Connecticut Statewide Dental Sealant Plan

July 2010

Connecticut Department of Public Health

Office of Oral Health
Pamela Kilbey- Fox, M.P.H. Interim State Dental Director

TABLE OF CONTENTS

1. INTRODUCTION…….PAGE 3

2. STATE OVERVIEW…….PAGE 4

3. STATE DENTAL SEALANT OBJECTIVES……...PAGE 4

4. CURRENT DENTAL INFRASTRUCTURE……PAGE 5

5. NEEDS ASSESSMENT……PAGE 6

   - FREE AND REDUCED LUNCH PROGRAM……..PAGE 6
   - ORAL HEALTH STATUS OF CT CHILDREN……PAGE 7

6. ACCESS TO CARE……PAGE 9

   - CONNECTICUT'S CHIP PROGRAM –HUSKY……..PAGE 9
   - HUSKY ENROLLMENT……PAGE 11
   - SAFETY NET DENTAL PROVIDERS……..PAGE 11
   - DISTRIBUTION OF DENTISTS……PAGE 13
   - COMMUNITY WATER FLUORIDATION……PAGE 14

7. DENTAL SEALANT PILOT……...PAGE 15

8. SUSTAINABILITY…….PAGE 16

9. EXPANSION OF DENTAL SEALANT PROGRAMS……..PAGE 16

10. REFERENCES……PAGE 18-20

Introduction

As stated in the Surgeon General's first report on the oral health status of Americans in 2000, oral health is an essential and integral component of health throughout life. No one can be truly healthy unless he or she is free from the burden of oral and craniofacial diseases and conditions.[1] Dental caries is the single most common chronic disease of childhood, occurring five to eight times as frequently as asthma, the second most common chronic disease in children.[1] Despite the reduction in cases of caries in recent years, more than half of all children have caries by the second grade, and, by the time students finish high school, about 80 percent have caries.[1] Dental caries is a preventable disease. With the use of fluorides, good diet, good hygiene practices, and dental sealants, virtually all dental caries can be prevented.[1]

Dental caries has declined significantly among school-aged children since the early 1970s. For adolescents and youths, dental sealant prevalence has increased and dental caries have decreased. However, the prevalence of dental caries in the primary dentition for youths aged 2–5 years increased from 1988–1994 to 1999–2004. [2]

Pit-and-fissure dental sealants, plastic coatings bonded to susceptible tooth surfaces, have been approved for use for over forty years and have been recommended by professional health associations and public health agencies. First permanent molars erupt into the mouth at about age 6 years. Placing sealants on these teeth shortly after their eruption protects them from the development of caries in areas of the teeth where food and bacteria are retained. If sealants were applied routinely to susceptible tooth surfaces in conjunction with the appropriate use of fluoride, a large percentage of tooth decay in children could be prevented. [2]

Dental sealants are a proven, safe, and cost-effective caries prevention strategy that has been available since the 1960's, but did not become widely used until the 1980's. [3] Despite the availability of this protective intervention, in Connecticut only 38% of third graders had received sealants, [4] 12% lower than the Healthy People 2010 oral health objective of 50%. [5]

The Connecticut Department of Public Health (CT DPH), Office of Oral Health, created in 2005, promotes the oral health of Connecticut residents and the reduction of disease and health disparities to ensure the public's overall health and well-being. To accomplish this mission, one of the objectives of the Office is to plan, develop, implement and evaluate oral health programs and services. One program that has never been established in Connecticut is a statewide dental sealant program.

In 2008 the Connecticut Department of Public Health, Office of Oral Health entered into a cooperative agreement with the Centers for Disease Control and Prevention (CDC) to fund a "State-Based Oral Disease Prevention Program" to create, strengthen and enhance the infrastructure and capacity of state and territorial health departments in planning, implementing, and evaluating population-based oral disease prevention and promotion programs. One of the essential components to a strong state oral health

program is a statewide dental sealant program. This dental sealant plan for Connecticut will describe our plans to implement a statewide dental sealant program.

State Overview

Connecticut is New England's second smallest and southernmost state. In 2009, Connecticut ranked twenty-ninth in population with 3.5 million people.[6] In 2008, Connecticut ranked third nationally in median household income ($68,595) and fourth in percent of population with a bachelor's degree or more (34.6).[7]

Although Connecticut is viewed as one of the wealthiest states in the nation, income levels are not evenly distributed across the state. Southern Fairfield County, which borders New York, boasts affluent towns with median household incomes in the $100,000 - $200,000 range according to the 2008 Census Estimates. On the other end of the spectrum is the city of Hartford with a median household income of $25,000.[8]

In Connecticut, 9.1% of the population lives below the federal poverty level compared to 13.2% of the nation's population, according to 2008 estimates from the U.S. Census Bureau's American Community Survey.[9]

