

The Evolution of State-Based Dental Sealant Programs in Oregon Within the Context of the State Health Care Transformation Process

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ABSTRACT

Context: The 2007 Oregon Smile Survey of first, second, and third graders found that, since the first (2002) Smile Survey, all major measures of Oregon children's oral health had worsened. The Centers for Disease Control and Prevention recommends 2 interventions proven effective in preventing dental caries (cavities) in a population: community water fluoridation and school dental sealant programs. Repeated attempts at the state level to mandate water fluoridation had failed. State government therefore moved to increase the number of school dental sealant programs.

Objectives: The objective of this article is to demonstrate how 2 interventions and subsequent statewide collaboration addressed the deterioration of children's oral health from 2002 to 2007.

Design: An 11-year observational study to increase the number of schools in Oregon with dental sealant programs in the state of Oregon during health care transformation.

Interventions: (1) Providing state general funds for a state school dental sealant program and (2) establishing an incentivized sealant metric for the Coordinated Care Organizations contracted to serve the Medicaid population.

Results: In school year (SY) 2006-2007, only 26% (n = 92) of the state's eligible elementary schools had dental sealant programs. By SY 2013-2014, the use of state general funds increased the number of schools served to 78% (363 schools). By SY 2017-2018, with the establishment of the sealant metric, state and local programs served 92% (n = 473) of the eligible early elementary grades and 65% (n = 172) of the newly eligible middle school grades.

Conclusion: Providing state general funds and establishing a sealant metric increased the number of schools served by school dental sealant programs and may have contributed to recent improvements in oral health.

KEY WORDS: dental sealants, public health, school dentistry

Context

The Centers for Disease Control and Prevention recommends 2 interventions to reduce dental caries (cavities) at the population level: (1) community water fluoridation and (2) school-based dental sealant

programs.¹ All water contains some fluoride. Community water fluoridation is the adjustment of the fluoride content in the public water supply to 0.7 parts per million, an intervention that has been shown to decrease caries by 25%.²

A dental sealant is a liquid coating applied to the pits and fissures of the chewing surfaces of the back teeth—the surfaces where 90% of caries occur. The coating fills in the tooth surface irregularities and prevents food and bacteria from lodging there. The coating is hardened with a curing light, no anesthetic is needed, and no tooth structure is removed. School dental sealant programs (SDSPs) bring dental providers into the schools to screen the students and provide sealants when appropriate for the students who have parental permission.

The Community Preventive Services Task Force has identified school-based programs to prevent dental caries by delivering dental sealants among children as an evidence-based program. Programs that delivered sealants within school settings increased the proportion of students who received sealants and

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decreased occurrence of tooth decay. Implementing a sealant delivery program led to a 26 percentage point increase in the number of students who received sealants (2 studies).³ Greater increases were seen among students from low-income families. Students who received dental sealants had a median of 50% fewer cavities up to 4 years later as compared with students who did not receive sealants (2 studies).³ In the systematic review of sealant efficacy, dental sealants were shown to reduce dental caries by a median of 81% at 2-year follow-up (12 studies).³

In Oregon to date, only 22% of the population has access to optimally fluoridated water compared with 74% of the rest of the nation.⁴ Attempts to mandate water fluoridation statewide have failed in the Oregon legislature several times—in 1999, 2001, 2005, and finally again in 2007—primarily due to strong opposition from anti-fluoridation groups.

The 2007 Oregon Smile Survey, an oral health survey conducted every 5 years by the state oral health program, found that since the first Smile Survey in 2002, every major measure of children's oral health had worsened. Of Oregon's first, second, and third graders, 64% had caries experience (an increase of 12%); 17% had caries in permanent teeth (an increase of 42%); 20% had rampant caries (cavities in ≥ 7 teeth, an increase of 25%); 36% had untreated caries (an increase of 50%); and only 30% had dental sealants (a decrease of 6%).⁵ It was clear that significant change was needed to reverse this downward trend.

During the 2007 Oregon State legislative session, legislators provided general funds for the Oregon Health Authority (OHA) to establish a position for a state school oral health programs coordinator and to purchase portable dental equipment.⁶ The legislature also passed House Bill (HB) 2867, allowing dental hygienists to determine the need for and appropriateness of dental sealants and to apply dental sealants in certain locations, including schools, without a dentist's supervision.⁷ This change in the law regarding scope of practice enabled a less-expensive, yet qualified, provider to deliver services. The funding of a state SDSP was expected to have a positive effect on the number of children receiving preventive dental sealants and eventually to improve oral health.

