2018 BASIC SCREENING SURVEY

EVALUATING THE ORAL HEALTH OF AI/AN CHILDREN 1-5 YEARS

NATIONAL CONTACTS

Project Consultant
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301-945-3230
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Nathan Mork (Central Time)
218-983-6254
nathan.mork@ihs.gov

LOCAL CONTACTS

- Your local contact will check in on a regular basis to monitor progress
  - Area Dental Officer/Consultant
  - Dental Support Center

LOCAL CONTACTS

Area	Contact Name	Contact Email
Alaska	Sarah Shoffstall-Cone	sshoffstallcone@anthc.org
Albuquerque	Elaine Sanchez	esanchez@nappr.org
Bemidji	Nathan Mork	nathan.mork@ihs.gov
Billings	Richard Troyer (IHS Clinics) Travis Fisher (Tribal Clinics)	richard.troyer@ihs.gov travis.fisher@ihs.gov
California	Consuelo Gambino	cgambino@crihb.org
Great Plains	Flauryse Baguidy	flauryse.baguidy@ihs.gov
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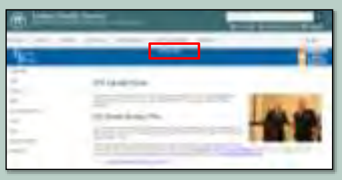
Navajo	Nadine Brown	nadine.brown@ihs.gov
Oklahoma City	Keasha Myrick	keasha.myrick@ihs.gov
Phoenix	Nadine Brown	nadine.brown@ihs.gov
Portland	Cheryl Sixkiller	cheryl.sixkiller@ihs.gov
Tucson	Thuc Ngo	thuc.ngo@ihs.gov

FORMS & OTHER RESOURCES

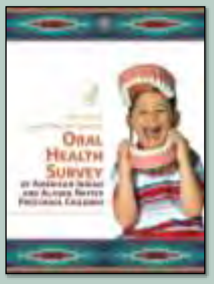
- www.ihs.gov/doh/
  - Login
  - Go to surveillance tab



PURPOSE OF SURVEY

- To obtain National and Area level estimates of oral health status in AI/AN children
  - 12 months to 71 months of age (1-5 years)
- Evaluate oral health trends over time
- Provide Tribal specific data that local programs can use for advocacy and grant writing

FOLLOW-UP TO 2010 & 2014 SURVEYS



WHO SHOULD PARTICIPATE?

- Probability sample of IHS/Tribal dental clinics
  - We are encouraging all clinics that participated in 2010 or 2014 to also participate in this survey
- Any IHS/Tribal clinic can volunteer to participate
  - Great way to get local data

MINIMUM SAMPLE SIZE PER AREA

12-23 months	24-35 months	36-47 months	48-59 months	60-71 months	TOTAL
80	80	80	80	80	400

Even Distribution of Children Between Age Groups

MINIMUM SAMPLE SIZE PER CLINIC

- Ranges from 5-100 per clinic based on population size
  - Clinics should already have target numbers (Excel file)
    - If not, send an email to your local contact
- Feel free to screen more than the minimum
  - The bigger the numbers the better the information

WHO WILL BE SCREENED?

- Pediatric / Medical Clinic Patients
  - Well-child & immunization clinics
  - Sick child if child is not too sick
  - Primarily 1-3 year olds
- WIC
  - Primarily 1-3 year olds

WHO WILL BE SCREENED?

- Head Start
  - Primarily 3-4 year olds
  - Screen all Head Start children, not just minimum number
- Other preschool locations
  - Early Head Start
  - Tribal preschool / daycare

OTHER POTENTIAL SITES

- Kindergarten
  - Primarily 5 year old children
- Community events such as health fairs

VERY IMPORTANT

- ***Do not screen*** dental clinic patients or do chart audits
  - Young children that come to the clinic often have problems
  - Significantly overestimates the prevalence of disease

EXCEPTION TO THE RULE

- Can screen in dental clinic if….
  - Entire Head Start program is screened in clinic
  - All children scheduled for a well-child visit are screened in clinic

