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Report of the Sealant Work Group

Recommendations & Products

children's dental health *project*

Introduction

What Is at Stake

In 1967, researchers at the Eastman Dental Center in Rochester, N.Y. published the first research paper on the successful application of dental sealants to pit-and-fissure surfaces of teeth.[1] Today, sealants are widely recognized as an evidence-based approach to preventing tooth decay. The U.S. Community Preventive Services Task Force—a panel of independent health experts—recommends school sealant programs (SSPs), citing "strong evidence of effectiveness" in reducing tooth decay among school-aged children.[2] The task force's analysis has revealed that the benefits of SSPs "exceed their costs when implemented in schools that have a large number of students at high risk for cavities."[3]

The Centers for Disease Control and Prevention (CDC) observes that SSPs are "especially important for reaching children from low-income families who are less likely to receive private dental care."[4]

Although tooth decay remains the most common chronic disease of childhood, many kids at high risk for tooth decay are not receiving dental sealants. National data gathered in 2011-12 showed only 43 percent of adolescents had at least one permanent tooth with a dental sealant.[5] A 2015 report by the Pew Charitable Trusts revealed only 11 states have SSPs in most of their high-need schools.[6] Many children are not receiving sealants for a variety of reasons, and some of these reasons are intricately connected with how SSPs are regulated, are operated and their financial sustainability.

SSPs' cost savings and preventive impact have been confirmed and cited by multiple sources. For example, the U.S. Community Preventive Services Task Force noted that SSPs save money in a community within two years of operation. Additionally, a 2016 study revealed that over the course of a year, an SSP serving 1,000 students prevents toothaches in 133 children and averts the need for 485 fillings.[7] The National Governors Association (NGA) published a 2015 paper identifying dental sealant programs—"particularly those administered in schools"—as one of three "health investments that pay off" by reducing states' oral health treatment costs.[8] The NGA paper suggests key decision-makers are increasingly recognizing the value of expanding sealant programs to reach more children. The recommendations in this report are aimed at strengthening SSPs' operations and sustainability in this opportune environment.

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The Process

In 2014, with funding from the CDC, the Children's Dental Health Project (CDHP) produced a report examining the challenges of SSPs and identifying four keys to success for effective operations and sustainability. This report recommended the creation of one or more work groups to convene experts to develop new strategies for improving operations and sustainability.[9]

One year later, CDHP took steps to form and convene the national Sealant Work Group (SWG). In the fall of 2015, CDHP invited 13 individuals to serve on the SWG for the purpose of developing recommendations and any appropriate products to strengthen the operations and sustainability of SSPs. At CDHP's request, all of those invited to serve on the SWG completed a conflict-of-interest disclosure form; no conflicts were identified that excluded participation by any of them. These 13 individuals were chosen because they had considerable experience in managing, researching or implementing SSPs. In addition, these individuals were ethnically, culturally and racially diverse, and they hailed from different regions of the country.

The members of the SWG began their task by responding to a survey in which they were asked to prioritize nine different challenges that SSPs face related to sustainability and operations. These nine challenges were drawn mostly from CDHP's **2014 report**. Early in this process, SWG Chairman Matt Crespin encouraged the work group to focus its deliberations on helping SSPs move from being good programs to being excellent programs. It was noted that newly formed SSPs receive guidance from the ***Seal America: The Prevention Invention*** manual (2016), which was developed by Nancy Carter with assistance from the American Association for Community Dental Programs and the National Maternal and Child Oral Health Resource Center. SWG members concurred with how Crespin defined the SWG's role.[10]

In January 2016, SWG members gathered in Washington D.C. and discussed these challenges during an all-day meeting, eventually choosing five priorities to guide the work group's mission. These priorities were (not in order of preference): evidence-based and promising practices; collecting and analyzing data; communicating with parents and the community; communicating with school officials and staff; and Medicaid and regulatory hurdles. A number of web-conference calls followed this in-person meeting.

Teams were established for each priority to develop recommendations and potential products (e.g., tools or templates) to strengthen SSPs. In May 2016, the two teams focused on communication priorities agreed to hold joint discussions—a reflection that the strategies needed to address these challenges are similar. Eventually, SWG members decided to merge these two priorities into a single communication section.

In August 2016, the SWG finalized its draft recommendations and related products and submitted them to four external reviewers. Following this external review, additional revisions were made

before the report was prepared for dissemination. This document provides the SWG's recommendations and products, and we hope these strategies and resources will strengthen SSPs' ability to expand and serve more children.

