



Oral Health Toolkit

A Guide to Promoting Oral Health
in Pediatric Primary Care and
Achieving Medical-Dental
Integration

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Oral Health Integration Sub Committee Member Organizations

The following organizations contributed to the creation of this toolkit:

CareOregon Dental

Providence St. Vincent Medical Center

FamilyCare

Tuality Healthcare

Legacy Meridian Park Medical Center

Virginia Garcia Memorial Health Center

Oregon Oral Health Coalition

Washington County Public Health Division



Introduction

Dental disease is universally prevalent among the general population. In 2000, the U.S. Surgeon General labeled it a “silent epidemic.” Children, adolescents, low-income families, minorities, and those with special health care needs are particularly vulnerable to dental disease. The lack of access to oral health services for these populations contributes to the oral health disparities in the United States.

Historically, oral health was not considered a significant component of overall health. However, over the years, research has found oral health to be an integral part of systemic health. “Simple cavities” can escalate through childhood and into adulthood, causing youth to miss significant numbers of school days and even causing difficulties in finding a job. Poor oral health has also been linked to cardiovascular disease, dementia, respiratory infections, and diabetic complications.

The American Academy of Pediatric Dentistry (AAPD) recommends that children see a pediatric dentist when the first tooth appears or no later than the first birthday. The AAPD also recommends a check-up every six months in order to prevent cavities or other dental problems. Yet, approximately 17 million low-income children in the United States go without dental care each year. In February 2014, the Health Resources and Services Administration (HRSA) released a report, *Integration of Oral Health and Primary Care Practice*, which provides a framework for medical-dental integration in primary care. The integration of medical and dental services is key to reducing oral health disparities. The integration of medical and dental services will improve capacity and utilization of preventive oral health services for priority populations.

Purpose

This toolkit was developed by the Washington County Access to Integrated Care Oral Health Integration Subcommittee in collaboration with the Oregon Oral Health Coalition and the Washington County Public Health Division. It was developed through a quality improvement process to address integration barriers faced by local providers. The toolkit was also developed to promote awareness among pediatric primary care medical providers and ancillary staff of the impact of oral health on systemic health. It includes recommendations and tools and will serve as a resource for pediatric primary care providers as they look to achieve medical-dental integration through the use of the First Tooth program.

How to Use This Toolkit

This toolkit consists of 4 sections:

1. Oral Health in Children
2. Medical-Dental Integration
3. Payment and Reimbursement
4. Appendix

The first section contains information regarding oral health in children. This section includes key dental terms with the goal of creating a common medical-dental language regarding oral health prevention and disease. The second section includes recommendations and techniques on how to best integrate the four components of the First Tooth Training into primary care. The third section focuses on payment and reimbursement, and provides resources related to billing and coding. The appendix contains tools and sample documents as referenced in the text that will help facilitate ease of integration of the First Tooth Program.

Oregon Oral Health Statistics

2012 Oregon Smile Survey¹

Among 6- to 9-year-olds:

- Children from lower-income households had substantially higher cavity rates compared to children from higher-income households (63% vs. 38%), almost twice the rate of untreated decay (25% vs. 13%) and more than twice the rate of rampant decay (19% vs. 8%).
- Hispanic/Latino children had substantially higher rates of cavities, untreated decay, and rampant decay when compared to white children, black/African American children had even higher rates of untreated decay.
- One in five children (20%) had untreated decay in their primary or permanent teeth.
- More than one in two children (52%) has had a cavity, representing about 66,000 Oregon school children.
- 19% of children were in need of early or urgent dental care, representing more than 24,000 children needing access to professional care.

2011/12 National Survey of Children's Health (NSCH)²

- 48% of children ages 1-5 compared to 11% of children ages 6-11 had no preventive dental care visits in the past year.
- 10% of children ages 1-5 had one or more oral health problems in the past 12 months, in comparison with 28% of children 6-11 year olds.³
- 1/3 (30%) of Hispanic children versus 17% of white, non-Hispanic children had one or more oral health problem in the past 12 months.⁴
- One in three children (30%) 0 - 99% of the Federal Poverty Level (FPL) had decayed teeth or cavities in the past 12 months, versus 27% of children 100-199% FPL, 17% of children 200-399% FPL, and 11% of children 400% or higher of the FPL.⁵
- One in five children (20%) who experienced gaps in insurance coverage in the last year had fair/poor teeth condition compared to 10% who had no gaps in insurance.
- Only 5% of children whose care met all criteria for a medical home had teeth in fair/poor condition, in comparison with 19% of children whose care did not meet all medical home criteria.⁶

2009-2011 Pregnancy Risk Assessment Monitoring System (PRAMS)⁷

- 74% of 2 year olds in Washington County had not been to a dentist or dental clinic.
- 36% of Washington County 2 year olds had not been to a dentist or dental clinic because the parent/caregiver didn't know their child needed to go to a dentist.
- 20% of Washington County 2 year olds had not been to a dentist or dental clinic because a health care or dental provider told them their child was too young to see the dentist.

¹ The Oregon Smile survey involves a clinical examination, where a specially trained dental hygienist screens (5,258) children in 1st, 2nd and 3rd grades from a statewide representative sample of (82) elementary schools in Oregon. The survey focuses on caries experience, untreated tooth decay, sealants, and early childhood caries.

² The NSCH is a random digit dial phone sampling of parents regarding one child in the household - data includes children ages 1-17.

³ The jump in preventive dental care visits and oral health problems for ages 6-11 could highlight a lack of access to preventive care for children ages 0-5, a lack of oral health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

⁴ Oral health problems including toothaches, decayed teeth, or unfilled cavities were included in this measure.

⁵ A household between 0 and 99% of the federal poverty level (FPL) is considered low-income, while 100% to 199% FPL is considered moderate income. Households at or above 300% FPL are considered high-income.

⁶ Medical home is a multidimensional measure which uses the American Academy of Pediatrics criteria for quality care delivery among children. For more information on how medical home is defined and measured, please see the CAHMI at medical home manual

⁷ PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.

First Tooth Training Program

In 2009, The Oregon Oral Health Program in collaboration with the Oregon Oral Health Coalition (OrOHC) launched First Tooth. The program transitioned to OrOHC operational control in 2012.

The goal of First Tooth is to reduce early childhood caries in Oregon by training medical and dental providers to implement preventive oral health services for infants and toddlers ages three and under.

Both the **American Academy of Pediatrics** and the **American Academy of Pediatric Dentistry** recommend an oral health risk assessment, including a visual screening, anticipatory guidance, preventive strategies, (such as fluoride varnish), and the establishment of a dental home by age 1. (Research studies show that application of fluoride varnish can reduce tooth decay between 30% - 69% in primary teeth of high-risk children.)

To achieve these goals, First Tooth offers a no-cost training for dental and medical communities. The training is also available to WIC programs, Head Start programs and other entities that have a vested interest in the oral health of young children.

First Tooth training topics cover: the prevalence and impact of oral disease, risk assessment, culturally appropriate anticipatory guidance, fluoride varnish application, program implementation, workflow tips and access to dental care and a dental home. First Tooth also provides on-site support to build collaboration between dental and medical providers.



The First Tooth training includes:

- In-office continuing education, in-service training times or evenings, approximately 1.5 - 2 hours depending on need
- Training for *all* providers and staff on how oral health preventive services can easily be integrated into current services
- Instruction on fluoride varnish application
- Culturally appropriate handouts, exam/waiting room posters and anticipatory guidance that can be shared with parents and caregivers
- Guidelines to help refer children to a dental home by age one
- Continued support and technical assistance from FIRST TOOTH staff on systems-based implementation, workflow and clinical instruction

Since 2010, First Tooth has trained over 3,800 medical and dental staff throughout Oregon.

Visit <http://www.orohe.org/content/first-tooth> for more information.

Oral Health in Children

Despite improvements in oral health outcomes for Oregonian children over the past 9 years, oral disease still remains a major public health issue that disproportionately affects socially disadvantaged children. Oral disease can not only affect the quality of life of a child, but also has social and economic consequences into adulthood.

Early Childhood Caries

Oral disease in very young children is a major determinant of the quality of their overall health. In addition to infection, pain, and a high risk of developing tooth decay in permanent teeth, childhood oral disease is directly linked to a child's ability to concentrate, impaired language development, low self-esteem, and other critical developmental issues.

Early childhood caries (ECC, also known as tooth decay) is the most common chronic disease in children, affecting five times more children than asthma. Over 52% of 1st graders in Oregon have had a cavity, and 34% currently have untreated cavities.

Priority Populations

Cavity rates among 6- to 9-year-old children in 2012 were generally at or above 50% throughout the state of Oregon.⁸ Children from low income families have an increased risk, with low-income minority children at an even higher risk.

Prevention

Early childhood caries is transmissible, preventable, and treatable. By using simple tools, like those that First Tooth offers, we can improve overall health of young children and help equalize the balance of health equity by reducing the oral disease that disproportionately impacts the lives of low income children.

The First Tooth program trains dental providers and staff, caregivers (such as those working in Head Start and Early Head Start programs), and pediatric and family practice providers and staff about how to include preventive services in their daily work.



