

# REACHING NEW HEIGHTS IN HEALTH WITH SCHOOL-BASED ORAL HEALTH PROGRAMS

## WHITE PAPER



MASSACHUSETTS COALITION FOR ORAL HEALTH

2011



**The Massachusetts Coalition for Oral Health (MCOH) is comprised of public and private sector organizations whose mission is to promote effective community preventive measures to improve the oral health of all Massachusetts residents.**

**The Massachusetts Coalition for Oral Health is committed to improving oral health through education, prevention, access to care, and health promotion.**

**The Massachusetts Coalition for Oral Health:**

- **Operates as an oral health “think tank.”**
- **Writes policy and position papers that support oral health initiatives across the state.**
- **Provides consultation to communities and organizations.**
- **Acts as the “Go To” organization for up-to-date, scientific oral health information, resources, and recommendations on prevention, fluoridation, access, and other oral health issues.**

**For more information about MCOH and for other oral health resources go to [www.bu.edu/mcoh](http://www.bu.edu/mcoh)**



**All information contained in this White Paper is based on current literature in the year 2011.**

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## SCHOOL-BASED ORAL HEALTH PROGRAMS

### I. CHILDREN'S ORAL HEALTH



Tooth decay is the single most common chronic childhood disease, occurring five to eight times as frequently as asthma.<sup>1</sup> Oral health problems affect our ability to eat certain foods, the way we communicate, how we view ourselves, and how others perceive us. A major theme of the Surgeon General's Report on Oral Health<sup>2</sup> is that oral health means much more than healthy teeth and gums. It means being free from oral pain, oral cancers, birth defects, and other diseases or problems that affect our daily functioning.

Children who have decay, abscesses, and chronic dental pain are more frequently absent from school. In fact, more than 51 million school hours are lost each year to dental related illness.<sup>2</sup> Additionally, children who are in pain from tooth decay cannot concentrate on, nor excel in, their school work and are unable to actively participate in their learning environments.

There are many barriers to dental care that cause children to needlessly suffer from dental disease. School-based oral health programs are one way to overcome these obstacles and ensure equal access to oral health services for all children. In taking steps to eliminate the oral health disparities that we currently see across the State, it is important to include pediatric and family physicians, school health providers, and parents/caregivers. Collaborative, community-based oral health promotion programs are vital to improving the oral health of the children in Massachusetts.

### II. PREVALENCE OF DENTAL DISEASE IN MASSACHUSETTS' CHILDREN

Dental disease in Massachusetts' children has been well documented. In 2008, a report<sup>3</sup> was issued from the Catalyst Institute describing the results of a statewide survey of children's oral health. The report showed that children in the Commonwealth suffer from significant levels of dental disease, with at least one in every four children having experienced dental disease by grade six. Almost 18% of third grade students in Massachusetts are attending school with untreated dental disease.



The report also indicated that disparities exist among our state's children. Children from racial and ethnic minority groups experience 1.5 times more dental caries (cavities) as compared to their white, non-Hispanic peers. Additionally, children from low income families experience almost 2 times more dental caries as compared to their peers from higher income families. Furthermore, children from racial and ethnic minority groups and children from low income families are less likely to have their dental disease treated.

### III. PREVENTING DENTAL DISEASE

#### FLUORIDE AND FLUORIDATION

Fluoride, a naturally occurring element, plays a critical role in the prevention of tooth decay. By adjusting the naturally occurring fluoride levels found in public water supplies there is less tooth decay in the population being served. Topical fluorides, such as toothpastes, rinses and professionally applied fluoride treatments provide a complimentary benefit for the prevention of tooth decay.

#### COMMUNITY WATER FLUORIDATION



Community water fluoridation, adjusting the naturally occurring levels of fluoride in the drinking water to those most optimal for preventing tooth decay, should be the foundation for improving the oral health of everyone in a community. Community water fluoridation is the most cost-effective preventive measure for tooth decay, as everyone in the community benefits. It is estimated that for every \$1 spent on fluoridation, there is a savings of \$38 in future dental treatment that will not be needed. At the recommended level, fluoride is safe, odorless, colorless, and tasteless. For an up-to-date listing of fluoridating communities in Massachusetts contact the Massachusetts Department of Public Health at

