AHCCCS
Arizona Health Care Cost Containment System

Back To Basics – Children's Dental

7/11/18

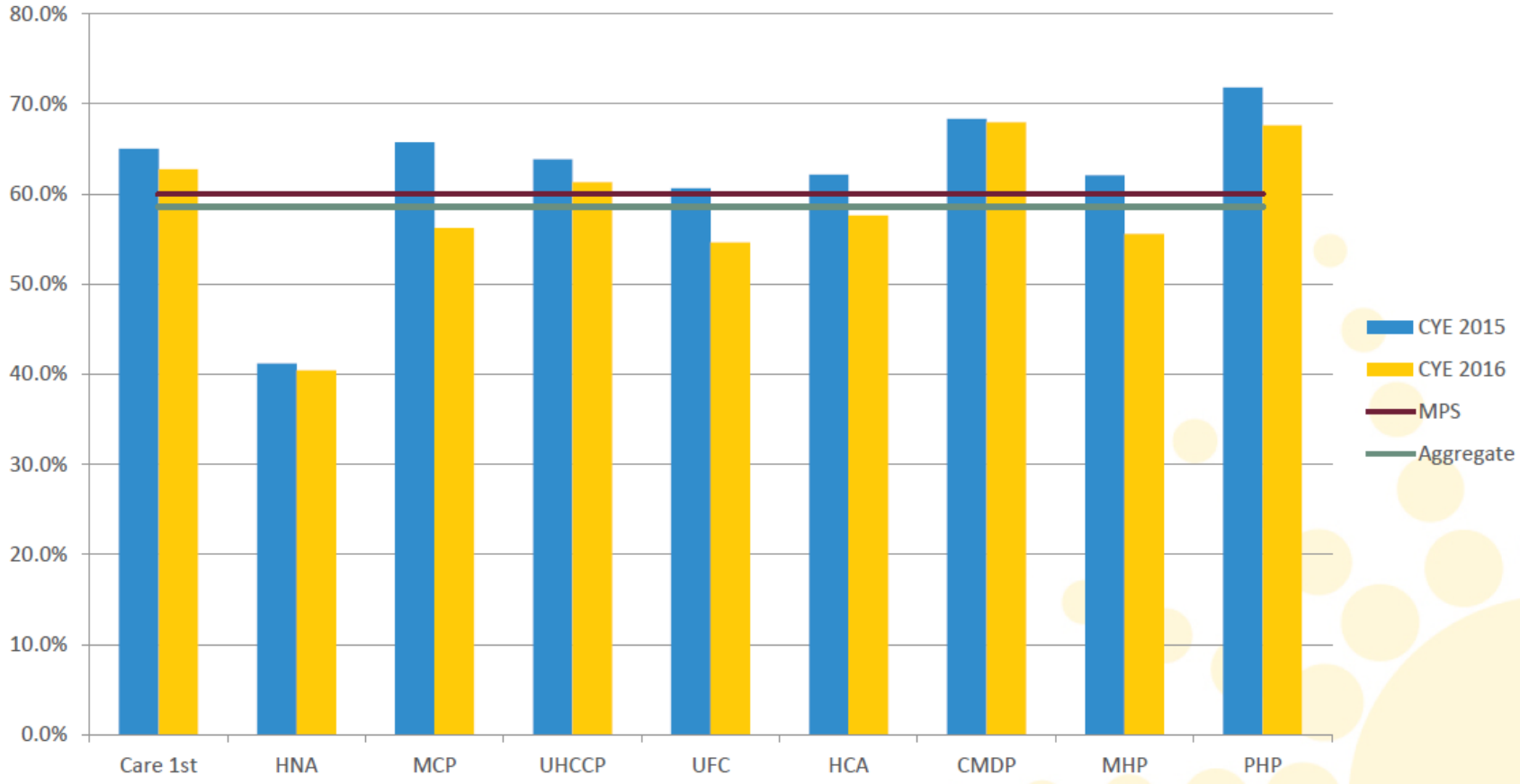
General Considerations

Dental Periodicity Schedule

Select Quality Measures

Measure	CYE 2013	CY 2014	CYE 2015	CYE 2016
Children's Access 12-24 mo	97.4	97.1	95.1	92.1
Children's Access 25 mo-6 y	89.2	88.5	87.7	85.4
Children's Access 7-11 y	91.4	92.4	91.5	90.6
Children's Access 12-19	89.4	90.1	89.3	88
Well child 6+ in 15 months	67.9	71.5	62.1	57.7
Well Child 3-6	65.5	64.9	64.6	61
Adolescent	39.7	40.7	39.9	39.2
Dental	59.2	63.5	63.7	58.6
EPSDT	59.2	63.5	63.7	58.6

AHCCCS Annual Dental Visits Performance Data



Annual Dental Visit Methodology

Annual Dental Visits (ADV)	HEDIS 2018, Vol 2
The percentage of members 2 through 20 years of age who had at least one dental visit during the measurement period	
Data Collection	Administrative
Time Frame	Analysis based on 12-month rolling period, ending with the last day of the previous quarter
Member Ages	2 through 20 years of age
Anchor Date	December 31 of the measurement period
Variants	Time Frame, Anchor Date, and Rate Stratification - The Contractor is to provide the numerator, denominator, and percentage (rate) for members 2 through 20 years of age, thus giving a total rate that is being reported
# Numerator	The total number of members having one or more dental visits with a dental practitioner during the measurement period
# Denominator	The total eligible population
%	The number of members 2 through 20 years of age who had at least one dental visit during the measurement period divided by the total eligible population

Preventative Dental Services Methodology

Percentage of Eligibles Who Received Preventative Dental Services (PDENT-CH)	CMS 2017 Children's Core
Percentage of members ages 1 to 20 who are enrolled for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period	
Data Collection	Administrative (Form CMS-416)
Time Frame	Analysis based on 12-month rolling period, ending with the last day of the previous quarter
Member Ages	1 to 20 years of age
Anchor Date	N/A
Variants	Time Frame and Reporting Stratification - The Contractor is to provide the numerator, denominator, and percentage (rate) for all ages combined, thus giving an overall rate that is being reported
# Numerator	The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist
# Denominator	The total unduplicated number of individuals ages 1 to 20 who have been continuously enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 days and are eligible to receive EPSDT services
%	Number of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period divided by the number of unduplicated individuals ages 1 to 20 who have been continuously enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 days and are eligible to receive EPSDT services

Dental Sealants Methodology

Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH)	CMS 2017 Children's Core
Percentage of children ages 6 to 9 at elevated risk of dental caries (i.e., "moderate" or "high" risk) who received a sealant on a permanent first molar tooth within the measurement period	
Data Collection	Administrative
Time Frame	Analysis based on 12-month rolling period, ending with the last day of the previous quarter
Member Ages	6 to 9 years of age
Anchor Date	None
# Numerator	The unduplicated number of eligible children ages 6 to 9 at "elevated" risk for dental caries (i.e., "moderate" or "high" risk) who received a sealant on a permanent first molar tooth as a dental service
# Denominator	The unduplicated number of eligible children ages 6 to 9 at "elevated" risk for dental caries (i.e., "moderate" or "high" risk)
%	The unduplicated number of enrolled children ages 6 to 9 at elevated risk of dental caries (i.e., "moderate" or "high" risk) who received a sealant on a permanent first molar tooth within the measurement period divided by the unduplicated number of eligible children ages 6 to 9 at "elevated" risk for dental caries

AHCCCS MPS (Contract)

Annual Dental Visits (ADV): (**ages 2-20**)	60%
Percentage of Eligibles Who Received Preventive Dental Services(PDENT)	46%
Dental Sealants for Children Ages 6-9 at Elevated Caries Risk (SEAL)	Baseline Measurement Year*; CMS will be establishing MPS

CDC Statistics

- About 1 of 5 (20%) children aged 5 to 11 years have at least one untreated decayed tooth.
- 1 of 7 (13%) adolescents aged 12 to 19 years have at least one untreated decayed tooth.
- Children aged 5 to 19 years from low-income families are twice as likely (25%) to have cavities, compared with children from higher-income households (11%).
- Children who have poor oral health miss more school and receive lower grades than their peers who have good oral care.
- https://www.cdc.gov/mmwr/volumes/65/wr/mm6541e1.htm?s_cid=mm6541e1_w

AMPM Exhibit 431 1 AHCCCS Dental Periodicity Schedule

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*				
These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.				
AGE	**12-24 months**	**2-6 years**	**6-12 years**	**12 years and older**
Clinical oral examination including but not limited to the following:[1]	X	X	X	X
➢ Assess oral growth and development	X	X	X	X
➢ Caries-risk Assessment	X	X	X	X
➢ Assessment for need for fluoride supplementation	X	X	X	X
➢ Anticipatory Guidance/Counseling	X	X	X	X
➢ Oral hygiene counseling	X	X	X	X
➢ Dietary counseling	X	X	X	X
➢ Injury prevention counseling	X	X	X	X
➢ Counseling for nonnutritive habits	X	X	X	X
➢ Substance abuse counseling			X	X
➢ Counseling for intraoral/perioral piercing			X	X
➢ Assessment for pit and fissure sealants		X	X	X
Radiographic Assessment	X	X	X	X
Prophylaxis and topical fluoride	X	X	X	X

[1] First examination is encouraged to begin by age 1. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.

NOTE: Parents or caregivers should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

NOTE: As in all medical care, dental care must be based on the individual needs of the member and the professional judgment of the oral health provider.

