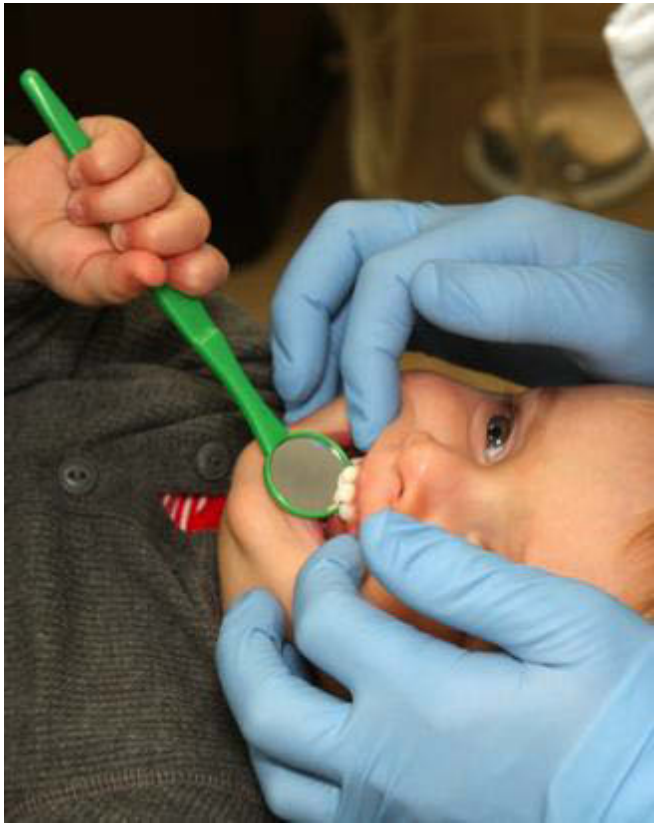
Access to Baby & Child Dentistry™

DENTAL TRAINING

the center for pediatric dentistry

A PARTNERSHIP OF University of Washington & Seattle Children's

Washington Dental Service Building



Oral Health for Infants and Toddlers

New Provider Training

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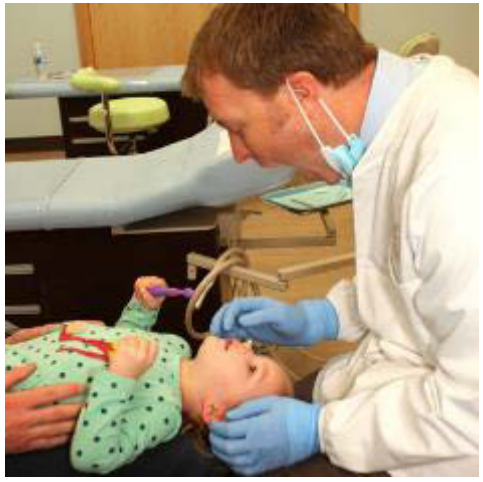
ABCD Dental Training: Oral Health for Children Birth to Age 6



Access to Baby and Child Dentistry program (ABCD) puts young children on a lifelong path to good oral health. It connects low-income families with dentists who know how to care for young kids, preventing tooth decay early and educating parents about how to take good care of their children's teeth. ABCD has made Washington a national leader in increasing utilization for young children

Learning Objectives

1. The ABCD program history, goals, components and services

2. Dental Health Messages

3. The knee-to-knee technique, lift the lip exam, and fluoride varnish application

4. The importance of building primary medical care and pediatric dentistry specialty care relationships

Learning Objective 1: About the ABCD Program

- Rationale & History
- Goals
- Components
- Services

National Caries Epidemic

- The most common chronic disease of childhood
- 5 times more common than asthma
- 7 times more common than hay fever
- On the rise *nationally* among young children (primary teeth) for the first time in 40 years[1]

Caries Epidemic in Our State

- Low-Income Children are disproportionally affected by dental decay – and some 50% of Washington children 0-5 receive their dental coverage through Medicaid (Apple Health)
- Washington's decay rates for preschoolers and 3rd graders are higher than national Healthy People 2020 Oral Health Objectives[2]
- Over 3/4 of untreated decay in permanent teeth is found in approximately 25% of children 5-17 years old[3]

History.

1990s.

- Spokane County concerns regarding the severe lack of dental access for high-risk preschool age population.
- State & local government, public health and dental community collaborate on the solution – ABCD.
- Spokane establishes Washington's first ABCD Program in 1995.

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"ABCD was…a way to level the playing field and to give the Medicaid-enrolled child a good and equal dental beginning. The concept was simple. If one could get Medicaid children into a dental office to take care of their preventive and restorative needs, then their long-term dental health should hopefully be the same as … insured and private pay patients."

—Dale Reumping, DDS, MSD
Spokane County Dental Champion, retired

History

- Spokane's successful ABCD model replicated in three Central Washington counties (1999)
- American Academy of Pediatric Dentistry recognizes ABCD as a "best practice" by (2001)
- Pew Foundation recognizes ABCD as a "proven strategy that can help policy makers … deliver a strong return on taxpayers' investment." (2010)
- **TODAY:** ABCD active in every WA county and the number of children visiting the dentist before the second birthday has more than quadrupled

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ABCD: A Unique Partnership

"ABCD is a **premiere example of public and private partners** working together to address dental disease among Washington's Medicaid-insured youngsters. We've been able to efficiently and effectively leverage public-private resources, investing in a program that focuses on prevention and improving oral health for thousands of young children in our state."

— Preston Cody
WA Health Care Authority (Medicaid)

ABCD's Public-Private Partners

- UW School of Dentistry
- WSDA & Local Dental Societies
- ABCD Champions and Community Dentists
- Arcora Foundation
  (Foundation of Delta Dental of Washington)
- Washington State Health Care Authority
  (Apple Health/Medicaid)
- Washington Department of Health WIC Program
- Local ABCD Programs & Community Partners

ABCD Goals

1. Reduce the extent of disparities in oral health for Washington's young children
2. Decrease dental disease rates by providing Medicaid-enrolled children, birth to age 6, with access to early preventive dental care
3. Emphasize:
   - early intervention
   - prevention
   - education
   - comprehensive care

ABCD Components

- ABCD Certified Dentists
- Local Dental Champion works to identify, recruit, train, and mentor local dentists
- More than **2000** ABCD trained dental providers since 1995 in communities across Washington
  - Pediatric & general dentists
  - UW dental students
  - Pediatric dental residents

In a training… "the whole clinic team hears the same thing – the message and techniques of preventive dentistry, significant restorative techniques and administrative approaches to enable front desk personnel to feel comfortable with the paperwork."

—Dale Reumping, DDS, MSD
Spokane County Dental Champion, retired

ABCD Components

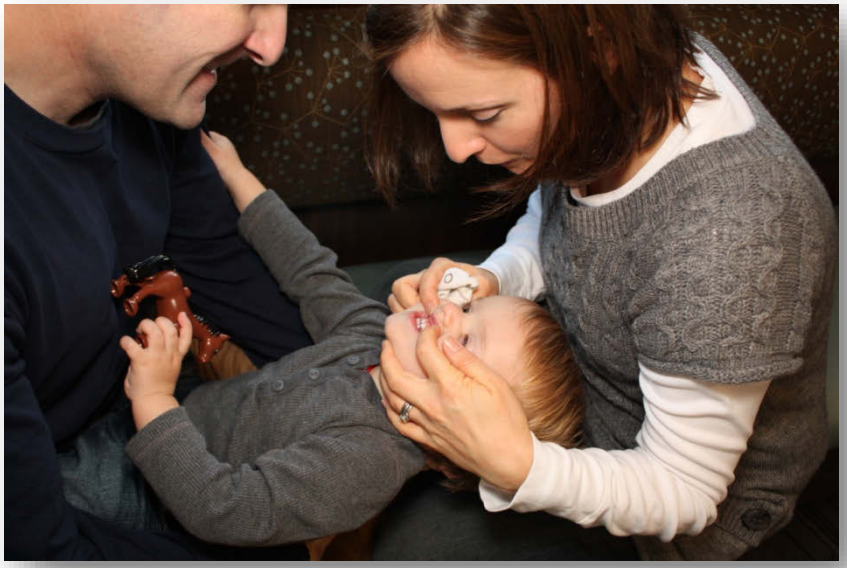
- Enhanced dental benefits & fees to ABCD certified dentists

"It's a program that is really easy for us – billing is simple and Medicaid reimburses us in a timely manner."

—Jared Evans, DDS
Spokane County Dental Champion

ABCD Components

- Local program provides outreach to families and case management



"Working with our local ABCD Program Coordinator has made seeing new ABCD patients easy and rewarding."

—Jeff Hays, DDS
Kitsap County ABCD Champion

ABCD Services for Families

- Anticipatory Guidance/Counseling/ Family Oral Health Education
- Dental Exam
- Prophylaxis
- Risk Assessment
- Fluoride Varnish Treatment
- Dental Treatment

Why Participate in ABCD?

