

# TOOLKIT

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## **Purpose Statement**

The purpose of From the First Tooth (FTFT) is to improve the oral health of Maine's children by increasing access to preventive oral health services. FTFT will accomplish this by using evidence-based approaches recommended by the United States Preventive Services Task Force (USPSTF) (see Appendix 1).

#### USPSTF recommends<sup>1</sup>:

- Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.
- Primary care clinicians apply fluoride varnish to the primary teeth of infants and children starting at the age of primary tooth eruption through the age of 5.

#### **Program Goal**

To eliminate dental disease among Maine children by greatly increasing the number of young children from 6 months through 5 years who receive preventive oral health care.

#### **Program Objective**

To fully integrate the From the First Tooth model into 100% of primary care practices serving children ages 6 months through 5 years.

#### From the First Tooth Model

FTFT provides a model to integrate pediatric oral health as the standard of care for all children from birth through the age of 5 at well-child visits within medical practices. FTFT supports participating practices by sharing the tools and processes to perform:

- 1. Oral Health Risk Assessment
- 2. Oral Health Clinical Evaluation
- 3. Primary Care Oral Health Plan Fluoride Varnish Application
- 4. Parent/Caregiver Anticipatory Guidance and Education
- 5. Referral to a Dental Home

This approach ensures that Maine's children will have access to preventive oral health services within their comprehensive, family-centered, and primary care medical homes.

## **Problem Statement**

Early Childhood Caries is the most widespread, chronic, infectious disease among children living in the United States. The prevalence of Early Childhood Caries in 2-year-old children is 11% and rapidly increases to 44% in 5-year-old children.<sup>2</sup> The consequences of untreated decay include pain and infection, impaired speech, delays in learning, problems with eating, social development, and, potentially, reduced quality of life.<sup>3</sup>

Multiple interrelated social and demographic factors --including income, race, parents' access to dental care, and educational level--can affect children's access to preventive dental care.<sup>4,5</sup> For example, it is well documented that low-income children are only half as likely as middleand high-income children to access preventive dental services, despite the higher occurrence of dental problems in this population. Low-income children are also two to three times more likely to suffer from untreated dental disease than their more affluent peers.<sup>6</sup> Adding to this issue, most Maine counties contain federally designated Dental Health Professional Shortage Areas (**see Appendix 2**).

Unfortunately, U.S. populations with the greatest burden of dental caries are the least likely to have access to dental care. Without access to regular preventive dental services, dental care for many children is postponed until the disease has to be treated in the operating room or symptoms such as toothaches and facial abscesses become so acute that care is sought in hospital emergency departments. The latter consequence of failed prevention not only is wasteful and costly to the healthcare system, but also rarely addresses the problem, as few emergency departments deliver comprehensive dental services.

Moreover, in the current healthcare system, dentists generally play a limited role in an infant's health. The U.S. Public Health Service Oral Health Coordinating Committee suggests that pediatricians play a more active role in addressing infant oral health.<sup>7</sup> The U.S. Department of Health and Human Services Oral Health Strategic Framework has provided a foundation of evidence-based solutions to many healthcare access issues and is beginning to address oral health care and reshape the dental care system for young children.

Often healthcare providers see children more than six times in their first year for well-child visits before the child ever sees a dentist.<sup>8</sup> The medical home can play a vital role in improving the oral health of children. In fact, the American Academy of Pediatrics established a policy stating that every child, 6 months through 5 years old, should receive an oral health assessment by a healthcare professional, including a caries risk assessment during the well-child visit.<sup>9</sup>

## **Etiology of Early Childhood Caries**

#### The Triad

Dental caries is a multi-step process that results in destruction of the tooth structure. Oral bacteria (Streptococcus mutans) metabolize the sugars from fermentable carbohydrates into acid. The acid demineralizes the tooth enamel.<sup>10</sup> If the cycle of acid production and demineralization continues, the enamel becomes weakened and breaks down into a cavity.<sup>11</sup>



#### It is not just *what* but also *how often* children eat.<sup>12</sup>

- Oral bacteria produce acids that persist for 20–40 minutes after ingesting fermentable carbohydrates.
- Oral acids lead to enamel demineralization.
- Remineralization occurs when acid is buffered by saliva.
- If fermentable carbohydrates are consumed frequently, there is insufficient time for the remineralization process to occur. The tooth is subjected to continued demineralization, and the caries process progresses.
- If fermentable carbohydrates are consumed infrequently, teeth are able to fully remineralize, and the caries process halts.



## Integrating Oral Health into Primary Care Practices

It is strongly recommended the medical home provide the following oral health services at well-child visits: oral health risk assessment and oral evaluation, application of fluoride varnish, family education, and referral to a dental home.

#### The Implementation Plan

#### Implementation Step 1: Oral Health Risk Assessment

- First, assess whether at least one of the child's teeth have erupted. If no, deliver anticipatory guidance and reassess at the next visit.
- Maine Oral Health Risk Assessment and Referral Tool for Primary Care (see Appendix 3) is utilized at well-child visits from birth through age 5 as part of the child's routine care. The information gathered from this tool can be integrated into the electronic medical record.
- The oral health risk assessment questions (below) should be administered by clinical support staff and should be answered by a parent/caregiver who is familiar with the child's history. If an answer to any one of the questions indicates the presence of a risk factor, the child is at moderate to high risk for dental decay, and fluoride varnish application is recommended.
  - Has the child seen a dentist in the past year? "No" indicates risk factor.
  - Does the child have his/her teeth brushed daily with toothpaste? "No" indicates risk factor.
  - Has the child ever had cavities or fillings? "Yes" indicates risk factor.
  - Has the mother/primary caregiver had active or untreated cavities in the past year? "Yes" indicates risk factor.

#### Implementation Step 2: Oral Health Clinical Evaluation

- The clinical evaluation must be performed by the primary care provider.
- The visual assessment is performed wearing gloves and using a light. The clinician will retract the cheeks and visually inspect the teeth and soft tissues of the mouth.
- The child is considered to be at moderate to high risk for dental decay, and fluoride varnish application is recommended, if the provider documents an answer of yes to any of these questions:
  - Is there visible plaque on the teeth? "Yes" indicates risk factor.
  - Are there signs of visible decay or white lesions on the teeth? "Yes" indicates risk factor.
  - Does the child have any other oral conditions of concern (abscess, broken tooth, pain)? "Yes" indicates risk factor. See Appendix 3 for photos of oral conditions.

#### Implementation Step 3: Fluoride Varnish Application

- It is recommended that all children receive a fluoride varnish application, especially if the child has one or more risk factors or has not received fluoride varnish at their dental home.
- Fluoride varnish can be applied by either the clinician or clinical support staff depending on what is most appropriate for the well-child workflow.
- The primary care provider can provide oral health anticipatory guidance and prescribe fluoride supplements if indicated. In addition, the primary care provider can make a recommendation for the child to see a dental professional by the age of 1.

## Implementation Step 4: Parent/Caregiver Anticipatory Guidance and Education

- Clinical staff can provide anticipatory guidance to parents and caregivers on behavioral risk factors and preventive measures that can impact the prevalence of Early Childhood Carries.
- Parent and caregiver education is based on a child's age and status of tooth eruption.

#### **Implementation Step 5: Referral to Dental Home**

- A dental home referral is completed by the provider and faxed to a dentist. When the child receives care from a dental professional, the date of the visit and relevant information about the dental plan should be faxed back to the referring primary care provider.
- See **Appendix 4** for a sample dental referral form.

#### Successful Oral Health Care Integration

#### **Element of Success 1: Implementation of All Five Steps**

• Practice has successfully implemented the oral health risk assessment, oral health clinical evaluation, fluoride varnish application, parent and caregiver education, and referral to a dental home into the well-child visit.

#### **Element of Success 2: From the First Tooth Practice Training**

- All new clinical and administrative staff are trained upon hire through incorporation of FTFT training in orientation.
- All practice staff are retrained every three years using an FTFT training method (inperson/virtual or trained by a practice staff member).

#### **Element of Success 3: EMR Integration**

• Oral health risk assessment is provided at well-child visits as part of the child's routine care, and this information is captured within the child's electronic medical record.