* Adaptation from the American Academy of Pediatric Dentistry Schedule

Caries Risk Assessment

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➢ Assessment for need for fluoride supplementation	X	X	X	X
➢ Anticipatory Guidance/Counseling	X	X	X	X
➢ Oral hygiene counseling	X	X	X	X
➢ Dietary counseling	X	X	X	X
➢ Injury prevention counseling	X	X	X	X
➢ Counseling for nonnutritive habits	X	X	X	X
➢ Substance abuse counseling			X	X
➢ Counseling for intraoral/perioral piercing			X	X
➢ Assessment for pit and fissure sealants		X	X	X
Radiographic Assessment	X	X	X	X
Prophylaxis and topical fluoride	X	X	X	X

[1] First examination is encouraged to begin by age 1. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.

NOTE: Parents or caregivers should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

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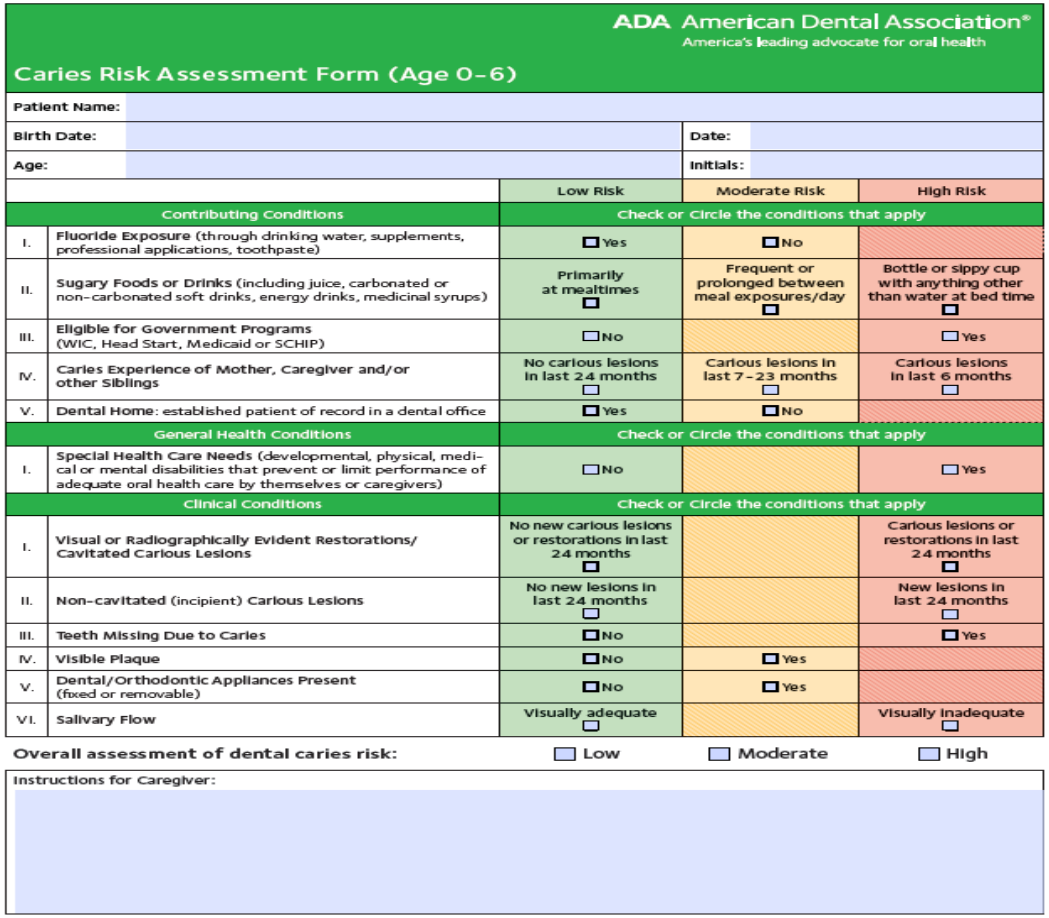
Caries Risk Assessment



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)	☐ Yes	☐ No	
II.	Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐	Frequent or prolonged between meal exposures/day ☐	Bottle or sippy cup with anything other than water at bed time ☐
III.	Eligible for Government Programs (WIC, Head Start, Medicaid or SCHIP)	☐ No		☐ Yes
IV.	Caries Experience of Mother, Caregiver and/or other Siblings	No carious lesions in last 24 months ☐	Carious lesions in last 7–23 months ☐	Carious lesions in last 6 months ☐
V.	Dental Home: established patient of record in a dental office	☐ Yes	☐ 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)	☐ No		☐ 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 ☐		Carious lesions or restorations in last 24 months ☐
II.	Non-cavitated (incipient) Carious Lesions	No new lesions in last 24 months ☐		New lesions in last 24 months ☐
III.	Teeth Missing Due to Caries	☐ No		☐ Yes
IV.	Visible Plaque	☐ No	☐ Yes	
V.	Dental/Orthodontic Appliances Present (fixed or removable)	☐ No	☐ Yes	
VI.	Salivary Flow	Visually adequate ☐		Visually inadequate ☐

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Instructions for Caregiver:

Caries Risk Assessment

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age 0-6)

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.

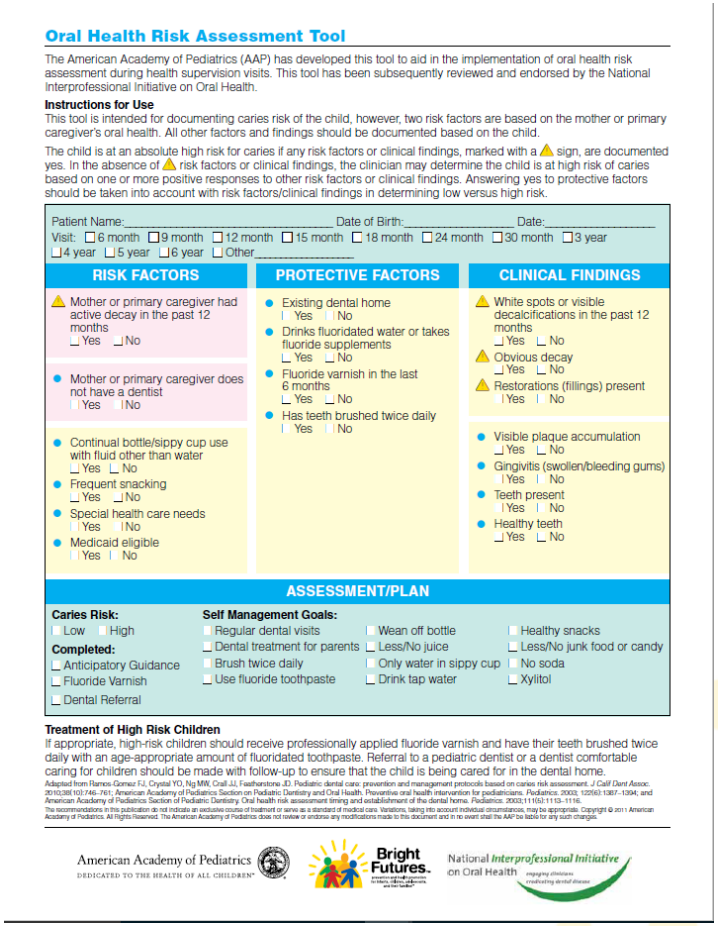
Signatures

Patient, Parent or Guardian _____

Student _____

Faculty Advisor _____

AAP Oral Heath Risk Assessment



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: ☐6 month ☐9 month ☐12 month ☐15 month ☐18 month ☐24 month ☐30 month ☐3 year ☐4 year ☐5 year ☐6 year ☐Other_____

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
⚠ Mother or primary caregiver had active decay in the past 12 months ☐Yes ☐No	• Existing dental home ☐Yes ☐No	⚠ White spots or visible decalcifications in the past 12 months ☐Yes ☐No
• Mother or primary caregiver does not have a dentist ☐Yes ☐No	• Drinks fluoridated water or takes fluoride supplements ☐Yes ☐No	⚠ Obvious decay ☐Yes ☐No
• Continual bottle/sippy cup use with fluid other than water ☐Yes ☐No	• Fluoride varnish in the last 6 months ☐Yes ☐No	⚠ Restorations (fillings) present ☐Yes ☐No
• Frequent snacking ☐Yes ☐No	• Has teeth brushed twice daily ☐Yes ☐No	• Visible plaque accumulation ☐Yes ☐No
• Special health care needs ☐Yes ☐No		• Gingivitis (swollen/bleeding gums) ☐Yes ☐No
• Medicaid eligible ☐Yes ☐No		• Teeth present ☐Yes ☐No
		• Healthy teeth ☐Yes ☐No

ASSESSMENT/PLAN

Caries Risk: ☐Low ☐High

Completed:
☐Anticipatory Guidance
☐Fluoride Varnish
☐Dental Referral

Self Management Goals:

☐Regular dental visits	☐Wean off bottle	☐Healthy snacks
☐Dental treatment for parents	☐Less/No juice	☐Less/No junk food or candy
☐Brush twice daily	☐Only water in sippy cup	☐No soda
☐Use fluoride toothpaste	☐Drink tap water	☐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):745–761; American Academy of Pediatrics Section on Pediatric Dentistry and Oral Health. Preventive oral health intervention for pediatricians. *Pediatrics*. 2008; 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.

