



Administration Manual

August 2025

Introduction

Welcome to Wisconsin Seal-A-Smile

Wisconsin Seal-A-Smile (SAS) is a collaborative effort between Children's Health Alliance of Wisconsin (Alliance), Wisconsin Department of Health Services (DHS) and Delta Dental of Wisconsin. The mission of the SAS program is to improve the oral health of Wisconsin children through school-based dental sealant programs. SAS uses current evidence-based guidelines for providing preventative dental services.

SAS is funded by Wisconsin General Purpose Revenue and Delta Dental of Wisconsin. Funding for school-based sealant programs is provided to local grantees including dentists, dental hygienists, schools, hospitals, local health departments, community health centers, non-profit agencies and free clinics.

This Administration Manual provides information to assist with the administration of Wisconsin SAS grantees and provide consistency across all programs. Additional information along with many of the forms described in this manual are available on the Alliance SAS [webpage](#).

This manual is not intended to be a comprehensive guide to operating a school-based dental sealant program. For more comprehensive information on the development and implementation of a school-based dental sealant program, see [School-Based Dental Sealant Programs \(mchoralhealth.org\)](#).

Thank you for your commitment to improving the oral health of Wisconsin's children. We look forward to working with you.

Contact information

Lindsay Deinhammer BSN, RN Program Manager Oral Health Children's Health Alliance of Wisconsin 6737 W. Washington Ave Ste.4300 West Allis, WI 53215 (414) 337-4563 chawsealasmile@childrenswi.org	Carrey Spencer, BSDH, RDH Oral Health Prevention Program Coordinator Division of Public Health State of Wisconsin Department of Health Services 1 W. Wilson St. Rm 218 Madison, WI 53701 (608) 334-8864 dhssealasmile@dhs.wisconsin.gov
--	---

Special thank you and attributes to the Iowa Department of Health's I-Smile program for allowing us to utilize portions of their school-based sealant program manual for this update.

Table of Contents

ADMINISTRATIVE & REGULATORY GUIDELINES	4
WISCONSIN SAS ADMINISTRATIVE POLICY	4
PROGRAM OVERSIGHT	4
SITE VISITS	4
ANNUAL MEETING	5
TECHNICAL ASSISTANCE	5
COMMUNICATION	5
PERFORMANCE BENCHMARKS & STANDARDS	5
PERFORMANCE BENCHMARKS:	6
PERFORMANCE STANDARDS	6
WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES (DSPS)	8
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION	8
INFECTION CONTROL	9
PRINCIPLE I: TAKE ACTION TO STAY HEALTHY	10
PRINCIPLE II: AVOID CONTACT WITH BLOOD AND OTHER POTENTIALLY INFECTIOUS BODY SUBSTANCES	11
PRINCIPLE III: MAKE INSTRUMENTS AND EQUIPMENT SAFE	13
PRINCIPLE IV: LIMIT THE SPREAD OF BLOOD AND OTHER INFECTIOUS BODY SUBSTANCES	15
PROGRAM REQUIREMENTS	16
STAFFING/PERSONNEL REQUIREMENTS	16
SCHOOL, GRADE AND TOOTH SELECTION	17
SCHOOL SELECTION	17
GRADE SELECTION	17
TOOTH SELECTION	17
EQUIPMENT	17
SEALANT MATERIALS	18
PARTICIPATION	18
SEALANT APPLICATION	19
RETENTION CHECKS/EVALUATION	19
FLUORIDE VARNISH APPLICATION	20
CASE MANAGEMENT	21
ANNUAL MEETING	21
PUBLICITY AND USE OF SAS LOGO	21
FORMS, REPORTING & RECORDING	22
CONSENT FORMS	22
ONLINE CONSENT	22

DENTAL HOME	22
SPECIAL NEEDS SCREENING QUESTIONS	23
ADDITIONAL HEALTH HISTORY/CONSENT FORM GUIDANCE.....	24
MEDICAID BILLING	25
DENTASeal DATA REPORTING	25
PATIENT RECORDS & RETENTION.....	26
EXPENSE REPORTING	26
INVOICE SUBMISSION (WHEN APPLICABLE)	26
REIMBURSEMENT	26
OTHER REPORTING AND COMPLIANCE REQUIREMENTS	27
BUDGET AND FUNDING INFORMATION	27
REQUEST FOR PROPOSALS	27
FUNDING AGREEMENT PACKET INSTRUCTIONS	28
EXPENSES	28
FUNDING FORMULA.....	28
PROJECT CHANGES AND APPROVALS.....	28
EQUIPMENT.....	29
APPENDICES	29
APPENDIX 1: INFECTION CONTROL: MANAGEMENT AND FOLLOW-UP OF OCCUPATIONAL EXPOSURE	29
APPENDIX 2: INFECTION CONTROL PRACTICES FOR SCHOOL-BASED DENTAL SEALANT PROGRAMS	30
APPENDIX 3: SAFE DELIVERY OF ORAL CARE OUTSIDE THE DENTAL OFFICE.....	31

Administrative & Regulatory Guidelines

Wisconsin SAS Administrative Policy

All Wisconsin SAS grantees must comply with all aspects of the Wisconsin SAS program manual through the contracting process. Failure to comply with any aspects of the manual without prior written approval from contract administration is a breach of contract which may result in a loss of funding and potentially impact future SAS funding.

Program Oversight

Wisconsin SAS uses several tools to assess project progress including regular communication with project partners, site visits, phone calls, mid-year reviews and DentaSeal data. These tools are subject to change. Updates will be released through e-mail communication. Projects will be evaluated annually and results may have an impact on future and continued funding.

Site visits

Periodically, SAS administrators will request to visit your program. This is an opportunity for us to gather important information about your project and provide you with feedback to help improve various aspects of individual programs (i.e. efficiency, safety, clinical treatment, billing and charting). In addition, it allows administrators to highlight positive practice efforts to share with other programs. At least once every three years, SAS administrators will conduct a comprehensive site visit. The site visit is a proactive assessment aimed at identifying program strengths, improving overall program performance and intercepting potential problems that a local program may have.

During the site visit, SAS administrators will conduct a clinical review of the program's procedures and an administrative review of program policies, procedures, use of patient records (based on review of a random sample) and other operational considerations. Administrators will hold a brief exit interview to provide immediate feedback on findings and a follow up meeting.

On a situational basis, Wisconsin SAS may conduct focused site reviews to gather additional information on specific problems suggested by information obtained through review of grant proposals and reports, communication regarding a program or comprehensive site reviews. SAS administrators may solicit feedback from school administrators, parents or the community. SAS administrators may review Medicaid billing practices. Unlike a comprehensive review, a focused site visit concentrates on one or more aspects of the program, not the entire program. The focused review may be a blend of information gathering and technical assistance. The focused site review utilizes portions of the comprehensive visit procedures relating to the issue(s) being reviewed.

Periodically, SAS administrators may request to visit programs for an informal review or to show the program to a potential funder, legislator, community leader or future SAS grantee.

Annual meeting

All SAS grantees are expected to have at least one representative attend the Wisconsin SAS annual grantee kickoff meeting for the entire meeting. It is recommended that grantees consider sending at least one clinical and one administrative staff. The meeting date, time and location will typically be available when the RFP is released. All programs are expected to not only attend but actively participate and stay for the entire duration of the meeting.

Technical assistance

Technical assistance (TA) is provided to help programs improve performance, achieve program goals and meet Wisconsin SAS standards. SAS administrators will provide TA for any program upon request. In addition, SAS administrators may identify programs that can be required to participate in additional TA. The need for TA is based on information gathered through review of grant proposals, program reports or site visits. TA may be conducted via telephone, email, meetings and/or site visits by SAS administrators as appropriate. If performance benchmarks are not met, a formal improvement plan may be necessary. The improvement plan may be required by SAS administration and must delineate steps to be taken, along with a timeframe for accomplishing them and who is responsible.