In 2007, 10.6% of Connecticut children under 18 (85,530 children) lived in a family with income below the Federal Poverty Level ($21.027 for a two-parent family with two children). A 2008 Connecticut Commission on Children report, indicated that children living in poverty are unevenly distributed across Connecticut's 169 towns. While 38 towns had child poverty rates of less than 2% in the 2000 Census, seven towns had a rate above 23%, led by Hartford. In 2007, the state's largest cities had extremely high child poverty rates -- Hartford (47.0%), Waterbury (31.4%), New Haven (28.7%) and Bridgeport (28.4%). [10]

Having some of the wealthiest as well as some of the poorest cities in the nation has earned the state the title of the "Two Connecticut's". [10]

State Dental Sealant Objectives

The Office of Oral Health, as part of the Connecticut Coalition for an Oral Health Plan, published our first state oral health plan, *Oral Health Improvement Plan for Connecticut, 2007- 2012*. One of the objectives of the plan is that fifty percent (50%) of Connecticut's children should receive age appropriate dental sealants.[11] This objective is in line with the Healthy People 2010 (HP 2010) objective, 21-8 to increase the proportion of children who have received dental sealants on their molar teeth**.** The target for this HP2010 objective was to have an increase from the 1988 – 1994 baseline of twenty-three percent (23%) of children aged 8 receiving dental sealants to fifty percent (50%) and for adolescents, from 15% to 50%.[5] The objective for the statewide sealant plan will align with both our state plan objective and the HP 2010 objective to increase the percentage of children receiving age appropriate dental sealants to 50%.

Baseline dental sealant data was collected in the first Basic Screening Survey (BSS) conducted in Connecticut to assess the oral health of Connecticut's children during the 2006 to 2007 school year. The BSS is a nationally recognized tool developed by the American State and Territorial Dental Directors (ASTDD) and the Centers for Disease Control and Prevention (CDC) to standardize data collection on the oral health status of children in America and its territories. This "open-mouth" survey revealed that 38% of third grade children in Connecticut, typically aged 8 and 9, had dental sealants. The survey, called *Every Smile Counts,* included children in Head Start programs, kindergarten and third grades. No other grades were surveyed and the presence of dental sealant was not assessed in either the Head Start or Kindergarten students, therefore, baseline data are not currently available for another age group. [4]

Current Infrastructure

In Connecticut, there currently is not a statewide dental sealant program either funded or administered by the Department of Public Health's Office of Oral Health. There are, however, several dental programs offered in schools that do include dental sealants as part of the services they provide. There is only one school district in the state that has a dental sealant only program for second grade students in all of their elementary schools. All of the other school-based dental programs provide varying levels of services. These consist of programs that offer only oral health education; oral health education, screenings and referrals outside of the program for the child's restorative needs; oral health education, preventive services and referral outside of the program for the child's restorative needs; or programs which offer comprehensive dental care. These programs are funded by a variety of resources such as patient fees, local health departments or regional health districts, boards of education, school-based health centers, foundations, a hospital, grants and federally qualified health centers. [12]

Elementary schools are the primary location for the majority of the school-based dental programs that offer dental sealants as one of their clinical services. There are, however, some middle schools and high school with dental programs. For the purposes of this Plan, elementary school-based programs will be the primary focus. There are **43** towns/cities in Connecticut with school-based/linked dental programs in a total of **229** elementary schools that provide dental sealants. [12]

The school-based dental services in these locations are offered in fixed dental sites, mobile vans, using portable dental equipment or a combination of them all. Some offer services throughout the schools utilizing full-time or part-time staff that are stationed at only one school or rotate among the schools. Others, in particular the mobile vans and those who use portable equipment, will set up at the schools for a period of time, screen the children and stay at that school until the children's dental needs are met, whether they be preventive and/or restorative. Staffing for the programs is dependent on which services are offered, with the majority of the programs employing dental hygienists. [12] In CT, registered dental hygienists with two years of clinical experience, can provide dental hygiene services, which includes dental sealant placement, without the supervision of a dentist.[13]

Obtaining parental consent varies from program to program, the majority of which are positive consent. In one of the larger, long standing programs, parents sign a consent form when their child enters into the school system and is good for the entire time the child stays in the school system, even if they transfer within schools. The programs that provide services on a regular basis in the schools typically will include the consent form for parents to sign if they want their children to receive dental care, along with all the other forms parents complete in the beginning of the school year, which is good for that school year only. Others distribute the consent form through the teachers or school nurses at the beginning of the year. [12]

Needs Assessment

Free and Reduced Lunch Program

The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or free lunches to children each school day. [14]

This program typically referred to as the Federal Free and Reduced Lunch Program (FRLP) has various means to determine a child's eligibility to participate. A child is automatically eligible for this program if they meet one of the following criteria:

- A member of the child's household is receiving assistance under the Food Stamp Program, the Food Distribution Program on Indian Reservations or Temporary Assistance for Needy Children Program;
- Enrollment in Head Start;
- A migrant child;
- A homeless child;
- A runaway child who is receiving assistance from the program under the Runaway and Homeless Youth Act.[12]

