the local DOHCs to serve as experts on oral health promotion and dental disease prevention for schools participating in the SOHP. DOHCs were to act as liaisons between schools and the OHP, and serve as the resource/contact persons for their public health district. The way the position was envisioned within the pilot project did not add programmatic duties for the DOHCs as much as it added responsibilities for organizing activities and reporting.

The pilot project evaluation indicated that it was successful in meeting its goals and desired outcomes: consistent messaging, increased sealant program enrollment, identification of a district point of contact, providing TA to local schools, and increased coordination with the Maine OHP, were all successfully implemented to some degree in each of the pilot sites. Limitations were associated with the limited funds available. Unfortunately, funding was not available to continue the DOHC function. If resources permit the continuation and expansion of the DOHCs, accountability within the structure would likely be more formalized, and reporting would be shared across sites to facilitate their ability to build on, replicate, or coordinate with activities happening in other parts of the state.

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