Dental Public Health Activity Descriptive Summary

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Statewide School Fluoride Program

The Oral Health Unit of the Oregon Health Authority (OHA), Public Health Division administers the statewide School Fluoride Program, a school-based program providing weekly fluoride mouthrinses or daily chewable fluoride tablets to children in grades K-6. The fluoride mouth rinse program began statewide in 1974. Chewable tablets were added as an option in 1987. Schools are eligible if at least 30% of the students are eligible for the national Free and Reduced Lunch Program. Only 22% of Oregon's population is served by optimally fluoridated water systems, so participation in the tablet program is encouraged in non-fluoridated areas; the rinse program is recommended in fluoridated areas.

The School Fluoride Program is supervised and coordinated statewide by a dental hygienist who serves as the School Oral Health Programs Coordinator. The Coordinator introduces the program to new schools and provides training and technical support to the school staff responsible for administering the fluoride. The program provides fluoride rinse, tablets, toothbrushes, and training materials at no cost to the schools. The fluoride is administered to the students by school nurses, teachers, health aides, school administrative staff, parents and/or volunteers as determined by each school. Funding for the program comes from Maternal and Child Health Title V block grant. The biennium budget is $95,100 for program supplies and services (e.g., toothbrushes, fluoride supplies, form translations and printing, etc.). The School Fluoride Program costs approximately $5.39 per child per school year. During the 2016-17 school year, 49 grade schools participated in the program, providing fluoride mouth rinses or tablets to a total of 8,814 children. The program has decreased from serving 79 schools in the 2006-07 school year to serving 49 schools in 2016-17. This decrease may be due to the additional internal demands placed on school staff and the addition of fluoride varnish to services that other school oral health programs provide.

Lessons Learned:

Oregon has debated which fluoride modality is the most effective and cost-effective to use in the school setting statewide. Administering fluoride varnish would be much less time-consuming than administering fluoride rinse and tablets throughout the year – and less of a burden for school staff (although the CDC recommends low levels of fluoride received frequently). Evidence-based research, however, requires 2 to 4 fluoride varnishes per year. The first fluoride varnish application could be completed in conjunction with a school dental sealant program. The subsequent fluoride varnish application(s), however, involves additional staff time that is expensive. In Oregon, varnish can only be administered by dentists, dental hygienists, trained staff in a WIC or Head Start program, or dental assistants under direct supervision (i.e. hygienist or dentist must be onsite). We are considering the possibility of a rule change to allow assistants to apply varnish under general supervision (i.e. the service can be prescribed and then provided by the assistants without the presence of a dentist/hygienist).

The OHA has found that a school champion, advocating for the School Fluoride Program, increases the chance of success. Once the protocols are understood and a routine is established, school staff reports that the program is easy to administer.

The main challenges are to persuade a school to participate and then to ensure the program is actually implemented once the school has made a commitment. There have been a few instances when a school committed to the program and then returned the fluoride at the end of the year, never having implemented the program. There have also been indications that the fluoride is not always administered consistently. During the training, the OHA stresses the importance of tracking data to ensure accountability.

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