A child can also be eligible for the program as determined by their household size and income levels. The Secretary of Agriculture annually prescribes the guidelines for this eligibility. The 2009 guidelines were at or below 130 percent of Federal poverty level and the reduced price guidelines are between 130 and below 185 percent of the Federal poverty guidelines.[12]

With 2009 Federal poverty guidelines, 130% of the Federal poverty level for a family of four translates into an annual income at or below $28,665. For 185% of the Federal poverty guidelines for a family of four, the annual income would be at or below $40,793.[12]

For the purposes of this dental sealant plan's needs assessment, data was collected on the number of schools with 40% to 49%, and those with 50% or more of the second grade student population participating in the FRLP. Second grade was chosen, as this is the grade typically targeted for dental sealant placement in elementary schools. The following tables illustrates, the number of second grade children and schools with high percentage of students participating in the FRLP in Connecticut, during the 2007-2008 school year. (see Table 1) [15]

Table 1: Number of Connecticut 2nd Grade Students & Schools with High % FRLP Participation		
FRLP Participation	Schools	2nd Grade Students
40%- 49%	31	2028
50% & over	161	10,440

It is of note that the schools with the highest participation are in the larger urban areas, as well as the more rural communities in the state. [15]

Oral Health Status of Children in Connecticut

Prior to 2007, very little oral health data existed for Connecticut. The only oral health data collected on a regular basis was collected as part of the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing telephone survey of adult residents 18 years of age and older. The BRFSS provides data on health behaviors, risk factors, and health conditions. Data on tooth loss from dental caries and/or periodontal disease, dental visits, access to dental services, and annual dental cleanings are collected through the BRFSS every year, but data on dental sealants was collected only in 2004 in a state-added question.

Respondents were asked if there were any children in the household between the ages of 6 and 15 years of age and whether they had dental sealants placed on their teeth. Among respondents, 54% reported the presence of sealants. The data revealed that the presence of dental sealants was related to both income and race (see Figures 1, 2).[4]

Table 3: Percentage of Connecticut Third Grade Students with at least one dental sealant, by Race/Ethnicity, Every Smile Counts, 2006-2007.		
	Number	Percentage
Overall	4,400	38.1%
White, Non-Hispanic	2,852	40.9%
African-American	476	25.5%*
Hispanic	437	38.8%
Asian	86	44.7%
Other/Unknown	581	35.0%

* Significantly different from White, Non-Hispanic ($p<0.05$)
Source: Connecticut Department of Public Health: Office of Oral Public Health. Every Smile Counts: The Oral Health of Connecticut's Children. Hartford, CT: Connecticut Department of Public Health, December 2007.

During the 2006 – 2007 school year, The Office of Oral Health completed its first Basic Screening Survey (BSS) called “Every Smile Counts”. This survey was conducted in a stratified sampling of Head Start, Kindergarten and Third grade students enrolled in each of the 8 counties in Connecticut. Data collected included decay experience, untreated decay, treatment urgency and the presence of dental sealants among third graders. Also collected were race/ethnicity, age, and the percentage of children in the school that participated in the federal “Free and Reduced Lunch Program” (FRLP).[4]

Data collected on 4,440 students found that 38.1% of Connecticut third-graders had dental sealants, significantly higher than the national estimate of 20.28%, but still shy of the Healthy People 2010 goal of 50% [4]
In Connecticut, African American third-graders were significantly less likely to have received dental sealants than their White, non-Hispanic peers (25.5% vs. 40.9% respectively) (see Table 3) [4]. The percentage of students with dental sealants did not differ significantly with respect to the number of students enrolled in the school who were eligible for Free/Reduced Lunch (a proxy for the income status of enrolled students’ families) [4]

The following figures illustrate additional key finding that demonstrated the oral health status of Connecticut during 2006-2007. This survey will be repeated during the 2010-2011 school year targeting kindergarten and third grade.