Communication

Communication between programs and SAS administration may occur via telephone, email and site visits. Prompt response to SAS requests via any form of communication is expected.

SAS administrators will share important information, requests, and policy updates with the program fiscal agent. It is the fiscal agent's responsibility to ensure the information is subsequently shared with the appropriate program personnel. This communication chain is critical for keeping all staff informed and knowledgeable about the SAS program.

Performance Benchmarks & Standards

Performance benchmarks are specific numerical points of reference for measuring individual program performance. Wisconsin SAS has established benchmarks based on years of data from all Wisconsin SAS funded programs. Any program that does not meet approved performance benchmarks and standards risks the loss of current and future funding.

Wisconsin SAS wants to assure a statewide program that provides high quality care that meet or exceed program expectations. Performance that deviates from a benchmark/standard will trigger further assessment and, as appropriate, initiation of steps for improvement, such as additional technical assistance and/or a focused site review/visit. In some situations, an improvement plan, approved by SAS administrators, must be developed to address substandard performance. Programs must comply with the plan and

demonstrate improvement in all areas that fall short. Failure to achieve performance benchmarks/standards and/or implement the improvement plan will impact future funding.

Performance Benchmarks:

Requirements:

- 100 percent of children returning consent forms will receive all services. Wisconsin SAS has a zero-tolerance policy regarding the refusal of treatment of any student. Program funding will be discontinued if SAS administrators verify programs are refusing to provide the full scope of treatment to any student who has returned a consent form.
- 100 percent of children examined for retention will have this information entered into DentaSeal.
- 100 percent of children seen by grantees will be entered into DentaSeal (this includes follow up and retention information) and all DentaSeal visits will be completed and closed within 10 days of finishing at a school.
- Grantees will annually update infection control policies and procedures and review with all clinicians.

Aims:

- Increase participation rate at schools in comparison to participation rate from previous school year.
- All grades at a school are offered participation in the program, including HeadStart.
- The proposed number of children to be sealed in the approved RFP receive sealants.
- Provide preventive care to a minimum of 3-4 students per hour or 14-18 students per school day/provider.
- As a best practice, check sealant retention at each screening.
- 100 percent short term sealant retention rate (less than 6 months after placement) and at least 90 percent long term sealant retention rate (8-14 months after placement).
- As a best practice, SAS programs should be prepared to place sealants at **ALL** school visits to achieve the overarching goal of reducing caries in Wisconsin's children.

Performance Standards

Performance standards are *basic requirements* that the Wisconsin SAS program expects of all programs. Programs that do not meet these minimal requirements are not eligible for funding from Wisconsin SAS. Failure to comply with performance standards will result in the loss of funding and can impact future funding.

- Compliance with all applicable federal, state and local regulations.
- Compliance with OSHA and CDC infection control guidelines and interim infection control guidance and requirements.
- All programs are required to adhere to the [Guidelines and Recommendations | Infection Prevention & Control in Dental Settings | Division of Oral Health | CDC.](#)
- Compliance with all guidelines in Wisconsin SAS Administration Manual.
- Effectively targets high risk schools (FRMP is equal or greater than 35%).
- Consent form includes required elements.
- Signed consent on file for all students who receive treatment.
- Offers all services to all children, regardless of insurance status.
- Once consent forms are distributed, services are provided to all children who returned a consent form, regardless of the return rate at the school.
- Evidence-based tooth selection criteria are followed.
- Evidence-based sealant placement/materials guidelines are followed.
- Submit accurate and appropriate claim to Medicaid for all eligible children.
- Track insurance reimbursement for SAS services and accurately report in DentaSeal.
- Complete cooperation and participation in SAS site reviews.
- All DentaSeal entry will be up to date at all times.
- Participation in required trainings (i.e. annual meeting, DentaSeal training).
- All reports are timely, complete, accurate and reasonable.
- Provide at least two fluoride varnish treatments to all eligible children using the current ADA evidence-based guidelines. Appropriate time intervals between applications should be followed.
- Develop referral sources for patients found to have needs beyond what the program provides. This goes beyond distributing a list of local providers and should involve building relationships with local providers who agree to be part of a referral network for your program.
- Use of DHS and CHAW logo only with prior approval.
- Wisconsin SAS requires that all children are provided with a follow up form on the date of service that includes the services provided, any clinical findings/recommendations and any additional clinical notes the parent or guardian should be aware of.

Wisconsin Department of Safety and Professional Services (DSPS)

The Wisconsin DSPS has a mission to promote economic growth and stability while protecting the citizens of Wisconsin as designated by statute. All providers who provide any dental services as part of the Wisconsin SAS program must have a current dental or dental hygiene license in good standing. Additionally, programs may need to be in compliance with [DE-10: Mobile Dentistry](#). It is the responsibility of individual programs to determine if they are required to register with DSPS under DE-10 and to maintain all requirements outlined as part of DE-10.

Occupational Safety and Health Administration

The Occupational Safety and Health Act of 1970 was passed to prevent workers from being killed or seriously harmed at work. The law requires employers to provide their employees with working conditions that are free of known dangers. The act created the Occupational Safety and Health Administration (OSHA) that sets and enforces protective workplace safety and health standards. OSHA also provides information, training and assistance to workers and employers. OSHA regulations are found at **www.osha.gov**.

Each SAS program is responsible for assuring their operation is in compliance with all applicable OSHA requirements.

The OSHA Bloodborne Pathogens Standard specifies safeguards to protect oral health care workers against the health hazards of bloodborne pathogens. The standard provides the following requirements for the oral health workforce:

- A written exposure control plan must be reviewed and updated annually to include common and potential health hazards.
- Infection control training is required prior to employees working in an environment where exposure to blood or other potentially infectious materials may occur, and on an annual basis thereafter.
- Personal protective equipment (eye protection, gloves and protective clothing) must be worn by all dental personnel.
- Appropriate hand washing must be performed.
- Instruments that can withstand heat must be sterilized in an autoclave. If the instruments cannot withstand heat, a high-level disinfectant must be used according to manufacturer's directions.
- Disposable items must not be re-used.
- Proper handling and disposal of sharps is required.

- The autoclave must be monitored weekly by biologic spore testing to ensure proper functioning.
- Environmental surfaces must be cleaned and disinfected. Barrier techniques must be used for items that are difficult to clean or disinfect, such as air water syringes.
- Food/drink is not permitted in clinic areas.

OSHA regulations and interpretations are available at:

<https://www.osha.gov/SLTC/dentistry/index.html> and

<http://www.osha.gov/SLTC/bloodborne pathogens/index.html>.

Infection Control

All programs are required to adhere to the [Guidelines and Recommendations | Infection Prevention & Control in Dental Settings | Division of Oral Health | CDC](#).

Wisconsin SAS requires all grantees to comply with all infection control guidelines and standards. This would include OSHA and state regulations and [Centers for Disease Control and Prevention \(CDC\) recommendations](#). It is important to understand that these recommendations are the basic guidelines SAS requires your program to follow in order to ensure safety of both providers and the public. SAS Administration may require annual infection control training for all staff who interact with children at schools. If required, all program staff must complete the annual training prior to providing care or interacting with children in a program year.

