

# Take a 1<sup>st</sup> Look A Healthy Smile = A Healthy Child

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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Alabama Chapter

## July 2014

Produced by the Alabama Department of Public Health  
Video Communications and Distance Learning Division

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# Faculty Disclosure

Please note that the speakers, Richard Simpson, DMD, and Grant R. Allen, MD, FAAP:

A. DO intend to discuss commercial products or services (fluoride varnish).

B. DO intend to discuss non-FDA approved uses of products/providers of services (fluoride varnish).

C. Do NOT have any relevant financial relationships or affiliations related to this topic.



# Dental Fluoride Varnishing and Oral Assessment Program for Pediatricians



# **Module 2: Child Oral Health**

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# Smiles for Life

*A national oral health curriculum*

Module 2:

## Child Oral Health



Third Edition June 2010  
[www.smilesforlifeoralhealth.org](http://www.smilesforlifeoralhealth.org)

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# Oral Health Risk Assessment Training for Pediatricians and Other Child Health Professionals

- Developed by American Academy of Pediatrics Pediatrics Collaborative Care (PedCare) Program
- Supported by the Maternal and Child Health Bureau, Health Resources and Services Administration Department of Health and Human Services

**U93MC00184**

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Alabama Chapter

# Child Health Professionals' Role in Promoting Oral Health

- See children early and regularly
- Become experts in oral health prevention strategies
- Advocate for child health
  - Oral health is part of overall health!



# **AAP Recommendations for an Oral Health Risk Assessment**

- **Assess mother's / caregiver's oral health**
- **Assess oral health risk of infants and children**
- **Recognize signs and symptoms of caries**
- **Assess child's exposure to fluoride**

# **AAP Recommendations for an Oral Health Risk Assessment**

- **Provide anticipatory guidance and oral hygiene instructions**
  - **Brush / floss**
- **Make timely referral to a dental home**

# **Educational Objectives**

- **Discuss the prevalence, etiology, and consequences of Early Childhood Caries (ECC)**
- **Recognize the various stages of ECC on oral examination**
- **Assess a child's risk of developing ECC**

# **Educational Objectives**

- **Implement prevention of ECC through use of fluoride, proper hygiene, diet, and appropriate dental referral**
- **Manage other oral conditions in pregnancy**
- **Understand the safety of common dental interventions in pregnancy**
- **Discuss common dental developmental issues in children and offer appropriate guidance to parents**

# Early Childhood Caries

- **Chapter Objectives**
  - **Discuss the prevalence, etiology, and consequences of early childhood caries**
  - **Recognize the various stages of ECC during an oral examination**

# What is ECC?

- **Etiology**
  - **Infectious, chronic disease that destroys tooth structure leading to loss of chewing function, pain, and infection**
  - **A variety of feeding habits beyond just nursing or bottle use are implicated**
  - **Affects 35% of 3 year olds from low income families**

# What is ECC?

- Progression
  - Upper front teeth that are least protected by saliva are affected first
  - Disease moves posteriorly as teeth erupt



# Prevalence

- **ECC is the most common chronic disease in children and is five times more common than asthma**
- **30 - 50 % of low income children have ECC**
- **ECC prevalence in children 2 to 5 years old increased from 24% in 1988 – 1994 to 28% in 1999 – 2004**

# Prevalence

- 80 % of decay occurs in 20% of children
- Up to 70% of Native American children may have ECC



# Children with Caries as Infants and Toddlers

- 80% of teeth go untreated if living in poverty
- Will continue to develop new caries at an annual rate at least twice that of preschoolers without caries
- Caries likely larger, more rapidly progressing, with higher potential for pain or other complications

# Factors Necessary for Caries

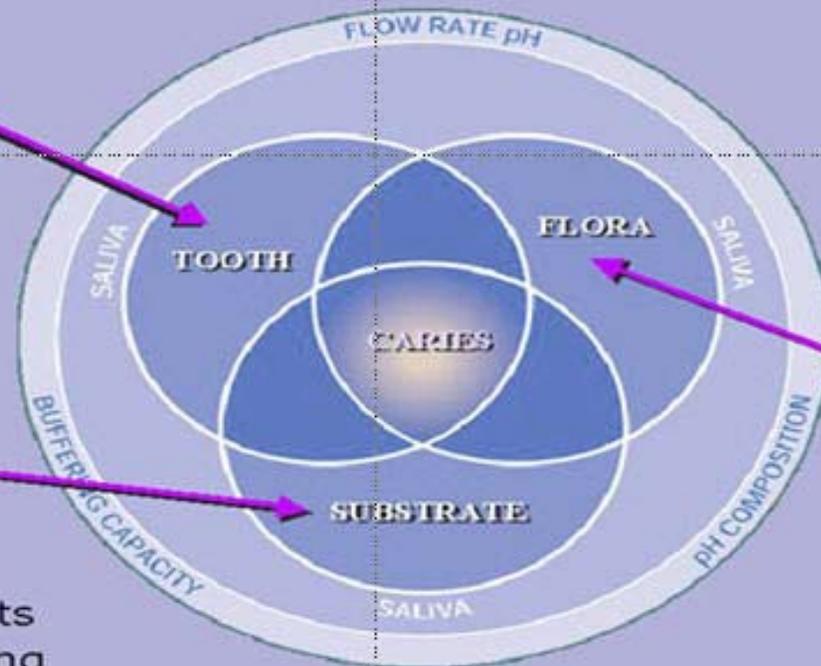
## Dental Caries: Etiology

### TOOTH

Age  
Fluorides  
Morphology  
Nutrition  
Trace Elements  
Carbonate Level

### SUBSTRATE

Oral Clearance  
Oral Hygiene  
Salivary Stimulants  
Frequency of Eating  
Carbohydrate (type, concentration)