CDHP wishes to thank the 13 members of the SWG, who gave so generously of their time, shared their insights and worked productively as a team. (Their names, credentials and affiliations are provided below.) We appreciate the leadership provided by Matt Crespin, who chaired the work group over its 14 months of service. In addition, we thank Lori Kepler Cofano for facilitating the SWG's dialogue and helping to plan agendas for each meeting. The SWG wishes to thank the four external reviewers who provided valuable insights and suggestions: Carrie Farquhar, Christine Farrell, Kim Herremans and Katrina Holt. On CDHP's behalf, Matt Jacob coordinated the SWG's schedule and activities, and he oversaw this report's design and production.

CDHP expresses its gratitude to the funders who supported the work of the SWG: the American Dental Hygienists' Association's Institute for Oral Health, Delta Dental of Iowa Foundation, Delta Dental of Minnesota Foundation, Future Smiles, Oral Health America, The Pew Charitable Trusts and Washington Dental Service Foundation.

Sealant Work Group Members

Donna Behrens, RN, MPH, BSN
Director, School-Based Oral Health Service
School-Based Health Alliance
Washington, DC

Virginia Black, MPH, BSN, RN, LSN
Columbus City Schools
Department of Health, Family and Community Services
Columbus, OH

Mary Pat Burgess, RDH, MBA
Program Director
School-Based Oral Health Program
Chicago Department of Public Health
Chicago, IL

Richard Champany, DDS, MPH
Consultant, Navajo Area
Indian Health Service
Farmington, NM

Terri Chandler, RDH
Founder and Executive Director
Future Smiles
Las Vegas, NV

Lori Kepler Cofano, RDH, BSDH
(Facilitator)
Dental Public Health Consultant
Driftwood, TX

Matt Crespin, MPH, RDH (Chairperson)
Associate Director
Children's Health Alliance of Wisconsin
West Allis, WI

Jodie Hostetter, RDH, BSDH
Miles of Smiles Program Coordinator
San Antonio Metropolitan Health District
Dental Division
San Antonio, TX

Ana Karina Mascarenhas, BDS, MPH, DrPH
Associate Dean of Research
Professor and Former Chief, Divisions of Primary Care
Nova Southeastern College of Dental Medicine
Fort Lauderdale, FL

Daniel Romo, DDS
Dental Director
Eisner Pediatric & Family Medical Center
Los Angeles, CA

Bob Russell, DDS, MPH
Public Health Dental Director
Oral Health Bureau
Iowa Department of Public Health
Des Moines, IA

Armando E. Soto-Rojas, DDS, MPH
Associate Professor
Director, Seal Indiana
Department of Cariology, Operative Dentistry and Dental Public Health
Indiana University School of Dentistry
Indianapolis, IN

Merry Jo Thoele, MPH, RDH
Oral Health Director
Minnesota Department of Health
St. Paul, MN

Recommendations in Four Priority Areas

PRIORITY

Promoting Evidence-Based and Promising Practices

The health experts who developed the "Triple Aim" model—improving population health, reducing per capita costs and improving the experience of care—recognized the crucial role of ensuring that care is evidence-based.[11] Most SSPs are committed to delivering services that are aligned with the Community Preventive Services Task Force recommendations and clinical evidence, which is described in this report's introduction.

RECOMMENDATION 1

State health departments should develop certification standards for SSPs and actively involve experts in the discussion of the certification process.

Using evidence-based practices and operating in an ethical manner are important to gain the support of school nurses, teachers, administrators and families. Providing services that fulfill commitments made to school officials, serving both insured and uninsured children, and billing only for necessary services are some of the ways to strengthen accountability and bolster school officials' confidence that an SSP is delivering oral health services in an efficient, safe and ethical manner.

Some states have produced guidance that establishes expectations for how SSPs should operate; however, the SWG believes a certification process is appropriate.[12] Oregon's SSP certification requirements provide one example of a model that might be used as guidance for initiating such a process. Certification facilitates oversight on important issues, including infection control in mobile settings, evidence-based practices, and requirements to collect and share uniform data. Certification might also include a calibration process for providers to ensure a clinical consistency.

RECOMMENDATION 2

SSPs should commit to having a culturally competent and proficient staff, guided by public health principles, who work to the fullest extent allowable by their education, training and state license.