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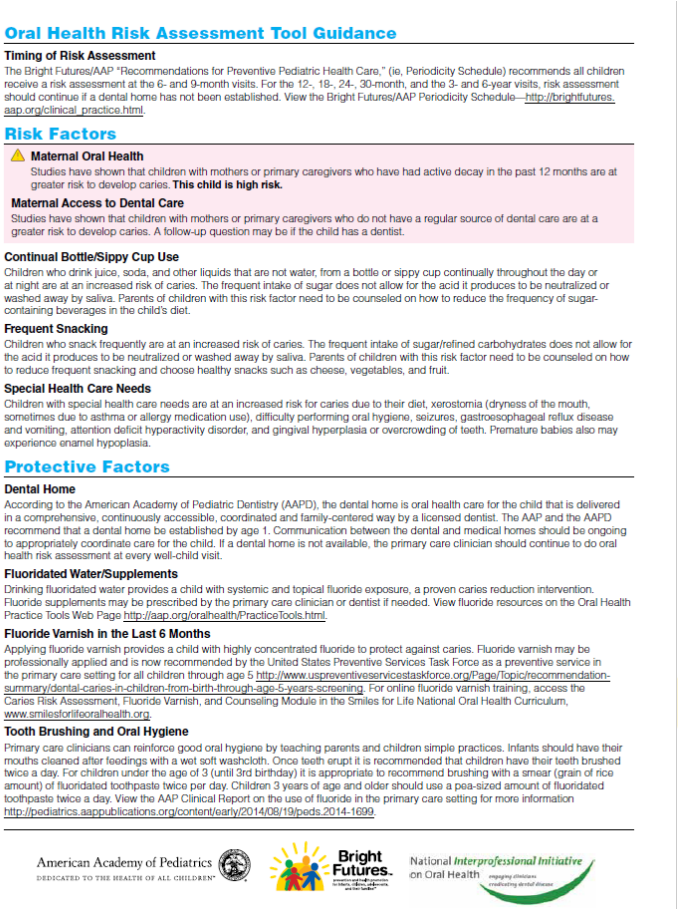
AAP Oral Health Risk Assessment



Oral Health Risk Assessment Tool Guidance

Timing of Risk Assessment

The Bright Futures/AAP "Recommendations for Preventive Pediatric Health Care," (ie, Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright Futures/AAP Periodicity Schedule—http://brightfutures.aap.org/clinical_practice.html.

Risk Factors

Maternal Oral Health

Studies have shown that children with mothers or primary caregivers who have had active decay in the past 12 months are at greater risk to develop caries. **This child is high risk.**

Maternal Access to Dental Care

Studies have shown that children with mothers or primary caregivers who do not have a regular source of dental care are at a greater risk to develop caries. A follow-up question may be if the child has a dentist.

Continual Bottle/Sippy Cup Use

Children who drink juice, soda, and other liquids that are not water, from a bottle or sippy cup continually throughout the day or at night are at an increased risk of caries. The frequent intake of sugar does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce the frequency of sugar-containing beverages in the child's diet.

Frequent Snacking

Children who snack frequently are at an increased risk of caries. The frequent intake of sugar/refined carbohydrates does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce frequent snacking and choose healthy snacks such as cheese, vegetables, and fruit.

Special Health Care Needs

Children with special health care needs are at an increased risk for caries due to their diet, xerostomia (dryness of the mouth, sometimes due to asthma or allergy medication use), difficulty performing oral hygiene, seizures, gastroesophageal reflux disease and vomiting, attention deficit hyperactivity disorder, and gingival hyperplasia or overcrowding of teeth. Premature babies also may experience enamel hypoplasia.

Protective Factors

Dental Home

According to the American Academy of Pediatric Dentistry (AAPD), the dental home is oral health care for the child that is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. The AAP and the AAPD recommend that a dental home be established by age 1. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the primary care clinician should continue to do oral health risk assessment at every well-child visit.

Fluoridated Water/Supplements

Drinking fluoridated water provides a child with systemic and topical fluoride exposure, a proven caries reduction intervention. Fluoride supplements may be prescribed by the primary care clinician or dentist if needed. View fluoride resources on the Oral Health Practice Tools Web Page http://aap.org/oralhealth/PracticeTools.html.

Fluoride Varnish in the Last 6 Months

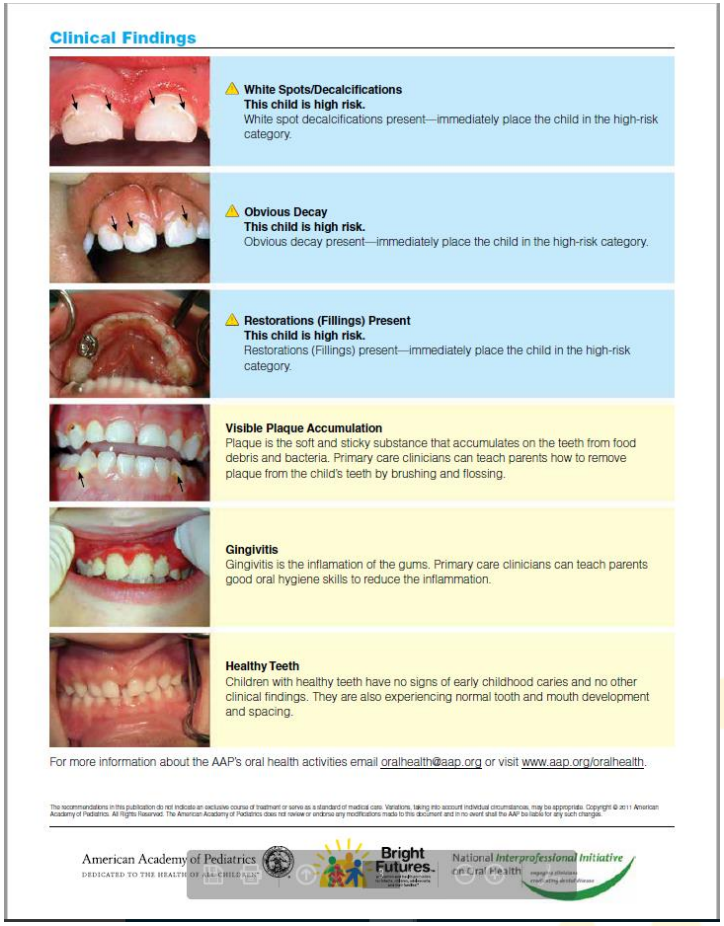
Applying fluoride varnish provides a child with highly concentrated fluoride to protect against caries. Fluoride varnish may be professionally applied and is now recommended by the United States Preventive Services Task Force as a preventive service in the primary care setting for all children through age 5 http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/dental-caries-in-children-from-birth-through-age-5-years-screening. For online fluoride varnish training, access the Caries Risk Assessment, Fluoride Varnish, and Counseling Module in the Smiles for Life National Oral Health Curriculum, www.smilesforlifeoralhealth.org.

Tooth Brushing and Oral Hygiene

Primary care clinicians can reinforce good oral hygiene by teaching parents and children simple practices. Infants should have their mouths cleaned after feedings with a wet soft washcloth. Once teeth erupt it is recommended that children have their teeth brushed twice a day. For children under the age of 3 (until 3rd birthday) it is appropriate to recommend brushing with a smear (grain of rice amount) of fluoridated toothpaste twice per day. Children 3 years of age and older should use a pea-sized amount of fluoridated toothpaste twice a day. View the AAP Clinical Report on the use of fluoride in the primary care setting for more information http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1699.

American Academy of Pediatrics DEDICATED TO THE HEALTH OF ALL CHILDREN™ Bright Futures. National Interprofessional Initiative on Oral Health engaging clinicians eradicating dental disease

AAP Oral Health Risk Assessment



Clinical Findings

White Spots/Decalcifications
This child is high risk.
White spot decalcifications present—immediately place the child in the high-risk category.

Obvious Decay
This child is high risk.
Obvious decay present—immediately place the child in the high-risk category.

Restorations (Fillings) Present
This child is high risk.
Restorations (Fillings) present—immediately place the child in the high-risk category.

Visible Plaque Accumulation
Plaque is the soft and sticky substance that accumulates on the teeth from food debris and bacteria. Primary care clinicians can teach parents how to remove plaque from the child's teeth by brushing and flossing.

Gingivitis
Gingivitis is the inflamation of the gums. Primary care clinicians can teach parents good oral hygiene skills to reduce the inflammation.

Healthy Teeth
Children with healthy teeth have no signs of early childhood caries and no other clinical findings. They are also experiencing normal tooth and mouth development and spacing.

For more information about the AAP's oral health activities email oralhealth@aap.org or visit www.aap.org/oralhealth.

