

I-Smile™ Coordinator Handbook



2nd edition

September 2016

Overview



Background

The I-Smile™ program is the outcome of legislation passed in 2005 by the Iowa Legislature. House File 841, about Medicaid reform, included the following language:

“...every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings and preventive care identified in the oral health standards under the Early and Periodic Screening, Diagnostic, and Treatment program.”

In response, the Iowa Department of Human Services, who administers the Medicaid program, partnered with the Iowa Department of Public Health (IDPH), the Iowa Dental Association, the Iowa Dental Hygienists' Association, Delta Dental of Iowa, and the University of Iowa College of Dentistry to develop a plan that would fulfill the dental home mandate.

The result is called the I-Smile™ Dental Home Program.

Original Objectives of the I-Smile™ Program

The workgroup that developed the I-Smile™ concept identified four overall objectives and ten specific steps to meet those objectives and achieve a coordinated service delivery system statewide. (Figure 1)

Figure 1: I-Smile™ dental home proposal, 2006

Objective	Steps
I. Improve the Dental Support System for Families	<ol style="list-style-type: none">1. Provide funding to local Title V agencies to increase dental program infrastructure2. Increase funding to strengthen the state Title V database system for tracking patient care coordination and appointments3. Fund public oral health education and promotions4. Fund training programs and create mandatory continuing education requirements for dental and other health care providers regarding children's oral health
II. Improve the Dental Medicaid Program	<ol style="list-style-type: none">5. Contract with a familiar dental insurance carrier to improve dentist participation in Medicaid6. Create a dental screening code and specific reimbursement for physicians7. Allow reimbursement for oral screening and fluoride application by non-dental providers8. Reinstate coverage of periodontal services to adult dental Medicaid enrollees
III. Implement Recruitment and Retention Strategies for Underserved Areas	<ol style="list-style-type: none">9. Create a dentist/dental hygienist student loan repayment program to increase the dental workforce in shortage areas

IV. Integrate Dental Services into Rural and Critical Access Hospitals

10. Work with rural hospitals to develop dental clinics

The first objective, to improve the dental support system for families, has been the basis for the I-Smile™ program that has become familiar throughout the state and is conducted as part of the statewide Title V Child & Adolescent Health (CAH) program. IDPH provides funding for I-Smile™ to CAH contractors through an annual application process.

I-Smile™ helps children establish dental homes and achieve optimal oral health, particularly children on Medicaid. Activities also include a focus on pregnant women to assure good oral health during pregnancy and optimal birth outcomes and oral health for infants.

The I-Smile™ Dental Home Definition

The ultimate goal of a dental home is to ensure that children receive age-appropriate comprehensive dental care. The American Academy of Pediatric Dentistry's definition of a dental home helped to frame the I-Smile™ program guidelines, recommending referral for preventive and routine oral health care as early as 6 months of age and no later than 12 months. Periodicity of re-appointment is recommended based upon assessing a child's risk for oral disease (tooth decay). The Iowa Dental Periodicity Schedule is available on the IDPH/Oral Health Center (OHC) website:

http://idph.iowa.gov/Portals/1/userfiles/34/ohc_resources/ia_dental_periodicity_20150731.pdf

The definition of the I-Smile™ dental home, finalized in 2009 in Iowa Administrative Code 641(50), is:

A network of individualized care based on risk assessment, which includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services.

This I-Smile™ dental home concept is based on a team approach to manage and prevent oral disease. Primary prevention and care coordination are major components of the I-Smile™ program, centered in Iowa's public health system. Health professionals such as dental hygienists, physicians, nurse practitioners, and nurses are part of an expanded network providing oral screenings, education, anticipatory guidance, and preventive services as needed. Through referrals, dentists provide treatment and definitive evaluation.

Several outcomes are anticipated as a result of the I-Smile™ dental home approach:

- An integrated dental service delivery system,
- Early identification of disease risk,
- Enhanced prevention services,
- Improved care coordination and data tracking, and
- Strengthened parental involvement.

Ultimately, at-risk children who may be excluded from the traditional dental care delivery system will be reached and will have a dental home.

I-Smile™ within Iowa's Title V Maternal and Child & Adolescent Health System

The Title V Maternal and Child & Adolescent Health (MCAH) program is a federal-state partnership to ensure the health of mothers, women, children and youth, including children and youth with special health care needs. The Iowa Department of Public Health (IDPH) contracts with private/non-profit and public agencies throughout the state to implement the state's MCAH program. All 99 Iowa counties are included.

Iowa's local MCAH contractors have a network of community partners and work to assure that Medicaid-enrolled, uninsured, and underinsured children and pregnant women receive health-related services. Because of this, public health agencies are optimal sites to implement I-Smile™, which relies on an integrated health system using different levels of care and provider types. The Child & Adolescent Health (CAH) contractors receive funding for I-Smile™ and are designated as the central care coordination, prevention, and referral network for the I-Smile™ dental home.

Because the health of pregnant women directly impacts the health of newborn infants, I-Smile™ activities also include focus on clients of the Maternal Health (MH) programs, to assure access to dental services, education, and gap-filling preventive services.

I-Smile™ Coordinators

At the heart of the I-Smile™ program are local I-Smile™ Coordinators. Each Title V CAH contractor is required to have a dental hygienist serving as the coordinator for its service area. The I-Smile™ Coordinator is the single point of contact for I-Smile™ activities in each Title V CAH service area. I-Smile™ Coordinators must work at least 20 hours a week on activities to build the local public health system capacity and assure enabling and population-based oral health services. These activities lead to a strong local oral health infrastructure; availability of dental referral networks; oral health promotion and public awareness about oral health; and help for families to access oral health care.

The overall staffing capacity for oral health services must be adequate to meet the service area's needs, including the number of at-risk children and the size of the service area. For example, an I-Smile™ Coordinator working in a heavily populated county or a large service area of several counties would likely need to work 4-5 days a week to fulfill I-Smile™ responsibilities, with additional dental hygienists on staff to provide direct care services.

The responsibilities of coordinators are specifically outlined in Chapter 2.

Title V Compliance

Because I-Smile™ is a component of the Title V CAH program, program activities must adhere to all requirements and regulations associated with Title V. This includes MCAH essential services and standards, client confidentiality, maintaining data and client records, appropriate billing, release of information, consent for services, infection control, and HIPAA requirements.

Details may be found below and in Iowa's Title V Administrative Manual for Community-based Programs. The chapter in that manual about oral health services (700) is also chapter 5 of this I-Smile™ Coordinator handbook.

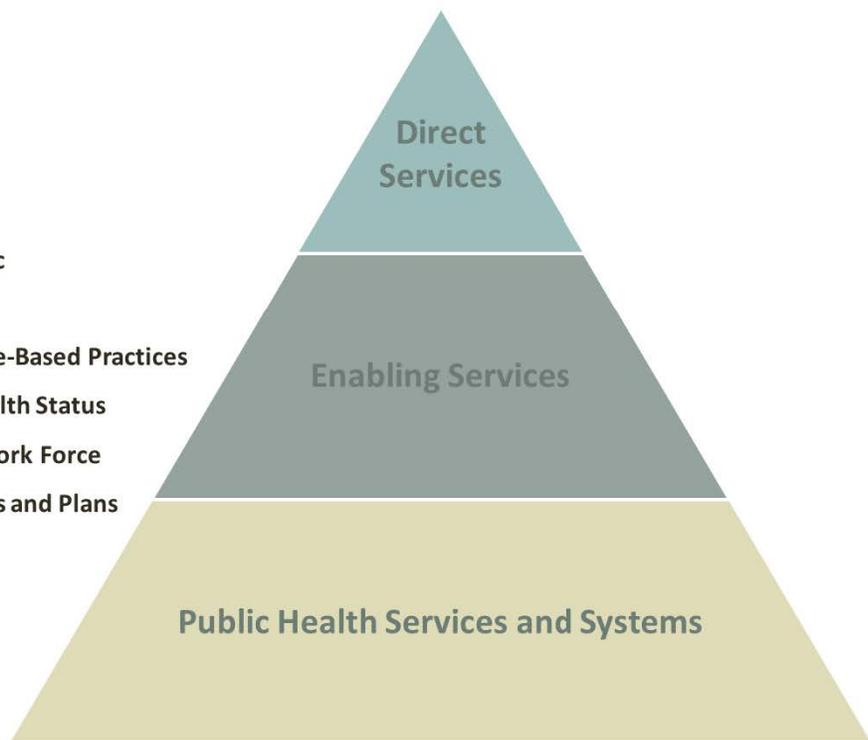
MCAH Essential Services and Public Health Standards

MCAH program activities are based on public health standards that include three levels of care and ten essential services as noted in the MCH pyramid:

Public Health Services for MCH Populations: The Title V MCH Services Block Grant

MCH ESSENTIAL SERVICES

1. Provide Access to Care
2. Investigate Health Problems
3. Inform and Educate the Public
4. Engage Community Partners
5. Promote/Implement Evidence-Based Practices
6. Assess and Monitor MCH Health Status
7. Maintain the Public Health Work Force
8. Develop Public Health Policies and Plans
9. Enforce Public Health Laws
10. Ensure Quality Improvement



The first level, **public health services and systems**, focuses on infrastructure-building activities to carry out the core public health functions of assessment, assurance, and policy development. This includes quality improvement activities; collecting, monitoring, tracking, and reporting data; engaging the public and seeking input; developing integrated systems of health care services, programs, and supports; workforce development and provider training; policy development; and population-based disease prevention and health promotion campaigns.

Oral health examples include:

- Conducting oral health community needs assessment
- Developing agency oral health protocols
- Providing oral health trainings
- Providing oral health surveys and education
- Oral health promotion campaigns

- Surveying dental offices to set up referral networks

The next level, **enabling services**, is the care coordination that provides the support families need to access health care, overcome barriers to oral health care and improve health outcomes. This includes referrals, translation/interpretation, transportation, outreach and enrollment assistance for public or private insurance, health education for individuals or families, health literacy, and outreach.

Oral health examples include:

- Assisting clients with locating dentists
- Assisting with scheduling dental appointments
- Reminding clients that periodic oral screenings or exams are due
- Counseling clients about the importance of keeping appointments
- Providing follow-up to assure that oral health care was received
- Arranging support services such as transportation, child care or translation/interpreter services
- Reinforcing anticipatory guidance
- Linking families to other community services (e.g., WIC)

And the third level, **direct services**, focuses on preventive clinical services for pregnant women, infants, children and adolescents who may not otherwise access care. These services must be gap-filling and not duplicative of services provided by dentists.

Oral health examples include:

- Gap-filling oral screenings and risk assessment
- Fluoride varnish applications
- Dental sealant applications
- Oral prophylaxes
- Radiographs
- Oral hygiene instruction/nutrition and tobacco counseling

The ultimate goal of the MCAH system is that all clients have a dental and medical home. Therefore, the MCAH contractors' activities are concentrated on the lower levels of the pyramid in order to support existing health care systems in meeting the needs of underserved families. Direct care services are provided when needed to fill any gaps.

The MCAH public health standards and essential services are the foundation for the responsibilities of I-Smile™ Coordinators. Each coordinator must work to build public health system capacity and assure population-based and enabling services. This leads to a strong local oral health infrastructure, referral networks, oral health promotion, public awareness about oral health, and help for families to access oral health care.

I-Smile™ Coordinator



Coordinator

I-Smile™ Coordinator

Establishing an Iowa-licensed dental hygienist as the I-Smile™ Coordinator in each Title V Child & Adolescent Health (CAH) service area is the first step for building local capacity within the I-Smile™ dental home system.

The coordinator must work a minimum of twenty hours a week to build public health system capacity and assure enabling and population-based oral health services. These activities lead to a strong local oral health infrastructure; availability of dental referral networks; oral health promotion and public awareness about oral health; and help for families to access oral health care. The I-Smile™ Coordinator is the single point of contact for I-Smile™ activities.

Each coordinator is responsible for assuring I-Smile™ activities are conducted in ALL counties of their service area. I-Smile™ Coordinators are liaisons between public health, families, dentists, businesses, schools, medical providers, and community organizations to ensure that children receive early and regular preventive and restorative dental care.

Coordinators must attend all required I-Smile™ trainings/meetings held by the Iowa Department of Public Health to assure a consistent statewide program message, maintain awareness of program and policy changes and impacts, and to stay informed about relevant issues and opportunities.

Responsibilities of each I-Smile™ Coordinator are outlined below. The following pages provide further detail about activities related to each responsibility.

- 1. Develop community partnerships and participate in health promotion and planning to strengthen the dental public health system.**
- 2. Link with the local board(s) of health to assist in assessment, policy development, and assurance of local oral health initiatives.**
- 3. Provide oral health education and training for health care professionals.**
- 4. Provide annual training about oral health for all Title V agency staff and additional ongoing training for staff that provide dental care coordination and/or direct dental services.**
- 5. Develop protocols for Title V agency staff to provide oral health services (dental care coordination and direct dental services).**
- 6. Ensure dental care coordination services are provided.**

- 7. Ensure completion of risk assessments and provision of periodic screenings and gap- filling preventive services, such as fluoride varnish applications, prophylaxes, and/or sealants.**

Partnerships and Planning

1. Develop community partnerships and participate in health promotion and planning to strengthen the dental public health system.

Developing community partnerships may be the most important aspect of an I-Smile™ Coordinator's job. Identifying and meeting with local partners in all service area counties strengthens the I-Smile™ program and is necessary for developing a coordinated referral network.

It is crucial that coordinators make local dental office staff aware of I-Smile™ and their role within the community. This includes familiarizing dental personnel about the screening, prevention, care coordination, and referral services that are part of I-Smile™. These relationships help families access dental care.

In addition to dental providers, coordinators must also build awareness with medical providers, particularly those in pediatric and family practice offices, as well as in rural health clinics and federally qualified health centers. Because young children are more likely to regularly see a medical provider than a dentist, it is imperative that physicians, physician assistants, nurse practitioners, and other medical staff know the importance of oral health for the young child. It is also important that they recognize the I-Smile™ Coordinator as a referral source to help their patients find a dentist who will see the young child and accept their insurance.

School nurses also play a valuable role in assuring children receive oral health services. They can identify children that need oral health services and refer to the I-Smile™ Coordinator. They can help with distributing and collecting school screening certificates and, if needed, provide oral screenings for kindergarten students. The I-Smile™ Coordinator can provide training to help increase nurses' knowledge and confidence with providing screenings.

Other partners, such as Head Start/Early Head Start, WIC, social service programs, Early Childhood Iowa, businesses, and civic and faith-based organizations are also vital to build local oral health infrastructure and to create awareness about the importance of oral health. There may be other health organizations and partners that are unique to a community; these, too, should be included as part of the I-Smile™ network.

The coordinator should regularly review, monitor, and use qualitative and quantitative data to share the I-Smile™ story with local partners and determine appropriate activities within the service area. I-Smile™ Coordinators must participate with local health planning and needs assessments, such as the Community Health Needs Assessment and Health Improvement Planning (CHNA-HIP) process.

The I-Smile™ Coordinator must be able to identify local health disparities and inequities and address them when planning and carrying out I-Smile™ activities. Considerations include racial, ethnic, geographic, religious, and cultural differences.

Local partners can be particularly helpful with oral health promotion and outreach activities. These activities help families and others in the community become aware of I-Smile™ and the importance of oral health. Community outreach and health promotion examples include:

- Participation in cultural and community events
- Placement of oral health information, such as on grocery or pharmacy bags
- Public service announcements
- I-Smile™ displays at libraries or other locations
- Creating and distributing posters for medical and dental offices
- Newspaper articles and advertisements
- Participation at health fairs
- Education for parent groups

As an I-Smile™ Coordinator, get to know your community. Talk to others. Learn as much as you can about possible resources. These linkages are the key to a strong I-Smile™ dental home program.

