

Exhibit No. 1Date 1/14/2010Bill No. SB 2

Montana Dental Hygienists' Association  
 SB2 Supportive Testimony  
 January 14, 2011

Thank you for this opportunity to talk to you about SB2. My name is Colleen Grass and I represent the Montana Dental Hygienists' Association as a proponent of this bill to allow dental hygienists with Limited Access Permits to provide sealants in school settings for Montana children.

In a perfect world every child would have perfect teeth, regular checkups by a dentist, and in-office preventive care by their hygienist -- but we all know that this is NOT a perfect world, and the reality is that many children's first contact with a dentist is when they end up there frightened and sobbing with a toothache. I worked 28 years for Dr. Rader in Havre who often commented in frustration that he had just turned a child into a "dental cripple" for the rest of his life, when he was forced to extract a molar because that child showed up too late for the tooth to be restored, or the parents insisted on pulling the tooth because they could not afford a root canal and crown.

It is unfortunate but true that many children, especially poor children never find their way to a dental office until they have a toothache and then the costs of restoration are very expensive. But what if we could reach those children BEFORE that happens? What if we could PREVENT from 60 to 100% of their tooth decay? THAT is what SB2 aims to do by providing access to care for underserved children.

I know that you have received a lot of information about sealants and you are well aware of the issues that will be discussed today, so I'm going to cut right to the chase and address those issues first.

**AFFORDABILITY** - We know this is a huge concern, so here are the FACTS:

1. The latest reported Medicaid utilization rate for Montana children receiving dental services is 29.2%. Montana has appropriated a LOT of money for children's dental services that is not being used, and sealing a few hundred children's teeth will hardly make a dent in it.
2. Passing SB2 does not mean that a hoard of dental hygienists will descend on every school in the state and start sealing every tooth surface they see. Right now there are only 17 LAPs in the state and some of them are already working with the elderly. We believe that passing SB2 will encourage hygienists to get a limited access permit because they will be excited about helping kids, but the first thing they will have to do is round up funding for the equipment they need. School-based sealants will start slowly and reach only a few schools to begin with, so it will be several years before the state starts seeing increased reimbursement of LAPs for these services.
3. Allowing LAPs to provide school sealants does not initiate a program—it only creates opportunities.
4. SB2 places the burden on the hygienist rather than the state. Many states hire dental hygienists to run sealant programs and the state provides all of the administration and equipment. We realize that Montana doesn't have the resources to do that currently, so our model places the burden of buying equipment and supplies, developing and administering sealants on the LAP hygienists.
5. The federal government has expanded grants for school-based sealant programs for all 50 states. There is money available for sealants in Montana.
6. Many studies have been done to determine the cost-effectiveness of dental sealants:
  - a. The Journal of Public Health reported a North Carolina study of Medicaid treatment expenditures from 1985-1992 and determined that the savings in dollars of sealing teeth for children age 6-12 ranged from 76 cents for a low-risk 6 year old, to \$15.21 for a high risk 9 year old.
  - b. The Journal of Dental Research compared the costs of three different sealant strategies, "seal no child's teeth, seal all children, or seal only those with a history of tooth decay" and determined that sealing the teeth of children with a history of tooth decay will cost a state less than doing no sealants.
  - c. The National Institute of Dental and Craniofacial Research 2002 report concluded that 71% of tooth decay could be avoided by use of sealants.
  - d. Insurance companies pay for sealants because actuaries have determined that it will save them money.

- e. The Task Force on Community Preventive Services 2002 report strongly recommended school-based sealant programs on the basis of strong evidence of effectiveness in reducing decay on molars. Their economic evaluation studies reported cost effectiveness ratios ranging from \$0 to \$487 and hypothesized that a program that sealed first molars would be cost saving if unsealed molars were decaying at the average rate of half a surface per year.
- f. To realize what the savings of preventing decay adds up to, you need to know that locally a sealant costs less than \$30 but a one-surface filling costs over \$77.00. Bigger cavity – higher price. And if the decay is not prevented by a sealant and not detected early by a dentist, the cost of a root canal is \$689 or more and a crown costs upwards of \$734.
- g. The CDC estimates that if 50 percent of children at high risk participated in school sealant programs, over half of their tooth decay would be prevented and money would be saved on their treatment costs.

SAFETY and WELFARE – We know that you want to be sure that this is the right thing to do for Children, so here are the FACTS:

1. In regard to cleanliness and infection control, a hospital or dental office is no safer than a classroom. The walls, floors and air systems in dental offices are not sterile. But the instruments are sterile and the chair, equipment and everything a dentist or hygienist touches during a procedure has been disinfected. School-based sealant programs meet exactly those same criteria. Hospital grade disinfectants will be used. Instruments and materials will either be sealed, disposable, single use items or sterile instruments will be used on only one child and then taken back to an institution for sterilization before they can be used again.
2. In regard to concerns about sealing over decay, overwhelming volumes of research reviewed by the CDC, the American Dental Association and other organizations have ALL come to the same conclusion. **SEALING OVER NON-CAVITATED LESIONS PREVENTS THE PROGRESSION OF DECAY!** In plain English, if decay has started but there isn't a visible hole in the tooth yet, it is not just safe to seal the tooth; it is **RECOMMENDED!**
  - a. The evidence-based recommendations of the expert panel convened by the American Dental Association state that "sealants should be placed on early carious lesions to reduce the percentage of lesions that progress."
  - b. The Journal of Dental Research found that "sealing caries lesions reduced the probability of lesion progression," and further stated that "these findings not only support the placement of sealants to manage and arrest lesions...in the early carious stages, but also...support their placement for surfaces where caries status is uncertain."
  - c. The CDC expert panel recommendations for SBSPs released in 2009 says "Seal sound and noncavitated pit and fissure surfaces of [molars]. Their report "confirmed that sealants are effective in managing early [decay] by reducing the percentage of noncavitated lesions that progress to [cavities] and by lowering bacteria levels in lesions."
  - d. An article from the Indiana University School of Dentistry states, "A child who received a sealant at a SBSP on a lesion that extended into the dentin (the layer below enamel) may subsequently have the lesion identified with radiographs taken in a dental office....**Both the program and the dentist must understand that, based on the scientific literature, there is no reason to believe that the sealant placement caused harm. In fact, the sealant may have stopped the lesion from progressing before the dentist could assess the child.**"
3. We use the "Recommendations for School-based Sealant Programs" suggested by the CDC, American Dental Association Council on Scientific Affairs, and Association of State and Territorial Directors as the basis for LAPH school-based sealant protocol. The results published in the Journal of the American Dental Association, Nov 2009, recommend:
  - a. to seal sound surfaces and noncavitated posterior teeth
  - b. to use visual assessment to detect surface cavitation
  - c. to use a toothbrush or prophylaxis handpiece to clean tooth surfaces
  - d. to provide sealants to children even if follow-up cannot be ensured

**LEGALITY –** You will no doubt hear that it is illegal for dental hygienists to diagnose oral conditions. Let me assure you that **SB2 does not require LAP hygienists to diagnose tooth decay.**