*Strep mutans*  
(Substrate)  
Oral Hygiene  
Fluoride in  
Plaque

# **Etiology: Bacteria**

- **Etiology**
  - **Mutans streptococci is vertically transmitted from the primary caregiver, typically the mother**
  - **Transfer is thought to occur via saliva contact**
  - **The higher the bacteria level in the caregiver's mouth, the more likely the child will become colonized**

# **Etiology: Bacteria**

- **Caregivers can decrease the risk of passing bacteria to children by:**
  - **Receiving regular comprehensive dental care**
  - **Limiting the frequency of sugar in the diet**
  - **Maintaining excellent oral hygiene and using a fluoride containing toothpaste**

# **Etiology: Bacteria**

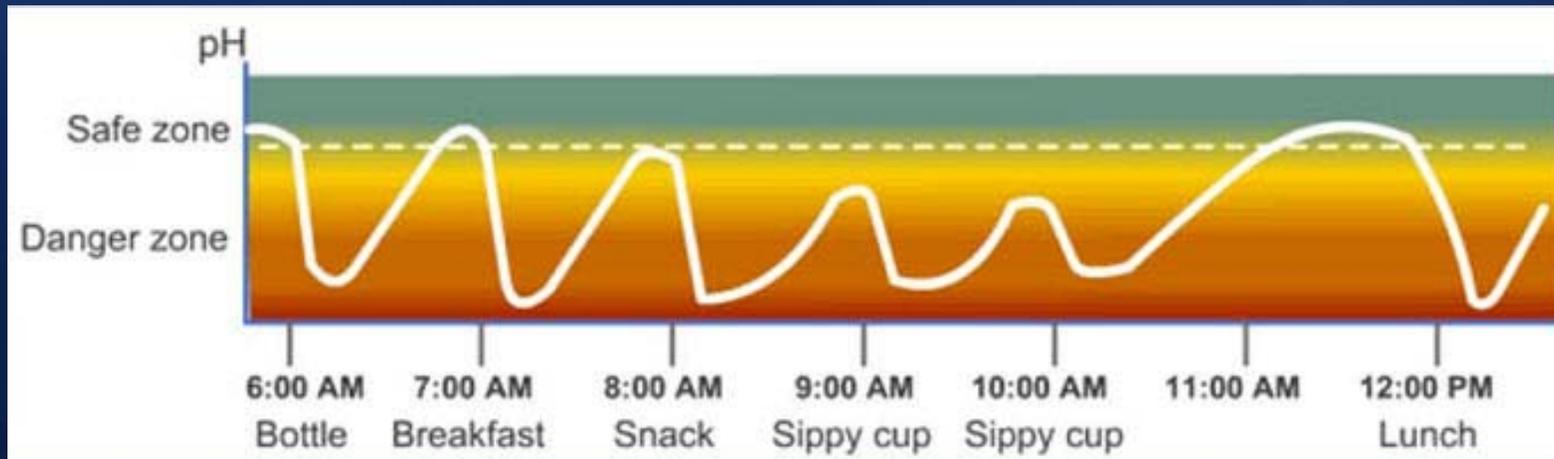
- Using preventive agents such as topical fluorides, antibacterial mouth rinses, and xylitol containing gums in appropriate age groups**

# **Etiology: Sugars**

- **It is not just WHAT, but HOW children eat**
  - **Oral bacteria produce acids that persist for 20 – 40 minutes after sugar ingestion**
  - **Oral acids lead to enamel demineralization**

# Etiology: Sugars

- Remineralization occurs when acid is buffered by saliva
- If sugars are consumed frequently, there is insufficient time for remineralization to occur



# Breastfeeding

- The AAP and AAPD strongly endorse breastfeeding
- Although breast milk alone is not cariogenic, it may be when combined with other carbohydrate sources
- For frequent night time feedings with anything but water after tooth eruption, consider an early dental home referral

# Etiology: Teeth

- **Nature of enamel defects**
  - **20 to 40% of children have enamel defects**
  - **Defects may appear as changes in translucency, color, or texture**
  - **May be difficult to distinguish enamel defects from early clinical signs of caries (right photo)**

# Etiology: Teeth

- Diagnosis is immaterial as it does not affect management
- Enamel defects are associated with substantially increased risk of ECC



# Healthy Teeth

- **Nature of healthy teeth**
  - **Creamy white with no signs of deviation in color, roughness, or other irregularities**
  - **If the clinician cannot determine whether an abnormality in the tooth surface is a defect versus an early cavity, it does not matter**

# Healthy Teeth

- Any child with enamel abnormalities is at high risk for caries and should be referred to a dentist for further evaluation



# White Spots

- **Appearance and Symptoms**
  - **White spots and lines are the first clinical signs of demineralized enamel**
  - **Typically begins at the gingival margin**
  - **If the disease process is not managed, lesions will progress to cavities that are initially yellow**