SSPs are planned and managed by a team of professionals who understand and carry out their distinct roles and responsibilities. These individuals should have a firm commitment to public health principles and working with underserved populations.[13]

In addition, SSP staff are more likely to be effective if they demonstrate a commitment to the underserved and working with diverse populations. SSPs should choose their staff in ways that reflect this commitment and maximize efficiency by giving staff the opportunity to work to the fullest extent allowable based on their education, training and state license. Recognizing that cultural competence is about more than language skills, SSPs should identify staff with the behaviors and attitudes that enable them to work effectively with children and families of diverse cultural and ethnic backgrounds.

Some health stakeholders have developed **planning guides** or other materials that can help SSPs strengthen the cultural competency of their workforce. The federal Office of Minority Health's website offers a **guide** to help health providers develop standards for culturally and linguistically appropriate services. Other competencies such as motivational interviewing should be sought by SSPs in providers' skill set.[14]

RECOMMENDATION 3

SSPs should be aware of tooth eruption patterns among the children they serve and take these patterns—and children's risk for tooth decay—into account when choosing the appropriate grades for sealant placement.

Targeting the right grades for sealant placement is important, and the appropriate grade levels might vary based on tooth eruption patterns among children living in a particular region or community. For example, a 2013 study found the timing of tooth eruption varied significantly between children in Ohio and a large group of American Indian/Alaska Native children. "When making decisions regarding the timing of sealant programs," the study's co-authors wrote, "the availability of susceptible teeth must be balanced with the prevalence of caries and expected patient behavior."[15]

To reduce caries and limit the need for restorative treatments, the most effective protocol is to target children of appropriate age and consider varying eruption patterns to assure that sealants are placed on newly erupted molars.

RECOMMENDATION 4

SSPs should use the criteria from the Association of State & Territorial Dental Directors' (ASTDD) Basic Screening Survey (BSS) to assess the severity of dental disease in children (see Table I).

While screening children and assessing their risk for tooth decay, it is important for SSPs to refer children with untreated decay to a dental provider or to their existing dental home. It is helpful for the school nurse, parents and the dental provider who is accepting the referral to be informed of the severity of the tooth decay. To this end, it is recommended that all SSPs use a standardized screening tool to assess the severity of a child's oral health condition.

By using the same criteria as other SSPs, a sealant program can compare data directly with other programs statewide or even nationwide. The following screening criteria are adapted from the ASTDD's BSS tool:

TABLE I: ORAL HEALTH DESIGNATION AND REFERRAL

Category	Recommendation for next dental visit	Criteria
Urgent need for dental care	As soon as possible	Signs or symptoms that include pain, infection, or swelling
Early dental care needed	Within several weeks	Caries without accompanying signs or symptoms or individuals with other oral health problems requiring care before their next routine dental visit
No obvious problems	Next regular checkup	Any patient without above problems

The information in this chart was adapted with permission from ASTDD.

RECOMMENDATION 5

SSPs should conduct retention checks 8-14 months after sealant placement on an appropriate sample size based on the number of children whose teeth were sealed.

Sealants can last for many years, however retention checks are a standard way to determine what percentage of sealants remain intact. These checks provide a vehicle for ensuring quality control within SSPs. Typically, both short-term and long-term retention checks are conducted on a sample of children who were served by an SSP. (For more information on the importance of retention checks and recommended intervals, see the *Seal America: The Prevention Invention*.)

Both short- and long-term retention checks are an important way for SSPs to monitor the quality of services they deliver. Short-term retention checks should be performed before an SSP moves to a new school to allow for prompt replacement of any missing sealants. This recommendation does not identify issues in program effectiveness, but it may identify a clinician's need for additional training. SSPs should have a remediation plan ready for any staff that might need additional training on sealant placement.

Long-term retention checks also are a key element of an SSP's quality assurance. In addition, long-term retention checks will allow for the reporting of a key data element: cavities averted.

SSPs should ensure retention checks are consistent, meaning all dental professionals are trained to use the same protocol (using calibration exercises) for assessing the integrity of a sealant. If possible, sealant retention checks should be performed by a licensed, trained and calibrated clinician who did not place the sealants being checked.

RECOMMENDATION 6

SSPs should incorporate a minimum of two fluoride varnish applications into the services they provide children each year.