1. ALL research and reports from expert reviews and recommendations including the US Centers for Disease Control and Prevention, the American Dental Association and the Association of State and Territorial Dental Directors call for "visual assessment." Assessment is not diagnosis. If you saw someone lying on the floor who did not respond when you did the CPR "shake and shout" assessment, and you then called 911 and reported that there was an unresponsive victim, you would have made an assessment, not a diagnosis.
2. When we assess a tooth for a sealant we simply observe whether we see a "hole" in the tooth, or not. Even if we see a stain that could be the beginning of tooth decay, we are not asked to diagnose whether it is decay or not because the guidelines recommend that "non-cavitated lesions" also be sealed.
3. Dental hygienists are already allowed in statute to perform school-based screenings without supervision or authorization by dentists, and screening IS visual assessment.
4. Furthermore, dental hygienists are educated to visually assess and recognize oral health conditions and we are required to do so when we take our national and state board examinations, so no dental hygienist in Montana has been licensed without proving her/his capability to assess oral conditions. LAP hygienists are further qualified to do so because they must have at least 3 years of experience and additional education.
5. Finally, in 2003 the Montana Dental Association supported the creation of the Limited Access Permit and agreed that the services LAP hygienists could provide did not constitute dental diagnosis and treatment. When the Legislature passed that bill it allowed dental hygienists to place sealants without a prior examination or authorization by a dentist. **You are not being asked to vote on that. You are only being asked to add schools to the settings where an LAP can work.**

**WORKFORCE –** You may wonder why LAPs should do this.

1. All but 15 counties in the state are considered dental professional shortage areas. With only 1200 licensed dental professionals (dentists and hygienists) in the state to care for nearly 1 million residents, it just makes sense to fully utilize all of them, including our LAP hygienists.
2. Of 219 respondents to the 2010 MDHA survey, 24% indicated that they intend to apply for a limited access permit at some time in the future.
3. SB2 does not prohibit dentists from providing school-based sealant programs and school-based dental screening. On the contrary, we welcome their participation.
4. The state has already set a precedent by allowing some schools as LAP sites.
5. Hygienists are the primary providers in school based sealant programs in 39 other states. This bill does not propose something brand new that has never been done before. There is 30 years of experience with hygienists providing sealants in other states, and the results are in! The headline on the CDC website says, "**School-based Sealant Programs Work.**" The webpage goes on to say that, "Findings from scientific studies clearly show that school dental sealant programs work to stop tooth decay."

**WORTHINESS –** Why should we do this?

1. Over 40% of students are eligible for the Free or Reduced Price School Lunch Program in 151 of Montana's school districts. Eligibility for FRPSL is an indicator of high risk for tooth decay, a fact that is born out by the 64% of Montana's third graders who have already experienced tooth decay.
2. In fact, tooth decay is the most common chronic disease of children aged 5 to 17 years, and some of those children never see an oral health professional until that decay progresses to being a toothache and perhaps even a medical emergency. We believe that we have a responsibility to those children.
3. We can provide an inexpensive sealant to prevent or halt tooth decay, which will save the state from big expenses like root canals and crowns. We will have several contacts with those students and communication with their parents to get the children who don't have a dental home to a dentist. We can also put the information in their hands to direct families to the assistance they need.
4. The only way to reduce future restorative costs for Medicaid is through preventive strategies. Any sealant program established through the ACA grants has to be done under the auspices of a

state agency. That state agency, in the development of the grant, would set the criteria for which children to serve and could direct services to high risk children where the savings ratio is even higher.

5. **It is time to start doing something!** We hoped to join the rest of the nation in providing better access to dental care for children in 2003 when schools were stripped out of the LAP bill. Since then, the situation has only grown worse. Montana used to provide a fluoride rinse program in schools and now we don't even do that. This neglect of children has earned us an embarrassing D when the states were graded for children's access to dental care.
6. **If nothing changes, nothing will change!** To begin with it may be only a few LAPHs reaching a small percentage of children in a few schools, but the longest journey begins with one small step.

We believe that this is an effort for which the time has come. Some of you, perhaps all of you have experienced that sense of feeling called to service. We might have saved our association a lot of hard work and money by avoiding this calling. But instead I told our members that this year our path had been chosen for us and that we should respond because it is the right thing to do. They agreed and voted unanimously to support this Committee bill.

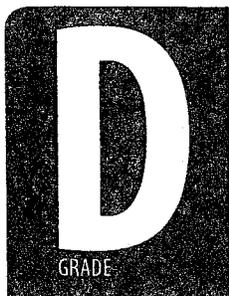
We hope you also will agree that SB2 is the right thing to do. Please weigh the evidence and vote to help Montana's most vulnerable citizens in this practical, proven, cost-saving way.

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# The Cost of Delay State Dental Policies Fail One in Five Children

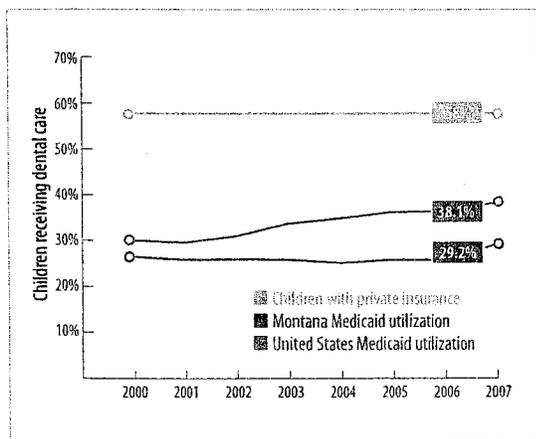
## Montana



**MONTANA** meets just three of eight policy benchmarks aimed at addressing children's dental health needs. Montana is one of just nine states that did not provide fluoridated water to half its population in 2006, the latest data available at this writing; more than 68 percent of its residents on community systems go without. The state also falls under the national averages for prevalence of school-based sealant programs and the rate at which it reimburses its dentists for services to Medicaid-enrolled children. On a positive note, Montana pays medical providers for offering basic preventive care to Medicaid-enrolled kids, and collects and submits nationally comparable data to the National Oral Health Surveillance System. In 2008, the state oral health program introduced a dental education agenda aimed at infant and childcare workers, but the program is so new that the results are not yet known.<sup>1</sup>

### HOW BAD IS THE PROBLEM?

**TOO MANY CHILDREN LACK ACCESS TO DENTAL CARE, WITH SEVERE OUTCOMES.** One measure of the problem: more than half of the children on Medicaid received no dental service in 2007.



**SOURCES FOR NATIONAL BENCHMARKS:** 1) Association of State and Territorial Dental Directors; 2) American Dental Hygienists' Association; 3) Centers for Medicare and Medicaid Services, CMS-416; 4) American Dental Association; 5) Pew Center on the States, National Academy for State Health Policy and American Academy of Pediatrics; 6) National Oral Health Surveillance System.

<sup>1</sup> Pew Center on the States communication with Veronica Newhart, oral health education specialist, December 8, 2009.

### HOW WELL IS MONTANA RESPONDING?

MEASURED AGAINST THE NATIONAL BENCHMARK FOR EIGHT POLICY APPROACHES

	STATE	NATIONAL	MEETS OR EXCEEDS
Share of high-risk schools with sealant programs, 2009	0%	25%	
Hygienists can place sealants without dentist's prior exam, 2009	Y	Y	●
Share of residents on fluoridated community water supplies, 2006	31.3%	75%	
Share of Medicaid-enrolled children getting dental care, 2007	29.2%	38.1%	
Share of dentists' median retail fees reimbursed by Medicaid, 2008	58.5%	60.5%	
Pays medical providers for early preventive dental health care, 2009	Y	Y	●
Authorizes new primary care dental providers, 2009	N	Y	
Tracks data on children's dental health, 2009	Y	Y	●
<b>Total score</b>	<b>D</b>		<b>3 of 8</b>

Grading: A = 6-8 points; B = 5 points; C = 4 points; D = 3 points; F = 0-2 points

Download the full report and explanatory notes by visiting [www.pewcenteronthestates.org/costofdelay](http://www.pewcenteronthestates.org/costofdelay).