- Make a difference in the community
- Pediatric dentist shortage in some areas
- Good for kids:
  - Establishes a dental home
  - Reinforces good oral health practices
  - Promotes positive dental visits
- Good for dental practice
  - Increased reimbursement and a Practice Builder
  - ABCD Clients have consistently low no-show rates (from <1% to 10%)

> "Knowing that there are 25 private dentists in our community willing to take Medicaid kids makes a real difference."
>
> **—Chris Phillips**
> *PeaceHealth St. Joseph Medical Center, Bellingham*

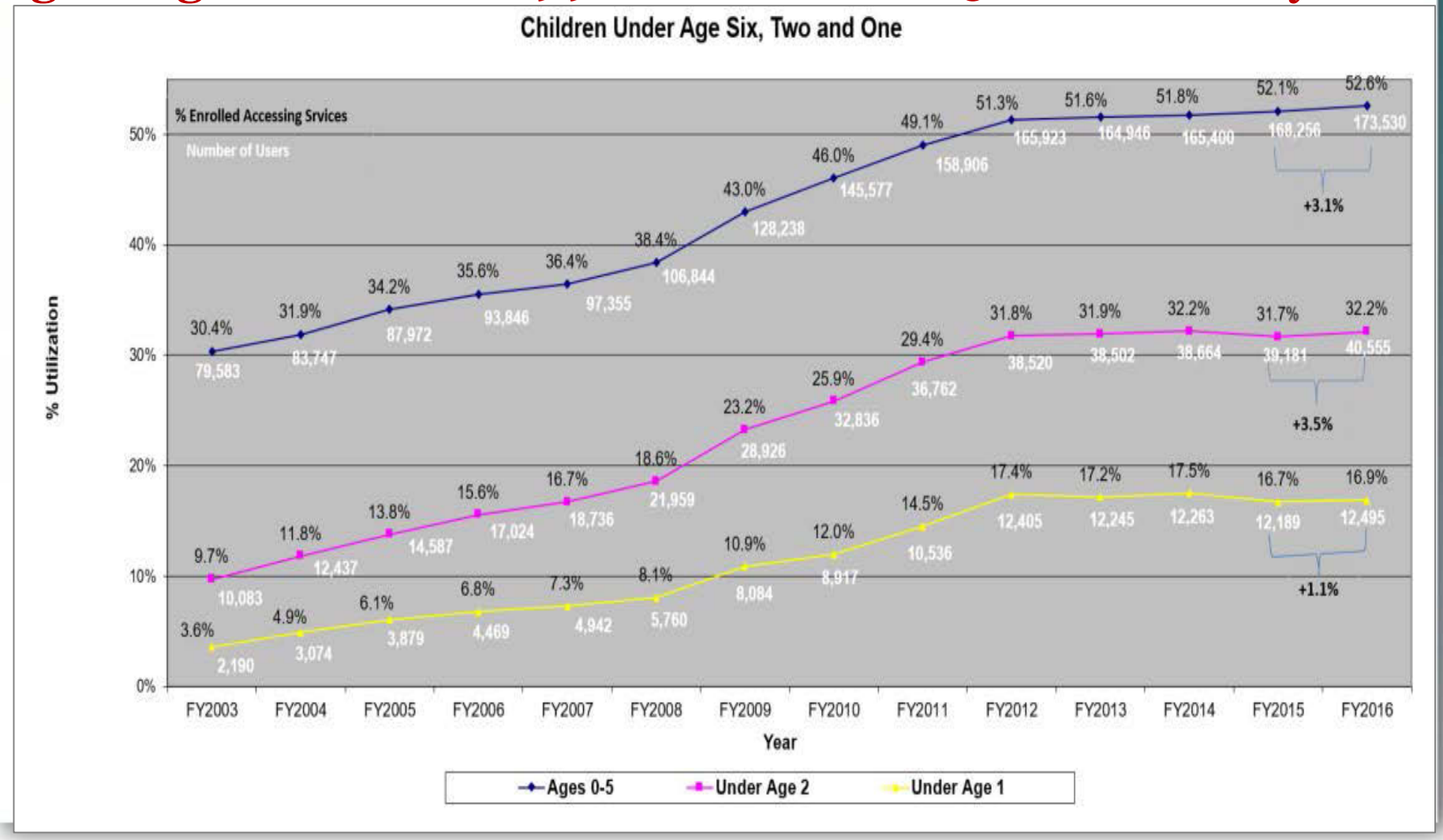
Why Participate in ABCD?

- ABCD dentists can control both the *number* of Medicaid children seen *& how/when* visits are scheduled
  - Some integrate into regular office schedule
  - Others schedule all ABCD visits on one day, seeing all young children at one time with access to translation & transportation
  - Local ABCD program staff may serve as a "gatekeeper" – orienting family before first visit and connecting client with a practice

- ABCD dentists have a "safety net"
  - Most are able to refer to ABCD-participating pediatric dentist for difficult treatment scenarios
  - UW Center for Pediatric Dentistry

ABCD Works!
The program has been extensively evaluated

ABCD Works! Only 1 in 5 Apple Health kids were getting care in late 1990s. More than 50% are today!



Smile Survey 2015:

ABCD is making a difference. Prevention is paying off.

- Fewer Washington youngsters have untreated tooth decay
- Untreated decay **down 35%** in low-income preschoolers, 2005 to 2015, an indicator that access to care has increased
- Untreated decay for 3rd graders is **down 37%,** 2005 to 2015
- Fewer low-income preschoolers in Washington have untreated decay compared to the rest of the country

Smile Survey 2015:

Yet there's still work to be done.

- Health disparities are wide-spread
  - Children of color in Washington have higher rates of untreated decay. Hispanic and American Indian/Alaskan Native children have a **50% higher decay rate** (compared to white children)
  - And low-income third-graders suffer from rampant decay at **2x** the rate of higher-income children

"ABCD's emphasis on prevention is making a huge difference in our state, not only for young children but for all Washingtonians.

By getting children into care when they're very young, the focus is on prevention rather than on the long-term cost of treating dental disease.

We're saving money and that benefits everyone."

—Representative Larry Seaquist
26th Legislative District

ABCD Program Surveys tell us….

- Parents of ABCD patients are more likely to seek care *before* oral health problems arise.
- Parents who said their child's first dental visit was at age 2 or younger *doubled* (23% to 48%)
- Parents who said their child had visited a dentist at least once/year *nearly tripled* (36% to 94%)
- **ABCD dentists were** three times as likely to be comfortable seeing children age one year or younger than non-ABCD dentists (57% vs. 16%)

National research verifies ABCD effectiveness:

Journal of the American Dental Association JADA[4]

Children in an ABCD county had better oral health than those in a non-ABCD county. On a per-child basis, ABCD's prevention cost substantially less than one filling.

Journal of Public Health Dentistry[7]

Enrollment in ABCD doubled utilization of preventive services for the youngest children

PEW Issue Brief[8]

ABCD is a proven strategy that can help policy makers prevent…(negative oral health) consequences and deliver a strong return on taxpayers' investment."

ABCD is Nationally Recognized

Testimony before United States Congress (2009)
"ABCD is effective in improving access and utilization by Medicaid-eligible children and in increasing provider participation."

American Academy of Pediatric Dentistry (2001)
ABCD named a "best practice" by AAPD, a recognition of programs that use resources efficiently and are culturally competent, replicable, integrated and sustainable.

W.K. Kellogg Foundation (2005)
ABCD is recognized as one of three innovative oral health models nationally.

Learning Objective #2: Dental Health Messages

- You probably already do this every day in your practice
- This review emphasizes sharing information that parents/caregivers can use at home
- FOHE

The Dental Home

All Children Should Have a Dental Home

Characteristics of a Dental Home:

- Comprehensive
- Continuously Accessible
- Coordinated with other medical services
- Family Centered
- Should happen no later than 12 months of age[9]

Family Oral Health Education

D9999: a billable service unique to the ABCD program

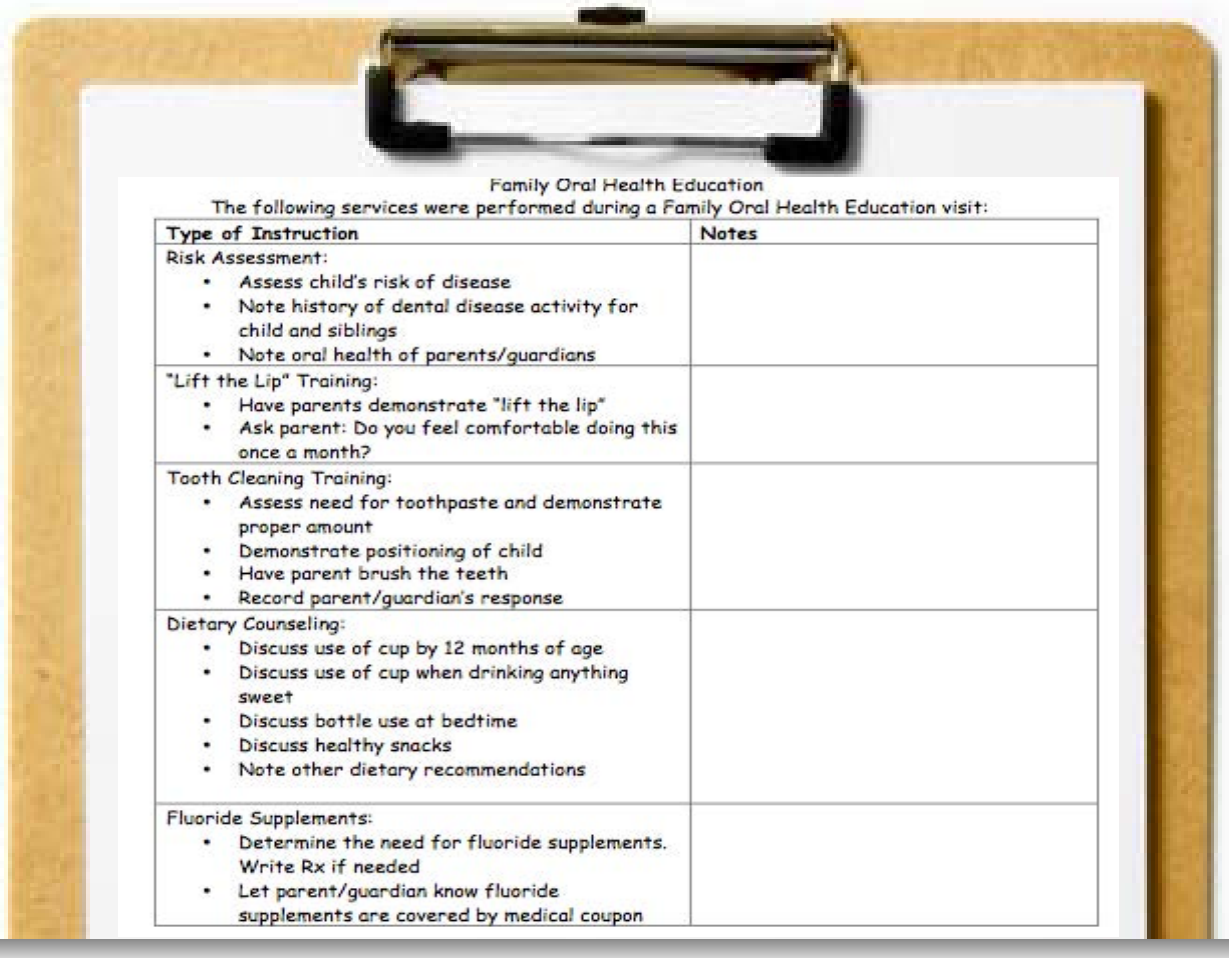
Limited to one visit per day, per family, with up to two visits **per child** over a 12-month period.