- The portable nature of mobile dental programs presents particular challenges for infection control (e.g., safe transport of sharps). The [CDC's Dental Check mobile app](#) has checklists that can be entered on a smart phone. This free app is a great tool to assess IPC practices and ensure they meet minimum expectations for safe care. The app allows you to assess administrative policies and staff patient care practices, print reports for your records, and links to key CDC recommendations.
- The CDC [Foundations – Building the Safest Dental Visit training](#) is a web-based training that provides three **free** American Dental Association Recognition Program Continuing Education (ADA CERP CE) units. **This training must be completed by a minimum of two staff members from each SAS program, one to be completed by Aug. 31 and the second staff member by Dec. 15.** To help with performance monitoring, the OHP asks that you submit your certificates of completion to the OHP via this [online survey](#). Follow the [OHP's instructions](#) to learn how to enroll in the Foundations training, and help the OHP track completion. A Summary of Infection Prevention Practices in Dental Settings – Basic Expectations for Safe Care, is a

resource for SAS programs. This summary guide provides IPC recommendations for traditional and nontraditional dental settings.

The CDC has identified levels of risk for transmission of infections and bloodborne diseases during dental services. These risk levels are based on the anticipated contact between the provider and patients' mucous membranes and/or blood and blood-contaminated saliva (see Table 1).

Sealant programs have two basic procedures: screening for tooth selection and sealant application. Each of these procedures pose a Level II risk, due to provider contact with patients' mucous membranes and saliva (but no anticipated contact with blood or saliva contaminated with blood). The CDC has four basic principles for infection control: 1.) take action to stay healthy, 2.) avoid contact with blood and other potentially infectious body substances, 3.) make instruments and equipment safe, and 4.) limit the spread of blood and other potentially infectious body substances. The following narrative is based on the four basic principles and a Level II risk.

Grantees who provide services beyond screening, sealants and varnish will need to access which level they are and comply accordingly.

Principle I: Take Action to Stay Healthy

Immunizations

Program staff immunizations should be current according to CDC's recommended adult immunization schedule. CDC's recommended adult immunization is available at: <https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf>. New staff should be tested for tuberculosis infection. Documentation of staff members' hepatitis B vaccination/immunity statuses must be kept on file.

Hand Hygiene

Appropriate hand washing must be performed. Although ideal to be in a room with a sink, this often is not possible. Grantees should select the best available site close to a sink. Soap and water, as well as alcohol-based hand sanitizers, may be used for cleansing hands. Hands must be cleansed before and after treating each patient, before donning or after removing gloves, after ungloved contact with surfaces or objects that may be contaminated by blood or other potentially infectious materials, before leaving the operatory, and when hands are visibly soiled. Soap and water (not hand sanitizers) must be used when hands are visibly soiled.

Staff should be trained in the procedures for hand washing and for the use of hand sanitizers. These procedures are as follows:

- Wash hands by vigorously rubbing soap and water over hands and fingers for 15 seconds before rinsing with cool water and thoroughly drying.

- If hand sanitizer is used, apply it to hands and rub hands together as if washing hands until hands are dry.
- Because hand sanitizers do not remove the powdery residue that can form under gloves, program staff using hand sanitizers should also wash hands periodically with soap and water.

Additional hand hygiene information is available at:

<http://www.cdc.gov/oralhealth/InfectionControl/fag/hand.htm>

Principle II: Avoid Contact with Blood and Other Potentially Infectious Body Substances

Personal Protective Equipment

Personal protective equipment (PPE) should be stored close to the patient care area and facilities should be available for disinfection of PPE (e.g., patient eyewear, utility gloves). PPE should be worn in the patient care area only.

Gloves

Gloves are single-use, disposable items, and they cannot be re-used or washed. Gloves that are damaged (e.g., torn, punctured) must be discarded. If gloves are damaged during a procedure, remove and discard them, wash hands immediately, and put on clean gloves. Over-gloving (e.g., putting a clean pair of gloves over a used pair) between patients is not permitted. Gloves should be removed carefully to avoid exposure to microorganisms from patients. Wearing gloves does not replace hand washing.

Programs must use non-latex gloves, due to possible latex sensitivity among patients and staff. This sensitivity could result in allergic reactions that range from skin rash to anaphylaxis.

Heavy-duty puncture-resistant gloves, along with protective clothing and face protection, must be worn during clean-up and preparation of instruments for sterilization. Utility gloves may be decontaminated and used again, but damaged or worn-out gloves should be discarded.

Face Protection

During sealant application, oral health professionals must wear face protection. Face protection includes a chin-length face shield or a surgical mask and eyewear with solid side shields. Masks should be changed between patients or during treatment if they become damp or visibly contaminated. Program staff should remove masks by the fasteners because the front of the mask is considered contaminated and should not be touched. Masks should not be worn off the face or around the neck.

Eyewear and face shields must be cleaned and disinfected between patients, at the end of the day, and if visibly soiled.

Protective Clothing

Protective clothing must be worn during sealant application and for screenings where spatter is anticipated due to use of the air/water syringe. Protective clothing must be washed, or, if disposable, discarded.

Protective clothing should be removed immediately, or as soon as possible, if blood or other infectious materials have penetrated it. Protective clothing does not need to be changed after each patient unless it is visibly soiled.

Program staff does not need fluid-resistant gowns unless contact with body fluid that would seep through a garment is anticipated.

Avoid Injuries

Program staff must receive education and training at least once per year regarding infection control principles and rationale for recommended infection control practices. In addition, training must be provided upon initial employment or when a change in duties or procedures may affect exposure. Staff designated for specific task responsibilities (e.g., instrument sterilization, waste disposal) should receive appropriate training for that task. Training should address the portable environment and OSHA regulations.

Safe Handling of Sharps

For SBSPs, sharps are generally limited to explorers. All sharps, sterile and contaminated, should be transported in securely closed containers that are puncture-resistant to sharps.

All contaminated disposable sharps must be discarded in a closeable, leak-proof container that is manufactured for that purpose and that is impervious to sharps. The container must be red or labeled with the biohazard symbol, or both. The container must also be labeled "sharps." The sharps container should be placed in a secure location as close to the user as possible. Program staff should receive training on the proper handling of sharps and their disposal.

Non-disposable contaminated sharps (e.g. explorers) must also be stored in a closable, leak-proof container that is impervious to sharps. This container must be clearly labeled as containing contaminated sharps. Containers with contaminated instruments also should have a biohazard symbol.

Written Policy with Post-Exposure Control Plan

Programs must have a written infection control plan (including a post-exposure control plan) that describes protocols and procedures. The plan should be maintained by a program staff member designated as the infection-control coordinator. In the event that

post-exposure care is needed, the program should have access to a health professional qualified to provide post-exposure care, counseling and follow-up. The infection control plan and procedures must be reviewed and evaluated at least annually by program staff and updated as necessary.

Infection Control: Management and Follow-up of Occupational Exposure is available in Appendix 1.

Principle III: Make Instruments and Equipment Safe

Instruments and Equipment

Between each patient, SAS requires heat sterilization of all reusable patient-care items that touch mucous membranes and can withstand repeated exposure to high heat. Instruments may be heat sterilized on- or off-site. Disposable instruments are a good alternative to reusable instruments.

Programs that use handpieces or air/water syringes that are detachable from the unit must heat sterilize them between patients and follow the manufacturer's instructions for sterilization and care. If the handpiece or air/water syringe is permanently attached to the unit, programs should barrier protect the handle and either use disposable tips or sterilize metal tips between patients.

SAS recommends single-use, disposable syringes for programs that use syringes to apply etchants and sealants. Multi-use syringes used in the sealant application process can easily become contaminated. Because these cannot be disinfected or heat-sterilized, the barrel of the syringe should be covered with a replaceable barrier. Programs that use this item must use a new disposable syringe tip for each patient.

Instrument Cleaning and Sterilization

Programs are not required to clean instruments immediately after use; however, soaking instruments immediately after use in detergent, disinfectant/detergent, or enzymatic cleaner in a puncture-resistant container prevents patient matter from drying and makes cleaning easier. If instruments are to be transported off-site, they should be removed from the solution and transported in a securely closed, appropriately labeled, and puncture-proof container. It is recommended that containers storing instruments or sharps for transportation off-site be placed in an additional container, as an additional precaution against spillage of instruments.