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APPENDIX

**TABLE 2. Percentage of Low-Income Children Receiving Dental Services, State by State**

Medicaid Utilization for Children Ages 1-18, Federal Fiscal Years 2000-2007

State	2000	2001	2002	2003	2004	2005	2006	2007
Alabama	23.9%	28.9%	32.2%	36.2%	39.6%	41.2%	42.5%	51.9%
Alaska	37.1%	38.8%	41.0%	41.1%	41.8%	43.3%	43.0%	41.9%
Arizona	23.9%	23.3%	29.2%	31.1%	31.6%	31.8%	37.9%	40.1%
Arkansas	24.5%	26.7%	28.9%	30.8%	32.6%	31.8%	32.6%	29.5%
California	32.4%	34.4%	34.1%	34.5%	32.6%	33.8%	31.1%	31.3%
Colorado	38.6%	30.2%	32.8%	38.6%	39.3%	47.2%	38.5%	40.2%
Connecticut	33.7%	30.3%	33.3%	34.5%	35.6%	33.0%	36.5%	41.4%
Delaware	23.1%	25.2%	17.3%	26.7%	29.3%	30.4%	32.4%	23.7%
District of Columbia	25.4%	30.5%	24.8%	19.8%	30.4%	32.0%	28.8%	35.5%
Florida	25.9%	24.0%	24.9%	25.8%	25.9%	22.5%	23.2%	23.8%
Georgia	24.5%	20.3%	23.8%	35.5%	37.9%	41.3%	39.4%	41.5%
Hawaii <sup>1</sup>	30.6%	37.4%	0.8%	0.8%	0.8%	43.8%	45.2%	39.9%
Idaho	29.9%	32.0%	20.9%	36.3%	29.2%	42.1%	43.9%	42.8%
Illinois	29.1%	29.5%	28.2%	30.3%	32.8%	35.7%	39.1%	40.1%
Indiana	32.2%	35.1%	37.4%	40.5%	41.1%	40.9%	42.5%	43.0%
Iowa <sup>1</sup>	35.1%	38.1%	3.3%	42.4%	43.6%	44.9%	46.0%	46.9%
Kansas	22.2%	22.5%	25.7%	29.9%	35.2%	38.2%	40.4%	41.2%
Kentucky <sup>1</sup>	35.1%	35.5%	38.3%	39.1%	20.3%	7.8%	36.4%	24.5%
Louisiana	28.6%	29.4%	30.9%	31.6%	33.7%	33.7%	30.2%	32.4%
Maine <sup>2</sup>	37.9%	35.0%	33.2%				35.8%	37.1%
Maryland	11.4%	20.0%	24.0%	28.5%	30.1%	33.0%	32.9%	36.1%
Massachusetts	33.8%	34.3%	35.7%	36.7%	38.9%	40.2%	41.6%	44.6%
Michigan	22.8%	24.0%	31.5%	32.6%	33.0%	33.0%	33.0%	34.5%
Minnesota	34.6%	32.2%	32.1%	35.2%	35.8%	37.3%	37.2%	37.7%
Mississippi <sup>1</sup>	27.6%	29.1%	27.1%	32.1%	69.4%	69.7%	37.3%	38.1%
Missouri	20.4%	21.6%	22.8%	23.3%	23.8%	24.1%	26.2%	27.9%
Montana	26.5%	25.9%	26.0%	25.9%	25.2%	25.9%	25.8%	29.2%
Nebraska	42.0%	42.5%	44.9%	43.2%	46.4%	47.5%	47.9%	49.9%
Nevada	20.6%	20.4%	17.1%	15.8%	13.8%	19.3%	22.4%	27.5%
New Hampshire	34.1%	34.7%	36.6%	27.7%	38.1%	42.3%	45.4%	47.0%
New Jersey	18.2%	19.7%	21.6%	23.4%	23.7%	25.5%	28.1%	33.9%
New Mexico	24.7%	29.8%	39.3%	42.8%	41.7%	33.0%	45.1%	47.6%
New York	27.3%	25.9%	27.1%	26.6%	27.7%	32.9%	30.1%	33.7%
North Carolina	24.6%	28.0%	32.3%	36.0%	37.2%	41.1%	43.3%	45.7%
North Dakota	13.8%	33.0%	31.6%	33.4%	27.8%	27.5%	21.2%	28.1%
Ohio	43.1%	25.6%	29.4%	33.2%	35.6%	37.0%	38.8%	39.9%
Oklahoma	17.0%	18.4%	14.3%	19.8%	29.2%	36.9%	40.5%	42.7%
Oregon	28.6%	32.8%	31.9%	30.1%	30.5%	32.0%	34.4%	34.9%
Pennsylvania	23.2%	27.8%	28.8%	31.3%	29.5%	29.9%	29.8%	32.2%
Rhode Island	36.7%	36.3%	36.4%	36.9%	37.7%	39.4%	41.0%	43.8%
South Carolina	31.3%	19.2%	38.8%	41.5%	42.9%	46.1%	46.8%	46.9%
South Dakota	14.6%	29.4%	31.5%	33.3%	33.7%	37.0%	37.5%	37.0%
Tennessee	29.5%	28.0%	28.5%	34.9%	40.2%	41.7%	40.7%	40.2%
Texas	42.8%	41.7%	42.5%	46.6%	47.6%	48.3%	47.8%	53.7%
Utah	34.0%	33.6%	36.1%	35.7%	37.5%	38.6%	39.3%	39.5%
Vermont	48.9%	49.5%	49.7%	50.9%	50.8%	52.7%	56.3%	57.1%
Virginia	21.8%	24.2%	20.9%	26.6%	26.8%	27.0%	35.4%	40.8%
Washington	46.7%	47.7%	41.1%	43.5%	43.2%	45.7%	46.1%	47.6%
West Virginia <sup>1,2</sup>	34.6%	35.4%	37.2%	37.7%		45.2%	62.2%	45.6%
Wisconsin	22.2%	20.9%	27.5%	32.4%	35.7%	23.0%	24.1%	25.7%
Wyoming	33.5%	28.7%	32.3%	32.2%	33.0%	35.8%	36.5%	37.3%
National	29.8%	29.4%	30.8%	33.6%	34.8%	36.1%	36.3%	38.1%

Source: Centers for Medicare and Medicaid Services, 1995-2007 Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit (CMS-416), [http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03\\_StateAgencyResponsibilities.asp](http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp) (accessed July 8, 2009).

Note: Percentages were calculated by dividing the number of children ages 1-18 receiving any dental service by the total number of enrollees ages 1-18.

<sup>1</sup> Hawaii submitted data in 2002, 2003 and 2004 that appear to be abnormally low, as did Iowa in 2002 and Kentucky in 2005. Mississippi submitted data in 2004 and 2005 that appear to be abnormally high, as did West Virginia in 2006, indicating possible problems with the submission. Please use caution when interpreting the data in question for these years.

<sup>2</sup> Blank values indicate that data were not submitted for the year in question.