Local Board of Health Linkage

2. Link with the local board(s) of health to assist in assessment, policy development, and assurance of local oral health initiatives

Local boards of health (LBOH) are responsible for health assessment, policy development and assurance of health services in all 99 Iowa counties. Working with LBOH is an integral systems-building activity of Title V Maternal and Child & Adolescent Health (MCAH) contractors.

LBOH members may have limited knowledge about oral health and the I-Smile™ dental home program. I-Smile™ Coordinators are a valuable resource to increase awareness and assure that oral health issues are considered during local health planning. I-Smile™ Coordinators must be familiar with the oral health needs and assets of the service area. Through this understanding, coordinators are well-situated to participate in the Community Health Needs Assessment and Health Improvement Planning (CHNA-HIP) process and other local needs assessment activities, providing oral health expertise.

Compliance with the state's school dental screening requirement for children entering kindergarten and ninth grade is the responsibility of the LBOH. I-Smile™

Coordinators must work with each LBOH in the service area to assure completion of the school screening audits and submission of data to the Iowa Department of Public Health, per Iowa Administrative Code;
<https://www.legis.iowa.gov/law/administrativeRules/rules?agency=641&chapter=51&pubDate=09-14-2016>

Each year, I-Smile™ Coordinators must attend at least one LBOH meeting within each county of the service area and share program highlights, oral health data, school screening information and planned activities. Input and feedback should be requested of LBOH members. In addition to the annual personal presentation, the I-Smile™ Coordinator may also provide written I-Smile™ reports for each LBOH in the service area. The county health department administrator is often the person responsible for planning the agenda; maintaining positive communication with the administrator is beneficial.

Health Care Professional Education

3. Provide oral health education and training for health care professionals.

The I-Smile™ dental home relies on multiple health care providers to assure that children receive comprehensive dental services. This allows the workforce to be used most efficiently, with dentists providing the most skilled levels of dental care and other health care professionals providing preventive services, education, and referrals, as appropriate.

Too often, children younger than 3 years of age do not see a dentist. I-Smile™ Coordinators need to help educate dental office personnel about the importance of early and regular dental visits and how to examine infants and toddlers to help ensure that very young children have access to a dentist once baby teeth begin to erupt.

The I-Smile™ Coordinator is also responsible for assuring that non-dental health care providers are informed about the I-Smile™ dental home system. Coordinators are a liaison between the non-dental and dental providers in the I-Smile™ network and can facilitate linkages for a smoother referral process.

Physicians, nurse practitioners, registered nurses, and physician assistants routinely see children younger than 3 years old for well-child visits. I-Smile™ Coordinators have the opportunity to not only assist these medical providers with referrals but to also offer training about children's oral health and provision of preventive care.

Referrals: Let medical providers know that they can refer children and pregnant women who need dental care to you, as the local I-Smile™ Coordinator, to then facilitate referrals to local dental offices. Reducing the barriers that medical

providers may face with dental referrals is an important strategy of the I-Smile™ program.

Training and education: Most medical professionals have had limited oral health training. By offering training about children's oral health to medical office staff, there is a greater likelihood that these offices will become part of the I-Smile™ dental home. Physicians, nurses, and physician assistants are important allies who can identify abnormalities, assure high-risk children receive proven prevention such as fluoride varnish applications, and educate parents about the importance of oral health and a dental visit by a child's first birthday.

Training materials are provided to all I-Smile™ Coordinators by the Iowa Department of Public Health/Oral Health Center.

Title V Agency Staff Training

4. Provide annual training about oral health for all Title V agency staff and additional ongoing training for staff that provide dental care coordination and/or direct dental services.

To ensure standardized care and a consistent oral health message is provided, as part of family-centered Title V services, the I-Smile™ Coordinator is responsible for annual trainings of staff, as well as additional updates when needed.

- Annual training is required for **all staff** to understand the importance of oral health and to review agency oral health protocols. Education should be ongoing and may occur through one-on-one sessions, staff meetings, in-service trainings, and written updates.
- **Care coordinators** must be educated annually about the importance of early and regular dental care and the need to link families to that care. This includes training on available payment sources for dental care, including the **hawk-i** dental-only option.
- Agency **staff that provides direct dental services** must be trained annually on risk assessment, proper techniques (e.g. screening and fluoride varnish application) and appropriate education topics. They should also be trained on how to complete the EPSDT Informing Process.

Nurses working for MH and CAH agencies who provide direct dental services (dental screenings, fluoride varnish applications, and education/counseling) must be trained using an approved IDPH oral health training prior to providing those services. In addition, documentation of the training must be sent to IDPH. Training documentation forms must be requested from your IDPH oral health consultant.

If an I-Smile™ Coordinator works for an agency with only the CAH contract, he/she must offer the training to the MH contract agency staff within the same service area and keep them up-to-date on any future oral health education changes.

Agency Oral Health Protocols

5. Develop protocols for Title V agency staff to provide oral health services (dental care coordination and direct dental services).

A protocol is a detailed plan that describes the steps to perform a procedure or complete a process. The I-Smile™ Coordinator is responsible for developing and regularly updating agency protocols for the provision of dental care coordination and direct dental services.

At a minimum, protocols should be reviewed annually to make adjustments for updated IDPH or agency program policies or for quality improvement, as needed.

If a coordinator works for an agency contracted for both MH and CAH programs, protocols must address oral health services for both MH and CAH programs. If the coordinator works for an agency with only the CAH contract, he/she must offer assistance to the MH contract agency staff within the same service area to develop protocols for oral health services for maternal health clients.

IDPH oral health consultants can provide examples of oral health protocols and assistance with protocol development.

Care Coordination

6. Ensure dental care coordination services are provided.

The I-Smile™ Coordinator's knowledge about oral health, understanding of the service area needs, and relationships with dental offices are the foundation for overseeing and providing dental care coordination within the MCAH agency.

Care coordination is an enabling service that helps families establish and maintain a dental home and assure access to dental services. MCAH contract agencies are responsible for providing care coordination to all child and maternal health clients regardless of payment source.

Dental care coordination activities may include:

- Maintaining communication with area dental offices
- Assisting families with finding a local dentist
- Scheduling dental appointments on behalf of a family

- Reminding families when they are due for appointments
- Educating families about the importance of keeping appointments
- Providing anticipatory guidance and oral health education
- Assisting families with finding payment sources for dental care
- Providing follow-up to assure that oral health care was received
- Arranging support services such as transportation, child care or translation/interpreter services

To monitor care coordination services, I-Smile™ Coordinators may need to develop a tracking system for patient appointments, referrals, and follow-up. In addition, MCAH agencies are required to document all services provided to clients, including care coordination, into an electronic data system provided by the Iowa Department of Public Health.

Additional information is available in the following resources:

- Iowa's Title V Administrative Manual for Community-based Programs includes information about billing care coordination to IDPH; found online at <http://idph.iowa.gov/family-health/resources>;
- The Maternal and Child Health online training module for care coordination on the MCH tools website under "On-line Training at ISU Extension Moodle Site" <http://idph.iowa.gov/Portals/1/userfiles/88/2015%20MCH%20training%20modules%20CC%20-%20Fall%20Seminar.pdf>

Risk Assessment, Screening, and Preventive Oral Health Services

7. Ensure completion of risk assessments and provision of periodic screenings and gap- filling preventive services, such as fluoride varnish applications, prophylaxes, and/or sealants.

Data indicates that many low-income children in Iowa do not receive the preventive dental services that they need, particularly those younger than age three. I-Smile™ is designed to help to fill these gaps when appropriate. I-Smile™ Coordinators are responsible for identifying the gaps based on local data, and designing a plan to assure the most at-risk children in the service area receive the preventive services they need.

I-Smile™ Coordinators must also work with maternal health (MH) staff, within the same contract agency or the MH contract agency in the service area, to assure pregnant women have access to dental services. This includes access to dental offices and through gap-filling preventive services.

The I-Smile™ Coordinator is responsible for the quality assurance of direct dental services provided by all staff. If available, direct service dental hygienists should be used to provide direct dental services. If needed, other licensed health professionals

(registered nurses, nurse practitioners, or physician assistants) may be trained by the coordinator to provide limited services.

The I-Smile™ Coordinator may provide direct services but must meet contractual requirements for minimum time spent on other program activities and/or as indicated by service area size and/or population.

Direct dental services that may be provided by MCAH agency staff are:

- Oral screenings and risk assessment
- Fluoride varnish applications
- Oral hygiene instruction/nutrition and tobacco counseling
- Dental sealant applications (only dental hygienists)
- Oral prophylaxes (only dental hygienists)
- Radiographs (only dental hygienists)

Likely locations for provision of preventive services include WIC clinics, preschools, Head Start/Early Head Start classrooms, child care sites (excluding in-home), and schools. Based on local health systems, the I-Smile™ Coordinator should also consider other unique settings as possible preventive service sites.

Results of an oral screening and I-Smile™ risk assessment will guide the preventive care and treatment plan for each child and pregnant women screened and will also provide insight about counseling and education needs. The risk assessment will also indicate the referral and follow-up care plan. The I-Smile™ Risk Assessment tool and a sample screening forms are included within the Forms section, chapter 4, of this handbook. Refer to Section 700 of Iowa's Title V Administrative Manual for Community-based Programs for additional guidelines (chapter 5 of this handbook).

Additional forms that are relevant to provision of direct oral health services are included in chapter 4 of this handbook.



- **Community Water Fluoridation in Iowa**
- **Dental Emergencies**
- **Facts About Periodontal Disease**
- **How Tobacco Use Affects Your Mouth**
- **Oral Health and Pregnancy**
- **Oral Health for Infants, Children, and Adolescents**
- **Thumb, Finger and Pacifier Habit**
- **Tips for a Healthy Mouth**
- **Tooth Decay**
- **Tooth Eruption and Teething**
- **What is Xylitol**

Oral Health Education

Educating children, parents, pregnant women, and the public about the importance of oral health is an integral component of I-Smile™. It is the role of the I-Smile™ Coordinator to identify opportunities for oral health education within the service area, whether it is one-on-one, group, or broader community-based oral health promotion.

One-on-one

When MCAH direct service staff provide oral screenings for children and pregnant women, they should also spend time providing oral hygiene instruction (e.g. proper brushing) and/or education about other oral health topics (e.g. how soda pop contributes to cavity development). For very young children, information should be shared with parents and other caregivers as a child is screened. Client education should be individualized and based on the findings of the oral screening and risk assessment.

When providing oral health education, it is important to keep messages simple and limit the number of topics discussed per interaction. Motivational Interviewing helps a parent or client identify reasons to change behavior. The direct care staff's role is to help the parent/clients' see reasons for change through discussion, and help them to identify new strategies they are willing to try. Staff must listen closely to the parent/client and understand their perspective.

For example, the initial question could be, "What, if anything, would you like to do for your oral health in the next week or two?" This helps to engage the parent/client and encourage conversation.

An example of motivational interviewing is helping a mom to discover why it is better for her children to drink water between meals instead of juice. Simple questions the direct care staff may use are:

- Does Tommy drink juice between meals?
- Some parents are concerned about their child's teeth when they give them juice between meals while others are not. What about you?
- How, if at all, does the sugar in juice cause problems for your child's teeth?
- Does the sugar lead to acid attacks on the teeth?
- How do you think you can keep the acid from attacking Tommy's teeth?
- What can you do to prevent tooth decay?

- What might be a reason to have your child drink water instead of juice?

A web-based learning module to help better understand motivational interviewing is available on the Prepare Iowa website: <http://prepareiowa.training-source.org/training>

Groups

Another way that I-Smile™ Coordinators and MCAH staff help educate is through oral health education within group settings. Examples of group education include sessions for Head Start parents, library reading hours, and as presentations for organizations.

As with one-on-one education, the I-Smile™ Coordinator and MCAH staff must consider the health literacy of the audience to keep messages understandable and concise. Health literacy is the ability to obtain, read, understand and use health care information to make appropriate health decisions and follow instructions for treatment. Messages must be tailored, based on the interest area(s) of the participants. For example, when speaking to a business group, you should address how oral health impacts workforce and insurance costs or how prevention can save money in the future.

Oral Health Promotion

I-Smile™ Coordinators have unique opportunities to educate the public about oral health through health promotion activities. Educational messages may be incorporated on materials such as posters, giveaways, and bags. Displays may be created for locations such as schools, libraries, or grocery stores. Articles may be written for newspapers or newsletters. Consider health promotion items that are of interest to the target audience and that have some relevance to oral health.

The I-Smile™ Coordinator is responsible for training all MCAH staff who have interaction with clients and for those who may provide public education. This will ensure factual and consistent messaging.

Educational topic areas that may be considered for one-on-one or group education or oral health promotion include:

- Importance of baby teeth
- First dental visit by age 1 and periodic visits based on client's risk assessment
- Proper daily cleaning and monthly "Lift the Lip" techniques for infants/children
- Oral hygiene care before, during, and after pregnancy
- Risks associated with certain foods and beverages

- Risks from bottle and sippy cup habits
- Importance of topical fluoride exposure
- Non-nutritive sucking (fingers or pacifier)
- Teething/eruption patterns
- Risks associated with certain medications (e.g. seizure medications, those that cause dry mouth, or sugary cough syrups used for an extended time)
- Pregnancy gingivitis
- Morning sickness
- Risks of periodontal disease and link to pre-term labor
- Systemic implications of oral diseases
- Fluoride
- Transfer of decay-causing bacteria from mother to child

The IDPH Oral Health Center website includes information that may serve as a basis for oral health education provided by MCAH staff and also to guide development of education materials. The publication, *Bright Futures in Practice: Oral Health* also provides the tools and strategies needed to promote a lifelong foundation for oral health. It is published by the National Center for Education in Maternal and Child Health and may be ordered from: www.brightfutures.org.

For additional educational resources, refer to the Oral Health Center website: <http://idph.iowa.gov/ohds/oral-health-center/resources> or the I-Smile™ website: www.ismiledentalhome.iowa.gov/

NOTE: Any materials, including articles and presentations, created by I-Smile™ Coordinators or other agency staff must be approved by the agency's IDPH oral health consultant prior to use.

COMMUNITY WATER FLUORIDATION IN IOWA

The Centers for Disease Control & Prevention, the U.S. Surgeon General, and the Iowa Department of Public Health support fluoridation of public water supplies because of its health benefits to the public. The U.S. Department of Health and Human Services' recommendation for the optimal level of fluoride in drinking water is 0.7 milligrams per liter.

TOOTH DECAY

Tooth decay affects all age groups. And although it is preventable, it is the most common chronic disease of childhood. Untreated decay can lead to pain, tooth loss, poor nutrition, and difficulty eating, sleeping, and learning. Nearly one-fifth of all health care spending for children is related to dental care.ⁱ

BENEFITS OF FLUORIDATION

Fluoride strengthens tooth enamel, making teeth more resistant to decay. When fluoride is found naturally or added to community drinking water at proper concentrations, tooth decay can be prevented. The entire community benefits – all ages and income levels.