These pictures show the progression of early childhood caries. See AAP flipchart and pocket guide for progression of early childhood caries.

⁸ Oregon Health Authority. (2013). Oregon Smile Survey 2012 Report (Rep.). OR.



Attendees are educated about the importance of oral health care during pregnancy, how to identify signs of early childhood caries, behavioral strategies for caries prevention, and how to apply fluoride varnish. Trainers also discuss program implementation, workflow tips, and strategies for creating access to dental care and a dental home. First Tooth trainers also provide on-site support to build collaboration between dental and medical providers.

Prevention should also be practiced on daily basis at home. Community health workers, pediatricians and family practice clinicians, dentists, and WIC and Head Start or Early Head Start staff can all promote healthy habits through education for parents and children.

Habits that help prevent early childhood caries include:

- Ensure mother's mouth is healthy before baby is born.
- Put babies to sleep without a bottle; fill it with water if the baby must have a bottle.
- Clean babies' teeth and gums with a clean washcloth or small, soft toothbrush at bedtime.
- Provide babies with a clean pacifier, not one dipped in something sweet.
- Avoid giving children soda pop, juice, and other sweet drinks.
- Make sure children brush their teeth for two minutes a day, twice a day, with fluoride toothpaste.
- Provide healthy snacks between meals and only give treats at meal times.

Babies should see a dentist or dental hygienist by their first birthday. Teeth and gums can be checked yearly. By age 3, children should already be seeing a dentist regularly and have an established "dental home". When children are old enough, they can use an alcohol-free fluoride rinse after brushing, provided they spit (not swallow) the rinse.

Dental Care and Pregnancy

Addressing oral health in pregnancy is the most upstream approach to preventing early childhood caries. Not only is poor oral health associated with poor pregnancy outcomes, but mothers/primary caregivers are also the main source of the bacteria responsible for causing caries in children. Improving maternal oral health reduces caries transmission from mother to baby and improves the overall health of the mother and child.

Among recent postpartum mothers in Washington County:

- 63% of mothers had their teeth cleaned during the 12 months before they got pregnant with their new baby.
- 45% of mothers did not go to a dentist or dental clinic during their most recent pregnancy.
- 58% of mothers said a dental or other health care worker talked with them about how to care for their teeth and gums.



Child Oral Health Resources

American Academy of Pediatric Dentistry (AAPD) Informational brochures for parents:

www.aapd.org/pediatricinformation/brochurelist.asp

Campaign for Dental Health

<http://ilikemyteeth.org/>

Help Me Be Healthy

Tools and Resources for a healthy start set of educational pamphlets developed by WIC's health professionals for an active and healthy community

<http://www.helpmebehealthy.net/>

National Center for Fluoridation Policy and Research (NCFPR)

<http://waterfluoridationcenter.org/>

New Resources on Special Health Care Needs for Providers and Caregivers

http://dental.washington.edu/departments/omed/decod/special_needs_facts.php

Oral Health America

Develops, implements, and facilitates educational and service programs designed to improve the oral health of all Americans.

www.oralhealthamerica.org

Smiles Across America

This site is an application to receive donated fluoride varnish.

<http://oralhealthamerica.org/wp-content/uploads/Product-Donation-Form-2011.pdf>

Washington Dental Service Foundation

<http://kidsoralhealth.org/>



Medical-Dental Integration

The integration of oral health into medical care is quickly becoming a best practice in order to address prevention at an early age. Many states have developed similar successful programs utilizing medical providers as the entry point for preventive oral health care. By the age of 3, a child has many well-child check-ups, yet many parents wouldn't know to bring their child to the dentist by their first birthday, which is the recommended first visit to a dentist. It is ideal for the initial assessment, guidance for parents, and referral to a dentist, to occur during one of these routine well-child



visits with the medical provider. Early preventive intervention for a young child and parent can lead to decreased risk of future cavities and decreased dental costs. If a parent learns to not put their infant to bed with a bottle of milk, for instance, cavities in the front teeth can be prevented. A toddler with severe cavities of the front teeth often requires treatment with general anesthesia in a hospital setting which can be risky and very costly. A medical provider doing an oral health assessment with a referral to a dentist can result in a timely referral into dental care that might not happen otherwise. By embracing an approach to comprehensive health care, integrating oral health into medical care can provide the perfect environment for strengthening access to oral health care, improve both provider and parent understanding of oral health, and provide the needed oral health care screening, preventive, and referral services that are essential to optimal health.

Systemic Health

The Surgeon General's Report in 2000 on the silent epidemic of oral health, clearly indicates that poor oral health in childhood can lead to much more serious problems later in life. There is a growing body of evidence indicating that periodontal (gum) disease is linked to cardiovascular disease, stroke, and diabetes. Diabetes is known to be linked to worsening gum disease and diabetics with uncontrolled gum disease have more difficulty controlling their blood sugar. The oral health of pregnant women and new moms is critically important because bacteria causing cavities are passed on from parents to their children. Many adults experience xerostomia or dry mouth, an adverse effect of many common medications and chronic conditions. Xerostomia increases the risk of oral infections and increases the rate of cavities, leading to increased dental expenditures and a decreased quality of life.

A United Health Care study published in 2013 looked specifically at the impact of various dental treatments on the medical and pharmacy costs for individuals with chronic medical conditions. Overall the net cost of medical treatment for those who had dental treatments was lower, even when adjusted for the cost of the dental treatment. This is a reminder of the importance of oral health care and maintenance when related to overall health. The benefits of prevention and promotion of oral health from an early age are substantial.

Dental Referral Strategies

For Medicaid Members:

If the patient has an established dental home:

Refer the patient to their dental home for dental care. Assist the patient by providing care coordination or calling/faxing/emailing the referral directly to the dental home.

If the patient DOES NOT have an established dental home:

For a dental referral, determine the patient's assigned Dental Care Organization (DCO), which may be listed on the member OHP/CCO card or letter, or call the patient's CCO customer service number. CCOs (Coordinated Care Organizations) delegate dental care to the DCOs rather than a dental provider network. When determining where to establish dental care, contact the DCO instead of calling individual providers to set up a dental home.

The DCO will list the health centers/providers that participate in the patient's dental benefit plan.

- Some patients are assigned to a specific dental clinic by their DCO. If the patient knows which clinic they are assigned to, they can contact that clinic directly. If it is difficult to determine the patient's assigned DCO, call the patient's CCO customer service number.
- If there is no assigned CCO, contact OHP Client Services at 1-800-273-0557 (TTY 711).
- If resources are available, provide navigation and care coordination for the patient (aid in determining the DCO and/or participating health centers/providers, scheduling, sending the referral).

If the patient is private pay/insurance or uninsured:

Ask if the patient has established care at a dental home.

- **If yes**, refer the patient to their dental home for dental care. Assist the patient by providing care coordination or calling/faxing/emailing the referral directly to the dental home.
- **If no dental home has been established**, refer patient back to their commercial insurance carrier to find a contracted dental provider, or provide patient with a list of dental providers that will accept their private insurance. Utilize safety net clinics for those below federal poverty line and/or uninsured. If resources are available, provide care coordination by calling/faxing/emailing the referral directly to the dental provider.

Changing Dental Providers

For Medicaid members:

To change dental providers at the health center or dental clinic where the member has already established care:

Ask the site to change the dental provider of record (Primary Dental Provider).

- There may be frequency limitations for changing Primary Dental Providers per the health center/dental clinic.

To change to a dental provider at a different health center or dental clinic:

Contact the patient's DCO (Dental Care Organization). The DCO is contracted with specific health centers/dental clinics. The DCO will inform the patient which health center/dental clinic or Primary Dental Provider they may choose from.

- This information may be found on the DCO website (links to DCO websites can be found within the member's CCO website) or by calling the DCO customer service number.
- There may be frequency limitations for changing health centers/dental clinics per the DCO.

To change the patient's assigned DCO:

DCOs partner with CCOs (Coordinate Care Organizations) to provide and coordinate dental health care. Members are assigned to a DCO through their CCO. To change the DCO assignment, contact the CCO customer service number.

- If there is no assigned CCO, contact OHP Client Services at 1-800-273-0557 (TTY 711).
- There may be frequency limitations for changing DCOs per the CCO.

If the patient is private pay/insurance or uninsured:

The patient needs to contact their new provider of choice to discuss transferring care from the current provider of record. The dental offices will coordinate the transfer of any pertinent records.



Payment and Reimbursement - D0191, D1206/99188

D0191

Medical Providers: MD/DO/APN/PA

- Have a certification of completion from Smiles for Life or First Tooth (OrOHC).

Per the OHA, D0191 is reimbursed up to age 6. Some CCOs have elected to provide an enhanced age benefit for D0191. Please check with your CCO on the age limit for this benefit. The mechanism for reimbursement by a medical provider is to add the code directly to the medical claim.

Dental Providers:

Dentist

- May submit D0191 for oral assessment twice a year for children under 19 years of age and once yearly for adults 19 and older.
- May be reimbursed for D0191 if there is not a dental exam (D0120-0180) performed on the same date assessment of a patient is included as part of an exam. An assessment does not take the place of the need for oral evaluations/exams.
- May be reimbursed if D0191 is performed outside of a dental office. For patients who do not have a CCO or DCO assignment, bill DMAP directly.

