
Updates for Programs Not Attending the OHA Clinical Training

Webinar

Monday, October 21, 2019



Housekeeping

- This webinar is being recorded. Please mute your phones to avoid background noise.
- If you have any questions during the webinar, please type them into the chat/questions feature. We will answer questions at the end of the webinar.
- Please do not put your phone on hold or take a call on another line during the webinar! Hang up and rejoin if necessary.
- The webinar recording and presentation slides will be uploaded to the OHA website in about a week.

<http://www.healthoregon.org/sealantcert>

OHA Oral Health Structure

OHA Health Policy & Analytics Division

- Bruce Austin: State Dental Director
- Sarah Wetherson: Transformation Analyst
- Sara Kleinschmit: Policy Advisor (CCO Metrics)

OHA Health Systems Division

- Kellie Skenandore: Operations & Policy Analyst (Medicaid)

Public Health Division's Oral Health Unit

- Cate Wilcox: Section Manager for Maternal & Child Health
- Amy Umphlett: Operations & Policy Analyst, Team Lead
- Karen Phillips: School Oral Health Programs Coordinator
- Sarah Kowalski: Dental Pilot Project Coordinator
- Kelly Hansen: Research Analyst
- Vanessa Cardona: Public Health Educator
- Mauri Mohler: Administrative Support

Federal Updates

Final Public Charge Regulation

- On August 12, 2019, the Department of Homeland Security announced that it had finalized a new public charge rule.
 - Proposed rule published on October 10, 2018.
 - Public comment period ended December 10, 2018.
- 266,077 public comments were received.
 - Vast majority of commenters opposed the rule.
- Federal judges have stopped the new Public Charge Rule from going into effect across the whole country.
 - It did not start on October 15, 2019.

Final Public Charge Regulation

- The new rule could make it harder for some immigrants who rely on certain government benefit programs to get lawful permanent residency if they are found to be a "public charge."
- The term "public charge test" is used by immigration officials to decide whether a person can enter the U.S. or get lawful permanent resident status (i.e. green card).
- New rule expands the list of benefits that would be considered in a public charge determination to include:
 - Non-emergency Medicaid for adults
 - Supplemental Nutrition Assistance Program (SNAP)
 - Several housing assistance programs

Final Public Charge Regulation

- The rule does not apply to these programs:
 - Medicaid for children under 21 and pregnant women (including 60 days postpartum)
 - Emergency Medicaid (CAWEM)
 - Children’s Health Insurance Program (CHIP)
 - WIC Program
 - Medicaid-covered special education services funded by the Individuals with Disabilities Act (IDEA)
 - School-based health services
 - Oregon’s Cover All Kids Program

Potential Impact to Clients

- Creates new barriers to getting a green card or immigrating to the U.S.
- Likely will lead to disenrollment from public benefits programs by many immigrants, including those not directly affected by the rule and U.S.-born dependents.
- Increases the number of uninsured individuals.
- Negatively affects the health and financial stability of families.

Proposed Food Stamp Rule Change

- USDA proposed a rule that would “close the loophole” of categorical eligibility in the Supplemental Nutrition Assistance Program (SNAP).
- Oregon is one of 43 states that currently allow families eligible for Temporary Assistance for Needy Families (TANF) to automatically enroll in SNAP.
- Under the proposed rule, this “categorical eligibility” would be eliminated. Families would have to separately qualify for and enroll in SNAP, verifying income and reporting their expenses again.
- Public comment period ended September 23, 2019.

Potential Impact

- Children who live in SNAP households automatically qualify for free school meals.
- SNAP participation is also used to determine which schools and districts are eligible to take advantage of the Community Eligibility Provision (CEP), which allows them to serve free meals to all students without qualifying paperwork.
- Proposed rule is expected to drop an estimated 500,000 children from automatically receiving free school meals.
- Approximately 3.1 million people could lose SNAP benefits nationwide.

State Updates

2019 Oregon State Legislative Session

HB 3165 Enrolled

- Requires OHA to provide planning grants to 10 school districts or education service districts (ESDs) to evaluate community needs for school-based health services.
- Requires OHA to provide operating funds to at least 6 school-based health center medical sponsors to open state-certified school-based health centers in grantee school districts or ESDs.
- Permits OHA to provide operating funds to up to 4 school districts or ESDs to implement five-year pilot projects testing approaches to providing school-based health services as alternatives to school-based health centers.

2019 Oregon State Legislative Session

SB 155 Enrolled

- Requires investigations of all reports involving suspected abuse or suspected sexual conduct by school employees, contractors, agents and volunteers.
- Establishes requirements for law enforcement agencies, Department of Human Services (DHS), Teacher Standards and Practices Commission, and the Oregon Department of Education (ODE) to conduct investigations related to reports of abuse **that involve child and person who is school employee, contractor, agent or volunteer.**

2019 Oregon State Legislative Session

SB 824 Enrolled

- Allows Oregon Board of Dentistry to accept results of national standardized examinations under specified circumstances when determining fitness of applicant to practice dentistry or dental hygiene.
- Requires board to accept results from regional and national testing agencies for laboratory and clinical examinations under specified circumstances.

CCO 2.0

OHA went through a process to select the CCOs who will serve the Oregon Health Plan's (OHP-Medicaid) one million members from January 1, 2020 – December 31, 2024.