# White Spots

- Treatment
  - Immediate dental referral
  - Dietary and oral hygiene counseling
  - Topical fluoride to reverse or arrest lesions



# Brown Cavitations

- Appearance and Symptoms
  - Brown cavitations represent areas where loss of enamel has exposed underlying dentin
  - Lesions darken as they become stained with pigments from food
- Treatment
  - Immediate dental referral

# Brown Cavitations

- Lesions are small enough that simplified restorative techniques that do not use high speed drills and local anesthesia can be used
- Dietary and oral hygiene counseling
- Topical fluoride to arrest lesions not requiring restorations



# Early Aggressive ECC

- Appearance and Symptoms
  - Abscesses and fistulae may be present
  - Patient may experience pain, but children may be too young to accurately verbalize it

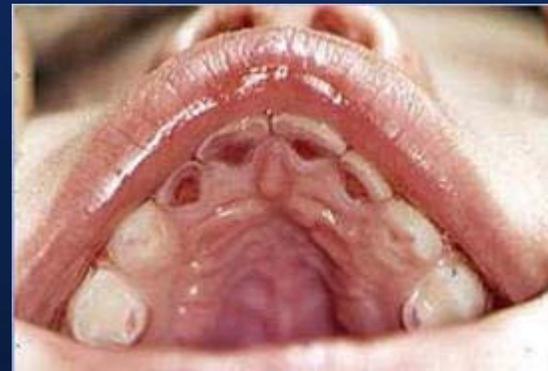


# Early Aggressive ECC

- **Treatment**
  - **Urgent dental referral for comprehensive treatment including extractions and / or silver crowns**
  - **Dietary and oral hygiene counseling**
  - **Topical fluoride to prevent development of new lesions**

# Advanced ECC

- Appearance and Symptoms
  - Multiple dark cavities appear in anterior and posterior teeth
  - Possible for abscesses and draining fistulae to be present
  - Patients may experience pain



# Advanced ECC

- **Treatment**
  - **Urgent dental referral for comprehensive treatment including extractions and / or silver crowns**
  - **Dietary and oral hygiene counseling**
  - **Use of fluoride to prevent development of new lesions**

# Caries Progression

- ECC affects the teeth that erupt early and are least protected by saliva
- Order of Progression
  - Upper incisors
    - Maxillary anterior teeth
  - First molars
    - Mandibular primary molars

# Caries Progression

– Second molars

- Maxillary primary molars



# Early Childhood Caries can Lead to...

- Extreme pain
- Spread of infection
- Difficulty chewing, poor weight gain
- Extensive and costly dental treatment
- Risk of dental decay in adult teeth
- Crooked bite (malocclusion)



# Consequences of Dental Caries

- Missed school days
- Impaired speech development
- Inability to concentrate in school
- Reduced self - esteem
- Possible systemic illness for children with special health care needs

# Why is it Important?

- 80% of ECC occurs in 20% of children
- Oral health risk assessment should begin around 4 to 6 months, just before the first tooth erupts
- A child's risk status determines
  - Age of first dental visit
  - Use of fluoride
  - Depth of nutritional and hygiene counseling provided

# High-Risk Groups for Caries

- Children with special health care needs
- Children from low socioeconomic and ethnocultural groups
- Children with suboptimal exposure to topical or systemic fluoride
- Children with poor dietary and feeding habits

# High-Risk Groups for Caries

- Children whose caregivers and/or siblings have caries
- Children with visible caries, white spots, plaque, or decay



# Children With Special Health Care Needs (CSHCN)

- **Recommendations for Child Health Professionals**
- **Be aware of oral health problems / complications associated with medical conditions**
- **Monitor impact of oral medications and therapies**

# Children With Special Health Care Needs (CSHCN)

- Choose non - sugar - containing medications if given repeatedly or for chronic conditions
- Refer early for dental care
  - Before or by age 1 year
- Emphasize preventive measures



# **Common Issues Among Children With Special Health Care Needs**

- **Children with asthma and allergies are often on medications that dry salivary secretions increasing risk of caries**
- **Children who are preterm or low birth weight have a much higher rate of enamel defects and are at increased risk of caries**

# Common Issues Among Children With Special Health Care Needs

- Children with congenital heart disease are at risk for systemic infection from untreated oral disease

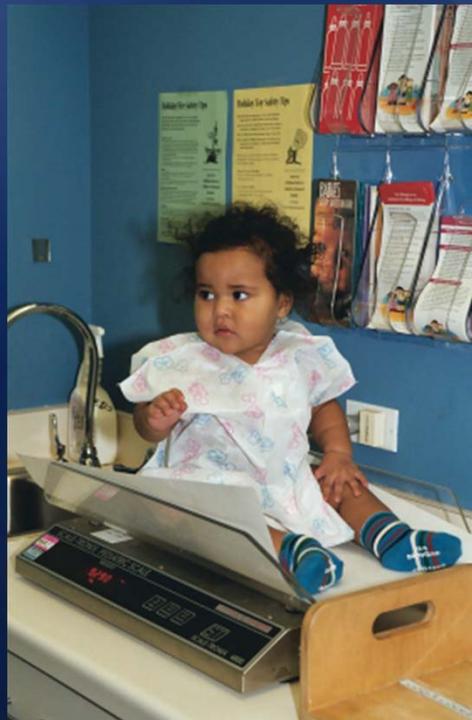


# **Socioeconomic Factors**

- **The rate of early childhood dental caries is near epidemic proportions in populations with low socioeconomic status**
  - **No health insurance and / or dental insurance**
  - **Parental education level less than high school or GED**