## **Importance of Fluoride**

Fluoride is the highest contributor to the reduction of dental decay among children in the United States. The mechanisms of fluoride application are both topical and systemic, but the topical effect is the most important, especially over the lifespan of the tooth. Fluoride is available from many sources and is divided into three major categories: professionally applied, tap water (and foods and beverages processed with fluoridated water), and home-administered.<sup>13</sup>

#### **Topical Fluoride Mechanisms of Action**

- Promotes enamel remineralization
- Reduces enamel demineralization
- Inhibits bacterial metabolism and acid production

#### Systemic Fluoride Mechanism of Action

Reduces enamel solubility through incorporation into its structure during tooth development

#### Fluoride Varnish

Evidence supports the efficacy of high-concentration fluoride varnish in preventing dental decay in children. The application of fluoride varnish reduces early childhood decay by protecting teeth, remineralizing tooth enamel, and arresting the progression of early decay. Fluoride varnish can be safely applied to children as early as the eruption of the first tooth.<sup>14</sup> Since applying fluoride varnish is a quick and easy procedure, it can be easily integrated into well-child visits and delegated to clinical support staff.

Fluoride varnish is a resin or synthetic base that contains a high concentration of fluoride. Fluoride varnish sets quickly on contact with teeth in the presence of saliva. Some fluoride remains on the enamel as a temporary layer of calcium fluoride-like material. The fluoride in the material releases when the pH level of the mouth drops in response to acid production. It then becomes available to remineralize enamel. This layer slowly disappears over the following months. Applications of fluoride varnish must be repeated to maintain effectiveness as a primary prevention strategy. Fluoride varnish application helps remineralize enamel even when there are early carious lesions.<sup>15,16</sup>

#### **Periodicity of Fluoride Varnish Applications**

Multiple applications of fluoride varnish on the primary teeth maintain the preventive benefit, as the effectiveness diminishes over time. This is especially important with high-risk children. Most guidelines recommend at least three professional applications of topical fluoride per year at intervals of three to four months for high-risk children. Research also shows that a threshold effect of at least four applications is required to obtain a detectable preventive benefit.<sup>17</sup> See Appendix 5 for periodicity schedules.

#### How to Apply Fluoride Varnish

Assessing the child's risk and performing an oral health evaluation will determine the need for fluoride varnish.

#### **Materials**

- 2" x 2" gauze square
- Gloves
- Disposable mouth mirror (optional)
- 0.25 ml dose of fluoride varnish (applicator brush is included within the packaging of this product)

#### Positioning

- Establish a knee-to-knee position between the medical provider and the parent/caregiver.
- Have the child's head in the medical provider's lap.
- Allow the parent/caregiver to place the child's legs around his/her waist.
- Parent/caregiver may further assist by holding the child's hand.



Photos: Mark Deutchman, MD | Smiles for Life, a national oral health curriculum

Application (See Appendix 6 for clinical competency checklist.)

- Remove the applicator brush from the holder.
- Stir the varnish to assure proper mixture.
- Using gentle finger pressure, open the child's mouth.
- Use the gauze square to wipe the child's teeth dry and remove obvious food particles that may be present.
- Using the gauze square, isolate the teeth.
- Using the applicator brush, apply the fluoride varnish to the teeth.
- Apply a thin layer of the varnish to all surfaces of the teeth; it is not necessary to apply varnish to open areas of decay.
- Once the varnish comes into contact with the saliva, the varnish will set.

#### **Post-Application Instructions**

- Consult the fluoride varnish manufacturer's instructions for recommendations on when to start teeth brushing after application.
- Remind the parent/caregiver to feed the child a soft diet for the remainder of the day; this will allow the fluoride varnish to stay in place for the optimal length of time.

Provide the parent/caregiver with the Baby Teeth Matter brochure, which includes these
post-application instructions (see Appendix 7). Brochures can be ordered from the
From the First Tooth website: <u>https://www.fromthefirsttooth.org/contact/ordermaterials/</u>

#### Silver Diamine Fluoride<sup>18</sup>

Silver Diamine Fluoride (SDF) is an evidence-based, safe, inexpensive, non-invasive medicament that is applied topically. Commonly prescribed formulations are 38% SDF, a silver fluoride salt made soluble in water through the addition of ammonia. SDF received Food and Drug Administration approval in 2014 as a treatment for dental hypersensitivity. Primary care providers should identify and refer patients to a dental home to assess the benefit of SDF therapy in cases where the parent/caregiver's responses to the oral health risk assessment questions indicate the child is at moderate to high risk for dental decay. Children may also receive SDF in public health settings from any dental provider who is licensed to provide the service. Children with stomatitis, ulcerative gingival conditions, or silver allergy are contraindicated. SDF therapy causes tooth decay to turn black. When black spots on teeth are noted on oral inspection, families should be asked whether SDF therapy is already being used.



[Image acquired from HelloSmile.com]

#### **Dietary Fluoride Supplementation**<sup>19</sup>

The use of fluoride supplements has been strongly associated with the reduction of dental decay in children. Primary care providers should assess the child's source of drinking water and prescribe fluoride supplements for children who are at high risk for dental decay and whose primary source of drinking water has suboptimal levels of fluoride.

If the child lives in a home that has public water supply, check the list of Maine Communities with Fluoridated Water Supply and Year Started or the Maine Center for Disease Control and Prevention's website for an up-to-date list **(see Appendix 8)**. If the family is on well water, ask the family whether they have had their well water tested and whether they know the results. If the well water has not been tested or the results are unknown, recommend that the family test the water using a kit that can be ordered from the Maine Center for Disease Control and Prevention's Health and Environmental Testing Lab (HETL). **See Appendix 9** for The Fluoride Test Kit Request form. If the family's water supply does not have optimal levels of fluoride, dietary fluoride supplements are recommended.

Dietary fluoride supplements are recommended for children at risk for dental decay as a single daily dose following the schedule established by the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatric Dentistry and the American Dental Association (table below). Ongoing monitoring at each primary care visit is necessary to ensure compliance with the supplements.

Obild's Ass	Water Fluoride Concentration						
Child S Age	<0.3 ppm	0.3–0.6 ppm	>6 ppm				
6 months-3 years	0.25 mg	None	None				
3-6 years	0.50 mg	0.25 mg	None				
>6 years	1.00 mg	1.50 mg	None				
Dosages are in milligrams F/day							

#### Dose Chart<sup>20</sup>

#### Summary of Fluoride Modalities for Low- and High-Risk Patients<sup>21</sup>

Fluoride Modality	Low Caries Risk	High Caries Risk
Toothpaste	Starting at tooth emergence	Starting at tooth emergence
Fluoride varnish	Every 3–6 months starting at tooth emergence	Every 3–6 months starting at tooth emergence
Over-the-counter mouth rinse	N/A	Starting at 6 years old if the child can reliably swish and spit
Dietary fluoride supplements	Yes, if drinking water supply is not fluoridated	Yes, if drinking water supply is not fluoridated

#### Fluorosis

The only scientifically proven risk of fluoride use is the development of fluorosis. Fluorosis of permanent teeth occurs when an excessive amount of fluoride is ingested over a long enough period of time while the tooth is developing underneath the gums. The risk of fluorosis exists in children younger than 8 years, and the most susceptible period is between 15 and 30 months of age. The risk of fluorosis is influenced by both the dose and frequency of exposure to fluoride during tooth development.<sup>22</sup>

#### **Clinical Appearance**

• Usually consists of white mottling



Photo: John McDowel, DDS

#### Prevalence and Risk Factors<sup>23</sup>

- Risk of developing fluorosis is greatest when a ratio of more than 0.06 milligrams per kilogram of body weight per day is ingested.
- Fluoride varnish is not a risk factor for fluorosis, as it is an irregular source of fluoride when applied at the recommended interval of two to four times per year between 6 months and 5 years of age when indicated.

#### Risk Reduction of Fluorosis<sup>24</sup>

- Avoid duplication of fluoride prescriptions.
- Advise patients/caregivers regarding the appropriate amount of fluoride toothpaste use by age, and recommend supervised brushing to reduce the incidence of children swallowing toothpaste (see below image for an appropriate amount for children).
- Keep fluoride-containing products out of the reach of small children.
- Determine fluoride content of current drinking water prior to recommending or prescribing dietary fluoride supplementation.



## Fluoride Varnish Frequently Asked Questions

#### Who can provide these oral health services in primary care practices?

Only a medical provider can perform and bill for the clinical oral health evaluation. Medical providers may also choose to conduct the applicable screenings and fluoride varnish applications. In this case, a medical provider is defined as a physician, physician's assistant, or nurse practitioner. Other properly trained clinical support staff such as RNs, LPNs, or medical assistants may perform the dental home and oral health risk assessments and apply the fluoride varnish under the supervision of a physician.

## I have heard that we do not have to prescribe fluoride tablets/drops if we are applying fluoride varnish. Is that true?