EPDH

- May submit D0191 for oral assessment twice a year for children under 19 years of age and once yearly for adults 19 and older.
- May be reimbursed for D0191 if there is not a dental exam (D0120-0180) performed on the same date. Assessment of a patient is included as part of an exam. An assessment does not take the place of the need for oral evaluations/exams.
- May be reimbursed if D0191 is performed within or outside of the dental office setting.

D0191 assessment of a patient from a medical provider does not count toward the maximum number of D0191 services allowed by a dental provider. D0191 is reimbursable to medical and dental providers at \$11.83 on the DMAP fee schedule for open card clients. If the child's receives physical health services through open card/fee-for service, bill DMAP directly.

The FQHC encounter rate is inclusive of this service when performed during the medical or dental visit.

First Tooth recommends all ECCP services, including an oral assessment, to be done at each well-child visit.

This code will not be reimbursed at all visits, but hopefully it will encourage more time to be built into the well-child visit to incorporate more comprehensive education at least once a year for the child's first 6 years. For more information on payment and/or reimbursement, refer to OAR 410-123-1260.

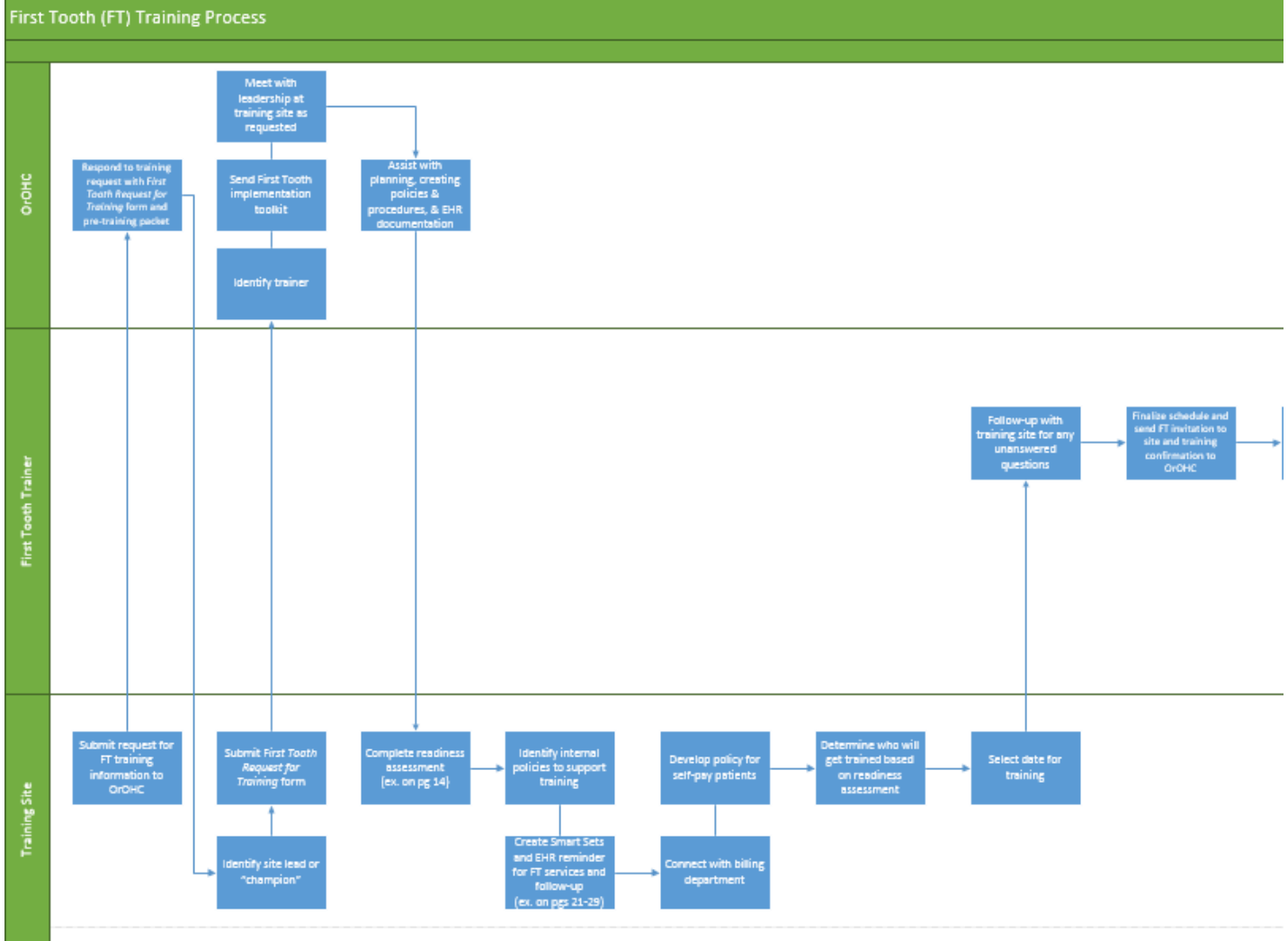
D1206/99188

Medical providers:

CDT D1206 or CPT 99188 fluoride application in a medical office is now to be covered by CCOs effective 1/1/14. Medical providers need to be trained in the application of fluoride varnish to bill for this procedure. If a medical provider delegates this procedure to a staff member, the staff member needs to be trained on the application of fluoride varnish.

The maximum limits of fluoride varnish application for a patient is cumulative from both Medical and Dental claims. Reimbursement for a child with low risk of decay is twice yearly. If a child is at high risk of decay, and it is documented in the chart, reimbursement is up to four times a year.

Appendix A: First Tooth Training and Integration Process Map



The complete First Tooth Training and Integration Process Map can be found here:

Appendix B: Readiness Assessment

Ready, Set, Implement

Medical Office

1. Determine who will deliver the services

- a. History/risk assessment: _____
- b. Screening (provider): _____
- c. Anticipatory guidance/patient education (oral hygiene, nutrition): _____
- d. Fluoride varnish education: _____
- e. Fluoride varnish application: _____

2. Decide when the services will be delivered (ex: Coordinate fluoride varnish with immunizations/well-child visits 6 mo, 9 mo, 12 mo, 15-18 mo, 24 mo, 36 mo. Separate visits for high-risk patients).

3. Identify an oral health champion in the office to:

- a. Order supplies (varnish and materials) and oral health education materials _____
- b. Identify and incorporate prompts for providers and patients _____
- c. Ensure new employees receive training _____

4. Create plan for fluoride varnish and oral health education materials

- a. Who will order: _____
- b. Where will they be stored: _____
- c. For patient visit, who will get supplies ready (ex: clip dose to chart): _____

5. Who will coordinate dental referrals and ensure that dental referral information is in exam room or at front desk _____

6. Establish process for documentation (ex: for paper charts- stickers or other prompts, intake form, exam form, determine location for tracking-immunization flip tab, dental tab, graphs, history section, etc.)

7. Create process for eligibility determination (ex: flag chart) and billing

Appendix C: Caries Risk Assessment Form Examples

You will need to select one of the following Caries Risk Assessment Forms endorsed by the OrOHC.

American Academy of Pediatrics (AAP)

Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a **▲** sign, are documented yes. In the absence of **▲** risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name: _____ Date of Birth: _____ Date: _____		
Visit: <input type="checkbox"/> 6 month <input type="checkbox"/> 9 month <input type="checkbox"/> 12 month <input type="checkbox"/> 15 month <input type="checkbox"/> 18 month <input type="checkbox"/> 24 month <input type="checkbox"/> 30 month <input type="checkbox"/> 3 year <input type="checkbox"/> 4 year <input type="checkbox"/> 5 year <input type="checkbox"/> 6 year <input type="checkbox"/> Other _____		
RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
<ul style="list-style-type: none"> ▲ Mother or primary caregiver had active decay in the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No 	<ul style="list-style-type: none"> ● Existing dental home <input type="checkbox"/> Yes <input type="checkbox"/> No ● Drinks fluoridated water or takes fluoride supplements <input type="checkbox"/> Yes <input type="checkbox"/> No ● Fluoride varnish in the last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No ● Has teeth brushed twice daily <input type="checkbox"/> Yes <input type="checkbox"/> No 	<ul style="list-style-type: none"> ▲ White spots or visible decalcifications in the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No ▲ Obvious decay <input type="checkbox"/> Yes <input type="checkbox"/> No ▲ Restorations (fillings) present <input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> ● Mother or primary caregiver does not have a dentist <input type="checkbox"/> Yes <input type="checkbox"/> No ● Continual bottle/sippy cup use with fluid other than water <input type="checkbox"/> Yes <input type="checkbox"/> No ● Frequent snacking <input type="checkbox"/> Yes <input type="checkbox"/> No ● Special health care needs <input type="checkbox"/> Yes <input type="checkbox"/> No ● Medicaid eligible <input type="checkbox"/> Yes <input type="checkbox"/> No 		<ul style="list-style-type: none"> ● Visible plaque accumulation <input type="checkbox"/> Yes <input type="checkbox"/> No ● Gingivitis (swollen/bleeding gums) <input type="checkbox"/> Yes <input type="checkbox"/> No ● Teeth present <input type="checkbox"/> Yes <input type="checkbox"/> No ● Healthy teeth <input type="checkbox"/> Yes <input type="checkbox"/> No
ASSESSMENT/PLAN		
Caries Risk: <input type="checkbox"/> Low <input type="checkbox"/> High	Self Management Goals:	
Completed: <input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Dental Referral	<input type="checkbox"/> Regular dental visits <input type="checkbox"/> Dental treatment for parents <input type="checkbox"/> Brush twice daily <input type="checkbox"/> Use fluoride toothpaste	<input type="checkbox"/> Wean off bottle <input type="checkbox"/> Less/No juice <input type="checkbox"/> Only water in sippy cup <input type="checkbox"/> Drink tap water
	<input type="checkbox"/> Healthy snacks <input type="checkbox"/> Less/No junk food or candy <input type="checkbox"/> No soda <input type="checkbox"/> Xylitol	

Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

Adapted from Ramos-Gomez FJ, Crystal YO, Ng MW, Crall JJ, Featherstone JD. Pediatric dental care: prevention and management protocols based on caries risk assessment. *J Calif Dent Assoc.* 2010;38(10):746-761; American Academy of Pediatrics Section on Pediatric Dentistry and Oral Health. Preventive oral health intervention for pediatricians. *Pediatrics.* 2003; 122(6):1387-1394, and American Academy of Pediatrics Section of Pediatric Dentistry. Oral health risk assessment timing and establishment of the dental home. *Pediatrics.* 2003; 111(5):1113-1116.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright © 2011 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

Table 1. Caries-risk Assessment Form for 0-3 Year Olds^{59,60}
(For Physicians and Other Non-Dental Health Care Providers)

Factors	High Risk	Low Risk
Biological		
Mother/primary caregiver has active cavities	Yes	
Parent/caregiver has low socioeconomic status	Yes	
Child has >3 between meal sugar-containing snacks or beverages per day	Yes	
Child is put to bed with a bottle containing natural or added sugar	Yes	
Child has special health care needs	Yes	
Child is a recent immigrant	Yes	
Protective		
Child receives optimally-fluoridated drinking water or fluoride supplements		Yes
Child has teeth brushed daily with fluoridated toothpaste		Yes
Child receives topical fluoride from health professional		Yes
Child has dental home/regular dental care		Yes
Clinical Findings		
Child has white spot lesions or enamel defects	Yes	
Child has visible cavities or fillings	Yes	
Child has plaque on teeth	Yes	

Circling those conditions that apply to a specific patient helps the health care worker and parent understand the factors that contribute to or protect from caries. Risk assessment categorization of low or high is based on preponderance of factors for the individual. However, clinical judgment may justify the use of one factor (eg, frequent exposure to sugar containing snacks or beverages, visible cavities) in determining overall risk.

Overall assessment of the child's dental caries risk: High Low

Table 2. Caries-risk Assessment Form for 0-5 Year Olds^{59,60}
(For Dental Providers)

Factors	High Risk	Moderate Risk	Low Risk
Biological			
Mother/primary caregiver has active caries	Yes		
Parent/caregiver has low socioeconomic status	Yes		
Child has >3 between meal sugar-containing snacks or beverages per day	Yes		
Child is put to bed with a bottle containing natural or added sugar	Yes		
Child has special health care needs		Yes	
Child is a recent immigrant		Yes	
Protective			
Child receives optimally-fluoridated drinking water or fluoride supplements			Yes
Child has teeth brushed daily with fluoridated toothpaste			Yes
Child receives topical fluoride from health professional			Yes
Child has dental home/regular dental care			Yes
Clinical Findings			
Child has >1 decayed/missing/filled surfaces	Yes		
Child has active white spot lesions or enamel defects	Yes		
Child has elevated mutans streptococci levels	Yes		
Child has plaque on teeth		Yes	

Circling those conditions that apply to a specific patient helps the practitioner and parent understand the factors that contribute to or protect from caries. Risk assessment categorization of low, moderate, or high is based on preponderance of factors for the individual. However, clinical judgment may justify the use of one factor (eg, frequent exposure to sugar-containing snacks or beverages, more than one dmfs) in determining overall risk.

Overall assessment of the child's dental caries risk: High Moderate Low

ADA American Dental Association® America's leading advocate for oral health			
Caries Risk Assessment Form (Age 0-6)			
Patient Name:			
Birth Date:		Date:	
Age:		Initials:	
	Low Risk	Moderate Risk	High Risk
Contributing Conditions		Check or Circle the conditions that apply	
I.	Fluoride Exposure (through drinking water, supplements, professional applications, toothpaste)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
II.	Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes <input type="checkbox"/>	Frequent or prolonged between meal exposures/day <input type="checkbox"/>
III.	Eligible for Government Programs (WIC, Head Start, Medicaid or SCHIP)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
IV.	Caries Experience of Mother, Caregiver and/or other Siblings	No carious lesions in last 24 months <input type="checkbox"/>	Carious lesions in last 7-23 months <input type="checkbox"/>
V.	Dental Home: established patient of record in a dental office	<input type="checkbox"/> Yes	<input type="checkbox"/> No
General Health Conditions		Check or Circle the conditions that apply	
I.	Special Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Clinical Conditions		Check or Circle the conditions that apply	
I.	Visual or Radiographically Evident Restorations/ Cavitated Carious Lesions	No new carious lesions or restorations in last 24 months <input type="checkbox"/>	Carious lesions or restorations in last 24 months <input type="checkbox"/>
II.	Non-cavitated (incipient) Carious Lesions	No new lesions in last 24 months <input type="checkbox"/>	New lesions in last 24 months <input type="checkbox"/>
III.	Teeth Missing Due to Caries	<input type="checkbox"/> No	<input type="checkbox"/> Yes
IV.	Visible Plaque	<input type="checkbox"/> No	<input type="checkbox"/> Yes
V.	Dental/Orthodontic Appliances Present (fixed or removable)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
VI.	Salivary Flow	Visually adequate <input type="checkbox"/>	Visually inadequate <input type="checkbox"/>
Overall assessment of dental caries risk:		<input type="checkbox"/> Low	<input type="checkbox"/> Moderate
		<input type="checkbox"/> High	
Instructions for Caregiver:			

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Circle or check the boxes of the conditions that apply. Low Risk – only conditions in "Low Risk" column present; Moderate Risk – only conditions in "Low" and/or "Moderate Risk" columns present; High Risk – one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

Oregon Oral Health Coalition Caries Risk Assessment <6

Lifestyle Assessment

	YES	NO
Does the child's mother/primary caregiver have active decay?		
Does the child consume carbohydrates between meals?		
Does the child receive inadequate systemic fluoride? (fluoridated water, supplements)		
Does the child use fluoride toothpaste less than twice daily?		
Does the child receive fluoride varnish less than twice a year?		
Does the child need a dental home?		
Is the child receiving any services from WIC, Head Start or Medicaid?		
Does the child have any special healthcare needs? (physical limitations, medications)		

Visual Assessment

	YES	NO
Are there visible white spot lesions or decay on the child's teeth?		
Has the child experienced previous caries? (both treated or untreated)		
Does the child have plaque?		

The child is at **high** risk if there are two or more YES responses.

Risk: _____ Low _____ High

Medical Referral Form

SERVICE REQUESTED

Referral to PCP

PATIENT INFORMATION

Date: _____ Member Name (First, MI, Last): _____
Responsible Person, if Minor: _____ DOB (MM/DD/YYYY): _____
Member ID #: _____ Phone# _____
Address: _____
City: _____ State: _____ Zip Code: _____

REQUEST

Referring Dentist: _____
Comments: _____

SELECT ALL THAT APPLY

Pregnant
 High Blood Pressure
 Other: _____

CONFIDENTIALITY NOTICE

This communication may contain information which is confidential or legally privileged. This information is intended for the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it is prohibited. If you received this communication in error, please notify the sender at the number listed above and destroy the information received.