Improve the behavioral health system and address barriers to the integration of care



Increase value and pay for performance



Focus on the social determinants of health and health equity



Maintain sustainable cost growth and ensure financial transparency

CCO 2.0 Application Timeline

- OHA released the request for applications (RFA) on January 25, 2019 which laid out the requirements applicants must meet to serve OHP members.
- OHA received 24 letters of intent by February 1, 2019.
- OHA received 19 applications by April 22, 2019.
- OHA announced their intent to award contracts to 15 applicants on July 9, 2019.
- OHA signed contracts with 15 organizations on October 4, 2019 to serve as CCOs.
 - 11 received five-year contracts.
 - 4 received one-year contracts.

Evaluation of Applications

- **Care coordination and integration:** Ability to coordinate with outside entities (including public and community-based organizations), between levels of care, for special populations of members and to **integrate behavioral and oral health services**.
- **Delivery system transformation:** Innovating to improve care delivery and quality (including primary care), access to culturally and linguistically appropriate care, measurement of value and efficiency of services.
- **Community engagement:** Strength of the Community Engagement Plan and of community engagement in developing the application.

Evaluation of Applications

- **Clinical and service delivery:** Utilization monitoring, ensuring appropriate access to services, clinical review and prior authorization, and approach to addressing complaints and grievances.
- **Business administration:** CCO business processes, member engagement and outreach, adoption of electronic health records, and supporting members during transition.
- **Finance:** Applicant solvency, plans for increasing value-based payments, tracking and reporting of social determinants of health investments and outcomes, managing within the global budget, and cost containment.

CCO 2.0 Contract Awardees

Awardee	Contract Length	Service Area
AllCare CCO	1 year	Josephine, Jackson, Curry, partial Douglas
Cascade Health Alliance	1 year	Partial Klamath
Columbia Pacific CCO	5 years	Clatsop, Columbia, Tillamook
Eastern Oregon CCO	5 years	Sherman, Gilliam, Morrow, Umatilla, Union, Wallowa, Wheeler, Grant, Baker, Lake, Harney, Malheur
Health Share of Oregon	5 years	Clackamas, Multnomah, Washington
InterCommunity Health Network	5 years	Lincoln, Benton, Linn
Jackson Care Connect	5 years	Jackson County

CCO 2.0 Contract Awardees

Awardee	Contract Length	Service Area
PacificSource Community Solutions - Central Oregon	5 years	Crook, Deschutes, Jefferson, partial Klamath
PacificSource - Columbia Gorge	5 years	Hood River, Wasco
PacificSource – Lane	5 years	Lane
PacificSource - Marion Polk	5 years	Marion, Polk
Trillium Community Health Plan	5 years	Lane, Clackamas, Multnomah, Washington, partial Linn, partial Douglas
Umpqua Health Alliance	1 year	Partial Douglas
Western Oregon Advanced Health	5 years	Coos, Curry
Yamhill County Care Organization	1 year	Yamhill, partial Polk, partial Washington

Oral Health Metrics

2019 CCO Incentive Metrics

- Each CCO is being paid for reaching benchmarks or making improvements on incentive measures from a “Quality Pool”*.
 - 19 metrics
 - 3 dental metrics
 - Children ages 6-9 and 10-14 who received a sealant on a permanent molar tooth.
 - Mental, physical, and dental health assessments within 60 days for children in DHS custody.
 - Oral evaluation for adults with diabetes