No, it is not true. Fluoride varnish is NOT a replacement for fluoride tablets or drops. The American Dental Association recently confirmed that children at high risk for caries still need their water assessed to determine whether they need dietary fluoride supplements. Dietary fluoride gets absorbed into developing teeth and is also re-excreted into saliva, thereby providing some topical benefit. The high concentration of fluoride in the varnish gives a boost to the fluoride content of the outer layer of the enamel, helping increase resistance to caries until the next application. Ingested fluoride in tablets provides a systemic effect to developing teeth.

#### Does fluoride varnish have any use once cavities have started?

Yes, fluoride varnish can help stop early dental decay from progressing. If a tooth has a white spot, which is an indication of an early cavity, the fluoride varnish will help harden the softened enamel and dentin and make that area of the tooth stronger so that a cavity does not progress. The area will become hard and shiny over time even though the white color will remain.

## How important is it to clean and dry the teeth before applying fluoride varnish?

It is not necessary to clean the teeth prior to applying fluoride varnish, but it is very important that the teeth be as dry as possible. Teeth can be dried by wiping them with gauze. As soon as the varnish is applied, you can allow teeth to get wet, as the varnish sets immediately upon contact with saliva.

## I find it challenging to go back and forth from the patient's mouth to the varnish container – any tips?

Some people dispense the varnish onto the back of their non-dominant gloved hand. Others prefer to hold the varnish container between the thumb and forefinger of their non-dominant hand. The non-dominant hand is often just helping to hold open the patient's

mouth, so it can play dual roles. If you feel comfortable, you can ask a family member to hold the varnish container for you.

#### Does fluoride varnish cause fluorosis?

No. Fluorosis is caused when children consume too much fluoride on an ongoing basis, which can happen when children use excessive amounts of toothpaste or take fluoride tablets when their water supply is fluoridated. Per the CDC, no published evidence indicates that professionally applied fluoride varnish is a risk factor for dental fluorosis, even among children younger than 6 years.<sup>25</sup> Properly applying fluoride varnish reduces the possibility that a patient will swallow it during application.

#### Why is fluoride varnish offered only every three to six months?

Fluoride varnish gets into the matrix of the tooth over the 18–24 hours it is "stuck" to the teeth. This boosts the fluoride content of the outer layer of the tooth enamel, creating a reservoir of fluoride that lasts for approximately three to six months. This reservoir then helps resist future decay and repair damaged enamel (remineralization).

## I am worried that applying fluoride varnish will take too long during a well-child visit. How long does it take to apply fluoride varnish?

Conducting the dental home and oral health screenings, performing the oral health evaluation, and applying fluoride varnish add very little time to a visit. Providers are already discussing diet and tooth brushing and are looking in children's mouths (we hope!). Fluoride varnish can be applied as part of the mouth examination and adds less than a minute to the process. Some practices have chosen to have clinical support staff apply the varnish during the time when vaccines are administered.

#### What is a dental home?

A dental home is characterized by an ongoing relationship between a dentist and patient, inclusive of all aspects of oral health care, including referrals to dental specialists. Care is delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home should begin no later than 12 months of age.<sup>26</sup> As with any other specialists children may see, it is important to coordinate care between dental and medical homes.

## Reimbursement for Fluoride Varnish & Oral Evaluation

#### Fluoride Varnish\*

#### MaineCare

#### Billing code: CPT99188

- Fluoride varnish by medical providers for children ages 6 months through 5 years (to the sixth birthday) is a USPSTF Grade B recommendation.
- MaineCare covers reimbursement to medical providers at \$12 (as of 2021) for fluoride varnish.

#### Billing code: D1206

- MaineCare also covers reimbursement at \$12 (as of 2021) for fluoride varnish (D1206) on the following schedules: (a) twice per calendar year for children under 3 years of age and (b) twice per calendar year with at least 150 days between applications for children ages 3 and over.
- Federally Qualified Health Centers, Rural Health Centers, and Indian Health Services are to use these codes for encounter purposes; reimbursement for the visit will continue to be paid at the core rate for the practice.

#### **Private Medical Insurers**

- Private medical insurers are required to cover all Grade B recommendations of the USPSTF.
- Fluoride varnish by medical providers for children ages 6 months through 5 years (to the sixth birthday) is a Grade B recommendation.
- Use CPT 99188 with a modifier 33 for billing private insurers (this is a medical code).
- If the provider is out of network, the claim could be denied. **See Appendix 10** for a sample fluoride application cost covering consent form.

#### **Oral Evaluation\***

#### MaineCare

Billing code: D0145

- MaineCare reimburses medical providers \$20/evaluation for oral evaluations performed every six months for children under 3 years of age.
- The medical provider is required to ask whether the child has a dental home. If the child has a dental home, the provider should not submit a claim to MaineCare for the oral evaluation.
- Federally Qualified Health Centers, Rural Health Centers, and Indian Health Services are to use these codes for encounter purposes; reimbursement for the evaluation will continue to be paid at the practice's core rate.

\*As of 2020, there may be some private medical insurers in Maine that reimburse for oral evaluation. Please consult with your billing department for more information.

## **Parent/Caregiver Education**

Below are examples of anticipatory guidance suggested by Smiles for Life: National Oral Health Curriculum. Oral health education should be integrated as part of comprehensive counseling with parents/caregivers during well-child visits. This education should include information about diet, oral hygiene, fluoride, and referral to a dental home. Recent evidence supports that oral health education by primary care providers reduces early childhood dental decay and can reduce dental expenditures. In addition, when primary care providers recommended that their pediatric patients visit the dentist, those children were more likely to have a dental visit.<sup>27</sup>

#### **Talking Points for Parents/Caregivers**

#### 4 to 11 Months

- Babies' front teeth often start to come in between 6 and 9 months of age. Ask your child's dentist or doctor about applying fluoride varnish to these first teeth.
- Start cleaning baby teeth as soon as they come in. You can use a soft cloth to wipe the little teeth or a baby toothbrush with a smear of fluoridated toothpaste the size of a grain of rice or less.
- Do not share spoons, cups, or toothbrushes with your baby. Adults can have bacteria in their mouths that can cause cavities in babies' teeth.
- If you put your baby to bed with a bottle, fill it with water only. Other drinks like milk, formula, juices, and sodas have sugar in them and can puddle around a sleeping baby's teeth, causing tooth decay.

#### 1 Year Old

- Your baby should have a first dental check by age 1. Schedule a visit with a dentist, or ask your doctor to look at your baby's teeth.
- Ask your dentist or doctor about fluoride varnish.
- Check your baby's mouth for spots or stains on the teeth.
- Brush your baby's teeth after breakfast and before bedtime. Use a soft baby toothbrush and a smear of fluoridated toothpaste the size of a grain of rice or less.
- Wean your baby off the bottle by age 1. Now your baby should be drinking from a sippy cup with water only.
- Milk and water are the best drinks for your baby. Do not give your baby juice. Most fruit juices are loaded with sugar and also contain natural acids that can cause cavities in your baby's teeth.

#### 1<sup>1</sup>/<sub>2</sub> to 2 Years Old

- Start using fluoride toothpaste to help prevent cavities. Use a grain of rice-sized amount of toothpaste on a soft toothbrush until your baby is 3 years old. If your child does not like the taste, try another flavor or use plain water.
- Ask your dentist or doctor about fluoride varnish.
- Floss your child's teeth as soon as two teeth touch each other.
- Tooth decay can be spread, so do not share with your baby anything that you have had in your mouth, like a spoon or pacifier.
- Milk and water are still the best drinks for your child. Do not give your toddler juice.

#### 3 to 9 Years Old

- Let your child start to brush their own teeth, but be there to help. Most children can't brush properly until 6 to 8 years old.
- Limit eating to three meals a day with two snacks between meals.
- Plain water and milk are still the best drinks for your child.
- Avoid carbonated beverages and juice drinks containing sugar. Reserve these, as well as candy and sweets, for special events.

#### Transitioning the Child to a Dental Home

Primary care practices can have a role in connecting children to a dental home. Identifying names of dentists in the community and establishing relationships with their staff can help facilitate this referral process. For a list of pediatric dental options, refer the the Dental Referral List that accompanied this toolkit. If you are unable to find a dentist use the resources listed below.

#### 211 Maine

Website: 211maine.org Phone: 211

#### MaineCare Provider Services

Email: MaineCareProvider@dxc.com Phone: 1-866-690-5585

## From the First Tooth Onboarding New Practice Procedure

FTFT staff is available to work with each practice to create a customized implementation plan that will ensure this program can be fully integrated into practice operations. Below is a proposed process that has been successful with many practices across Maine.