[www.mass.gov/dph/oralhealth](http://www.mass.gov/dph/oralhealth)

#### TOPICAL FLUORIDE

Topical fluoride provides an added benefit to community water fluoridation when it is used on a regular basis; though not all topical fluorides are equal in their effectiveness at preventing tooth decay. Professionally applied fluoride treatments administered by dentists, dental hygienists, physicians, nurses, and other health practitioners, come in the form of a gel or foam in trays or more recently, as a painted on varnish; and may be more effective at preventing tooth decay. A person at moderate to high-risk for tooth decay usually receives at least two or more professionally applied fluoride treatments each year. Over-the-counter topical fluoride may be found in toothpaste or mouth rinses and are an important component for preventing tooth decay. Everyone benefits from the daily use of fluoridated toothpaste.



In communities that don't have the benefit of community water fluoridation, fluoride mouth rinse programs may be implemented in schools. If you are a school in a non-fluoridated district, you can contact the Massachusetts Department of Public Health's Office of Oral Health at 617-624-5942 to see if school mouth rinse programs would be right for your school.

## DENTAL SEALANTS

Dental sealants are a thin layer of plastic material that is applied to the pits and fissures of the occlusal (chewing) surfaces of posterior (back) teeth in order to prevent dental decay. Sealants act as a physical barrier, preventing decay-causing bacteria from entering the difficult to clean deep grooves, where 90% of all dental decay in school-aged children occurs. Dental sealants are most frequently applied to permanent first and second molars soon after eruption because these teeth are at greatest risk for decay.

The application of dental sealants has proven to be a safe and effective means to prevent dental caries (tooth decay) as

well as to remineralize or stop the progression of early carious lesions. In fact, sealants are reported to be 100% effective for as long as they are completely retained on the teeth. There are two important factors that influence sealant retention. The first is the use of appropriate sealant material.<sup>6</sup> Resin-based sealants are the first choice of material for dental sealants due to their high retention rates;<sup>4</sup> therefore, all school-based programs should use resin-based sealant material. The second factor impacting retention is the ability to keep the tooth dry during the placement of the sealant. This is more complicated to evaluate because it is related to many factors including the operator's skill, procedures, and equipment as well as the child's cooperation. School sealant programs should be expected to maintain a retention rate of greater than 80% of the sealants that are placed.



Healthy People 2010<sup>5</sup> reports that “if sealants were applied routinely to susceptible tooth surfaces in conjunction with the appropriate use of fluoride, most tooth decay in children could be prevented,” and has set a goal for 50% of all third graders in the United States to have dental sealants on at least one permanent first molar tooth by the year 2010. Currently, just under 50% of Massachusetts’ third graders have dental sealants.

## IV. SCHOOL-BASED ORAL HEALTH PROGRAMS

### IMPROVED ACCESS

School-Based Oral Health Programs (SBOHP) are specifically designed to improve access to dental care by reducing barriers **for all children**. Typically, children with the most needs are the ones that are best served in SBOHP, but all children can benefit from the services provided by their school's program.

These services typically include:

- Dental education,
- Oral screenings,
- Fluoride applications,
- Sealant placement, and
- Referral for follow up dental treatment.



Children benefit from receiving oral health screenings and the dental care they may need while at school, in a familiar and non-threatening environment. SBOHP often benefit parents as well. For some parents, taking time during the work day to take a child to a dental appointment can be difficult – having dental services at school may mean that parents do not have to take time off from work for their child's dental appointments. In addition, school-based oral health care may eliminate barriers such as transportation and most programs welcome parents to their child's appointment. In all cases, SBOHP keep parents informed by providing clear notification of the child's condition and the treatment he/she received.



For schools, these programs offer the benefit of reducing time out of the classroom for each child who might otherwise take time during the day for a trip to the dentist. The presence of a program in a school allows teachers to integrate the importance of oral health into their classrooms, and demonstrates to parents and children that the school is committed to the total welfare of their students.

Another serious barrier to dental care access is the lack of availability of dentists in a community, particularly dentists who accept MassHealth (Medicaid) insurance. SBOHP are especially useful in communities that have a shortage of dentists or dentists who accept MassHealth. Eliminating this barrier by providing a SBOHP allows children's oral health needs to be addressed and relieves parents of the burden of finding a dentist/dental home on their own.

Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requires states to provide dental screenings as well as diagnostic, preventive, and treatment services to all Medicaid-covered children. While this should mean comprehensive dental coverage for children, for most children covered by Medicaid, this coverage has not resulted in actual care. The use of school-based programs can contribute to better access to dental care for these children.

### **SCHOOL HEALTH PROVIDERS' ROLE IN SCHOOL-BASED ORAL HEALTH PROGRAMS**



The school health provider has an essential role in school-based oral health programs, and the success of the program is dependent on his/her involvement and support. These health professionals often serve as an advocate to school administration and parents/guardians for oral health services to be offered in the school setting and often serve as the liaison between the school-based oral health program and others in the school.

School health providers should work in collaboration with the oral health program in a variety of areas, including providing input, as needed, on the medical histories of students participating in the program to ensure that the dental services can be provided safely. The school health provider may also collaborate on space and scheduling issues with teachers and administrators in the school so that oral health services can be delivered in a safe and efficient manner. Finally, the school health provider's promotion of the program and their involvement in the distribution and collection of the consent forms is essential for success.

School health providers may also serve as a liaison between the parents/guardians and dental program if additional health information is needed and if an immediate referral for additional dental treatment is required. In addition, the school health provider should ensure that the oral health program is providing them with appropriate and complete information on the dental services provided to each student, (see page 15). The school health provider is responsible for ensuring that proper documentation of consents, services provided and referrals are maintained in the student's school health record.

Finally, the school health provider should request from the oral health program a list of resources for follow-up dental care in the community and should be knowledgeable to address the concerns of parents/guardians after the oral health program has completed their work at the school.



## V. DENTAL CARE PROVIDED IN SCHOOL-BASED PROGRAMS

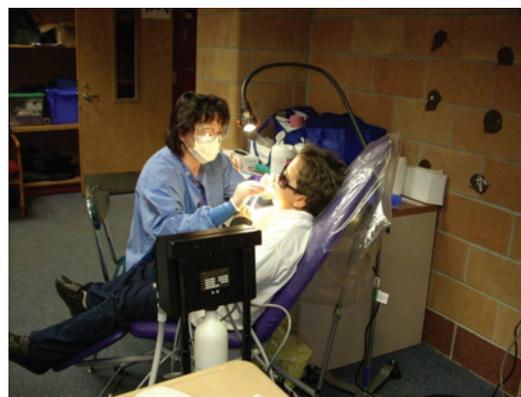
### PROGRAM TYPES



School-based oral health programs (SBOHP) can be mobile, portable, or fixed sites. Mobile dental programs utilize a full set of dental equipment that is located on a van or other mobile vehicle. Portable dental programs use dental equipment that can be transported via a car and set up within a school. A fixed clinic is one in which a full dental clinic is permanently installed within a school. Each of these oral health programs may be staffed by a variety of licensed dental professionals, including licensed dentists, limited license dentists, registered dental hygienists and/or public health dental hygienists.

There are many types of services provided by school-based programs, ranging from programs providing screenings only to those providing comprehensive dental care, and each of them can use any of the aforementioned equipment. Since individual communities have unique needs and school-based programs vary greatly, it is important to match needs with services when selecting an appropriate program. Tables 1 and 2 (see pages 11-13), provide basic information about the different types of SBOHP and can be used when selecting the appropriate program.

Due to most programs' limited resources, priority for sealant placement should be given to 6 to 8 year olds (for placement on 6 year molars), as well as to 11 to 13 year olds (for placement on 12 year molars). Most school-based programs primarily target the younger age group while a minority of programs attempt to reach those in the pre-teen to early teen years since during this time children often have more academic requirements, are more involved in sports and school activities, and are often less willing to participate in a school-based dental program.



### BILLING FOR SERVICES

Rarely, SBOHP are funded by grants that cover the costs of services provided to the children. Most commonly, SBOHP rely on the fees generated through billing for services to cover the costs of running the programs. Each program should clearly outline their billing practices in the information provided to the school and to the parent/guardian. This information should include whether insurance will be billed (if applicable) and any costs the parent/guardian may incur as a result of treatment.