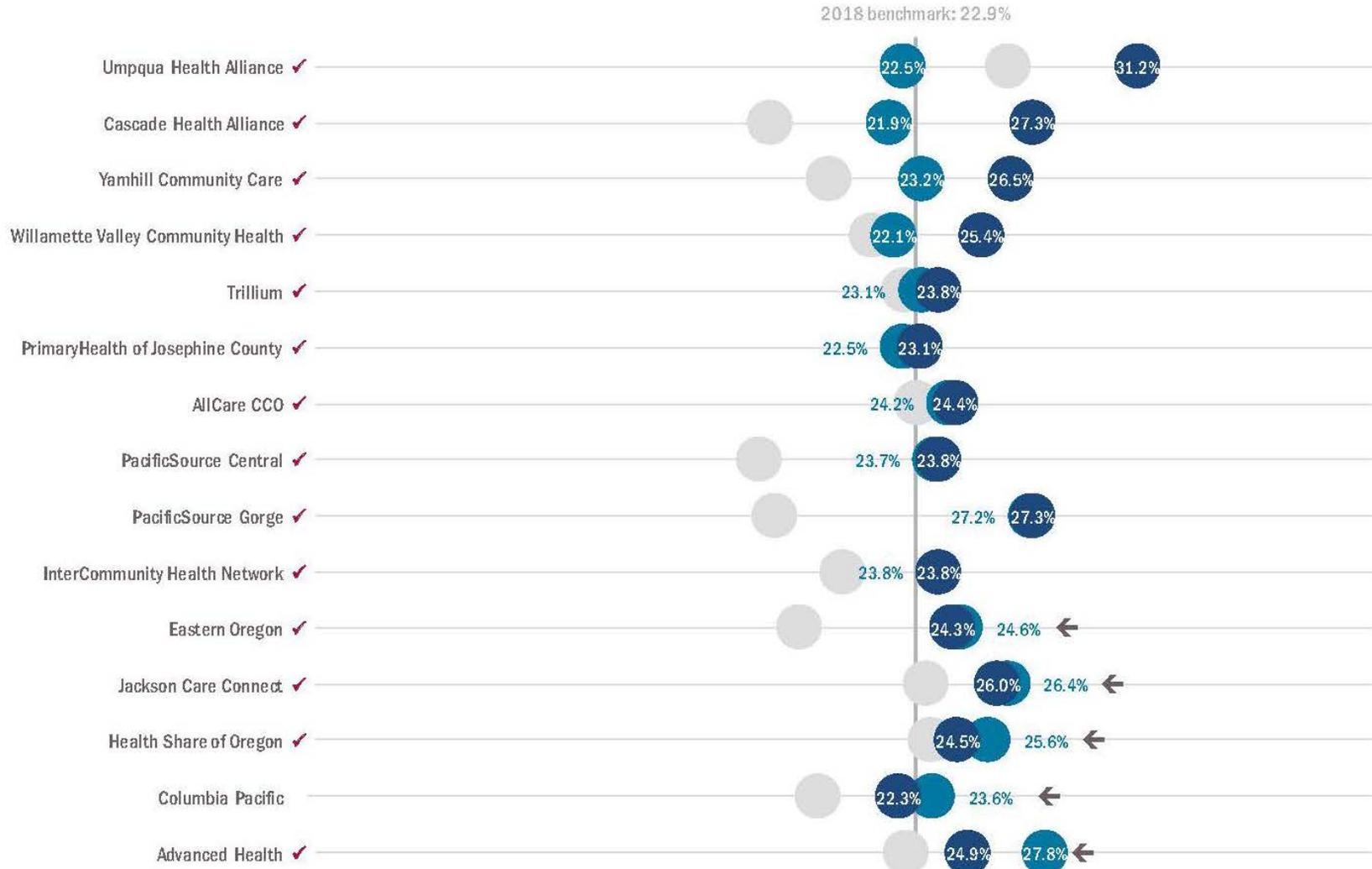
*Quality Pool: CCOs place into the pool a percentage of the aggregate payments they are contracted to receive. Only if they meet their metrics, do they receive it back. In 2018, it was 4.25%.



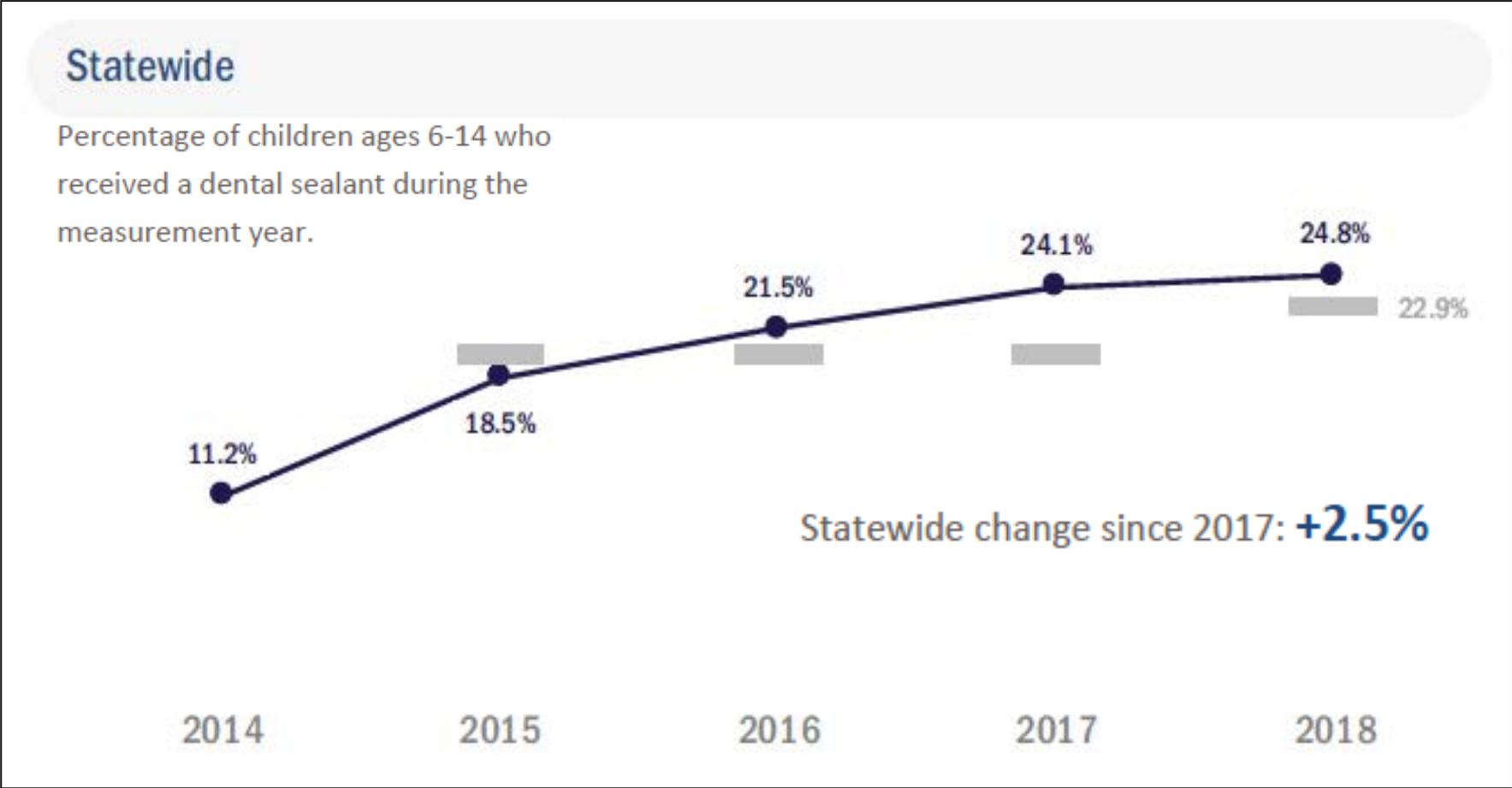
DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants on permanent molars for children (all ages) 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.