# Comparing the Costs of Three Sealant Delivery Strategies

Table 2.

Health and Economic Outcomes Associated with Three Sealant Delivery Strategies—SN, TARGET, and SN—under Baseline Assumptions

Outcome	Sealant Delivery Strategy		
	Seal None (SN)	Seal All (SA)	Target (TARGET)
Expected nine-year cumulative occlusal caries increment <i>per child</i> (discounted) <sup>a</sup>	$(\sum_{i=1}^9 C^i / 1.03^i) = 0.486$	$CI * [\sum_{i=1}^9 (SLR1 + SLR2 * 2 * (i-1)) / 1.03^i] = 0.208$	$Sn * 0.208 + (1 - Sn) * 0.486 = 0.309$
Expected restoration cost <i>per child</i> (discounted)	$0.486 * \$73.77 = \$35.84$	$0.208 * \$73.77 = \$15.35$	$0.309 * \$73.77 = \$22.82$
Expected sealant cost <i>per child</i>	0	\$27.00	$\$27 * [Sn * 9 * CI + (1 - Sp) * (1 - 9 * CI)] = \$12.06$
Total cost <i>per child</i> (discounted)	\$35.84	\$42.35	\$34.88

## Comparison of Sealant Delivery Strategies

Outcome	SN vs. SA	TARGET vs. SA	SN vs. TARGET
<sup>a</sup> Calculations of non-discounted values for SA and SN are shown in Web-Table 5.			
<sup>b</sup> CI represents annual caries increment, Sn and Sp represent sensitivity and specificity of screening for future caries, respectively, and SLR <sub>i</sub> represents sealant loss rate in period i.			
Averted decayed 1st molar occlusal surfaces	0.278	0.101	0.177
Net cost	$\$42.35 - \$35.84 = \$6.51$	$\$42.35 - \$34.88 = \$7.47$	$\$34.88 - \$35.84 < 0$
Cost-effectiveness	$\$6.51 / 0.278 = \$23.42$	$\$7.47 / 0.101 = \$73.96$	TARGET is cost-saving relative to SN.

Health and Economic Outcomes Associated with Three Sealant Delivery Strategies—SN, TARGET, and SN—under Baseline Assumptions

The expected *per-child* restoration costs for SN, SA, and TARGET are \$35.84, \$15.35, and \$22.82, respectively, and the expected sealant costs are \$0, \$27.00, and \$12.06. The total costs *per child* associated with SN, SA, and TARGET are \$35.84, \$42.35, and \$34.88, respectively. After averted decay is considered, TARGET dominates SN. Going from SN to SA would cost \$23.42 *per saved* tooth surface. Going from TARGET to SA would cost \$73.96 *per saved* tooth surface (Table 2<sup>↑</sup>).

*Target = children with history of decay*

# Dental Sealants



“...effective in the primary prevention of tooth decay.”<sup>1</sup>



## Dental Sealants: A Fact Sheet

### What is the problem?

Tooth decay, although preventable, is a chronic disease affecting children’s ability to concentrate and learn, as well as their speech development, eating habits, activity levels and self-esteem. In fact, it is the most common chronic disease of childhood.<sup>2</sup> Nationally, dental decay is five times more common than childhood asthma and seven times more common than hayfever.<sup>4</sup> Tooth decay, left untreated, can cause pain and tooth loss.

- 17% of children aged 2-4 years have already had decay.
- By the age of 8, approximately 52% of children have experienced decay,
- By the age of 17, dental decay affects 78% of children

**An estimated 7.8 million hours of school are lost annually in Colorado due to acute oral pain and infection<sup>4</sup>**

### What about dental sealants?

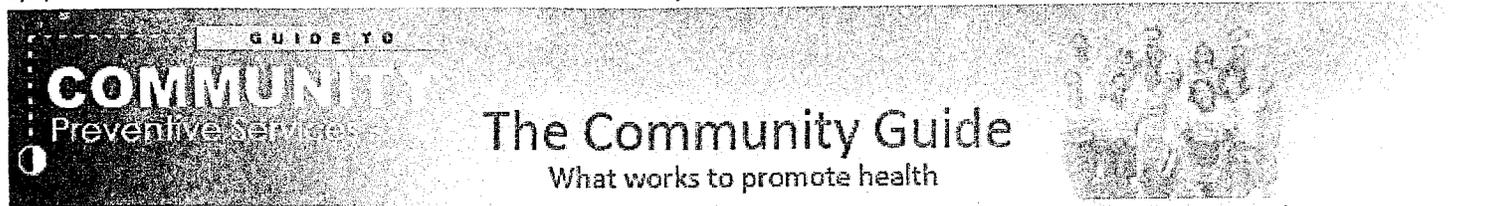
Dental sealants, a thin coating bonded into the pit and fissures of the chewing surface of permanent molars, are nearly 100 percent effective in preventing tooth decay.<sup>2</sup> When properly placed and retained, dental sealants are a highly effective primary preventive measure.<sup>4</sup> Sealants prevent tooth decay by creating a barrier between the teeth and decay-causing bacteria. Sealants also stop cavities from growing and can prevent the need for expensive fillings. Sealants are 100 percent effective if they are fully retained on the tooth.<sup>2</sup> According to the Surgeon General’s 2000 report on oral health, sealants have been shown to reduce decay by more than 70 percent.<sup>1</sup>

### Why are school-based dental sealant programs recommended?

In 2002, the Task Force on Community Preventive Services, a national independent, nonfederal, multidisciplinary task force appointed by the director of the Centers for Disease Control and Prevention (CDC), strongly recommended school sealant programs as an effective strategy to prevent tooth decay.<sup>3</sup> CDC further estimates that if 50 percent of children at high risk participated in school sealant programs, over half of their tooth decay would be prevented and money would be saved on their treatment costs.<sup>5</sup>

### Healthy People 2010 Objective:

Increase the proportion of children who have received dental sealants on their molar teeth.<sup>6</sup>



## The Community Guide

### Preventing Dental Caries: School-Based or -Linked Sealant Delivery

#### Task Force Findings\*

School-based or school-linked pit and fissure sealant delivery programs directly provide pit and fissure sealants to children unlikely to receive them otherwise. School-based programs are conducted entirely in the school setting, and school-linked programs are conducted in both schools and clinic settings outside schools. Such programs define a target population within a school district; verify unmet need for sealants (by conducting surveys); get financial, material, and policy support; apply rules for selecting schools and students; screen and enroll students at school; and apply sealant at school or offsite in clinics. Many programs target what are referred to as high-risk children with high-risk teeth. High-risk children include vulnerable populations less likely to receive private dental care, such as children eligible for free or reduced-cost lunch programs. High-risk teeth (i.e., those with deep pits and fissures) are the first and second permanent molars that erupt into the mouth around the ages of 6 and 12 years, respectively.

School-based and school-linked sealant delivery programs are strongly recommended on the basis of strong evidence of effectiveness in reducing caries on occlusal surfaces of posterior teeth among children.

Other potential positive and negative effects of school-based or school-linked sealant delivery programs have been mentioned but remain unsupported by empirical evidence of effectiveness. For example, successful programs may lead to the positive effects of (1) increased support for coordinated school-based programs to address related dental and nondental needs of children from low-income families (e.g., immunization and better nutrition); and (2) increased willingness of third-party payers to pay for sealants applied in all settings. Potential negative effects are expressed in concerns that (1) sealants containing Bisphenol-A may have estrogenic effects in the recipient; and (2) effective delivery of sealants (from all sources) might encourage recipients to ignore other anticaries interventions (e.g., use of fluorides).