It is common for SSPs to provide other preventive oral health services besides sealant placement. One such service is a fluoride varnish application—an evidence-based approach to make teeth more resistant to tooth decay.[18] Applying fluoride varnish takes only a few minutes per child, and there is strong evidence to support its use in preventing caries in children with moderate to high risk of developing caries.

However, clinical evidence shows the benefits of fluoride varnish improve when children receive at least two yearly applications. Children at high risk for tooth decay may need more than two applications annually.[19] Where possible, a child's history should be reviewed to determine if they have received fluoride varnish applications during a primary care visit. For this reason, SSPs should align their planning and delivery of services with this twice-yearly target.[20]

PRIORITY

Communicating with Families, the Community and School Staff

Clear and all-inclusive communication is essential for the success of any project. This includes the implementation and ongoing operations of an SSP. It is imperative to engage those who are impacted by the SSP, including families, children, the community and school staff—administrators, teachers, and school health staff.

SSPs should use a variety of health promotional tools and mechanisms to explain what a sealant is and why it is important for children's oral health. These educational communications should be directed to school staff, parents and children. Raising oral health literacy levels can enhance the perceived value of sealants, improve consent rates for sealant placement and lead to better understanding of the importance of all oral health services.

Communications to education staff should emphasize that SSPs may improve attendance by enabling students to receive dental services without leaving school. For families, keeping their children in school and not having to miss work time is a value proposition to highlight. Other members of the community should learn of both SSPs' cost savings and the link between better oral health and school attendance. For children, develop messages that are appropriate for their age group and that reinforce the importance of good oral health.

RECOMMENDATION 7

SSPs should develop and periodically update a communication plan that identifies the messages, communication vehicles and other details that will guide efforts to engage school officials, school staff, families and children, striving to strengthen and expand sealant programs.

Creating a communication plan will assist in nurturing relationships with school staff, parents, families and the broader community. This plan should reflect mutually agreed upon expectations of the services that an SSP will provide and later report back on. (The SWG has created **a worksheet** to assist SSPs in developing such a plan.) The manner in which SSPs communicate with each of these groups will vary based on the way each audience is impacted by the program.

The CDC and other experts **recommend** tailoring information to the health literacy and reading levels of audiences.[21] For SSPs, these levels vary, depending on whether parents, children or school staff, for example, is the intended audience.

The communication plan should identify opportunities for the SSP to become a strong and visible part of the school and parent community. An oral health advisory committee—including representatives of the school, families and community organizations—can be a vehicle for communicating key messages. For more guidance on establishing a committee, see the ***Seal America*** manual.

RECOMMENDATION 8

SSPs should create a memorandum of understanding (MOU) or a memorandum of agreement (MOA), signed by the SSP operator and an appropriate representative of the school or school district where services will be provided.

Developing an MOU or MOA can help ensure open and transparent communications between an SSP and a school or school district. It is important to consult with a legal advisor before drafting and finalizing an MOU or MOA, as this advisor can help ensure that the memorandum complies with laws regarding both education and medical information sharing (e.g., HIPAA and FERPA).

An MOU or MOA should clearly establish the roles and responsibilities of both parties. For example, SSPs may want to specify in the agreement what information will be collected, what consent process will be used, and how data will be stored and shared. For more information on creating an MOU or MOA, SSPs can communicate through dental public health listservs, consult the ***Seal America*** manual, or check with the **oral health program** in their state health department.

RECOMMENDATION 9

Oral health advocates and school officials should work together to communicate the value of investing in SSPs to state Medicaid programs, legislators, school board officials and other policymakers.

Although SSPs provide an excellent return on investment, state budget shortfalls sometimes prompt funding cuts for new or existing sealant programs. It's essential for oral health and school health advocates to use every opportunity to build positive relationships with state Medicaid staff, legislators and other policymakers, communicating why SSPs keep children healthy and in school—and better able to learn. Stakeholders should be aware that in many states Medicaid and CHIP are crucial funding streams for SSPs. Communication efforts can help key decision-makers recognize that SSPs offer real value.

Finally, SSPs should seek access to students' individual district identification numbers (or another unique identifier) to monitor each student's oral health status over time.

PRIORITY

Collecting, Analyzing and Reporting Data

Collecting, analyzing and reporting data is integral to operating a successful SSP. First and foremost, data enables an SSP to ensure quality control by, for example, determining sealant retention rates. Yet SSPs collect a variety of data and may not recognize the potential these numbers have to help them strengthen the confidence of funders, school officials and other stakeholders that their programs offer a cost-effective way to keep children healthy, in school and better able to learn.