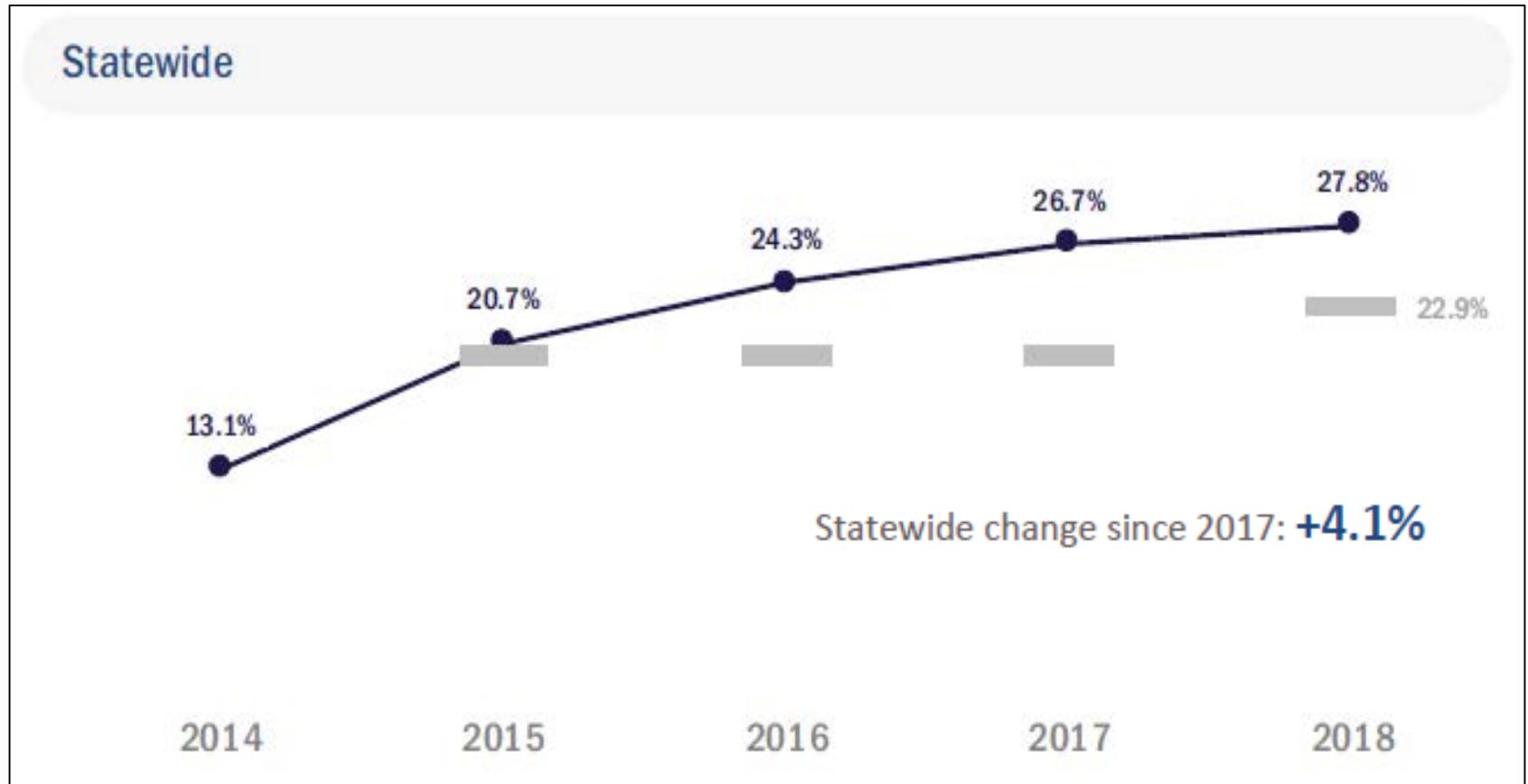


Dental Sealants on Permanent Molars (ages 6-14)