Instruments should be cleaned (manually and/or with an ultrasonic cleaner) before being placed in bags or pouches for sterilization. Bags or pouches should be sealed prior to sterilization. A chemical indicator should be placed in the middle of each bag or pouch. If the indicator is not visible through the bag or pouch material, an additional indicator should be placed on the outside. If the indicator does not change color, this may indicate there was a problem during sterilization. Bags or pouches should be clearly labeled with the date, to ensure that the first instruments sterilized will be the first instruments used.

The instrument processing area should be divided into two separate zones: 1.) a “dirty” zone for intake, cleaning, and packaging of contaminated items, and 2.) a “clean” zone for sterilizing instruments, removing packaged items from the sterilizer, cooling them, and storing them. Personal protective equipment and utility gloves should be worn when handling and cleaning contaminated instruments.

After appropriate sterilization, a bag or pouch is considered sterile unless it is compromised (e.g., torn, wet, dropped on floor). If a bag or pouch is compromised, the instruments should be cleaned, placed in a new bag or pouch, and sterilized again. Store packaged instruments in clearly and appropriately labeled puncture-proof and secured containers.

Off-site Sterilization

Proper instrument transport is critical for off-site sterilization. Sealant programs should use securely fastened containers for transporting instruments so that instruments will not spill when jostled. Cleaning instruments before transport is not required, but it can reduce possible exposure risk during transport.

On-site Sterilization

Adequate space for and design of the instrument-processing area is of primary importance for on-site sterilization. The sterilization area should have adequate ventilation, access to a sink, and be near the treatment area. It should have enough space to separate the dirty and clean zones and to allow for receiving, cleaning, packaging, sterilization/disinfection, and storing of processed instruments. Avoid carrying or scrubbing contaminated instruments at times when the area is crowded with children.

Sterilization Monitoring

The autoclave must be monitored every seven days, on the same day each week, by biologic testing (spore test) for proper functioning. Programs must document testing and keep a log with test results. Testing must be done weekly, even if a program operates only one day per week. If a spore test result is positive, SAS requires that immediate action be taken to ensure that heat sterilization is accomplished. While programs may do biological spore testing themselves, most SBSPs choose to use independent sterilization-monitoring services.

If the autoclave has been idle for an extended period (e.g., during summer break), staff should perform a biologic spore test before program start-up to ascertain whether the autoclave is functioning correctly.

Portable Dental Unit Water Quality

CDC recommends that water used for routine dental treatment meets Environmental Protection Agency (EPA) regulatory standards for drinking water (e.g., <500 CFU/mL of heterotrophic water bacteria). Some manufacturers of portable dental equipment advise that tap water of good quality from a municipal supply or distilled or purified water be used in the water-supply bottle. Programs should consult with the manufacturer of their dental units for appropriate methods and equipment to maintain and monitor dental-unit water quality.

Dental water line cleaners should be used according to the manufacturer's directions and in accordance with the dental unit manufacturer's recommendations. Some manufacturers also recommend draining the water at the end of each day.

CDC recommends that water and air be flushed for a minimum of 20–30 seconds after each patient from any device connected to the dental water system that enters the patient's mouth (e.g., air/water syringe). This is to expel organisms that may have been drawn into the waterline.

Principle IV: Limit the Spread of Blood and Other Infectious Body Substances

Spatter

Use the air/water syringe carefully to avoid creating backsplash or spatter. The high-velocity evacuation (HVE) tubing and container should also be used in such a way as to limit potential spatter. Patients must not close lips around the HVE tip to prevent potential “suck-back” of bacteria that may be in the tubing.

Barriers and Disinfection of Surfaces

Clinical-contact surfaces (e.g., tabletops, instrument tray, light handles) must be covered with barriers or cleaned and disinfected between patients. Barriers must be discarded and replaced between patients. If a surface is not barrier-protected or if contact is made under a barrier, the surface must be cleaned and disinfected with a hospital-grade disinfectant product that is registered with the EPA.

Use the following procedures to clean and disinfect clinical contact surfaces:

1. Spray surface with disinfectant.
2. Wipe surface to clean it and remove any debris.
3. Spray surface with disinfectant again.
4. Follow manufacturer's directions for the amount of contact time required to allow the product to achieve disinfection. Then wipe surface clean.

If disinfectant wipes are used, clean the surface and discard the wipe; then use a fresh wipe for disinfection. Follow the manufacturer's directions.

The HVE tubing and container should be disinfected. Refer to the manufacturer's instructions for proper disinfection. The entire system should be cleaned and disinfected by evacuating a cleaner/disinfectant through the entire hose assembly and waste bottle each time it is emptied. Thorough scrubbing of the entire assembly is also recommended each time the bottle is emptied.

Programs should have a protocol for the management, storage and disposal of chemical disinfectants. Products must be used appropriately for their intended purpose and with minimum exposure to the sealant team and patients. Areas where chemicals are used should be well-ventilated. Storage should prevent spills or contain them, in the event a spill

occurs. Products should not be exposed to high temperatures. Refer to the manufacturer's instructions for proper handling, storage and disposal of products.

Waste Disposal

Disposal of regulated medical waste (e.g., sharps, blood-soaked gauze) must comply with OSHA rules. Sharps containers should never be emptied. When the contents reach the fill/full line, dispose of the entire container and begin using a new one.

In the unlikely event that a program generates regulated medical waste (e.g., blood-soaked gauze), that waste must be contained in a leak-resistant, securely fastened bag/container. The container should be red or conspicuously labeled with the international biohazard symbol. SBSPs are typically small generators of infectious waste (less than 50 lbs. per month, with proper documentation of infectious waste's weight available for each month). This allows for the disposal of both non-regulated waste (e.g., gloves, masks, disposable instruments, cotton rolls, protective coverings) and regulated waste (infectious waste) in regular trash bags without special handling. It is best to consult with school personnel about their preferences before discarding non-regulated waste on-site.

CDC guidelines related to waste removal may be found at:

<http://www.cdc.gov/OralHealth/infectioncontrol/guidelines/index.htm>

Infection Control Practices for School-Based Dental Sealant Programs are summarized in Appendix 2.

Site Assessment

Assessment of the site prior to the date for providing dental services can help prevent concerns with set-up and infection control. The [CDC's Dental Check mobile app](#) has checklists that can be entered on a smart phone. This free app is a great tool to assess IPC practices and ensure they meet minimum expectations for safe care. The app allows you to assess administrative policies and staff patient care practices, print reports for your records, and links to key CDC recommendations.

Program Requirements

Staffing/Personnel Requirements

Wisconsin SAS requires the following for all SAS programs:

- All dentists and dental hygienists must have an active Wisconsin dental or dental hygiene license in good standing.
- Only a licensed dental provider may provide examinations, screenings, or any intra-oral or extra-oral services to patients.
- All dental providers, volunteers and program staff must complete appropriate infection control continuing education programs upon initiating role, followed by training at least once per year.
- Programs are encouraged to use dental assistants to assist with sealant placement. Four handed sealant application may improve the quality and efficiency of sealant

placement through shortened placement time, improved isolation, reduction in operator fatigue and enhanced patient care.

- For the safety of the program and the safety of the student it is recommended that two staff members be present at all times.
- Only a dentist or dental hygienist may apply fluoride varnish unless otherwise allowable by statute.
- A dental hygienist may not delegate any intra-oral or extra-oral procedures to anyone.
- A dental hygienist may only expose radiographs if ordered by a dentist.