Community water fluoridation is one of the top ten public health achievements of the twentieth century due to its impact in reducing the amount of tooth decay experienced by Americans, particularly children. Fluoridation safely and inexpensively reduces tooth decay by 25 percent over a lifetime.ⁱⁱ

The Task Force on Community Preventive Services – an independent, nonfederal, volunteer group of public health and prevention experts – strongly recommends community water fluoridation. Their systematic review found that stopping fluoridation was associated with an increase in tooth decay.ⁱⁱⁱ

COST AND SAVINGS

By preventing tooth decay, water fluoridation saves money, both for families and for the health care system. Depending on the number of residents in a community, every dollar spent on fluoridation can save up to \$38 in avoided dental bills. Over a lifetime, the cost of fluoridation can be less than the cost of one dental filling.^{iv} Although helpful, fluoride tablets, rinses, and toothpaste are more expensive and less effective than the fluoridation of drinking water.^v

ADDRESSING SAFETY CONCERNS

Fluoride is a naturally occurring element, present in water and food. In fact, in Iowa it is not uncommon to have naturally-occurring fluoride in water from 0.1 to greater than 1.0 milligrams per liter. Fluoridation of community drinking water involves adjusting the naturally-occurring concentration of fluoride to a level that is recommended for preventing tooth decay.

The recommended fluoride level for preventing tooth decay is 0.7 milligrams per liter. In the past, research showed that a range of 0.7 to 1.2 milligrams per liter was necessary due to different levels of water intake in hot versus cold climates. Updated research finds that water consumption no longer differs based on climate. This, along with the fact that people receive fluoride from a variety of sources (fluoridated toothpaste, over-the-counter rinses, and food and drink products processed with fluoridated water), has resulted in the recommended level of 0.7 milligrams per liter. The Iowa Department of Public Health monitors water systems that add fluoride to assure the concentration is appropriate.^{vi}

Iowa Department of Public Health - July 2015

ⁱ US Dept. of Health & Human Services, NIDCR, Oral Health in America: A Report of the Surgeon General. Rockville, MD, 2000.

ⁱⁱ Griffin SO, Regnier E, Griffin PM, Huntley VN. Effectiveness of fluoride in preventing caries in adults. J Dent Res. 2007;86(5):410-414.

ⁱⁱⁱ Truman BI, Gooch BF, Sulemana I, et al. Task Force on Community Preventive Services. Review of evidence on interventions to reduce dental caries, oral and pharyngeal cancers, and sports-related craniofacial injury. American Journal of Preventive Medicine. 2002. 23(15) 1-84.

^{iv} Griffin SO, Jones K, Tomar SL. An Economic Evaluation of Community Water Fluoridation. Journal of Dental Public Health. 2001;61(2):78-86.

^v Kumar JV, Moss ME. Fluorides in Dental Public Health Programs. Dent Clin N Am. 2008;52:387-401.

^{vi} U.S. Department of Health and Human Services Federal Panel on Community Water Fluoridation. U.S. Public Health Service Recommendation for Fluoride Concentration in Drinking Water for the Prevention of Dental Caries. Public Health Reports. 2015:130(4)

Dental Emergencies

Toothache

Rinse the mouth with warm water to clean it out. Place a cold compress or ice wrapped in a cloth on the outside of the cheek. Call and go to the dentist as soon as possible. Do NOT use heat or place aspirin on the tooth or gum tissue.

Broken Tooth

Rinse the mouth with warm water to clean the area. Place a cold compress on the face to reduce swelling. Call and go to the dentist as soon as possible. If possible, bring the broken tooth fragment with you to the dentist.

Knocked-Out Tooth

If it is a baby tooth, call the dentist as soon as possible. Do NOT attempt to put a baby tooth back in the socket.

If it is a permanent tooth, rinse it gently in cool water. Do NOT scrub it or clean it with soap.

If possible, put the tooth back in the socket and hold it there with clean gauze or a wash cloth.

If the tooth cannot be put back in the socket, place the tooth in a clean glass with milk, saliva, or water. Take the tooth and go to the dentist immediately.

Bitten Lip or Tongue

Clean the area gently with a cloth and apply direct pressure to the bleeding area. If swelling is present, apply a cold compress. If bleeding does not stop, go to a hospital emergency room immediately.



Know what to do if a painful dental emergency occurs with you or your child.

Objects Wedged Between Teeth

Try to remove the object with dental floss, guiding the floss carefully to avoid cutting the gums. If using floss does not work, call the dentist. Do NOT try to remove the object with a sharp or pointed object.

Possible Fractured Jaw

Apply a cold compress to control swelling. Go immediately to the emergency room of a local hospital. Head injuries can be life threatening.

Emergencias dentales

Dolor de dientes

Enjuague la boca con agua tibia para limpiarla. En la parte exterior de la mejilla coloque una compresa fría o hielo envuelto en un paño. Llame y acuda al dentista lo antes posible. NO use calor ni ponga una aspirina en el diente o en el tejido de la encía.

Diente roto

Enjuague la boca con agua tibia para limpiar el área. Coloque una compresa fría en la cara para reducir la inflamación. Llame y acuda al dentista lo antes posible. Si le es posible, lleve el fragmento del diente al dentista.

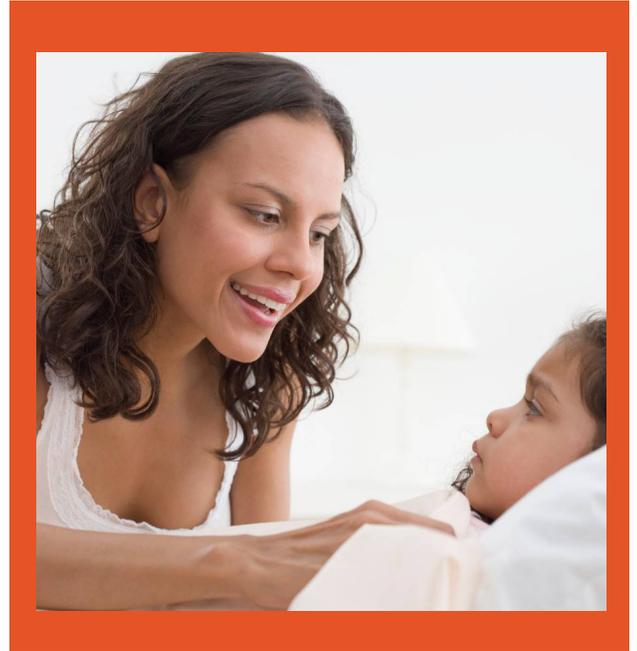
Pérdida de un diente por un golpe

Si el diente es de un bebé, llame a su dentista lo antes posible. NO intente volver a poner el diente del bebé en su cavidad.

Si es un diente permanente, lávelo suavemente con agua fría. NO lo frote ni lo lave con jabón. Si es posible, vuelva a poner el diente en su cavidad y manténgalo en su sitio con una gasa o paño limpio. Si no es posible volver a poner el diente en su cavidad, colóquelo en un vaso limpio con leche, saliva o agua. Tome el diente y vaya al dentista de inmediato.

Mordida en el labio o la lengua

Limpie el área con suavidad usando un paño y aplique presión directa al área que sangra. Si hay inflamación, aplique una compresa fría. Si el sangrado no se detiene, diríjase a una sala de emergencias de inmediato.



Sepa cómo actuar en caso de que usted o su hijo tengan una emergencia dental dolorosa.

Objetos atrapados entre los dientes

Trate de quitar el objeto con hilo dental, guiando el hilo con cuidado para evitar cortar las encías. Si no funciona el hilo dental, llame al dentista. NO intente quitar el objeto con un objeto filoso o puntiagudo.

Posible fractura de la mandíbula

Aplique una compresa fría para controlar la inflamación. Vaya de inmediato a la sala de emergencia de un hospital local. Las lesiones en la cabeza pueden ser potencialmente mortales.

The Facts on Periodontal Disease

Periodontal diseases are infections caused by germs that destroy the fibers and bones that support teeth.

Gingivitis - This is an infection of the gums and is the mildest form of periodontal disease. It is caused by the buildup of plaque (germs) along the tooth gumline and is reversible.

Periodontitis - When gingivitis is not treated, plaque will build up below the gumline. Toxins from plaque destroy the fibers and bones that support the teeth. If periodontitis is not treated, teeth may be lost.

Other Health Issues - Research has shown a link between periodontal disease and diabetes, heart disease and stroke, respiratory diseases, and pregnancy problems. Therefore, treating periodontal disease may also help to manage other health conditions.



Your dentist or dental hygienist can help you fight periodontal disease.

Do I Have Periodontal Disease?

Symptoms to look for include:

- Red, swollen, or tender gums.
- Bleeding while you brush, floss, or eat hard foods.
- Gums that are receding or are pulling away from the teeth. This will cause the teeth to look longer than normal.
- Loose or separating teeth.
- Pus between your gums and teeth.
- Sores in your mouth.
- Persistent bad breath.
- A change in the way your teeth fit together when you bite.
- A change in the fit of partial dentures.
- There may be no outward symptoms of the disease. Only a dentist can diagnose periodontal disease. Be sure to get regular checkups that include a periodontal exam.

Possible Contributing Factors for Periodontal Disease:

Poor oral hygiene • Smoking and tobacco use • Genetics • Female hormones • Stress • Medications • Diabetes

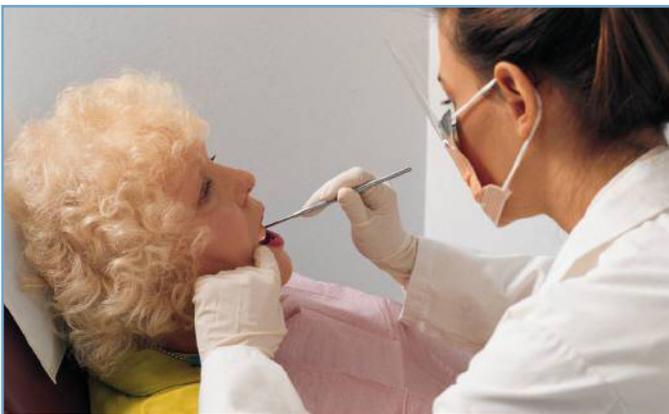
Datos sobre la enfermedad periodontal

Las enfermedades periodontales son infecciones causadas por gérmenes que destruyen las fibras y los huesos que sostienen los dientes.

Gingivitis – La gingivitis es una infección en las encías y es la etapa más temprana de la enfermedad periodontal. Es causada por un acumulamiento de placa (gérmenes) a lo largo de la línea de la encía del diente y es reversible.

Periodontitis – Cuando la gingivitis no se trata, la placa se acumulará por debajo de la línea de la encía. Las toxinas de la placa destruyen las fibras y huesos que sostienen los dientes. Si la periodontitis no se trata, se pueden perder dientes.

Otros problemas de salud – Las investigaciones muestran un vínculo entre la enfermedad periodontal y la diabetes, las cardiopatías y accidentes cerebrovasculares, enfermedades respiratorias y problemas en el embarazo. Por lo tanto, tratar la enfermedad periodontal también puede ayudar a manejar otras afecciones de salud.



Su dentista o higienista dental pueden ayudarlo a combatir la enfermedad periodontal.

¿Tengo Enfermedad Periodontal?

Los síntomas a tener en cuenta incluyen:

- Encías rojas, inflamadas y sensibles.
- Sangrado al cepillar los dientes, al utilizar hilo dental o al comer alimentos duros.
- Encías que se retraen o se separan de los dientes. Esto puede hacer que los dientes se vean más largos que lo normal.
- Dientes flojos o separados.
- Pus entre las encías y los dientes.
- Úlceras en la boca.
- Mal aliento constante.
- Un cambio en la forma en que sus dientes coinciden entre sí al morder.
- Cambio en el calce de las prótesis dentales parciales.
- Es posible que no presente ningún síntoma externo de la enfermedad. Solo un dentista puede diagnosticar enfermedad periodontal. Asegúrese de hacerse controles frecuentes que incluyan un examen periodontal.

Posibles factores que contribuyen a la enfermedad periodontal:

Mala higiene bucal • Fumar o consumir tabaco • Genética • Hormonas femeninas • Estrés • Medicamentos • Diabetes

How Tobacco Use Affects Your Mouth

Tobacco Use

Tobacco use, including cigarettes, cigars, pipes, and smokeless tobacco, can cause significant harm to your oral health, including:

- Oral cancer
- Periodontal (gum) disease - a leading cause of tooth loss and sensitivity
- Delayed healing after a tooth extraction or other oral surgery
- Loss of sense of taste and smell
- Bad breath
- Stained teeth and tongue

Smokeless Tobacco

Many people believe that smokeless tobacco (also known as dip, chew, or snuff) is a safe alternative to cigarette use. It is NOT. Like cigarettes, cigars, and pipes, smokeless tobacco products have toxins associated with cancer. Smokeless tobacco is known to cause cancers of the mouth, lip, and tongue.

Smokeless tobacco can also irritate your gum tissue and increase your risk for gum disease. Sugar is often added to improve the flavor of smokeless tobacco, which increases the risk for tooth decay. Smokeless tobacco also typically contains sand and grit, which can wear down your teeth.

Quitting Tobacco Use

Quitting tobacco use is difficult, but resources are available to assist you. Call Quitline Iowa at 1-800-784-8669 or visit their website at www.quitlineiowa.org.



Oral Cancer

Oral cancer most often occurs in those people who use tobacco in any form. Oral cancer can affect any area of the mouth including the lips, gums, cheeks, tongue, and the hard or soft palate. Signs and symptoms that may indicate oral cancer include:

- A sore that bleeds easily or does not heal
- A color change in the mouth (gray, red, or white spots or patches), rather than a healthy pink color
- Pain, tenderness, or numbness anywhere in your mouth or lips
- A lump or a leathery, wrinkled or rough patch inside your mouth
- Difficulty chewing, swallowing, speaking, or moving your jaw or tongue
- A change in the way your teeth fit together

See your dentist or physician if you notice any of these changes.

Como afecta a su boca el consumo de tabaco

Consumo de tabaco

El consumo de tabaco, incluidos los cigarrillos, cigarros, pipas y tabaco sin humo puede causar un daño importante en su salud bucal, incluido:

- Cáncer bucal.
- Enfermedad periodontal (encías) – una causa principal de pérdida de dientes y sensibilidad dental.
- Retraso en la cicatrización después de la extracción de un diente u otra cirugía bucal.
- Pérdida del sentido del gusto y el olfato.
- Mal aliento.
- Dientes y lengua manchados.

Tabaco sin humo

Muchas personas piensan que el tabaco sin humo (también conocido como dip, masticable o para aspirar) es una alternativa segura al consumo de cigarrillos. NO lo es. Los productos de tabaco sin humo al igual que los cigarrillos, los cigarros y las pipas tienen toxinas que se asocian con el cáncer. Se sabe que el tabaco sin humo causa cáncer en la boca, labios y lengua.

El tabaco sin humo también puede irritar el tejido de la encía e incrementar el riesgo de enfermedad de las encías. Algunas veces se agrega azúcar al tabaco sin humo para mejorar su sabor lo cual incrementa el riesgo de tener caries. Normalmente, el tabaco sin humo contiene arena y arenilla, esto puede llegar a desgastar sus dientes.

Abandonar el consumo de tabaco

Abandonar el consumo de tabaco es difícil, pero existen recursos disponibles para ayudarlo. Llame al Quitline Iowa 1-800-784-8669 o visite nuestro sitio web en www.quitlineiowa.org.



Cáncer bucal.