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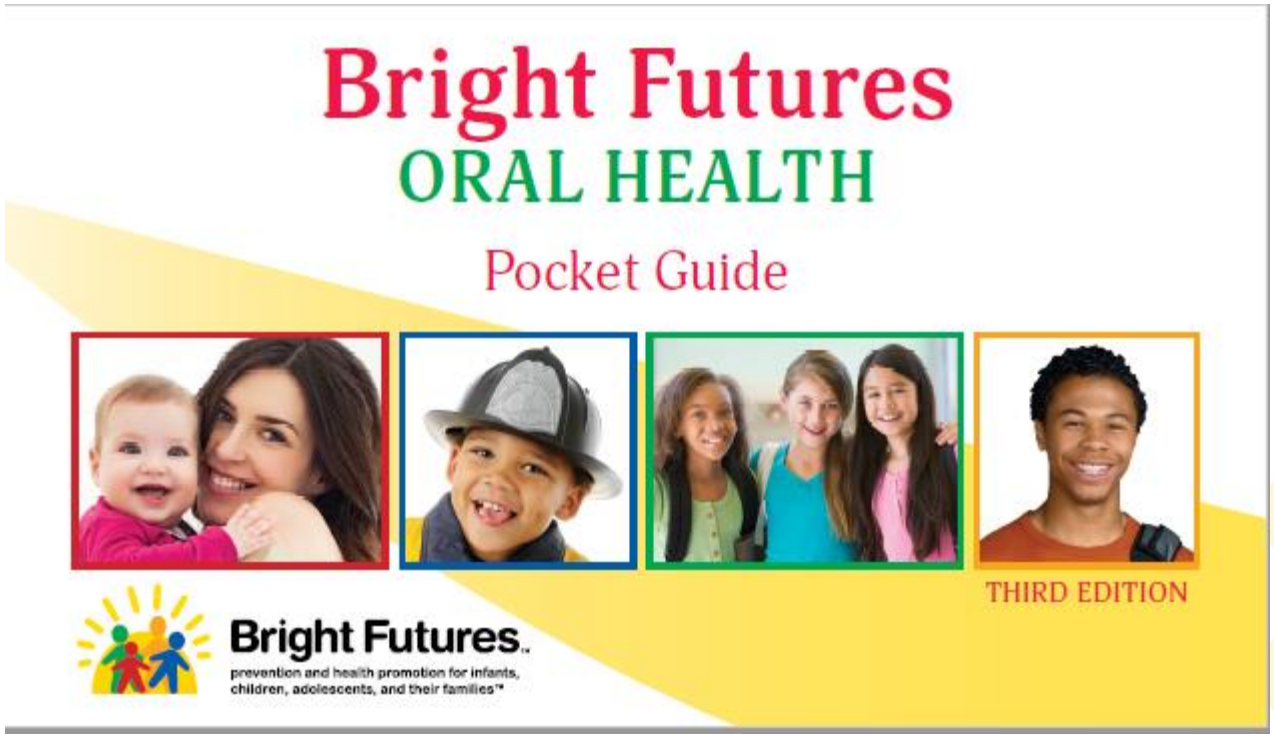
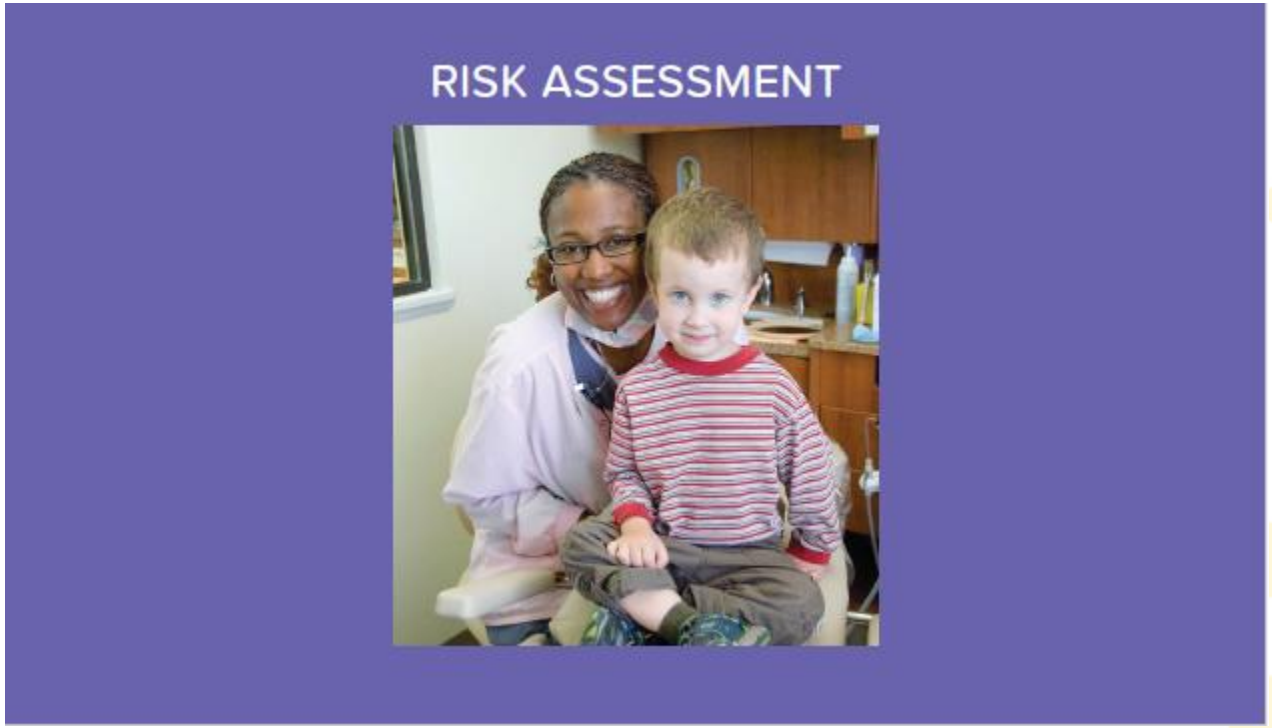
Bright Futures Oral Health Pocket Guide

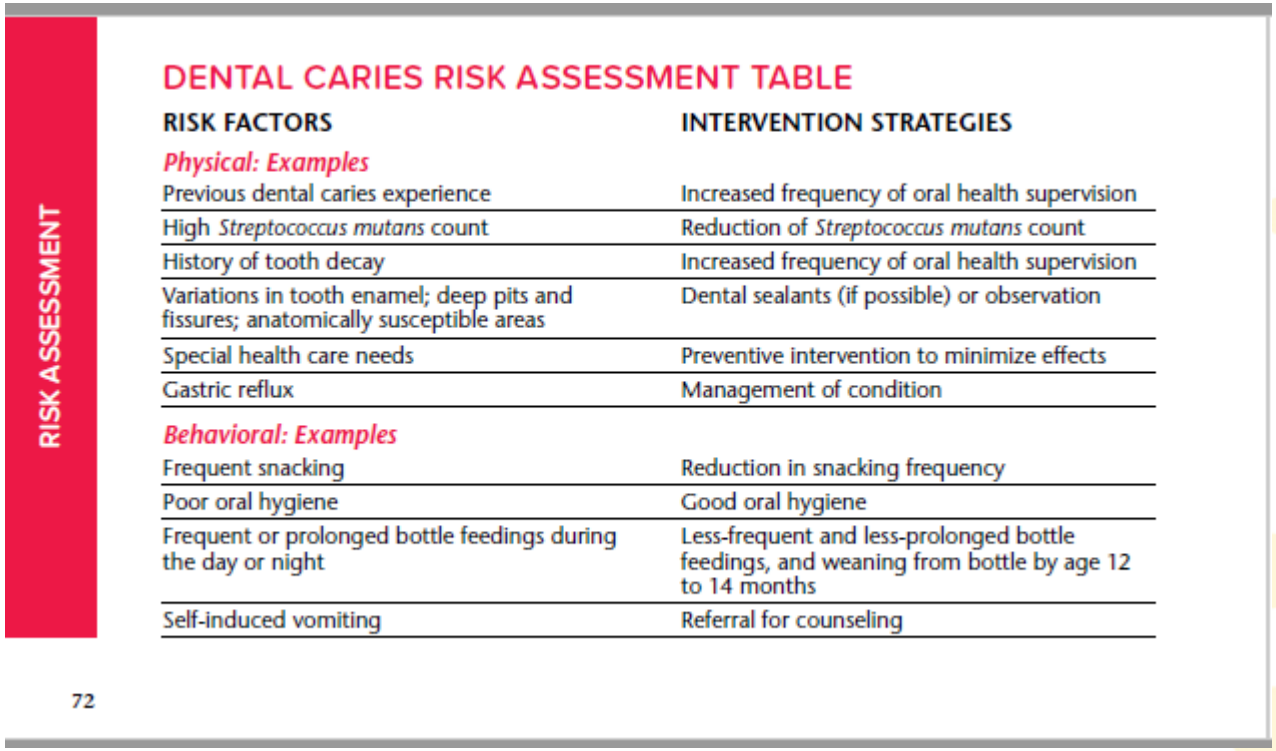
- https://www.mchoralhealth.org/pocket/



Bright Futures Risk Assessment



Dental Caries Risk



RISK ASSESSMENT

DENTAL CARIES RISK ASSESSMENT TABLE

RISK FACTORS	INTERVENTION STRATEGIES
Physical: Examples	
Previous dental caries experience	Increased frequency of oral health supervision
High *Streptococcus mutans* count	Reduction of *Streptococcus mutans* count
History of tooth decay	Increased frequency of oral health supervision
Variations in tooth enamel; deep pits and fissures; anatomically susceptible areas	Dental sealants (if possible) or observation
Special health care needs	Preventive intervention to minimize effects
Gastric reflux	Management of condition
Behavioral: Examples	
Frequent snacking	Reduction in snacking frequency
Poor oral hygiene	Good oral hygiene
Frequent or prolonged bottle feedings during the day or night	Less-frequent and less-prolonged bottle feedings, and weaning from bottle by age 12 to 14 months
Self-induced vomiting	Referral for counseling