Appendix E: EMR Examples

Smart or Dot Phrases for Documentation of the Oral Health Assessment and Fluoride Varnish Application in the EMR

ORAL HEALTH ASSESSMENT

Caregiver

Does mother/caregiver have a history of caries? {YES/NO:63}

Does mother/caregiver have a dentist? {YES/NO:63}

Referral for mother? {YES/NO:63}

Child

History

Existing dental home? {YES/NO:63}

Premature or low birth weight? {YES/NO:63}

Frequent snacking/juice intake? {YES/NO:63}

Special needs? {YES/NO:63}

SES? {LOW/MED/HIGH:10045}

Exam

Caries? {YES/NO:63}

Plaque? {YES/NO:63}

Demineralization? {YES/NO:63}

Fluoride

Supplement? {YES/NO:63}

Varnish indicated? ("Yes" to any two of the above indicates high risk) {YES/NO:63}

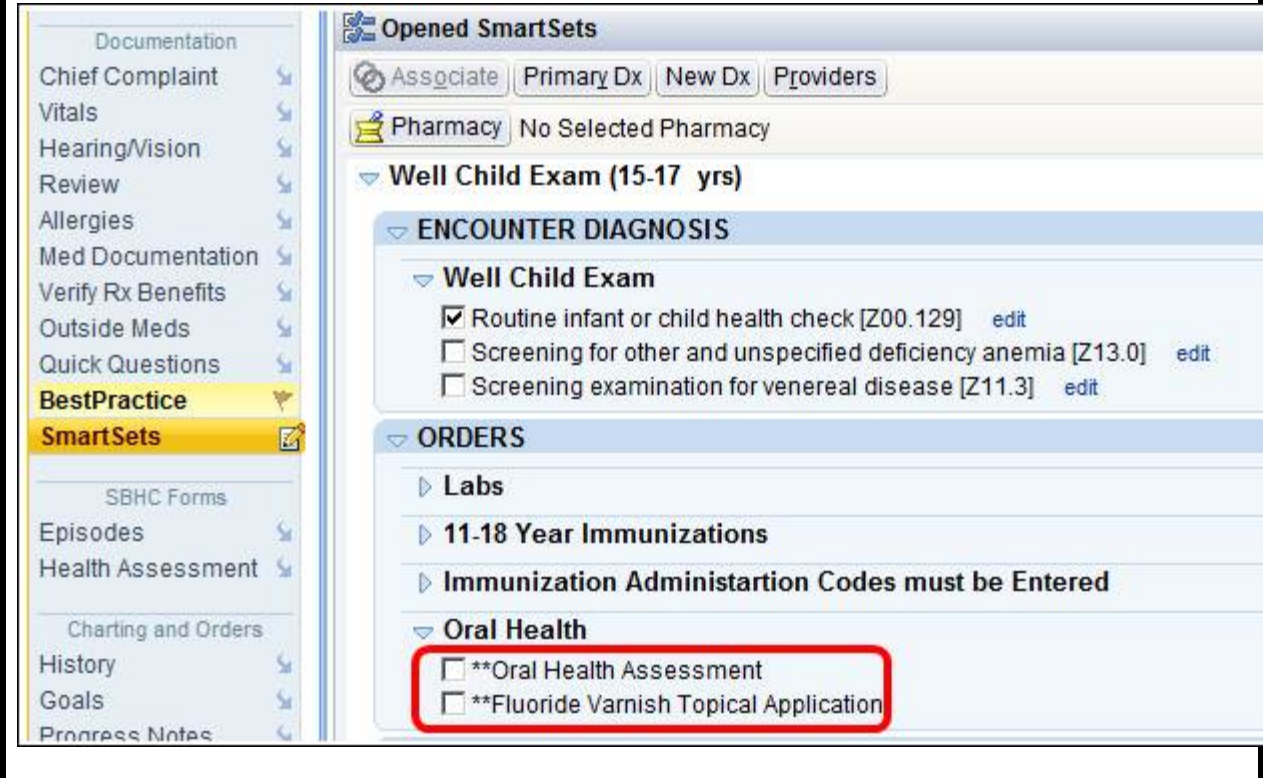
Applied? {YES/NO:63}

Referral? {YES/NO:63}

Comments: ***

Update **New Orders Sections in WCC SmartSets**

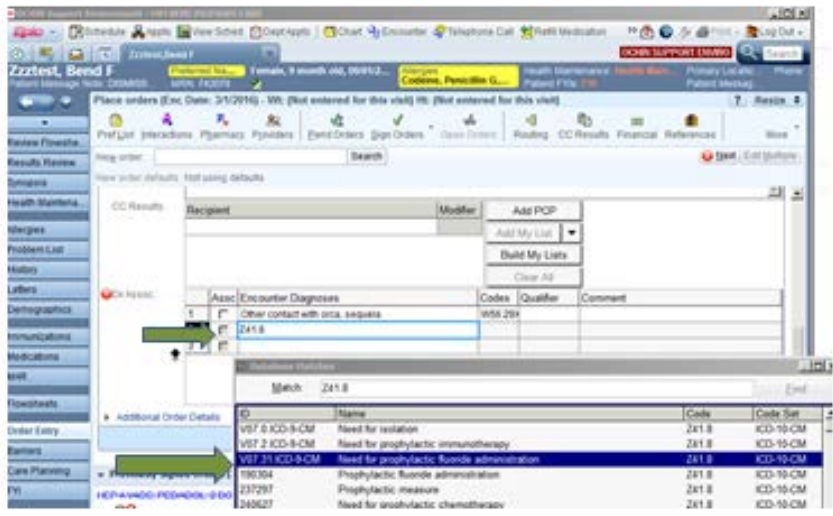
In order to better comply with USPSTF recommendations, OCHIN has added a new sub-section (Oral Health) to the Orders section of the Well Child Check SmartSets. This affects all WCC SmartSets from ages 9 months to 18 years.



Mosaic Medical- FQHC



Diagnoses



Encounter Diagnosis type "Z41.8" double click then look for "Need for prophylactic fluoride administration" click on that then click accept



Customized training for Kaiser with Kaiser specific EHR and workflow.

4 Documenting oral health services and findings

10/23/2014 visit with McNamara, Michael P, MD for Office Visit

Best Practice Advisory
BestPractice
Priority Questions
Patient Questionnaires
Online
Visit Info
Chief Complaint
Vitals
Exercise Vitals
Current Meds
Allergies
Hearing/Vision
Nursing Notes
History
Screening Questio...
Screening Trends

Screening Trends

Flowsheet Report

Review Flowsheet

Dental Varnish 10/23/2014

Fluoride varnish in last 6 months	0 - No
Caregiver/siblings have cavities	1 - Yes
Previous cavities	1 - Yes
2+ high sugar/starch snacks in between meals	1 - Yes
Special healthcare needs	1 - Yes
Drinks fluoridated water or supplements	1 - No
Brushes teeth 2x/day with fluoride toothpaste	1 - No
Receives services from Head Start or Medicaid	0 - No
Has a dentist	0 - Yes
SCORE	6

