2008 PREVENTION SUMMIT
A Summary Paper
NATIONAL NETWORK FOR ORAL HEALTH ACCESS
December 8, 2008

BRINGING EVIDENCE AND BEST PRACTICES INTO
HEALTH CENTER DENTAL PROGRAMS:
IMPROVING CHILDHOOD ORAL HEALTH
EXECUTIVE SUMMARY

The National Network for Oral Health Access (NNOHA) is pleased to present you with this summary of the proceedings of the 2008 Childhood Lifecycles Summit on Oral Disease Prevention, developed through our Cooperative Agreement with the Health Resources and Services Administration, (HRSA). NNOHA is the membership organization of oral health providers and supporters practicing in Community Health Centers across the nation. Our mission is to improve the health status of underserved populations through improved and increased access to oral health services. As our nation is focused on substantial challenges and sustainable changes, dentistry is also undergoing a paradigm shift to focus on evidence-based preventive approaches to oral diseases, rather than surgical or end-stage treatment.

Health care providers who serve our nation’s most vulnerable populations are on the cutting edge of technology exchange – putting the evidence for early oral disease prevention into practice. Furthermore, the populations who are most vulnerable to oral disease benefit from multiple prevention strategies that are defined in this Summary Paper.

The purpose of the Summit was to facilitate technology exchange among experts who share the commitment to bring oral disease prevention to all vulnerable children that are served in the safety net provider network.

On December 8, 2008 the nation’s best experts in oral disease prevention convened to review and recommend manageable and effective strategies that can be implemented in Health Centers and other safety net dental programs across the country. The summit focused on programs that have demonstrated success in caries prevention and management. Details of each program are included in the attached Summary Paper. The Summit explored how the integration of three models can create a continuum of oral disease preventive strategies in safety net settings to maintain and improve oral health from birth through adolescence.

The strategies discussed in this White Paper are not hypothetical – they have been tested and implemented in a variety of settings – with demonstrated results that are cost effective and are currently being employed in the safety net community. Under HRSA Program Expectations and PHS 330 regulations, Health Centers are required to have an oral disease prevention program. It is NNOHA’s vision that every Health Center in the nation will offer comprehensive oral disease preventive services across the childhood lifecycle.

It was evident in the December 8 proceedings that a clear definition of prevention needs to be developed. The strategies described in this White Paper represent a shared commitment to prevention and provide a basis for defining its meaning and scope.

NNOHA recommends the following next steps:

1) Establish and fund a provider pool to apply combined prevention strategies in a variety of clinical settings.
2) Guide/direct and coordinate strategies for implementation on a national scale.
3) Develop a cadre of technical assistance providers to support Health Centers in defining, learning and implementing prevention strategies.

This paper presents recommendations for a continuum of strategies that make the opportunities for access and oral disease prevention more attainable for children (and families) in community based or safety net settings.

NNOHA stands ready to partner with you to assure that the latest evidence in oral disease prevention is applied in Health Centers across the country.
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Introduction: The National Network for Oral Health Access (NNOHA) convened a Prevention Summit on December 8, 2008, in Washington, D.C. This meeting focused on caries and periodontal disease in pregnant women and children. This is another step toward developing a vision in which every Health Center in the country implements evidenced-based oral health prevention strategies that have been shown to have both positive clinical and financial outcomes.

The four strategies discussed at the Summit have the ability to create a seamless continuum of Health Center-based prevention activities that focus on the childhood lifecycle, starting before birth with the pregnant woman, through infancy, early childhood and the school-age years.

Caries and periodontal disease are transmissible infections that affect people of all ages. However, the focus of this Summit was the childhood lifecycle, starting before birth with the pregnant mother, through infancy, early childhood and the school-age years. The expert panel gathered at the Summit included presenters on the four prevention strategies, public and private funders, policy makers and practitioners. This document describes the four prevention strategies and summarizes the Summit participants' ideas about the key requirements for implementation of prevention strategies in Health Centers on a national level.