Data can help SSPs tell a powerful story. This has been the experience in Wisconsin—a state recognized as a leader in the delivery of sealants through school-based programs.[22] In 2003, the Wisconsin Seal-A-Smile (SAS) program moved from collecting data with basic spreadsheets to adopting SEALS, a data-collection system created by the CDC. Collecting robust data in a systematic and uniform manner helped demonstrate Wisconsin SAS's impact and cost-effectiveness. Between 2003 and 2016, SAS was able to obtain funding to grow from six programs in six counties to nearly 40 programs reaching approximately 80 percent of Wisconsin's 72 counties.[23]

RECOMMENDATION 10

SSPs should collect, analyze and report the following 11 types of data:

1. The insurance status of children served (i.e., Medicaid, Children's Health Insurance Program (CHIP), private insurance, uninsured, unknown)
2. The participation rate of children at targeted schools, including:
   - The number of consent forms distributed
   - The number of consent forms returned for children whose parents or caregivers agreed to have them receive preventive care
   - The number of consent forms returned for children whose parents or caregivers chose not to receive preventive care
3. The number of children served with special health care needs[24]
4. The number of children screened for sealant placement
5. The number of children with treated decay⋆
6. The number of children with untreated decay⋆, including a breakout of:
   - The number of children with early treatment needs⋆
   - The number of children with urgent treatment needs⋆
7. The number of screened children with sealants present when the SSP began serving the school(s)⋆
8. The number of children receiving sealants and each child's age, including a breakout of:⋆
   - The number of decayed permanent first molars
   - The number of sealed permanent first molars
   - The number of filled permanent first molars
   - The number of sealed permanent second molars
   - The number of other sealed (primary/premolar) teeth
9. The number of children referred for dental care who obtained necessary restorative and/or follow-up care
10. The SSP's sealant retention rates—specifically, the number of retained program sealants 8-14 months after sealant placement
11. The average cost per child served and the average cost per sealant placed, which requires SSPs to collect the following:
    - Labor cost
    - Equipment cost
    - Instrument cost
    - Consumable supply cost
    - Other program costs (e.g., travel, insurance)

⋆*The SWG recommends using criteria set forth by the ASTDD's Basic Screening Survey.*

Data guides SSPs, can demonstrate their impact and help to identify areas for improvement. These 11 data points are crucial because they enable an SSP to report the number of cavities averted, which shows the effectiveness of a program. Cost savings to the state Medicaid program also can be calculated and shared using these data. The ability to show cost effectiveness and savings of a program is important to funders. Additionally, SSPs that collect data on insurance status can use this information to enroll eligible children in Medicaid or CHIP. This is an example of an opportunity to use data that provides overarching benefits to families.

Collecting these specific data points using the recommended guidance also allows for programs within a state to submit uniform data to their state oral health program, health department or Medicaid agency. Moreover, states can, in turn, compare data uniformly across the country. The ability to collect and share uniform data across programs can assist efforts to improve efficiency and show an SSP's true impact.

The CDC is developing a calculator that enables SSPs to define the impact of their programs, such as the number of cavities averted. This report will be updated with a link to the calculator once the CDC makes it accessible.

RECOMMENDATION 11

SSPs should analyze the previously cited 11 types of data to support program improvement and share relevant information with funders, school officials, state oral health programs and other stakeholders to demonstrate the quality, impact and cost-effectiveness of their programs.

Strong data can spur funders or stakeholders to increase their commitment. Because both funders and elected officials increasingly look for metrics showing impact, SSPs that fail to collect sufficient data and analyze it will find it more challenging to be financially sustainable. In addition, reviewing these data enable SSPs to assess their operations, protocols and outcomes.

SSPs should explore the use of software to enable electronic data collection, increasing efficiency and enhancing the ability to analyze data more effectively. This can make it easier for SSPs to monitor their progress over time.

It is not enough to simply collect the data; using it to tell an SSP's story and show its impact will have a positive impact on a program. SSPs should create a one-page, data-sharing document with versions tailored to different audiences, such as school staff, families and policymakers. Sharing data is vital to demonstrating an SSP's impact and reflects a program's desire to be accountable for the services it provides. Communicating such data may help SSPs identify new champions for their programs.