**TABLE I: SCHOOL-BASED PREVENTION PROGRAMS**

<b>Program</b>	<b>Description</b>	<b>Services <u>Not</u> Typically Included</b>	<b>Equipment and Resources Needed</b>	<b>Considerations</b>
<b>Screening and Education</b>	<p>A dental professional does a visual assessment of the children’s oral health.</p> <p>Parents/guardians are notified of their children’s oral health status and a referral to care is provided for those children identified as having treatment needs.</p> <p>Oral health education is typically provided to all children in the classroom.</p>	<p>Sealants</p> <p>Fluoride</p> <p>Cleanings</p> <p>Radiographs</p> <p>Treatment</p>	<p>No dental equipment is needed.</p>	<p>No preventive or treatment services are provided to the children.</p> <p>During the assessment process children will be identified who may have untreated dental disease. Therefore, an important component of screening/education programs is to have a referral network of local dentists who are willing to diagnose and treat children who may be identified as having possible treatment needs.</p>
<b>Fluoride Rinse</b>	<p>Used in communities without water fluoridation.</p> <p>A fluoride rinse is swished in the mouth and then spit out. It is done on a daily or weekly basis, depending on resources.</p>	<p>Screenings</p> <p>Referrals for treatment</p> <p>Sealants</p> <p>Cleanings</p> <p>Radiographs</p> <p>Treatment</p>	<p>No dental equipment is needed.</p>	<p>Costs of the program will vary depending on whether one is using volunteers, existing school personnel, or paying someone just to administer the program.</p> <p>The Massachusetts Department of Public Health funds all necessary supplies for a school that is accepted into the program.</p>
<b>Fluoride Tablet</b>	<p>Used in communities without water fluoridation.</p> <p>A lozenge is used and swished in the mouth and then swallowed. It is given to children in school on a daily basis.</p>	<p>Screenings</p> <p>Referrals for treatment</p> <p>Sealants</p> <p>Cleanings</p> <p>Radiographs</p> <p>Treatment</p>	<p>No dental equipment is needed.</p>	<p>Costs of the program will vary depending on whether one is using volunteers, existing school personnel, or paying someone just to administer the program.</p> <p>The Massachusetts Department of Public Health funds all necessary supplies for a school that is accepted into the program.</p>

<p><b>Fluoride Varnish</b></p>	<p>Used in all settings.</p> <p>A resin-based fluoride varnish is applied to teeth by a dental professional. The resin quickly dries on the tooth and is absorbed over the course of several hours. Varnish is typically applied at least every six months, more often if there is a risk for tooth decay.</p> <p>Screenings and referrals are typically included in these programs.</p>	<p>Sealants Cleanings Radiographs Treatment</p>	<p>No dental equipment is needed.</p>	<p>Must have a licensed dental professional or other designated health professional apply the fluoride varnish.</p>
<p><b>Dental Sealant</b></p>	<p>Used in all settings.</p> <p>A dentist or dental hygienist will assess each child's need for dental sealants and will place the resin-based sealants. To provide the greatest benefit to children enrolled in these programs, school-based dental programs also provide fluoride varnish and/or dental cleanings.</p> <p>Priority is often given to 2<sup>nd</sup> &amp; 3<sup>rd</sup> graders (ages 6-8), as well as 6<sup>th</sup> and 7<sup>th</sup> graders (ages 11-13) for permanent teeth only.</p> <p>Oral health education is typically provided to all children in the classroom.</p>	<p>Radiographs Treatment</p>	<p>Necessary equipment: Dental Chair Light Source (Curing Light) Water and Suction Unit Compressor</p>	<p>Must have a dentist or dental hygienist apply the sealants.</p> <p>Although this program focuses on providing preventive services, during the assessments children will be identified who may have untreated dental disease. Therefore, an important component of a dental sealant program is to have a referral network of local dentists who are willing to diagnose and treat children with dental disease.</p> <p>The retention of sealants over time is an important indicator of program quality. High quality sealant programs will check the retention of the sealants they placed the previous year and should be able to provide you with a retention rate. Retention rates of greater than 80% should be expected. Most programs will also replace any lost sealants free of charge as long as the child is still enrolled in the program.</p>