Dental decay is the most common chronic childhood disease: Dental decay, the most common chronic childhood disease (five times more common than asthma), is a preventable bacterial infection, 80% of the disease burden occurs in 20% of the population, and this population is largely the poor and minorities (US Department of Health and Human Services, 2000). It is the panel's view that improving oral disease prevention reduces disparities in oral health status. Dental caries are almost entirely preventable. However, the evidence-based prevention strategies presented in this paper have not been systematically implemented.
Effective Preventive Solutions for Caries and Periodontal Disease Are Available:

1. Perinatal/Pregnant Women/Infants

The Health Resources and Services Administration (HRSA)-sponsored Oral Health Disparities Collaborative (OHDC) Pilot engaged four Health Centers in Colorado and Montana. The pilot targeted two Health Center populations: pregnant women and children zero to five years of age. One of the aims of the Collaborative is to shift the Health Center paradigm away from emergency and end-stage surgical treatment of oral diseases, and towards outreach, prevention and proactive management of early oral disease as a chronic illness. The Collaborative structure is based on the Chronic Care Model (2) which provides a framework that promotes an organizational approach to providing planned, proactive care for people within a primary care setting.

A key outcome of the OHDC Pilot was the development of infrastructure to facilitate Medical-Dental integration in the Health Center setting. For example, primary care medical providers adopted protocols to counsel their pregnant patients about the importance of their own oral health and for educating caregivers about infant oral care as part of the well child visit. Tools were developed to expedite the referral of pregnant women and very young children by medical staff to the Health Center dental program for comprehensive care. Parallel with these medical delivery system changes, the Health Center dental professionals were also engaged in prioritizing delivery of dental care to the two target populations (pregnant women and children zero to five years of age). As a result, it was possible to deliver comprehensive dental services to perinatal populations and risk assessment and disease management to very young children.

The result of the structure and process of the Collaborative was changing behavior of Health Center medical and dental professionals. An expert faculty was convened to present the most current scientific evidence and best practices in pediatric and perinatal oral health and on the quality improvement process. Note that the clinical prevention model for children 0-5 implemented in the OHDC pilot was the same model utilized in the MAYA Project described in the next section.

Each Health Center participated by way of a multidisciplinary team consisting of medical, dental and operations staff. They met in a series of in-person meetings (Learning Sessions) for joint learning and brainstorming on improvement options. The teams returned to their home Health Centers to implement and evaluate their system improvement ideas. Results of implementation efforts, both successes and failures, were then shared across teams at subsequent Learning Sessions. In this way, participants had the opportunity to learn new material and to test implementation on an interactive basis – learning from one another and from the faculty on how to translate science into practice. Both health outcomes and business results were measured (3), setting the stage for sustainability.

The Collaborative Pilot also focused on practice redesign and office efficiencies that supported improvement. As a result, Health Center teams were able to identify ways to deliver services to new populations (pregnant women and very young children) within the existing capacity of the Health Center. Examples of delivery system redesign included: 1) the ability for medical department staff to make dental appointments for their patients on-line, 2) full utilization of medical and dental auxiliary scope of practice to increase productivity, and 3) standardization of instrument set-ups. Additionally, productivity increases led to positive revenue impacts, which validated the business as well as clinical benefits of the Collaborative.
2. Early Childhood

The “MAYA” (Mother and Youth Access) project is a research and demonstration project sponsored by The NIDCR-UCSF CANDO Disparities Center at San Ysidro Community Health Center in conjunction with The University of California/Los Angeles Department of Pediatric Dentistry. The project focused on Early Childhood Caries (ECC) prevention in children under the age of three by integrating oral health into the Health Center’s primary medical care system. The project successfully engaged pregnant mothers and care givers of young children through outreach in the Health Centers surrounding community. “Patient Navigators” recruited participants to the program from Women Infants and Children (WIC) and Early Head Start sites in the Health Center’s service area. The patient navigators were the participants’ link to the Health Center’s services – sharing expertise about medical and dental services, insurance and other community resources. The project supported participants by staging “baby showers” and birthday celebrations where mothers and caregivers learned about how to prevent dental disease and other health issues, such as maternal depression, which also surfaced at the group meetings. (4)

San Ysidro health professionals performed a standardized six step oral health protocol involving: risk assessment, knee to knee exams, tooth brush cleaning, saliva sampling, application of fluoride varnish and self management goal setting with the care giver. This is the same protocol implemented in the Oral Health Disparities Collaborative (OHDC) Pilot described in the previous section. Although the research aspect of the MAYA project is still in progress, the experience to date shows that it is feasible for Health Centers to attract young children into the active patient population. Once in the Health Center delivery system, children receive evidence based caries prevention procedures. This project shows that prevention of disease is a combination of professional care delivery and patient commitment to changing high-risk practices.