Economic evaluation studies reported sealant program costs per person served ranging from \$18.50 to \$59.83 (median=\$39.10). The cost effectiveness ratios (adjusted cost per averted decayed surface) ranged from cost saving (<\$0) to \$487. A hypothetical school-based sealant program that sealed first permanent molars would be cost saving if unsealed molars were decaying at the average rate of >0.47 surfaces per year.

\*From the following publication:

Task Force on Community Preventive Services. Recommendations on selected interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. (./oral-ajpm-recs.pdf) *Am J Prev Med* 2002;23(1S):16-20.

- Page last reviewed: February 10, 2010
- Page last updated: September 28, 2010
- Content source: [The Guide to Community Preventive Services \(/\)](#)

This page includes all information available for this review. It will not be updated.

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**TABLE 2—Effects of Sealants on Occlusal Restoration and Treatment Expenditures for Nonsealed Molars vs Molars Sealed at 5 Years of Age: North Carolina, 1985–1992**

Age,y	Low Risk		Middle Risk		High Risk	
	(No Prior Molar Restorations)		(1 Prior Molar Restoration)		(≥2 Prior Molar Restorations)	
	Unsealed Teeth	Expected Decrease if Sealed	Unsealed Teeth	Expected Decrease if Sealed	Unsealed Teeth	Expected Decrease if Sealed
<b>Annual Likelihood of Occlusal Restoration per Molar<sup>a</sup></b>						
5	0.0073	0.0057	0.0178	0.0148	0.0229	0.0199
6	0.0271	0.0229	0.0633	0.0556	0.0800	0.0725
7	0.0517	0.0385	0.1159	0.0918	0.1439	0.1205
8	0.0658	0.0327	0.1444	0.0850	0.1777	0.1198
9	0.0582	0.0121	0.1296	0.0477	0.1604	0.0806
10	0.0484	0.0051	0.1095	0.0325	0.1364	0.0614
11	0.0356	0.0069	0.0820	0.0302	0.1030	0.0526
12	0.0303	0.0049	0.0704	0.0245	0.0887	0.0440
<b>Cumulative CRSO Expenditures (in Dollars) for All Occlusal Surface Treatments per Molar<sup>b</sup></b>						
5	0.23	0.17	1.56	1.30	3.94	2.95
6	0.85	0.76	4.57	4.15	9.64	8.61
7	1.41	1.32	7.04	6.60	13.57	12.50
8	2.01	1.84	9.21	8.42	16.49	14.60
9	2.62	2.27	11.18	9.54	18.93	15.21
10	2.92	2.31	12.06	9.36	19.97	14.15
11	3.10	2.26	12.61	8.97	20.66	13.11
12	3.16	2.13	12.80	8.48	20.92	12.24



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## Oral Health, U.S. 2002 Annual Report

### Section 2: PREVENTIVE INTERVENTIONS

This section examines water fluoridation and dental sealants. There has been a tremendous reduction in the prevalence and severity of dental caries over the past several decades. The widespread use of fluoride has been a major factor in this decline (CDC, 1992; CDC, 1999). There are currently many means of fluoride delivery, including water fluoridation and professional treatments with fluoride solutions, gels, and varnishes. Fluoride is also present in a variety of processed foods and beverages, mouth washes, toothpastes, and supplements. However, fluoridation of public water is the most cost-effective method of reducing dental caries since it reaches all residents regardless of income level and educational status (CDC, 1999). Approximately \$40 billion have been saved in reduced oral health care expenditures in the United States over the past 40 years due to public water fluoridation.

Fluoride is more effective on smooth surfaces than on pit and fissure surfaces (Backer et al., 1961). This has led to a change in the distribution of caries in areas where fluoridation is prevalent. At least 83% of childhood tooth caries are in pits and fissures (Brown et al., 1996). More recently, the introduction of dental sealants has led to a further reduction in dental caries. Sealants are thin plastic coatings that are applied to the pits and fissures of children's teeth, especially to the permanent first and second molars. Dental sealants are particularly effective in protecting these surfaces. Placing sealants on occlusal surfaces of these teeth shortly after eruption protects them from development of caries. A study of second-generation sealants found that 67% to 82% remained in place after 5 years (Mertz-Fairhurst et al., 1984). A 1993 analysis of previous research on sealants concluded that 71% of caries could be avoided by use of sealants (Llodra et al., 1993). Sealants may also be used in treatment of early caries. The use of sealants has increased since the 1980s, primarily among those of higher socioeconomic classes (Burt & Eklund, 1999).

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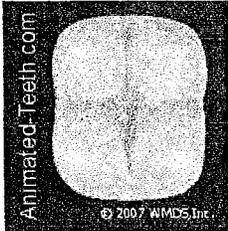
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## Questions and answers: Things to know about tooth sealants (dental sealants).

### Are dental sealants covered by dental insurance companies?

As a way of helping to make you aware of the benefits of this procedure, you might be interested to learn that many dental insurance policies do cover tooth sealants. Insurance companies rely on their "bean counters" to statistically determine what their projected claims costs will be. Since dental sealants are an effective means by which to reduce tooth decay, and therefore the need for fillings, dental insurance companies realize that if they do provide coverage for dental sealants it will save them money in the long run.

If you are covered by a dental insurance policy which does provide coverage for dental sealants you still must examine the policy. Some policies will only provide for this procedure for certain teeth, and only when the patient falls within a certain age group.

### The cost of maintaining dental sealants.

Once a dental sealant has been placed it is possible that a part, or even all, of the sealant will break off or dislodge. Dental sealants can only be relied upon to provide protection when they are fully intact. For your own information, you might ask your dentist what their policy is regarding the cost of replacing or repairing a tooth sealant. Many dental insurance companies will only provide benefits for sealing teeth once every three years.

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### The cost of sealing several teeth might be prohibitive, especially if you have several children.

You might find that the cost of placing dental sealants on all of the teeth your [dentist](#) has recommended to be a financial obstacle. If so, there can often be some compromise in the way this treatment is approached.

Dentists usually have a feel for which teeth have the most pressing need for the protection that sealants provide. The presence of stain in the grooves of a [tooth](#), the way the tooth's surface feels to the dentist's during examination, or the presence heavy plaque accumulation on the tooth's surface can each be tipoffs. Explain to your dentist that finances are a concern and ask them if it might be appropriate to seal some teeth now and seal the remainder later.

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# Evidence-Based Clinical Recommendations for the Use of Pit-and-Fissure Sealants

## A Report of the American Dental Association Council on Scientific Affairs

Jean Beauchamp, DDS, Page W. Caufield, DDS, PhD, James J. Crall, DDS, ScD, Kevin Donly, DDS, MS, Robert Feigal, DDS, PhD, Barbara Gooch, DMD, MPH, Amid Ismail, BDS, MPH, MBA, DrPH, William Kohn, DDS, Mark Siegal, DDS, MPH and Richard Simonsen, DDS, MS

This report was developed through a critical evaluation of the collective body of published scientific evidence, conducted by an expert panel that was convened by the American Dental Association Council on Scientific Affairs.