#### Meeting 1 – Introduction

Initially, FTFT team members will meet with identified members of the interested practice team, which could include the practice manager, clinical support staff, and one or more providers. During this meeting, FTFT will offer more information and details about the program as well as answer questions and respond to concerns. Once the practice agrees to participate, its staff complete a "Getting Started with Oral Health Prevention Services in Your Practice" questionnaire before Meeting 2 in order to prepare for implementation (see Appendix 11). Approximate Time Commitment: 1 hour

#### Meeting 2 – Practice Readiness and Process Mapping

At the next meeting, FTFT will work with as many practice staff as possible to review the practice's responses to the "Getting Started with Oral Health Prevention Services in Your Practice" questionnaire and clarify any questions. A FTFT staff member may facilitate a process mapping exercise with the team to understand current workflows. For example, fluoride varnish can be applied by the medical provider during the well-child exam, or this can be delegated to a nurse or medical assistant to perform at the same time as vaccinations. **See Appendix 12** for example workflow diagrams.

Reviewing a current workflow diagram is a great way to see how work is currently being done, to think about how it could be done in the future, and to trigger discussion about where and how important FTFT activities might take place. For example, FTFT educational materials (posters and brochures) can be available in the reception area to raise awareness about the importance of oral health among families as they arrive for an appointment. During check-in, families can receive information about fluoride varnish and be provided with the consent form for responsibility of payment if the service is not covered by their medical insurance. **Approximate Time Commitment: 1 hour** 

#### Meeting 3 – Training

FTFT provides training to practices using the Smiles for Life: National Oral Health Curriculum, Module 6: Caries Risk Assessment, Fluoride Varnish and Counseling. This module covers the etiology of early childhood decay, assessment of a child's risk of developing early childhood decay, oral health assessment, benefits and indications for fluoride varnish, application of fluoride varnish and family education on oral health, and referral to a dental home.

The curriculum was developed by the Society of Teachers of Family Medicine Group on Oral Health and endorsed nationally by many healthcare organizations including the American

Academy of Pediatrics, the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners, the American Academy of Physician Assistants, and the American Dental Association.

Trainings take approximately an hour and are completed in person or online at www.fromthefirsttooth.org/by-state/maine/on-demand-virtual-training/. The training reviews the Maine Oral Health Risk Assessment and Referral Tool for Primary Care and, if conducted in person, offers hands-on practice applying fluoride varnish.

#### Approximate Time Commitment: 1.5 hours

#### Meeting 4 – Implementation and Pilot Week

Once a workflow is established, parent/caregiver education is in place, the medical records and billing system are prepared, and all necessary staff have received an appropriate level of training for their role in delivering FTFT, the practice will agree on a go-live date. In advance of implementation, FTFT will supply the practice with:

- From the First Tooth Toolkit
- Educational materials for parents/caregivers
- Promotional materials for the practice
- Prompts and reminders for medical providers and clinical staff posters
- Toothbrushes and stickers
- Referral list of dentists
  - Contact MaineCare Provider Services (MaineCareProvider@dxc.com or 1-866-690-5585)

On the first day of implementation, FTFT will be available to provide a review of the procedure and the practice's agreed-upon workflow to any staff members who need it, to offer a demonstration of the application of fluoride varnish with each medical provider, and to assist the practice with issues related to workflow, documentation, billing, and referrals to dental practices. If desired by the practice, FTFT can develop a system for tracking children who receive/do not receive fluoride varnish during the pilot week and assist in data collection and analysis in order to troubleshoot and resolve barriers and challenges as they arise. **Approximate Time Commitment: 1 week pilot** 

#### Meeting 5 – Follow-Up

The FTFT technical assistance lead will follow up with the practice approximately two weeks post-implementation to see whether there are any questions or unresolved problems and to continue to monitor the practice's progress toward full implementation through Plan-Do-Study-Act (PDSA) cycles (**see Appendix 13** for a blank PDSA form). As part of the quality improvement process, it is recommended to establish ongoing data reports to monitor implementation status and to identify areas of improvement, to set goals, and to review and celebrate outcomes.

#### Approximate Time Commitment: 1 hour

## **Oral Health Metrics**

To monitor the success of program implementation, it is recommended practices track the percentage of oral health risk assessments, documentation of dental home, and fluoride varnish application through use of the EMR. Using these metrics practices can set targets, it is suggested that are practice set an initial target of 60% for each metric and assess monthly whether targets should be increased. Please see the table below for a calculation of each metric.

Metric	Definition	Numerator	Denominator
Oral Health Risk Assessment	% of children ages 6 months to 5 years with an oral health risk assessment completed	Total number of children ages 6 months to 5 years seen for a well-child visit (WCV) or other primary care provider (PCP) visit in the past year with an oral health risk assessment completed with classification as high/moderate or low risk	Total number of children ages 6 months to 5 years seen for a WCV or PCP visit in the past year
Dental Home Screening	% of children ages 6 months to 5 years with documentation of a dental home (defined as a dental office)	Total number of children ages 6 months to 5 years seen for a WCV or PCP visit in the past year with a dental home screening completed either yes or no	Total number of children ages 6 months to 5 years seen for a WCV or PCP visit in the past year
Fluoride Varnish Application	% of children ages 6 months to 5 years who had a fluoride varnish application	Total number of children ages 6 months to 5 years seen for a WCV or PCP visit in the past and a fluoride varnish application	Total number of children ages 6 months to 5 years seen for a WCV or PCP visit

#### **Example Metrics Tracker with 60% Target**

100000000000000000000000000000000000000							Januar	У					
FIRST FIRST TOOTH	Well Child Oral Health Risk Assessment					Dental Home Screening				Fluoride Varnish Application			
	# WCV	# of risk assessment s completed	# of refused risk assessments	# of risk assessments not offered	% of risk assessments completed	# of dental home screenings completed	# of refused dental home screenings	# of dental home screenings not offered	% of dental home screenings completed	# of fluoride varnish	# of refused fluoride varnish	# of fluoride varnish not offered	% of fluoride varnish completed
Practice 1	200	154	1	5	77%	150	2	48	75%	115	6	79	58%
Practice 2	23	22	1	0	76%	15	1	7	65%	23	0	0	100%
Practice 3	76	67	3	6	88%	70	0	6	92%	37	3	36	49%
	Well Child Visit	hild Oral Health Risk Assessment Dental Home Screening						Fluoride Varnis	sh Application				
Total WCV	299		· · · ·				_		1				
Total Risk Assessments		243	5	11									
Total Dental Home Screening						235	3	61					
Total Fluoride Varnish									·	175	9	115	
Total % Received				81%			7	9%			59	%	

## References

#### Purpose Statement

 Clinical Summary: Dental Caries in Children from Birth Through Age 5 Years: Screening. U.S. Preventive Services Task Force. October 2014. <u>https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening</u>.

#### Problem Statement

- 2. Satcher DS. Surgeon General's Report on Oral Health. Public Health Rep. 2000.
- 3. Anil S, Anand PS. (2017). Early Childhood Caries: Prevalence, Risk Factors, and Prevention. Retrieved from <a href="https://www.ncbi.nlm.nih.gov/pubmed/28770188">https://www.ncbi.nlm.nih.gov/pubmed/28770188</a>.
- Marmot M, Bell R. Social determinants and dental health. *Adv Dent Res.* 2011;23(2):201–
   6.
- Grembowski D, Spiekerman C, Milgrom P. Linking mother access to dental care and child oral health. *Community Dent Oral Epidemiol*. 2009;37(5):381–390. doi:10.1111/j.1600-0528.2009.00486.
- 6. CDC: low-income children at risk for dental caries. (2012). AGD Impact, 40(12), 10.
- 7. Oral Health Coordinating Committee. (2019). Retrieved from <u>https://www.hrsa.gov/oralhealth/ohcc/index.html</u>.
- 8. United States Department of Health and Human Services (2017). Oral Health Strategic Framework. Retrieved from
  - https://www.hrsa.gov/sites/default/files/oralhealth/oralhealthframework.pdf.
- 9. Policy statement: oral health risk assessment timing and establishment of the dental home. (2003). *Pediatrics*. 111(5), 1113–1116.

#### Etiology of Early Childhood Caries: The Triad

- 10. Fisher-Owens SA, Gansky SA, Platt LJ et al. Influences on Children's Oral Health: A Conceptual Model. *Pediatrics*. 2007. Vol. 120(3): pp. e510–e520.
- 11. Colak H, Dülgergil CT, Dalli M, Hamidi MM. Early childhood caries update: A review of causes, diagnoses, and treatments. *J Nat Sci Biol Med.* 2013; 4(1):29.