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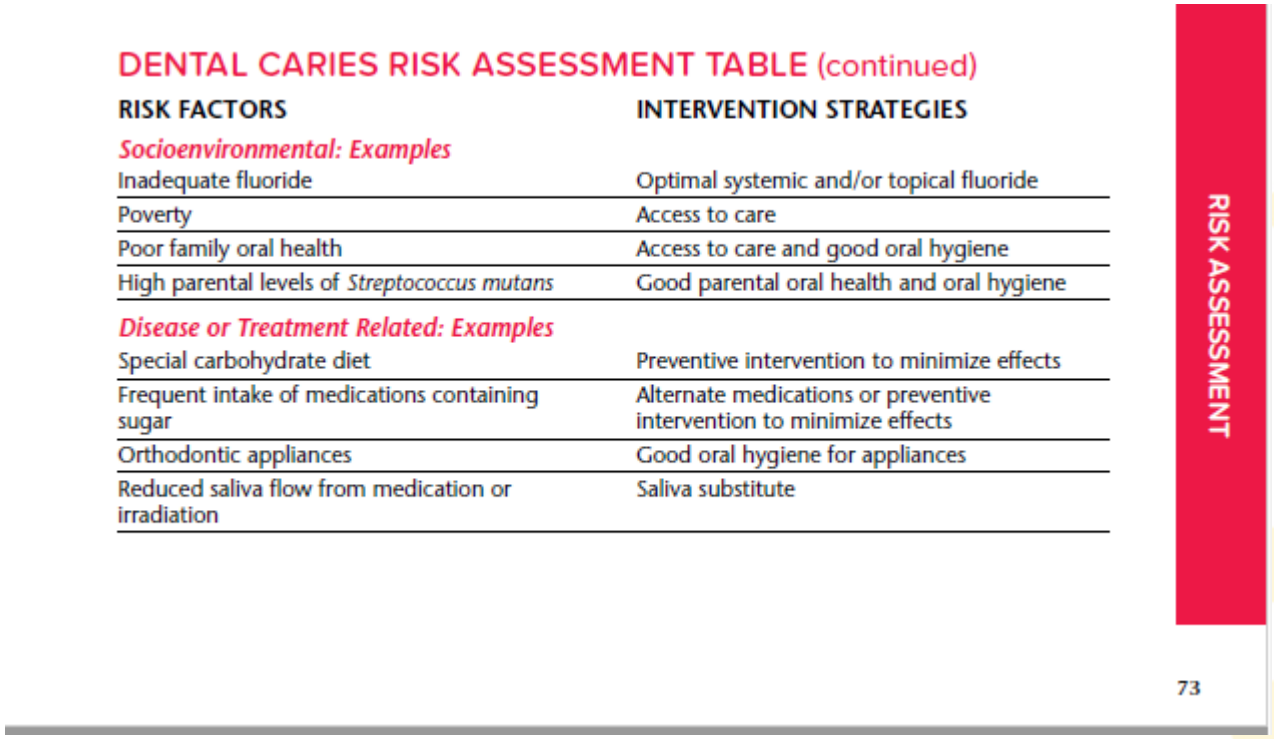
Dental Caries Risk



DENTAL CARIES RISK ASSESSMENT TABLE (continued)

RISK FACTORS	INTERVENTION STRATEGIES
Socioenvironmental: Examples	
Inadequate fluoride	Optimal systemic and/or topical fluoride
Poverty	Access to care
Poor family oral health	Access to care and good oral hygiene
High parental levels of *Streptococcus mutans*	Good parental oral health and oral hygiene
Disease or Treatment Related: Examples	
Special carbohydrate diet	Preventive intervention to minimize effects
Frequent intake of medications containing sugar	Alternate medications or preventive intervention to minimize effects
Orthodontic appliances	Good oral hygiene for appliances
Reduced saliva flow from medication or irradiation	Saliva substitute

RISK ASSESSMENT

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Periodontal Disease Risk

RISK ASSESSMENT

PERIODONTAL DISEASE RISK ASSESSMENT TABLE

RISK FACTORS	INTERVENTION STRATEGIES
Physical: Examples	
Gingivitis	Treatment of disease
Puberty	Preventive measures to address oral effects
Pregnancy	Preventive measures to address oral effects
Mouthbreathing	Management of mouthbreathing
Malpositioned or crowded teeth	Orthodontic care
Genetic predisposition	Preventive intervention to minimize effects
Anatomical variations (e.g., frenum)	Surgical correction
Behavioral: Examples	
Poor oral hygiene	Good oral hygiene
Tobacco use	Tobacco-use cessation
Birth control pills	Preventive measures to minimize effects
Socioenvironmental: Examples	
Poverty	Access to care
Poor family oral health	Access to care and good oral hygiene

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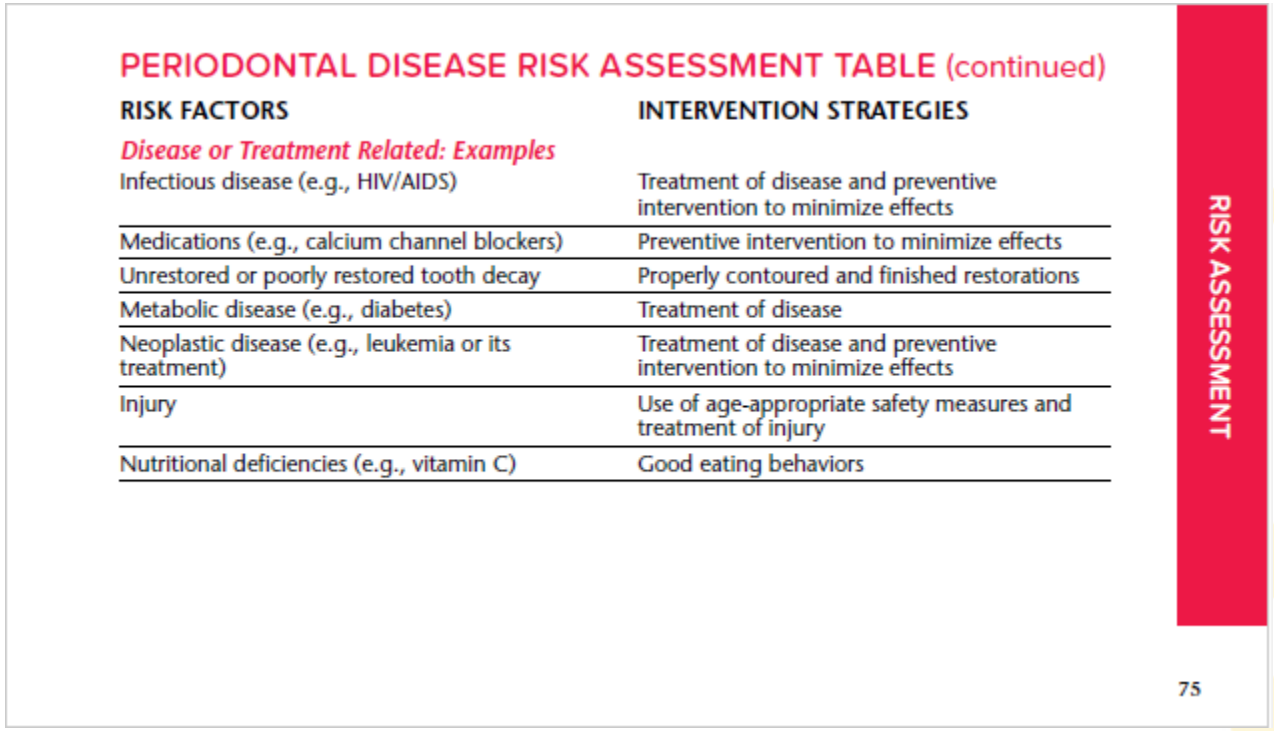
Periodontal Disease Risk



PERIODONTAL DISEASE RISK ASSESSMENT TABLE (continued)

RISK FACTORS	INTERVENTION STRATEGIES
Disease or Treatment Related: Examples	
Infectious disease (e.g., HIV/AIDS)	Treatment of disease and preventive intervention to minimize effects
Medications (e.g., calcium channel blockers)	Preventive intervention to minimize effects
Unrestored or poorly restored tooth decay	Properly contoured and finished restorations
Metabolic disease (e.g., diabetes)	Treatment of disease
Neoplastic disease (e.g., leukemia or its treatment)	Treatment of disease and preventive intervention to minimize effects
Injury	Use of age-appropriate safety measures and treatment of injury
Nutritional deficiencies (e.g., vitamin C)	Good eating behaviors

RISK ASSESSMENT

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Malocclusion Risk

RISK ASSESSMENT

MALOCCLUSION RISK ASSESSMENT TABLE

RISK FACTORS	INTERVENTION STRATEGIES
Physical: Examples	
Familial tendency for malocclusion	Early intervention
Conditions associated with malocclusion (e.g., cleft lip/palate)	Early intervention
Variations in development (e.g., tooth eruption delays and malpositioned teeth)	Early intervention
Congenital absence of teeth	Early intervention
Mouthbreathing	Management of mouthbreathing
Muscular imbalances	Early therapy
Behavioral: Examples	
Nonnutritive sucking habits in children ages 4 and above	Elimination of habit