10/23/2014

Review Flowsheet

SmartSets

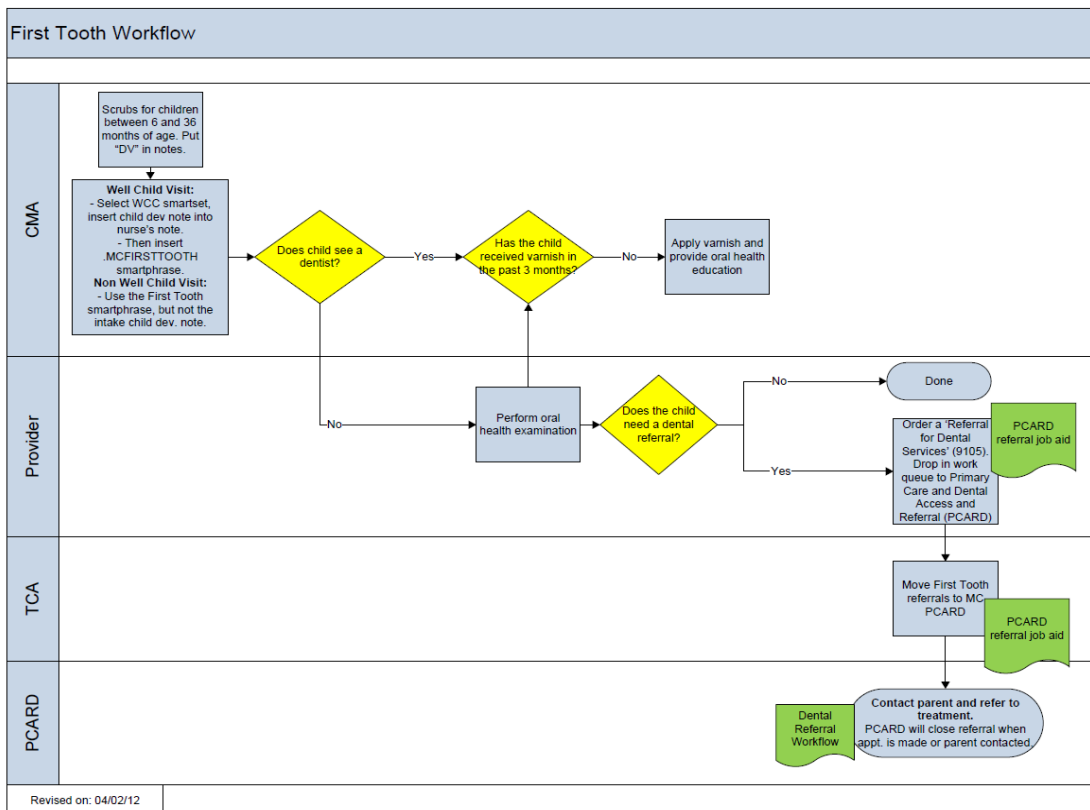
Search Add Advanced

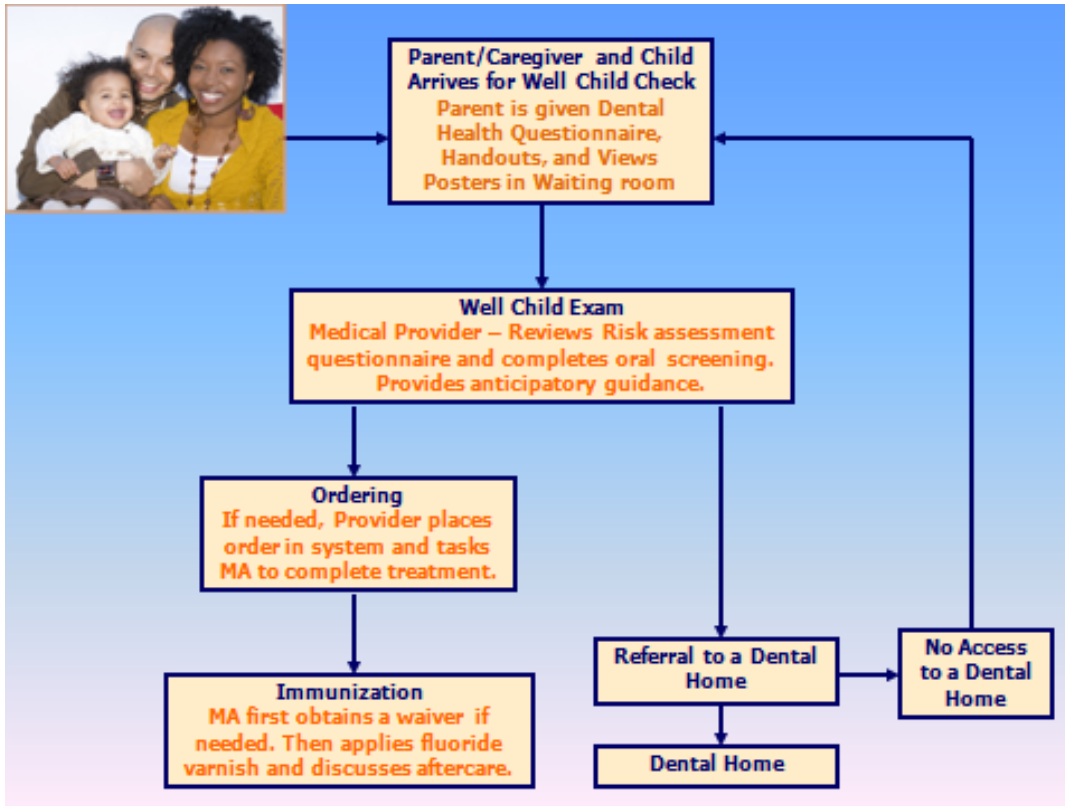
Suggestions



Multnomah County

Workflow and EHR documentation examples from 2012.





4 Clinic staff roles

Role	Main Duties
Support Staff (CMA)	<ul style="list-style-type: none"> • Scrubs for children between 6-36 months • Requests fluoride varnish procedure (provider signs) • Applies fluoride varnish • Provides oral health education
Provider	<ul style="list-style-type: none"> • Performs oral health examination • Refers child to PCARD
TCA	<ul style="list-style-type: none"> • Moves First Tooth referrals to PCARD
PCARD	<ul style="list-style-type: none"> • Contacts parent and refers to treatment



4 Smart phrases

.MCFIRSTTOOTH smart phrase

- Has child had fluoride varnish applied to teeth in last 3 months? {YES***/NO:60}
- Does {GUARDIAN:61} want fluoride varnish applied to child's teeth if not done in last 3 months? {YES/NO***:64}
- Demonstrated to {GUARDIAN:61} of @LNAME@ how to lift the child's lip and examine teeth for signs of decay, and how to brush child's teeth using only rice-sized amount of fluoride toothpaste.
- Fluoride Varnish {WAS/WAS NOT:9033} applied.



4 How to order and charge for fluoride varnish

Click the Special Services/Tests Drop Down and Select Dental Varnishing

Description	Service Item ID
Catheter, Urinary, Single	91703
Catheter Urinary of Grad	11200
Catheter Removal, One To Both	90210
Composites, Newborn	94750
Coronoid Visual Hemorrhage	30061
Dental Poling (Ultrasound) Pediatric	94654
Dental Varnishing	01206
DEVELOPMENTAL TEST, LAW	98710
ERG Test Interpretation And Report	93000
Elbow Dislocation	28440
Eye Screen (Smeller)	99173
Excision Wound, Strip	86262
HCG	89025
Heel, Finger (Peak, P12)	38416
Hemoglobin	82272
Hemoglobin	89018

Use V07.31 for ICD9 and Click on Place Order

Qty:	Code:	Office service:	Seq:	Strength:	Dose:	Units:	Route:	Side:	Site:
1	01206	Dental Varnishing							
		ICD9: Billing diagnosis:	Exp date:	Lot number:	Manufacturer:				
		V07.31 Need for prophylactic fluoride administ	/ /						
		Performed Schedule:							

Place Order





Metropolitan Pediatrics LLC

Financial Disclaimer for Dental Varnishing



Financial disclaimer responsibility: For and in consideration of the service provided to the patient, I promise to pay all charges for services rendered to or on behalf of the patient for the service(s) provided. I understand that my insurance may not cover the services provided and I agree to pay all costs involved within 30 days of receiving the statement of account. I understand that a billing fee may be assessed to my account for any balance past due beyond 30 days. I will bear the cost of collection and/or court cost and reasonable legal fees should this be required.

Examples of cost per service:

Dental Varnishing \$35

Signature of Responsible Party _____ Print Name _____
 Relationship to Patient _____ Date _____
 Print Patient Name _____ Acct/MR# _____
 DOB _____



Metropolitan Pediatrics

Dental Health Questionnaire



Date of Last Dental Visit: ___ / ___ / ___

Circle One

Are your child's teeth brushed 1 2 3 times per day

Does your child currently use fluoride? Yes No

Does your child have a history of cavities? Yes No

Is there a Family History of Cavities? Yes No

Did your child have a low birth weight? Yes No

Does your child drink from a bottle or breast feed in bed? Yes No

Patient Name _____ DOB _____

Provider _____ Date _____



Appendix F: Care Team Workflow Example

Care Team completes Visual Assessment and documents in EMR*

1. Receptionist gives patient Lifestyle Assessment
2. Patient/Caregiver completes Lifestyle Assessment
3. Patient returns Lifestyle Assessment to Medical Assistant
4. Medical Assistant enters Lifestyle Assessment into EMR
5. Provider reviews Lifestyle Assessment
6. Provider completes Visual Assessment on patient
7. Provider documents assessment exam in progress note by using MA Oral Health Risk Assessment note
 - i. Follow “make me an author” process
8. Complete documentation of Visual Assessment on progress note
 - i. Example: (dot phrase)
Oral Health Coalition Caries Risk Assessment <6

Lifestyle Assessment

Does the child’s mother /primary caregiver have active decay? {YES/NO:11221}

Does the child consume carbohydrates between meals? {YES/NO:11221}

Does the child receive inadequate systemic fluoride? (Fluoridated water, supplements)
{YES/NO:11221}

Does the child use fluoride toothpaste less than twice daily? {YES/NO:11221}

Does the child receive fluoride varnish less than twice a year? {YES/NO:11221}

Does the child need a dental home? {YES/NO:11221}

Is the child receiving any services from WIC, head Start or Medicaid? {YES/NO:11221}

Does the child have any special healthcare needs? (Physical Limitations, medications)
{YES/NO:11221}

Visual Assessment

Are there visible white spot lesions or decay on the child’s teeth? {YES/NO:11221}

Has the child experienced previous caries? (Both treated or untreated) {YES/NO:11221}

Does the child have plaque? {YES/NO:11221}

The child is at high risk if there are two or more Yes responses.

Risk: ***Low***High

9. Care Team provides oral health education
10. If Fluoride Varnish is needed, add D1206 or 99188
11. Add D0191Oral Assessment and enter the following diagnosis for assessments
 - i. Diagnosis code z13.84 “screening for dental disorder” (see list of codes on page 31)
 - ii. z91.89 risk of dental problems, or appropriate diagnosis when actual caries identified
12. If dental referral needed, order RF100012 Referral to dentist

**This is a modifiable example for OCHIN and EPIC Systems. Adapted from La Clinica (2016).*

Appendix G: Clinic Policy Example

Section:	Approved by:
Number	Adopted Date:
Procedure: First Tooth	Review Dates:
	Revision Dates: 11/21/13
Number of pages: 5	Retired Date:

Purpose: Basic Protocol for Medical Providers performing Oral Screenings for patients 0-5 years old.