#### The Dental Caries Process: It Is Not Just What, but How Often, Children Eat

- 12. Dülgergil Ç, Dalli M, Hamidi M, Çolak H. (2013). Early childhood caries update: A review of causes, diagnoses, and treatments. *Journal of Natural Science, Biology and Medicine*. 4(1):29. doi: 10.4103/0976-9668.107257 Fluoride.
- Weyant RJ, Tracy SL, Anselmo TT et al. Topical fluoride for caries prevention: executive summary of the updated clinical recommendations and supporting systematic review. American Dental Association Council on Scientific Affairs Expert Panel on Topical Fluoride Caries Preventive Agents. J Am Dent Assoc. 2013. 144(11):1279–91.

#### Fluoride Varnish

- 14. Pahel BT, Rozier RG, Stearns SC, Quiñonez RB. Effectiveness of preventive dental treatments by physicians for young Medicaid enrollees. *Pediatrics*. 2011.127:e682–e689.
- 15. Association of State and Territorial Dental Directors (2015). Fluoride Varnish Policy Statement. Retrieved from <u>https://www.astdd.org/docs/fluoride-varnish.pdf</u>.
- Bhavna T Pahel, BDS, MPH, PhD, R Gary Rozier, DDS, MPH, Sally C Sterns, PhD, Rocio B Quinonez, DMD, MS, MPH. Effectiveness of Preventive Dental Treatment by Physicians for Young Medicaid Enrollees. *Pediatrics*. 2011;127, (3), e682–e689.
- 17. Weintraub JA, Ramos-Gomez F, Jue B et al. Fluoride varnish efficacy in preventing early childhood caries. *J Dent Res.* 2006;85(2)172–176.

#### Silver Diamine Fluoride

18. Association of State and Territorial Dental Directors. (2017). Retrieved from https://www.astdd.org/www/docs/sdf-fact-sheet-09-07-2017.pdf.

#### Fluoride Supplements

- 19. American Dental Association (2019). Fluoride: Topical and Systemic Supplements. Retrieved from https://www.ada.org/en/member-center/oral-healthtopics/fluoridetopical-and-systemic-supplements.
- 20. The American Academy of Pediatric Dentistry (2018). Best Practices: Fluoride Therapy. Retrieved from

https://www.aapd.org/globalassets/media/policies\_guidelines/bp\_fluoridetherapy.pdf.

21. Clark MB, Slayton RL; AAP Section on Oral Health. Fluoride use in caries prevention in the primary care setting. *Pediatrics*. 2014. Sep;134(3):626–33.

#### <u>Fluorosis</u>

- 22. Pendrys DG. Risk of enamel fluorosis in nonfluoridated and optimally fluoridated populations: considerations for the dental professional. *Journal of the American Dental Association*. 2000;131(6):746–55.
- 23. Skotowski MC, Hunt RJ, Levy SM. Risk factors for dental fluorosis in pediatric dental patients. *J Public Health Dent*. 1995. Summer;55(3):154–9.
- 24. Wright JT, Hanson N, Ristic H et al. Fluoride toothpaste efficacy and safety in children younger than 6 years: A systematic review. *JADA*. 2014. 145(2): 182–189.

#### Fluoride Varnish Frequently Asked Questions

- 25. Centers for Disease Control and Prevention. (2019). Other Fluoride Products. Retrieved from <u>https://www.cdc.gov/fluoridation/basics/fluoride-products.html</u>.
- 26. American Dental Association. *The Reference Manual of Pediatric Dentistry*. Definition of a Dental Home. Updated 2018. Retrieved from <u>https://www.aapd.org/media/Policies\_Guidelines/D\_DentalHome.pdf</u>.

#### Parent/Caregiver Education

27. American Academy of Pediatrics. (2016). Bright Futures in Practice: Oral Health Pocket Guide. Retrieved from

https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4\_OralHealth.pdf.

## Appendices

- 1. U.S. Preventive Task Force: Preventing Dental Caries
- 2. Map of Maine Federally Designated Dental Health Professional Shortage Area
- 3. Maine Oral Health Risk Assessment and Referral Tool Primary Care
- 4. Dental Referral Form
- 5. Periodicity Schedules
- 6. Clinical Competency Validation Tool
- 7. Baby Teeth Matter Brochure
- 8. Maine Communities with Fluoridated Water
- 9. Maine CDC Water Testing Kit
- 10. Sample Consent Form
- 11. Getting Started with Oral Health Prevention Services
- 12. Sample Clinical Workflows
- 13. Blank PDSA Form



## Preventing Dental Caries in Children from Birth Through Age Five Years

The U.S. Preventive Services Task Force (Task Force) has issued a **final** recommendation statement on *Prevention of Dental Caries in Children From Birth Through Age Five Years.* 

This final recommendation statement applies to children from birth through age 5 and to preventive services provided by primary care clinicians. Primary care clinicians include doctors and nurses who provide general health care in a medical setting. This recommendation does not apply to care provided by dentists and other oral health professionals.

The final recommendation statement summarizes what the Task Force learned about the potential benefits and harms of efforts by primary care clinicians to prevent dental caries (tooth decay): (1) Primary care clinicians should prescribe oral fluoride supplements (such as drops, tablets, or lozenges) to children who don't get enough fluoride from their water supply. The supplements should start when a child is six months old. (2) Primary care clinicians should apply fluoride varnish to the teeth of all infants and children, starting with the appearance of the first primary ("baby") tooth. (3) There is not enough evidence to say whether having primary care clinicians regularly screen children for dental caries by examining their teeth improves children's future health.

This fact sheet explains the recommendation and what it might mean for you.

#### What are dental caries?

Dental caries, also known as tooth decay, occurs when bacteria in the mouth use the sugar in food and drinks to make acids. The acids wear away the outer layer of the tooth (enamel). Tooth decay can eventually lead to a hole, or cavity.

#### Facts About Tooth Decay and Fluoride

Any child whose teeth have come in can develop tooth decay. This risk is especially high for children whose water supply does not have enough fluoride. Almost half of children ages 2 to 11 have decay in their baby teeth (the first set of teeth that come in).

Tooth decay can be prevented. If tooth decay in children starts and is not treated, it can lead to pain and loss of the affected teeth, and can negatively affect a child's growth, speech, and appearance.

Fluoride is a mineral that helps strengthen teeth. It is often added to a community's water supply to help prevent tooth decay. However, many Americans live in communities without fluoridated water. Fluoride supplements (drops, tablets, or lozenges) can decrease the risk of tooth decay for children who live in areas with low levels of fluoride in their water. (*Water supply companies are required to produce an annual report that includes information about the fluoride level in the water they provide. Contact your water utility to find out the fluoride level of your water.*)

Studies also show that painting a thin coat of fluoride, called fluoride varnish, on the teeth of all young children can prevent tooth decay.

#### Potential Benefits and Harms of Actions to Prevent Tooth Decay in Young Children

Most young children do not visit a dentist, but they often do see a primary care doctor or nurse. Primary care clinicians, therefore, can complement the important role that dentists play in keeping children's teeth healthy.

The Task Force reviewed recent studies on the benefits and harms of actions that doctors or nurses can take to prevent tooth decay in infants and children up through age 5. They found two ways that primary care clinicians can help:

- Prescribing fluoride supplements (drops, tablets, or lozenges) to children whose water supply does not have enough fluoride. The supplements should start when children are six months old.
- Putting fluoride varnish on all children's teeth. This should be started when a child's first baby tooth has come in.

The Task Force found that any harms from these actions are likely to be small. In nearly all cases in the United States, these harms are very mild changes to the appearance of the teeth, such as small white spots.

The Task Force did not find enough evidence to determine whether regularly screening all children for dental caries will improve a child's future health. The Task Force found that any harms of screening are likely to be very small.

#### The Final Recommendations on Preventing Tooth Decay: What Do They Mean?

Here are the Task Force's final recommendations on actions to prevent tooth decay. The grades are based on the quality and strength of the evidence about the potential benefits and harms of these actions. They also are based on the size of the potential benefits and harms. Task Force recommendation grades are explained in the box at the end of this fact sheet.

When the Task Force recommends a preventive service (Grade B), it is because it has more potential benefits than potential harms. When there is not enough evidence to judge benefits and harms, the Task Force does not make a recommendation for or against—it issues an I Statement. The Notes explain key ideas.

Visit the Task Force Web site to read the full **final recommendation statement**. The statement explains the evidence the Task Force reviewed and how it decided on the grade. An **evidence report** provides more detail about the studies the Task Force reviewed.