In California, The Dental Health Foundation (DHF) is pioneering providing well baby dental visits (the six-step oral health protocol mentioned above) to children at WIC sites. DHF assists dental providers (including FQHCs, local dental programs, or private dentists) in setting up services at WIC sites. WIC staff educates parents about oral care as part of the required WIC educational programs. When services are provided by an FQHC, the services are performed by dentists. Generally county and non-profit dental programs utilize Registered Dental Hygienists in Advanced Practice. In rural areas, public health nurses have received extensive training to provide the services. Children needing restorative services are case managed into care by either dental staff or case managers, who can also assist in Medicaid enrollment. These services are generally billable through Medicaid, either at the encounter rate (for FHQCs) or at the fee-for-service rate for other dental providers. Proper use of dental providers and auxiliaries to the maximum duties allowed by individual state practice acts can facilitate efficient implementation of ECC prevention programs.

3. School Age Children

The main goal of the ForsythKids program is to provide elementary school based comprehensive prevention that increases access to care, improves health, and is financially sustainable based on Medicaid fees. Additional goals are to address the needs identified by the Surgeon General’s Report on Oral Health, meet the goals of Healthy People 2010, provide quality care as defined by the Institute of Medicine, and maintain HiPAA and OSHA standards.

To accomplish this, The Forsyth Institute, a Harvard affiliated, independent, non-profit oral health institute in Boston, Massachusetts, worked with the state Department of Public Health to identify schools and districts where
greater than 50% of the children participate in free/reduced lunch (a surrogate for poverty). The school districts and schools were queried to determine their interest in a caries prevention program. For interested schools, informational meetings were made and the program described (see below). Simultaneously, local Health Centers were queried to determine their interest in collaborating. Pilot programs were established in schools with a local Health Center.

The program occurs twice yearly. Parental consent is obtained. A dental team goes into the elementary school with portable equipment. Licensed dentists provide clinical examinations (without radiographs) and a treatment plan. Dental hygienists provide: prophylaxis, glass ionomer sealants and temporary restorations (when needed), fluoride varnish, oral hygiene instruction, toothbrushes and fluoride toothpaste. Time out-of-class is approximately 1 hour per year per child. Findings are recorded on electronic forms and children are followed longitudinally with an electronic dental record. Outcome data are gathered on a central database for analysis.

Starting in 4 schools in 2003, the program now offers preventive care to 50 schools and 18,000 children. Initial examinations indicate that greater than 50% of the children have untreated decay, and fewer than 10% had sealants. The outcome data indicates that there is a 50% reduction in new decay with each visit, and greater than 50% of the children have sealants. Over three years the program reduced the incidence of new decay to almost zero. Additionally, the incidence of acute abscess was reduced from approximately 10% to 0.1%. The program targets at-risk children, increases access to care, and exceed the goals of Healthy People 2010.

In Massachusetts, the cost to deliver care is approximately $100 per year per child. The Medicaid fees are approximately $200 per year per child. The program is therefore sustainable. By taking the “non technical” preventive care out of the Health Center, the program frees up chair time for surgical procedures and reduces disruptive Health Center emergencies.

4. Dental Home Across the Lifecycle

The fourth strategy is a concept rather than a model or a program. The concept is that of having a regular source of routine health care: prevention, chronic disease management and treatment for acute needs for patients of all ages. The concept assumes a relationship of continuity between the patient and the source of care so that individual needs can be anticipated and diseases, including dental disease, can be prevented and/or identified at the earliest stages. A newly formed partnership between the Office of Head Start and the American Academy of Pediatric Dentistry seeks to create a national network of pediatric and general dentists to provide quality Dental Homes for Head Start and Early Head Start children. Efforts are being made to link dentists more closely to Head Start programs for staff training, screening and Advisory Board participation.

Health Centers are uniquely positioned to deliver and be at the forefront of the “Health Home” concept because Health Centers are essential service sites for at risk, underserved populations. A Health Center with co-located dental, medical and enabling services, with a common information technology platform, is at an advantage in implementing the four prevention strategies described in this Summary Paper.
The expert panel agreed that the following are critical factors in assuring successful implementation of the strategies at Health Centers across the country:

- **Leadership — Of Health Center CEOs and CFOs**

  The panel agreed that the clinical protocols being used to prevent dental disease in each of the lifecycle stages were based on established evidence of clinical efficacy. There was consensus that in order to implement these protocols, Health Center leadership would need to be convinced of the “business case” for making changes in Health Center operations. The Summit attendees felt that it was important to be able to show the ways in which this spectrum of interventions resulted in positive outcomes – both clinical and financial.

