Dental Public Health Activity Descriptive Summary

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Use of Surveillance to Direct State and Local Oral Health Programs

The Oral Health Section (OHS), North Carolina Division of Public Health, determines the oral health of a community in three ways: (1) Dental assessments - measuring specific oral conditions such as the average number of decayed, missing and filled teeth and proportion of children with dental sealants, (2) Dental screenings - identifying children in need of dental care and referring them for care, and (3) Statewide epidemiological surveys - scientifically measuring the quantity and types of oral disease in a population. The epidemiological surveys are conducted approximately every 15 years. The North Carolina oral health program has been based on epidemiological studies beginning in the 1960's with a household dental survey of people of all ages. Findings were used to guide program planning through the 1970's. The 1960 household survey was repeated in 1976 to measure trends in oral health status and to provide baseline information for the newly implemented school-based dental prevention and education program. The next survey in 1986-87 was school-based and included almost 8,000 schoolchildren. The outcome of this survey resulted in a major programmatic change in the North Carolina oral health program emphasis from restorative treatment services to preventive services, especially dental sealants. The OHS believed it was necessary to closely monitor oral health trends in young children and therefore, implemented annual standardized Kindergarten and 5th grade dental assessments in 1995.The Statewide Evaluation of Community-Wide Strategies to Promote Dental Health, conducted in 2003-2004, was also a survey of school children. However, it included additional information to evaluate the Section's community-based prevention programs. In 2015, 5th grade was no longer targeted for assessment. The decision was made to target 3rd grade to be consistent with the National Oral Health Surveillance System (NOHSS) indicators. Implementation to begin 2017-2018 and every 5 years thereafter.

Lessons Learned:

Although the OHS has been doing annual assessments in schools for nearly 25 years, there continue to be lessons learned.

- Developing assessment protocols and selecting samples are relatively easy tasks. Getting into schools to conduct assessments can be a long, arduous process. If there is not an existing relationship with a school, it may take *at least* 1 year to establish trust and gain buy-in from key individuals within a school.
- If there is a local health department dental program or mobile dental program that provides clinical services in the schools, school administrators may be reluctant to allow a second party in the school because the assumption is a "duplication of efforts". Explaining the significance of surveillance and how it differs from what locals may be providing is important to gaining school access – although it is not always enough. If there is support from the superintendent and/or local health director, having them contact the school may be helpful.
- If there is a local health department dental program who also collects surveillance data in the schools, negotiation and creative collaboration will be required to ensure both parties get what they need. If a suitable agreement cannot be made, a replacement school may need to be selected.
- With this amount of data, consider the expertise, time and money required to build a database to house the information. This includes deciding in advance what type of reporting you want the database to be able to produce.

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