

The Sealant Work Group

A Summary of Recommendations

The U.S. Community Preventive Services Task Force—an independent, national panel of public health experts—has recommended school-based dental sealant programs “based on strong evidence of effectiveness” in preventing tooth decay among children.

In 2015, the Sealant Work Group (SWG) began meeting with the mission of developing recommendations to strengthen the operations and sustainability of school-based dental sealant programs (SSPs).

Convened by the Children’s Dental Health Project, the 13-member SWG issued its report in April 2017. This is a summary of the SWG’s recommendations. For a copy of the complete SWG report and a list of SWG members, please visit www.cdhp.org/sealants.



RECOMMENDATION 1

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

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.



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.

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).

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.

RECOMMENDATION 6

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

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.

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.

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.



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 needs¹
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.

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

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.

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.

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.

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.

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.

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.