The second intervention was introduced in 2014 by including the provision of dental sealants to 6- to 14-year-old children as a quality measure in the state's health care transformation plan.⁸ The purpose of this article is to describe the effect of these 2 interventions on the evolution of SDSPs in the state. To understand the context in which the dental sealant programs evolved, details of the health care transformation process are summarized.

State health care system transformation

Oregon began creating a system of coordinated care well in advance of the passage of the Patient Protection and Affordable Care Act (ACA) in 2010. Since the 1990s, the legislature had undertaken a series of initiatives that established a system of capitated physical, behavioral, and oral health care for Medicaid members provided by managed care organizations contracted by the state to provide the care. In 2009, the legislature passed a bill to establish the Patient-Centered Primary Care Home Program, and further legislation in 2012 launched 16 regional and self-governing Coordinated Care Organizations (CCOs) to provide physical, behavioral, and oral health care to the Medicaid population within a global budget and in partnership with community stakeholders.^{9,10} As part of the waiver negotiated between the state and the Centers for Medicare & Medicaid Services, a series of quality measures were agreed upon to document accountability and transparency. Some of the measures were tied to incentive payments for measurable outcomes achieved by the CCOs.¹¹ The incentive funds derived from a top-sliced percentage of the state Medicaid budget went to a quality pool and were distributed to the CCOs on the basis of their achievement of the quality metrics. A Metrics & Scoring Committee established by the state defined these incentive metrics.⁸ The CCOs integration was staggered with medical care and behavioral health care first, and in 2014 dental care was integrated as well.¹² To address accountability and transparency, progress toward the 17 CCO metrics was posted quarterly on a public Web site.¹³

Prior to the establishment of the CCO system, 9 Dental Care Organizations (DCOs) served the Medicaid population.¹⁴ After dental care was incorporated into the CCO delivery model, CCOs were required to develop contracts with every DCO in their respective geographic areas.¹² One dental incentive metric (which was aligned with a national clinical quality measure) was selected for measurement: "Children ages 6 to 9 and 10 to 14 who received a sealant on a permanent molar tooth." To receive incentive payments, the CCOs had to provide sealants and capture the encounters in the Medicaid database to document how their numbers progressed from their established baseline toward the state-defined benchmark (20%) or toward a defined improvement target.⁸ In 2013, before contracting with the CCOs, the DCOs provided sealants for only 11.7% of Medicaid-eligible 6- to 9-year-olds and 8.6% of 10- to 14-year-olds.¹⁵ With the incentive metric defined, it became imperative for the CCOs to ensure that the DCOs worked to meet the sealant metric to receive the additional

payment. Thus, the DCOs turned their attention to SDSPs.

Interventions

Prior to the provision of state general funds to the OHA in 2007, only 3 of Oregon's 36 counties had SDSPs and 22% of the eligible elementary schools were served. The OHA defined an eligible school as a school where at least 50% of the students were eligible for free and reduced meals under the National School Lunch Program. One large county, Multnomah County, had a robust program that had been in place since 1989. The OHA's intent was to replicate the Multnomah County model throughout the state. The OHA established a state OHA SDSP to serve first and second graders in eligible elementary schools. The strategy was to first serve a few schools in each county and then use the positive feedback from those schools to solicit participation from other schools in the area. When local dental sealant programs proved capable of providing quality services with sustainable funding, the OHA SDSP transitioned state-served schools to those local programs. These transitions freed up limited resources, allowing the OHA SDSP to expand to new, unserved schools. The local programs were administered by groups having a variety of funding sources—DCOs, Federally Qualified Health Centers, and community-based nonprofits.¹⁶

Several regions in the state had multiple overlapping CCOs and DCOs. The most populated region of the state (the tricity Portland Metro region of Multnomah, Washington, and Clackamas counties) proved the most complex. This region was served by 2 large CCOs and 9 DCOs and included 117 eligible elementary schools—94 already being served by the OHA SDSP or a local program, with 23 unserved. The potential for a very confusing situation with several providers trying to access the same schools was avoided when the otherwise competing DCOs themselves agreed to create a new nonprofit organization, Dental3 (D3), to become the single point of contact for the schools in the Metro area and coordinate all school-based outreach preventive oral health programs.¹⁷ D3 assumed responsibility for 33 schools formerly served by the OHA SDSP and partnered with the Multnomah County sealant program to ensure continued service for their 65 schools. To ensure continuity, D3 contracted with the OHA for 1 year for administrative assistance (form development, communication with the schools, loan of equipment) and used the same dental hygienists who had served the schools the previous year.