School, Grade and Tooth Selection

School Selection

Wisconsin SAS funding is limited to serving schools:

- With free and reduced meal program (FRMP) participation equal or greater than 35%.
- Identified as high need based on community needs assessment (with SAS administration approval)
- With a high percentage of immigrant, migrant worker, refugee and/or other vulnerable and underserved populations. (with SAS administration approval)
- Not currently being served by another SAS program. Programs adding schools during the contract year must gain approval from SAS administration prior to engaging in programming with a school not approved as part of the RFP process.

Grade selection

Wisconsin SAS programs may provide care in all grades at eligible schools and are encouraged to do so by program administration. Programs are also encouraged to expand and serve all grades in areas where movement from school to school is high and when annual participation is low at a school.

Tooth Selection

Only sound or non-cavitated carious pit and fissure surfaces of posterior teeth may be sealed. Dental providers should use the current available sealant placement recommendations available from the American Dental Association in JADA (August 2016) [Practice Guidelines](#) and [Original Contributions](#). Priority should be focused on first and second molars. Premolar teeth and deciduous molars may be sealed as needed based on an individual risk assessment that should be well documented in the patient chart in the event an audit is necessary.

Equipment

Programs are required to use appropriate equipment, supplies and techniques to apply dental sealants.

These products are widely available from a variety of vendors. Individual programs may select equipment to meet their program needs but all equipment purchases using SAS funding must be approved by SAS administration.

Equipment maintenance is offered free of charge at the SAS annual meeting and grantees are highly encouraged to have all equipment serviced annually. If programs do not keep up with annual maintenance funding for future purchases may not be approved for replacement equipment or funding to support repairs that could be prevented through annual maintenance.

Sealant materials

Wisconsin SAS does not require the use of specific brands of sealant material. However, the selected sealant product must be hydrophobic resin-based material. Because dental hygienists in Wisconsin are unable to adjust occlusion in the event of an overfilled sealant, the sealant material should quickly self-adjust through normal occlusion; therefore, programs should use resin-based sealant materials that have a low viscosity (less than 10% filler). Glass ionomer cements or hydrophilic sealants should ONLY be used sparingly in unique situations when concerns about moisture control are present and not as a standard protocol.

When choosing a material your program should consider cost-effectiveness, prolonged retention properties and simplicity of application. [School-Based Dental Sealant Programs \(mchoralhealth.org\)](http://mchoralhealth.org) provides a useful overview of the attributes of sealant materials that are appropriate for use in school-based programs.

Programs must use a phosphoric acid etch to prepare the tooth for sealant placement. Guidelines from the American Dental Association note that a separate etching step (not combined with a bonding agent) may result in higher retention rates. Thus, SAS programs may not use any self-etch materials to prepare tooth surfaces for sealant placement.

Bonding agents are not required and are considered a supplemental technique. If used, a bonding agent should not be combined with etch and should be compatible with the sealant material. All manufacture instructions regarding etch and curing time should be followed. There is limited evidence that retention is improved if a bonding agent containing both an adhesive and primer is used between the previously etched tooth surfaces.

Participation

Programs may not single out children on Medicaid or that participate in the school's FRMP program. Once a school is selected to receive school-based sealant program services, all children **MUST** have the ability to participate in the program and receive the same services regardless of insurance type. SAS grant funding must be used to cover costs associated with this program. Co-payments and other billing mechanisms may not be used. No bills or fees are allowed to be charged to any child or their family for services provided by a Wisconsin SAS program. In addition, all children that return a permission slip must receive services during the school year.

Sealant Application

Manufacture instructions should be used in the placement of sealants. All programs should ensure proper cleanliness of pits and fissures and isolation prior to etching, rinsing, drying and sealant application steps. Sealants should be light cured and inspected for appropriate retention and any possible defects or areas that may be high. If the sealant is overfilled appropriate steps should be taken to ensure a dentist can adjust the occlusion as this is not a step that can be performed by a dental hygienist.

Recommendations from Techniques for Assessing Tooth Surfaces in School-based Sealant Programs, JADA 2010, Fontana, M. et al, have been adopted by Wisconsin SAS as protocol and should be followed accordingly. These include the following:

- Unaided visual examination is the method of choice when deciding whether a tooth is cavitated and whether a sealant should be placed.
- All sound permanent molar teeth and any with non-cavitated carious lesions should receive sealant placement.
- Explorers may not be used to determine if a tooth has a cavitation as there is risk of causing a cavitation or unintentionally introducing bacteria to an area.
- Magnification may be used however unaided visual assessment of tooth surfaces is the appropriate approach for detection of cavitation.
- Radiographs are not indicated in school-based sealant programs as they do not show images of approximal surfaces.
- Caries detection devices and technologies (e.g. DIAGNOdent) are not permitted to be used in Wisconsin SAS programs to determine the need for sealant placement. These devices do not detect cavitation and their misuse could lead to teeth being misclassified and incorrectly precluded from sealant placement.
- No mechanical preparation (i.e. use of a burr or fissureotomy) of a tooth surface is allowed by SAS programs.
- Preparation of the tooth surface prior to etching can be done using a toothbrush.

Retention Checks/Evaluation

Retention checks can detect clinical problems related to application technique, equipment and/or dental materials. Programs should have a mechanism in place to evaluate both short- and long-term retention. Checking retention at each screening is a recommended best practice. The Wisconsin SAS program requires retention checks be performed on at least 10 percent of the children receiving sealants at EACH school. These retention checks should be performed 8 to 14 months after sealant placement and, when possible, by a dental professional that did not place the sealant initially.

Programs should check for retention of all sealants, regardless of if the sealant was placed by your program or another SAS program. There should be no need to determine what SAS program previously placed a sealant because DentaSeal is programed to calculate retention rates based on the program that originally placed the sealant.

The performance benchmark established for retention checks done in the 8-to-14-month timeframe is at least a 90 percent retention rate. Retention of sealants can and should

occur for program sealants placed more than 14 months ago. It is anticipated that retention rates will go down the longer a sealant has been on a tooth.

When retention rates fall below the performance benchmark of 90 percent, programs should perform further evaluation to determine the cause. The type or brand of sealant material used, a faulty curing light, insufficient curing time, inadequate tooth isolation or other provider techniques are examples that may impact program wide retention rates. Efforts should be made to implement changes that will improve the quality of the sealants placed. This may include program wide policy changes, calibration of all staff, or providing remediation to specific providers. All sealants evaluated for retention must be documented in DentaSeal. When a tooth is evaluated and the sealant is fully intact, protecting the intended pits and fissures, the sealant should be marked as a retained sealant in DentaSeal. If the sealant is partially lost, requires a 'touch up" or is completely lost the tooth should be resealed and marked accordingly in DentaSeal. It is critical that appropriate documentation in both DentaSeal and the patient record take place.

Fluoride Varnish Application

The benefits of fluoride varnish make it extremely useful within public health programs. Wisconsin SAS requires that all grantees incorporate fluoride varnish applications as part of their preventive services. Programs should apply fluoride varnish a minimum of 2 times (3 recommended) during the school year on all children determined to be high risk.

Fluoride varnish is highly effective in preventing decay and re-mineralizing white spot lesions. It is recommended for use on at-risk children as soon as teeth begin to erupt. When applied to teeth, fluoride varnish sets upon contact with saliva. The hardened layer of fluoride is then absorbed into enamel. If not brushed off the teeth, it will continue to be absorbed for several hours. The absorption time is much longer than for traditional fluoride gels and foams. Fluoride varnish application may be applied up to four times a year, based on risk assessment.

Because of the hardening and small amount used, the risk of ingestion and toxicity of fluoride varnish is extremely low, making it safe for young children.