# Socioeconomic Factors

- Families lacking usual source of dental care
- Families living in rural areas



# Ethnocultural Factors

- Increased rate of dental caries in certain ethnic groups
- Diet / feeding practices and child - rearing techniques influenced by culture



# Child Oral Health Assessment

- Prepare for the examination
  - Provide rationale
  - Describe caregiver role
  - Ensure adequate lighting
  - Assemble necessary equipment



# Positioning Child for Oral Examination

- Position the child in the caregiver's lap facing the caregiver
- Sit with knees touching the knees of the caregiver
- Lower the child's head onto your lap
- Lift the lip to inspect teeth and the soft tissue

# Positioning Child for Oral Examination



# What To Look For

- Lift the lip to inspect soft tissue and teeth
- Assess for
  - Presence of plaque
  - Presence of white spots or dental decay
  - Presence of tooth defects (enamel)
  - Presence of dental crowding

# What To Look For

- Provide education on brushing and diet during examination



# AAPD Caries Risk Assessment Tool (CAT)

		Low Risk	Moderate Risk	High Risk
<b>Caries Risk Indicators</b>	<b>Clinical Conditions</b>	<ul style="list-style-type: none"> <li>•No carious teeth in past 24 months</li> <li>•No enamel demineralization (enamel caries “white spot lesions”)</li> <li>•No visible plaque; no gingivitis</li> </ul>	<ul style="list-style-type: none"> <li>•Carious teeth in the past 24 months</li> <li>•1 area of enamel demineralization (enamel caries “white spot lesions”)</li> <li>•Gingivitis</li> </ul>	<ul style="list-style-type: none"> <li>•Carious teeth in the past 12 months</li> <li>•More than 1 area of enamel demineralization (enamel caries “white –spot lesions”)</li> <li>•Visible plaque on anterior (front) teeth</li> <li>•Radiographic enamel caries</li> <li>•High titers of mutans streptococci</li> <li>•Wearing dental or orthodontic appliances</li> <li>•Enamel hypoplasia</li> </ul>
	<b>Environmental Characteristics</b>	<ul style="list-style-type: none"> <li>•Optimal systemic and topical fluoride exposure</li> <li>•Consumption of simple sugars or foods strongly associated with caries initiation primarily at mealtimes</li> <li>•High caregiver socioeconomic status</li> <li>•Regular use of dental care in an established dental home</li> </ul>	<ul style="list-style-type: none"> <li>•Suboptimal systemic fluoride exposure with optimal topical exposure</li> <li>•Occasional (ie, 1-2) between-meal exposures to simple sugars or foods strongly associated with caries</li> <li>•Mid-level caregiver socioeconomic status (ie eligible for school lunch program or SCHIP)</li> <li>•Irregular use of dental services</li> </ul>	<ul style="list-style-type: none"> <li>•Suboptimal topical fluoride exposure</li> <li>•Frequent (ie, 3 or more) between-meal exposures to simple sugars or foods strongly associated with caries</li> <li>•Low-level caregiver socioeconomic status (ie, eligible for Medicaid)</li> <li>•No usual source of dental care</li> <li>•Active caries present in the mother</li> </ul>
	<b>General Health Conditions</b>			<ul style="list-style-type: none"> <li>•Children with special health care needs</li> <li>•Conditions impairing saliva composition/flow</li> </ul>

Complete AAPD Policy Statement with CAT available at:  
<http://www.aapd.org/pdf/policycariesriskassessmenttool.pdf>

## 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.

### 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.

Visit:  6 month,  9 month,  12 month,  15 month,  18 month,  24 month,  30 month,  3 years,  4 years,  5 years,  6 years,  other \_\_\_\_\_

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
 Mother or primary caregiver had active decay in the past 12 months Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Existing dental home Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Drinks fluoridated water or takes fluoride supplements Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Fluoride varnish in the last 6 months Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Has teeth brushed daily Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>	 White spots or visible decalcifications in the past 12 months Yes <input type="checkbox"/> No <input type="checkbox"/>  Obvious decay Yes <input type="checkbox"/> No <input type="checkbox"/>  Restorations (fillings) present Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> <li>Mother or primary caregiver does not have a dentist Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Continual bottle/sippy cup use with fluid other than water Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Frequent snacking Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Special health care needs Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Medicaid eligible Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>		<ul style="list-style-type: none"> <li>Visible plaque accumulation Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Gingivitis (swollen/bleeding gums) Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Teeth present Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>Healthy teeth Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>

Caries Risk:  Low  High  
 Completed:  Anticipatory Guidance  Fluoride Varnish  Dental Referral

### Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed 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 James Gomez F.D., Crystal YD, Ng MM, Chaff J., Featherstone JD. Pediatric dental care: prevention and management protocols based on caries risk assessment. J Clin Dent Assoc. 2010;36(10):748-761. American Academy of Pediatrics Section on Pediatric Dentistry and Oral Health. Prevention and Health Promotion for pediatricians. Pediatrics. 2003; 112(5):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):1112-1116. The recommendations in this publication do not include an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright © 2011 American Academy of Pediatrics. All rights reserved. The American Academy of Pediatrics does not make or endorse any modifications made to this document and it is not responsible for any such changes.