Includes:

- Anticipatory guidance
- Risk assessment for early childhood caries
- Lift the Lip training for parents and practice in knee-to-knee/positioning child to clean teeth
- Oral hygiene instruction
- Dietary counseling, nutrition & healthy snacking
- Discussion of Fluoride supplements and/or prescription if needed

These activities should be documented in the patient's chart

Family Oral Health Education Documentation *King Documentation Insert*



Family Oral Health Education

The following services were performed during a Family Oral Health Education visit:

Type of Instruction	Notes
Risk Assessment: • Assess child's risk of disease • Note history of dental disease activity for child and siblings • Note oral health of parents/guardians	
"Lift the Lip" Training: • Have parents demonstrate "lift the lip" • Ask parent: Do you feel comfortable doing this once a month?	
Tooth Cleaning Training: • Assess need for toothpaste and demonstrate proper amount • Demonstrate positioning of child • Have parent brush the teeth • Record parent/guardian's response	
Dietary Counseling: • Discuss use of cup by 12 months of age • Discuss use of cup when drinking anything sweet • Discuss bottle use at bedtime • Discuss healthy snacks • Note other dietary recommendations	
Fluoride Supplements: • Determine the need for fluoride supplements. Write Rx if needed • Let parent/guardian know fluoride supplements are covered by medical coupon	

Anticipatory Guidance

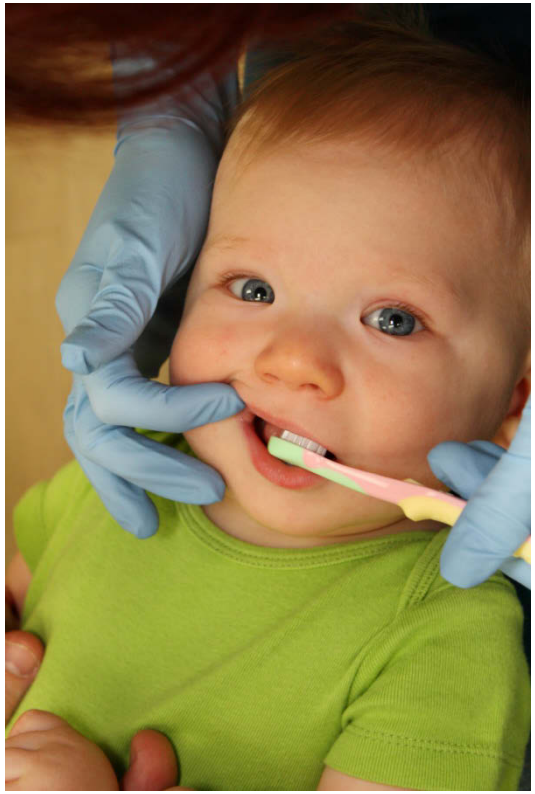
Individualized patient counseling that focuses on:

- Prevention
- Education
- Health promotion

Anticipatory Guidance Topics

- First dental visit
- Importance of primary teeth
- Dental development
- The caries process
- Oral hygiene
- Nutrition & healthy snacking
- Fluoride
- Injury prevention and trauma

First Dental Visit



First Screening by First Birthday

- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- American Academy of Pediatric Dentistry (AAPD)

….all recommend children be screened by their first birthday by dentist or medical provider[9]

Importance of Primary Teeth

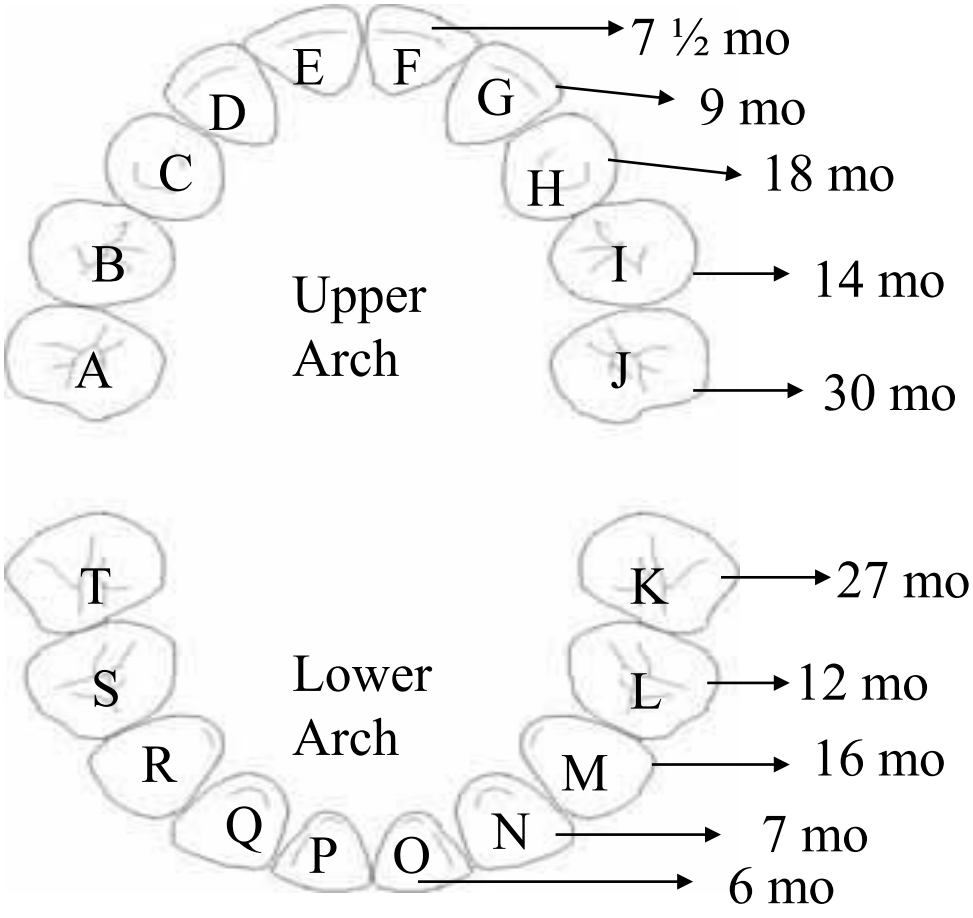
- Needed for good nutrition
- Important for pronunciation and language development
- Maintain space for permanent teeth
- Positive self-image

Dental Development

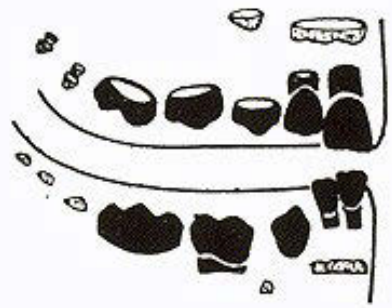
- Tooth development begins in utero
- Primary mineralization during the 2nd trimester
- First primary tooth emerges around 6 months — typically lower central incisors

- Primary dentition is complete by about 30 months
- 20 teeth total

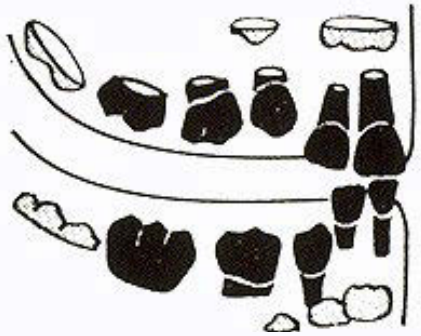
Dental Development: Eruption



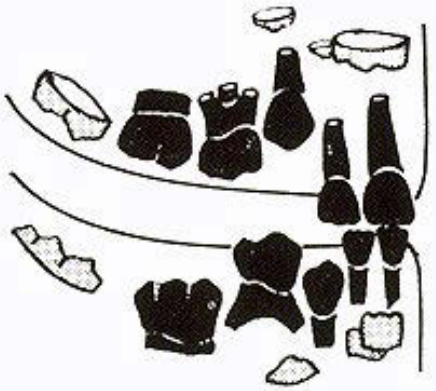
Dental Development: Eruption



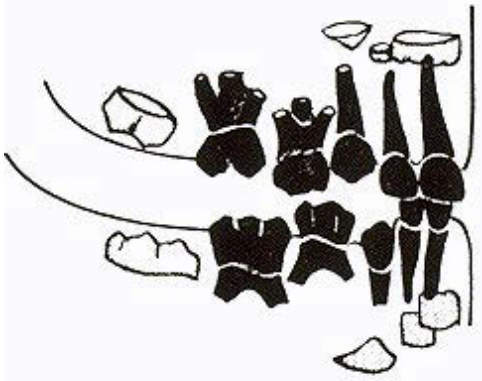
6 mos.
(±2mos.)



9 mos.
(±2mos.)

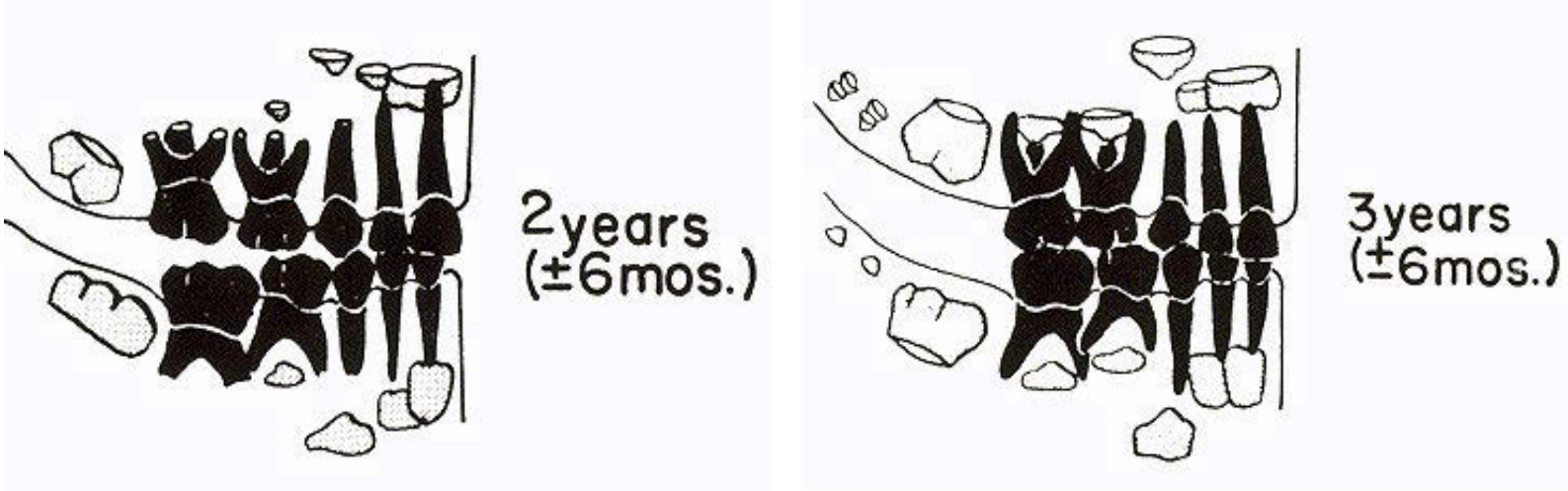


1 year
(±3mos.)