- The Task Force recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. Grade B
- The Task Force recommends that primary care clinicians apply fluoride varnish to the primary teeth of infants and children starting at the age of primary tooth eruption. Grade B
- 3 The Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening examinations for dental caries performed by primary care clinicians in children from birth to age 5 years. I Statement

#### Taking Action to Prevent Tooth Decay in Young Children

Getting the best health care means making smart decisions about what preventive medications, screening tests, and counseling services to get and when to get them. Many people don't get the medications, tests, or counseling they need. Others get medications, tests, or counseling they don't need or that may be harmful to them.

Task Force recommendations can help you learn about preventive medications, screening tests, and counseling services. These services can keep you and your family healthy and prevent disease. The Task Force recommendations do not cover diagnosis (tests to find out why you are sick) or treatment of disease.

Task Force recommendations also apply to some groups of people, but not others. For example, this recommendation applies only to infants and young children ages five and younger.

#### Notes

#### 1 primary care clinicians

Health care professionals who provide general health care, including doctors, nurses, physician assistants, and nurse practitioners. This recommendation does not apply to care provided by dentists and other oral health professionals.

#### oral

Taken by mouth.

#### supplementation

Getting fluoride through drops, tablets, or lozenges.

#### deficient

Doesn't have enough (fewer than 6 parts per million).

2 primary teeth The first set of teeth that come in; also called baby teeth.

#### starting at the age of primary tooth eruption Beginning when the first baby tooth has come in.

3 current evidence is insufficient

The Task Force did not find enough information on screening children ages five and younger to determine potential benefits and harms.

#### screening

Examining a child's entire mouth to see whether a child has dental caries.

#### Talking to your doctor about preventing tooth decay in infants and young children

You can do many things to keep your children's teeth healthy and strong. Make sure they have a healthy diet, brush every day with fluoridated toothpaste, and see a dental professional regularly.

Your primary care clinician will likely want to talk with you about applying a fluoride varnish to your child's teeth once the baby teeth come in. If you live in an area where the local water supply is not fluoridated, he or she may also talk with you about giving your child fluoride supplements. Discuss your child's risk factors for tooth decay and whether your child is already seeing a dentist. Be comfortable that all your questions have been answered. And consider scientific recommendations, like this one from the Task Force. Use this information to become fully informed about preventing tooth decay.

#### What is the U.S. Preventive Services Task Force?

The Task Force is an independent group of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, or preventive medicines. The recommendations apply to people with no signs or symptoms of the disease being discussed.

To develop a recommendation statement, Task Force members consider the best available science and research on a topic. For each topic, the Task Force posts draft documents for public comment, including a draft recommendation statement. All comments are reviewed and considered in developing the **final recommendation statement**. To learn more, visit the **Task Force Web site**.

USPSTF Recommendation Grades							
Grade	Definition						
А	Recommended.						
В	Recommended.						
С	Recommendation depends on the patient's situation.						
D	Not recommended.						
l statement	There is not enough evidence to make a recommendation.						



Click Here to Learn More About Preventing Tooth Decay

- Take Care of Your Child's Teeth (healthfinder.gov)
- The Tooth Decay Process: How to Reverse It and Avoid a Cavity (National Institute of Dental and Craniofacial Research)
- Children's Oral Health (Centers for Disease Control and Prevention)

Tooth Decay–Early Childhood (MedlinePlus)



#### Federally Designated Dental Health Professional Shortage Areas





# FROM THE FIRST TOOTH Checklist

## Oral Health Risk Assessment

Fluoride Varnish Application

Parent/Caregiver Education

Document and Bill



For more information visit WWW.FROMTHEFIRSTTOOTH.ORG



#### SECTION A: ORAL HEALTH RISK ASSESSMENT QUESTIONS

ANSWERS WITH INDICATE RISK FACTORS

(

) N0\*

YES

May be administed by clinical support staff
Q1. Does the child have teeth?

Q2. Has the child seen a dentist in the past year?	<b>YES</b>	<b>N</b> 0
Q3. Does the child have his/her teeth brushed daily with toothpaste?	<b>YES</b>	
Q4. Has the child ever had cavities or fillings?	<b>YES</b>	
Q5. Has the mother/primary caregiver had active/untreated cavities in the past year?	<b>YES</b>	
*If 'no' stop and reassess at next well child visit.		

#### SECTION B: ORAL EVALUATION AND PLAN

Must be performed by Primary Care Provider

URAL EVALUATION							
Q6. Is there visible plaque	YES NO						
Q7. Are there signs of vis	7. Are there signs of visible decay or white spot lesions on the teeth?						
Q8. Does the child have o	ther oral conditions of concerr	? (abscess, broken tooth, pain, etc?) YES NO					
CARIES RISK ASSE		OW MODERATE/HIGH 0 RISK FACTOR 1+ RISK FACTOR					
VISUAL GUIDE		ORAL HEALTH PLAN					
HEALTHY TEETH*	PLAQUE ON TEETH	Consider fluoride varnish for all children up to age 6					
A A AND	RET OF	FOR ALL CHILDREN					
A. 1.48		Prescribed Eluoride Supplement (circle dosage)					
A ANA ANT	Joshing (	0.25mg 0.5mg 1.0mg					
HITE SPOT LESION AND ARLY TOOTH DECAY*	TEETH WITH DECAY	Fluoride Supplements not indicated					
a joint		Provided Oral Health Anticipatory Guidance					
100000	6000-4	Completed Risk Assessment w/ Oral Evaluation					
Vine		FOR CHILDEN WHO HAVE NOT SEEN					
EVERE TOOTH DECAY WITH ENTAL ABSCESS*	TEETH WITH RESTORATIONS	A DENTIST IN PAST YEAR (Q2)					
1/10		Completed Caries Risk Assessment w/ Oral Evaluatio					
( and		Applied Fluoride Varnish					
K	The Case	Patient/Family declined Fluoride Varnish					
		Referred Child to Dentist					





#### DENTAL REFERRAL FORM FOR MEDICAL PROVIDERS

MEDICAL PROVIDER REFERRAL TO DENTIST

Today's Date	Reason for Refer	ferral: Referral 🗖 Immediate Referral				
Referring Practice	Referring Provide	er				
Referring Provider Fax	Referring Provide	er Phone				
Patient Name		M F	DOB:			
Parent/Guardian Name Relationship to Child	Insurance: Description Medicaid ID#: Description Other Insurance:					
Interpreter needed? Y N		Dental Insurance:				
Significant medical history:	There are factor and/or dental to	tors that could hinder performing an oral exam,x-rays I treatment for this child.				
This child has allergies: 🗖 No 🗖 Yes List:	Date of last fluc	uoride varnish application(s):				
	Fluoride supple	lements prescribed: 🗖 No 🗖 Yes				
I am the parent/guardian for this child. I consent to this medical provider sharing information about my child with the dentist/dental practice named below. I also consent to the dentist sharing information about my child with this medical provider.						
Signature:			_ Date: _			
Dentist/Dental Practice Name		Phone		Fax		
DENTAL REPORT	TO THE MEDI	CAL PROVIDER				

Date of Dental Appointment(s):								
Treatment Provided:  Oral Hygiene Instructions  Prophylaxis  Fluoride Treatment  Fluoride Prescription  Restorative Treatment: Extractions: Other:								
Summary Statement	Summary Statement							
Practice Name & Address								
Dentist Name Dentist Signature Date								

Adapted from the Maine Oral Health Risk Assessment and Referral Tool – Primary Care

#### Periodicity Schedule & Alternatives for Pediatric Preventive Oral Health in Primary Care

Schedule is based on the eruption of the first tooth and MaineCare reimbursement limitations.

MaineCare covers reimbursement to medical providers at \$20 twice per calendar year for an Oral Evaluation (D0145) for patients under 3 years of age. MaineCare covers reimbursement to medical providers at \$12 for fluoride varnish using CPT99188 or D1206. See below for D code limitations:

(a) Twice per calendar year for children under age 3 years

(b) Twice per calendar year with at least 150 days between applications for children ages 3 and over.