Elsewhere in the state, other organizations chose alternative methods for reaching the CCO sealant

metrics. Moda Health, in partnership with the Oregon Dental Foundation and the Oregon Education Association, provided services for school children using the *Tooth Taxi* mobile unit. Moda Health entered sealant data into the Medicaid database and also provided vouchers for restorative services.¹⁸ The Willamette Dental Group and Kaiser Dental promoted sealants within their dental offices.^{19,20}

Certification required by statute

Ultimately, the wide variation in program protocols and billing mechanisms prompted legislative intervention. In 2015, Oregon Senate Bill (SB) 660 (SB 660) was introduced to require the OHA SDSP to provide all the sealant services in the schools to ensure standardized quality across the state. The amended SB 660 that finally passed, however, required all school sealant programs to become a part of the CCO managed care system and to operate within the CCO global budget. The OHA SDSP was to transition to an oversight role and to develop a mandatory certification program to ensure quality services were provided statewide.²¹

A voluntary certification process, previously developed by the OHA with federal grant funds, served as the foundation for mandatory certification. The OHA SDSP was to continue to provide sealant services until local programs met all the requirements of certification (eg, had capacity, could bill Medicaid, had sustainable funding, and could submit aggregate data to the OHA). When local programs demonstrated the capacity to serve schools, the OHA SDSP was required to transition state-served schools to them. The OHA SDSP staff provided a required one-time certification training session for program administrators in various locations throughout the state, provided an annual clinical training session for hygienists serving in the school setting, and conducted site visits to ensure compliance with the rules.²²

The delivery of sealants in a school program is quite different from providing sealants in a private dental office. Population programs require significant planning to ensure services are evidence-based, quality control measures are in place, and data are captured. The American Dental Association and the Association of State and Territorial Dental Directors have specific guidelines for SDSPs.^{23,24} The guidelines include the implementation of quality measures, such as tracking parent permission form return rates, sealant retention at 1 year, eliciting school satisfaction feedback, and demonstrating that services are provided in an efficient and cost-effective manner. Sealant program staff had to be respectful of the school environment,

behave appropriately as *guests*, and ensure there was as little disruption to classroom time as possible.

Initially, provisional certification was granted to existing programs unable to meet the certification requirements but that had a plan to meet those requirements (eg, a method to submit encounters to the Medicaid database). A process for de-certification was in place for programs that failed to comply. SB 660 required the OHA to ensure sealant programs were available to all eligible schools. In 2015, acknowledging the new capacity to serve additional schools, the OHA moved to include all eligible elementary and middle schools where at least 40% of the students were eligible for free and reduced meals under the National School Lunch Program. Research supported targeting these schools to reach a significant number of high-risk children.²⁵

Results

The 2 interventions—designation of state general funds and the establishment of an incentivized CCO sealant metric—increased the number of children receiving dental sealants. The sealant metric led the DCOs to participate and collaborate to ensure more children received sealants and therefore made significant progress in integrating SDSPs into the existing Medicaid (CCO) system.

Table 1 illustrates the effect of legislative funding on the state dental sealant program (OHA SDSP). There was a steady increase from 11 schools served in 3 counties in SY 2006-2007 to more than 150 schools served in 25 counties in SY 2013-2014, reaching the limits of the funding. Table 1 further illustrates the subsequent, gradual decline in the number of OHA SDSP-served schools, as local programs assumed greater responsibility for providing clinical services and funding was shifted from state general funds to funding through the capitated Medicaid program (Figure 1).