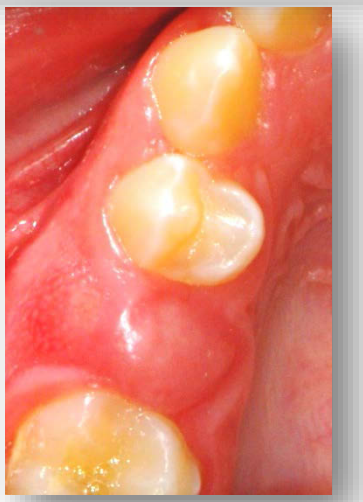
18mos.
(±3mos.)

Dental Development: Eruption



Dental Development: Eruption Hematoma

- Bluish swelling over an erupting tooth
- Usually asymptomatic
- No treatment required unless there is pain
- Usually rupture spontaneously and tooth emerges normally



Dental Development:
Oral Pathology in Early Childhood

Bohn's Nodules

Epstein's Pearls

Dental Development:
Oral Pathology in Early Childhood

Ankyloglossia (tongue tie)

Dental Development:
Oral Pathology in Early Childhood

Natal and Neonatal Teeth

Dental Development: Teething

- Symptoms:
  - Baby may have tender gums when teeth begin to erupt
  - May cause child to become fussy, irritable, and sleepless
- No evidence that teething is associated with fever and/or diarrhea
- Before attributing any signs or symptoms of potentially serious illness to teething, clinicians and parents must rule out other possible causes

Dental Development: Treating Teething

- Chilled teething rings
- Cold washcloth
- Systemic pain meds (Tylenol)

Avoid topical pain relievers (i.e. Orajel) due to potential toxicity[10]

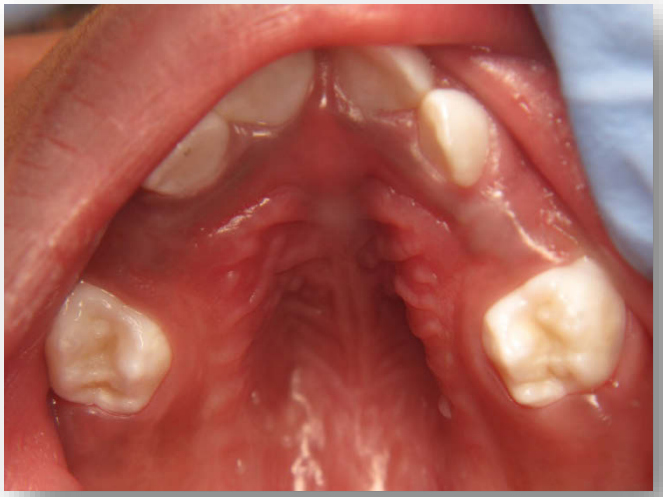
Dental Development: Non-Nutritive Sucking

- Pacifiers, thumb, fingers, or other objects
- May contribute to:
  - decreased maxillary arch width
  - increased overjet
  - decreased overbite
  - anterior open bite
  - posterior crossbite

Dental Development: Non-Nutritive Sucking

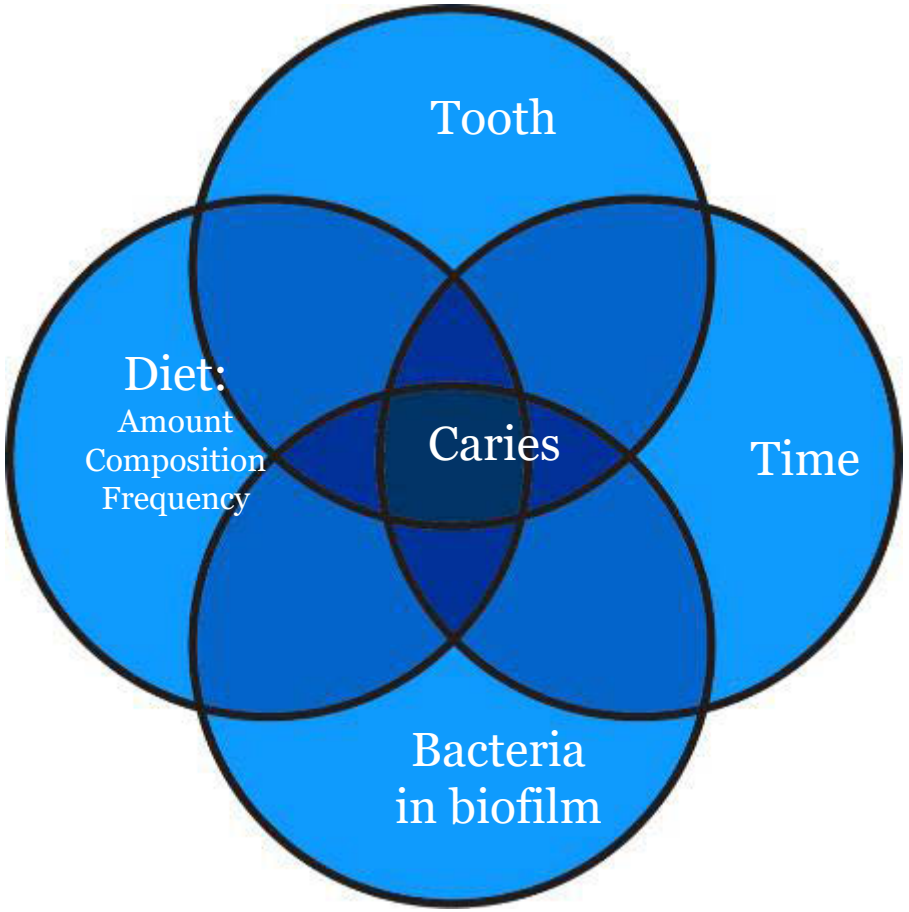
Dental Development: Non-Nutritive Sucking

- Considered a natural condition up to age 3, encourage cessation if habit persists after this age[11]
- To avoid long-term dental effects, discontinue habits before permanent teeth erupt



The Caries Process

- Tooth
- Bacteria
- Substrate (fermentable carbohydrates)
- + TIME

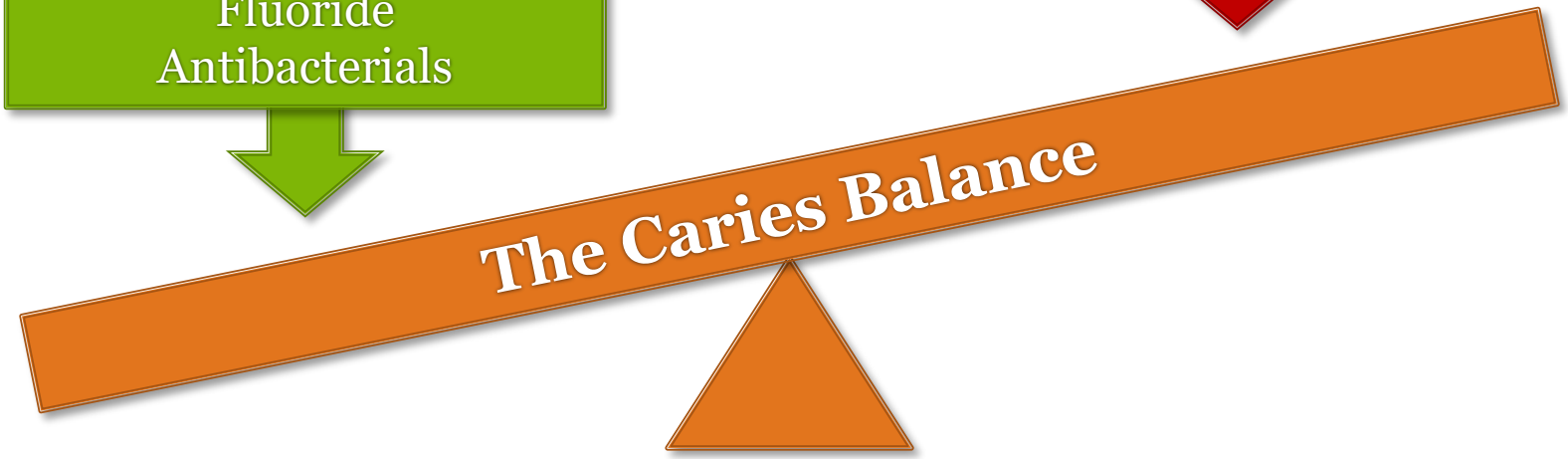


The Caries Process

The Caries Process

Pathologic Factors
Acid-producing Bacteria
Frequent Carbohydrates
Reduced Saliva

Protective Factors
Saliva
Fluoride
Antibacterials



NO CARIES

CARIES

Featherstone[12]

The Caries Process:

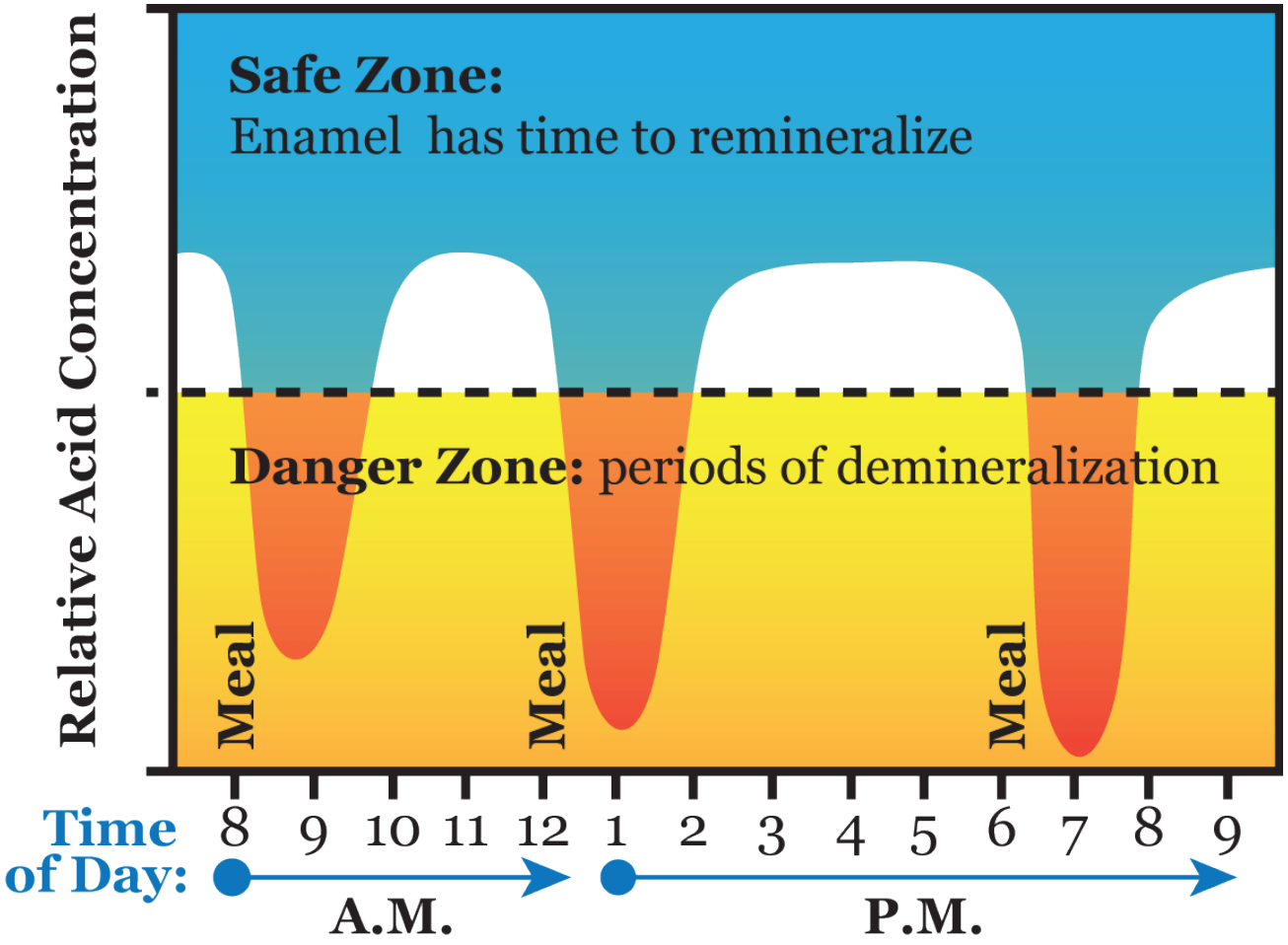
Frequency

- Oral Bacteria produce *acids* that persist for 20-40 minutes after eating
- Enamel demineralizes
- Cavitation occurs after sufficient demineralization

Saliva buffers acid attack and remineralizes teeth

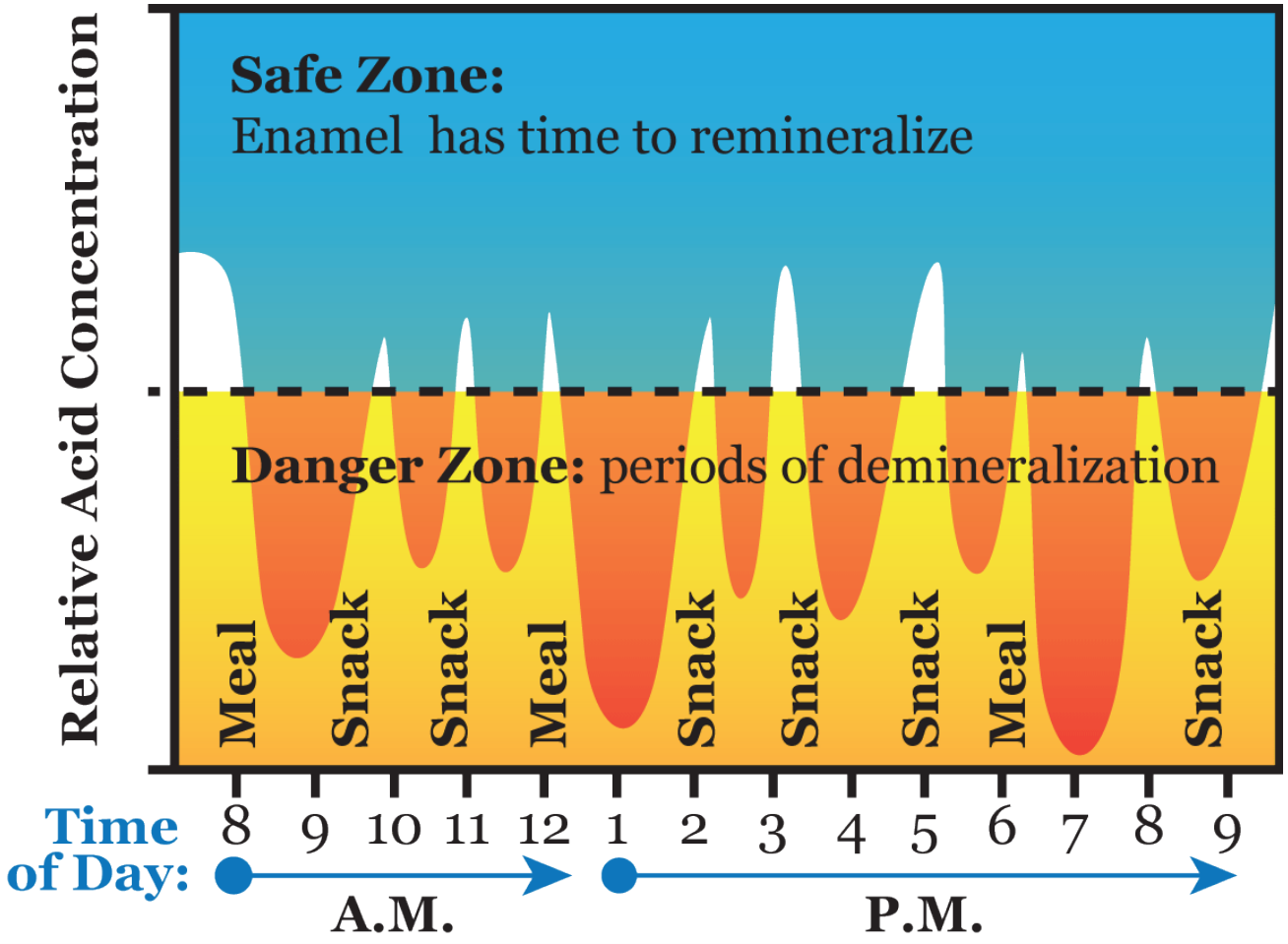
Given adequate remineralization time teeth will not decay

The Caries Process: normal meals



Limiting the FREQUENCY of high sugar/ carbohydrate foods and drinks is key

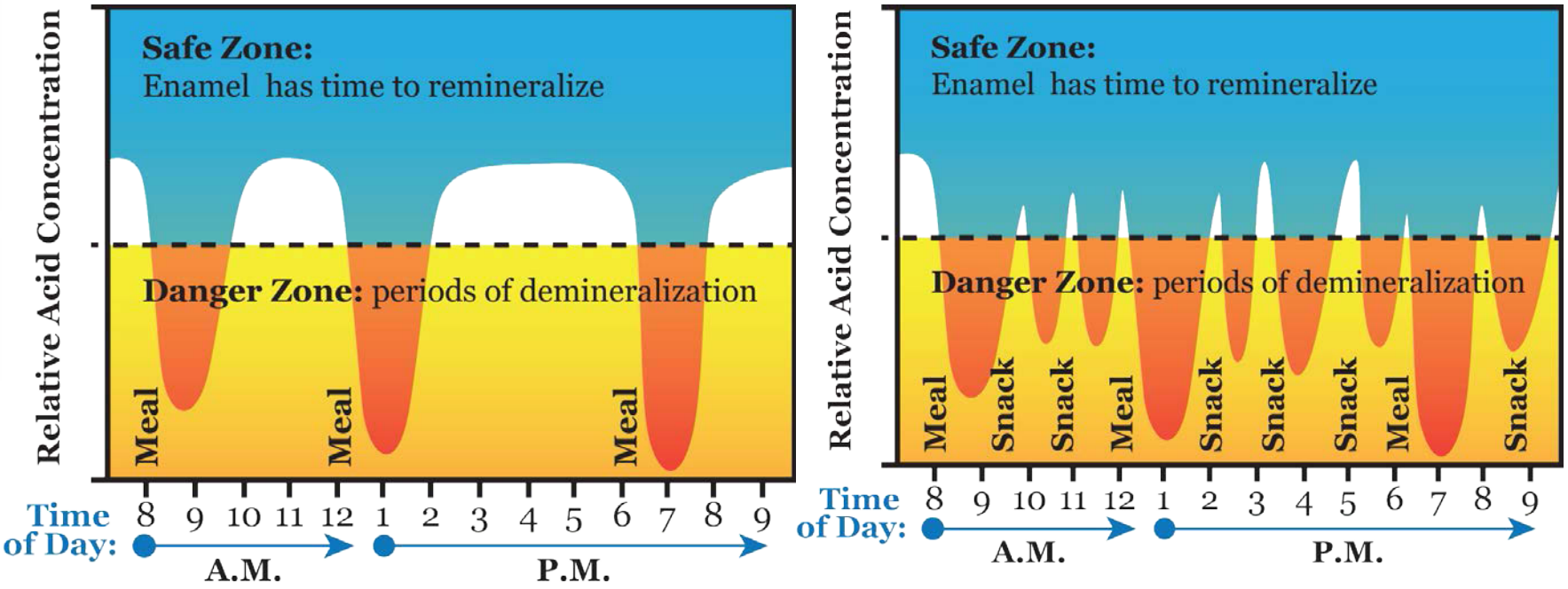
The Caries Process: snacking



Limiting the FREQUENCY of high sugar/ carbohydrate foods and drinks is key

The Caries Process:

normal meals vs. snacking/grazing



Nutritional Messages

- Limit cariogenic snacks between meals
- Encourage water between meals
  - Naturally cleanses the mouth & helps establish neutral pH
- Children should not carry around juice or soda pop in a bottle or sippy cup
- If a baby is put to bed with a bottle it should contain only plain water
- Nursing through the night or co-sleeping may put child at higher risk
  - Frequent or continuous feeding is problematic. Breast feeding as a meal is not[13-15]
  - Should increase oral hygiene efforts if parent wishes to do this

Healthy Snacks

Tooth-unhealthy Snacks

Cariogenic

Sweet & sticky foods are more likely to cause cavities.