**TABLE II: A COMPARISON OF SCHOOL-BASED PREVENTION AND COMPREHENSIVE PROGRAMS**

	<b>Prevention Only</b>	<b>Comprehensive</b>
<b>Services Provided</b>	<p>Dental Hygiene Examination Screenings Fluoride Sealants Referrals for Diagnosis/Treatment Cleanings*</p> <p>*Cleanings are not necessary for the placement of dental sealants.</p>	<p>Dental Examinations Cleanings Fluoride Sealants Radiographs Diagnosis/Treatment by a Licensed Dentist Fillings Simple Extractions Crowns (on baby teeth) Referrals as needed</p>
<b>Necessary Equipment</b>	<p>For Dental Sealants Only: Dental Chair Light Source (Curing Light) Water and Suction Unit Compressor</p>	<p>Dental Chair Light Source (Curing Light) Water and Suction Unit Compressor X-Ray Machine (portable)</p>
<b>Services Commonly Referred Out</b>	<p>X-Rays Dental Diagnosis/Treatment</p>	<p>Complex Fillings** Complex Extractions** Root Canals Crowns Orthodontics Services for children with behavior management needs.</p> <p>**Not all programs are created equal. Comprehensive programs may provide various and differing services. Speak with the provider about what is provided versus what is referred out.</p>

## VI. REGULATORY CONSIDERATIONS

On August 20, 2010, updated Rules and Regulations governing the practice of dentistry in the Commonwealth took effect (see “Statutes Rules and Regulations” at [www.mass.gov/dph/boards/dn](http://www.mass.gov/dph/boards/dn)).



These regulations include specific requirements for all licensed dental professionals providing services in a public health setting such as a school. The regulations also include the requirement that all mobile dental facilities (e.g. vans) and portable dental operations (e.g. dental equipment and materials used outside a dental office) must obtain a

Permit M issued by the Massachusetts Board of Registration in Dentistry effective February 20, 2011; unless they are operated under the auspices of an accredited dental school or licensed clinic or hospital.

The following information is a guide to some of the regulatory provisions that pertain to school-based oral health services. This is not a substitute for the applicable state statutes and regulations pertaining to the practice of dentistry and dental hygiene, (see [www.mass.gov/dph/boards/dn](http://www.mass.gov/dph/boards/dn) for complete and up-to-date information).

**INFORMED CONSENT:** Dental services provided in a school setting require written, informed consent and must describe the scope of services that are to be provided as well as a timeframe for the delivery of these services. Dental services may only be provided if signed consent is received from the parent/legal guardian or an emancipated minor. Oral health programs should provide the consent form(s) translated into the language(s) most appropriate for the children and families they are serving and should conform to state and local requirements for the type of service being provided.



**PATIENT AND STUDENT HEALTH RECORDS:** All dental records must be maintained in a manner that ensures confidentiality and access for the student's parent/guardian and authorized practitioners who may wish to obtain a copy of the patient record and conform to the record-keeping requirements established by the Board of Registration in Dentistry. It is the responsibility of the school health professional to document in the student's school health record all dental services and referrals made by the oral health program.

**INFORMATION SHEET:** At the conclusion of each visit, the dental professional must provide a written report to the parent/guardian, as well as the official designated by the school. The information sheet should include:

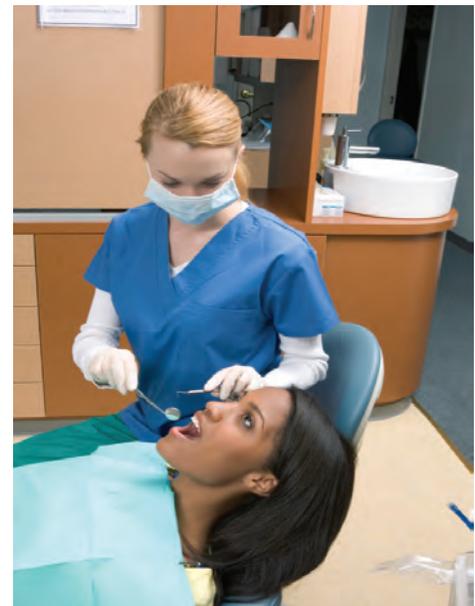
1. Results of the dental and/or dental hygiene examination;
2. The name(s) of the licensed dentist and/or dental auxiliaries who provided services;
3. A description of the treatment rendered, including billed service codes and fees associated with treatment, and tooth numbers when appropriate;
4. Information on how to contact the Mobile Dental Facility (MDF) or Portable Dental Operation (PDO);
5. A timely written referral (refer to Referral Section) to a dentist in order to address emergent needs and achieve positive oral health outcomes for the patient;
6. Names of dentists or other organizations providing dental services located within a reasonable geographic distance from the patient's home and with whom the MDF or PDO has communicated regarding acceptance of referrals; and
7. The name and signature of the dentist(s) or dental hygienist(s) providing the treatment.