The criteria for application of fluoride varnish include:

- Patient is high risk for caries and used for prevention
- Suspected tooth decay
- White spot lesions
- Visible plaque
- History of decay (fillings or crowns)
- Low socio-economic status

Fluoride varnish application must be provided according to the manufacturer's guidelines. The basic application guidelines are:

- Clean the teeth. Teeth need to be "toothbrush clean" before fluoride varnish is applied.

- Dry the quadrant to be treated with gauze or air.
- Apply the varnish to all exposed surfaces of the teeth, including the chewing and interproximal surfaces.
- Repeat for all remaining quadrants.
- Provide patient instruction (to parent or patient):
 - Patient should not brush or floss their teeth for four to six hours following the application.
 - Patient should wait 2 hours after application before eating crunchy foods or drinking hot drinks.
 - Patient should be informed that the teeth may appear discolored until the varnish is brushed off.

Case Management

Grantees are expected to assist children and families in identifying a provider and securing any follow up needs identified during the screening. This task should not be left with the school nurse/staff to complete. Grantees that do not directly provide comprehensive care at the school should work with area dental clinics to secure a referral source for any child with early or urgent dental needs. This must go beyond a handout with clinics that accept Medical Assistance. Developing relationships with local dental providers is critical to the success of our program and helps to ensure children find necessary follow up care. Connecting with the community dental professionals can include making them aware of the services that will be provided in the local schools, developing an informal referral agreement, or developing a formal written agreement for referral. Grantees that require assistance developing a relationship with a local dental provider are highly encouraged to work with SAS administration and the Wisconsin Dental Association. Programs required to register under DE-10 must ensure compliance with requirements set forth by DSPS.

Wisconsin SAS requires that all children are provided with a follow up form on the date of service that includes the services provided, any clinical findings/recommendations and any additional clinical notes the parent or guardian should be aware of. The follow up form must include a phone number to contact the program directly, the provider who treated the child along with their Wisconsin license number and the mobile dentistry registration number (if applicable).

Annual meeting

All SAS grantees are expected to have in attendance at least one representative at the annual Wisconsin SAS grantee kickoff meeting for the entire duration of the meeting. It is recommended that programs consider sending at least one clinical and one administrative staff. This meeting will be held annually in late August or early September.

Publicity and use of SAS Logo

The Wisconsin SAS program, Children's Health Alliance of Wisconsin and Wisconsin Department of Health Services regards publicity as an opportunity to collaborate with project partners. Please inform the Wisconsin SAS program of any media inquiries received.

Assistance will be provided to ensure a response that meets the expectations of all partners.

It is anticipated that various media venues will host information about local school-based sealant program activities, either through general press announcements, proactive stories or media queries to community partners. Wisconsin SAS would like to have copies of these to add to your project file and share with potential funders, legislators and community partners.

Programs should not represent themselves as Wisconsin Seal-A-Smile (SAS). Programs are funded by Wisconsin SAS but do not represent the program as a whole. Please append the following statement to any project publicity: This project is funded [SELECT ONE – in part or wholly] by the Wisconsin Seal-A-Smile program, a collaborative program of Children's Health Alliance of Wisconsin, the Wisconsin Department of Health Services and Delta Dental of Wisconsin.

Grantees SHOULD ONLY use the Wisconsin SAS, Children's Health Alliance of Wisconsin's and Wisconsin Department of Health Services name and logos on additional paperwork (i.e. websites, information letter to parents, teachers, schools; consent forms and follow-up letters) upon approval of the Wisconsin SAS program. If you are using one of the two above mentioned logos on your paperwork, you must have this approved annually. Programs are encouraged to use the SAS name in program materials to ensure all program partners understand the link between your program and Wisconsin SAS.

Forms, Reporting & Recording

Consent forms

All children must have a signed consent form on file before any treatment (including fluoride varnish) can be completed by the program who has been granted consent. Consent forms cannot be transferred from one program to another. The following aspects must be included on all consent forms. A template consent form in multiple languages is available on the Wisconsin SAS website that can be modified for individual programs use. Programs are required by [Wisconsin Administrative Code Chapter DE-14](#) to obtain informed consent as outlined in the rule.

Online consent

Grantees are encouraged to use the Wisconsin SAS online consent tool. This tool has been developed to ensure the appropriate level of security is needed in collecting and transferring patient information in accordance with HIPAA. The [link](#) to the online consent form can be shared with schools to promote on their school website, online newsletters or online learning platforms that are used by children and families. More information including a training video for grantees is available on the SAS website.

Dental Home

The following wording must be included on all SAS funded program consent forms. This information should be on the form that is signed by the parent/caregiver and not on other accompanying documentation.

The treatment which your child will receive in this program is not meant to be an alternative to regular dental care. It is still strongly recommended that you seek out a dental home (family dentist) for routine dental care including any follow-up care which may be recommended after your child has completed this school-based oral health program.

(Spanish) El tratamiento que su niño recibirá en este programa no es una alternativa al cuidado dental regular. Todavía es fuertemente recomendado que usted busque una oficina dental (dentista de familia) para el cuidado dental rutinario incluso alguno persiguen el cuidado que puede ser recomendado después de que su niño ha completado el programa de salud oral basado escolar.

A concise and simple consent form aids in increased program participation. Requesting information that is not pertinent to providing care in a school-based dental sealant program can discourage a parent/caregiver from filling out the form and returning it to school.

If your program does provide comprehensive care and acts as the child's dental home this wording can be removed from the consent form but should only be done so with prior approval from SAS administration.

Special needs screening questions

To accurately collect data on children and youth with special health care needs (CYSHCN), funded programs are required to incorporate CYSHCN screening questions into the health history form. The screening questions, developed by the Child and Adolescent Health Measurement Initiative, will assist in accurately and consistently identifying CYSHCN. The questions were specifically designed to reflect the broad Maternal and Child Health Bureau definition of children with special health care needs. Many of these questions can replace questions already included on the health history form. When incorporating these questions into an existing form, it is not necessary, or recommended, to point out that these questions are used to determine if a child has special needs.

Instructions: If the parent checks "YES" to any of the first 5 boxes and checks "YES" to the follow-up question related to the duration or expected duration, then indicate in SEALS data that this child has a special need. Please note that there must be a "YES" regarding duration in order to identify the child as having a special need.

The required questions to include in the health history for are as follows:

Does your child (check one):

- Use medicine prescribed by a doctor? ☐ yes ☐ no

If YES, list medications: _____

- Need or use more medical care than other children the same age? ☐ yes ☐ no
- Have trouble doing things most children the same age can do? ☐ yes ☐ no

- Need or get special therapy, such as physical therapy, occupational therapy or speech therapy? ☐ yes ☐ no
- Need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking or activities other children the same age can do? ☐ yes ☐ no

If you checked any of the boxes above:

- Has this problem lasted or is expected to last at least 12 months? ☐ yes ☐ no

Additional Health History/Consent form guidance

Maximizing participation at each school is important. One effective way to increase the number of consent forms returned is to ensure the consent form is simple to complete. A form that asks numerous questions that are unnecessary for school-based sealant programs may deter parents from completing the form. The following are examples of questions that are NOT necessary to ask on a health history for a school-based dental sealant program:

- Does or has your child had any of the following: rheumatic fever, asthma, heart murmur, heart defect, etc. REASONING: In the past, this information was used to determine the need for administering premedication. Premedication should only be administered using the current ADA and American Heart Association recommendations which no longer include most preventive procedures.
- Insurance provider address, member ID number, policy number, etc. REASONING: When billing Medicaid, the only information about the child that is required is the child's name and date of birth. By asking for a policy number, this is an extra step that may discourage a parent from completing and/or returning the form. In addition, many programs find benefit in verifying the Medicaid status of all children who return a consent form, regardless of indicated insurance status.
- Does your child have access to: fluoridated community water, fluoride supplements, regular dental care, medical care, etc. REASONING: Gaining this additional information may be informative; however, it can again deter a parent from completing the form. In addition, knowing this information will not change the way in which you would provide services.