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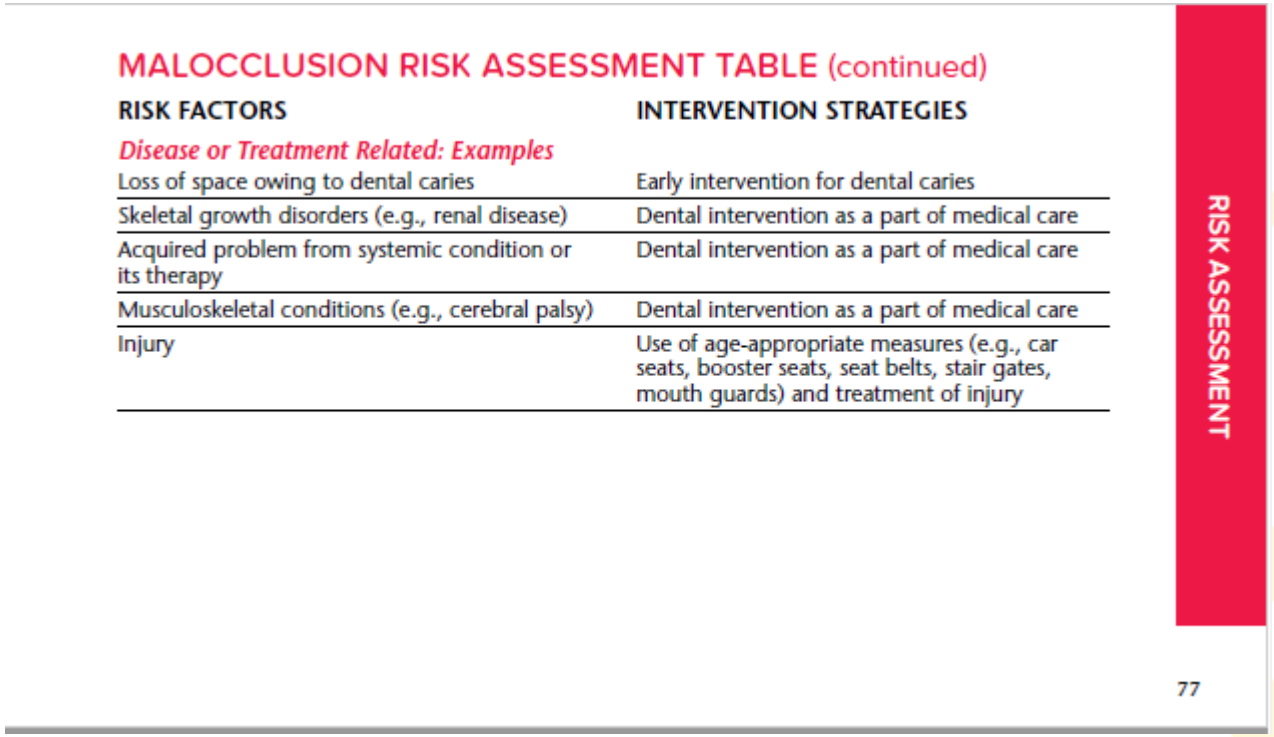
Malocclusion Risk



MALOCCLUSION RISK ASSESSMENT TABLE (continued)

RISK FACTORS	INTERVENTION STRATEGIES
Disease or Treatment Related: Examples	
Loss of space owing to dental caries	Early intervention for dental caries
Skeletal growth disorders (e.g., renal disease)	Dental intervention as a part of medical care
Acquired problem from systemic condition or its therapy	Dental intervention as a part of medical care
Musculoskeletal conditions (e.g., cerebral palsy)	Dental intervention as a part of medical care
Injury	Use of age-appropriate measures (e.g., car seats, booster seats, seat belts, stair gates, mouth guards) and treatment of injury

RISK ASSESSMENT

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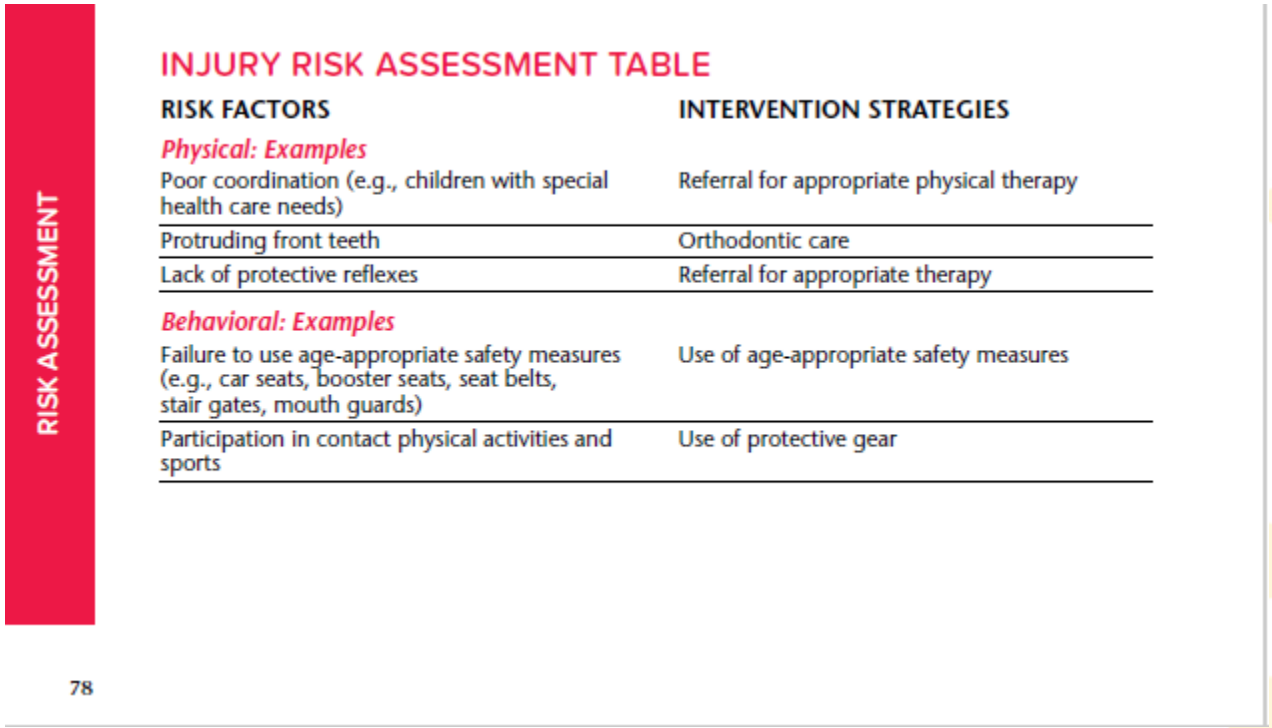
Injury Risk Assessment



RISK ASSESSMENT

INJURY RISK ASSESSMENT TABLE

RISK FACTORS	INTERVENTION STRATEGIES
Physical: Examples	
Poor coordination (e.g., children with special health care needs)	Referral for appropriate physical therapy
Protruding front teeth	Orthodontic care
Lack of protective reflexes	Referral for appropriate therapy
Behavioral: Examples	
Failure to use age-appropriate safety measures (e.g., car seats, booster seats, seat belts, stair gates, mouth guards)	Use of age-appropriate safety measures
Participation in contact physical activities and sports	Use of protective gear

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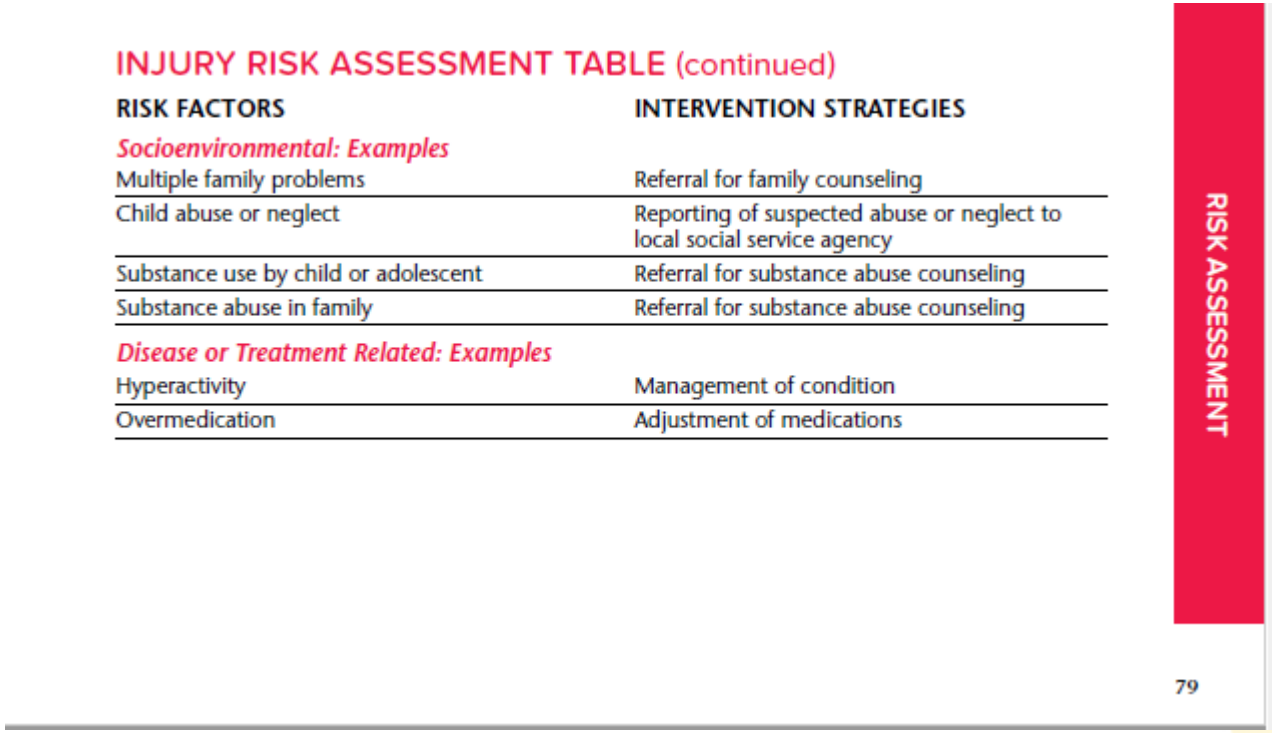
Injury Risk Assessment



INJURY RISK ASSESSMENT TABLE (continued)

RISK FACTORS	INTERVENTION STRATEGIES
Socioenvironmental: Examples	
Multiple family problems	Referral for family counseling
Child abuse or neglect	Reporting of suspected abuse or neglect to local social service agency
Substance use by child or adolescent	Referral for substance abuse counseling
Substance abuse in family	Referral for substance abuse counseling
Disease or Treatment Related: Examples	
Hyperactivity	Management of condition
Overmedication	Adjustment of medications

RISK ASSESSMENT

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Oral Health and Children with Developmental Disabilities

- http://pediatrics.aappublications.org/content/131/3/614

Oral and Dental Aspects of Child Abuse and Neglect

- http://pediatrics.aappublications.org/content/140/2/e20171487

Anticipatory Guidance - Fluoride

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*

These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.