(limit these snacks)

- Cookies
- Chips & pretzels
- Soda
- Juice and sports drinks
- Fruit roll-ups
- Sugary cereals
- Candy
- Crackers
- Dried fruit
- Bagels

Tooth-healthy Snacks

Low cariogenic

Whole grain or foods low in carbohydrates are less likely to cause cavities.

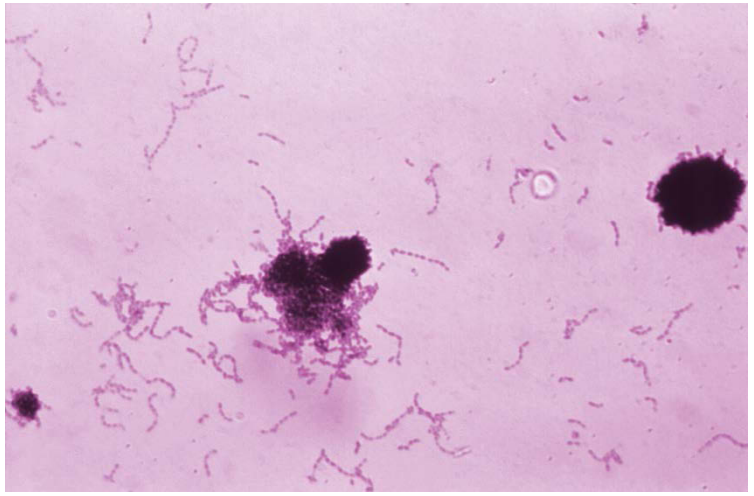
(choose these snacks)

- Vegetables
- Fresh fruits
- Cheese
- Peanut butter
- Whole grains
- Meat
- Nuts

Note: Snacks should be age appropriate

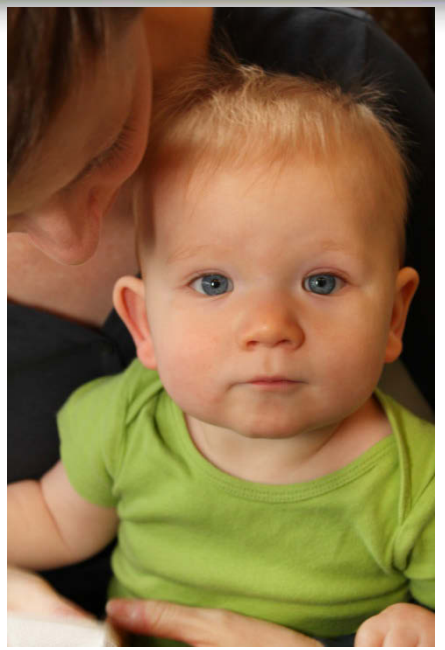
Transmission of Cariogenic Bacteria

- Streptococcus Mutans is transmitted from mom to baby
- Window of infectivity: 6-30 months of age[16]
- 20% of infants 12-16 months old are infected[17]
- Critically important for moms to practice good hygiene when baby's teeth emerge[18]



Streptococcus mutans. Gram stain. Used with permission of CDC, Dr. R. Facklam

Transmission of Cariogenic Bacteria



Transmission is natural

- DON'T—Decrease contact with infants
- DO—Decrease maternal strep mutans
- Encourage mothers to maintain optimal oral health—including good home and professional dental care
- Provide dental care to expectant mothers (covered by Medicaid)
- Recommend gum with xylitol 4-5 times/day

Early Childhood Caries (ECC)

- Process
- Appearance (examples follow)
- Risk Assessment
- Treatment or Referral

Early Childhood Caries (ECC)

Early Childhood Caries

The presence of one or more decayed noncavitated or cavitated lesions), missing (due to caries), or filled tooth surfaces in any primary tooth in a child under the age of six.[19]

Previously known as:

- Nursing Caries
- Baby Bottle Tooth Decay

Risk Assessment

- Dental caries is not equally distributed within the US population
- Identifying and targeting high risk children enables more efficient prevention

Risk Factors

- Lack of fluoride exposure
- Frequent feeding/snacking on fermentable carbohydrates
- Low Socioeconomic Status (SES) and cultural factors
- Child, sibling, or family history of decay
- No established dental home
- Chronic medical conditions (Special Health Care Needs)
- Poor oral hygiene
- Enamel defects (Low Birth Weight/ Premature birth)[20]

Caries Risk Assessment Form (Age >6)

Patient Name: **Score:**
Birth Date: **Date:**
Age: **Initials:**

		Low Risk (0)	Moderate Risk (1)	High Risk (10)	Patient Risk
	Contributing Conditions				
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**	
III.	**Caries Experience of Mother, Caregiver** and/or other **Siblings** (for patients ages 6-14)	No carious lesions in last 24 months	Carious lesions in last 7-23 months	Carious lesions in last 6 months	
IV.	**Dental Home**: established patient of record, receiving regular dental care in a dental office	Yes	No		
	General Health Conditions				
I.	**Special Health Care Needs***	No	Yes (over age 14)	Yes (ages 6-14)	
II.	**Chemo/Radiation Therapy**	No		Yes	
III.	**Eating Disorders**	No	Yes		
IV.	**Medications that Reduce Salivary Flow**	No	Yes		
V.	**Drug/Alcohol Abuse**	No	Yes		
	Clinical Conditions				
I.	**Cavitated or Non-Cavitated** (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	No new carious lesions or restorations in last 36 months	1 or 2 new carious lesions or restorations in last 36 months	3 or more carious lesions or restorations in last 36 months	
II.	**Teeth Missing Due to Caries in past 36 months**	No		Yes	
III.	**Visible Plaque**	No	Yes		
IV.	**Unusual Tooth Morphology** that compromises oral hygiene	No	Yes		
V.	**Interproximal Restorations - 1 or more**	No	Yes		
VI.	**Exposed Root Surfaces** Present	No	Yes		
VII.	**Restorations with Overhangs** and/or **Open Margins**; **Open Contacts** with Food Impaction	No	Yes		
VIII.	**Dental/Orthodontic Appliances** (fixed or removable)	No	Yes		
IX.	**Severe Dry Mouth (Xerostomia)**	No		Yes	
				TOTAL:	

Patient Instructions:

*Patients with developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers.

ADA American Dental Association®

Low Socioeconomic Status

- Eligibility for Government Programs (Women Infants and Children [WIC], Head Start, Medicaid or State Children's Health Insurance Program)may be a good indicator
- Children of low socioeconomic status experience the majority of tooth decay
- There is a high prevalence of dental caries in children of low SES
  - Approximately 40% of 3 year olds enrolled in WIC or Head Start had tooth decay
  - This compares to 21% of 3 year olds from more affluent families [3, 21, 22]

Enamel Defects

- Low birth weight (less than 2500g, 5.5 lbs) is correlated with enamel defects/hypoplasia[23]
- Hypoplastic teeth are more susceptible to tooth decay[24-26]

Chronic Medical Conditions

Children with special healthcare needs are at higher risk for decay

- Enamel quality may be affected in these children
- Frequent feedings may be necessary
- Medications often contain sugar and affect saliva quality and quantity
- Oral aversion may impede home care
- Motor skills maybe be delayed
  - longer use of the bottle
  - unable to brush

ECC Characteristics

- Involves primary dentition
- Usually affects maxillary incisors first
  (often lingual surfaces)
- Lesions can progress rapidly because enamel on primary teeth is thinner than on permanent teeth
- Children with enamel hypoplasia at high risk

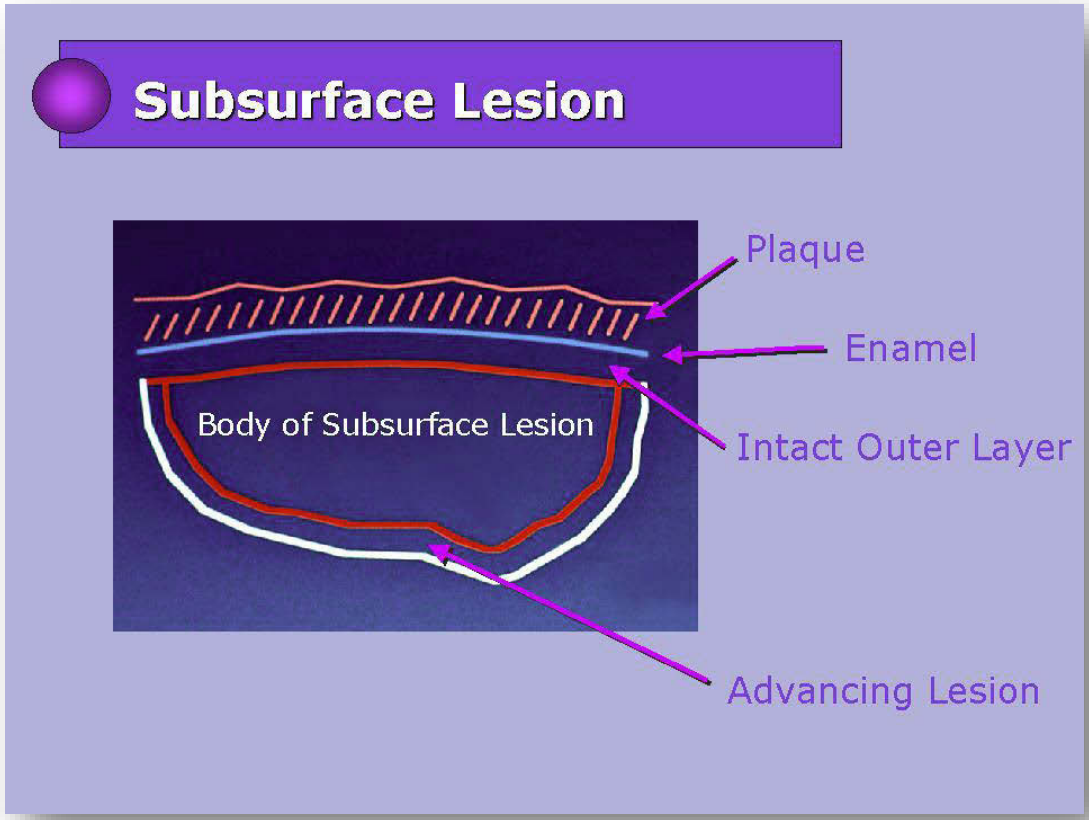
ECC Stages

- White Spot Lesion
- Mild Decay
- Moderate Decay
- Severe Decay

The White Spot Lesion

The White Spot Lesion

- White appearance is earliest visual sign of demineralization
- Critical period for prevention of cavitation through fluoride application
- White spots can be remineralized