- **Commitment — To Innovation And Continuous Improvement**

  For Health Center personnel to explore and test integrating the four identified prevention strategies into the existing care model, they need to create a culture of commitment to innovation and to continuous improvement. In some cases a “cultural change” process is needed – starting with Health Center leaders articulating innovation, quality improvement and prevention as core values for their organizations.

- **Readiness — To Change The Oral Health Delivery System**

  Health Centers must determine if there is sufficient commitment to dedicate the time and energy needed to prepare the Health Center staff for implementation of prevention strategies.

- **Engagement — Of Health Professionals**

  Health professionals need to be engaged in learning new procedures and adopting them in practice. Opportunities should be provided for different disciplines to learn each other’s languages, present clinical evidence about the disease process, and learn how to prevent, arrest, and potentially reverse the process. Peer and expert support should be provided during implementation trials.
• **Collaboration — With Opportunities and Incentives**

Each of the prevention strategies identified depended on a capacity to collaborate across “jurisdictional” lines. In some cases, the collaboration was internal to the Health Center e.g. dental professionals educating physicians and their staff about the dental disease process and effective prevention protocols. In other cases, collaboration was external; Health Centers reached across sectors and embedded oral health in childcare programs (Head Start), in nutrition programs (Women, Infants, and Children) and in school systems. Collaboration also extended to multiple funding sources including private and public philanthropy as well as federal sources beyond the HRSA Bureau of Primary Health Care. Therefore, investment in developing Health Center capacity to collaborate was viewed as a critical implementation factor. The panel noted that development of this capacity brings with it an understanding that the change process is not “linear”, that interdependence requires the ability to trust, be patient, be resourceful and persistent and that accountability for outcomes must be shared.

• **Champions — Are A Catalyst For Change**

The expert panel noted that successful implementation of each of the prevention strategies involved a catalyst or champion whose belief in the health improvement mission of the Health Center enabled them to inspire and lead their colleagues to change. These champions need to be identified and supported.

• Other critical elements that were common to successful implementation of all four preventive strategies include: (a) use of case management/patient navigator, (b) maximizing the use of auxiliary personnel, and (c) data (medical/dental) integration via electronic health records.

1 See Appendix A for list of 2008 Prevention Summit attendees
2 E. H. Wagner et al.1999 “Care of Older people With Chronic Illness” New York: Springer
5 JADA vol.139 August, 2008 p-1040-1050
SUMMARY

Health Centers are well positioned to stake a claim in the health field to being what a true comprehensive “health home”, including dental services, should look like. This Summary Paper presents examples of how different best practice models for preventing dental disease have been implemented in a financially viable way in Health Centers. With this collection of examples, Health Centers can create and deliver a continuum of prevention services, which can positively impact the oral health status of patients from birth through adolescence, making huge strides in reducing the burden of pervasive and generational dental disease that affects overall health and strains resources.

NNOHA recommends the following next steps:

1) Establish and fund a provider pool to apply combined prevention strategies in a variety of clinical settings.

2) Guide/direct and coordinate strategies for implementation on a national scale.

3) Develop a cadre of technical assistance providers to support Health Centers in defining, learning and implementing prevention strategies.

To realize the goal of all Health Centers offering this spectrum of prevention, attention must also be paid to the Critical Factors identified above. Additional information for each of these initiatives, including implementation strategies, can be obtained from the individuals and sites listed on the following resource list.
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### ORAL HEALTH DISPARITIES COLLABORATIVE MEASURES

#### PERINATAL MEASURES

#### CORE (REQUIRED)

Definitions for phases in **RED TEXT** are found on the following pages.

<table>
<thead>
<tr>
<th>Measure—</th>
<th>Short Description (percent: numerator/denominator x 100)</th>
<th>Measure—</th>
<th>Detailed Description</th>
<th>Numerator (count in the clinical information system- for IT staff)</th>
<th>Denominator (count in the clinical information system- for IT staff)</th>
<th>Change trying to drive with measure</th>
<th>Notes/Comments</th>
<th>Goal %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Comprehensive oral exam and treatment plan</strong></td>
<td>Pregnant women with comprehensive dental exam completed while pregnant</td>
<td>Pregnant women with comprehensive dental exam completed while pregnant</td>
<td>Pregnant women in last 12 months</td>
<td>Change previous dental system reluctance to providing dental treatment to pregnant women</td>
<td>Comprehensive dental exam includes periodontal assessment as well as determination of presence of decay.</td>
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<tr>
<td>2. <strong>Dental Treatment Completed</strong></td>
<td>Pregnant women with completed Phase I dental treatment plan within 6 months of exam</td>
<td>Pregnant women with completed Phase I dental treatment plan within 6 months of exam (12 months)</td>
<td>Pregnant women with comprehensive oral health exam while pregnant (12 months)</td>
<td>Provide routine &amp; emergency dental treatment to pregnant women and drive changes in delivery system (redesign) to allow completion of treatment in a timely manner</td>
<td>OPR measure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Self Management Goal:</strong> medical and/or dental setting</td>
<td>Pregnant women with SMGS developed in either the medical and/or dental setting while pregnant</td>
<td>Pregnant women with SMGS in last 12 months</td>
<td>Pregnant women in registry (12 months)</td>
<td>Drive medical or dental staff to deliver appropriate AG including developing SM Goal</td>
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</tbody>
</table>
# EARLY CHILDHOOD CARIES (ECC) MEASURES