Periodicity Schedule: Preventive Oral Health in Primary Care											
	6 Month s	9 Month s	12 Months	15 Months	18 Months	24 Months	30 Months	3 Years	4 Years	5 Years	6 Years
Parent/Caregiver Oral Health Education	•	•	•	•	•	•	•	•	•	•	•
Oral Health Assessment	٠	٠	٠		٠	•	٠	٠	٠	•	٠
Fluoride Varnish	•		•		•	•	•	•	•	•	
Fluoride Supplementation	•	•	•	•	•	٠	•	•	•	•	•

Periodicity Schedule: Preventive Oral Health in Primary Care

Alternative 1: First Tooth Eruption at 9 Months											
6 Month s9 Month s12 Months15 Months18 Months24 Months30 Months3 Years4 Years								5 Years	6 Years		
Parent/Caregiver Oral Health Education	•	•	•	•	•	•	•	٠	•	•	•
Oral Health Assessment		•	•	•		•	•	•	•	•	•
Fluoride Varnish		•		•		•	•	•	•	•	
Fluoride Supplementation		•	•	•	•	•	•	•	•	•	•

	Alternative 2: First Tooth Eruption at 15 Months										
	6 Month s	9 Month s	12 Months	15 Months	18 Months	24 Months	30 Months	3 Years	4 Years	5 Years	6 Years
Parent/Caregiver Oral Health Education	•	•	•	•	•	•	•	•	•	•	•
Oral Health Assessment				•	•	•		•	•	٠	•
Fluoride Varnish				•		•	•	•	•	•	
Fluoride Supplementation				•	•	٠	•	•	•	•	•

<sup>1</sup> Pahel BT, Rozier RG, Stearns SC, Quinonez RB Effectiveness of Preventive Dental Treatment by Physicians for Young Medicaid Enrollees. *Pediatrics*, 2011;127(3):e682-9

<sup>2</sup> Weintraub JA, Ramos-Gomez F, Jue B, et al. Fluoride varnish efficacy in preventing early childhood caries. J Dent Res. 2006;85(2)172-176

## **Competency Validation Tool**

### From the First Tooth Fluoride Varnish Application Process

Training	Performed	Date
Attend in-person From the First Tooth Training		
Participate in virtual training module:		
(http://www.fromthefirsttooth.org/by-state/maine/on-		
demand-virtual-training/)		
Provide completed CME certificate from in-person or virtual		
From the First Tooth Training to supervisor		

	west Observation	Performed	Unable to
וט	rect Observation	Independently	perform
1.	Checks patient's medical and dental history for any		
	contraindications (Does patient have an established dental		
	home?)		
2.	Chooses fluoride varnish appropriately (unidose .25ml 5%		
	NaF)		
3.	Assembles armamentarium: fluoride varnish product,		
	gauze, and a good light source		
4.	Educates parent or caregiver of benefits of fluoride varnish		
	and procedure		
	Safe and effective		
	<ul> <li>Strengthens enamel and prevents initiation of</li> </ul>		
	disease		
	<ul> <li>Studies demonstrate 30-35% reduction in caries with</li> </ul>		
	use		
	<ul> <li>Can reverse early decay (white spots) and slow</li> </ul>		
	enamel destruction in active ECC.		
5.	Don PPE: gloves		
6.	Places child in knee-to-knee position, if appropriate		
	<ul> <li>Child is held facing caregiver in a straddle position</li> </ul>		
	Child leans back on clinician while caregiver holds		
	child's hands		
	Clinician starts fluoride varnish application process		
	<u>Or</u>		
	Place child on exam table and start fluoride varnish		
	application process		
7.	Prior to application: Removes excess saliva using gauze		

8.	Applies a <u>very thin layer</u> over the tooth, mandibular teeth					
9.	Informs patient of all post treatment instructions per					
	manufacturer's directions.					
	<ul> <li>Eat only soft foods for at least 2 hours after the</li> </ul>					
	treatment					
	<ul> <li>Do not consume hot drinks or sticky and crunchy</li> </ul>					
	foods for at least 6 hours after treatment					
	<ul> <li>Wait until the next day to resume normal oral</li> </ul>					
	hygiene					
10	10. Maintains aseptic technique throughout procedure					
11	Document fluoride varnish was applied in EHR					

#### Ability to teach others? Y/N

Action Plan (Only if unable to perform independently)

## **The First Year**

#### Your baby's first year of life is a time of growth. Here are some tips for those first teeth.

#### How to brush:

- Before your baby has teeth, clean the mouth with a washcloth every day.
- Start cleaning baby teeth as soon as they come in. Use a baby toothbrush with a smear of toothpaste that has fluoride in it.

#### Other tips:

- Don't share spoons, cups, or toothbrushes with your baby. Adults can have germs in their mouths that can cause cavities in babies' teeth.
- If you put your baby to bed with a bottle, fill it with water only. Milk, formula, juices, soda, and breast milk all have sugar in them that can puddle around a sleeping baby's teeth. This can cause tooth decay.
- If you have well water, talk to your doctor about getting it tested for fluoride.



# What is a Fluoride Application?

Your child's doctor, dentist, or dental hygienist can put fluoride on your child's teeth as soon as they appear in the mouth.

- Fluoride varnish is a clear protective coating applied to the outside of teeth. It stays on for one day and gives your child benefits for months to come.
- Fluoride varnish helps to prevent and even stop decay that has already started.
- Fluoride varnish is safe, painless and quick to apply.

#### After fluoride varnish is applied:

- Do not brush your child's teeth today.
- Start brushing your child's teeth tomorrow.
- Do not feed your child hard, sticky or hot food.

## Healthy Smiles for Life

## Tips for protecting the little smiles you love



## For more information visit **FROMTHEFIRSTTOOTH.ORG**



## MaineHealth

From the First Tooth is funded by grants from the Sadie and Harry Davis Foundation and DentaQuest Foundation, is led and administered by MaineHealth and implemented in partnership with EMHS and MaineGeneral Health. Toothpaste image courtesy of MouthHealthy.org, the American Dental Association's website for parents.

Did you know kids with tooth decay in their baby teeth are more likely to get cavities in their permanent teeth? They are also more likely to have tooth loss later in life! Here are some tips for protecting your child's teeth.





SMEAR (BIRTH-3 YEARS)

PEA (3-6 YEARS)

## 1-2 Years Old

Time to get ready for your child's first dental check! Here are some tips for caring for teeth when your baby is 1–2 years old.

#### How to brush:

• Brush baby's teeth twice a day. Use a baby toothbrush with a smear of toothpaste that has fluoride in it. A smear is the size of a grain of rice.

#### Going to the Dentist:

• Your baby should have a first dental check by age 1. Schedule a visit with a dentist or ask your medical doctor to look at your child's teeth.

#### What about fluoride?

• Ask your baby's medical doctor about a simple fluoride application.

#### Other tips:

- Wean your baby from the bottle by age 1. Now your baby should be drinking from a sippy cup with water only. Limit juice to meal times.
- Check your baby's mouth for spots and stains on the teeth.

## 2-3 Years Old

Work on regular brushing to help save that smile! Here are some tips for caring for teeth when your baby is 2–3 years old.

#### How to brush:

• Brush your child's teeth twice a day. Use a baby tooth brush with a smear of tooth paste that has fluoride in it. A smear is the size of a grain of rice.

#### Going to the Dentist:

• Schedule a visit with your child's dentist.

#### What about fluoride?

• Ask your child's medical doctor about a simple fluoride application.

#### Other tips:

• Limit juice drinks to 4-6 ounces per day (about half a cup). Most fruit juices have a lot of sugar that can cause tooth decay.





## 3-6 Years Old

Your child is learning how to do many tasks for themselves. Let brushing be one of them! Here are some tips for caring for teeth when your child is 3–6.

#### How to brush:

- Let your child start learning to brush their own teeth, but be there to help. Kids aren't expected to brush properly until they are about 6-8 years old.
- Use a pea sized amount of toothpaste with fluoride in it.

#### Going to the Dentist:

• Schedule a visit with your child's dentist.

#### What about fluoride?

• Ask your child's medical doctor about a simple fluoride application.

#### Other tips:

• Limit juice drinks to 4-6 ounces per day (about half a cup). Most fruit juices have a lot of sugar that can cause tooth decay.