Visit:  6 month,  9 month,  12 month,  15 month,  18 month,  24 month,  30 month,  3 years,  4 years,  5 years,  6 years,  other \_\_\_\_\_

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
<p> Mother or primary caregiver had active decay in the past 12 months Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<ul style="list-style-type: none"> <li> Existing dental home Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li> Drinks fluoridated water or takes fluoride supplements Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li> Fluoride varnish in the last 6 months Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li> Has teeth brushed daily Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>	<p> White spots or visible decalcifications in the past 12 months Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p> Obvious decay Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p> Restorations (fillings) present Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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<ul style="list-style-type: none"> <li> Continual bottle/sippy cup use with fluid other than water Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li> Frequent snacking Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li> Special health care needs Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li> Medicaid eligible Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>		<ul style="list-style-type: none"> <li> Teeth present Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li> Healthy teeth Yes <input type="checkbox"/> No <input type="checkbox"/></li> </ul>
<p>Caries Risk: <input type="checkbox"/> Low <input type="checkbox"/> High</p> <p>Completed: <input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Dental Referral</p>		

# ECC Prevention

- **Chapter Objective**
  - **Implement prevention of ECC through use of fluoride, proper hygiene, diet, and appropriate dental referral**

# Why Medical Clinicians?

- **Medical clinicians are well positioned to promote oral health:**
  - **89% of children have access to a usual source of primary medical care**
  - **Primary care clinicians have regular, consistent contact through well – child visits**
  - **74% of poor children 19 – 35 months of age receive all their vaccines**

# Anticipatory Guidance

- Minimize risk of infection
- Optimize oral hygiene
- Reduce dietary sugars
- Remove existing dental decay
- Administer fluorides judiciously



# **Minimize Risk for Infection**

- **Address active oral health disease in mother / caregiver**
- **Educate about the mechanism of cariogenic bacteria transmission**
- **Model positive oral hygiene behaviors**
- **Provide xylitol gum in certain cases**

# Xylitol for Mothers

- Xylitol gum or mints four times a day may prevent transmissions of cariogenic bacteria to infants
  - Helps reduce the development of dental caries
  - A “sugar” that bacteria can not use easily

# Xylitol for Mothers

- Resists fermentation by mouth bacteria
- Reduces plaque formation
- Increases salivary flow to aid in the repair of damaged tooth enamel



# Effects and Sources of Fluoride

- **Topical Mechanisms (main effect)**
  - Inhibiting tooth demineralization
  - Enhancing remineralization
  - Inhibiting bacterial metabolism
- **Systemic Mechanisms**
  - Reducing enamel solubility through incorporation into its structure during tooth development

# Effects and Sources of Fluoride

- Fluoride Sources
  - Topical: fluoride toothpastes, water fluoridation, fluoride varnish, gels, foams, mouthwashes (after age 6-8)
  - Dietary: water fluoridation, swallowed fluoride toothpaste (less than age 3), dietary fluoride supplements

# Systemic Fluoride

- **Guidelines**
  - All children at high – caries risk should receive fluoride through systemic water fluoridation or dietary supplements
  - Children who drink optimally fluoridated water should NOT receive supplements
  - Optimal water fluoridation is 0.7 ppm

# Systemic Fluoride

- Determine patient's water source and fluoride content
  - Public water supply
    - Local health department or water company can provide fluoridation levels
  - Bottled water (often contains fluoride)
  - Well water (variable fluoride levels, requires testing)

# Fluoride Supplementation

- **Guidelines**
  - If fluoride content of water cannot be determined, do not prescribe
  - In optimally fluoridated communities where children drink bottled water, supplements should not be prescribed due to halo effect

# Fluoride Supplementation

- Supplements are not recommended for infants until age six months
- All prescriptions for fluoride should specify a sugar - free prescription

Child's Age	Water Fluoride Concentration		
	< 0.3 ppm	0.3 – 0.6 ppm	> 0.6 ppm
6 mos – 3 yrs	0.25 mg	None	None
3 yrs – 6 yrs	0.50 mg	0.25 mg	None
> 6 years	1.00 mg	0.50 mg	None

Dosages are in milligrams F/day

# Fluorosis

- Appearance and Significance
  - White mottling of teeth due to chronic excessive exposure to fluoride during tooth development
  - Cosmetic issue that does not affect systemic health



# Fluorosis

- Risk Reduction
  - Determine fluoride content of drinking water before prescribing current dosage schedules
  - Avoid duplicating fluoride prescriptions
  - Use only a smear (< 2 years) or pea sized dab (> 2 years) of toothpaste
  - Fluoride varnish is not a risk factor for fluorosis

# Hygiene: Tooth Brushing

- **Guidelines**
  - **Brush teeth twice daily beginning as soon as teeth erupt**
    - **Bedtime is most critical due to increased salivary flow at night**
  - **Caregiver should brush child's teeth until age 6**
    - **Young children have difficulty brushing all areas**

# Hygiene: Tooth Brushing

- Caregiver should stand or sit behind child
- Lift lip and brush join between gum and teeth
- Child should spit out, not rinse, after brushing to increase topical fluoride exposure