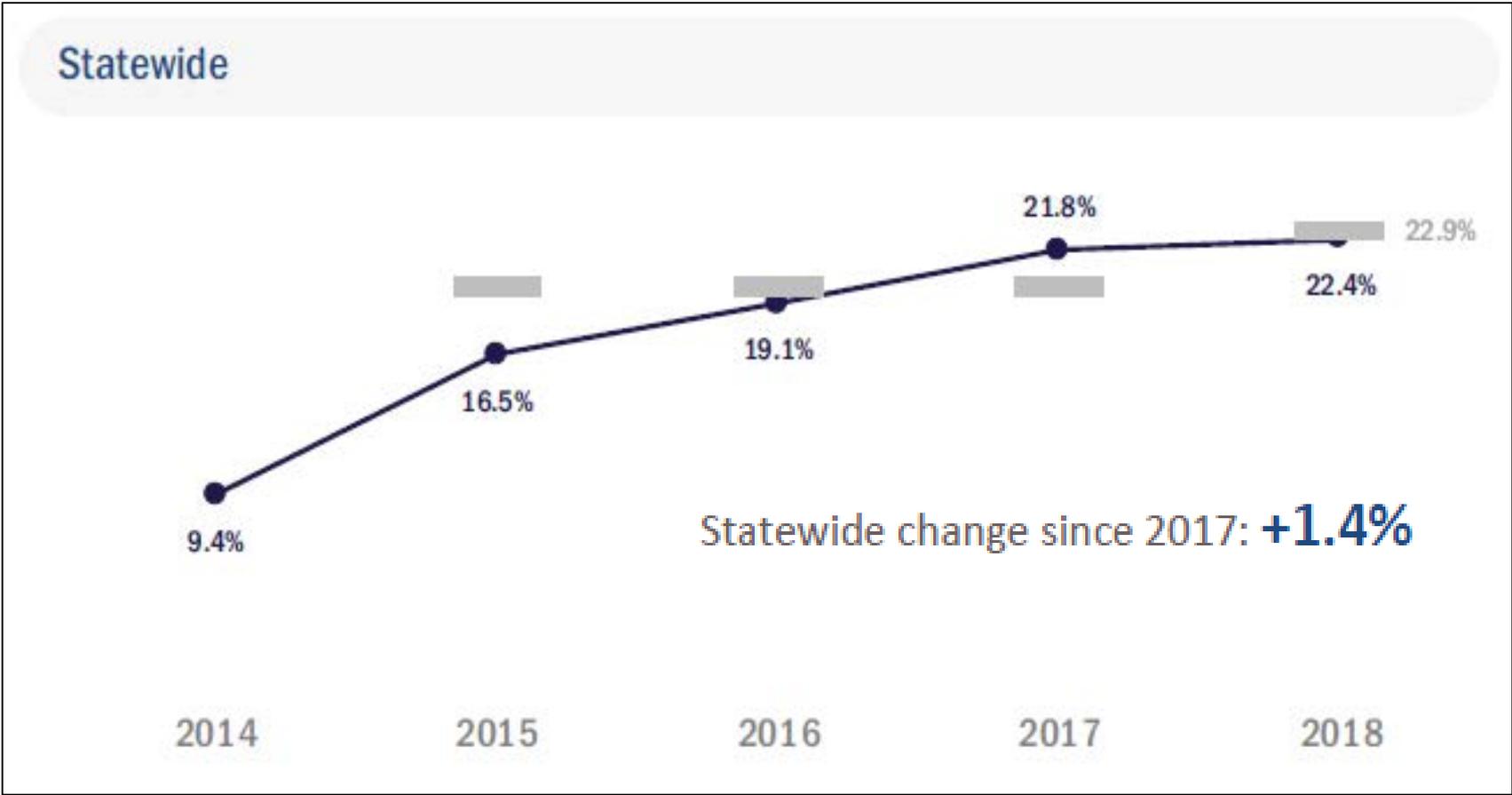
Oregon Health System Transformation: CCO Metrics 2018 Final Report.
July 2019. <https://www.oregon.gov/oha/OHPB/CCODocuments/2018-CCO-Report.pdf>

Dental Sealants on Permanent Molars (ages 6-9)



Oregon Health System Transformation: CCO Metrics 2018 Final Report.
July 2019. <https://www.oregon.gov/oha/OHPB/CCODocuments/2018-CCO-Report.pdf>

Dental Sealants on Permanent Molars (ages 10-14)



Oregon Health System Transformation: CCO Metrics 2018 Final Report.
July 2019. <https://www.oregon.gov/oha/OHPB/CCODocuments/2018-CCO-Report.pdf>



2020 CCO Incentive Metrics

- Metrics and Scoring Committee approved the final measure set of CCO incentive metrics for 2020 on July 19, 2019.
 - Reduced the number of metrics from 19 down to 13.
 - Dental sealants was taken off the list.
- Considerable time was spent looking at the draft Dental Quality Alliance (DQA) dental sealant specifications.
 - DQA changed the specifications 3 different times.
- Next steps are to finalize the benchmarks and measure specifications for each metric.