Mild Decay

Moderate Decay

Severe Decay

Lesions often located on maxillary anterior lingual surfaces

These must be carefully examined

Fluoride

- Alters Bacterial Enzymes
- Decreases Enamel Solubility
- Attracts Calcium and Phosphate

Fluoride

Systemic

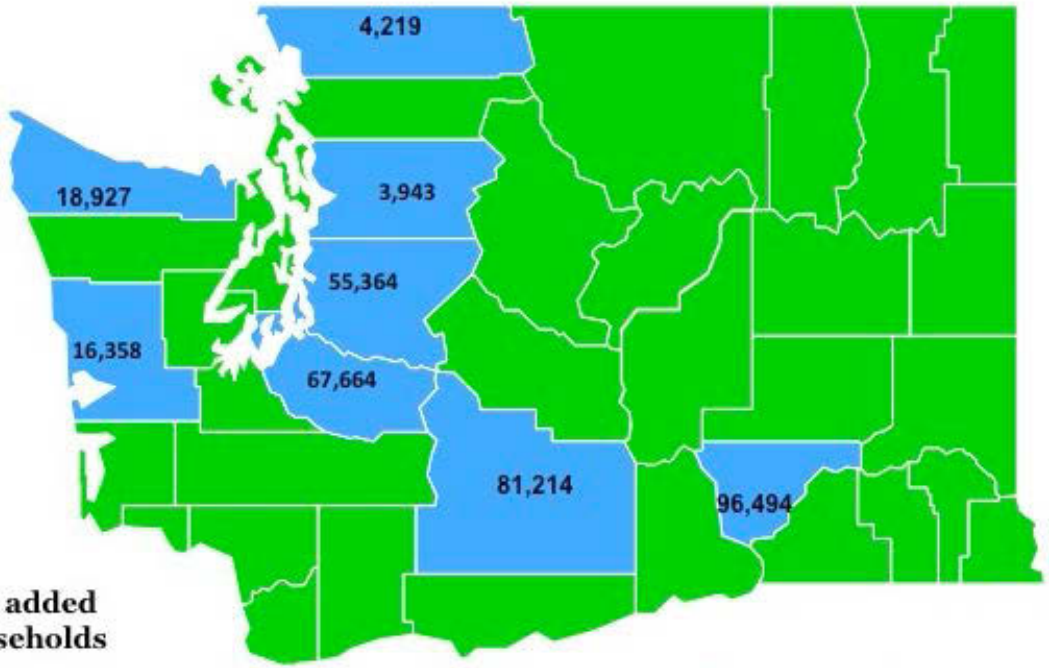
- supplements
- water fluoridation

Topical

- toothpaste
- rinses
- professional applications (varnish, foam, gels)
- supplements
- water fluoridation

Water Fluoridation

65% of Washington's residents on public water supplies receive fluoridated water – compared to 74% nationally[27]



Since 1999 – added 344,183 households

Blue shaded counties = success area

Community Water Fluoridation:

- Reduces tooth decay by between 25 to 40 percent in communities[28]
- New *proposed* recommendation is 0.7 parts per million nationwide, decreased from the original 1.2-0.7 parts per million[29]
- Initial recommendations were made in an era when fluoride was found primarily in water
- New recommendation allows for continued optimal fluoride benefits and limits risk of fluorosis in light of additional exposure from other sources like toothpaste, professional products, or food

Fluoride Supplementation

- May provide increased protection when used appropriately
- Supplements should be prescribed:
  - only to children who reside and drink the majority of their water from non-fluoridated sources
  - only after assessing the child's total fluoride exposure
  - only to children determined to be at high risk[30]
- For list of WA. water systems w/fluoride:

www.doh.wa.gov/Portals/1/Documents/4200/fluoride-data.xls

Fluoride Supplementation

Age	Fluoride Ion Level In Drinking Water (PPM)*		
	<0.3	0.3-0.6	>0.6
Birth-6 months	None	None	None
6 months-3 years	0.25 mg/day**	None	None
3-6 years	0.50 mg/day	0.25 mg/day	None
6-16 years	1.0 mg/day	0.5 mg/day	None

*1.0 part per million (ppm) = 1 milligram per liter (mg/l)
**2.2 mg sodium fluoride contains 1 mg fluoride ion

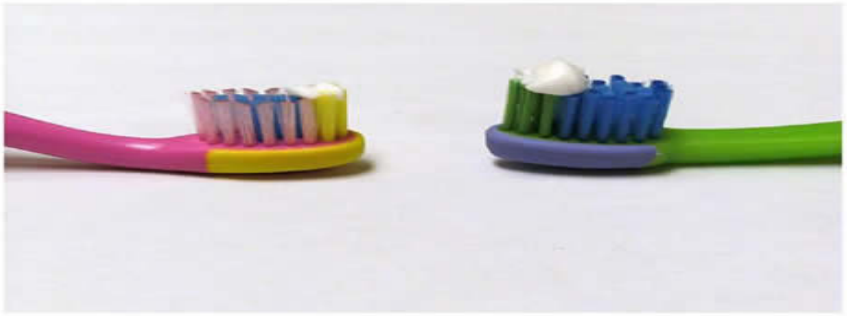
Fluoride Toothpaste

Over the Counter Fluoride Toothpaste = 1000-1100 PPM Fluoride

- Children under age 7 have been shown to swallow approximately 1/2 of toothpaste used for brushing[31]
- Dosing fluoride toothpaste is critical

Under Age 2 = smear for moderate/high caries risk children

Age 2 + pea size = amount for all children (twice daily)[10]



Oral Hygiene

Oral Hygiene is a Supervised Event

- Most children under age 8 cannot adequately brush teeth

Use of Fluoridated Toothpaste Twice Daily

- Smear: Moderate/High risk children under age 2
- Pea Size: All Children 2 and over[10]

Injury Prevention and Trauma

- Child proofing the home
- Seatbelts/Car seats
- Mouthguards (older children)
- Treatment of a dental injury
  - Don't replant primary teeth
  - Contact dentist immediately in case of emergency

Learning Objective #3:

- The knee-to-knee technique
- Lift the lip exam
- Fluoride varnish application

Knee-to-Knee Exam

- Provides good positioning for oral exam and varnish application
- Allows parent to visualize mouth as dentist demonstrates oral hygiene techniques
- Parent can use at home to perform oral hygiene

Prepare for the Exam

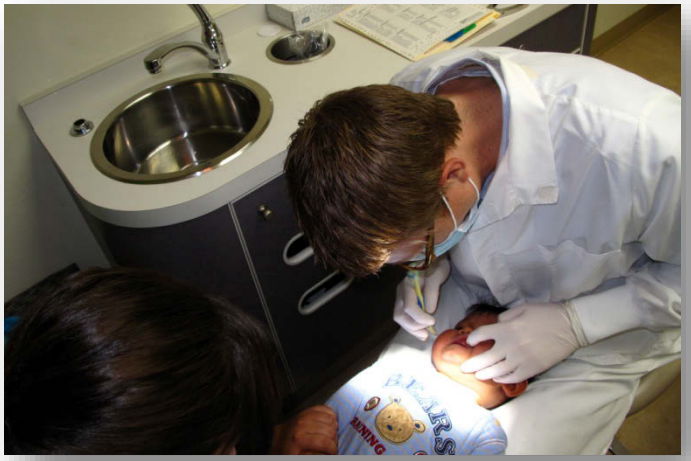
- Have materials ready *before* examination
  - Light, mirror, gauze, etc.
- Discuss items of anticipatory guidance *before* examining child
  - Child may be disruptive after, and conveying message can be difficult
- Let parents know that child may cry or be fussy
  - While it may distress parent, this is typical behavior for young children

Knee-to-Knee Exam Steps

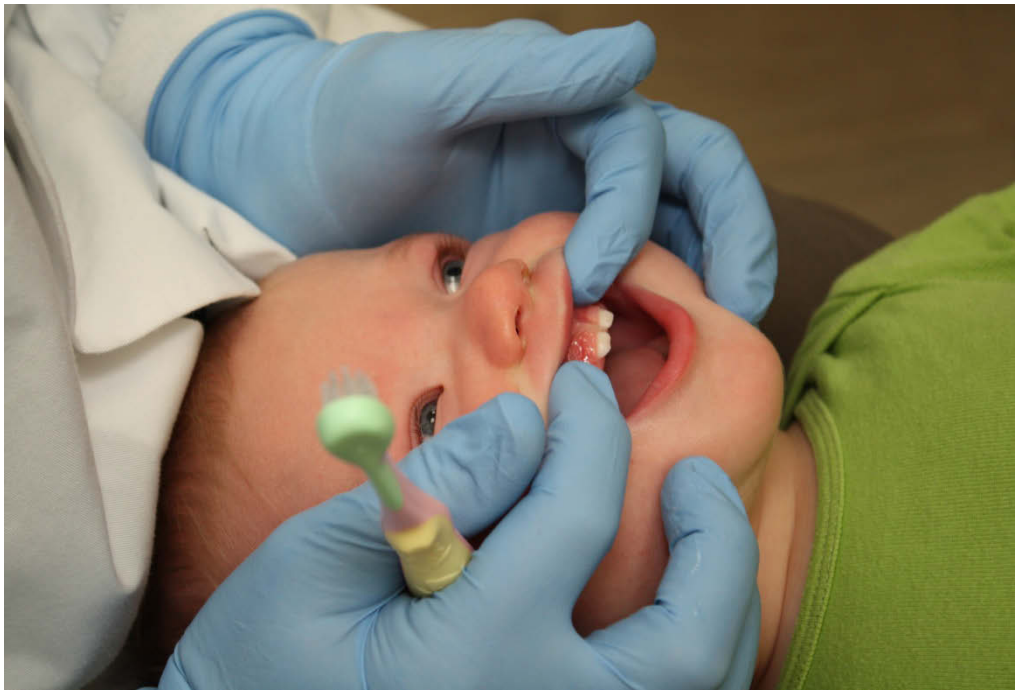
1. Place the child in the knee-to-knee position
2. Use toothbrush to prompt the child to open their mouth
3. Place mirror in child's cheek to prevent it from fogging up
4. Examine the front surfaces of 4 upper front teeth
5. Using the mirror, examine the back surfaces of 4 upper front teeth
6. Examine the rest of the mouth, using the mirror where appropriate