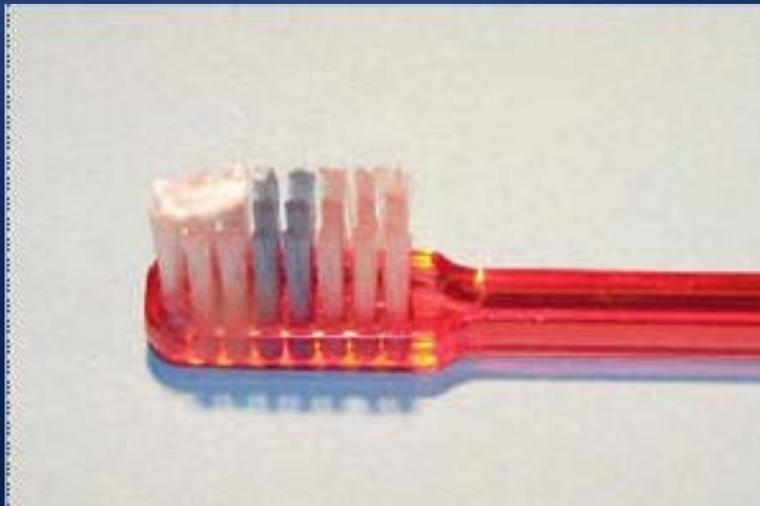
# How Much Toothpaste?

- **Guidelines**
  - Most preschool children swallow much of the toothpaste placed on the brush
  - These guidelines take this into account and these amounts are safe to swallow, but spitting out should always be encouraged

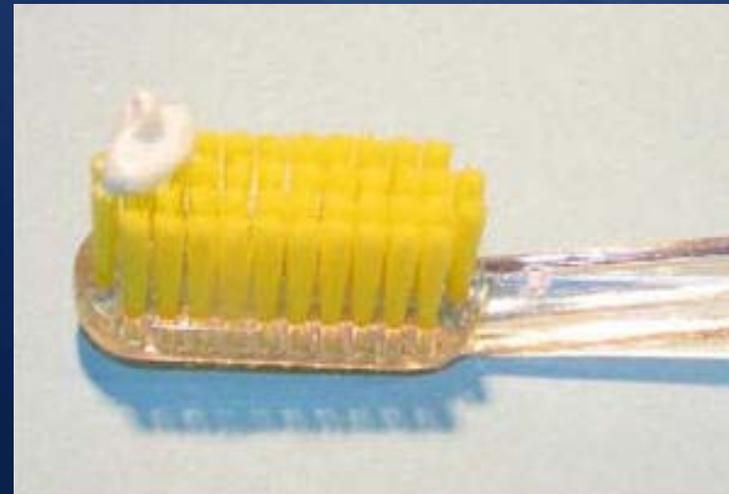
# How Much Toothpaste?

- Parents should keep toothpaste tubes out of reach of small children

Less than 2 years: small smear



2 years and over: pea sized



# Brushing Techniques

- **Guidelines**
  - **Caregiver should stand or sit behind the child**
  - **Lift lip to allow proper visualization**
  - **Brush the join between the gum and tooth, both on the outside (buccal) and inside (lingual) of tooth**

# Brushing Techniques

- Brush the top or chewing surface (occlusal)
- Use small backwards and forwards brushing movements or small circles
- Spit out toothpaste and do not rinse after brushing
- No food or drink after brushing

# Brushing Techniques

**Lift the lip**



**Brush behind teeth**



# Cariogenicity of Foods

## Low Cariogenic Snacks

- Fruit
  - Veggies
  - Cheese
  - Crackers
  - Pretzels
  - Popcorn
  - Nuts
  - Sugar free gum
  - Plain milk
  - Cheese & whole wheat crackers
  - Water
- 

## High Cariogenic Snacks

- Fruit Roll-ups
  - Gummy bears
  - Cookies
  - Cupcakes
  - Donuts
  - Granola bars
  - Pop tarts
  - Sugared Cereals
  - Soda, Iced tea
  - Sugared drinks
  - Raisins
- 

# Avoid High Risk Eating Patterns

- Follow these tips to lower caries risk
  - Avoid frequent snacking between meals, especially foods high in simple sugars
  - Avoid juices and other drinks between meals
    - Encourage water and white milk

# **Avoid High Risk Eating Patterns**

- Refrain from eating sticky, retentive snacks**
- Do not eat or drink before bed after tooth brushing**
- Water only at night**

# **Diet Advice: 0-12 Months**

- **Recommendations**
  - **Strongly encourage breast feeding**
  - **Hold infant for bottle feeding**
  - **Avoid giving bottles at bedtime or naptime**
  - **Do not use sweetened pacifiers**
  - **Introduce cup at 6 months**

# **Diet Advice: 0-12 Months**

- Wean bottle by 12 months**
- Avoid ad lib use of sippy cup unless it contains water**
- Snacks should contain no added sugar**

# **Diet Advice: 1 - 5 Years**

- **Recommendations**
  - **Discontinue bottle by 12 months**
  - **Limit juice to 4 oz. and serve with meals only**
  - **Avoid carbonated beverages and juice drinks containing sweeteners**
  - **Choose fresh fruits, vegetables, or sugar free whole grain snacks**

# **Diet Advice: 1 - 5 Years**

- Only drink milk or water between meals**
- Limit eating occasions to 3 meals a day with 1 snack in between**
- Reserve soda, candy, and sweets for special occasions with meals**