Figure 4: Decay Experience & Untreated Decay Head Start, K and Third Grades

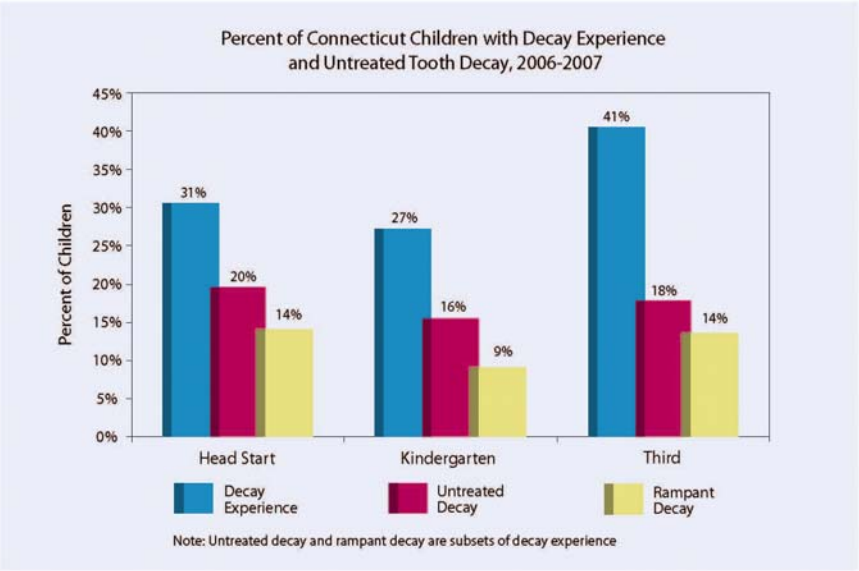


Figure reference: Connecticut Department of Public Health**.** *Every Smile Counts: The Oral Health of Connecticut’s Children*. Office of Oral Health, 2007.

Decay experience means that a child has had tooth decay in the primary (baby) and/or permanent (adult) teeth during his or her lifetime. Decay experience can be past (fillings, crowns, or teeth that have been extracted because of decay) or present (untreated tooth decay or cavities).

Figure 5: Oral Health Status of CT Kindergarten & Third Grade Students

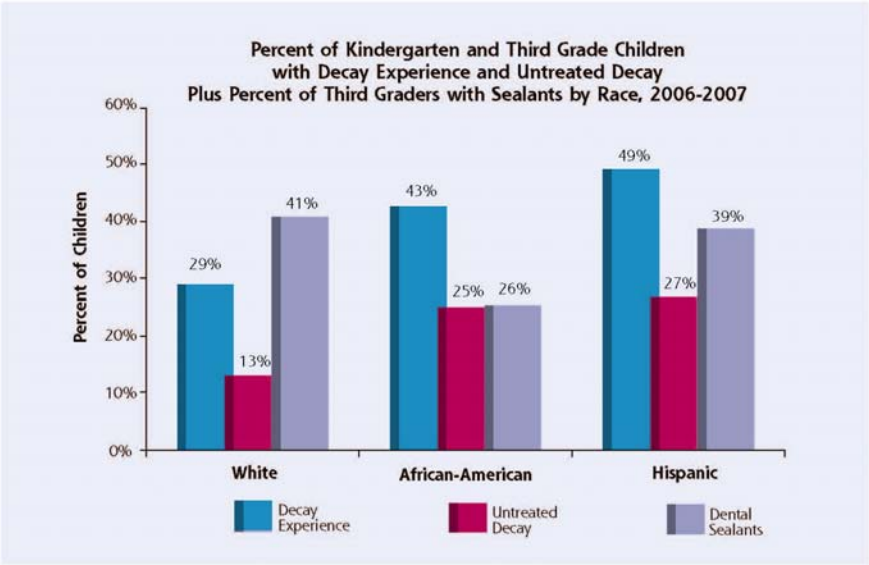


Figure reference: Connecticut Department of Public Health. *Every Smile Counts: The Oral Health of Connecticut's Children*. Office of Oral Health, 2007.

Access to Care

HUSKY - Connecticut's CHIP Program

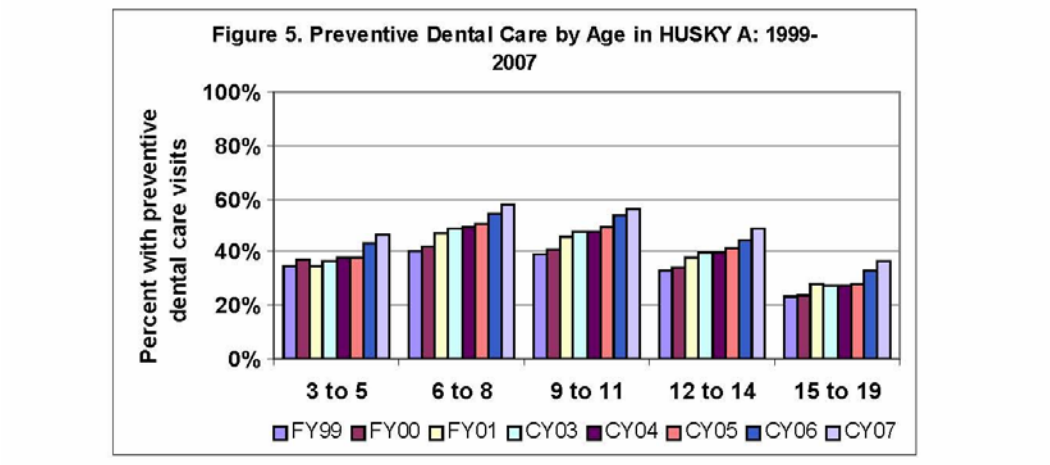
Connecticut's Children's Health Insurance Program (CHIP) is called the HUSKY program. It consists of 2 components, HUSKY A, which is free insurance coverage for children and families with incomes at or below 185% of the Federal poverty level and pregnant women at or below 200% of the guidelines. The second component, HUSKY B, provides health care coverage for children and families with some co-payments for children and families with incomes at or below 200% of the Federal poverty level, but also provides coverage with co-payments and monthly premiums on a sliding scale for children and families with incomes up to 400% of the Federal poverty level. Under both Husky A and B, children are eligible for health care coverage until 19 years of age, but dental coverage is available until the age of 21. [16]