2020 CCO Incentive Metrics

- Kindergarten metric 1: Preventive dental visits for ages 1-5, 6-14
- Kindergarten metric 2: Well-child visits for ages 3-6
- Timeliness of postpartum care
- Disparity measure: ED utilization for members with mental illness
- Oral evaluation for adults with diabetes
- Cigarette smoking prevalence
- Depression screening and follow-up

2020 CCO Incentive Metrics

- Diabetes: HbA1c poor control
- Adolescent immunization
- Initiation, engagement and treatment for drug and alcohol use
- Alcohol & drug misuse: screening, brief intervention and referral to treatment (SBIRT)
- Childhood immunization status
- Mental, physical, and dental health assessments within 60 days for children in DHS custody

Infection Control

CDC Recommendations

- Administrative Measures
- Infection Prevention Education and Training
- Dental Health Care Personnel Safety
- Program Evaluation
- Standard Precautions
- Dental Unit Water Quality

Immunizations Strongly Recommended for Health-Care Personnel (2017)

Vaccines	Recommendations in Brief
Hepatitis B	<p>If you don't have documented evidence of a complete hepB vaccine series, or if you don't have an up-to-date blood test that shows you are immune to hepatitis B (i.e., no serologic evidence of immunity or prior vaccination) then you should</p> <p>Get the 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2). Get anti-HBs serologic tested 1–2 months after dose #3.</p>
Influenza	<p>Get one dose annually.</p>
Measles, Mumps, Rubella (MMR)	<p>If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to measles or mumps get 2 doses of MMR (1 dose now and the 2nd dose at least 28 days later).</p> <p>If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to rubella, only 1 dose of MMR is recommended.</p>
Varicella (Chickenpox)	<p>If you have not had chickenpox (varicella), if you haven't had varicella vaccine, or if you don't have an up-to-date blood test that shows you are immune to varicella (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of varicella vaccine, 4 weeks apart.</p>
Tetanus, Diphtheria, Pertussis (Tdap)	<p>Get a one-time dose of Tdap as soon as possible if you have not received Tdap previously (regardless of when previous dose of Td was received). Get Td boosters every 10 years thereafter. Pregnant HCWs need to get a dose of Tdap during each pregnancy.</p>
Meningococcal	<p>Those who are routinely exposed to isolates of <i>N. meningitidis</i> should get one dose.</p>

Standard Precautions: Hand Hygiene

CDC:

- For routine and nonsurgical procedures, use either plain or antimicrobial soap and water. If the hands are not visibly soiled, an alcohol-based hand rub is adequate.
- Wearing gloves does not eliminate the need for hand washing.
- Hands should be washed/rubbed and dried before gloves are donned. Moisture causes bacterial growth.

Standard Precautions PPE: Gloves

Site Visit Situations

When reaching into supplies during procedures while wearing contaminated gloves:

- Use clean, at the ready forceps to retrieve item, then place contaminated forceps on patient tray to be sterilized.
- Remove contaminated glove/s, perform hand hygiene, don new, clean glove and retrieve item.

Standard Precautions: PPE: Gloves

CDC:

- Change gloves between each patient.
- Do not wash or reuse gloves.
- Ensure latex-sensitive patients are not exposed to latex.

OHA:

- All gloves should be latex-free and powder-free.
- Boxes of gloves should be kept away from possible contamination.

Standard Precautions: PPE: Gowns

- CDC: OSHA requires sleeves to cover the providers forearms if spray or splatter is anticipated.
- Remove gowns (All PPE) before leaving the clinical area- into the classroom or other areas of a school.

Standard Precautions: PPE: Masks

CDC:

- Masks should cover the nose and mouth.
- If the mask becomes wet, between procedures or during a procedure, it should be changed.

OHA:

- Masks touched with contaminated hands or gloves are contaminated.
- Either change the mask after contaminating or don't touch the mask.

Standard Precautions: PPE: Masks

ASTM levels of masks

- Level 1 - Low barrier and low likelihood of splash or splatter. Suitable for exams/screenings and operator cleaning.
- Level 2 - Moderate barrier and used for moderately generated splash or splatter. Appropriate for prophylaxis, sealants and most restorative procedures.
- Level 3 - High barrier and likelihood of heavy amounts of splash or splatter. Use with ultrasonic scaling and periodontal surgery.

Protective Eyewear and Loupes

Site Visit Observations

- When donning or adjusting loupes or eyewear, do so before final hand hygiene and donning gloves.
- Avoid touching eyewear or shields during patient treatment.
- Disinfect eyewear, loupes and light shields between patients according to manufacturer's directions.
- Use a cleaner with alcohol concentration less than 70%.

Protective Eyewear and Loupes

- “If you wish to disinfect your loupe, you may do so using a low-alcohol disinfectant. We recommend using CaviCide™, CaviCide1™, CaviWipes™, or CaviWipes1™ brands of surface disinfectants. Never spray directly on your loupe. First, apply the liquid to a soft wipe or cloth, and then wipe your loupe. Be sure to squeeze excess fluid out of the cloth/wipe before using. Depending on the alcohol content, some disinfectants may leave streaks on the lenses of your loupe.”

Orasoptic Manual

CDC Classifications

- **Critical:** items used to penetrate soft tissue or bone
 - Requires heat sterilization
- **Semi-critical:** touches mucous membranes or non-intact skin
 - Requires heat sterilization

CDC Classifications

- **Non-critical:** contact only intact skin
 - Cleaning and disinfection
 - If difficult to clean, then cleaning/disinfection/barriers
 - Suction handles
 - Air-water syringe buttons
 - Light handles, switches

Semi-Critical Items

Site Visit Observations - Sealant and Etch Syringes

- Remove used syringe-tip and discard. Twist on storage cap. Storage of the syringe with a used dispensing tip, or without the storage cap, will allow drying or curing of the product and consequent clogging of the system. Replace storage cap with a new dispensing tip at next use.
- Cleaning and disinfection: Discard used syringe tip. Replace with syringe storage cap. Clean and disinfect the capped syringe as recommended by the guidance by the CDC.
- Follow disinfectant manufacturer's instructions for wet contact time.