Table 2 shows the growth in the percentage of eligible schools served by both the OHA SDSP and local programs. From SY 2006-2007 to SY 2013-2014, the total served grew from 92 elementary schools served (26% of eligible) in 3 counties to 363 elementary schools served (78% of eligible) in 33 of Oregon’s 36 counties.²⁶ The 2012 Oregon Smile Survey found the state had already exceeded the Healthy People (HP) 2020 objective for 6- to 9-year-olds receiving a dental sealant (HP 2020: 28.1%; Oregon: 38.1%).²⁷ In 2015, the Pew Charitable Trusts acknowledged Oregon as one of 3 states meeting the Pew’s benchmarks for SDSPs.²⁸

Table 2 also documents the effect of the sealant metric on the number of schools served. Even with the

TABLE 1 Oregon Health Authority School Dental Sealant Program Results by School Year

	School Year												
	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	
# Schools	11	43	62	140	138	141	155	153	143	88	62	23	
# Students screened	451	1 605	4 113	7 375	6 896	6 940	8 108	7 532	6 600	3 439	2 714	1 642	
# Students receiving a sealant	427	1 276	3 317	5 842	5 157	5 113	5 384	5 117	4 721	2 484	2 135	1 046	
# Sealants provided	1 201	3 697	10 771	19 774	16 163	16 227	17 108	16 348	15 108	8 193	7 371	3 578	
% Students referred	38	38	37	35	32	32	28	30	29	32	32	21	
% Permission forms returned (yes) ^a	53	33	49	44	41	43	44	40	36	34	32	34	
% Permission forms returned (yes/no) ^c	...	...	...	...	...	...	...	...	55	52	53	66
% Program retention at 1 Y	...	...	...	...	...	92	86	89	90	90	88	...

^a % Permission forms returned (yes): Parents accepted services.

^b Not available (eg, permission forms declining services were not tracked prior to 2014-2015; retention was not documented prior to 2011-2012).

^c % Permission forms returned (yes/no): Parents either accepted or declined services (total tracked to ensure parents received forms).

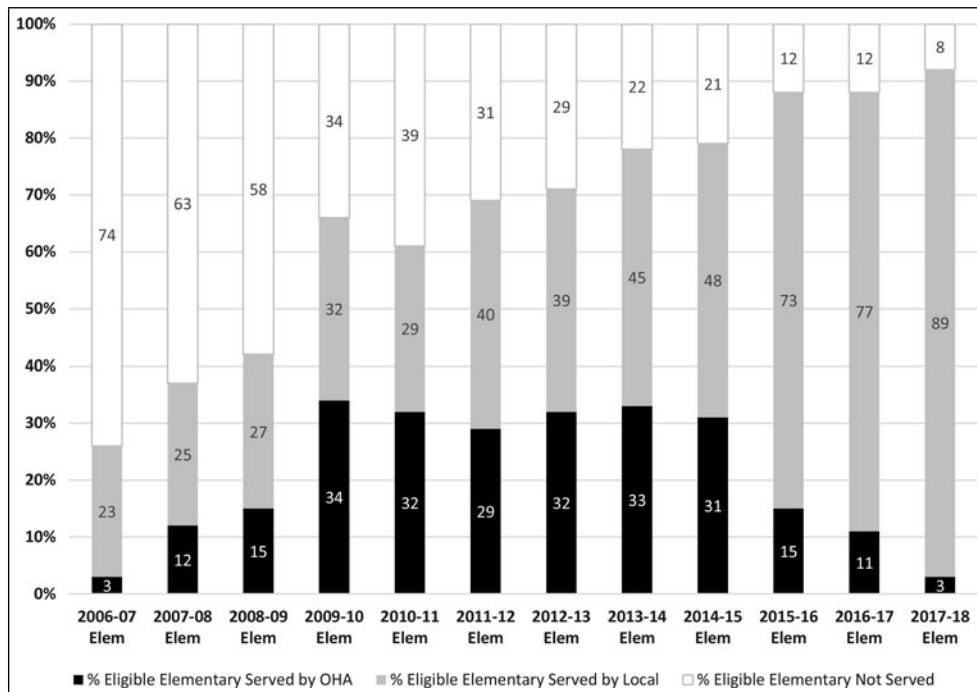


FIGURE 1 Percentage of Eligible Elementary Grades Served/Unserved by the OHA SDSP and Local Programs
Abbreviations: OHA, Oregon Health Authority; SDSP, school dental sealant program.

substantial increase in the number of eligible schools that first year (SY 2015-2016), sealant programs served 88% of the eligible elementary and 47% of the eligible middle schools. Figure 2 portrays the growth over time in the number of schools served statewide.