### **Pit-and-fissure sealants can be used effectively as part of a comprehensive approach to caries prevention on an individual basis or as a public health measure for at-risk populations.**

Pit-and-fissure sealants are underused, particularly among those at high risk of experiencing caries; that population includes children in lower-income and certain racial and ethnic groups.<sup>13</sup> The national oral health objectives for dental sealants, as stated in the U.S. Department of Health and Human Services initiative Healthy People 2010, includes increasing the proportion of children who have received dental sealants on their molar teeth to 50 percent.<sup>14</sup>

### **▶ PANEL CONCLUSIONS BASED ON THE EVIDENCE**

The following evidence statements and corresponding classification of evidence in parentheses represent the conclusions of the expert panel.

#### **Evidence regarding sealants for caries prevention.**

- Placement of resin-based sealants on the permanent molars of children and adolescents is effective for caries reduction<sup>5</sup> (Ia).
- **Reduction of caries incidence in children and adolescents after placement of resin-based sealants ranges from 86 percent at one year to 78.6 percent at two years and 58.6 percent at four years<sup>2,5</sup> (Ia).**
- Sealants are effective in reducing occlusal caries incidence in permanent first molars of children, with caries reductions of 76.3 percent at four years, when sealants were reapplied as needed. Caries reduction was 65 percent at nine years from initial treatment, with no reapplication during the last five years<sup>47</sup> (Ib).

#### **Evidence regarding placing sealants over early (noncavitated) lesions.**

- Placement of pit-and-fissure sealants significantly reduces the percentage of noncavitated carious lesions that progress in children, adolescents and young adults for as long as five years after sealant placement, compared with unsealed teeth<sup>82</sup> (Ia).
- **There are no findings that bacteria increase under sealants. When placed over existing caries, sealants lower the number of viable bacteria by at least 100-fold and reduce the number of lesions with any viable bacteria by 50 percent<sup>83</sup> (Ia).**

will receive funding, dependent on the availability of funding, through fiscal year 2014. Improving oral health infrastructure is crucial to solving access to care barriers.

**Goal:** Expand sealant programs for kids who need them most

- **Expands school-based sealant programs (Title IV, Section 4102)**  
With the appropriation of funding, the provision amends instructions to CDC and the Health Resources and Services Administration (HRSA) to provide grants to each of the 50 states, territories, Indian tribes and organizations. These grants are to provide for the development of school-based dental sealant programs to improve the access of children to sealants.

**Goal:** Help expand access to optimally fluoridated water

- **Increases community understanding of water fluoridation and other preventive activities (Title IV, Section 4102)**  
The Secretary of Health and Human Services, acting through the director of the Centers for Disease Control and Prevention, will work with each of the 50 states, territories, and tribal organizations, to implement a national, science-based public education campaign focused on oral healthcare. This campaign will run for 5 years and will include — among other things — oral health prevention messages about water fluoridation, early childhood caries (ECC, the process which causes cavities), periodontal disease and oral cancer. Planning begins immediately, and the campaign begins no later than 2012 with funding authorized from fiscal year 2010 through fiscal year 2014. Using effective methods to educate the public about water fluoridation should increase community understanding and support for fluoridation.

#### **Additional Provisions Related to Children's Oral Health**

- **Monitors Trends in Oral Health (Title IV, Section 4102)**  
Having comprehensive and accurate data is critical for states to gauge their challenges and develop sound strategies. This provision allows for the continuation of the National Oral Healthcare Surveillance System (NOHSS) — one of the four data-collection systems). Participation in NOHSS was a benchmark used by the Pew Children's Dental Campaign to grade states on dental health and access to care. Currently, only 16 States participate in NOHSS, and the goal is to increase participation to all 50 States, territories, and the District of Columbia. This provision, which also expands the collection of oral health data in other public health surveys, is subject to available funding.
- **Support for school-based health centers (Title IV, Sec. 4101)**  
Under this provision, school-based health centers or sponsoring facilities of a school-based health center may apply for a grant, with preference given to centers that serve large populations of children under Medicaid or similar programs. Oral health assessments and referrals are part of the core services that the school-based health centers

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- **There are no findings that bacteria increase under sealants. When placed over existing caries, sealants lower the number of viable bacteria by at least 100-fold and reduce the number of lesions with any viable bacteria by 50 percent<sup>83</sup> (Ia).**

**Sealants should be placed on pits and fissures of children's and adolescents' permanent teeth when it is determined that the tooth, or the patient, is at risk of experiencing caries<sup>2,5,33,46,47,55,66</sup> (Ia, B).<sup>\*†</sup>**

Pit-and-fissure sealants should be placed on early (noncavitated) carious lesions, as defined in this document, in children, adolescents and young adults to reduce the percentage of lesions that progress<sup>82</sup> (Ia, B).<sup>†</sup>

**Visual examination after cleaning and drying the tooth is sufficient to detect early noncavitated lesions in pits and fissures.**

## ▶ FOOTNOTES

Dr. Beauchamp is in private practice in Clarksville, Tenn. At the time these recommendations were developed, she was a member, Council on Access, Prevention and Interprofessional Relations, American Dental Association, Chicago.

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**Disclosure:** None of the authors reported any disclosures.

These excerpts were taken from the Journal of the American Dental Association: J Am Dent Assoc, Vol 139, No 3, 257-268. © 2008

## DISCUSSION

We found that sealing caries lesions reduced the probability of lesion progression. The summary prevented fraction was more than 70%, and in the sensitivity analyses, the lower bound of the 95%CI always exceeded 50%. The consistency in size and direction across included studies and under a range of conservative assumptions indicates that the findings are robust.

Because non-cavitated lesions accounted for almost 90% of teeth in this study, the evidence supporting the sealing of non-cavitated lesions (NC) was stronger than that for the sealing of cavitated (C) lesions. The median annualized probability of progression for NC lesions was very low (2.6%). This finding does not support reported concerns about poorer outcomes associated with the inadvertent sealing of caries and should lessen the reluctance of practitioners to provide sealants—an intervention proven to be highly effective in preventing caries. The annualized probability reflects progression in lesions recognized as “early or incipient” and suggests that the probability of progression for pit-and-fissure surfaces with caries considered “questionable” could be even lower. These findings not only support the placement of sealants to manage and arrest lesions determined to be in the early carious stages, but also, just as importantly, support their placement for surfaces where caries status is uncertain.

Another notable finding of this review was the low annualized probability of progression (12.6%) for not-sealed, non-cavitated lesions. This finding suggests that immediate surgical treatment of such lesions may not be necessary. Thus, practitioners can consider sealing these surfaces or can simply wait and monitor them for signs of active progression. Approaches focusing on prevention and management (*e.g.*, sealants) are particularly attractive, since they could potentially preserve tooth structure and lower the likelihood of future complex restorations.

While limitations of this analysis have been carefully described, the strengths of these studies, and of the meta-analysis as well, should be clearly noted. First, we conducted a sensitivity analysis that adjusted for correlation among multiple observations *per* person to determine the most conservative (widest) confidence interval for the summary prevented fraction. Other systematic reviews of sealant effectiveness have included studies with multiple observations *per* person, and this systematic review is likely the first study that adjusted data for this limitation. In addition, the consistency of the effect measure across studies also lends support for the quality of the 6 studies; it is very unlikely that such consistency among estimates based on studies with noted variations occurred by chance alone.