Devices Attached to Hoses

CDC:

- Air-water syringes and suction handles:
 - “Although they do not enter the patient’s oral cavity, they are likely to become contaminated with oral fluids during treatment procedures. Such components should be covered with impervious barriers that are changed after each use.”
 - “If the item becomes visibly contaminated during use, personnel should clean and disinfect.”

CDC Recommendations

Clean, Disinfection Steps

- **CDC** – Cleaning and disinfection or barrier protection
 - OHA recommends cleaning, disinfection and barrier protection on hard to clean items.
- Cleaning should always precede disinfection.
- Change gloves and perform hand hygiene between removing disposables, cleaning, disinfection and clean set-up for next student.
- Barriers should be placed on clinical contact items and difficult to clean items.
- Follow manufacture's directions for cleaning and disinfection (amount, contact time, safe use and disposal).

OHA SDSP Infection Control

OHA uses disinfection plus barriers on:

- Chair head
- Air-water syringe
- Suction handles
- Overhead light switch
- Cure light
- Sealant and etch syringes

Sterilization: Recommendations & Requirements

CDC and the American Dental Association (ADA):

1. Weekly spore testing, every week that patients are treated
2. Indicator strips or indicator tape every time the sterilizer is used
3. Monitor sterilization gauges, pressure, temperature and exposure time

Sterilization Recommendations and Requirements

Oregon Board of Dentistry requirements:

818-012-0040, (4) *“Heat sterilizing devices shall be tested for proper function by means of a biological monitoring system that indicates microorganisms kill each calendar week in which scheduled patients are treated. Testing results shall be retained by the licensee for the current calendar year and the two preceding calendar years.”*

DNTLworks Waterline Maintenance Recommendations

- Use an approved waterline cleaner or additive.
- Purge the water out of the system at the end of every day and leave the cap off until next use.
- Clean the evacuation system out at the end of every day.
- Drain the air tank purge line on the back of unit at the end of every day.

Bob Kennedy, DNTLworks, July, 2019

Site Visit Observations

- Students are asked to close around the suction.
- “Studies have reported that backflow in low-volume suction lines can occur and microorganisms be present in the lines retracted into the patient’s mouth when a seal around the saliva ejector is created.”
- “Do not advise patients to close their lips tightly around the tip of the saliva ejector to evacuate oral fluids.”

CDC 2003

Research Updates

Dental Sealants Continue to be Underused

- Pits and fissure caries has not kept pace with the decrease of smooth surface caries in children and adolescents.
- “From 1999–2004 to 2011–2014, sealant use prevalence increased by about 70% among low-income children and 23% among higher-income children. However, this effective intervention still remains underused. Less than half of children aged 6 to 11 years have dental sealants.”

Barriers to Receiving Sealants

- A California study of third graders showed that their parent's health literacy and English speaking at home were strong predictors of the child receiving dental sealants.
- Institute of Medicine report on dental care access among underserved populations found that low health literacy was a barrier to receiving preventive dental services.

3 Stages of Prevention

- 1. Primary:** Keeps the disease process from becoming established by eliminating causes of disease or increasing resistance to disease.
- 2. Secondary:** Interrupts the disease process before it progresses to symptomatic disease.
- 3. Tertiary:** Treatment of symptomatic disease to prevent its progression to disability or premature death.

Sealants – Primary & Secondary Prevention

- From a **primary prevention** perspective, anatomic grooves or pits and fissures on occlusal surfaces of permanent molars trap food debris and promote the presence of bacterial biofilm, thereby increasing the risk of developing carious lesions.
- Effectively penetrating and sealing these surfaces with a dental material—for example, pit-and-fissure sealants—can prevent lesions and is part of a comprehensive caries management approach.

Sealants – Primary & Secondary Prevention

- From a **secondary prevention** perspective, there is evidence that sealants also can inhibit the progression of non-cavitated carious lesions.
- The use of sealants to arrest or inhibit the progression of carious lesions is important to the clinician when determining the appropriate intervention for non-cavitated carious lesions.

Regarding Secondary Prevention

To further confirm non-cavitated caries can be sealed:

- Recent research found that caries progression after 12 months, then 2 years, was minimal with use of resin or GI sealants on ICDAS 3 (localized enamel breakdown). - Stay tuned
- No statistical difference in caries progression between resin and GI sealant material.

School Dental Sealant Programs

- Are highly effective for delivering sealants to children who might be less likely to receive regular or private dental care.
- For the approximately 6.5 million low-income children who do not have sealants, receiving sealants in a school program could prevent more than 3 million cavities over 4 years and save up to \$300 million in future dental treatment costs.

Sealing Buccals and Linguals

- Buccal and lingual pits are the two most frequent surfaces of sealant failures.
- Clinicians tend to avoid sealing these surfaces, which are shallower and difficult to etch.
- However, a national survey found that buccal and lingual surfaces are the second most common caries site for children ages 12–19 (i.e. more common than interproximal mesial/distal).
- So, be sure to seal the buccals and linguals, and strive to improve retention.