A report produced by the Connecticut Voices for Children in 2007 demonstrates in 2007, 9% of children enrolled in HUSKY, aged 3 to 19 had at least one sealant placed, with an average of 4.41 sealants per child. Children aged 6 to 8 and 12 to 14 had the highest sealant rates (14.6 and 14.7%, respectively). The percentage of children with sealants has increased steadily over previous years (from 8.3% with an average of 3.37

sealants per child in 2006 and 7.0% with an average of 3.37 sealants per child in 2005).[17]

This report indicated that there was an increase in preventive dental visits for children on HUSKY from 1999 to 2007 (see figure #6)[17], however finding a private dentist that accepted HUSKY was difficult.[17]

Figure #6. Preventive Dental Care in Husky A



One of the primary reasons indicated for the shortage of private dentists accepting the HUSKY insurance in 2007 was the fact that very few dentists participated in the HUSKY program due to the exceptionally low reimbursement rates for dental services. Until 2008, there had been no enhancement of the reimbursement rates for children since 1993. [18]

In 2008, as a result of a class action lawsuit,[18] the reimbursement rates increased significantly for children's dental services (see Table 4). [19] At the time, dental services under the HUSKY program were "carved out" of the Medicaid managed care system and are now administered by one Administrative Services Organization (ASO), as opposed to the multiple administrators in the past.

This ASO has been named the Connecticut Dental Health Partnership (CDHP), which consists of the Department of Social Services through which the dental providers are credentialed and claims are processed and paid and Benecare Dental Plans (administrator of CDHP) which provides provider recruitment, care management, (which includes appointment scheduling, transportation and translation assistance) and outreach, both at the patient and community level. These services are provided focusing on the "dental home"/primary care dentist concept. [20]

This new system has had a dramatic impact on the number of providers who now accept HUSKY. In 2007, there were less than 300 dentists participating as providers in the HUSKY program out of the nearly 3000 practicing dentists in the state.[21]

As of May 2010, there are 1067 dentists (including specialists) and 89 dental hygienists enrolled as providers under the HUSKY program (see Table 5).[19]

Table 4: Example of HUSKY Dental fee schedule increase effective April 1, 2008

Code	Old Rate (Prior to August 2008)	New Rate (After August 2008)
Oral Exam	$18.80	$35.00
Cleaning	$22.56	$46.00
Fluoride	$15.75	$29.00
Sealant	$18.46	$40.00

Table 5: Participating Dental Practitioners as of May 2010

County	Endo	General Dentists	Oral Surgeons	Ortho	Pediatric Dentists	Perio	Hygienists		Totals
FAIRFIELD	4	164	11	6	20	0	24		229
HARTFORD	5	239	28	23	30	0	26		351
LITCHFIELD	0	34	2	1	3	0	0		40
MIDDLESEX	0	37	1	1	8	0	10		57
NEW HAVEN	7	176	28	13	20	0	11		255
NEW LONDON	2	39	3	2	6	0	6		58
TOLLAND	0	24	1	3	2	0	0		30
WINDHAM	0	32	0	1	0	0	4		37
Out of State		58		3					61
Totals	18	803	74	53	89	0	81		1,118

HUSKY Enrollment

As of June 2010, there were more than 560,000 children and adults enrolled in HUSKY. This covers nearly 1 in 3 of Connecticut's Children and is the largest dental plan in the State. This includes:

- HUSKY A (Medicaid for children & caregivers)
- HUSKY B (SCHIP for children)
- Title XIX / Fee-for-Service (Traditional Medicaid)
- SAGA (Assistance program for single adults). [19]

Safety Net Dental Providers

The dental safety net system in Connecticut is made up of dental clinics owned and operated by public and private sector organizations and provides services to the underserved populations that have difficulty obtaining care in the private sector. Most safety net care is delivered in community dental clinics such as Federally Qualified Health Centers (FQHC) and look-a-like community health centers (CHC), school-based/linked programs, hospital dental clinics and dental education programs. [24]

There are 25 dental clinics located in 17 towns associated with community health centers. [22] They accept all patients regardless of their ability to pay. Some CHCs receive significant additional public subsidies that are not available to non-federally qualified health centers. [22]

In 2008, the Connecticut community health center safety net system included 49.69 Full Time Equivalent (FTE) dentists, 39.33 FTE registered dental hygienists and 79.99 FTE dental assistants. The CHCs in Connecticut provided 209,723 dental patient visits that year. [23]

Another *important* part of the safety net system are dental clinics associated with public schools. School-based/linked dental services across the state are offered to school age youth through a variety of different venues: 1) within existing school-based health centers, 2) fixed –equipment school-based dental sites, 3) through mobile vans and portable dental equipment that provide periodic visits to multiple schools or 4) a combination of all three. These safety net dental systems can be administered by community health centers, hospitals, local health departments or public school systems. [12]