Maine Communities With Fluoridated Water Supplies And Years Started							
Anson	1983	Guilford	1972	Scarborough (Pine Point)	1988		
Arundel	2004	Hampden	1965	Scarborough	1997		
Ashland	1966	Hartland	2002	Skowhegan	1973		
Auburn	1969	Hermon	1967	Southport	2003		
Augusta	1997	Holden	1967	South Freeport	2000		
Baileyville	1955	Houlton	1968	South Gardiner	1962		
Bangor	1967	Hulls Cove	1963	South Portland	1997		
Bar Harbor	1963	Indian Island	1963	Springvale	1972		
Bath	1969	Indian Township	1984	Standish	1997		
Belfast	1960	Island Falls	1967	Thomaston	1969		
Benton	1965	Kennebunk	2004	Topsham	1955		
Berwick	2003	Kennebunkport	2004	Van Buren	1967		
Bethel	1970	Lewiston	1970	Vassalboro (part)	1965		
Biddeford	1988	Limestone	1987	Vassalboro	1997		
Biddeford (Biddeford Pool &		Lubec	1972	Veazie	1962		
Fortunes' Rocks)	2004	Machias	1966	Waldoboro *			
Blaine	1971	Madawaska	1960	Warren *			
Boothbay	2003	Madison	1983	Washburn	1961		
Boothbay Harbor	2003	Manchester	1997	Waterville	1965		
Bradlev	1963	Mars Hill	1971	Wells	2004		
Brewer	1967	Mechanic Falls	1971	West Bath	1969		
Bridgton	1963	Medway	1966	Westbrook	1997		
Brunswick	1955	Mexico	1967	Westfield (part)	1971		
Bucksport	1969	Milford	1963	Windham	1997		
Camden	1969	Millinocket	1960	Winslow	1965		
Cape Elizabeth	1997	Monmouth	2001	Winterport	1973		
Caribou	1959	Newcastle	1971	Winthron (part)	1972		
Chelsea	1997	Newport	1972	Winthron ("Fast")	1997		
Clifton	1967	Northport	1998	Wiscasset	1989		
Cumberland	1997	Norway	1952	Woolwich	1969		
Damariscotta	1971	Oakland	1992	Vork (part)	2004		
Devter	1984	Ogunquit	2004	Tork (part)	2004		
Dover-Foxcroft	2000	Old Orchard Beach	1988	Notes:			
Divfield	1071	Old Town	1963	* = Community water supplies with nati	urally occurring		
Fagle Lake	107/	Orono	1963	fluoride			
East Millinocket	1974	Orrington (part)	1962	Communities listed by name indicates th	aat all aitimana		
East Willindeket	1060	Owls Head	1967	served by the community water supply r	eceive		
Eddington	1909	Dittofield	1909	fluoridated water (0.7 ppm).			
Ellaworth	1907	Dittaton	1905	These communities listed with "(nort)"	indianta aithan		
Eliswoltii	1909	Plasant Doint	19/5	that different parts of the community im	plemented		
	1961	Pleasant Point	1909	fluoridation at different times, or that no	t all citizens		
	1905	Portiand Dreague Isle	1997	served by the public water supply receiv	e fluoridated		
Faimouth	1997	Presque Isle	1960	one water supply.	by more man		
raminguale	19/3	Randolph	19/3	Provided by the Maine Center for Disea	se Control and		
Fort Fairfield	1939	Kaymond	2002	Prevention, Department of Health & Hu	man Services		
rort Kent	19/2	Rockiand	1969	6/2013			
	2000	Rockport	1969	For more information, conta	act:		
Friendship *	1071	Rumford	1959	Oral Health Program 287-2361			
Fryeburg	1971	Saco	1988	207 2501			
Gardiner	1973	Salisbury Cove	1983	Department of H and Human Sei	lealth rvices		
Gorham	1997	Sanford	1972	Maine Peop Safe, Healthy and Product	le Living ive Lives		
Greening Island	1959	Sangerville	1972	Prul P LeProp Governor Mary C Mrybew Con	missioner		

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Maine Center for Disease Control and Prevention An Office of the Department of Health and Human Services

#### FLUORIDE TEST KIT REQUEST

Name:		Telephone #	
Address:_			
Town, Sta	ate, Zip Code:		
The cost of the "Treasurer, Sta Visa or MasterC	e fluoride test is <b>\$20.00. Please enclos</b> e ate of Maine". <u>Do not send cash</u> . For yo Card.	e a check or money o our convenience, paym	order made out to lent may be made by
Visa MC	Card Number		Expiration Date
	Signature of Card Holder	\$ Amount	
	If you have a problem paying for this te However, you must meet <b>ALL</b> of th	est, the cost <b>may</b> be wai he following conditions.	ved.

The water you drink comes from a private well, and not from a public water system.

There is an existing health condition or a professional reason to get this test result. Examples include:
a medical or dental health provider's advice that your water be tested because of an existing illness or
health-related need, such as existing dental disease (tooth decay), a high risk for dental disease, and/or
the need to determine the correct level of fluoride supplements <b>OR</b>

unnatural contamination, such as suspected waste or spills that contaminate nearby groundwater.

You provide proof that you participate in any of these programs: Food Stamps, TANF, WIC, or MaineCare. Write the program name and your ID number in the spaces at the bottom of this form.

You must provide the information listed here at the same time as this test request.
Please write the name of the program and your ID number in the spaces below, and enclose a copy of the
medical or professional justification with this form, or, use the list as a checklist and have the health
provider sign it. Please note: If all of the requested information is not submitted together with this
request, your request for a fee waiver will be denied.

Program Name:	ID Number:
Health Provider signature:	

Revised 08/01/2010

## SAMPLE CONSENT FORM FLUORIDE VARNISH PARENT CONSENT FORM

Dear Parent/Caregiver,

As a preventive dental service of \_\_\_\_\_\_ is offering the application of a protective coating called *fluoride varnish* to your child's teeth to help protect against cavities.

Fluoride varnish is a protective coating that is painted on teeth. The varnish releases the fluoride over a period of time, which strengthens the teeth and prevents tooth decay. Tooth decay is the most common chronic disease in children.

Although some medical insurances are covering this service, **not all insurances are covering fluoride varnish.** The fee is \$XX per application.

Please indicate below whether you give permission for your child to receive the application of fluoride varnish

- YES, I give permission for my child to receive the fluoride varnish application.
   I understand that I may be responsible for the fee if my insurance does not cover this application.
- □ **NO**, I do not give permission for my child to receive this preventive fluoride varnish application.

Name of Child:	Date of Birth:
Signature of Caregiver:	Date:
Caregiver's Name (please print):	



#### **Getting Started with Oral Health Prevention Services in Your Practice**

Congratulations on your decision to provide preventive oral health services to improve your patients overall health. Here is a list of some things to consider in order to be prepared for implementation of the From the First Tooth initiative.

- ✓ Determine who will deliver the 4 services:
  - Screening/risk assessment (provider): \_\_\_\_\_\_
  - Anticipatory guidance/patient education:
  - Fluoride Varnish: \_\_\_\_\_\_
  - Referral to a dental professional \_\_\_\_\_\_
- ✓ Determine when the services will be delivered:
  - Well Child Visits at: 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 36 months
- ✓ Determine whether to implement a consent form for parents regarding payment if not covered by insurance.
  - Who will give this to the parent: \_\_\_\_\_\_
- ✓ Create a plan for fluoride varnish materials and oral health information
  - Who will order supplies:\_\_\_\_\_\_
  - Where will they be stored: \_\_\_\_\_\_
  - Where will the patient information be displayed: \_\_\_\_\_\_
  - Who will give the information on fluoride to the parent: \_\_\_\_\_\_
  - For the patient visit, who will get the supplies ready:
- Establish documentation
  - EMR: Who will add dental fields:
  - EMR: Who will enter the data during the visit:
  - Who will add the dental codes to the billing sheets and the billing system:
- ✓ Identify and incorporate prompts for providers and patients.
- ✓ Schedule a date for training your practice: \_\_\_\_\_\_

Note: From The First Tooth will provide the practice with posters, reminders, and patient education materials. All materials are available in the Training Toolkit and on the website: <u>www.fromthefirsttooth.org</u>

#### Questions about implementation or other aspects of the program? Contact mhfirsttooth@mmc.org

Adapted by From The First Tooth. Used with permission from WA Dental Service Foundation





#### **PDSA Worksheet and Action Plan**

#### Once completed please leave a copy of your plan on your table

Practice Name:	Date:	
<b>Background:</b> What successes has your practice had?		
What challenges has your practice had?		
What is a key change that you want to work on in the next 90 d	ays?	
Who is your target population?		

#### **Aim Statement:**

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_ by \_\_\_\_\_.

Example: We will decrease the number of no shows each month from 18% to 10% or less by June 2017.

#### Plan

We will

List the members of your team:

Describe your test of change		Person Responsible	When to be done	Where to be done
List action steps needed to set up this test of change	1.			
	2.			
	3.			
Predict what will		Measures to		
happen when this		determine if		
test is carried out		prediction succeeds		

We will revisit this plan and look at our data on: \_\_/\_\_/\_\_\_\_

**Do** Describe what actually happened when you ran the test

**Study** Describe the measured results and how they compared to the predictions

<u>Act</u> Describe what modifications to the plan will be made for the next cycle from what you learned?