**AVAILABILITY OF PATIENT RECORDS:** The patient Information Sheet and/or other written summary of the screening, examination, or treatment shall be provided to the official designated by the school.

**REFERRALS:** Dental professionals providing services in schools must have a written procedure for referral of the student's for emergency or other follow-up treatment; and must provide necessary follow-up treatment or make a timely referral for a follow-up examination and treatment by the student's dentist or by another dentist with whom the licensed provider has communicated regarding acceptance of referrals.

The dental professional must:

1. Provide the parent/guardian (student) with the names of dentists, community health centers, or dental school clinics located within a reasonable geographic distance from the patient's home and with whom the MDF or PDO has communicated with regarding the acceptance of referrals; and
2. Where consent has been granted, provide the subsequent provider with treatment information, including a copy of radiographs, within a reasonable period of time.



**INFECTION CONTROL:** All licensed providers must comply with all applicable local, state, and federal statutes, regulations, or ordinances concerning radiographic equipment, flammability, ventilation, construction, sanitation, zoning, infectious waste management, OSHA Standards at 29 CFR, *CDC Guidelines*, and for the registration and operation of a motor vehicle being used, for the provision of mobile or portable dental services.

All mobile facilities and portable dental operations must have:

1. Handicap access;
2. Equipment and sterilization systems which are necessary to comply with *CDC Guidelines*;
3. Ready access to an adequate supply of potable water;
4. Ready access to hand-washing and toilet facilities;
5. A covered galvanized, stainless steel, or other non-corrosive container for deposit of refuse and waste material as required by 310 CMR 73.00: Amalgam, Wastewater and Recycling;
6. Regulations for Dental Facilities; and
7. Equipment necessary for the services being provided.



**CESSATION OF OPERATION:** Upon cessation of the mobile facility or portable program the licensed dental professional must:

1. Notify each person (parent/guardian) who has received treatment within two years of the date of cessation of operations by letter or electronic notice or public notice in appropriate newspaper(s) or by other means which is widely disseminated as to how they may obtain a copy of their dental records; and
2. Within 30-calendar days make arrangements with the each person served by the dental program for the transfer of their records, including if applicable, radiographs or copies thereof, to a succeeding practitioner, or, at the written request of the parent/guardian, to themselves.
3. A minimum of 30-calendar days prior to cessation of operation, notify any and all entities for whom the dental program is providing services or who are hosting said services.

## VII. CONCLUSION



School-based oral health programs (SBOHP) are instrumental to improving the oral health of Massachusetts' children by increasing access and removing barriers to care for all children. Those children from communities where access to dental care is a problem especially benefit from school-based program. SBOHP reduce these barriers to care by providing preventive and in some cases restorative dental services at school where a child can easily access those services. Although SBOHP can be a minor disruption while they are in the schools, overall the schools' benefit as well. Students actually lose less classroom time when dental services are



provided on site, and the students will be healthier and ready to learn. These collaborations between SBOHP and community schools or school districts are thus “win-win partnerships” that set the students on the path to good oral and overall health, benefitting them throughout their lives.





## VIII. RESOURCES

<sup>1</sup>Edelstein B. and Douglass C. *Dispelling the cavity free myth*. Public Health Reports 110:522-530, 1995.

<sup>2</sup>U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

<sup>3</sup>Catalyst Institute. *The Oral Health of Massachusetts' Children*, 2008.

<sup>4</sup>Beauchamp J., Caufield P., Crall J. et al. *Evidence based Clinical Recommendations for the Use of Pit and Fissure Sealants*. JADA 139:257-268, 2008.

<sup>5</sup>U.S. Department of Health and Human Services. *Healthy People 2010: Focus Area 21: Oral Health*, 2001.