PARENTAL CONSENT

- If parent/guardian is present …
  - Verbal consent is adequate
- If parent/guardian is not present …
  - Can use blanket consent if already obtained for Early Head Start, Head Start or other preschool programs
  - Can use passive consent for kindergarten
    - Sample passive consent form on IHS/DOH website

PASSIVE CONSENT

- Sample consent letter
  - www.ihs.gov/doh

TIMELINE

July August
- Attend training
- Obtain approval from medical/pediatric clinic
- Obtain approval from HS, EHS, tribal preschool/daycare programs
- Set screening dates
- Order supplies

July Through December
- Conduct screenings
- Complete by December 15, 2018
- Mail screening forms to Kathy Phipps, 255 Bradley Avenue, Morro Bay, CA 93442

WHY ARE WE HAVING THIS TRAINING?

- Caries diagnosis varies among clinicians
  - 10 clinicians – 1 patient = 10 different treatment plans
- Purpose of training is to assure consistency
  - New Screeners
    - Provide detailed information on "diagnostic" criteria
  - Previous Screeners
    - ***To meet national standards***, must have annual refresher

NATIONAL ORAL HEALTH SURVEILLANCE SYSTEM

www.cdc.gov/oralhealthdata/

IMPORTANCE OF CONSISTENCY

- With multiple examiners, it is essential that everyone screen children in the same manner
- Set diagnostic criteria are used
  - ***Everyone must follow the criteria***
  - Will underestimate disease
  - Used in all state and national surveys

Screening Logistics

WHO CAN DO THE SCREENINGS

- Dentists, hygienists and therapists that have attended or watched the training webinar
- **ALL** screeners must have attended or watched the webinar

LIGHTING

- Do not rely on natural light
- Lighting options
  - Strong penlight (LED lights are good)
  - Small flashlight
  - Headlamp
  - Portable dental light
  - Always carry extra batteries

RETRACTION & VISUALIZATION

- Options
  - Tongue blade
  - Dental mirror
    - Disposable mirrors
    - Regular mirrors from clinic
- Dental mirrors are nice but not necessary

WHAT ABOUT MY LOUPES?

- **DO NOT USE**

CDC/NIDCR do not use loupes in caries surveillance

TEETH SHOULD BE CLEAN & DRY

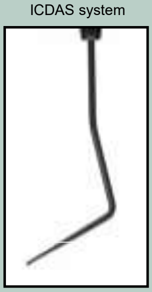
- Remove debris with
  - Toothbrush, 2X2 gauze, toothpick
- Saliva
  - Soak up saliva with
    - 2X2 gauze or Q-tip
  - Ask child to swallow

INSTRUMENTATION

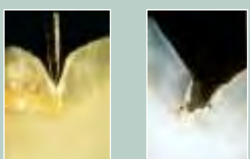
- Do NOT use dental explorers
- Screening must be non-invasive

CARIES RESEARCH USES PERIO PROBES

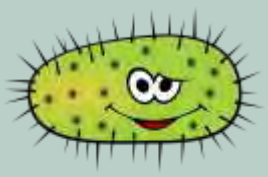
ICDAS system

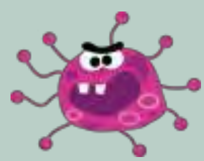


Explorers are not recommended as they may produce traumatic defects



INFECTION CONTROL





AVOID TOUCHING THE CHILD

INFECTION CONTROL PROTOCOL

- Always wear gloves
- Change gloves between each child
- If you do not touch the child
  - No need to wash hands
- If you do touch the child
  - Wash hands or use antiseptic rinse
- Not necessary …
  - Masks, gown, eye protection

MOST COMMON "MISTAKES"