Twenty-one programs became fully certified in 2016. Certification required local programs to submit aggregate data to enable statewide reporting and to allow site visits by the OHA.²² It is important to note that Table 2 pertains to *eligible* schools served. During SY 2016-2017—the first year data submission was required—649 schools were served (total number of schools served, eligible and ineligible); 41 442 students were screened; 22 127 students received at least 1 sealant; and 72 528 sealants were placed. In 2017, the national Children’s Dental Health Project Sealant Workgroup named Oregon’s certification program as an example of a quality assurance measure.²⁹

In SY 2017-2018, a total of 21 programs were fully certified—4 programs merged into 2; 2 new programs became certified. The data submitted showed increases from the previous year in the number of schools served (from 649 to 687), the number of children screened (from 41 442 to 59 978), the number of children receiving sealants (from 22 127 to 25 434), and the number of sealants provided (from 72 528 to 80 511) (OHA, unpublished data, 2018).

The certification program proved effective in reducing the number of schools served by more than 1 program from 22 schools in SY 2016-2017 to 2 schools in SY 2017-2018. Having more than 1 dental program in a school is confusing both for the school staff and for parents (eg, duplication of forms). Retention of sealants at 1 year—another quality measure—also improved, with programs reporting a range of 57% to 99% retention in SY 2016-2017, improving to 81% to 98% retention by SY 2017-2018.

The 2016 CCO metric report indicated that 15 of the 16 CCOs met their sealant metric targets and received the associated incentive payments. The one CCO that did not improve in 2016 had already surpassed the benchmark in 2015 (3% improvement each year is a target goal).³⁰ In 2017, all CCOs met their sealant metric target.³¹

From SY 2013-2014 to SY 2017-2018, the percentage of programs capturing sealant services in the Medicaid database increased as more local programs assumed responsibility for services (see Figure 1). (The OHA SDSP was not able to enter services directly into the database.) Capturing sealants in the Medicaid database allowed for a more accurate national assessment of the services provided in Oregon for this population.

TABLE 2
Eligible Schools Served by the OHA SDSP and by Local SDSPs, 2006-2018

	Eligible Elem Schools		Eligible Middle Schools		OHA SDSP			Local Programs			Statewide (SDSP and Local)				
	Eligible Elem Schools	Eligible Middle Schools	Elem	Middle	SDSP Total	Elem	Middle	Local Total	Eligible Served Elem Schools	% Eligible Served Elem	Eligible Served Middle Schools	% Eligible Served Middle	Eligible Served Elem	Eligible Served Middle	Eligible Served Middle
2006-2007	358	0	11	0	11	81	0	81	92	26	0	0	26	0	0
2007-2008	378	0	43	0	43	96	0	96	139	37	0	0	37	0	0
2008-2009	411	0	62	0	62	112	0	112	174	42	0	0	42	0	0
2009-2010	409	0	140	0	140	129	0	129	269	66	0	0	66	0	0
2010-2011	436	0	138	0	138	126	0	126	264	61	0	0	61	0	0
2011-2012	478	0	141	0	141	189	0	189	330	69	0	0	69	0	0
2012-2013	484	0	155	0	155	190	0	190	345	71	0	0	71	0	0
2013-2014	467	0	153	0	153	210	0	210	363	78	0	0	78	0	0
2014-2015	460	0	143	0	143	220	0	220	363	79	0	0	79	0	0
2015-2016 ^a	524	281	80	8	88	382	124	506	462	88	132	47	88	132	47
2016-2017 ^a	506	269	57	5	62	392	178	570	449	89	183	68	89	183	68
2017-2018 ^a	515	263	17	6	23	456	166	622	473	92	172	65	92	172	65

Abbreviations: Elem, elementary; OHA, Oregon Health Authority; SDSP, school dental sealant program.
^aSome schools have both elementary and middle grades and were entered as separate schools, rather than as units of the first, second, and third grades (elementary) or sixth, seventh, and eighth grades (middle). In 2015-2016, this allocation pertained to 45 schools; in 2016-2017 to 62 schools; in 2017-2018 to 133 schools.