The following are examples of questions that SHOULD be included on a health history:

- Is your child allergic to anything? (i.e. medications, food, latex, etc.) If so, what? _____ REASONING: You want to know about any potential allergies, however it is not necessary to provide a long list of possibly allergies... Asking the general question provides opportunity to capture all allergies.
- Insurance type - Choices should include the following: Medicaid/BadgerCare/Forward Health; Private Insurance (i.e. Delta, Cigna, Humana); no insurance. REASONING: This is data captured in DentaSeal and it is imperative that the data collected is complete and accurate. To accomplish this, all three options must be included on the consent form. This format will also assist with efforts to bill MA for eligible children.

- Consent: Programs must gain consent to provide treatment and to bill insurance for services provided. It is not necessary, or recommended, to have parents check off specific procedures they consent to and have them sign in multiple places. A recommended statement to be used at the bottom of a consent form is as follows:

I give my child (or am the rightful legal guardian of this child) permission to participate in the school-based oral health program and receive any preventive treatments determined to be necessary limited to a dental exam/screening, fluoride treatments and application of sealants. In addition, I give permission to bill my insurance for any appropriate procedures (when applicable). This consent is good for XXX month(s)/year(s) from the date in which is signed. Programs may not gain consent that lasts longer than 24 months. I have the ability to un-enroll from this program at any time by providing written withdrawal of consent.

Medicaid Billing

Wisconsin SAS grantees are required to bill all third-party payers, as allowable. Grantees must make all reasonable efforts to identify all children they serve who are Medicaid eligible and must collect reimbursement due to the program. A valid estimate of the Medicaid income is expected in the grant application and full reporting of Medicaid billing and collection is required in the year end program reporting. Grantees are expected to provide services to all children regardless of the insurance status. First party billing is not allowed. All diagnostic and preventive services must be provided at no cost to the family, child and schools. Programs/organizations must disclose in the RFP if they receive enhanced reimbursement through designation as a FQHC, a FQHC look-a-like, other designation that qualifies for enhanced payment or through a contractual agreement with an FQHC or FQHC look-a-like. If so, within the RFP they must indicate your specific designation and/or explain the contractual agreement details.

DentaSeal Data Reporting

The Wisconsin Seal-A-Smile program in collaboration with Delta Dental of Wisconsin and Marshfield Clinic Research Foundation have developed DentaSeal, an online dental sealant data collection tool. All SAS funded programs are required to enter data into DentaSeal on all children that the programs provide care to. This data collection system is meant to increase the ability for programs to enter real time data, preferably chair side while seeing patients.

Data must be entered not later than 10 days after the child has been seen by the program and program visits must be closed out by the program no more than 10 days after the completion of the visit. All DentaSeal edits must be submitted through the [DentaSeal edits survey](#) and questions emailed to dhssealasmile@dhs.wisconsin.gov. Re-opening of visits for data modifications and edits will occur at the discretion of program administrators to ensure data integrity.

Programs should not wait to enter data until the end of the year as has been done in years past. All data must be complete for the current grant cycle no later than July 15. Programs are responsible for updating their annual program data prior to submitting their final invoice for payment.

Additional information on DentaSeal can be found on the [SAS website](#), including a user guide and training materials.

Patient Records & Retention

DentaSeal is not meant to completely eliminate the need for a paper record. Programs should keep appropriate patient records and follow rules set forth by DSPS as outlined in [Wisconsin Administrative Code Chapter DE-8](#). Clinical notes and copies of patient consent forms and health histories should be maintained and retained according to DE-8. Appropriate steps should be taken to ensure programs are collecting electronic signatures from providers to meet the requirements set forth by Medicaid.

Expense reporting

Funds for each project are provided upon receipt of an invoice and required accompanying documentation. Only the fiscal agent listed on the funding agreement and contract may directly invoice Children's Health Alliance of Wisconsin for reimbursement. Please refer to the budget and funding information section of the manual for an outline of allowable and non-allowable expenses along with other budget requirements.

Invoice Submission (when applicable)

Invoices must be submitted three times annually. The first invoice must be submitted no later than December 15 of the program year. A second invoice must be submitted no later than March 31 and a final invoice is due no later than June 15 or 10 days after the final day of services being provided. Programs who do not meet these invoicing dates may not be eligible for the discretionary incentive at the end of the year.

The fiscal agent should use the SAS Invoice to request payment for. The invoice form will be emailed to programs following the receipt of their award letter and subaward/contract. The invoice form should be submitted via email by each due date to chawsealasmile@childrenswi.org. A SAS reimbursement form for annual SAS launch meeting expenses and approved equipment costs will also be emailed to funded programs following the launch meeting. All required invoices/reimbursement forms and appropriate receipts should be attached to the SAS Invoice/Reimbursement form.

Invoicing for expenses beyond the maximum award amount will only be paid through gaining prior approval from SAS Administration.

Reimbursement

Children's Health Alliance of Wisconsin reviews and approves all SAS Invoice/Reimbursement forms submitted. Invoices must contain the PO number assigned to the program at the beginning of the program year. Upon approval by SAS Administration, payment request will be forwarded to Children's Wisconsin accounts payable. Children's Hospital of Wisconsin may request that a W9 form be filled out by the fiscal agent if they do not currently have one on file or the current one is outdated.

A payment will be mailed/transmitted electronically to the project fiscal agent within 30 days after the SAS Invoice/Reimbursement Form submission is approved by Children's Health Alliance of Wisconsin.

Reimbursement will be made to programs based on a formula that includes payments for children screened, children sealed, children receiving at least 2 varnish applications and data entry. Programs receiving enhanced reimbursement through either an FQHC or through another form of contracting will only receive funding for data entry but must follow all SAS policies and procedures. Invoices should include the number of children receiving services during the specified time frame and should be accompanied by a corresponding comprehensive report from DentaSeal as back up evidence.

Reimbursement for travel, accommodations and expenses will be covered by the SAS program for up to two attendees and the amount will be included in your award letter. Appropriate documentation will be required to be submitted for reimbursement and must align with the allowable and non-allowable costs to be reimbursed.

Programs will submit one Impact Story with their first invoice that is due on Dec. 15. Impact stories should follow the guidelines and Impact Story form provided to grantees. Please note, additional Impact stories can be submitted at any time throughout the year.

Other reporting and compliance requirements

Programs are not required to submit mid-year reports to SAS administration. DentaSeal data will be reviewed throughout the year to determine progress towards meeting program goals. Newly funded programs may be required to complete a grantee onboarding meeting prior to contracting.

Budget and Funding Information

Request for proposals

Programs interested in being a part of Wisconsin SAS are required to submit a request for proposal (RFP) annually. The RFP is released annually in June. RFPs will be reviewed beginning in July and awards announced no later than August 1. Requests for funding may continue beyond this time should funds remain available. The fiscal agent for each funded program (grantee) will receive an award letter via email and a funding agreement through DocuSign.

The RFP project period is July 1 to June 30 of the following year. Programs should use information in this manual as a guide for program design and implementation. Specific RFP submission instructions are outlined in the announcement letter and Grant Guidance document, available on the Alliance SAS webpage.

Schools submitted and approved by SAS administration will be assigned in DentaSeal upon execution of the funding agreement. Programs wishing to add additional schools must do

so with the approval of SAS administration. Schools already being served by another SAS program will not be approved without written documentation from the authorized school administrator noting their desire to have a different SAS program serve their school.