Touching the Child

Flashlight in Mouth

DEMOGRAPHIC INDICATORS

DEMOGRAPHIC INDICATORS

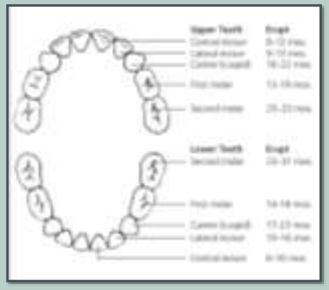
- Date of birth
  - Ask parent or teacher
- Age in years
  - Ask parent, teacher or child
  - Learn to read fingers
  - Record in full years
    - I'm 3 and a half = 3
    - I'll be 4 next week = 3
  - < 12 months = 0

DEMOGRAPHIC INDICATORS

- Gender
  - Male
  - Female
- Race
  - AI/AN
    - If a child is AI/AN plus another race, race=AI/AN
  - Not AI/AN

ORAL HEALTH INDICATORS

ERUPTION PATTERN REFRESHER



UNTREATED DECAY

UNTREATED DECAY

- A tooth is considered to have untreated decay when the screener can readily observe breakdown of the enamel surface.
- ***Only cavitated lesions are considered to be untreated decay***

UNTREATED DECAY

- Reference – detectable using PSR/CPI perio probe

UNTREATED DECAY

Smooth Surface

UNTREATED DECAY

Pits & Fissures

UNTREATED DECAY

- Retained roots = decay

This tooth would be classified as having untreated decay.

NOT UNTREATED DECAY

- Broken or chipped teeth are considered injured unless a cavity is also present

NOT
Untreated Decay
Code as Injured

NOT UNTREATED DECAY

- Temporary fillings are a filling rather than untreated decay
  - Includes glass ionomers placed for palliative reasons

This tooth has a filling but NO untreated decay.

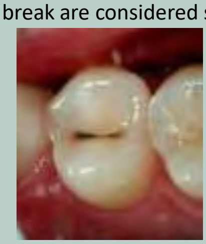
NOT UNTREATED DECAY

- Broken fillings are considered to be filled rather than decayed unless a cavity is also present

This tooth has a filling but NO untreated decay.

NOT UNTREATED DECAY

- Teeth with stained pits & fissures and NO enamel break are considered sound



This tooth has stain but NO enamel break so it is SOUND.

NOT UNTREATED DECAY

- “White spot” lesions are not untreated decay

These teeth have “white spots” but no break in the enamel surface.

RULE OF THUMB

When in doubt, be conservative. That means that if you are not sure if a cavity is present, assume it is not.

A FEW EXAMPLES

Source: www.univiss.net

WHITE DISCOLORATION

Not visible without prolonged air drying
Untreated caries = NO

May be visible without drying, fissures appear wider but no “break” in enamel integrity
Untreated caries = NO

Has definitive break in enamel surface
Untreated caries = YES

Source: www.univiss.net

WHITE-BROWN DISCOLORATION

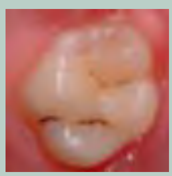
Not visible without prolonged air drying
Untreated caries = NO

Visible without drying, fissures appear dark & wider but no “break” in enamel integrity
Untreated caries = NO

Has definitive break in enamel surface
Untreated caries = YES

Source: www.univiss.net

DARK BROWN DISCOLORATION



Visible without air drying, stain
Untreated caries = NO

Visible without air drying, stain
Untreated caries = NO

Has definitive break in enamel surface
Untreated caries = YES

Source: www.univiss.net

POTENTIALLY ARRESTED DECAY

WHY "POTENTIALLY" ARRESTED DECAY?

- Confirming arrested decay requires a probe to determine if the surface is hard. The BSS does not use probes so the determination of arrested is based on a visual assessment only.

ARRESTED DECAY

- Break in enamel but surface appears hard and dark

EXAMPLES

TREATED DECAY

FILLINGS

- Does the tooth have a filling?
- Includes
  - Amalgam and composite restorations
  - Glass ionomer restorations
  - Temporary restorations

CROWNS

- Does the tooth have a crown placed because of decay?