El cáncer bucal se presenta más a menudo en aquellas personas que consumen tabaco en cualquiera de sus formas. El cáncer bucal puede afectar a cualquier área de la boca, incluidos los labios, las encías, las mejillas, la lengua y al paladar duro o blando. Los signos y síntomas que pueden indicar cáncer bucal incluyen:

- Una úlcera que sangra fácilmente o que no sana.
- Un cambio en el color de la lengua (manchas grises, rojas o blancas) en lugar de un color rosa saludable.
- Dolor, sensibilidad o entumecimiento en cualquier lugar de la boca o labios.
- Un bulto o una mancha áspera, arrugada o gruesa dentro de su boca.
- Dificultad para masticar, tragar, hablar o mover la mandíbula o la lengua.
- Un cambio en la forma en que sus dientes coinciden entre sí.

Consulte a su dentista o médico si nota cualquiera de estos cambios.

Oral Health and Pregnancy

A healthy mouth is essential for a healthy pregnancy. Diet and hormonal changes that occur during pregnancy may increase a woman's risk for tooth decay and gum disease. Infections from tooth decay and gum disease can affect the health of a mother and her baby.

How does my pregnancy affect my oral health?

Vomiting caused by morning sickness can allow stomach acid to weaken your tooth enamel. This can increase your risk for cavities. Morning sickness can also make it difficult to brush and floss which also increases your risk for cavities and gum disease.

Hormonal changes during pregnancy can lead to an increased risk for gingivitis, an infection in your gums caused by plaque (germs). Hormonal changes can also cause your mouth to be drier. Less saliva or spit can increase your risk for cavities.

Eating more frequently during pregnancy can increase your risk for cavities, especially if you choose sugary or starchy foods.

How does my oral health affect my pregnancy?

If you have gum disease during pregnancy, the germs in your mouth can spread to your entire body. These germs can cause you to deliver a premature, low birth weight baby. They can also increase your risk for diabetes or preeclampsia (high blood pressure) during pregnancy.

How does my oral health affect my baby?

After your baby is born, germs that cause tooth decay can easily pass from your mouth to your baby's mouth. These germs can be passed through kissing, sharing utensils, or putting your baby's pacifier or hands in your mouth.

What should I do to keep my mouth healthy?

Visit a dentist at least one time during your pregnancy.

- Dental work is safe at any time during your pregnancy, but it may be more comfortable during your second trimester.
- A dentist can tell if you have any problems in your mouth and give you advice on how to keep you mouth healthy.

Choose healthy snacks.

- Limit sugary and starchy foods to mealtime only.
- Choose fruit rather than fruit juice.
- Avoid soda pop, including diet soda.
- Use gum and mints that contain xylitol.

Take care of your mouth.

- Brush your teeth, especially along the gumline, at least two times per day.
- Use a small, soft toothbrush.
- Use toothpaste with fluoride.
- Floss at least once daily to clean between teeth and under your gums.

For frequent nausea or vomiting.

- Eat small amounts of healthy foods throughout the day such as fruits, vegetables, yogurt, or cheese.
- Use a fluoride mouthrinse daily.
- Rinse your mouth with water or a combination of baking soda and water after vomiting to stop the acid attack on your teeth.

Good oral hygiene during pregnancy can have a positive impact on your health and the health of your baby!

La salud bucal y el embarazo

Una boca saludable es esencial para un embarazo saludable. La dieta y los cambios hormonales que ocurren en el embarazo pueden incrementar en la mujer, el riesgo de caries y enfermedad de las encías. Las infecciones de la caries y la enfermedad de las encías pueden afectar la salud de la madre y de su bebé.

¿Cómo puede mi embarazo afectar mi salud bucal?

El vómito causado por las náuseas matinales puede hacer que el ácido del estómago debilite el esmalte de sus dientes. Esto puede aumentar su riesgo de caries. El malestar matutino también puede dificultar el cepillado y uso del hilo dental lo que a su vez aumenta su riesgo de caries y enfermedad de las encías.

Los cambios hormonales durante el embarazo pueden llevar a un mayor riesgo de gingivitis, una infección en las encías causada por la placa (gérmenes). Los cambios hormonales también pueden causar que su boca esté más seca. Producir menos saliva puede aumentar el riesgo de caries.

Comer más frecuentemente durante el embarazo puede aumentar su riesgo de caries, especialmente si escoge alimentos con azúcar y almidón.

¿Cómo puede mi embarazo afectar mi salud bucal?

Si tiene enfermedad de las encías durante su embarazo, los gérmenes que se encuentran en su boca pueden propagarse a todo su cuerpo. Estos gérmenes pueden hacer que tenga un bebé prematuro y de bajo peso. Y también pueden aumentar su riesgo de padecer diabetes o preeclampsia (presión arterial alta) durante el embarazo.

¿Cómo mi salud bucal afecta a mi bebé?

Después de que su bebé nace, los gérmenes que causan las caries pueden pasar fácilmente de su boca a la boca de su bebé. Estos gérmenes se pueden pasar a través de un beso, compartir los cubiertos o al poner el chupete o las manos del bebé en su boca.

¿Qué debo hacer para mantener mi boca saludable?

Visite a su dentista al menos una vez durante su embarazo.

- Los procedimientos dentales son seguros en cualquier etapa de su embarazo, pero pueden ser más cómodos durante el segundo trimestre.
- Un dentista puede decirle si tiene algún problema en su boca y aconsejarle sobre cómo mantener su boca saludable.

Elija bocadillos saludables.

- Limite solo para la hora de la comida, los alimentos con azúcar y almidón.
- Elija fruta en lugar de jugo de fruta.
- Evite las gaseosas, incluidas las gaseosas dietéticas.
- Consuma goma de mascar y mentas que contengan xilitol.

Cuide su boca.

- Cepíllese los dientes, especialmente a lo largo de la línea de las encías, por lo menos dos veces al día.
- Use un cepillo de dientes pequeño y suave.
- Use pasta dental con flúor.
- Use hilo dental por lo menos una vez al día para limpiar entre los dientes y debajo de las encías.

Para mejorar el problema de náuseas o vómitos frecuentes.

- Consuma pequeñas cantidades de alimentos saludables a lo largo del día, como frutas, verduras, yogur o queso.
- Use enjuague bucal con flúor diariamente.
- Después de vomitar, enjuáguese la boca con agua o una mezcla de agua y bicarbonato para detener el ataque del ácido a sus dientes.

La buena higiene bucal durante su embarazo puede tener un impacto positivo en su salud y la salud de su bebé.

Oral Health for Infants, Children, and Adolescents

Beginning at birth, establish a daily routine for a lifetime of good oral health.

Infants (Birth until 2 years)

- Prior to tooth eruption, clean the infant's gums with a damp washcloth at least once a day.
- As soon as the first tooth appears, brush with a soft infant-sized toothbrush at least once a day - preferably at bedtime.
- For children younger than 2 years, talk to your health care professional about the use of fluoride toothpaste.
- Schedule the first dental visit by the child's first birthday.



Children (Ages 2 to 12 years)



- Brush teeth with a child-sized toothbrush at least twice a day - preferably after breakfast and before bedtime.
- Parents must help with brushing until children are at least 7 to 8 years old.
- Replace toothbrush every 3 to 4 months or when bristles are frayed.
- Use a pea-sized amount of fluoride toothpaste.
- Encourage children to spit excess toothpaste into the sink.
- Daily flossing should begin as soon as teeth touch each other - parents must help floss children's teeth until they are at least 8 to 9 years old.
- Continue regular dental visits. A dentist can decide how often visits are needed.
- Talk to a dentist about the need for sealants and additional fluoride.

Adolescents (Ages 13 years and older)

- Brush teeth at least twice a day - preferably after breakfast and before bedtime.
- Replace toothbrush every 3 to 4 months or when bristles are frayed.
- Use fluoride toothpaste.
- Floss at least once daily.
- Continue regular dental visits. A dentist can decide how often visits are needed.
- Talk to a dentist about the need for additional fluoride.



Salud bucal para bebés, niños y adolescentes.

A partir del nacimiento, establezca una rutina diaria para una buena salud bucal para toda la vida.

Bebés (recién nacidos hasta 2 años)

- Antes de que salgan los dientes, limpie las encías del bebé con un paño húmedo por lo menos una vez al día.
- En cuanto aparezca el primer diente, cepille utilizando un cepillo de dientes suave del tamaño adecuado para bebés, por lo menos una vez al día, preferentemente antes de acostarlo.
- Para niños menores de 2 años, hable con su profesional de atención a la salud con respecto al uso de pasta dental con flúor.
- Al cumplir el primer año de edad de su hijo, programe la primera visita al dentista.



Niños (2 a 12 años)



- Cepille sus dientes con un cepillo de dientes de tamaño infantil por lo menos dos veces al día, de preferencia, después del desayuno y antes de acostarse.
- Los padres deben ayudar a hijos a cepillarse los dientes por lo menos hasta los 7 u 8 años de edad.
- Cambie los cepillos de dientes cada 3 o 4 meses o cuando las cerdas estén desgastadas.
- Use una cantidad de pasta dental con flúor del tamaño de un guisante.
- Aliente a los niños a escupir el exceso de pasta dental en el lavabo.
- El uso del hilo dental debe comenzar en cuanto los dientes se tocan entre sí – los padres deben ayudar a los niños a usar el hilo dental hasta que cumplan los 8 o 9 años de edad.

Adolescentes (13 años de edad y más)

- Cepille los dientes por lo menos dos veces al día – de preferencia, después del desayuno y antes de acostarse.
- Cambie los cepillos de dientes cada 3 o 4 meses o cuando las cerdas estén desgastadas.
- Use pasta dental con flúor.
- Use hilo dental por lo menos una vez al día.
- Continúe visitando al dentista regularmente. Un dentista puede decidir con qué frecuencia son necesarias las visitas.
- Consulte a un dentista sobre la necesidad de usar flúor adicional.



Thumb, Finger, & Pacifier Habits

Sucking on a thumb, finger, or pacifier is a natural reflex for a baby. Sucking can help an infant feel happy and more secure, and it can also help young children soothe themselves to fall asleep.

Are sucking habits harmful for my child's teeth?

Most children stop sucking on thumbs, fingers, or pacifiers on their own between the ages of 2 and 4 years, and no harm is done to their teeth or jaws. If a child continues the sucking habit after the permanent teeth come in, there may be bite problems or the child can have crowded, crooked teeth. Pacifiers can affect the teeth the same way as sucking fingers or thumbs. However, the pacifier habit is often easier to break.



What are some tips when using pacifiers?

- DO use a pacifier with a plastic shield that is wider than your child's mouth.
- DO use a pacifier with ventilation holes.
- Do NOT tie a pacifier around your child's neck.
- Do NOT dip a pacifier in sugar or sweet liquids. This can increase your child's risk for tooth decay.
- Do NOT clean a pacifier in your mouth before giving it to your child. This can pass cavity-causing germs to your child.

What can I do to stop my child's habit?

Encouraging your child to stop the habit should begin by age 3, so that the sucking will have stopped entirely by age 4. Some tips to help encourage your child to stop the habit are:

- Praise your child for not sucking instead of scolding them when they are.
- Children often want to suck when feeling insecure or needing comfort. Try to find the cause of the anxiety and provide comfort for your child.
- Involve your child in choosing the method of stopping.
- Remind your child of the habit by wrapping the thumb or finger or putting a sock on their hand at night.
- Visit your dentist for help. The dentist can encourage your child and explain what could happen to their teeth if they do not stop sucking.

Hábitos de succionar el pulgar, el dedo o un chupete

Para un bebé, succionar su pulgar, su dedo o el chupete es un reflejo natural. La succión puede ayudar a un bebé a sentirse feliz y más seguro, puede incluso ayudar a niños pequeños a calmarse ellos mismos hasta quedar dormidos.

¿Los hábitos de succión de mi bebé son dañinos para sus dientes?

La mayoría de los niños dejan de succionar sus pulgares, dedos o chupetes por sí solos, entre los 2 y 4 años de edad, y no se produce ningún daño a sus dientes o mandíbulas. Si el niño continúa con el hábito de succión después de que aparecen los dientes permanentes, esto puede causar problemas en la mordida o el niño podría tener los dientes torcidos o encimados. Los chupetes al igual que succionar el pulgar o los dedos, pueden afectar los dientes de igual manera. Sin embargo, el hábito del chupete es más fácil de romper.



¿Cuáles son algunos consejos sobre uso de los chupetes?

- USE chupetes que tengan la parte del plástico más ancha que la boca del niño.
- USE chupetes que tengan orificios de ventilación.
- NO ate el chupete alrededor del cuello del bebé.
- NO sumerja el chupete en líquidos dulces o azúcar. Esto puede aumentar el riesgo de caries del niño.
- NO limpie el chupete en su boca antes de dárselo a su niño. Esto puede hacer que le pase gérmenes que causen caries.

¿Qué puedo hacer para romper con el hábito de mi hijo?

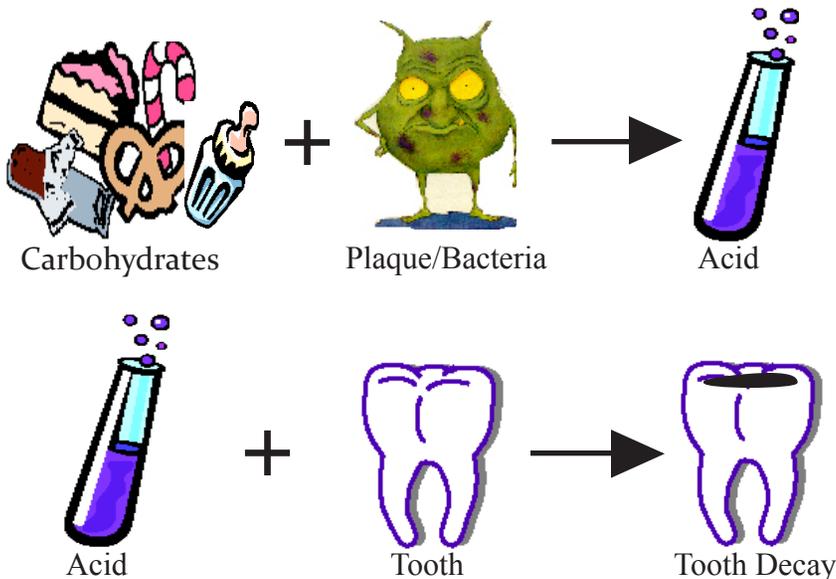
A los 3 años debe comenzar a alentar a su hijo a que deje el hábito de modo que deje de hacerlo completamente cuando tenga 4 años. Algunos consejos para ayudarlo a incentivar a su hijo a romper el hábito son:

- Elogie a su hijo cuando no use el chupete ni se chupe el dedo en lugar de rezongarlo cuando lo haga.
- A menudo los niños succionan cuando se sienten inseguros o necesitan consuelo. Trate de encontrar la causa de su ansiedad y reconforte a su hijo.
- Haga que su hijo participe en la elección del método para romper con su hábito.
- Recuérdele el hábito a su hijo envolviéndole el pulgar o el dedo o poniéndole un calcetín en su mano por la noche.
- Visite a su dentista para obtener ayuda. El dentista puede incentivar al niño y explicarle lo que le podría suceder a sus dientes si no deja el hábito de succión.

Tips for a Healthy Mouth

Tooth Decay

- This is the most common chronic disease of childhood.
- Germs in the mouth use sugars and starches from foods and drinks to make acids. These acids attack teeth and cause cavities.



Gingivitis (Gum Disease)

- This is an infection that occurs in the mouth when plaque germs are allowed to build-up along the gums.
- Signs of infection are gums that are red, tender, swollen, and likely to bleed when brushing or flossing.

Home Care

- Brush at least twice a day. This is especially important before bedtime.
- Parents should help with brushing until children are 7 to 8 years old.
- Floss at least once per day.
- Parents should help with flossing until child is at least 8 to 9 years old.