PRIORITY

Addressing Medicaid and Regulatory Hurdles

Many SSPs seek reimbursement from Medicaid for the services they provide. These reimbursements are an important funding stream that can bolster SSPs' financial sustainability. However, some oral health professionals may encounter hurdles with billing or becoming an authorized Medicaid provider. Challenges to becoming a provider may hinder efforts to deliver sealants in school settings more efficiently and cost-effectively.

RECOMMENDATION 12

State licensing boards and/or legislatures should evaluate existing rules and regulations that restrict the use of appropriately trained and licensed members of the workforce. Rules, laws and/or regulations should be changed to allow patients to receive services in the most cost-effective manner.

State dental practice acts have the potential to impact the cost-effectiveness of SSPs. For example, a 2015 report revealed that 13 states significantly restrict the ability of non-dentist oral health professionals (e.g., dental hygienists and dental therapists) to apply sealants.[25] In most cases, the restrictions in state dental practice acts require a dentist to examine a child's teeth before another licensed dental professional can place sealants. This prior exam rule is not grounded in scientific or clinical evidence. The professionals who work in SSPs graduate from institutions accredited by the Commission on Dental Accreditation and are educated and trained to determine the need for sealant placement.

The U.S. Community Preventive Services Task Force examined SSPs and concluded that labor expenses accounted for roughly two-thirds of a sealant program's cost per child and that sealant placement was more cost-effective "when sealants were applied in less time or when dental hygienists, rather than dentists, were used to determine whether sealants were appropriate for individual students."[26] In other words, restrictive rules by states make SSPs less efficient and more costly.[27]

A report by the Centers for Medicare & Medicaid Services recommends that states improve children's oral health access by reducing supervision requirements for dental hygienists who work in schools and other community-based settings.[28] In addition, a report by the National Governor's Association cites the challenge of meeting the demand for oral health services, recommending that states "can consider doing more to allow dental hygienists to fulfill these needs by freeing them to practice to the full extent of their education and training."[29] Minimizing barriers can enable SSPs to serve more children cost-effectively by allowing licensed oral health professionals to work to the fullest extent of their education and training without compromising quality or safety.

RECOMMENDATION 13

State Medicaid programs should allow all licensed dental providers (e.g., dental hygienists and dental therapists) to enroll as Medicaid providers, as well as allowing them to submit claims and receive direct reimbursement for oral health services in all settings, particularly in states where they can place sealants without a prior exam by a dentist.

One of the challenges SSPs face is that some states do not permit dental hygienists—the professionals who typically work in and oversee SSPs—to submit Medicaid claims for oral health services. In addition, a few states do not reimburse for dental services provided in school settings. This creates obstacles for SSPs. According to the American Dental Hygienists' Association, less than 40 percent of states allow dental hygienists to enroll as a Medicaid provider and receive reimbursement directly from Medicaid.[30] SSPs grew tenfold within two years of Wisconsin allowing dental hygienists to enroll as Medicaid providers and receive direct reimbursement from Medicaid.

RECOMMENDATION 14

States should simplify the Medicaid application and credentialing process for all licensed dental professionals. This would help to facilitate the efforts of SSPs.

In many states, the application and credentialing process to become a Medicaid provider is needlessly cumbersome and time-consuming. In recent years, some states have taken positive steps to encourage and facilitate provider participation. Maryland streamlined its Medicaid credentialing process and, expedited payment of clean claims.[31] (Clean claims are those that do not entail investigation and are filed in a timely manner.) Oklahoma launched a uniform, **online enrollment** process for providers.[32] New Jersey's Medicaid program created a **single form** that can be used regardless of the insurance provider.[33] Other states may want to look to these initiatives as they explore ways to streamline Medicaid procedures.

State Medicaid programs should offer provider training to enable SSPs to better understand the enrollment process, billing policies and procedures, dental benefit package—including frequency and limitation on services—and improve the accuracy and efficiency of submitting claims, reducing delays in the processing of claims.

RECOMMENDATION 15

State Medicaid programs should require that managed care organizations (MCO) abide by the same payment and contracting requirements that govern the state Medicaid program.

Most Medicaid enrollees are served by MCOs.[34] However, MCOs do not always follow state Medicaid programs' rules and protocols when accepting and approving reimbursements for oral health services. For

example, in states whose Medicaid agencies have allowed dental hygienists to bill for services, it has been reported that some MCOs have rejected these submissions—instead, requiring dentists to submit the claims.