EXTRACTED TEETH

- Has a tooth been extracted because of decay?
  - Do NOT include teeth that have exfoliated naturally
    - Most 5 year olds can tell you why teeth are missing
  - Do NOT include congenitally missing teeth

EXTRACTED TEETH

X X X X

- 4 year old child
- 4 maxillary anteriors have been extracted because of decay

OTHER CODES

DENTAL SEALANTS

DENTAL SEALANTS

- Include partially & fully retained sealants

Partially Retained Sealant

Fully Retained Sealant

RESTORATION OR SEALANT?

- Use your best clinical judgment to decide if a glass ionomer was placed as a restoration or as a sealant


HYPOPLASIA DEVELOPMENTAL DEFECTS OF ENAMEL

- Does the tooth have hypoplasia (code=H) without decay or a filling?

Opaque Defect

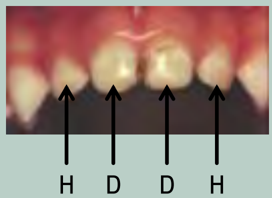
Pitted Defect

HYPOPLASIA & CARIES

Linear defects
Code as Hypoplasia

Linear defects plus caries
Code as Decayed

EXAMPLE



INJURED TEETH

- Code injured teeth as I


SPECIAL CIRCUMSTANCES


CONGENITALLY MISSING TEETH

- Code congenitally missing teeth as "UE" = unerupted

UE UE

FUSED TEETH

- Consider them as 2 separate teeth

TREATMENT URGENCY

TREATMENT URGENCY

- 3 levels based on how soon a child should visit the dentist for a clinical diagnosis and any necessary treatment
  - Urgent need
  - Early care needed
  - No obvious problem

TREATMENT URGENCY

- Urgent need
  - Needs dental care within the next week because of signs or symptoms that include ***pain, infection, or swelling***
  - A child with an abscess should always be coded as urgent
    - Even if the abscess is draining

TREATMENT URGENCY

This child has an abscess so they need URGENT care

TREATMENT URGENCY

This child has a draining abscess and should be coded as URGENT care

TREATMENT URGENCY

- Early dental care
  - Needs to see a dentist because of untreated decay or broken restorations but they do not have pain or an infection
  - Should see a dentist within the next several weeks or before their next regularly scheduled dental appointment

TREATMENT URGENCY

This child needs early dental care – no pain or infection

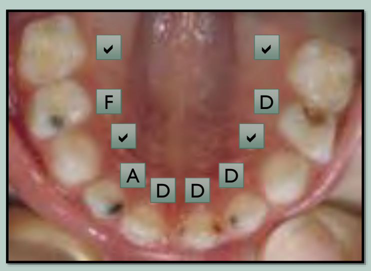
TREATMENT URGENCY

- No obvious problems
  - Individuals with no cavitated decay or other dental problems requiring early attention are considered to have no obvious problem, which means that they should receive routine dental checkups
  - Decay only on primary teeth about to be exfoliated
    - Child can have decayed teeth but not need treatment

TREATMENT URGENCY

This child has no obvious need for dental care

EXAMPLE



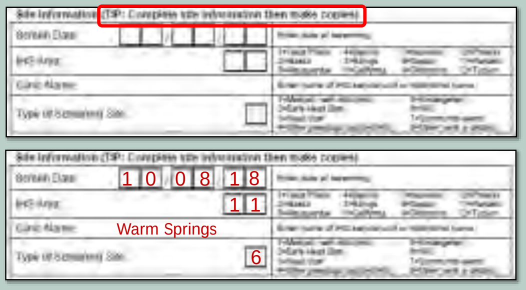
Screening Form Details

Use 2018 Form

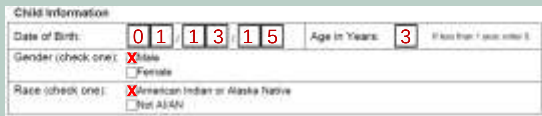
YOUR DENTAL ASSISTANTS ARE VERY IMPORTANT

- Please review project, screening form and codes with your dental assistants – they are the key to good quality data

SITE INFORMATION



CHILD INFORMATION

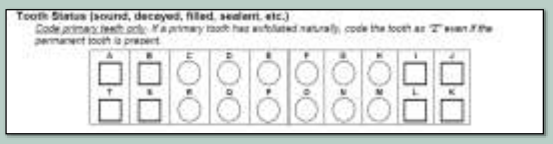


If date of birth is not available, leave blank.
Age: Round down

Race:

If a child is AI/AN plus another race, race=AI/AN
If a child is not AI/AN, race=Not AI/AN

TOOTH CHART



Code Primary Teeth Only
If tooth has exfoliated naturally, code tooth as "Z".