## CORE (REQUIRED)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Short Description (percent: numerator/denominator x 100)</th>
<th>Measure</th>
<th>Detailed Description</th>
<th>Numerator (count in the clinical information system- for IT staff)</th>
<th>Denominator (count in the clinical information system- for IT staff)</th>
<th>Change trying to drive with measure</th>
<th>Notes/Comments</th>
<th>Goal %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Dental Exam Measure (by 12 months)</td>
<td></td>
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<tr>
<td></td>
<td>Children with dental exam by age 12 months</td>
<td>Children &lt;= 24 months of age with dental exam by age 12 months</td>
<td>Children &lt;= 24 months of age</td>
<td>Referral of 1 y/o from medical to dental clinic. Reduce dental provider &amp; system barriers to performing exam &amp; ECC risk assessment on 1 y/o</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1b. Dental Exam Measure (12-60 months)</td>
<td>Children age 12 to 60 months with exam</td>
<td>Children age 12 to 60 months with exam in the last 12 months</td>
<td>Children age 12 to 60 months of age</td>
<td>Referral of 2-5 y/o from medical to dental clinic. Reduce dental provider &amp; system barriers to performing exam, ECC risk assessment and dental treatment on 2-5 y/o</td>
<td></td>
<td></td>
<td>The measure is distinct from measure 2a, which emphasizes 1 year olds.</td>
<td></td>
</tr>
<tr>
<td>2. Treatment Plan Completed Measure (12-60 months) (HP 2010 21.2)</td>
<td>Children age 12 to 60 months with completed Phase 1 Treatment plan within 12 months of exam</td>
<td>Children age 12 to 60 months with initial exam and Phase 1 Treatment completed within 12 months of the initial exam</td>
<td>All children age 12 to 60 months with exam</td>
<td>Provide preventive, routine &amp; emergency dental treatment to 2-5 y/o and drive changes in delivery system (redesign) to allow completion of treatment in a timely manner</td>
<td></td>
<td>OPR Measure (Phase 1 treatment includes dental caries treatment)</td>
<td></td>
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</tr>
<tr>
<td>3. Self-Management Goal: medical and/or dental setting</td>
<td>Children ages 12 to 60 months whose caregivers developed SMGS in either the medical or dental setting</td>
<td>Children ages 12 to 60 months whose caregivers developed SMGS in last 12 months</td>
<td>Children ages 12 to 60 months</td>
<td>Drive medical or dental staff to deliver appropriate AG including developing SM Goal to caregivers of POF since caregivers responsible for modulating ECC risk factors in these age groups</td>
<td>(1) Caregivers focus. (2) Agreement to practice good oral health habits (health behavior counseling or contracting) is not the only topic for SM goal setting. (3) In PECS, we will interpret Self Management Goal associated with a child’s registry information as referring to self-management of the caregiver.</td>
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</tbody>
</table>
DEFINITIONS OF TERMS USED IN MEASURES

I. PHASE 1 TREATMENT

Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: oral cancer prevention and early diagnosis; prevention education and services; emergency treatment; diagnostic services and treatment planning; restorative treatment; basic periodontal therapy (non surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy; and space maintenance and tooth eruption guidance for transitional dentition.

II. ELEMENTS OF THE COMPREHENSIVE ORAL EXAM, DIAGNOSIS AND TREATMENT PLAN

A. Intra/Extra-Oral Exam

The clinical examination should document the oral condition as to:

- Missing and decayed teeth, existing restorations
- Endodontic status
- Occlusal status
- Soft tissue/oral cancer exam
- Periodontal status, including probing

Use of the PSR: The PSR is not a diagnostic tool. Use of the PSR is acceptable for screening, as long as patients scoring a Code 4 in one sextant or Code 3 in two or more sextants receive a complete periodontal examination including full mouth probing.