There is additional evidence for sealant effectiveness in the management of caries. Two other studies identified in the larger systematic review also examined the impact of sealants on caries progression, but did not report % of lesions progressing. One study found that caries lesions measured by radiographic assessment were more likely to regress under intact sealants than under defective sealants (Handelman *et al.*, 1986). Another RCT found that the mean depth change in caries lesions was significantly lower in the sealed group than in the not-sealed group (49  $\mu\text{m}$  vs. 614  $\mu\text{m}$  depth change; Mertz-Fairhurst *et al.*, 1979). In addition, several studies have found that sealing caries reduces bacteria levels (Jeronimus *et al.*, 1975; Jensen and Handelman, 1980).

Excerpts from Journal of Dental Research, Feb 2008, vol 87, no.2, 169-174

**TABLE****Recommendations for school-based sealant programs.**

These recommendations update earlier guidelines<sup>15</sup> and support policies and practices for school-based dental sealant programs that are appropriate, feasible and consistent with current scientific information. This update focuses on indications for sealant placement on permanent posterior teeth that are based on caries status, and methods of assessing tooth surfaces. These recommendations also address methods of cleaning tooth surfaces, use of an assistant during sealant placement and follow-up issues. These topics should be considered in the context of the essential steps in sealant placement, including cleaning pits and fissures, acid-etching surfaces and maintaining a dry field while the sealant is placed and cured.<sup>16</sup> Practitioners should consult manufacturers' instructions for specific sealant products.

School-based sealant programs also can connect participating students with sources of dental care in the community and enroll eligible children in public insurance programs.<sup>3</sup> Programs should prioritize referral of students with cavitated carious lesions and urgent treatment needs. For students with cavitated carious lesions who are unlikely to receive treatment promptly, dental practitioners in sealant programs may use interim management strategies. Strategies could include placement of sealants for small cavitations with no visual signs of dentinal caries and atraumatic restorative procedures.<sup>15,62-64</sup>

<b>TOPIC</b>	<b>RECOMMENDATION</b>
<b>Indications for Sealant Placement</b>	Seal sound and noncavitated pit and fissure surfaces of posterior teeth, with first and second permanent molars receiving highest priority.
<b>Tooth Surface Assessment</b>	Differentiate cavitated and noncavitated lesions. <ul style="list-style-type: none"> <li>■ Unaided visual assessment is appropriate and adequate.</li> <li>■ Dry teeth before assessment with cotton rolls, gauze or, when available, compressed air.</li> <li>■ An explorer may be used to gently confirm cavitations (that is, breaks in the continuity of the surface); do not use a sharp explorer under force.</li> <li>■ Radiographs are unnecessary solely for sealant placement.</li> <li>■ Other diagnostic technologies are not required.</li> </ul>
<b>Sealant Placement and Evaluation</b>	Clean the tooth surface. <ul style="list-style-type: none"> <li>■ Toothbrush prophylaxis is acceptable.</li> <li>■ Additional surface preparation methods, such as air abrasion or enameloplasty, are not recommended.</li> </ul> Use a four-handed technique, when resources allow. Seal teeth of children even if follow-up cannot be ensured. Evaluate sealant retention within one year.

**37-4-405. Dental hygienist to practice under supervision of licensed dentist -- exceptions -- definitions.** (1) A licensed dental hygienist may:

- (a) with the permission of the supervising dentist, practice in the office of a licensed and actively practicing dentist under the general supervision of a licensed dentist; or
- (b) provide dental hygiene preventative services in a public health facility under the general supervision of a licensed dentist or, subject to the provisions of subsection (4), under public health supervision.

(2) A dental hygienist may give instruction in oral hygiene without the direct supervision or general supervision of a licensed dentist in a public or private institution or hospital or extended care facility or under a board of health or in a public clinic.

(3) For the purposes of this section, the following definitions apply:

(a) "direct supervision" means treatment by a dental auxiliary or licensed dental hygienist provided with the intent and knowledge of the dentist. The treatment must be performed while the dentist is on the premises.

(b) "general supervision" means treatment, except the administration of local anesthesia, by a licensed dental hygienist provided with the intent and knowledge of the dentist licensed and residing in the state of Montana. The supervising dentist need not be on the premises.

(c) "public health facility" means:

(i) federally qualified health centers; federally funded community health centers, migrant health care centers, or programs for health services for the homeless established pursuant to the Public Health Service Act, 42 U.S.C. 254b; nursing homes; extended care facilities; home health agencies; group homes for the elderly, disabled, and youth; head start programs; migrant worker facilities; local public health clinics and facilities; public institutions under the department of public health and human services; and mobile public health clinics; and

(ii) other public health facilities and programs identified by the board under subsection (6); and

(d) "public health supervision" means the provision of limited dental hygiene preventative services without the prior authorization or presence of a licensed dentist in a public health facility.

(4) (a) A licensed dental hygienist practicing under public health supervision may provide dental hygiene preventative services that include removal of deposits and stains from the surfaces of teeth, the application of topical fluoride, polishing restorations, root planing, placing of sealants, oral cancer screening, exposing radiographs, and charting of services provided.

(b) A licensed dental hygienist practicing under public health supervision may not provide dental hygiene preventative services that include local anesthesia, denture soft lines, temporary restorations; or any other service prohibited under 37-4-401.

(c) A licensed dental hygienist practicing under public health supervision shall provide:

(i) for the referral to a licensed dentist of any patient needing treatment outside the scope of practice authorized for a licensed dental hygienist under this subsection (4); and

(ii) treatment based upon medical and dental health guidelines adopted by rule by the board.

(5) (a) A dental hygienist practicing under public health supervision shall obtain a limited access permit from the board.

(b) The board shall adopt rules:

(i) defining the qualifications necessary to obtain a limited access permit; and

(ii) providing a process for obtaining a limited access permit.

(c) **Except as provided in subsection (6)**, the provision of services under a limited access permit is limited to patients or residents of facilities or programs who, due to age, infirmity, disability, or financial constraints, are unable to receive regular dental care.

**(6) A dental hygienist with a limited access permit may provide a school based sealant program without the prior authorization or presence of a dentist.**

~~(6)~~**(7)** The board may identify, by rule, other public health facilities and programs, in addition to those listed in subsection (3)(c), at which services under a limited access permit may be provided.

State of Illinois  
Rod R. Blagojevich, Governor  
Department of Public Health  
Eric E. Whitaker, M.D., M.P.H., Director

# Providing Dental Services in Schools...

## Easier than you may think!

### Myths and Facts

#### **Insist on dental sealants – proven to prevent dental decay!**

Dental sealants are plastic coatings applied to the chewing surfaces of molars that prevent dental decay. When combined with appropriate use of fluorides, dental sealants can virtually eradicate dental decay, the most prevalent dental disease!

#### **Myth**

Too much time is lost when taking students out of the classroom for school-based dental care.

#### **Fact**

More time is lost when students miss school because of toothaches. An estimated 51 million school hours per year are lost due to dental related illness. Overall, children with good oral health spend more time in school learning.

#### **Myth**

It is too costly to provide dental services in schools.

#### **Fact**

The Illinois Department of Public Health's **Dental Sealant Grant Program** provides grant funds to local communities throughout the state to implement school-based dental sealant programs. Illinois dental service providers, community dentists and dental hygienists provide preventive services **at no cost to your school**. A value cannot be placed on the averted dental disease, or the pain and suffering of a child with oral disease.

#### **Myth**

Dental equipment takes up too much space in the schools and takes a long time for dental staff to set up.