Scope: MD, FNP, RN, LPN

Definition

Related Forms

Appendices 1: Varnish Workflow

Appendices 2: Knee to Knee technique

Procedure:

Medical Assistant:

If patient presents for Well Child:

1. Open Progress Note
2. Insert .CHCORAL to complete risk assessment smartset

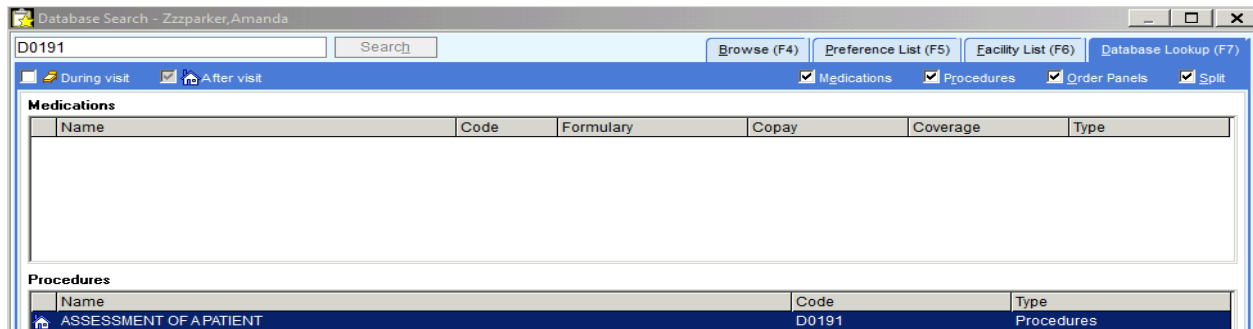
.chc

Abbrev	Expansion
CHCORAL	Caregiver: Does mother/caregiver have a history of caries? {YES/...

3. Insert .CHCFIRSTTOOTH to complete varnish smartset

CHCFIRSTTOOTH	Has child had fluoride varnish applied to teeth in last 3 months?
---------------	---

4. Order "Fluoride Varnish Treatment" or "TR050"
5. Order "Fluoride Varnish" or "EX021"
6. Order "Oral Assessment of a Patient" or "D0191"



7. Associate with WCC (V20.2)

8. Pend for Provider signature

For Interim Visits:

1. Open Progress Note
2. Insert .CHCORAL to complete risk assessment smartset

.chc

Abbrev	Expansion
CHCORAL	Caregiver: Does mother/caregiver have a history of caries? {YES/...

3. Insert .CHCFIRSTTOOTH to complete varnish smart phrase

Abbrev	Expansion
CHCFIRSTTOOTH	Has child had fluoride varnish applied to teeth in last 3 months?

4. Order “Topical Application of Fluoride” or “TX409”
5. Order “Fluoride Varnish” or “EX021”

Name	Code	Formulary	Copay	Coverage	Type
Medications					
Procedures					
TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUD)	TX409				Procedures

Name	Code	Formulary	Copay	Coverage	Type
Medications					
Procedures					
FLUORIDE VARNISH	EX021				Other

6. If child does not see a dentist then the Provider must perform the oral health examination prior to varnish being applied.
7. If a child does see a dentist and the child has not received varnish in the past 3 months, proceed with applying varnish as described below and provide oral health education.
(see attached diagram)

Varnish Application:

1. Open Fluoride pouch stir if needed.
2. Dry mouth/teeth with 2x2 cotton sponge if needed, (mouth does not need to be completely dry).
3. Brush Fluoride lightly on the biting (occlusal) and cheek side (bucal) surfaces of the teeth.
4. Have patient spit out any excess if they are able, for younger patients wipe around tongue if there is any excess fluoride in the mouth.
5. Sit patient up and advise parent/guardian not to brush patient’s teeth for at least 4 hours. If you are using Vanish Varnish and ProFlu.

Appendix H: Reimbursement Codes

I. Fluoride Varnish

a. Diagnostic codes

- i. Z41.8-Encounter for other procedures for purposes other than remedying health state
- ii. Z00.129- Encounter for routine child health examination without abnormal findings
- iii. Z00.121- Encounter for routine child health examination with abnormal findings
- iv. Z13.84- Encounter for screening for dental disorders

b. Procedure codes

- i. D1206
- ii. CPT 99188
 - 1. F Varnish is reimbursed 2 X year up to age 19. If the child is at high risk of caries, as is documented in the chart, F Varnish is reimbursed 4 X year.
 - 2. Person applying F varnish must be trained, but the training is not specified.
 - 3. F Varnish is not reimbursed as a stand-alone procedure in an FQHC

II. Oral Health Assessment

a. Diagnostic codes

- i. Z41.8-Encounter for other procedures for purposes other than remedying health state
- ii. Z00.129- Encounter for routine child health examination without abnormal findings
- iii. Z00.121- Encounter for routine child health examination with abnormal findings
- iv. Z13.84- Encounter for screening for dental disorders

b. Procedure codes

- i. D0191- Oral Assessment of a Patient
- ii. Reimbursed up to a maximum of once every 12 months for children. Check with CCO for ages of eligibility.
- iii. For reimbursement, the performing provider must meet all of the following criteria:
 - 1. Be a physician (MD or DO), an advance practice nurse, or a licensed physician assistant;
 - 2. Hold a certificate of completion from one of the following approved training programs within the previous three years- First Tooth (through the Oregon Oral Health Coalition;) or Smiles for Life
- iv. For reimbursement in a medical setting, D0191-Assessment of a patient must include all of the following components:
 - 1. Caries risk assessment using a standardized tool endorsed by Oregon Oral Health Coalition, the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics;
 - 2. Anticipatory guidance and counseling with the client's caregiver on good oral hygiene practices and nutrition;
 - 3. Referral to a dentist in order to establish a dental home;
 - 4. Documentation in medical chart of risk assessment findings and service components provide

Appendix I: Supply Orders



Suppliers for ECCP Materials



Estimated Costs

- Fluoride Varnish (32 unit dose – 0.25 ml) ~ \$45.00
- Infant Toothbrush (each) \$0.50 - \$2.25
- Toddler Toothbrush (each) \$0.25 - \$2.00
- 2x2 Sterile Gauze Sponges – 12 ply (200 per pack) ~ \$5.00

Fluoride Varnish Recommendations

- Based on our experience, most medical offices prefer unit dose packaging.
- Dosage: 0.25 ml is for primary dentition and sufficient for young children.

Supply Companies

- Try ordering directly through your medical supply company first. Some companies have a medical and dental division within the same organization.

Larger Dental Supply Companies	
Henry Schein Medical & Dental Supply 1-800-372-4346 www.henryschein.com/	Patterson Dental 1-800-328-5536 http://www.pattersondental.com/
Pearson Dental 1-800-535-4535 www.pearsondental.com	

Toothbrushes	
Supplier	Description
Henry Schein Medical & Dental Supply 1-800-372-4346 www.henryschein.com/	Infant Toddler Safety Toothbrush/Teether Toothbrush Infant/Toddler Aquafresh Infant Toothbrush
Patterson Dental 1-800-328-5536 http://www.pattersondental.com/	Aquafresh Baby Training Toothbrush Infant Toddler Safety Toothbrush/Teether Patterson Junior Toothbrush P27 Junior Toothbrush
Plak Smacker 1-800-558-6684 http://www.plaksmacker.com	Infant Brush Lil' Grip Toothbrush Junior Youth Toothbrush Children's Sparkle Toothbrush

Free Fluoride Varnish Resources

Oral Health America's The Smiles Across America® (SAA) Product Donation Project
<http://oralhealthamerica.org/resources/saa-product-donation-project/>

- Based on eligibility requirements, your practice may qualify to receive free fluoride varnish.

Fluoride Varnish		
Product	Description	Manufacturer
Cavity Shield 5% sodium fluoride	32 unit dose – 0.25 ml 200 unit dose – 0.25 ml 32 unit dose – 0.4 ml 200 unit dose – 0.4 ml	Omni Preventive Care A 3M ESPE Company 1-800- 634-2249 www.3mespe.com/preventivecare
Kolorz ClearShield 5% sodium fluoride	35 unit dose – 0.4 ml 200 unit dose – 0.4 ml	DMG America 1-800-662-6383 www.dmg-america.com
Duraflor 5% sodium fluoride (US)	32 unit dose – 0.25 ml 200 unit dose – 0.25 ml 10 ml tube (20-30 applications per tube) 32 unit dose – 0.4 ml 200 unit dose – 0.4 ml	Medicom, Inc. 1-800-361-2862 www.medicom.com
DuraShield 5% sodium fluoride	32 unit dose – 0.4 ml 200 unit dose – 0.4 ml	Sultan Healthcare 1-800-637-8582 www.sultanhealthcare.com
Enamel Pro Varnish 5% sodium fluoride	35 unit dose – 0.25 ml 35 unit dose – 0.4 ml	Premier Dental Products 1-888-670-6100 www.premusa.com/dental/products.asp
Flor-Opal Varnish 5% sodium fluoride	Syringe application 40 syringes & tips – 0.5ml	Ultradent Products, Inc. 1-888-230-1420 www.ultradent.com
Preident Varnish 5% sodium fluoride	50 unit dose – 0.4 ml	Colgate Oral Pharmaceuticals 1-800-372-4346 www.colgateprofessional.com
Value Varnish 5% sodium fluoride	100 unit dose – 0.4 ml	Sentry Dental Products 800-603-1224 www.valuevarnish.com/
VarnishAmerica 5% sodium fluoride	32 unit dose – 0.25 ml 200 unit dose – 0.25 ml 32 unit dose – 0.4 ml 200 unit dose – 0.4 ml	Medical Products Laboratories, Inc. 1-800-523-0191 www.medicalproductslaboratories.com

Appendix J: Oral Health Education and Resources for Providers

Smiles for Life

Smiles for Life produces educational resources to ensure the integration of oral health and primary care.

www.smilesforlifeoralhealth.org

Access to Baby and Child Dentistry (ABCD): A Manual for Dental Providers

Developed by the University of Washington, School of Dentistry, this guide is for clinicians who intend to implement effective preventive and early intervention oral health therapies for infants and toddlers.