Funding agreement packet instructions

Each program is required to complete and submit the following items as a complete funding agreement packet. Programs will receive a funding award letter when their plan has been approved by the SAS review committee. The funding award letter will be sent electronically via email to the fiscal agent with the program manager CC'd. The contract/subaward will be sent electronically for signature via DocuSign to the fiscal agent with the program manager CC'd. Unless otherwise noted the schools submitted as part of the RFP are the schools that will be assigned to the program for the current year.

Expenses

Funding formula

Wisconsin Seal-A-Smile will provide funding to programs based on outcomes and services provided throughout the year. Based on program proposals, programs will be reimbursed for children screened, children sealed, children receiving 2 varnish applications within the current school year and data entry. This funding will be referred to as outcomes-based payments and these funds can be used for direct or indirect expenses the program incurs.

For programs/organizations who are awarded Seal-A-Smile funds, but also receive enhanced reimbursement through designation as a FQHC, a FQHC look-a-like, other designation that qualifies for enhanced payment or through a contractual agreement with an FQHC or FQHC look-a-like- SAS grant funding will be limited to the following metric "children's records entered".

Project Changes and Approvals

The terms of the funding agreement may only be modified or amended by a written addendum signed by the authorized representative of the fiscal agent, as listed in the executed funding agreement, and Wisconsin SAS program. All project changes need to be approved, in writing, by the Wisconsin SAS program in advance of any changes being made. This includes but is not limited to the schools the program intends to serve. To submit a change to your project you will need to submit, in writing, an updated work plan, and justification on annual basis.

Scope of work

All changes to your project proposal are subject to review and approval by the Wisconsin SAS program on a case-by-case basis. It is expected SAS funded programs will achieve their objectives as stated in the approved proposal. Due to the dynamic and evolving nature of projects, Wisconsin SAS understands that minor adaptations to project objectives and activities might occur. Grantees must report any changes to the proposed schools to be

served. It is expected that once grantees distribute consent forms at schools, they will serve all children who have returned a form, regardless of the return rate at the school during that school year.

Equipment

Any equipment purchased using Wisconsin SAS funding is expected to be maintained by the individual grantee. Requests for allowable equipment are to be included as part of the online proposal. If cessation of operation occurs, all equipment purchased with SAS funding will be relinquished back to Children's Health Alliance of Wisconsin within 30 days of program suspending operation or turned over with SAS Administration approval to another SAS program. Under no circumstance can any equipment purchased with SAS funding or by SAS administrations be sold to a third party.

Appendices

Appendix 1: Infection Control: Management and Follow-Up of Occupational Exposure

SBSPs must have an exposure-control plan that delineates program specific post-exposure policies and procedures to follow in case of occupational exposure to blood and other potentially infectious materials. Staff must receive training about these policies and procedures. OSHA has available a sample exposure control plan available at <https://www.osha.gov/Publications/osh3186.pdf>.

Programs should have access to up-to-date contact information for parents or guardians so that they can quickly obtain informed consent to test a child in case of an occupational exposure. If there is a blood exposure, the exposed person (or the health professional involved, if the exposed person is a patient) should immediately report the exposure to the agency infection-control coordinator. The infection-control coordinator should initiate a referral to appropriate healthcare personnel to provide post-exposure care, counseling, and follow-up and should complete necessary reports about the exposure.

If occupational exposure to a communicable disease occurs, the health professional affected should report the incident to his or her employer. The employer should immediately initiate post-exposure procedures, as appropriate, and should keep a detailed exposure report in the exposed employee's confidential medical record.

Because multiple factors contribute to the risk of infection after an occupational exposure to blood, the following information should be included in the exposure report, recorded in the exposed person's confidential medical record and provided to the qualified healthcare professional:

- Date and time of exposure;

- Where, when and how the exposure occurred;
- Identification of the source individual (unless infeasible or prohibited by law);
- Details of the exposure, including its severity and the depth of the wound;
- Details regarding whether the source material was known to contain HIV or other bloodborne pathogens, and, if the source was infected with HIV, the stage of disease, history of antiretroviral therapy, and viral load, if known;
- Details regarding the exposed person (e.g., Hepatitis B vaccination and vaccine response status);
- Details regarding counseling, post-exposure management, and follow-up; and
- Other pertinent information

The confidential medical evaluation must document the circumstances of exposure, identifying and testing the source individual if feasible, testing the exposed employee's blood (with consent), post-exposure prophylaxis, counseling and evaluation of reported illness. Health care professionals must be provided information to facilitate their evaluation.

The employer will be given a copy of the evaluating health care professional's written opinion. Findings and diagnoses, other than hepatitis B status, shall be kept confidential and not included in the written report. OSHA requires that employers ensure that employee medical records are kept confidential and not disclosed without the employee's written consent.

Adapted from CDC.gov. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis. MMWR June 29, 2001 / 50 (No. RR11).

Appendix 2: Infection Control Practices for School-Based Dental Sealant Programs

Principles of Infection Control	SEALANT APPLICATION and ASSESSMENT to SELECT TEETH FOR SEALANTS Level II CONTACT is anticipated (with patient's mucous membranes and saliva; not with blood or saliva with blood).
1. Take action to stay healthy <i>Immunizations</i> • Hepatitis B • Vaccine preventable • Annual influenza Hand hygiene	Yes ¹ Yes, if not immune Yes Yes
2. Avoid contact with blood <i>Personal Protective Equipment (PPE)</i> • Gloves	Yes

¹ If dental provider – Hepatitis B immunity is not required for an individual who is solely recorded for tooth selection, is not subject to spray or splatter from the air/water syringe and has no contact with patients' mucous membranes and/or with instruments/items that have contact with patients' mucous membranes.

• Surgical Masks • Protective eyewear or chin-length face shield • Long sleeve outer clothing <i>Avoid injuries</i> <i>Safe Handling of Sharps</i> <i>Written policy with exposure control plan</i>	Yes Yes Yes Yes Yes Yes
3. Make patient care items safe for use <i>Instruments</i> <i>Sterilization</i> <i>Sterilization Monitoring</i> <i>Portable Dental Unit Water Quality</i>	Dispose or heat sterilize² Yes Yes Yes
4. Limit the spread of blood and other infectious bloody substances <i>Control contamination</i> • High volume evacuation (HVE) • Disinfection/Barriers • Waste handling³	Yes Yes Yes

Appendix 3: Safe delivery of oral care outside the dental office

The Centers for Disease Control and Prevention (CDC) published infection control guidelines for dental healthcare settings in 2003. Although the 2003 recommendations are applicable to all settings in which dental treatment is provided, the recommendations focus mainly on dental settings that use traditional, fixed equipment (e.g., private practice dental settings). In contrast, a variety of non-traditional dental settings, such as school-based dental programs, use portable dental equipment. These programs often operate in challenging settings. For example, hallways, gymnasiums, or other high-traffic locations may be the only space available for dental screenings or treatment. Additional guidance may be useful in these unique situations, where space and resources needed to comply with recommended infection control practices may be limited (e.g., absence of sinks) or other challenges exist. To address these issues, stakeholders in academia and public health worked together to identify some of these challenges and to provide strategies and suggestions for implementing CDC recommendations. A national advisory group took the draft guidance and field-tested the format and content of a site assessment and checklist.

² If reusable instruments (e.g., mouth mirrors) are used, these must be cleaned and heat sterilized. If using disposable instruments or disposable tongue blades, place directly in waste container after use.

³ Disposal of medical waste must comply with OSHA rules and IAC Chapter 109.

Site Assessment Worksheet -

<https://health.maryland.gov/phpa/oralhealth/Documents/OSAPConsiderations.pdf>

Infection Control Checklist for Dental Settings Using Mobile Vans or Portable Dental Equipment- <https://www.osap.org/assets/docs/resources/portable-mobile/portable-mobile-checklist.pdf>