## IX. GLOSSARY

**Community-Based Oral Health Promotion Program** - Population-based oral health program implemented based on public health principles of disease prevention, within vulnerable community groups such as schools, nursing homes, community health centers, and other public centers.

**Community Water Fluoridation** - Adjustment of the existing, naturally occurring fluoride levels in drinking water to an optimal fluoride level recommended by the U.S. Public Health Service (0.7 - 1.2 parts per million) for the prevention of tooth decay. Community water fluoridation is the single most effective public health measure to prevent tooth decay (American Dental Association).

**Licensed Dentist** – Has a current license to practice dentistry in the Commonwealth and may practice without supervision.

**Limited License Dentist** – Qualified to practice dentistry in a specific public health setting and only under the general supervision of a specifically-named, fully-licensed dentist. Also known as Limited License Dental Intern or Limited Faculty Licensed Dentist.

**MassHealth (Medicaid)** - Public program that provides comprehensive health insurance — or help in paying for private health insurance — to more than one million Massachusetts children, families, seniors, and people with disabilities (MassHealth). To find MassHealth dental providers go to <http://masshealth-dental.net/MemberServices/FindProvider.aspx>

**Massachusetts Board of Registration in Dentistry** - Board responsible for licensing dentists and dental hygienists for practice in the Commonwealth, establishing rules, regulations, and policies governing the practice of dentistry, dental hygiene and dental assisting, and investigating complaints against licensed dental professionals. [[www.mass.gov/dph/boards/dn](http://www.mass.gov/dph/boards/dn)]

**Mobile Dental Facility (MDF)** - Any self-contained facility where dentistry will be practiced, which may be driven, moved, towed or transported from one location to another, (234 CMR 7.00).

**Patient Record** - An legal and official record of dental services provided by the oral health program which includes, but is not limited to, dental charts, photographs, patient histories, examination, assessment, screening and test results, diagnoses, treatment plans, progress notes, anesthesia charts, models, prescriptions, radiographs, patient consents and billing records, (234 CMR 5.14(3)).

**Portable Dental Operation (PDO)** - Any dental practice where a portable dental unit is transported to and utilized on a temporary basis at an out-of-office location (234 CMR 7.00).

**Public Health Dental Hygienist** – Licensed dental hygienist who has fulfilled additional education and training requirements of the Board of Registration in Dentistry and who has a Collaborative Agreement with a licensed dentist to perform dental hygiene procedures in a specified public health setting.

**Registered Dental Hygienist** – Licensed to practice dental hygiene under the supervision of a licensed dentist.

**Retention Rates** - Rate at which a dental sealant material is fully retained within the tooth's occlusal surfaces and a key indicator for measuring dental sealant quality. Sealant quality can be measured by checking short-term retention rates, 1-year retention rates, or both.

**School-based** - Program that physically takes place on school property/grounds and is implemented during school operating hours.

**School Health Provider** – This includes, but is not limited to, registered nurses, licensed practical nurses, nurse practitioners, physician assistants and physicians.

**School-linked** - Program associated with the school, but takes place at another health facility or appropriate location.

**Student Health Record** – A legal record, containing complete demographics, immunizations, licensed provider orders, the health care plan, problems or concerns to which plans are addressed, sequential narrative notes, services and treatments provided, and outcomes of specific procedures or interventions. It should contain an accurate and complete database. The format, whether paper or electronic, should be sequential and consistent, (Massachusetts Comprehensive School Health Manual).

**Tooth Decay/Dental Caries** - Tooth decay is a destruction of the tooth enamel. It occurs when foods containing carbohydrates (sugars and starches) such as milk, pop, raisins, cakes or candy are frequently left on the teeth. Bacteria that live in the mouth thrive on these foods, producing acids as a result. Over a period of time, these acids destroy tooth enamel, resulting in tooth decay (American Dental Association 2010).

**Topical Fluoride** - Fluoride applied to the tooth surface only for the purpose of tooth decay prevention benefits. Topical fluoride sources can include toothpaste, mouth rinses, fluoride varnish, foams and gels, and fluoridated water. High-dose topical fluoride sources, which include foams, gels and varnish, may only be applied by dental/some medical professionals.

## NOTES





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For more information about the Massachusetts Coalition for Oral Health and for other oral health resources go to [www.bu.edu/mcoh](http://www.bu.edu/mcoh)