<http://www.scribd.com/doc/11827499/ABCD-Pedodontia>

American Academy of Pediatrics (AAP)

AAP offers an extensive list of and easy access to on-line resources for the pediatric health provider.

www.aap.org/oralhealth

Oregon Health Plan dental benefits

Providers or organizations who work with Oregon Health Plan (OHP) clients can download the brochure from the Oregon Health Authority's website. <https://apps.state.or.us/Forms/Served/HE7224.pdf>

PACT Training

PACT curriculum trains pediatricians to become more knowledgeable about child oral health, more competent in providing oral health guidance and preventive care, and more comfortable sharing the responsibility of oral health with dental colleagues.

<http://www2.aap.org/ORALHEALTH/pact/index-cme.cfm>

EQIPP: Oral Health

The EQIPP online course helps providers recognize the role pediatric primary healthcare providers (PPHPs) play in providing oral health care. <http://shop.aap.org/EQIPP-Oral-Health>

All 4 Oral Health

The All 4 Oral Health Blog is the combined effort of the Oral Health Nursing and Education Practice (OHNEP) and Teaching Oral-Systemic Health (TOSH) programs. Collectively, these programs aim to build interprofessional oral health competencies among future primary care providers in order to develop a primary care workforce that is collaborative practice-ready for providing quality, patient-centered oral health care.

<https://all4oralhealth.wordpress.com/>

Appendix K: Oral Health Education and Resources for Staff

Bright Futures in Practice: Oral Health

This guide is designed to help health professionals implement specific oral health guidelines during infancy, early childhood, middle childhood, and adolescence.

<http://www.brightfutures.org/bf2/pdf/index.html>

The CDA Foundation

CDA Produced Cavity Keep Away and Oral Health during Pregnancy & Early Childhood: Evidence-based Guidelines for Health Professionals. The resources are available on the CDA Foundation Web site free of charge.

<http://www.cdafoundation.org/cavitykeepaway>

Health Literacy Universal Precautions Toolkit

The toolkit offers primary care practices a way to assess their services for health literacy considerations, raise awareness of the entire staff, and work on specific areas.

<http://www.ahrq.gov/qual/literacy/>

National Maternal and Child Oral Health Resource Center

Website contains a variety of information for individuals working in oral health. The site contains a database of oral health programs, which is used to collect and provide contact and program information to those working in oral health. It also contains the brochures about Head Start and the Two Healthy Smiles brochures.

www.mchoralhealth.org

The 2000 Report of the Surgeon General: Oral Health in America:

The Surgeon General of the Public Health Service has focused the Nation's attention on important public health issues. Reports have heightened America's awareness of important public health issues and generated major public health initiatives.

<http://www.surgeongeneral.gov/library/reports/oralhealth>

Oral Health: An Essential Component of Primary Care

Watch this video for information about actions primary care teams can take to improve their patients' oral health. <https://www.youtube.com/watch?v=8XPxDSiR9ig&feature=youtu.be>

Oral Health-Primary Care Integration Model

The Rural Health Information Hub provides a toolkit to aid in integration of oral health and primary care.

<https://www.ruralhealthinfo.org/community-health/oral-health/2/primary-care-integration-model>

Appendix L: Oral Health Education and Resources for Leadership

Centers for Disease Control and Prevention (CDC)

This site provides resources for oral health across the lifespan. www.cdc.gov/OralHealth/index.htm

U.S. Preventive Services Task Force – Recommendations for Primary Care Practice:

This site contains tools that can help a variety of audiences better understand what clinical preventive services are and how they can be implemented in the real world.

<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening>

HRSA: Integration of Oral Health and Primary Care Practice

The report and its recommendations serve as guiding principles and provide a framework for the design of a competency-based, interprofessional practice model to integrate oral health and primary care.

<http://www.hrsa.gov/publichealth/clinical/oralhealth/primarycare/>

HHS Oral Health Strategic Framework 2014–2017

The HHS Oral Health Strategic Framework 2014–2017 provides a roadmap to prevent oral disease; increase access to services; develop and disseminate oral health information; advance public policy and research and translate policy and research into practice; strengthen the oral health workforce; and eliminate oral health disparities. <http://www.nccpa.net/Uploads/docs/HHSOralHealthFramework.pdf>

Healthy People 2020 Oral Health

This site contains science-based, 10-year national objectives for improving the health of all Americans.

<https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health/>

Integrating Primary Care and Oral Health

This site contains ideas and best practices for implementing the right practices and new ideas for programs that build the health of communities. <http://www.careinnovations.org/knowledge-center/facilitating-care-integration/integrating-primary-care-and-oral-health>

Virginia Oral Health Coalition Integration Toolkit: Integrating Oral and Overall Health

This site contains several resources for integrating oral health and physical health care.

<http://www.vaoralhealth.org>

Oral Health Toolkit: A Guide to Promoting Oral Health in Community Health Centers and Achieving Medical-Dental Integration

This site contains several resources aimed at promoting interprofessional activities among medical and dental programs in Community Health Centers.

<http://www.aachc.org/resources/clinical-resources/dental/>

Appendix M: Additional Resources

The National Institute of Dental and Craniofacial Research (NICDR) provides free brochures and educational handouts for oral health across the lifespan. These resources can be found: <http://www.nidcr.nih.gov/OralHealth/>



A-Z

Text size:

[NIDCR Home](#) | [Oral Health](#) | [Clinical Trials](#) | [Research](#) | [Grants & Funding](#)

NIDCR Home > Oral Health

Order Free Publications



- ▶ Adult Oral Health
- ▶ Burning Mouth
- ▶ Children's Oral Health
- ▶ Developmental Disabilities
- ▶ Diabetes and Oral Health
- ▶ Dry Mouth
- ▶ HIV/AIDS
- ▶ Low-Cost Dental Care
- ▶ Oral Cancer
- ▶ Oral Complications of Cancer Treatment
- ▶ Organ Transplantation
- ▶ Periodontal (Gum) Disease
- ▶ Smokeless Tobacco
- ▶ Spanish-Language Publications
- ▶ Special Care
- ▶ TMJ Disorders

▶ Many of our publications are also available in Spanish

The Oregon Oral Health Coalition (OrOHC) provides resources for First Tooth as well as oral health across the lifespan. These resources can be found: <http://www.oroHC.org/>



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First Tooth Materials

Some materials are free and available for printing. Other materials must be ordered through OrOHC - please fill out the **Materials Order Form** and e-mail it to arlen.bates@ocdc.net. Ordered materials require a shipping and handling cost and will be sent by USPS unless otherwise noted. *First Tooth trainers, please use the Trainer Material Order Form. Thank you.

Posters

First Tooth posters are available through OrOHC for \$0.59 + shipping or can be downloaded and printed.

- Pregnancy Poster - English
- Pregnancy Poster - Spanish
- Babies Poster - English
- Babies Poster - Spanish
- Toddlers Poster - English
- Toddlers Poster - Spanish
- Toothbrush Tips - English
- Toothbrush Tips - Spanish
- Toothpaste Tips - English
- Toothpaste Tips - Spanish

Babies

A beautiful smile begins even before your baby's teeth start to show.

The first year of your baby's life is a great time to practice healthy habits you want to teach your child as he or she grows.

- Clean your baby's gums with a clean damp cloth after each feeding.
- Begin using a toothbrush and a smear of toothpaste with fluoride when the first tooth comes in.
- Write your baby's doctor or dentist about fluoride supplements when your baby is 6 months old.
- If you put your baby to bed with a bottle, use only plain water.
- When your baby begins eating solid food, choose those without sugar.

Did you know? Your baby should see a dentist before the first tooth comes in (or later when age 1).

First Tooth Documents

- First Tooth Project Summary
- Guidelines for Oral Health Care in Pregnancy
- Oral Health During Pregnancy Consensus Statement
- OrOHC Caries Risk Assessment
- Give Your Teeth a Chance Handout - English/Spanish
- Motivational Interviewing Goal Setting Tool - English/Spanish
- Recommendations for Fluoride Usage
- Fluoride Varnish Application: 3 Simple Steps
- Fluoride Varnish - What You Need to Know Handout
- General FAQs
- Billing FAQs
- Childcare FAQs
- DMAP OHP Plus Dental Benefits
- DMAP Simplified Chart of OHP Coverage of Dental Services
- Ready, Set, Implement
- Varnish Suppliers

Additional Resources

- AAP Dental Home Policy Statement
- Bright Futures Toolbox Resources
- DCO OHP 101
- Dental Hygienists and Head Start
- Dental Outreach OR, OHP Dentists
- Dentists and Head Start
- EHR Documentation
- Glossary of Terms
- Medical Providers and Head Start