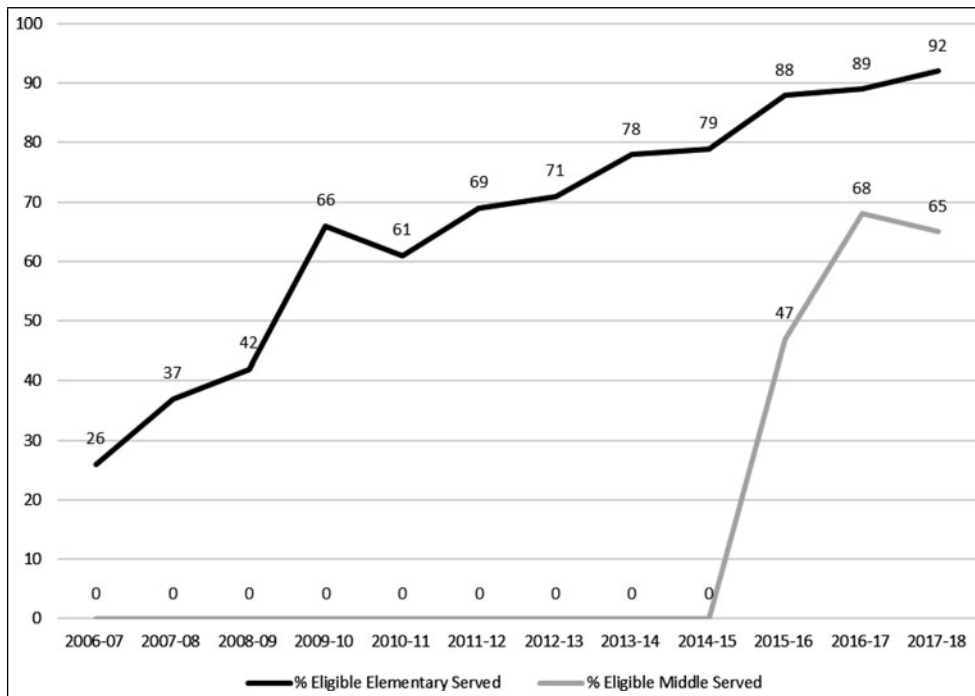


FIGURE 2 Percentage of Eligible Elementary and Middle Grades Served by the OHA SDSP and Local Programs
Abbreviations: OHA, Oregon Health Authority; SDSP, school dental sealant program.

Discussion

The greater story in this evolution of the OHA SDSP is that, over an extended period of time, the Oral Health Program (within the Oregon Public Health Division) was allowed to develop and role model an effective and evidence-based preventive oral health program financed by state general funds at a time when the state-supported managed dental care system was not yet up to the task. Through a coordinated effort comprising effective legislation and rule making that emphasized integration and coordination of oral, behavioral, and physical health care for the Medicaid population supported by incentive quality metrics, performance goals, and certification standards, the managed dental care system became convinced of the value of pursuing these preventive activities to make them part of the standard of care. The state’s role in the sustained provision of the dental sealant program could be reduced and funds directed to other purposes while a growing number of Medicaid children were able to benefit from the program.

The negative trend in oral health of Oregon’s first, second, and third graders has reversed for now. The Oregon Smile Surveys from 2007, 2012, and 2017 show a gradual decline in caries experience in primary and permanent teeth (64% to 52% to 49%) and in permanent teeth specifically (17% to 10% to 5%), a decline in untreated caries (36% to 20% to

19%), a decline in rampant decay (20% to 14% to 5%), and an increase in the number of children receiving sealants (30% to 38% to 42%)²⁷ (also OHA, unpublished data, 2018) (Table 3). SDSPs may be contributing to this improvement directly by identifying the children with needs, providing sealants, and facilitating further care, or these programs may be, at the very least, increasing the level of awareness about the importance of oral health.

The establishment of the CCO sealant metric increased the number of sealants provided through SDSPs. The Pew Center on the States (2017) “Financial Incentives Improve Dental Sealant Rates for Oregon Children” reported on the effect of the sealant metric on Oregon’s private practitioners, CCOs, DCOs, and state SDSP. The report acknowledged that private dentists sometimes found that patients scheduled for sealants may have already received them in the school program.³²

Prior to the metric, several organizations provided pro bono dental care within school programs and struggled to meet the new requirements of certification (eg, entering sealant data in the Medicaid system). All programs are now entering data into the Medicaid system and are experiencing various levels of reimbursement from the managed care system, based on contractual agreements.