Fluoride

- Fluoride makes the teeth stronger and protects against the acids in the mouth that cause cavities.
- All children ages 2 and older should use a pea-sized amount of toothpaste with fluoride each time they brush.
- Choose fluoridated water. If you use bottled water, check to see if it contains fluoride.

Diet and Snacking Habits

- Limit sugary and starchy foods and drinks to mealtimes only.
- Limit soda pop, sports drinks, and other drinks that contain sugar.
- Choose drinks like water and milk and foods like cheese, yogurt, and fresh fruits and vegetables.

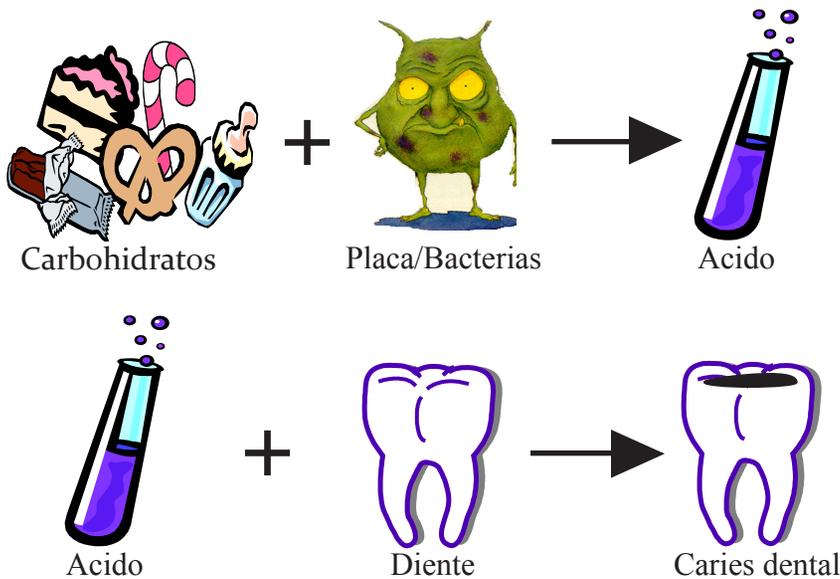
Dental Visits

- All children should have their first dental visit by their first birthday.
- Early and regular visits to the dentist are important to prevent dental disease.

Consejos para una boca saludable

Caries

- Esta es la enfermedad crónica más común en la infancia.
- Los gérmenes en la boca utilizan los azúcares y almidones de los alimentos y las bebidas para producir ácidos. Estos ácidos atacan los dientes y causan caries.



Gingivitis (enfermedad de las encías)

- Esta es una infección que aparece en la boca cuando se deja que los gérmenes de la placa se acumulen a lo largo de las encías.
- Los signos de infección son encías que se encuentran rojas, sensibles, inflamadas y probablemente sangren al cepillarse o al usar hilo dental.

Cuidado en casa

- Cepílese por lo menos dos veces al día. Es especialmente importante hacer esto antes de irse a dormir.
- Los padres deben ayudar con el cepillado hasta que los niños tengan 7 u 8 años de edad.
- Use el hilo dental al menos una vez al día.
- Los padres deben ayudar con el uso de hilo dental hasta que los niños tengan 8 u 9 años de edad.

Flúor

- El flúor fortalece los dientes y los protege contra los ácidos de la boca que causan caries.
- A partir de los 2 años de edad, todos los niños deben usar una cantidad de pasta dental con flúor del tamaño de un guisante, cada vez que se cepillan los dientes.
- Elija agua fluorada. Si consume agua embotellada, verifique si contiene flúor.

Hábitos de alimentación y bocadillos

- Limite el consumo de alimentos y bebidas azucaradas y con almidón únicamente a los horarios de comidas.
- Limite el consumo de gaseosas, bebidas deportivas y otras bebidas que contengan azúcar.
- Elija bebidas como el agua y la leche y alimentos como el queso, el yogur y las frutas y verduras frescas.

Visitas al dentista

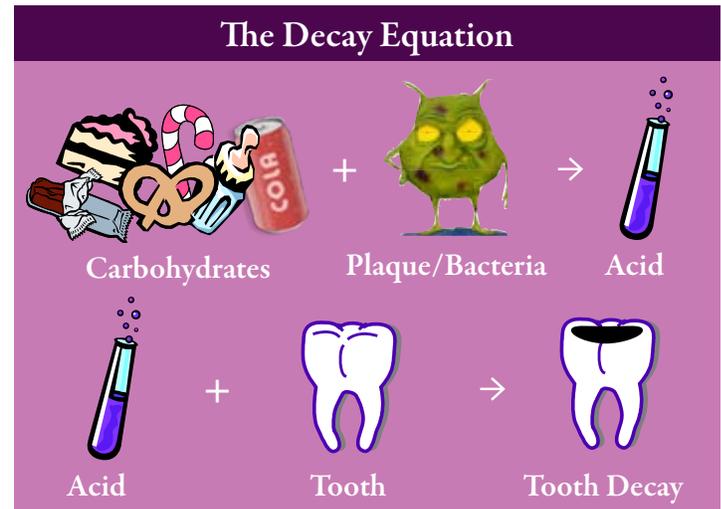
- Todos los niños deben de visitar a su dentista al cumplir su primer año de edad.
- Las visitas precoces y regulares al dentista son importantes para prevenir enfermedades dentales.

Tooth Decay

How Tooth Decay Happens

Three things are needed for tooth decay to occur - a tooth, carbohydrates (sweets and starches), and bacteria (germs). Bacteria in the mouth use sweet and starchy foods and drinks to make acid. After repeated acid attacks, the tooth enamel can break down, and a hole or cavity forms in the tooth.

As soon as a baby's first teeth appear - usually by age 6 months - a child is at risk for tooth decay. Tooth decay can cause difficulty with eating, sleeping, and speaking. It can also affect a child's ability to do well in school or an adult's ability to work.



Preventing Tooth Decay

Use of a baby bottle or sippy cup

- A naptime or bedtime bottle should only be filled with water.
- Juice and other sugary liquids - like chocolate milk, soda pop, Karo syrup, or sports drinks - should not be put in a baby's bottle. Encourage drinking from a cup by age 1.
- A sippy cup used between meals, at naptime, or at bedtime should only be filled with water.

Between-meal snacks

- Sweet and starchy foods should be limited to mealtime.
- Sticky foods - like dried fruit, chewy candy, potato chips, and crackers - stick to teeth and increase acid attacks.
- Hard candy, breath mints, and cough drops also stay in the mouth a long time and cause repeated acid attacks. Use sugarless products if possible.
- Choose snacks that help prevent cavities, such as cheese, yogurt, and milk - or make other healthy choices like fresh fruits and vegetables.

Soda pop and other beverages with sugar

- Limit soda pop and other sugary drinks - like sports drinks, fruit juice, and lemonade. Sipping on these drinks throughout the day can cause repeated acid attacks.
- Choose beverages like water, coffee, tea, and sugar-free noncarbonated drinks.
- Drink 6 to 8 glasses of fluoridated water every day.

Daily home care

- Brush twice a day with fluoride toothpaste.
- Floss at least once a day, especially at bedtime.
- After brushing and flossing at night, do not eat or drink anything except water.

Caries dental

¿Cómo aparecen las caries?

Se necesitan tres cosas para que aparezcan las caries - un diente, carbohidratos (azúcares y almidones) y bacterias (gérmenes). Las bacterias en la boca usan el azúcar y el almidón de los alimentos y las bebidas para producir ácidos. Después de repetidos ataques de ácido, el esmalte de sus dientes se puede romper y se forma un agujero o cavidad en el diente.

Tan pronto aparecen los primeros dientes del bebé - normalmente a los 6 meses - un niño puede estar en riesgo de sufrir caries. Las caries pueden causar dificultad para comer, dormir y hablar. También pueden afectar el desempeño de un niño en la escuela y el de un adulto en su trabajo.



Prevención de las caries

Uso de un biberón o vaso para bebé

- El biberón que se usa antes de la hora de la siesta o antes de ir a dormir, solo se debe de llenar con agua.
- Un biberón no debe llenarse con jugo y otras bebidas azucaradas como leche achocolatada, gaseosas, jarabe Karo o bebidas deportivas. Incentive el uso de una taza o vaso al año de edad.
- El vaso para bebé que se usa entre comidas, a la hora de la siesta o antes de ir a dormir, solo debe llenarse con agua.

Bocadillos entre comidas

- Limite los alimentos dulces y con almidón para las horas de las comidas.
- La comida pegajosa como la fruta seca, los caramelos masticables, las papas fritas y las galletas, se queda adherida a los dientes y aumentan los ataques de ácidos.
- Los caramelos duros, las mentas para el aliento y las gotas para la tos también permanecen en la boca por un largo tiempo y causan ataques de ácidos repetidos. Consuma productos sin azúcar si es posible.
- Elija bocadillos como el queso, yogur y la leche u otras alternativas saludables como frutas y verduras frescas, que ayudan a prevenir las caries.

Gaseosas y otras bebidas con azúcar

- Limite el consumo de gaseosas y otras bebidas azucaradas como las bebidas deportivas, los jugos de fruta y la limonada. Tomar estas bebidas durante todo el día puede causar ataques de ácidos repetidos.
- Elija bebidas como agua, café, té y bebidas sin gas y sin azúcar.
- Beba de 6 a 8 vasos de agua fluorada todos los días.

Cuidado diario en casa

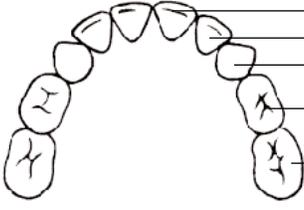
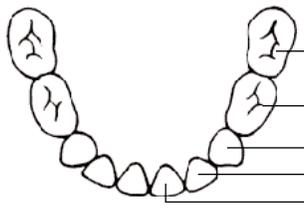
- Cepílese los dientes dos veces al día con pasta dental fluorada.
- Use hilo dental al menos una vez al día, especialmente a la hora de ir a dormir.
- Después de cepillarse y usar el hilo dental por la noche, no coma ni beba nada excepto agua.

Tooth Eruption & Teething

Tooth Eruption

A baby's teeth begin to erupt at about 6 months of age. The lower front teeth are usually first, followed by the upper front teeth. By age 2 to 2½, most children have all 20 primary (baby) teeth.

Permanent teeth begin to erupt at ages 6 to 7 years old. The lower front teeth and the first molars are usually the first permanent teeth to erupt.

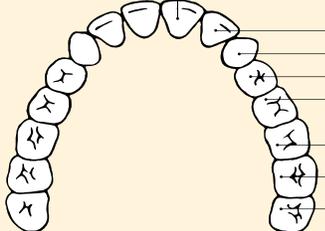
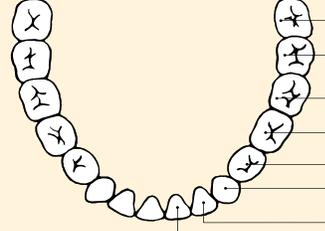
PRIMARY TEETH			
	Upper Teeth	Erupt	Shed
	Central incisor	8-12 mos.	6-7 yrs.
	Lateral incisor	9-13 mos.	7-8 yrs.
	Canine (cuspid)	16-22 mos.	10-12 yrs.
	First molar	13-19 mos.	9-11 yrs.
	Lower Teeth	Erupt	Shed
	Second molar	23-31 mos.	10-12 yrs.
	First molar	14-18 mos.	9-11 yrs.
	Canine (cuspid)	17-23 mos.	9-12 yrs.
	Lateral incisor	10-16 mos.	7-8 yrs.
	Central incisor	6-10 mos.	6-7 yrs.

Teething Symptoms

Your child may have sore gums when teeth erupt. Normal symptoms of teething include:

- Drooling more than usual
- Fussy behavior
- Crying
- Not sleeping well
- Loss of appetite

Diarrhea, rashes, and fever are not normal for a teething baby. If your baby has any of these symptoms while teething or continues to be fussy, call your physician.

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

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Teething Do's and Don'ts

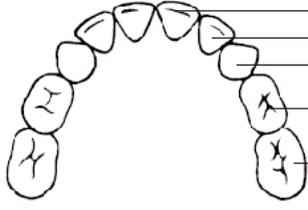
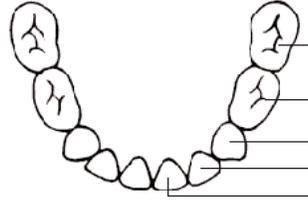
- DO gently rub your child's gums with a clean finger or something cool like a small spoon or a wet washcloth.
- DO use solid teething rings.
- Do NOT use a plastic teething ring with liquid filling. Your child could chew through the plastic.
- Do NOT use teething biscuits. The biscuits can increase your child's risk for tooth decay.
- Do NOT use a medicine for your child's gums without the advice of your dentist or doctor.

Erupción de los dientes y dentición

Erupción de los dientes

Hacia los 6 meses de edad, comienzan a salir los primeros dientes de los bebés. Normalmente, los dientes delanteros inferiores son los primeros en salir seguidos de los dientes delanteros superiores. De los 2 a los 2 años y medio de edad, la mayoría de los niños ya tienen los 20 dientes de leche.

A los 6 o 7 años de edad, es cuando comienzan a salir los dientes permanentes. Generalmente, los dientes delanteros inferiores y los primeros molares son los primeros dientes permanentes en salir.

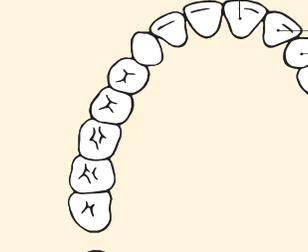
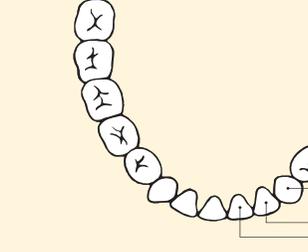
DIENTES DE LECHE			
	Upper Teeth	Erupt	Shed
	Central incisor	8-12 mos.	6-7 yrs.
	Lateral incisor	9-13 mos.	7-8 yrs.
	Canine (cuspid)	16-22 mos.	10-12 yrs.
	First molar	13-19 mos.	9-11 yrs.
	Lower Teeth	Erupt	Shed
	Second molar	23-31 mos.	10-12 yrs.
	First molar	14-18 mos.	9-11 yrs.
	Canine (cuspid)	17-23 mos.	9-12 yrs.
	Lateral incisor	10-16 mos.	7-8 yrs.
	Central incisor	6-10 mos.	6-7 yrs.

Síntomas de dentición

Su hijo puede tener las encías adoloridas al momento de la erupción del diente. Algunos síntomas normales de la dentición incluyen:

- Salivar más de lo normal
- Comportamiento irritable
- Llanto
- No poder dormir bien
- Pérdida del apetito

La diarrea, el sarpullido, y la fiebre no son síntomas normales en un bebé cuando le están por salir los dientes. Si su bebé tiene cualquiera de estos síntomas durante la dentición o continúa estando irritable, llame a su médico.

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

Tablas reimprimadas con el permiso de la American Dental Association

Lo que DEBE y NO DEBE hacerse durante la dentición

SÍ, frote suavemente las encías de su hijo con el dedo limpio o con algo frío como una cuchara pequeña o un paño húmedo.

SÍ use anillos de dentición macizos.

NO use anillos de dentición de plástico con rellenos líquidos. Su hijo podría morder y perforar el plástico.

NO use galletas para la dentición. Esto puede aumentar el riesgo de caries de su hijo.

NO use ningún medicamento para las encías de su hijo sin la recomendación de su dentista o médico.