Lift the Lip Exam Steps

1. Parent and the examiner sit knee-to-knee
2. Parent places the child on their lap facing the parent
3. Parent puts child's legs around the parent's waist and secures the child's legs under their arms
4. Child is tipped back into the examiner's lap
5. Parent holds the child's hands
6. Examiner stabilizes the child's head with one hand and "lifts the lip" with the other



Lift the Lip Exam



- Is easy for staff and parents to use
  - Teach parents through the exam
  - Demonstrate brushing during the exam
- Front teeth can be screened quickly for decay and plaque

Helpful Hints

- Enlist parent's support and assistance
- Start with a toothbrush
- Begin with the child sitting up, gain their confidence, then transition to reclined position
- Identify people on your team who are effective with infants and toddlers

Fluoride Varnish Efficacy

22,600 PPM Fluoride

Research shows 38% caries reduction in populations who received fluoride varnish[32]

Fluoride Varnish Safety

Blood plasma levels of fluoride following varnish treatment:

- comparable to those found after brushing with fluoridated toothpaste
- considerably lower than APF gel[33]

Risk of fluorosis is minimal because children are infrequently exposed and ingestion is limited[32]

Fluoride Varnish

- Safe
- Effective
- Quick Application

Fluoride Varnish

- Can be applied by dentists, dental hygienists, and assistants during dental visits
- Primary care medical providers can apply fluoride varnish during well-child visits
- Dental Practice can bill Medicaid 3 times a year
  - Low Risk Children: May not have any increased benefit
  - Moderate Risk Children: Apply every 6 months
  - High Risk Children: Apply every 3-6 months[34]

Fluoride Varnish

- Dry tooth facilitates fluoride uptake
- Sets on contact with moisture
- Not rendered inactive by plaque
- Taste is tolerable

Fluoride Varnish Application

- Have everything ready
- Place child in the knee-to-knee position and lift the lip

Fluoride Varnish Application

Dry Teeth with
Cotton Gauze

Fluoride Varnish Application

- Apply Fluoride With Disposable Applicator
- Cover All Surfaces of the Dry Teeth
- Focus Efforts on Highest Risk Areas First: Maxillary Anterior

Post Varnish Instructions

- Teeth may appear yellowish temporarily after application
- Do not brush teeth until the next day
- Children can eat or drink immediately after a varnish application
- Avoid crunchy foods for the rest of the day

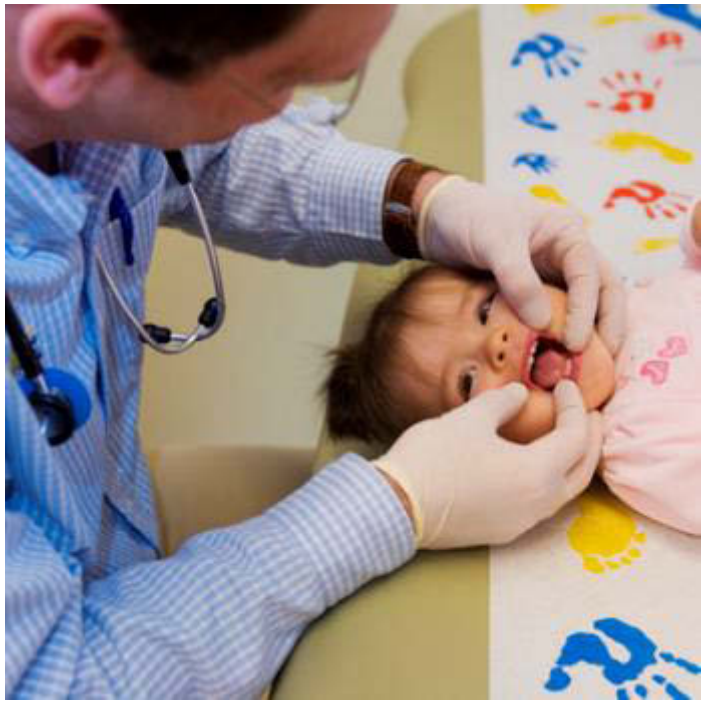
Learning Objective #4:

The importance of building primary medical care and pediatric dentistry specialty care relationships

Partners in Prevention

- Infants/toddlers have approximately 12 well-child visits by age 3[35]
- First dental screening by age 1 is recommendation by medical and dental professional associations
- Primary care medical providers may provide:
  - Screening
  - Risk Assessment
  - Family oral health education/ anticipatory guidance
  - Fluoride varnish treatment
  - Referral to a dental provider

Benefits of Collaboration



- Increases the number of young children receiving oral prevention services & early intervention
- Increases awareness of the importance of oral health in the medical community
- Builds strong and sustaining dental practices
- Promotes collaboration with primary medical providers-especially for patients with chronic medical conditions
- Can increase referrals to ABCD providers

Develop Relationships With Pediatric Dentist Colleagues

- When you begin seeing more young children you will encounter dental decay in primary teeth
- Specialist colleagues may be able to help coach you and/or provide treatment in cases where you are not comfortable

How to Make ABCD/Medicaid Work in Your Practice: Mercer Advisors Survey Operational Strategies

Characteristics of Washington practices surveyed that were successful in incorporating Medicaid insured patients included:

- smooth predictable patient flows
- quality, efficient care with good staff-skills mix
- staff commitment to serving Medicaid-insured patients
- streamlined billing procedures (electronic claims submissions)
- metrics tracking

How to Make ABCD/Medicaid Work in Your Practice: Mercer Advisors Survey Operational Strategies

The surveyed Medicaid practices maintained high volume and a healthy patient mix by:

- Using associates and making full use of expanded-function hygienists and dental assistants
- Operating efficient practices with economies of scale
- Generate additional revenue from underutilized capacity (“empty chairs”)

Learning Objectives

1. The ABCD program history, goals, components, and services
2. Dental Health Messages
3. The knee-to-knee technique, lift the lip exam, and fluoride varnish application
4. The importance of building primary medical care and pediatric dentistry specialty care relationships

For Further Information or Assistance

ABCD Curriculum or Treatment Questions:

- Your local ABCD Champion
- ABCD Educational Coordinator, UW Department of Pediatric Dentistry (206) 543-4885

The local ABCD Program, changes in numbers of clients you can accept and issues in working with families:

- Your local ABCD program Coordinator

For Further Information or Assistance

Medicaid billing and Family Eligibility:

- Washington Health Care Authority Dental Program Manager Janice Tadeo, 360-725-1583
- Janice.tadeo@hca.wa.gov

Other ABCD Program Questions and Issues

- State ABCD Program Managing Director, Arcora Foundation
- Kathy O'Meara-Wyman 509-307.8929
- kathyomw@gmail. com

Resources for Offices

American Academy of Pediatric Dentistry Fluoride Recommendations:

http://www.aapd.org/media/Policies_Guidelines/G_fluoridetherapy.pdf

Order free parent/caregiver materials through Arcora Foundation:
http://ddwa.force.com/brochureswebform

- Brochure: Taking Care of Your Child's Baby Teeth (5 languages)
- Brochure: Cavity Free for Baby and Me (3 languages)
- Poster (English and Spanish): Healthy Snacking/Give Your Teeth a Chance

Kidsoralhealth.org website

More information about taking care of children's baby teeth, healthy nutrition & dental resources

Parting Thoughts….

"My staff is proud of our involvement with ABCD and we enjoy seeing the improved oral health when these youngsters come back for recall."

—Jared Evans, DDS
Spokane County ABCD Champion

"I'm proud to be part of such a clearly effective and well-run program."

—Jeff Hays, DDS
Kitsap County ABCD Champion

Parting Thoughts

"ABCD's emphasis on prevention is making a huge difference in our state, not only for young children but for all Washingtonians."

—Representative Larry Seaquist
26th Legislative District

Access to Baby & Child Dentistry

DENTAL TRAINING

the center for pediatric dentistry

The University of Washington Department of Pediatric Dentistry developed this training with funding from the Washington Dental Service Foundation

SCHOOL OF DENTISTRY

UNIVERSITY of WASHINGTON

DELTA DENTAL

Washington Dental Service Foundation

Community Advocates for Oral Health

Photo Credit

Dr. Simon Lin

Dr. Travis Nelson

Dr. Rebecca Slayton

Washington Dental Service Foundation

Access to Baby & Child Dentistry

DENTAL TRAINING

the center for pediatric dentistry

On behalf of Washington's Children, Thank you!

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Documentation example for use of protective stabilization

Billing code D9920

Diagnosis/Problem list:

- Difficult behavior management
- Difficulty with homecare

Treatment performed today:

Verbal consent obtained from Mom to utilize a medium safety immobilization device, the patient's head was stabilized by an additional head holder. The duration of procedure was approximately 10 minutes

Behavior:

(-/-) verbal consent from mom to use PB, used medium PB. Pt cried throughout exam, and cleaning but recovered afterwards

Documentation examples for Family Oral Health Counselling

ABCD oral health counselling: **Billing code D9999**

Elements to include in chart notes:

- Lift the Lip training Y/N
- Oral hygiene training Y/N
- Caries Risk Assessment Y/N (describe)
- Fluoride use /supplementation (describe)
- Injury prevention
- Family member present
- Time spent counselling

UW Documentation examples for Family Oral Health Counselling

ABCD oral health counselling: **Billing code D9999**

Oral health education provided to: mother/father/guardian

Duration: 10 minutes

Risk Assessment:

- Caries risk: low/moderate/high
- Caries history for siblings:
- Oral health of parents/guardians:

"Lift the Lip" Training:

- Parents demonstrated "lift the lip"
- Parent states comfort with doing this once a month

Tooth Cleaning Training:

- Demonstrated proper amount of toothpaste
- Demonstrated positioning of child
- Parent demonstrated tooth brushing

Dietary Counseling

- Discussed use of cup by 12 months of age
- Discussed use of cup when drinking anything sweet
- Discouraged use of bottle at bedtime except for water
- Discussed healthy snacks: cheese, fruit, veggies

UW Documentation examples for Family Oral Health Counselling

continued:

ABCD oral health Billing code D9999

Fluoride use/supplementation

Drinks fluoridated/bottled water

Fluoride supplements are/are not indicated

Anticipatory guidance

Discussed importance of primary teeth

Discussed dental development and timing

Explained the caries process

Oral hygiene recommendations given – brushing 2 times daily with fluoride toothpaste

Fluoride benefits explained

Injury prevention and trauma discussed including car seats, bike helmets, and athletic mouth guards