A number of states may contract with one or more MCOs to administer and/or deliver services under Medicaid. In states with multiple MCOs, SSPs can face an added burden as they are required to be credentialed by each MCO. In addition, some states require individual practitioners to be credentialed. Moreover, the MCO landscape can change every few years, meaning that SSPs and their practitioners must reapply for credentials on an ongoing basis. The time and energy required to complete these credentialing processes can inhibit the ability of SSPs to expand and serve more children.

RECOMMENDATION 16

State Medicaid programs should complete a cost-benefit and budget impact analysis on the recently approved Current Dental Terminology (CDT) codes for case management services to prepare for implementing these codes. In addition, Medicaid agencies should educate dental providers on the types of case management that are covered and how to use these codes appropriately.

In January 2016, federal officials released a tool-kit identifying five high-impact opportunities to improve school-based health, one of them being the use of case managers "to connect Medicaid-enrolled students in schools to necessary health care and related support services."[35] Case management services can strengthen outreach to families by answering their questions about sealants and guiding them in finding a dental home for their children.

Although case management is a critical component for SSPs, it is currently not reimbursed by Medicaid. Effective January 1, 2017, four new case management codes became part of the CDT codes.[36] However, it's up to states to decide whether to include these case management codes in their benefits package. There is precedent for this as some state Medicaid programs reimburse for case management services related to other chronic health conditions.

States should consider creating a committee with SSP representation to develop guidelines for effective use of case management codes for oral health services. SSPs can offer insights into how case management could enhance delivery of services and help families find a dental home.

By covering case management services, Medicaid can help SSPs serve more children in a financially sustainable manner. The SWG encourages oral health and school health advocates to work together to convey the importance of case management services. These advocates should urge their state Medicaid programs to evaluate the costs and benefits—and the budget impact—of reimbursing for these newly adopted CDT codes. State oral health coalitions and advocacy groups can partner in seeking this change. ■

Endnotes

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10 Seal America: The Prevention Invention, 3rd Ed., National Maternal and Child Oral Health Resource Center (Georgetown University), 2016, **https://www.mchoralhealth.org/seal/**.

11 Institute for Healthcare Improvement, "IHI Triple Aim Initiative," accessed in November 2016 at **http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx**.

12 These manuals can provide helpful guidance to SSPs. For example, the **Minnesota Department of Health**'s manual has a good section on safety and emergencies. In the **Washington State Department of Health**'s manual, chapter 6 advises SSPs on the quantitative data they must collect and reminds SSP operators of the quarterly reports they are required to file under state law. The **Indiana University School of Dentistry**'s manual enumerates 10 infection control procedures for SSP staff.

13 The Centers for Disease Control and Prevention has outlined several values that characterize public health initiatives. These values include "understanding and addressing the unique issues" affecting the uninsured, the poor and other vulnerable groups, as well as making "primary, secondary, and tertiary prevention strategies" the key thrust of health practices. Accordingly, as the Indian Health Service (IHS) explains, "Resources must be directed to activities that most prevent the deterioration of oral health among the greatest number of people over the longest period of time" (Indian Health Manual, Chapter 2, Part 3). These resources should be expended using evidence-based dentistry. An example is placing a sealant over incipient decay. In an evidence-based public health program, incipient decay should be treated through a sealant and not by restoration.

14 Numerous research papers have explored the nature and impact of motivational interviewing (MI) in health care. Elsevier's Early Childhood Caries Resource Center provides access to numerous articles on research related to MI's use to strengthen oral health. Visit **http://earlychildhoodcariesresourcecenter.elsevier.com/content/prevention-ecc-oral-health-care**.

15 K. R. Phipps, T.L. Ricks and P. Blahut, "Permanent first molar eruption and caries patterns in American Indian and Alaska Native children: challenging the concept of targeting second grade for school-based sealant programs," *Journal of Public Health Dentistry*, 2013, (73:3) 175–178.

16 Leading dental organizations have prepared criteria for conducting an oral health risk assessment of children. For more information, see these guidelines from the American Academy of Pediatric Dentistry (**http://www.aapd.org/media/policies_guidelines/g_cariesriskassessment.pdf**) and the American Dental Association (**http://www.ada.org/en/member-center/oral-health-topics/caries-risk-assessment-and-management**).