- Other findings viewed as pertinent by the examining dentist

B. Diagnosis

Written notation and/or tooth charting shall be used to indicate pathologic conditions including but not limited to:

- Untreated caries, defective restorations
- Soft tissue abnormalities
- Periodontal disease
- Malocclusion or developmental pathology
- Hard tissue pathology observable on available radiographs such as impactions
- Other existing conditions i.e. TMJ, attrition, abrasion etc.

Consultation and referral shall occur where necessary to complete diagnosis.

A diagnosis shall be supported by recording clinical symptoms and conditions.
C. Treatment Plan

A complete treatment plan should include the following:

- Provision for relief of pain, elimination of infection
- Preventive plan component
- Periodontal treatment plan if necessary
- Elimination of caries
- Replacement or maintenance of tooth space or function
- Consultation or referral for conditions where treatment is beyond the scope of services offered
- Determination of adequate recall interval

✓ Please note that treatment planning for ECC interventions for children 0-5 may also include interventions such as prescribing chlorhexidine for the caregiver, that should be documented in both the caregiver's and child's treatment records

III. Self-Management Goal:

A collaborative activity in which the patient, or patient/caregiver dyad, and the health care provider establish a goal that:

- is reasonable
- describes what, where, when, how, how much
- the patient has a high level of confidence in achieving
- is something the patient WANTS to do
- has a follow up plan

IV. PCP Dental Counseling in the Medical Setting

- Appropriate Anticipatory Guidance for pregnant women or young child
- Reinforcement of the importance of oral health through the life-cycle
- Reinforce and support the importance of attending and completing dental treatment
2008 PREVENTION SUMMIT RESOURCE LIST

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Reference Sites
   www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/ImprovementStories/FS
   http://healthdisparities.net
   www.nnoha.org  OHCD Manual/change package
   (New York State Department of Health)
   National Maternal and Child Oral Health Resource Center, Georgetown University

SAN YSIDRO COMMUNITY HEALTH CENTER “MAYA PROJECT/ CALIFORNIA WIC PROJECTS

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Reference Sites
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   www.ucsf.edu/cando
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**ORAL HEALTH HOME**

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**ORAL HEALTH & PREVENTION**

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WHAT IS NNOHA?

The National Network for Oral Health Access (NNOHA) is a 501 (c) 3 non-profit organization that was founded in 1990 by a group of dental directors from Federally Qualified Community Health Centers (FQHCs) who recognized the need for peer-to-peer networking, services, and collaboration to most effectively operate Health Center dental programs that serve underserved populations. NNOHA has a diverse membership of Health Center oral health providers: dental directors, dental hygienists, and their supporters. NNOHA’s membership represents the diversity of Health Center oral health settings – from novice to experienced dental directors (from 30 days to 30+ years) to diverse Health Center settings - from isolated, rural, one dentist clinics, to large urban practices with 20 or more dentists. NNOHA coordinates efforts to benefit community, migrant, and homeless health center dental clinics across the United States.

OUR MISSION

The Mission of the National Network for Oral Health Access (NNOHA) is to improve the oral health status of the underserved through advocacy and support for health centers.

JOIN NNOHA

To become a member of NNOHA, visit www.nnoha.org, call 303-957-0635, or write to info@nnoha.org.

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MEMBERSHIP APPLICATION

APPLICANT CONTACT INFORMATION

Name:
Title:
Organization:
Name of Health Center:
(if different from Organization name)
Address:
City: State: Zip Code:
Phone: Fax:
E-mail:

NNOHA Membership Category
❑ Individual Member (dues $25)  ❑ Organizational Member (dues $250)

If you are applying as an Organizational Member, please attach a list of the names, titles, and E-mail addresses of the employees you wish to include in the membership.

Referred by:
(name of NNOHA Member)

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I am interested in participating on the:
❑ Membership Services Committee  ❑ Advocacy & Strategic Partnerships Committee
❑ Health information Technology Committee  ❑ Practice Management
❑ Workforce Development Committee  ❑ Any committee

Please complete this form and mail it with your check made payable to NNOHA to:

NNOHA, PMB 329, 3700 Quebec Street, Unit 100, Denver, CO 80207-1639
Individual Annual Membership = $25.00
Annual Organizational Membership = $250.00

For more information, contact:
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