What is Xylitol?

Xylitol is a natural sugar substitute that is found in many fruits and vegetables and is added to chewing gum and mint products. It is as sweet as sucrose, has no after-taste, and is safe for diabetics since it contains 40 percent less calories than sugar.

What are the benefits of xylitol?

- Strengthens teeth
- Reduces new tooth decay
- Reduces the number of cavity-causing bacteria
- Inhibits the growth of dental plaque
- Stimulates saliva flow
- Prevents cavity-causing germs (bacteria) passing from mother to child



Chewing xylitol gum can help reduce tooth decay.

When should I use xylitol?

Chewing xylitol gum or sucking on xylitol mints 3 to 5 times per day is recommended. Ideally, the xylitol product should be used immediately after a meal or snack. If a person snacks more frequently, more frequent xylitol use would be needed.



Many mint products contain xylitol.

Who can benefit from xylitol use?

- Children over 4 years of age who have had previous cavities
- Pregnant women
- New mothers of infants and toddlers
- Anyone at high risk for tooth decay
- Older adults with exposed root surfaces and those with dry mouth
- Anyone with a high sugar or high starch diet

Where can you find xylitol products?

There are many gum and mint products that contain xylitol. They can be found at most grocery and drug stores. Xylitol will be listed on the label as an ingredient.

¿Qué es el xilitol?

El xilitol es un sustituto natural del azúcar que se encuentra en muchas frutas y verduras y se agrega a la goma de mascar y productos de menta. Es tan dulce como la sacarosa, no deja un regusto y es seguro para personas con diabetes ya que contiene 40 por ciento menos calorías que el azúcar.

¿Cuáles son los beneficios del xilitol?

- Fortalece los dientes.
- Reduce la aparición de nuevas caries.
- Reduce la cantidad de bacterias que causan caries.
- Inhibe el crecimiento de la placa dental.
- Estimula el flujo de saliva.
- Evita que los gérmenes (bacteria) que causan caries pasen de la madre al hijo.



Masticar goma de mascar con xilitol puede ayudar a reducir las caries.

¿Cuándo debo usar xilitol?

Se recomienda masticar goma de mascar y chupar mentas que contengan xilitol de 3 a 5 veces por día. Idealmente, el producto con xilitol se debe consumir inmediatamente después de una comida o bocadillo. Si la persona consume bocadillos con más frecuencia, necesitará consumir xilitol con más frecuencia.



Muchos productos de menta contienen xilitol.

¿Quién se puede beneficiar del uso de xilitol?

- Niños de más de 4 años que hayan tenido caries previamente.
- Mujeres embarazadas.
- Mamás de bebés y niños pequeños.
- Cualquiera con alto riesgo de caries.
- Adultos mayores que tengan superficies expuestas de la raíz y aquellos con boca seca.
- Cualquiera que tenga una dieta alta en azúcares y almidones.

¿En dónde puedo encontrar productos con xilitol?

Existen muchos productos para mascar y de menta que contienen xilitol. Pueden encontrarse en la mayoría de los supermercados y farmacias. Debe encontrar el nombre de xilitol en la etiqueta como un ingrediente.

Forms





Consent Form – Template Screening and “Other” Service – Parent Present

Child’s Name:	Age:	Date of Birth:
Address:	Cell Phone: Other Phone:	
Child’s Physician:	Child’s Dentist:	
If applicable, child’s Medicaid ID number:		

YES, I give permission for my child to receive a dental screening and fluoride varnish application, sealant, prophylaxis (cleaning), x-rays.

If prophys will be provided, more detailed medical history questions must be added to evaluate a client’s risk for bacterial endocarditis or other conditions

Please answer the following questions:

1. Is your child currently under a physician’s care? Yes No
2. Is your child currently taking any medications? Yes No
3. Does your child have any allergies? Yes No

Please explain any YES answers: _____

NO, I do not give permission for my child to receive a dental screening and fluoride varnish application, sealant, prophylaxis (cleaning), x-rays.

Please answer the following:

1. Does your child have a regular dentist? Yes No
2. If yes, does your child see that dentist at least once a year? Yes No
3. My child’s most recent dental visit was within the past: (please check one)
 6 months 1 year 3 years 5 years has never seen a dentist
4. How do you pay for your child’s dental care? (please check one)
 Self Medicaid/Title XIX *hawk-i* Private dental insurance Other
5. List any concerns you have about your child’s mouth or teeth: _____

I consent to **(insert agency name)** use of email and texting to send me scheduling and child health services information.

Yes No Email address: _____

- I was offered a Notice of Privacy Practices.
- I understand that this consent is valid for one (1) year unless withdrawn in writing by parent or guardian.
- I understand that the services that will be received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child & Adolescent Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health, Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.

Parent/Guardian Signature

Date



Consent and Release of Information – Template Screening, Varnish + Sealants – Parent NOT Present

Child's Name:		Age:	Date of Birth:	
Address:		Cell Phone: Other Phone:		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	<input type="checkbox"/> White <input type="checkbox"/> Black	<input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Native American <input type="checkbox"/> Other
School:		Teacher's Name:		Grade:
Child's Physician:		Child's Dentist:		
If applicable, child's Medicaid ID number:				

_____ **YES**, I give permission for my child to receive a dental screening, sealants, and fluoride varnish application.
If prophyls will be provided, more detailed medical history questions must be added to evaluate a client's risk for bacterial endocarditis or other conditions

Please answer the following questions:

1. Is your child currently under a physician's care? Yes No
2. Is your child currently taking any medications? Yes No
3. Does your child have any allergies? Yes No

Please explain any YES answers: _____

_____ **NO**, I do not give permission for my child to receive a dental screening, sealants and fluoride varnish application.

Please answer the following:

1. Does your child have a regular dentist? Yes No
2. If yes, does your child see that dentist at least once a year? Yes No
3. Is your child eligible for the free/reduced lunch program at school? Yes No
3. My child's most recent dental visit was within the past: (please check one)
 6 months 1 year 3 years 5 years has never seen a dentist
4. How do you pay for your child's dental care? (please check one)
 Self Medicaid/Title XIX *hawk-i* Private dental insurance Other
5. List any concerns you have about your child's mouth or teeth: _____

I consent to **(insert agency name)** use of email and texting to send me scheduling and child health services information.
 Yes No Email address: _____

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- I understand that the information from these records may be shared with the Iowa Department of Public Health, Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.

Parent/Guardian Signature _____ **Date** _____

I voluntarily authorize _____ (insert agency name) _____ to release, obtain, or exchange information with the following: _____ (insert a list of specific possibilities – e.g. physicians, dentists, Head Start centers)

This release does *not* authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDS-related information.

Parent/Guardian Signature _____ **Date** _____

AGENCY NAME/LOGO

DATE

Dear Parent or Guardian:

As part of the I-Smile™ program, your child received a dental screening. No x-rays were taken and the screening does not replace a dental check-up by your family dentist or a medical checkup by your family doctor.

The results of the dental screening show that:

- Your child appears to have no obvious oral problems but should continue to have regular checkups by your family dentist.
- Your child appears to have some teeth that should be checked by your family dentist. Your dentist will tell you if treatment is needed.
- Your child appears to have some teeth that look like they need immediate care. Contact your family dentist as soon as possible for a complete check-up.
- Your child had fluoride varnish applied today. Your child's teeth may be temporarily discolored. Please have your child avoid crunchy foods today and please do not brush or floss until tomorrow morning.

If you do not have a family dentist or have difficulty making a dental appointment, please contact NAME OF COORDINATOR or CARE COORDINATOR at NAME of AGENCY at PHONE NUMBER.

Release of Information Form

AUTHORIZATION TO RELEASE, OBTAIN, AND EXCHANGE INFORMATION

AGENCY NAME: _____

AGENCY ADDRESS: _____

CLIENT NAME: _____ CLIENT CHART NUMBER: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____

STATE: _____ ZIP CODE: _____

Reason for request to release information: _____

I VOLUNTARILY AUTHORIZE (*insert MCAH agency name*) _____ staff to release, obtain, and exchange information with the following agencies:

NAME/AGENCY	ADDRESS	PHONE

I authorize the release and exchange of the following information:

- General Medical Care: _____ School Records: _____
 Screening Results: _____ Insurance Provider (payer): _____
 Social and Family History: _____ Other: _____

Specific Authorization for Release of Information Protected by State or Federal Law:

I acknowledge that information to be released may include material that is protected by federal and/ or state law applicable to substance abuse, mental health, and/ or HIV/AIDS – related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Please check the applicable boxes.]

Mental Health* yes no

Substance Abuse** yes no

HIV/AIDS yes no

Signature: _____

Patient Signature: _____

Signature: _____

Relationship: _____

Relationship: _____

Relationship: _____

Note in order for this information to be released you must also sign at the bottom of this page.

*Only client 18 years of age or emancipated teenager, or legal representative can authorize release of mental health information.

**Only client, regardless of age, can authorize release of substance abuse information.

I UNDERSTAND that the AUTHORIZATION TO RELEASE, OBTAIN, AND EXCHANGE INFORMATION form is limited to the agencies, groups, or persons named; and this information is not to be passed on to anyone else or to be used for any purpose other than those specified.

I understand that I have the right to see this information at any time. I can revoke my consent by writing to both the persons giving and the persons receiving the information. However, any information already released may be used as stated on this authorization form. I understand the information is needed to plan services or to determine eligibility for services. This authorization is effective for no longer than one year from the date of signature or for _____ months. This authorization is not automatically renewable. It expires from the date of signature. I have read this release or it has been read to me, and I understand its content. Photocopies of this release will be as valid as the original.

I certify that any person(s) who furnish such information concerning me shall not be held accountable for providing this information, and I do hereby release said person(s) from any and all liability which may be incurred as a result. I further release the Iowa Department of Public Health from any and all liability which may be incurred as a result of collecting or disclosing such information.

Note: See disclosure and re-disclosure on back side of this page before signing.

Signature of Client or Representative: _____ Date: _____

Relationship of Authorized Representative: _____ Date: _____

DISCLOSURE AND RE-DISCLOSURE

Iowa and federal law provides that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit additional disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Iowa Code Chapters 141A and 228.0 and other applicable laws.

This form does not authorize re-disclosure of medical information beyond the limits of the consent.

Child's Name: _____ ID: _____ DOB: _____

I-Smile Decay Risk Assessment

If a risk factor is present, check the appropriate box(es). Responses should be based on information gathered from an oral screening, parental consent form, and/or parent interview.

High Risk – If box is checked, client is considered high risk for decay.

Oral screening

<input type="checkbox"/>	Suspected or obvious decay
--------------------------	----------------------------

Moderate Risk – If the client is not high risk and any box below is checked, client is considered moderate risk for decay.

Oral screening

<input type="checkbox"/>	Demineralization (white spot lesions)
<input type="checkbox"/>	Visible plaque
<input type="checkbox"/>	Enamel defects (e.g. deep pits/fissures)
<input type="checkbox"/>	Stained fissures
<input type="checkbox"/>	Decay history (e.g. presence of fillings or crowns)
<input type="checkbox"/>	Other (e.g. presence of orthodontia, dry mouth, gingivitis)

Client Information

<input type="checkbox"/>	Parent's socio-economic status \leq 200% FPL (<i>from consent form</i>)
<input type="checkbox"/>	Dental visits - less than annually
<input type="checkbox"/>	Parent or sibling have untreated decay
<input type="checkbox"/>	Parent or sibling have history of decay (e.g. presence of fillings or crowns)
<input type="checkbox"/>	Child has special health care needs
<input type="checkbox"/>	Exposure to sugars/carbohydrates 1-2x/day, other than mealtime
<input type="checkbox"/>	No fluoride in toothpaste or no fluoride in water
<input type="checkbox"/>	Brushes 1 or fewer times per day

Low Risk – If none of the high or moderate risk factors above are present, client is considered low risk for decay.

Provider name and credentials: _____ Date: _____

Child's Name: _____ ID: _____ DOB: _____

I-Smile Care Plan

High Risk

- Primary prevention
- Education and anticipatory guidance
- Care coordination

If obvious or suspected decay present: Needs urgent dental care

- Refer **immediately** to dentist for disease diagnosis and management
- Re-assess risk in **3 months** (or assurance of regular exams by a dentist)

Moderate Risk

- Primary prevention
- Education and anticipatory guidance
- Care coordination

If demineralization or multiple risk factors are present: Needs dental care

- Refer for dental exam within **3 months**
- Re-assess risk in **3-6 months** (or assurance of regular exams by a dentist)

If no demineralization and less than 3 risk factors present:

- Refer for dental exam within **6 months**
- Re-assess risk in **3-6 months** (or assurance of regular exams by a dentist)

Low Risk

- Primary prevention
- Education and anticipatory guidance
- Care coordination

If no obvious problem:

- Refer for dental exam within **12 months**
- Re-assess risk in **6 months** (or assurance of regular exams by a dentist)

Provider name and credentials: _____ Date: _____

I-SMILE™ CHILD ORAL HEALTH SERVICES—SCREENING + OTHER SERVICES

RISK LEVEL:	Low D0601	Moderate D0602	High D0603	Decay: yes no
				Filled: yes no
				Sealed: yes no

Client Name: _____ **Medicaid/Client ID:** _____
DOB: _____ **Age:** _____ **Service Site:** _____ **Date of Service(s):** _____

Medical history reviewed: Yes No Notes: _____

ORAL SCREENING **D0190 CC** (INITIAL SCREEN) **D0190** (PERIODIC SCREEN) **D0145** (ORAL EVAL) **TD MODIFIER** (nurse provided)

<i>Condition of hard tissue</i>	<i>Documentation</i>	<i>Condition of soft tissue</i>	<i>Documentation</i>
Suspected decay or demineralization:		Gum redness, bleeding, (e.g. when brushing)	
Visible plaque:		Swelling or lumps:	
Decay history: (fillings or crowns)		Trauma or injury:	
Stained fissures, enamel defects, trauma or injury:		Other:	
Sealed teeth:		Findings of Parent Concern as noted on Consent	

Topic(s) of oral health education provided : teething/eruption non-nutritive sucking home care dietary habits
 fluoride regular dental visits sealants injury prevention bottle/sippy cup use

Notes: _____

Products recommended or dispensed: Toothbrush Toothpaste Floss Fluoride Rinse Anti-Microbial Rinse
 Salt Water Rinse None Other:

OTHER ORAL HEALTH SERVICES – DELETE THE SERVICES NOT PROVIDED

<i>Service</i>	<i>Documentation/Notes</i>		
Fluoride varnish	Type:	Fl Concentration:	
Sealant application	Tooth number(s) and surface(s):	Product used:	
Prophylaxis			
Radiographs	Number taken:	Type:	Tooth number/Quadrant:
Oral Hygiene Instruction			Time in:*
Nutritional Counseling			Time out:*

*Required

DENTAL REFERRAL /CARE COORDINATION

Parent letter with screening results and post-op instructions for varnish given Yes No
 Dentist referred to: _____
 Notes: _____

Referral need (based on risk assessment): Immediate Within 3 months Within 6 months Within 12 months

Provider Name and Credentials: _____ **Provider Signature:** _____ **Date:** _____

Service(s) documented in CARES	Oral Health Status documented in CARES
Need(s) documented in CARES	Risk documented in CARES

I-SMILE™ CHILD ORAL HEALTH SERVICES—SCREENING + OTHER SERVICES

RISK LEVEL:	Low D0601	Moderate D0602	High D0603
--------------------	------------------	-----------------------	-------------------