17 For basic information about sealant retention, see this fact sheet posted on the website of Native American Professional Parent Resources: **http://www.nappr.org/files/dental-resource-guide/HPDP/Resin%20Sealant%20Retention%20Tips.pdf**.

18 American Dental Association, "Topical fluoride for caries prevention: Full report of the updated clinical recommendations and supporting systematic review," report of the Council on Scientific Affairs, Nov 2013, **http://ebd.ada.org/~/media/EBD/Files/Topical_fluoride_for_caries_prevention_2013_update.ashx**.

19 The American Academy of Pediatric Dentistry (AAPD) advises that decisions about fluoride treatments should be "based on the unique needs of each patient," including their risk for tooth decay. The AAPD has concluded that children who are "at increased caries risk" should receive fluoride treatments at least every six months. See: **http://www.aapd.org/media/policies_guidelines/g_fluoridetherapy.pdf**.

20 In SSPs with minimal resources, two applications of fluoride varnish might be the most that can be provided within the span of one year. Ideally, the first application can be provided during the sealant placement visit, and the second one can occur when a retention check is being performed.

21 *Simply Put: A guide for creating easy-to-understand materials*, Centers for Disease Control and Prevention, 2009 (3rd edition), 3, 5-7, 27-37, **https://www.cdc.gov/healthliteracy/pdf/Simply_Put.pdf**.

22 Wisconsin was one of only three states to receive an A grade in 50-state reports on school sealant programs that were issued by the Pew Charitable Trusts in 2013 and 2015. For more information, see: *States Stalled on Dental Sealant Programs*, 2015, and *Falling Short: Most States Lag on Dental Sealants*, 2013, Pew Charitable Trusts, **http://www.pewtrusts.org/en/projects/dental-campaign**.

23 Unpublished data provided by the Children's Health Alliance of Wisconsin.

24 Many SSPs use the U.S. Maternal and Child Health Bureau's definition of children with special health care needs (CSHCN).

25 *States Stalled on Dental Sealant Programs*, Pew Charitable Trusts, June 2015, 7-8, **http://www.pewtrusts.org/~/media/assets/2015/04/dental_sealantreport_final.pdf**.

26 U.S. Community Preventive Services Task Force, April 2013.

27 Virginia health officials conducted a pilot project and found that the per-child cost for sealant placement was 25 percent higher under a dentist's general supervision than under remote supervision. See: "Final Report on Services Provided by Virginia Department of Health (VDH) Dental Hygienists Pursuant to a Practice Protocol in Lenowisco, Cumberland Plateau, and Southside Health Districts," Virginia Department of Health, 2011, Report Document No. 299, **http://leg2.state.va.us/dls/h&sdocs.nsf/execsummaryreport/RD2992011**.

28 *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents*, Centers for Medicare & Medicaid Services, Sept 2013, **https://www.medicaid.gov/medicaid/benefits/downloads/keep-kids-smiling.pdf**.

29 The Role of Dental Hygienists in Providing Access to Oral Health Care, National Governors Association, Jan 2014, 13, **https://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf**

30 American Dental Hygienists Association, "Advocacy: Reimbursement," accessed on July 29, 2016 at **http://www.adha.org/reimbursement**.

31 *Improving Oral Health Care Delivery in Medicaid and CHIP: A Toolkit for States*, The Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program, June 2014, 24.

32 "SoonerCare Provider Enrollment," Oklahoma Health Care Authority, accessed at **https://www.ohcaprovider.com/enrollment/(S(1k1gbx1kfyypgnuzqasg4fiq))/site/home/home.aspx**.

33 "Information for Providers & Stakeholders: Contracts, Legal Notices," Division of Medical Assistance and Health Services, State of New Jersey, accessed at **http://www.nj.gov/humanservices/dmahs/info/**,

34 Centers for Medicare & Medicaid Services, "Managed Care," accessed at **https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html**.

35 *Healthy Students, Promising Futures: State and Local Action Steps and Practices to Improve School-Based Health*, U.S. Department of Health and Human Services & U.S. Department of Education, January 2016, **http://www2.ed.gov/admins/lead/safety/healthy-students/toolkit.pdf**.

36 Email communication to the Children's Dental Health Project from Dr. Lynn Mouden, chief dental officer at the Centers for Medicare & Medicaid Services, May 11, 2016.

Children’s Dental Health Project
1020 19th Street NW, Ste. 400 | Washington, DC 20036
T: 202-833-8288
cdhp.org | @Teeth_Matter

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