AGE	12-24 months	2-6 years	6-12 years	12 years and older
Clinical oral examination including but not limited to the following[1]	X	X	X	X
➢ Assess oral growth and development	X	X	X	X
➢ Caries-risk Assessment	X	X	X	X
➢ Assessment for need for fluoride supplementation	X	X	X	X
➢ Anticipatory Guidance/Counseling	X	X	X	X
➢ Oral hygiene counseling	X	X	X	X
➢ Dietary counseling	X	X	X	X
➢ Injury prevention counseling	X	X	X	X
➢ Counseling for nonnutritive habits	X	X	X	X
➢ Substance abuse counseling			X	X
➢ Counseling for intraoral/perioral piercing			X	X
➢ Assessment for pit and fissure sealants		X	X	X
Radiographic Assessment	X	X	X	X
Prophylaxis and topical fluoride	X	X	X	X

[1] First examination is encouraged to begin by age 1. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.

NOTE: Parents or caregivers should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

NOTE: As in all medical care, dental care must be based on the individual needs of the member and the professional judgment of the oral health provider.

* Adaptation from the American Academy of Pediatric Dentistry Schedule

Fluoride Supplementation

Dietary Fluoride Supplementation Schedule for Children and Adolescents at High Risk for Developing Caries

	Fluoride Ion Level in Drinking Water [a]		
Age	**< 0.3 ppm**	**0.3–0.6 ppm**	**> 0.6 ppm**
Newborn–6 months	None	None	None
6 months–3 years	0.25 mg/day [b]	None	None
3–6 years	0.50 mg/day	0.25 mg/day	None
6–16 years	1.0 mg/day	0.50 mg/day	None

[a] 1.0 ppm = 1 mg/L.

[b] 2.2 mg sodium fluoride contains 1 mg fluoride ion.

Reproduced with permission from the American Dental Association from *ADA Guide to Dental Therapeutics* (2nd ed.).

Dental Development

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*				
These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.				
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Clinical oral examination including but not limited to the following:[1]	X	X	X	X
➢ Assess oral growth and development	X	X	X	X
➢ Caries-risk Assessment	X	X	X	X
➢ Assessment for need for fluoride supplementation	X	X	X	X
➢ Anticipatory Guidance/Counseling	X	X	X	X
➢ Oral hygiene counseling	X	X	X	X
➢ Dietary counseling	X	X	X	X
➢ Injury prevention counseling	X	X	X	X
➢ Counseling for nonnutritive habits	X	X	X	X
➢ Substance abuse counseling			X	X
➢ Counseling for intraoral/perioral piercing			X	X
➢ Assessment for pit and fissure sealants		X	X	X
Radiographic Assessment	X	X	X	X
Prophylaxis and topical fluoride	X	X	X	X

[1] First examination is encouraged to begin by age 1. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.

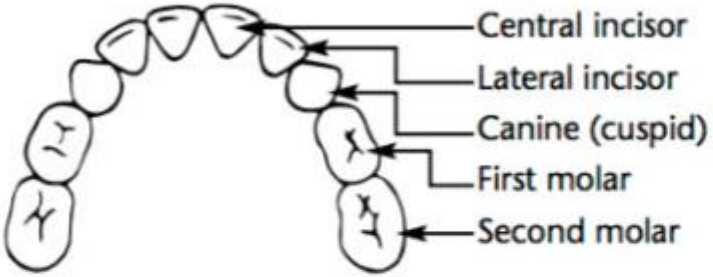
NOTE: Parents or caregivers should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

NOTE: As in all medical care, dental care must be based on the individual needs of the member and the professional judgment of the oral health provider.

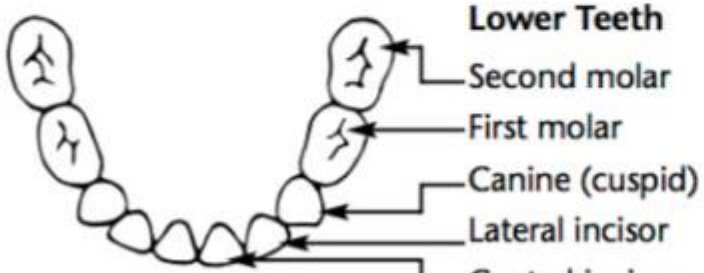
* Adaptation from the American Academy of Pediatric Dentistry Schedule

Tooth Eruption – Primary Dentition

PRIMARY DENTITION



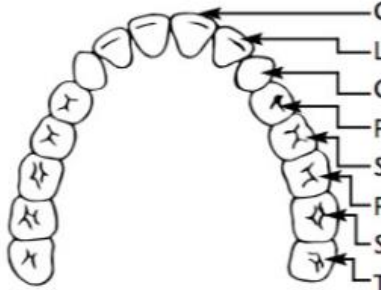
Upper Teeth	Erupt	Exfoliate
Central incisor	8-12 months	6-7 years
Lateral incisor	9-13 months	7-8 years
Canine (cuspid)	16-22 months	10-12 years
First molar	13-19 months	9-11 years
Second molar	25-33 months	10-12 years



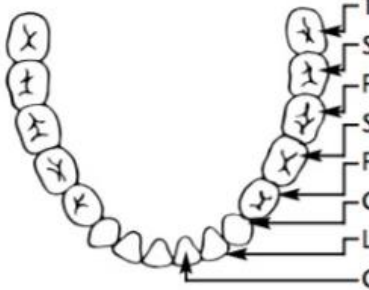
Lower Teeth	Erupt	Exfoliate
Second molar	23-31 months	10-12 years
First molar	14-18 months	9-11 years
Canine (cuspid)	17-23 months	9-12 years
Lateral incisor	10-16 months	7-8 years
Central incisor	6-10 months	6-7 years

Tooth Eruption – Permanent Dentition

PERMANENT DENTITION



Upper Teeth	Erupt
Central incisor	7-8 years
Lateral incisor	8-9 years
Canine (cuspid)	11-12 years
First premolar (first bicuspid)	10-11 years
Second premolar (second bicuspid)	10-12 years
First molar	6-7 years
Second molar	12-13 years
Third molar (wisdom tooth)	17-21 years



Lower Teeth	Erupt
Third molar (wisdom tooth)	17-21 years
Second molar	12-13 years
First molar	6-7 years
Second premolar (second bicuspid)	10-12 years
First premolar (first bicuspid)	10-11 years
Canine (cuspid)	11-12 years
Lateral incisor	8-9 years
Central incisor	7-8 years

Anticipatory Guidance

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*

These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.

AGE	12-24 months	2-6 years	6-12 years	12 years and older
Clinical oral examination including but not limited to the following[1]	X	X	X	X
➢ Assess oral growth and development	X	X	X	X
➢ Caries-risk Assessment	X	X	X	X
➢ Assessment for need for fluoride supplementation	X	X	X	X
➢ Anticipatory Guidance/Counseling	X	X	X	X
➢ Oral hygiene counseling	X	X	X	X
➢ Dietary counseling	X	X	X	X
➢ Injury prevention counseling	X	X	X	X
➢ Counseling for nonnutritive habits	X	X	X	X
➢ Substance abuse counseling			X	X
➢ Counseling for intraoral/perioral piercing			X	X
➢ Assessment for pit and fissure sealants		X	X	X
Radiographic Assessment	X	X	X	X
Prophylaxis and topical fluoride	X	X	X	X

[1] First examination is encouraged to begin by age 1. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.

NOTE: Parents or caregivers should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

NOTE: As in all medical care, dental care must be based on the individual needs of the member and the professional judgment of the oral health provider.