Decay:	yes	no
Filled:	yes	no
Sealed:	yes	no

Client Name: _____ Medicaid/Client ID: _____

DOB: _____ Age: _____ Service Site: _____ Date of Service(s): _____

Immunizations up-to-date YES NO

Translator needed: YES NO

PARENT INTERVIEW

	<i>Documentation</i>		<i>Documentation</i>
Medical history reviewed:		Dental visit frequency:	
Parent concerns:		Daily home care:	
Current/previous problems:		Feeding/snacking habits:	
Family decay history:		Fluoride exposure:	

ORAL SCREENING **D0190 CC** (INITIAL SCREEN) **D0190** (PERIODIC SCREEN) **D0145** (ORAL EVAL) **TD MODIFIER** (nurse provided)

<i>Condition of hard tissue</i>	<i>Documentation</i>	<i>Condition of soft tissue</i>	<i>Documentation</i>
Suspected decay or demineralization:		Gum redness, bleeding, (e.g. when brushing)	
Visible plaque:		Swelling or lumps:	
Decay history: (fillings or crowns)		Trauma or injury:	
Stained fissures, enamel defects, trauma or injury:		Other:	
Sealed teeth:			

Topic(s) of oral health education provided : teething/eruption non-nutritive sucking home care dietary habits
 fluoride regular dental visits sealants injury prevention bottle/sippy cup use
Notes: _____

Products recommended or dispensed: Toothbrush Toothpaste Floss Fluoride Rinse Anti-Microbial Rinse
 Salt Water Rinse None Other: _____

OTHER ORAL HEALTH SERVICES – DELETE THE SERVICES NOT PROVIDED

<i>Service</i>	<i>Documentation/Notes</i>		
Fluoride varnish	Type:	Fl Concentration:	
Sealant application	Tooth number(s) and surface(s):	Product used:	
Prophylaxis			
Radiographs	Number taken:	Type:	Tooth number/Quadrant:
Oral Hygiene Instruction			Time in:*
Nutritional Counseling			Time out:*

*Required

DENTAL REFERRAL /CARE COORDINATION

Dentist referred to: _____

Notes: _____

Referral need (based on risk assessment): Immediate Within 3 months Within 6 months Within 12 months

Provider Name and Credentials: _____ **Provider Signature:** _____ **Date:** _____

	Service(s) documented in CARES	Oral Health Status documented in CARES
	Need(s) documented in CARES	Risk documented in CARES

Sample Sealant Data Recording Form

Risk Level: Low D0601
 Moderate D0602
 High D0603
 Decay: Yes No
 Filled: Yes No
 Sealed: Yes No

ID#	Name	County #	DOB	Age
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	School District	School		Grade
Date of Service	Race	Translator Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid ID #	
Has a Dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Free/Reduced Lunch? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Most Recent Visit? <input type="checkbox"/> 6m <input type="checkbox"/> 12m <input type="checkbox"/> 3y <input type="checkbox"/> 5y <input type="checkbox"/> Never		Payment? <input type="checkbox"/> Self <input type="checkbox"/> XIX <input type="checkbox"/> hawk-i <input type="checkbox"/> Ins <input type="checkbox"/> Other		

<p>Oral Screening: <input type="checkbox"/> Medical history reviewed from consent form <input type="checkbox"/> D0190CC (initial screening) <input type="checkbox"/> D0190 (periodic screening) Visible plaque: <input type="checkbox"/> none <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy</p> <p>Soft Tissues: <input type="checkbox"/> no problems <input type="checkbox"/> gingivitis: localized___/generalized___ <input type="checkbox"/> trauma <input type="checkbox"/> lesions <input type="checkbox"/> swelling Describe: _____</p> <p>Hard Tissues: <input type="checkbox"/> no problems <input type="checkbox"/> chip <input type="checkbox"/> stained pits/fissures <input type="checkbox"/> decay <input type="checkbox"/> demineralized <input type="checkbox"/> other _____ Describe: _____</p> <p>D1351 Sealant application: <input type="checkbox"/> yes <input type="checkbox"/> no Date: _____ Products used: (ex: 40% Phosphoric Acid Etch Gel & Clinpro Sealant)</p> <p>D1206 Fluoride Varnish application: <input type="checkbox"/> yes <input type="checkbox"/> no Product used: (ex: Varnish America 0.25mL) Fluoride concentration: (ex: 5% NaF12 varnish)</p> <p>Education given: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Dietary <input type="checkbox"/> Home Care <input type="checkbox"/> Fluoride <input type="checkbox"/> Other Notes:</p> <p>D1330 Oral Hygiene Instruction: <input type="checkbox"/> yes <input type="checkbox"/> no Time In: _____ Time Out: _____ Notes:</p> <p>Referral to: _____ Referral: <input type="checkbox"/> Immediate <input type="checkbox"/> Within ___ months CArES Follow-up Date: <input type="checkbox"/> 3mo <input type="checkbox"/> 6mo <input type="checkbox"/> 1 year Parent letter with post-op instructions given for <input type="checkbox"/> varnish <input type="checkbox"/> sealants Provider Name/Credentials: Provider Signature:</p>	<p>UPPER RIGHT</p>	1		
		2		
		3		
		4 A		
		5 B		
		6 C		
		7 D		
		8 E		
	<p>UPPER LEFT</p>	9 F		
		10 G		
		11 H		
		12 I		
		13 J		
		14		
		15		
		16		
	<p>LOWER LEFT</p>	17		
		18		
		19		
		20 K		
		21 L		
		22 M		
		23 N		
		24 O		
	<p>LOWER RIGHT</p>	25 P		
		26 Q		
		27 R		
		28 S		
		29 T		
		30		
		31		
		32		

Sample Sealant Data Recording Form

Risk Level:	<input type="checkbox"/> Low D0601	<input type="checkbox"/> Moderate D0602	<input type="checkbox"/> High D0603	Decay: <input type="checkbox"/> Yes <input type="checkbox"/> No
				Filled: <input type="checkbox"/> Yes <input type="checkbox"/> No
				Sealed: <input type="checkbox"/> Yes <input type="checkbox"/> No

Recording Key

RACE

- 1 White
- 2 Black
- 3 Hispanic
- 4 Asian/Pacific Islander
- 5 Native American
- 6 Other
- 7 Undetermined/Unknown

COUNTY CODE *(enter service area counties)*

- 01 County A
- 02 County B
- 03 County C
- 04 County D

CARIES PREVALENCE

- 0 Unerupted / congenitally missing permanent tooth
- 1 Sound permanent tooth
- 2 Filled permanent tooth
- 3 Questionable permanent tooth
- 4 Decayed permanent tooth
- 5 Crowned permanent tooth

- a Sound primary tooth
- b Filled primary tooth
- c Questionable primary tooth
- d Decayed primary tooth
- e Crowned primary tooth

- S Sealed permanent or primary tooth



Maternal Oral Health Consent Form – Template

Name:		Date of Birth:
Address:		Cell Phone: Other Phone:
If applicable Medicaid ID number:		

YES, I give permission to receive a dental screening **and fluoride varnish application, sealant, prophylaxis (cleaning), x-rays.**

NO, I do not give permission for my child to receive a dental screening **and fluoride varnish application, sealant, prophylaxis (cleaning), x-rays.**

If prophylaxis will be provided, more detailed medical history questions must be added to evaluate a client's risk for bacterial endocarditis or other conditions

Medical Questions:

1. Name of physician: _____ 2. Delivery/Due date: _____
3. Are you currently under a physician's care for any health problems (other than pregnancy)? Yes No
4. Are you currently taking any medication? Yes No
5. Do you have any allergies? Yes No
6. Do you have any concerns or problems with your mouth or teeth? Yes No

Please explain any YES answers: _____

Dental Questions:

1. Do you have a regular dentist? Yes No If yes, name of dentist: _____
2. When was your last dental visit? (please check one)
 Within 1 year 1-3 years ago More than 3 years ago Never been to a dentist
3. What are your barriers to dental visits? (check all that apply)
 Cost Dentist does not accept Medicaid Lack of transportation Fear
 Inconvenient office hours None Other: (List)
4. How do you pay for your dental visits? (please check one)
 Self Medicaid/Title XIX *hawk-i* Private dental insurance Other: (List)

I consent to **(insert agency name)** use of email and texting to send me scheduling and maternal health services information.
 Yes No Email address: _____

I understand that:

- I was offered a Notice of Privacy Practices on _____
- This consent is valid for one (1) year unless withdrawn in writing.
- The services received do not take the place of regular dental check-ups at a dental office.
- These services are provided under the Iowa Department of Public Health, Maternal and Child & Adolescent Health Program.
- Records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- The information from these records may be shared with the Iowa Department of Public Health, Iowa Medicaid Enterprise, or designee, for audit and quality improvement purposes or other legally authorized purposes.

Client Signature

Date

Name: _____

ID: _____

Maternal Oral Health Risk Assessment

If a risk factor is present, check the appropriate box(es). Responses should be based on information gathered from consent form, client interview and oral screening.

High Risk – If box is checked, client is considered high risk for oral disease.

Oral Screening

	Suspected or obvious decay
	Suspected or obvious gum disease (moderate to severe redness, swelling, bleeding, exudate; loose teeth)

Moderate Risk – If the client is not high risk and any box below is checked, client is considered moderate risk for oral disease.

Oral Screening

	Mild gum inflammation (slight gum redness, swelling, or bleeding)
	Demineralization
	Visible plaque, calculus, or stain
	Enamel defects (deep pits/fissures)
	Decay history (presence of fillings or crowns)
	Other (e.g. presence of orthodontia, dry mouth, exposed root surfaces)

Consent Form/Client Interview

	Eligible for government programs (e.g. Medicaid, <i>hawk-i</i> , WIC, Head Start)
	Dental visits – less than annually
	Exposure to sugars/carbohydrates 1-3 times/day - other than mealtime (including soft drinks, juice)
	No fluoride in toothpaste or no fluoride in water
	Brushes 1 or fewer times per day
	Morning sickness – vomiting more than 1 time/day
	Tobacco use or drug/alcohol abuse

Low Risk – If none of the high or moderate risk factors above are present, client is considered low risk for oral disease.

Provider name and credentials: _____ Date: _____

Maternal Oral Health Care Plan

High Risk

- Primary prevention
- Education
- Care coordination

If suspected or obvious decay or gum disease present:

- Refer **immediately** to dentist for disease diagnosis and management
- Re-assess risk in **3 months** (or assurance of regular exams by a dentist)

Moderate Risk

- Primary prevention
- Education
- Care coordination

If gingival inflammation or demineralization present:

- Refer for dental exam **within 3 months**
- Re-assess risk in **3-6 months** (or assurance of regular exams by a dentist)

If no gingival inflammation or demineralization present, but other moderate risk factors noted:

- Refer for dental exam **within 6 months**
- Re-assess risk in **3-6 months** (or assurance of regular exams by a dentist)

Low Risk

- Primary prevention
- Education
- Care coordination

If no obvious problems, and no risk factors noted:

- Refer for dental exam **within 12 months**
- Re-assess risk in **6 months** (or assurance of regular exams by a dentist)

Provider name and credentials: _____ Date: _____

I-SMILE™ MATERNAL ORAL HEALTH SERVICES FORM

SAMPLE

RISK LEVEL:	Low	Moderate	High
	D0601	D0602	D0603

Decay:	yes	no
Filled:	yes	no
Gingivitis:	yes	no

Client Name: _____ Medicaid/Client ID: _____
 DOB: _____ Service Site: _____ Date of Service: _____
 Dentist Name: _____ Physician Name: _____

MEDICAL/DENTAL HISTORY

DELIVERY DUE DATE: _____

	<i>Documentation</i>		<i>Documentation</i>
Medical conditions related to oral health:		Daily home care:	
Current medications, allergies:		Eating/snacking habits:	
Tobacco, alcohol, or drug use:		Fluoride exposure:	
Oral concerns:		Other:	

ORAL SCREENING **D0190 CC** (INITIAL SCREEN) **D0190** (PERIODIC SCREEN) **TD MODIFIER** (nurse provided)

<i>Condition of hard tissue</i>	<i>Documentation</i>	<i>Condition of soft tissue</i>	<i>Documentation</i>
Suspected decay or demineralization:		Gum redness, bleeding, exudate:	
Visible plaque, calculus or stain:		Swelling or lumps:	
Decay history: (fillings or crowns)		Trauma or injury:	
Loose or missing teeth:		Recession:	
Enamel defects, trauma or injury:		Other:	

Topic(s) of oral health education provided: pregnancy gingivitis morning sickness daily home care dietary habits fluoride regular dental visits gum disease & systemic implications infant oral health transmission of bacteria
 Notes: _____

Products recommended or dispensed: Toothbrush Toothpaste Floss Fluoride Rinse Anti-Microbial Rinse Xylitol Sensodyne Biotene Salt Water Rinse None Other: _____

OTHER ORAL HEALTH SERVICES DELETE THE SERVICES NOT PROVIDED

<i>Service</i>	<i>Documentation/Notes</i>		
Fluoride varnish	Type:	Fl Concentration:	
Sealant application	Tooth number(s) and surface(s):	Product used:	
Prophylaxis			
Radiographs	Number taken:	Type:	Tooth number/Quadrant:
Oral Hygiene Instruction	Demonstration provided: Issue(s) addressed:	Time in:	Time out:
Tobacco Counseling	Issue(s) addressed:	Time in:	Time out:
Nutritional Counseling	Issue(s) addressed:	Time in:	Time out:

DENTAL REFERRAL

Dentist referred to: _____

Referral need (based on risk assessment): Immediate Within 3 months Within 6 months Within 12 months

Provider Name and Credentials: _____ **Provider Signature:** _____ **Date:** _____

Services(s) documented in WHIS	Barrier(s) documented in WHIS
--------------------------------	-------------------------------

Release of Information Form

AUTHORIZATION TO RELEASE, OBTAIN, AND EXCHANGE INFORMATION

AGENCY NAME: _____

AGENCY ADDRESS: _____

CLIENT NAME: _____ CLIENT CHART NUMBER: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____

STATE: _____ ZIP CODE: _____

Reason for request to release information: _____

I VOLUNTARILY AUTHORIZE (*insert MCH agency name*) _____ staff to release, obtain, and exchange information with the following agencies:

NAME/AGENCY	ADDRESS	PHONE

I authorize the release and exchange of the following information:

- General Medical Care: _____ School Records: _____
 Screening Results: _____ Insurance Provider (payer): _____
 Social and Family History: _____ Other: _____

Specific Authorization for Release of Information Protected by State or Federal Law :

I acknowledge that information to be released may include material that is protected by federal and/ or state law applicable to substance abuse, mental health, and/ or HIV/AIDS – related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Please check the applicable boxes.]

Mental Health* yes no

Substance Abuse** yes no

HIV/AIDS yes no

Signature: _____

Patient Signature: _____

Signature: _____

Relationship: _____

Relationship: _____

Relationship: _____

Note in order for this information to be released you must also sign at the bottom of this page.

*Only client 18 years of age or emancipated teenager, or legal representative can authorize release of mental health information.

**Only client, regardless of age, can authorize release of substance abuse information.

I UNDERSTAND that the AUTHORIZATION TO RELEASE, OBTAIN, AND EXCHANGE INFORMATION form is limited to the agencies, groups, or persons named; and this information is not to be passed on to anyone else or to be used for any purpose other than those specified.

I understand that I have the right to see this information at any time. I can revoke my consent by writing to both the persons giving and the persons receiving the information. However, any information already released may be used as stated on this authorization form. I understand the information is needed to plan services or to determine eligibility for services. This authorization is effective for no longer than one year from the date of signature or for _____ months. This authorization is not automatically renewable. It expires from the date of signature. I have read this release or it has been read to me, and I understand its content. Photocopies of this release will be as valid as the original.