# **Establish a Dental Home**

- **The American Academy of Pediatric Dentistry and the American Academy of Pediatrics both recommend establishment of a dental home by the first birthday**
- **Dentist will provide**
  - **Enhanced preventative services**
  - **Comprehensive evaluation and diagnosis of oral disease**

# Establish a Dental Home

- Evaluation of growth and development
- Counseling on oral habits and interceptive orthodontic treatment as needed
- Fluoride varnish and cleanings
- Dental x - rays when indicated
- Sealants to permanent molars as child grows

# Developmental Issues

- **Chapter Objective:**
  - **Discuss common developmental issues in children and offer appropriate guidance to parents**

# Teething

- **Concerns**
  - **Teething does not cause upper respiratory infection, ear infection, or diarrhea**
  - **Teething may cause fussiness**
  - **Drooling is developmentally common at this age**

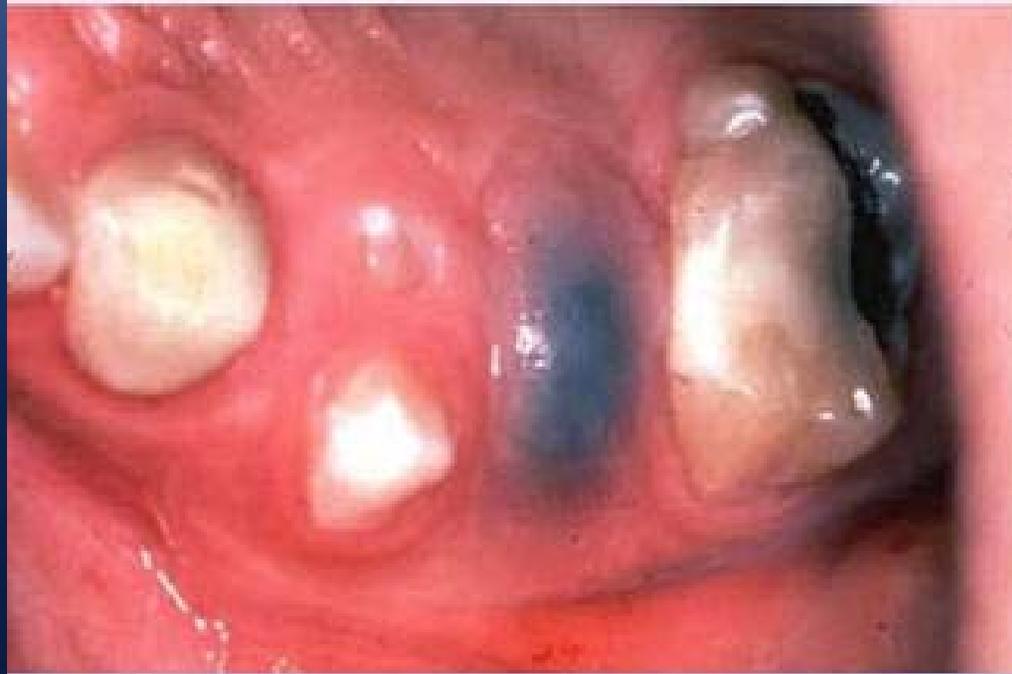
# Teething

- **Anticipatory Guidance**
  - Apply cold teething ring or cloth to gums
  - Provide acetaminophen or ibuprofen if necessary
  - Avoid teething gels
  - Tooth eruption may be preceded by a hematoma

# Teething

- No treatment is needed in primary dentition

**Eruption Hematoma**



# Nonnutritive Sucking

- **Etiology**
  - Satisfies a psychological need and decreases as the child ages
  - Increases risk of anterior open bite and delayed speech development if habit persists
- **Anticipatory Guidance**
  - Intervene to stop habit by 36 months, especially if changes to occlusion are noted

# **Nonnutritive Sucking**

- Breaking the habit**
  - Restrict to limited situations**
  - Cover hands at night with mittens**
  - Provide alternative comfort objects such as stuffed animal**
- Pacifier use is preferable to digit sucking**

# Take Home Messages

- ECC develops through the interaction of bacteria, dietary sugars, and teeth
- Assess teeth and risk factors
- Prevention by medical clinicians targets:
  - Hygiene
  - Fluoride
  - Diet

# Take Home Messages

- Establish a dental home by age one for all children where possible

# Questions?



# Alabama Medicaid Agency

**1<sup>st</sup> Look Program**

# Take a 1st Look

A Healthy Smile = A Healthy Child

# Overview

- **1<sup>st</sup> Look Program goals**
- **Qualified physicians**
- **Who qualifies for the program?**
- **Billing / eligible services**
- **Documentation requirements**
- **Referrals**
- **Program contacts**

# 1<sup>st</sup> Look Program

- Developed by the agency in partnership with the state's pediatric dentists and pediatricians
- Began in January 2009

# Program Goals

- The 1<sup>st</sup> Look program is designed to:
  - Improve awareness of early childhood caries
  - Increase early prevention education
  - Enlarge the dental provider referral base
  - Provide anticipatory guidance
  - Apply fluoride varnishes
  - Refer children to a dental home

# Qualified Physicians

- Limited to Patient 1<sup>st</sup> PMPs and their professional staff
- Must complete and successfully pass the Medicaid approved training program to be reimbursed for these services
- A score of 75% on the post test is required for successful completion