* Adaptation from the American Academy of Pediatric Dentistry Schedule

Anticipatory Guidance - Pregnancy

- Family Preparation
- Interview
- Examinations
- Screening
- Oral Health Care
- Oral Hygiene
- Nutrition
- Injury Prevention
- Substance Use/Avoidance
- Outcomes

Anticipatory Guidance - Infancy

- Family Preparation
- Interview
- Risk Assessment
- Screening
- Examination/Preventative Procedures
- Oral Health Care
- Oral Hygiene
- Nutrition
- Non-nutritive Sucking
- Substance Use/ Avoidance
- Outcomes

Anticipatory Guidance – Early Childhood

- Family Preparation
- Interview
- Risk Assessment
- Screening
- Examination/Preventative Procedures
- Oral Health Care
- Oral Hygiene
- Nutrition
- Non-nutritive Sucking
- Injury Prevention
- Substance Use/Avoidance
- Outcomes

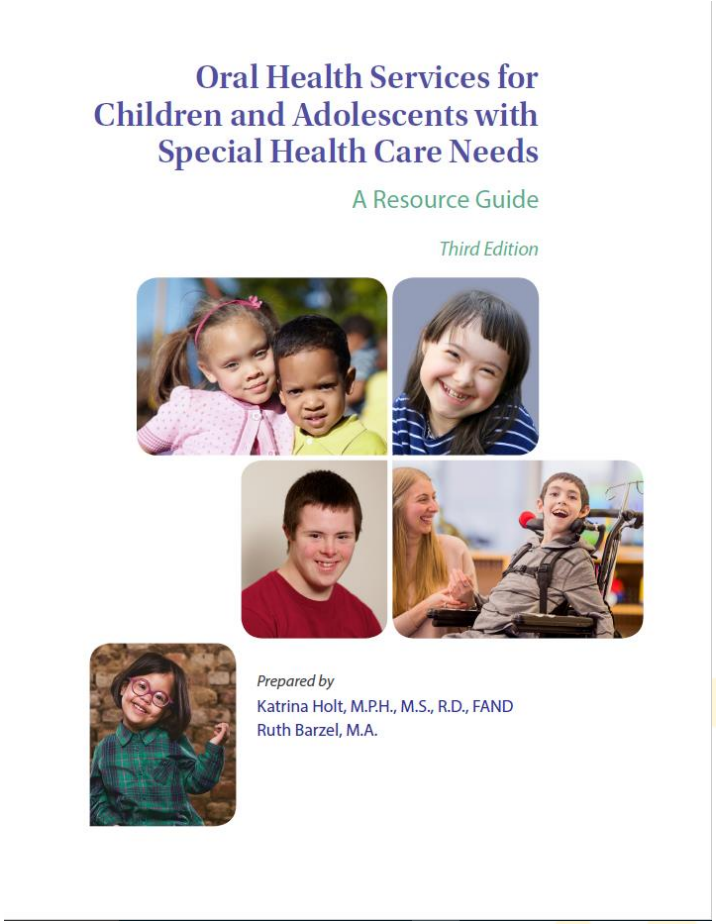
Anticipatory Guidance Middle Childhood

- Family Preparation
- Interview
- Risk Assessment
- Screening
- Examination/Preventative Procedures
- Oral Health Care
- Oral Hygiene
- Nutrition
- Non-nutritive Sucking
- Injury Prevention
- Substance use/avoidance
- Outcomes

Anticipatory Guidance - Adolescence

- Family Preparation
- Interview
- Risk Assessment
- Screening
- Nutrition
- Examination
- Oral Health Care
- Oral Hygiene
- Nutrition
- Injury prevention
- Substance Abuse/Avoidance
- Outcomes

https://www.mchoralhealth.org/PDFs/cshcn-resource-guide.pdf



Oral Health Services for Children and Adolescents with Special Health Care Needs

A Resource Guide

Third Edition

Prepared by

Katrina Holt, M.P.H., M.S., R.D., FAND

Ruth Barzel, M.A.

https://www.mchoralhealth.org/SpecialCare/

Welcome

Welcome to *Special Care: An Oral Health Professional's Guide to Serving Children with Special Health Care Needs* (2nd ed.)

This series of five modules is designed to provide oral health professionals with information to help ensure that children with special health care needs have access to health promotion and disease prevention services that address their unique oral health needs in a comprehensive, family-centered, and community-based manner.

Modules

1. An Overview of Children with Special Health Care Needs and Oral Health
2. Providing Optimal Oral Health Care
3. Oral Health Supervision
4. Prevention of Oral Disease
5. Behavior Guidance

Post-Tests and Registration

After completing the modules, you can take the post-tests (credit and non-credit options). Registration is required for the credit option.

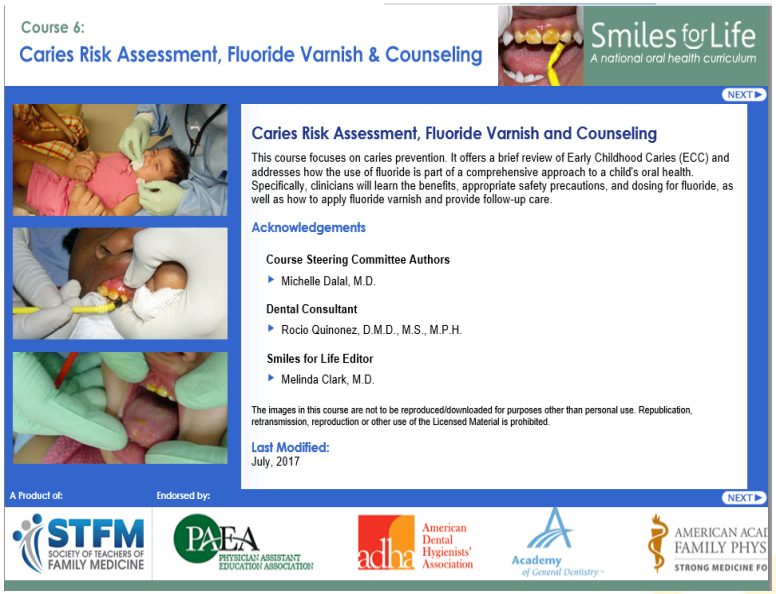
Post-Tests and registration (registration is required for credit option)

After completing the modules and post-tests, please take a moment to fill out the curriculum evaluation. Your feedback will help to improve the curriculum.

Included in the curricula is an organizations section that lists federal agencies and national organizations that may serve as resources for information and services.

Provider Training

- http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbreceipt=0.



AzAAP Provider Training

Fluoride Varnish Application

Location of Training: An online training module is available online at:
http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbreceipt=0.

Description of Training: At the conclusion of this activity, participants will be able to: 1) Discuss the etiology of early childhood caries, 2) Assess a child's risk for developing early childhood caries, 3) Perform an appropriate oral examination on small children, 4) Recognize the various stages of early childhood caries, 5) Discuss the effects, sources, benefits and safe use of fluoride, 6) Demonstrate the application of fluoride varnish.

Schedule your Training: Users do not need to schedule trainings and can participate at your leisure.

Fee: This is been provided free of charge by the Society of Teachers of Family Medicine.

Other trainings: Certificates dated before August 1, 2014 will be accepted. From time to time, web-based learning opportunities present and/or conferences are hosted nationwide to provide training on oral health risk assessment and fluoride varnish application. Providers who can submit certificates that they participated in a fluoride varnish application training sponsored by one of the following organizations will be considered "certified" by AHCCCS:

- Smiles for Life, a National Oral Health Curriculum
- American Dental Association (or any of its State Chapters)
- American Academy of Pediatric Dentistry (or any of its State Chapters)
- American Academy of Pediatrics (or any of its State Chapters)
- American Academy of Family Physicians (or any of its State Chapters)
- American Osteopathic Medical Association (or any of its State Chapters)
- National Association of Pediatric Nurse Practitioners (or any of its State Chapters)
- American Nurses Association (or any of its State Chapters)
- American Academy of Physician's Assistants (or any of its State Chapters)

How to Get Paid:

1. Submit your certificate to CAQH. This fax cover sheet should be used to send the required documentation of your completed training.

2. Provide fluoride varnish starting from the first tooth eruption to the 2nd birthday. Varnish can be applied every 6 months. (Kids need to be referred by 1yr of age.) Code: D1206

Purchasing Materials: Purchase fluoride varnish materials at any reputable dental supply house such as:

- Henry Schein Dental Supply
- Patterson Dental Supply
- Burkhart Dental Supply
- Darby Dental Supply

Questions

QUESTION	TRUE	FALSE
All Children older than six (6) months should receive a fluoride supplement every day?		
Parents should start cleaning a child's teeth as soon as the first tooth appears?		
Parents should start brushing their child's teeth with toothpaste that contains fluoride at age 3?		
Children younger than 6 years of age should use enough toothpaste with fluoride to cover the toothbrush?		
Parents should brush their child's teeth twice a day until the child ca handle the toothbrush alone?		
Young children should always use fluoride mouth rinses after brushing		

Answers

QUESTION	TRUE	FALSE
All Children older than six (6) months should receive a fluoride supplement every day?		Check with your child's doctor or dentist about your child's specific fluoride needs. Parents of a child older than 6 months should discuss the need for a fluoride supplement with the doctor or dentist if drinking water does not have enough fluoride to help prevent cavities
Parents should start cleaning a child's teeth as soon as the first tooth appears?	√	
Parents should start brushing their child's teeth with toothpaste that contains fluoride at age 3?		Parents should start using toothpaste with fluoride to brush their child's teeth at age 2. Toothpaste with fluoride may be used earlier if the child's doctor or dentist recommends it.
Children younger than 6 years of age should use enough toothpaste with fluoride to cover the toothbrush?		Young children should use only a pea-sized amount of fluoride toothpaste. Fluoride is important for fighting cavities, but if children younger than 6 years swallow too much fluoride, their permanent teeth may have white spots. Using no more than a pea-sized amount of toothpaste with fluoride can help keep this from happening
Young children should always use fluoride mouth rinses after brushing		Fluoride mouth rinses have a high concentration of fluoride. Children younger than 6 years should not use fluoride mouth rinses unless the child's doctor or dentist recommends it. Young children tend to swallow rather than spit, and swallowing too much fluoride before age 6 may cause the permanent teeth to have white spots.
Parents should brush their child's teeth twice a day until the child can handle the toothbrush alone?	√	

Questions?

Thank You.