You can note if permanent molars/incisors are erupted.

TOOTH CODES

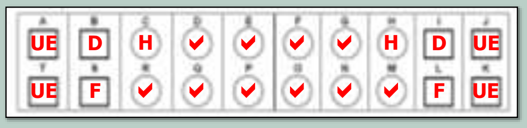
Healthy Teeth
- ✓ Sound
- S Sealant

Carious Teeth
- A Arrested
- D Decayed
- F Filled
- C Crown due to decay
- X Extracted due to decay

Missing Teeth
- UE Unerupted
- Z Exfoliated naturally
- X Extracted due to decay
- I Missing due to injury

Other Codes
- I Fractured, restored or missing due to injury
- H Hypoplasia

PUT A CODE IN EVERY SPACE

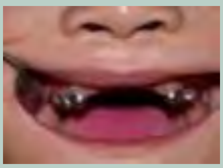


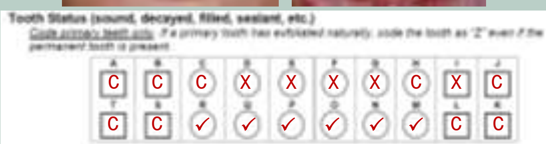
Do not leave any space blank.

ONE CODE PER TOOTH SPACE

- Decay supersedes all other calls
  - If a tooth is filled & decayed, code as “D”
  - If a tooth is sealed & decayed, code as “D”
  - If a tooth has hypoplasia & decay, code as “D”
- Fillings supersede sealants
  - If a tooth is filled & sealed, code as “F”
  - If a tooth has hypoplasia & filled, code as “F”

EXAMPLE



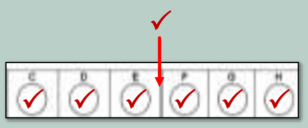


FUSED TEETH

Score each tooth separately

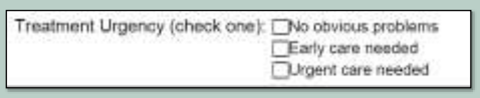
SUPERNUMERARY TEETH

- Add arrow to form and code tooth



TREATMENT URGENCY

- Assign code for treatment urgency



EXAMINER MATERIALS WWW.IHS.GOV/DOH

- Login to Dental Portal for the following
  - Data collection form
  - Slides from examiner training webinar
  - Sample passive consent forms
  - Sample referral letter
  - Answers to FAQs
  - Coding cheat sheet
  - Recording of training webinar

SEND COMPLETED FORMS TO…

Kathy Phipps
255 Bradley Avenue
Morro Bay, CA 93442

You may scan and email to
kathyphipps1234@gmail.com

If you scan forms, please do not use colored paper

THINGS TO CONSIDER

- Provide a service during the screening
  - Fluoride varnish
  - Anticipatory guidance
- If possible, bill for the service
- Count toward GPRA objectives

SUPPLIES

- Necessary
  - Non-latex gloves
  - Antiseptic hand wash
  - Tongue blades or mouth mirrors
  - Light – penlight, small flashlight, etc.
  - Extra batteries
  - Screening forms and pencil/pen

SUPPLIES

- Nice but not necessary
  - Toothpicks
  - Toothbrushes
    - Remove debris plus a "gift" for the child
  - 2x2 gauze
    - Remove debris & saliva
  - Some type of cover to put supplies on
    - Paper plates, tray covers, or heavy paper towels
  - Stickers – kids love stickers

ANY QUESTIONS?