# Qualified Physicians

- Physician has to be trained before other professional office staff members are eligible to be trained

# Who Qualifies?

- **Children between the ages of 6 months and 36 months**
- **Children must have at least two high risk indicators using the AAPD Caries Risk Assessment Tool**
- **If a child has been seen by a dentist, the child does not qualify for the 1<sup>st</sup> Look program and the medical provider should not render services**

# Who Qualifies?

- **It is the responsibility of the provider to verify eligibility before service is rendered**
- **It is recommended that provider review the benefits limits section of the eligibility verification of each patient to identify services already billed in order to avoid denial of payments**

# Eligible Services / Billing

- **1<sup>st</sup> Look providers will be able to bill for initial oral assessment, once, under D0145 (oral exam < 3 years old, counseling)**
- **D0145 may be billed once by a medical provider and once by a dental provider for children age 6 months to 36 months**

# Eligible Services

- **Provider may also bill for the application of fluoride varnish for high caries risk children under D1206 (topical application)**
- **Varnish procedure will be limited to 3 per calendar year, regardless of provider, not to exceed a max of 6 applications between 6 months and 36 months of age**

# Eligible Services

- The allowed frequency will be no less than 90 days

# Billing Requirements

- **99381-EP 99392-EP**
  - **New Patient EPSDT Periodic Screening linked to V20.2 or appropriate diagnosis**
- **99391-EP 99392-EP**
  - **Established Patient EPSDT Periodic Screening linked to V20.2 or appropriate diagnosis**

# Billing Requirements

- Billed on same day with dental codes
- \*D0145 Dental Exam or D1206  
Dental Varnishing linked only to  
V72.2

# Documentation Requirements

- Medical record must document
  - Content of anticipatory guidance
  - Counseling given to parents / caregivers
  - Results of Caries Assessment Tool
  - Documentation that a referral has been made

# Referrals

- Providers required to refer high-risk patients (those with two or more indicators) to a Patient 1<sup>st</sup> Care Coordinator to assist in establishing a dental home
- A list of Care Coordinators can be found on Medicaid website [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) under Referrals

# Referrals

- The list of Care Coordinators can be found under “Patient 1<sup>st</sup> > Information for Providers”
- Once a child has been referred to a dental home:
  - Information is to be kept on file with the medical provider
  - No further fluoride varnish application treatment by the medical provider will be permitted

# **Program Contacts**

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**334-242-5620**

# Dental Fluoride Varnishing and Oral Assessment Program for Pediatricians



# Overview

- **Introduction**
- **Benefit Objectives**
- **Qualified Providers**
- **Course Requirements**
- **Benefit Guidelines**
- **Reimbursement Guidelines**
- **Eligibility**
- **Program Contact**

# Introduction

- **The ALL Kids fluoride varnishing and oral assessment benefit for pediatricians, which was effective October 1, 2011, is modeled after Alabama Medicaid's 1st Look Program with some variations**

# **Benefit Objectives**

- **Implement oral assessments and fluoride varnishes for children who do not have a dental home**
- **Provide preventive education for oral and dental care**
- **Promote oral health at an early age**
- **Refer children to a dental home**

# Qualified Providers

- **Limited to BCBS AL PMD  
Pediatricians and their  
professional staff**
- **Pediatricians must be trained before  
their professional office staff  
members are eligible to be trained**

# Course Requirements

- **Completion of the web based training and post test**
- **A score of at least 75% on the post test is required for successful completion**
- **Upon completion and certification, notify the dental program contact at ALL Kids with provider information**

# **Benefit Guidelines**

- **Payment will be based on the BCBS AL Preferred Provider Organization (PPO) dental fee schedule for the procedure codes covered under this benefit**
- **The procedures must be done in conjunction with a routine visit**

# Benefit Guidelines

- **Claims must be filed on a medical claim form for the following services provided: Oral Assessment, CDT code D0145 and Topical Fluoride Varnishing, CDT code D1206**
- **Encounter claims:**
  - **Claims will be bundled and paid as part of the encounter rate and will not be paid separately as fee for service**

# Reimbursement Guidelines

- **Oral Assessment, CDT code D0145**  
limited to one assessment by a medical provider and one assessment by a dental provider for children six months to 36 months of age
- **Topical Fluoride Varnishing, CDT code D1206** limited to three per calendar year, regardless of the provider

# Reimbursement Guidelines

- Not to exceed a maximum of six applications between six months and 36 months of age with a frequency of no less than 90 days
- Once a child is referred to a dental home, no further fluoride varnish treatment is allowed by the medical provider

# Eligibility

- **If a child has been seen by a dentist, the child does not qualify for these services and the provider should not provide the services**
- **Payment for these procedures will be denied if the patient has previously seen a dentist**



# Program Contact

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**Thanks to**  
**The American Academy of**  
**Pediatrics**  
**and**  
**Smiles for Life**

**To complete the process for  
both CME and 1<sup>st</sup> Look  
Certification,**

**please return to “POST TEST”  
and “EVALUATION” on the  
Chapter’s Oral Health Risk  
Assessment Training page at:**

**<http://tinyurl.com/mbjyqr8>**

**Produced by the  
Video Communications &  
Distance Learning Division  
Alabama Department of Public Health  
(334) 206-5618  
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July 2014**