As of March 2010, a total of 36 dental clinics are located in existing school-based health centers (SBHCs). Dental services within existing SBHCs are located in thirteen of the 169 towns in Connecticut. [12]

Currently, there are 364 schools in 50 Connecticut towns/cities (including SBHCs) that offer clinical dental services. These services range from programs that offer preventive and educational services to full comprehensive services (education, prevention, & restorative). [12]

In addition to the community health centers and school-based/linked programs that offer dental services, CT has 12 hospital clinics that provide dental care. Three of these hospital programs offer services only to children with special health care needs; one is a pediatric clinic and one offers only oral surgery. [24]

The services offered through Connecticut's dental professional's education system provide another resource that makes up the dental safety net in our state. There is one dental school, the University of Connecticut, School of Dental Medicine, which offers a wide range of dental services provided by dental students and their attending dentists.[24]

Our state has 4 dental hygiene schools, one of which is Fones School of Dental Hygiene, which is the birthplace of the profession of dental hygiene. [25] These schools provide valuable prevention and educational services within their school clinics, as well as oral health education in schools, nursing homes, Head Start programs prisons and special needs populations. [24]

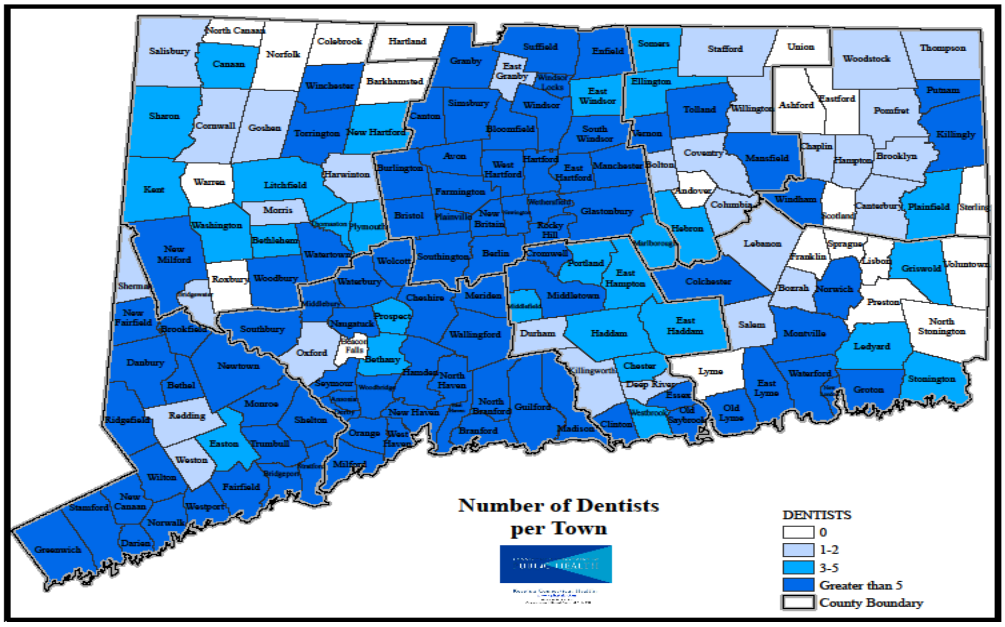
While these safety net programs improve access to dental services, they not provide statewide coverage or adequate coverage for those areas of the state with few or no dentists.

Distribution of Dentists

The US Bureau of the Census has estimated that the population of Connecticut was 3,405,584 in the year 2000. [26] The number of professionally active dentists in the state of Connecticut for that year was 2,591. Most (74%) were general practitioners, 10% were women, 28% were specialists, with only 3% pediatric dentists. The mean age was 52 years. [21]

According to data from the 2000 U.S. Census, the ratio of practicing dentists to the overall population in the state was 1:1,514.42.[21] However, Connecticut's dentists are not adequately distributed to serve the needs of the population. Windham County's dentist to population ratio in 2000 (1:2,728) was more than double that of Fairfield County, which had the best dentist to population ratio (1:1,277).[21] Approximately 12% of towns (more than 60,000 residents) in Connecticut have no professionally active dentists and almost 45% of towns in Connecticut have five or fewer dentists . (see Figure #7) [21]

Figure 7: Distribution of Dentists by Town based on 2000 Census



The Connecticut population is projected to increase in the next 15 years. In contrast, the number of professionally active dentists has stopped growing and, since 1991, has started to decline. This situation is expected to continue as the dental workforce declines.[21] Additionally, the number of Connecticut dentists expected to retire from practice may exceed the number of new dentists expected to enter practice, during the period from 2001 to 2015.[21]