Unfilled vs. Filled

- For school dental sealant programs, it is important to use less than 10% filled sealant material (self-adjusting; no need to adjust with a handpiece).
- Sealants without fillers appear to have better penetration into fissures than sealants incorporating filler particles, due to their lower viscosity.
- Retention for unfilled (64.4%) was better than for filled (53.57%).

Resin and Glass Ionomer (GI)

- The ADA panel was unable to determine superiority of one type of sealant over another owing to the very low quality of evidence.
- Suggests that clinicians take into account the lack of retention when choosing the most appropriate type of sealant material.
- If a tooth cannot be isolated (e.g. is operculated), then GI can be used; retention of GI is less and must be checked more often.
- GI is considered a provisional sealant and must be replaced with a resin-based sealant when better isolation is possible.

Outcomes

- Retention is a “process” outcome (i.e. research has shown that a retained sealant can be 100% effective).
- Reduction in caries is a true “health outcome”.
- There is the suggestion in the literature that GI sealants reduce cavities even after they can no longer be detected.
- GI might be the better material for sealing partially erupted molars, as well as when salivary contamination cannot be avoided.

Bisphenol A (BPA)

- Check product components.
- Clinpro: “Bis-GMA/TEGDMA resin composite”
- Bis-DMA and Bis-GMA are both produced using BPA as a starting ingredient, so residual BPA not chemically converted into Bis-DMA or Bis-GMA is likely present in trace amounts in any dental material containing these ingredients.
- It is important to have program protocols that specifically address the removal of BPA.

Manufacturer's Guidelines

Saliva Contamination After Etchant

- If the etched enamel gets exposed to salivary proteins for as little as 0.5 sec, it can be contaminated.

Dentistry Journal, December 2017

- Microscopic examination of saliva-contaminated acid-etched enamel showed the formation of an organic pellicle that could not be removed by water.

Journal of Conservative Dentistry, April-June 2010

Saliva Contamination After Etchant

- Although Clinpro recommends re-etching for only 5 seconds after saliva contamination, research indicates that re-etching for at least 15 seconds improves retention.

Correr, G. M., et al. (2004). Effect of saliva contamination and re-etching time on the shear bond strength of a pit and fissure sealant. <http://dx.doi.org/10.1590/S1678-77572004000300007>

Site Visits Observations

- Observation: Never using an explorer.
 - Clinicians may use an explorer to:
 - Gently remove plaque and debris from the tooth surface.
 - Detect changes or breaks in the surface contour by moving it gently in cases in which there is doubt about the presence of a cavitation.
 - Evaluate the smoothness or roughness of the tooth surface to help determine lesion activity.
 - Help in the assessment of sealant integrity and retention. (JADA, 2010 & Dentistry Journal, 2017)

Site Visits Observations

- Observation: Not drying thoroughly before the etch.
 - Manufacturer’s guidelines: “Isolate Teeth and Dry, then etch”.
- Observation: Etching all molars, then going back to seal all molars.
 - Inadequate isolation; treat only as many teeth as you can isolate.
 - Cheek, tongue, gloves, or lips touching tooth mid-sealant will wick saliva onto the tooth.
 - Do not allow any saliva contamination from beginning to end.

Research: Importance of Isolation

- “Before the etch, isolate, then dry teeth with air for 20-30 seconds.”
- “Sealant application involves strict attention to detail and dry field isolation throughout the procedure.”
- “Saliva contamination before sealant placement is the most commonly reported reason for sealant failure.”
- “It is critical that saliva does not come into contact with the prepared tooth surfaces.”
- “Strategies to improve sealant retention include the use of four-handed dentistry, strict isolation techniques...”

Research: Importance of Isolation

- “Manufacturers’ instructions usually detail cleaning and isolation of the occlusal surface and encourage a dry environment during sealant placement and curing.”
- “Either exchange wet cotton rolls for dry ones in a manner that does not contaminate etched surfaces with saliva or place dry cotton rolls and/or dry angle-type shields over moist ones that shall be suctioned first to remove excess saliva.”

Site Visits Observations

- Observation: Using “mirror-only” or gloved finger to isolate.
 - Clinpro manufacturers guidelines: “While a rubber dam provides the best isolation, cotton rolls used in conjunction with isolation shields are acceptable.”
 - Don’t hesitate to use as many cotton rolls and dri-aides as you need (i.e. cotton rolls cost 1 cent; staff time to replace a sealant or a student experiencing a cavity costs many \$).

Site Visits Observations

- Observations:
 - Student allowed to swallow mid-sealant (saliva contamination inevitable)
 - Failure to add/replace cotton roll when other one wet (risk of saliva contamination)
 - Student's head NOT tipped back for maxillary
 - Assistant not able to see the tooth (ensure assistant can see, to assist with isolation)

Site Visits Observations

- Observations:
 - Assistant never in the mouth or not in the mouth during “waiting times”
 - Hygienist and assistant should both be in the mouth, actively ensuring isolation. Isolation is more important than passing instruments. Instruments should be within easy reach of both hygienist and assistant.

Questions?

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