Programs entering the arena in response to the incentivized sealant metric were often used to operating

TABLE 3
Oral Health of Oregon Children in First, Second, and Third Grades

	Smile Survey Year				Healthy People 2020 Objectives for 6- to 9-y-Olds
	2002	2007	2012	2017	
Caries experience ^a (primary or permanent)	57%	64%	52%	49%	49.0%
Caries experience ^a (permanent)	12%	17%	10%	5%	
Untreated caries ^b	24%	36%	20%	19%	25.9%
Rampant decay ^c	16%	20%	14%	5%	
Children with sealants ^d	32%	30%	38%	42%	28.1%
Number of children screened	3956	3865	5258	8008	

^aCaries experience: Cavities that are untreated or have received treatment.

^bUntreated caries: Cavities that have not received appropriate treatment.

^cRampant decay: 7 or more teeth with treated or untreated decay.

^dChildren with sealants: 1 or more permanent molars with a sealant.

on a business model and found it difficult to justify expenditures that did not produce a documentable and immediate return on investment. SDSP administrators soon realized that only one-third to one-half of the sealants provided in each school were for children who were members of the plan funding the program while the remaining sealants were for members of other plans, those with no insurance, or those with private insurance. This problem is indicative of a broader concern. In Oregon, many of the expenses for health care services provided in the schools are absorbed by the school system, rather than the health care system. Legislation has been proposed to assign funding responsibilities more appropriately. For example, SB 111 (2017) required a pilot project to increase Medicaid reimbursement for school nursing services and HB 3354 (2019) requires a joint responsibility for local public health authorities and CCOs to fund school-based oral health programs.^{33,34}

Presently, there is uncertainty around changes in the specifications of the dental sealant metric and whether this quality metric will be maintained if most managed dental care organizations are able to achieve the incentive benchmark year after year. Other concerns relate to possibly exchanging the dental sealant metric with another dental quality metric and whether such a situation will have an impact on the CCOs' interest in providing sealants in the schools, which might lead to the progress made being reversed. It is important to note the decline in student participation reflected in the OHA SDSP data (Table 1). In 2014, the OHA SDSP began tracking parent permission forms returned—both accepting services and declining services—to ensure parents were actually receiving the information. The data not only showed a steady number of parent permission forms returned

but also revealed that the number of forms consenting to services was declining. As has been noted in the literature, successful public health programs can experience a decline in participation when attention and efforts turn elsewhere.³⁵ Programs must be continually reinvigorated by offering additional educational opportunities, providing new incentives, or improving existing models.

Program administrators have generated several ideas to improve participation—parent permission forms in the school registration packets or forms that can be filled out online; opt-out screenings (which requires opt-in parent permission later for sealants); posters and brochures in the school foyer; short videos for parents (explaining the value, quality, and ease of the program) located online, linked in an e-mail blast, or as part of the school's video wall display; paragraph in the school newsletter; teacher incentives for high classroom participation; student incentives to return forms, while guarding against a stigma for students whose parents will not return forms; and for older students in middle school, contacting parents directly to gain permission since forms may not have reached home. School staff may be able to provide the added connection to nonresponsive parents as they are often more aware of the social challenges experienced by individual families. These parents may respond to one-on-one encouragement by these trusted school staff members.

Conclusion

The allocation of state general funds and the establishment of the CCO sealant metric increased significantly the number of sealants received by children in Oregon through the SDSPs and may have contributed

Implications for Policy & Practice

- Conduct periodic surveys of the target population to establish the burden of disease and share the results with stakeholders.
- Establish policy to ensure prevention programs are incorporated into the system of care, stating that while prevention does not provide an immediate return on investment for the individual service provider, it benefits the population as a whole.
- Provide periodic training for program administrators and clinicians and conduct site visits to ensure quality, evidence-based services are provided.
- Require programs to submit data and ensure data requirements are compatible with and included in established data sets of a comprehensive health care information system.
- Engage continually with program administrators to address concerns, find solutions, and share information, including successes with community engagement, increasing program participation, and program sustainability.

to an improvement in oral health. Implementation of the sealant metric proved both challenging and rewarding. All stakeholders were required to change their existing protocols—either incrementally or profoundly—to move toward a more coordinated and sustainable system of care. Several organizations are now collaborating, learning, and evolving to improve the health of children in Oregon. The results, demonstrated through the data, are encouraging.

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