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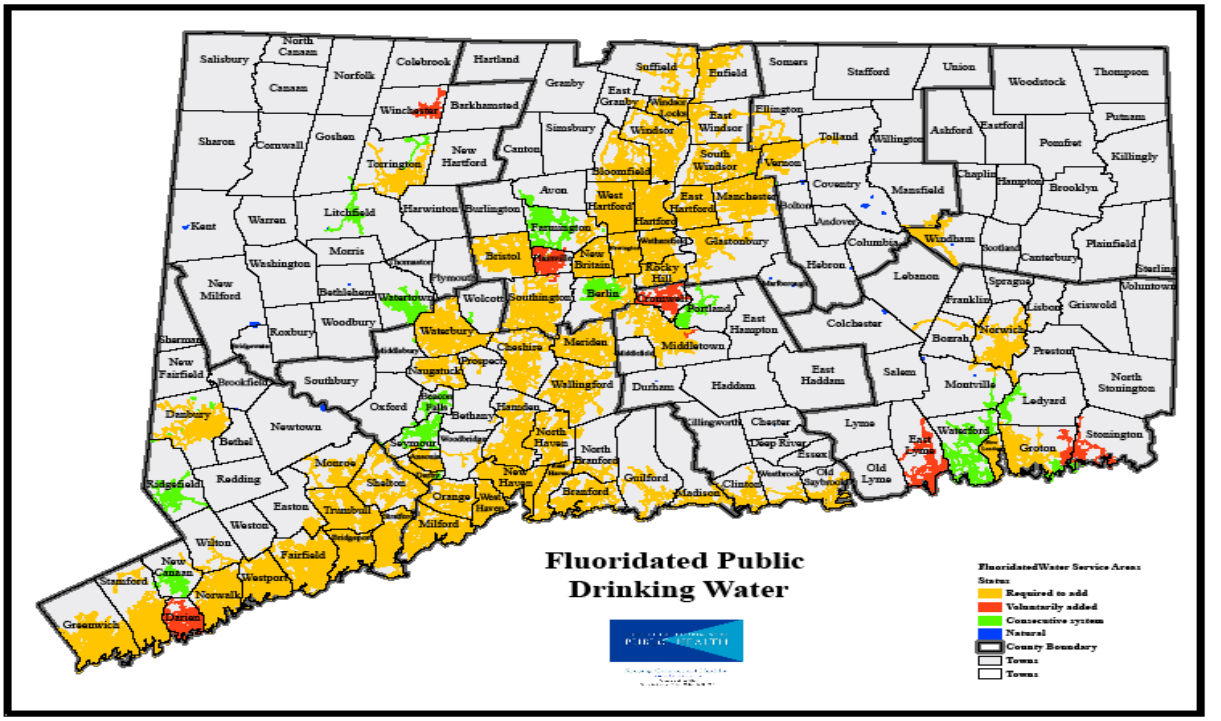
It is estimated that by 2015 there will be a net loss of approximately 15 percent of the dental workforce.[21] Because of continued decreases in numbers of dentists and increases in fees, access to dental care is likely to become more difficult for the entire population, but particularly for the working poor, ethnic and racial minorities, the elderly, children, and those with public dental insurance.[21]

Community Water Fluoridation

In 1965, a mandate was established that requires all public water systems in Connecticut serving 20,000 or more people, to add fluoride to the water, maintaining an optimal fluoride content between 0.8 mg/l and 1.2 mg/l.[27] For Connecticut, the most benefit to oral health is achieved when waters are fluoridated to 1.0 mg/l.[26]

In Connecticut, there are 33 public water systems that adjust their fluoride levels and some of these water systems sell their fluoridated water to other public water systems as well. Connecticut is fortunate to have 30 public water systems that are considered naturally fluoridated (0.8 –1.2 mg/l) (see Figure 8).[27]

Figure 8: Water Fluoridation in Connecticut



Dental Sealant Pilot Program

As Connecticut does not have an existing statewide dental sealant program, the initial stages to develop a statewide program will be to implement a demonstration dental sealant pilot that will be evaluated and can be integrated throughout the state.

Connecticut is a relatively small state and throughout the state there is a wide variety of oral health focused services offered in schools, which range from a dental professional who may be a parent of a child in a school offering oral health education to a classroom, all the way to full restorative and preventive services provided in a school or district.[12]

Elementary schools are the primary location for the majority of the school-based/linked dental programs that offer dental sealants as one of their clinical services. For the purposes of this Demonstration Pilot, elementary school-based/linked dental programs will be the primary focus. There are **43** towns/cities in CT with school-based/linked dental programs in a total of **229** elementary schools that provide dental sealants [12] This represents a third (33%) of the 687 public, charter and magnet elementary schools in Connecticut.[28]

The Connecticut Dental Sealant Demonstration Pilot will center on these existing school-based dental sealant programs and the integration of SEALS into their programs. By utilizing the capacities of the SEALS software, the existing programs will have the means to collect valuable dental sealant data such as, student demographics; oral health status; retention rates, and cost/benefit analysis, in addition to being able to, for the first time, provide comprehensive, statewide dental sealant data to the Office of Oral Health. Without these data, the only resource for statewide dental sealant data is the utilization rates from the HUSKY program, which does not include those elementary school children who may have private insurance or no insurance at all. In addition to the above mentioned benefits, school-based/linked dental programs and the state will have significant dental sealant data to pursue funding opportunities that can enhance and expand dental sealant delivery systems for Connecticut's children. This pilot will be conducted during the 2010-2011 school year.