#### **Fact**

Portable dental equipment can be set up in a school gymnasium, library, classroom corner or a hallway if necessary. It takes approximately 45 to 60 minutes to set up equipment and supplies and approximately 30 to 45 minutes to disassemble and pack up.

**Myth**

Students are apprehensive about receiving dental care in a school setting, especially when parents are not present.

**Fact**

Students actually do very well when receiving school-based dental services. Students tend to find dental care less threatening when they observe their classmates receiving care.

**Myth**

School-based dental services are second rate.

**Fact**

Quality care is priority with school-based services. **The Dental Sealant Grant Program** requires rigorous standards for quality assurance through grantee performance reviews, audits and sealant retention rate standards.

**Myth**

It is the responsibility of the parent, not the school, to ensure that children have good oral health.

**Fact**

Unfortunately, many parents cannot afford or access dental care. Schools can help children receive necessary preventive care in order to stay healthy.

**Myth**

Dental sealants don't make a big difference in a child's oral health status.

**Fact**

Dental sealants are effective in preventing dental decay. School-based dental sealant programs have been shown to reduce dental decay on the chewing surfaces of back teeth by 60 percent over a five-year period. They are 100 percent effective when fully retained.

**\*Reminder - Illinois law now requires all children in kindergarten, second and sixth grades to have a dental examination. Utilizing school-based services may be a viable way to help your students fulfill this requirement.**

Printed by Authority of the State of Illinois

P.O.#346088 2M 2/06

January 10, 2011

Senate Public Health, Welfare and Safety Committee  
Montana Legislative Session 2011  
Helena, MT

Dear Committee Members:

As the Executive Director of Young Parents' Education Center I am writing to extend my support for the bill SB2, Sealants for Montana Kids. The Dental Hygiene Preventive Services for elementary school children proposed by dental hygienists in Montana would have remarkable educational and preventive results for years to come.

Kim Dunlap is a local dental hygienist and a state advocate for services to young children with barriers to accessing proper dental care. She started a pilot program with our young families, teen parents and their infants and toddlers. The preventive and educational components of dental hygiene that Ms. Dunlap has provided to our students and their children have been an outstanding addition to our program. The young families that participate in our program are the highest risk families in our community. Their children are quite young, infants through three, and the parents are age 15 through 24. Approximately 90% annually are considered low-income by the USDA food program guidelines. The majority of the children and some of the parents receive Medicaid.

The barriers facing these young families are many - transportation, financial, educational. Ms. Dunlap has brought her services to our center, provided the education for the teens to understand the importance of immediate dental care for their children and themselves. All of our children have had the sealants and she has assisted the parents with referrals to local dentists for their needs. Without her on-site visits to our location within Paris Gibson Education Center these families would not have received dental services. Good dental health encourages better general health and therefore, better school attendance.

Young Parents' Education Center strongly supports this bill to extend the Sealant Program to all children with barriers to accessing dental services. Please give serious consideration to the proposal presented to you via SB2. Ms. Dunlap and her colleagues are innovative professionals who deserve your support. If you need further information, feel free to contact me at 268-6665 or e-mail [linda\\_bennetts@gfps.k12.mt.us](mailto:linda_bennetts@gfps.k12.mt.us).

Sincerely,

Linda Bennetts, Executive Director  
Young Parents' Education Center

**JAN DONALDSON, RN, BSN**  
100 Stuart St.. Helena, Montana 59601  
406-443-5006 [JanD1943@gmail.com](mailto:JanD1943@gmail.com)

January 7, 2010

To: Members of Senate Committee on Public Health, Welfare and Safety

Re: Senate Bill 2: Allowing Dental Hygienists with a Limited Access Permit to Conduct School-based Sealant Programs

I urge you to vote "Yes" on Senate Bill 2. As a nurse who has worked with children for over 20 years, I am aware of the significant impact that dental caries can have on a child's ability to function successfully in a school setting. Chronic pain interrupts attention and learning. Young children may not even be able to articulate discomfort very well except by irritability and inattention to task.

Dental hygienists are well trained, experienced professionals who are capable of making visual assessments to determine which children qualify for sealant placement and to administer the sealant. Using their skills in a school setting is an efficient method of administering sealant to a greater number of children than can be handled in a dental office setting.

Many Montana families are encountering significant financial constraints in the present economy. Routine dental care may be one place they cut back to be able to pay for food, gas, housing, and child care – all necessary to enable parents to work. This program will provide a service that might otherwise be excluded from a child's health care. It will cost the state no monies since sealants are already covered by the Healthy Montana Kids program.

Please vote "yes" on Senate Bill 2, to provide some of our youngest citizens the dental health care they need.



**TOOTH SAVERS LLC**

509-863-2250

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Gail Heacox RDH,BS  
1616 N Sand Brook ST  
Spokane, WA 99224

January 4, 2011

**Senate Public Health, Welfare and Safety Committee**

Re: SB2 Montana / Supportive Testimony

Dear Members of the Committee,

I am a dental hygienist from Washington State. I started a School Sealant and Fluoride Varnish Program in Spokane County 3 years ago. There are many challenges in starting a business and it may be especially true when you are bringing in a business that is not understood well. I started out with 3 schools and I am now serving preventative services in 6 Spokane school districts and 4 rural ECEAP schools in Whitman County.

At first, I needed to educate many people in the school districts, as well as people in my own field of dentistry in regards to what a School Sealant and Fluoride Varnish Program could do in the school and how we could do it safely. I had to share with them the scientific research, the pediatric articles, and CDC articles about the safety and effectiveness of School Sealant and Fluoride Varnish Programs. I even had to show my community members the support I have from our own State Department of Health.

There are many resources in the dental community that help dental hygienists like me to be successful in a School Sealant Program. I've worked closely with our Public Health department, Communities in Schools org., school nurses and school officials to form my program to fit the needs of our community. I started with a pilot program in 2008 and I now have 26 schools and 4 ECEAP classes that I service. From September to mid December this year I saw 279 children for preventative services.

My dental hygiene team helps provide safe and affordable access to preventative dental care in Spokane County, Washington. Many of these children had no current dentist for 1-5 years and were not receiving any preventative dental care. I have had no incidents in regards to safety. This is proof of success!

Sincerely yours,

Gail Heacox RDH,BS

To: Senate Public Health, Welfare and Safety Committee

Date: January 2011

RE: Support for SB2

In 2003 I testified in support of SB190, legislation to create the Limited Access Permit (LAP) for dental hygienists. Passage of this legislation increased the access to dental hygiene services in public health settings.

Being the first hygienist to secure the Limited Access Permit, I can assure you that it works. I am currently serving in two separate programs for the elderly, at a long-term care facility, and with the PACE program. It is rewarding, challenging and successful.

Reimbursement for dental hygiene services is provided through various methods. At the long-term care facility, Medicaid or private pay is the method of payment. Being under contract with the PACE program, I am paid directly through their program funding provided by a Federal grant.

With the passage of SB2, you have the opportunity to expand the settings where the LAP can be utilized. The initial bill in 2003 included "schools" in the list of acceptable settings. Opposition from dentistry led to the deletion of this setting due to lack of definition of "school". SB2 is straight-forward and leaves no doubt as to the setting and what service will be provided. This legislation represents an opportunity to offer preventative services to hundreds of children, who may not currently have access to dental care. It is also a chance to recognize those in need and refer for further treatment, if possible.

Please join me in support of SB2.

Judith Harbrecht, RDH  
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