A dental sealant advisory has been convened, consisting of representatives from the existing school-based/linked dental programs and other stakeholders from around the state. The initial meeting consisted of an introduction to SEALS and all of its capabilities, an overview of the draft Connecticut Dental Sealant Plan and the proposed demonstration pilot. The reaction to SEALS was very positive, especially for some of the small programs with few data collection resources. Several programs requested a training session in SEALS over the summer months and those that do not operate request training in September 2010. All attending were assured that technical assistance will be available to them as long and as often as needed to make the pilot a success. Subsequent to this initial meeting, the Dental Sealant Coordinator has meet with the program managers from two of the Community Health Centers that provide dental services to a number of schools in the state; to discuss the possibility of

exporting data they already collect in the schools, into the SEALS software in an effort to collect uniform statewide data.

A second meeting is scheduled for the beginning of September 2010 with quarterly meeting thereafter. These meetings will provide an opportunity to share their experiences with SEALS, both positive and negative, as well as a forum to discuss their programs, share their successes and learn from each other. These learning opportunities and utilization of SEALS can only enhance the school-based/linked dental services in our state.

The evaluator for the Office of Oral Health will evaluate the effectiveness and ease of utilization of the SEALS software after the end of the 2010 – 2011 school year and results will be provided to our Cooperative Agreement Program Manager and Evaluator for review.

Sustainability

Several factors will ensure the sustainability of the existing school-based/linked dental programs that offer dental sealants to students. First, maintaining a reasonable reimbursement rate for dental services for children under the HUSKY program is essential. Several of the existing programs report that the recent increases in reimbursement rates have resulted in increased revenues and a dramatic impact on their ability to continue or expand their prevention programs. This in large part is due to the fact that most of the programs employ dental hygienists, whose salaries are much lower than those provided to dentists.[12]

Next, funding opportunities need to be explored. On a state level, the Office of Oral Health will be discussing with our Maternal and Child Health Branch, the availability of funds through the Maternal and Child Health Block Grant (MCHBG) which the state receives, to fund expansion of existing programs or developing new programs. In addition, all grants and other funding opportunities to promote, provide education or fund dental sealant delivery in our state will be pursued.

On a local level, existing programs will need to seek funding from community foundations and/or organizations to help sustain or enhance their programs. Any technical support in grant writing or collaboration opportunities will be made available to the programs.
Armed with the data gathered by utilizing SEALS, these programs will be in a much better position to request financial support to ensure their sustainability to provide school aged children dental sealants in school-based/linked programs.

Expansion of Dental Sealant Programs

The state of Connecticut does not currently administer or fund a statewide dental sealant program. In an effort to develop a statewide system of uniform data collection on school-based/linked dental sealants, existing programs will be encouraged to utilize

the SEALS software as part of the Statewide Dental Sealant Demonstration Pilot during the 2010 -2011 school year and beyond. By capitalizing on the many beneficial features of SEALS, the programs will have valuable data to pursue funding opportunities that can increase the number of children receiving dental sealants in the schools in which they already operate or expand to new schools and/or districts. In addition, the opportunity to collect statewide dental sealant data will enhance the Office of Oral Health's efforts to obtain resources and funding to promote the efficacy of dental sealants, the benefits and cost effectiveness of providing dental sealants in schools, enhance existing programs and/or developing new school-based/linked dental sealant programs where none currently exist.

The establishment of a statewide dental sealant advisory will provide increased communication relative to school-based/linked dental services in the state and can lead to the development of collaborative opportunities to enhance or expand dental sealant delivery in schools across Connecticut.

Based on the results of the Basic Screening Survey "Every Smile Counts" of third grade students in Connecticut during the 2006-2007 school, we must do a better job in promoting and delivery dental sealant placement in our state, especially in school-based/linked settings. That survey indicated that only 38% of third grade students had at least one molar protected by a dental sealant. [4] This is short of the Healthy People 2010 goal [5] and the Connecticut Oral Health Improvement Plan objective, that at least 50% of third grade students have dental sealants on a molar [11].

The goal of Office of Oral Health and all of its stakeholders will be to increase the percentage of children receiving dental sealants, in particular second grade students to 50% by 2015. This will be accomplished by more children having access to school-based/linked dental programs to provide dental sealants, maintaining reimbursement rates under the state's HUSKY program, educating dental providers and parents in the efficacy and cost effectiveness of dental sealants, developing collaborations and pursuing funding opportunities on a statewide and local level that will enhance or expand school-based dental and/or dental sealant programs.

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