I certify that any person(s) who furnish such information concerning me shall not be held accountable for providing this information, and I do hereby release said person(s) from any and all liability which may be incurred as a result. I further release the Iowa Department of Public Health from any and all liability which may be incurred as a result of collecting or disclosing such information.

Note: See disclosure and re-disclosure on back side of this page before signing.

Signature of Client or Representative: _____ Date: _____

Relationship of Authorized Representative: _____ Date: _____

DISCLOSURE AND RE-DISCLOSURE

Iowa and federal law provides that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit additional disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Iowa Code Chapters 141A and 228.0 and other applicable laws.

This form does not authorize re-disclosure of medical information beyond the limits of the consent.



Iowa: Recommendations for EPSDT Care for Kids Dental Services

These recommendations are based upon guidelines from the American Academy of Pediatric Dentistry¹ and Iowa's definition of a dental home in [Iowa Administrative Code](#).

Component	Child's Age	
	Birth to 12 months	1 year through 20 years
Clinical oral examination/oral screening	Upon the eruption of the first tooth and no later than 12 months	Every 6 months, or as indicated by child's risk assessment
Caries risk assessment	At every visit	At every visit
Radiographs	For trauma or emergency	Timing, selection, and frequency determined by child's history, clinical findings, and risk assessment
Prophylaxis	NA	Timing, selection, and frequency determined by child's history, clinical findings, and risk assessment
Fluoride varnish	2 – 4 times per year, as indicated by child's risk assessment	2 – 4 times per year, as indicated by child's risk assessment
Pit and fissure sealants	NA	Through age 18, as indicated by risk assessment (primary molars and/or permanent molars/premolars)
Oral hygiene instruction/dietary counseling	At every visit (with parent)	At every visit (with parent and/or child)
Anticipatory guidance/counseling	At every visit (with parent) <ul style="list-style-type: none"> • Injury prevention • Non-nutritive sucking • Speech/language development • Fluoride exposure • Diet/carbohydrate exposure 	At every visit (with parent and/or child) <ul style="list-style-type: none"> • Injury prevention • Non-nutritive sucking • Speech/language development • Fluoride exposure • Diet/ carbohydrate exposure • Substance abuse • Intraoral/perioral piercing
Assessment and treatment of developing malocclusion	NA	As indicated
Assessment and/or removal of third molars	NA	Children over 12 years of age

¹ www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf;
www.aapd.org/media/Policies_Guidelines/G_DentalPeriodicitySchedule.pdf

Administrative Manual



Section 700



Section 700

Oral Health Services

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701 –MATERNAL, CHILD & ADOLESCENT ORAL HEALTH SERVICES

Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Sec 506 [42 USC 706]

Effective Date: October 1, 2016

Overview

Maternal and Child & Adolescent Health (MCAH) contract agencies are responsible for ensuring access to oral health services, with an emphasis on early intervention and preventive oral health care beginning at or near the age of 12 months and into adulthood.

Through the core public health functions of assessment, policy development and assurance, contract agencies should work to develop comprehensive oral health service systems by:

- Building public health services and systems
- Providing enabling services to assure access to dental care
- Providing gap-filling direct dental services

A MCAH contract agency is required to provide these services based on the community needs assessment and as specified in the approved application plan on file with the Iowa Department of Public Health (IDPH).

Oral Health Center (OHC) staff within IDPH are available upon request to provide consultation and technical assistance for MCAH contract agencies.

Iowa Administrative Code

The Iowa Administrative Code (IAC) 641 IAC 50 describes the purpose and responsibilities of the state oral health program and dental director. Chapter 641 IAC 50 rules can be found at:

<https://www.legis.iowa.gov/law/administrativeRules/rules?agency=641&chapter=50&pubDate=04-07-2010>



702 –THE I-SMILE™ PROGRAM

Authority: IOWA ADMINISTRATIVE CODE 441 IAC 84; 42CFR 441.B

Effective Date: October 1, 2016

Background

In 2005, the Iowa legislature mandated that all Medicaid-enrolled children age 12 and younger have a designated dental home and be provided with dental screenings and preventive, diagnostic, treatment and emergency services as identified in the oral health standards under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The I-Smile™ program was developed in response to this mandate and serves as the comprehensive program to improve the oral health of Iowa children.

Program Overview

The basis of I-Smile™ is a conceptual dental home, with a focus on prevention and care coordination. The program relies on an integrated health system using different levels of care and different types of providers. Health professionals such as dental hygienists, physicians, advanced registered nurse practitioners, registered nurses, physician assistants and dietitians are part of a network providing oral screenings, education, anticipatory guidance and/or preventive services as needed. Through referrals, dentists provide definitive evaluation and treatment.

Due to their existing network of community partners and health-related services for Medicaid-enrolled, uninsured and underinsured children, CAH agencies are the center of the I-Smile™ dental home network.

Each CAH service area must have one Iowa-licensed dental hygienist as I-Smile™ Coordinator. The I-Smile™ Coordinator, with assistance from the CAH project director and other applicable staff, is responsible for developing and implementing activities within the service region. These activities are included on an activity worksheet, developed each year through the Title V CAH application process.

I-Smile™ activities must be based on the needs and assets of the service area. All counties served must be regularly assessed to determine available oral health resources as well as gaps in oral health services. Each county within the service area must be involved in the planning process and the plan must assure that children in all counties will be served.

Refer to the I-Smile™ Coordinator Handbook, 2nd edition, for additional information.

I-Smile™ Coordinator Requirements

In addition to maintaining an Iowa license to practice dental hygiene, I-Smile™ Coordinators must work a minimum of 20 hours a week to build public health system capacity and assure enabling/population-based oral health services. These activities lead to a strong local oral health infrastructure; availability of dental referral networks; oral health promotion and public awareness about oral health; and help for



families to access oral health care. The I-Smile™ Coordinator is the single point of contact for I-Smile™ activities.

The overall staffing capacity for oral health services must adequately reflect the service area's needs, including the number of at-risk children and the size of the service area (e.g. an I-Smile™ Coordinator working in a heavily populated and/or a large service area would work 4-5 days a week to fulfill I-Smile™ responsibilities, with additional dental hygienists on staff to provide direct dental services).

I-Smile™ Coordinators are required to participate in IDPH trainings and must also successfully complete the IDPH Public Health Training for Oral Health Professionals.

I-Smile™ Strategies

The I-Smile™ Coordinator is responsible for implementing the following I-Smile™ strategies to improve the dental support system for underserved children. Examples of activities are provided for each strategy. More detail may be found in the I-Smile™ Coordinator Handbook, 2nd edition.

1. Develop community partnerships and participate in health promotion and planning to strengthen the dental public health system.
 - a. Develop partnerships with local public health, dental and medical providers, local boards of health, schools, WIC, Head Start, migrant and community health centers, businesses, and civic and other community organizations
 - b. Establish an I-Smile™ dental referral network
 - c. Participate in community health planning and needs assessments
 - d. Conduct community oral health promotion (e.g. news articles, flyers, giveaways, social media)
2. Link with the local board(s) of health to assist in assessment, policy development, and assurance of local oral health initiatives.
 - a. Provide I-Smile™ program updates to each local board of health
 - b. Participate in local Community Health Needs Assessment and Health Improvement Plan (CHNA-HIP) process
 - c. Coordinate the school screening audit process and report to the local board(s) of health
3. Provide oral health education and training for health care professionals.
 - a. Meet with dental office staff to promote age 1 dental visits, encourage participation in Medicaid and *hawk-i*, and to offer training on seeing very young children to help ensure that young children have access to a dentist
 - b. Train non-dental primary care providers, such as physicians, nurse practitioners, registered nurses and physician's assistants, to provide oral screenings, fluoride varnish applications and education
 - c. Provide I-Smile™ referral information and patient education materials to hospitals, free clinics, and medical offices
4. Provide training about oral health for all Title V agency staff and additional ongoing training for staff that provide dental care coordination and/or direct dental services. Education should be

ongoing and may occur through one-on-one sessions, staff meetings, in-service trainings, and written updates.

- a. Provide annual all-staff training, to assure an understanding about the importance of oral health and to review agency oral health protocols
 - b. Educate care coordination staff about the importance of early and regular dental care and the need to link families to that care. This would include training on dental insurance options, including *hawk-i* dental-only
 - c. Train agency staff that provides direct dental services on risk assessment, proper techniques (e.g. screening and fluoride varnish application) and appropriate education topics
5. Develop protocols for Title V agency staff to provide oral health services (dental care coordination and direct dental services).
- a. Work with CAH contract agency staff to develop oral health protocols, including a plan for ongoing community needs assessment and program planning
 - b. Review protocols annually, to make adjustments for updated IDPH or agency program policies or for quality improvement, as needed
6. Ensure dental care coordination services are provided.
- a. Establish a dental referral list (e.g. dentists who accept Medicaid, dentists who see young children, dentists who see new patients)
 - b. Schedule dental appointments
 - c. Remind families when they are due for appointments
 - d. Provide anticipatory guidance and oral health education
 - e. Assist families with finding payment sources for dental care
 - f. Provide follow-up to assure that oral health care was received
 - g. Arrange support services such as transportation, child care or translation/interpreter services
7. Ensure completion of risk assessments and provision of periodic screenings and gap-filling preventive services.
- a. Oral screenings and risk assessments
 - b. Fluoride varnish applications
 - c. Oral hygiene instruction/nutrition and tobacco counseling
 - d. Dental sealant applications (only dental hygienists)
 - e. Prophylaxes (only dental hygienists)
 - f. Radiographs (only dental hygienists)

703 –THE I-SMILE™ @ SCHOOL PROGRAM

Authority: IOWA ADMINISTRATIVE CODE 441 IAC 84; 42CFR 441.B

Effective Date: October 1, 2016

Program Overview

I-Smile™ @ School is a school-based dental sealant and education program, providing services to vulnerable children less likely to receive routine dental care, such as children eligible for free or reduced-cost lunch programs. Direct services are conducted in school settings, with teams of dental providers (which may include dentists, dental hygienists, and/or dental assistants) using portable dental equipment. School-based dental sealant and education programs seek to assure that children receive preventive dental services through a community-based approach.

Dental sealants are effective in preventing decay and are particularly beneficial for children from low-income families who may not have access to regular dental care. A sealant is a tooth-colored material that is applied to the pit-and-fissure surface of posterior teeth. Sealants provide a physical barrier that prevents food debris and decay-causing bacteria from collecting in the pits and fissures of vulnerable teeth. Applying dental sealants within schools is an effective way to assure that children at greatest risk for tooth decay in newly erupting permanent molars have access to this low-cost, beneficial prevention.

Strategies

Successful CAH applicants will be responsible for the following I-Smile™ @ School strategies:

1. Serving a minimum of 200 students per contract period in their service area
2. Serving children in grades 2 and 3 (optional: serving grades in 1, 4, 5, 6, 7, and/or 8)
3. Targeting all schools with 40% or greater free/reduced lunch program participation. (Applicants may include schools with free/reduced lunch rates <40% within their sealant program services, but must use other sources of funding for those costs)
4. Providing oral health education for all 2nd and 3rd grade students, at a minimum, in all service area schools with 40% or greater free/reduced lunch programs. (Education is also encouraged in schools below 40% free/reduced lunch program rate.)

Note: To avoid duplication of services, the I-Smile™ @ School program will not be implemented in counties currently served by existing non-IDPH school-based sealant programs.

To meet the I-Smile™ @ School strategies, successful CAH applicants must:

1. Assess all schools within the service area to determine eligibility of schools and/or grades in which services may be provided to reach moderate and high-risk students. Each year of the project period schools must be reassessed to determine eligibility of additional schools and/or grades in which services will be expanded
2. Partner with local schools and dental providers (hygienists, assistants, dentists) to implement the program



3. Offer program services to all students within the intended grades in participating schools, regardless of insurance or payment source
4. Use appropriate equipment, supplies, techniques and procedures according to the I-Smile™ @ School program manual
5. Use IDPH I-Smile™ @ School outreach and promotion materials as directed throughout the project period
6. Use standardized IDPH forms, including materials found in the I-Smile™ @ School Program Manual
7. Provide care coordination for children and adolescents identified with dental treatment needs by referring students to dental offices for care, assisting families in making appointments, assisting families in finding payment sources for care, and educating families about the need for good oral health and regular care
8. Assure collaboration with I-Smile™ objectives and activities to improve the dental support system for families
9. Bill Medicaid for services provided to Medicaid-enrolled students and IDPH for billable care coordination services
10. Use the IowaGrants.gov system to submit monthly service and consent tracking data to IDPH
11. Enter services into the IDPH integrated data system
12. Participate in required meetings

For more information on the I-Smile™ @ School Program see the School-Based Dental Sealant Program Manual.

704 –MCAH ORAL HEALTH FUNDING

Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Section 506 [42 USC 706]

Effective Date: October 1, 2016

Overview

Oral health program funding is available for CAH contract agencies to develop oral health service systems and should be allocated according to an agency needs assessment. Limited funding is also available for MH agencies. The types and allowable use of funds are listed below.

CH-Dental Funding (CAH)

CAH contractors may use CH-Dental grant funds for the following:

- Costs for activities to build public health system capacity that provide support for developing and maintaining comprehensive oral health service systems in communities; and/or
- Costs associated with preventive direct dental services provided by approved CAH agency professional staff (dental hygienists, nurses, nurse practitioners, physician assistants) for Title V eligible children and adolescents from birth through age 21; and/or
- Reimbursement, at Title XIX approved rates, to local dentists providing a limited level of preventive and/or restorative dental services for Title V eligible children and adolescents from birth through age 21. (Funding may not be used to support direct dental services provided within federally qualified health center (FQHC) dental clinics.)

I-Smile™ Funding (CAH)

CAH contractors may use I-Smile™ grant funds for the following:

- Costs associated with building public health systems capacity, including assurance of population-based oral health services and non-billable enabling services, to develop local systems to assure a dental home for Medicaid-enrolled children.
- Costs associated with maintaining a dental hygienist as the I-Smile™ Coordinator, responsible for implementing the agency's I-Smile™ project activities and ensuring integration and completion of I-Smile™ strategies within the oral health program plan.

I-Smile™ funds may not be used for any costs for the provision of direct care services, including salaries and supplies.

I-Smile™ @ School Funding (CAH)

Most CAH contractors are eligible for I-Smile™ @ School grant funds to implement school-based sealant and education programs within schools at 40% or greater participation in the free/reduced lunch program (based on Iowa Department of Education data).



CAH contractors may use grant funds for the following:

- Costs associated with implementing a school-based sealant program, including personnel and supplies based on limitations within applicable RFPs, RFAs and contracts.
- Costs associated with providing classroom education on oral health to 2nd and 3rd grade students.

Other funds from local service organizations and/or private foundations may be used to provide services within schools with lower than 40% free/reduced lunch program rates.

No more than 20% of I-Smile™ @ School funds may be used for direct care. For the purposes of the I-Smile™ @ School Program, direct service costs only include personnel time spent providing oral screenings and application of sealant and/or fluoride varnish.

Maternal Oral Health Funding (MH)

Although there is no oral health-specific grant funding for MH contract agencies, Title V MH grant funds may be used for oral health-related activities for building public health services and systems, enabling, and direct dental services. In addition, some MH services may be available as part of the CAH contract agency's I-Smile™ program.

Medicaid Revenue (CAH and MH)

MH and CAH agencies must bill Medicaid for allowable direct dental services from a qualified provider to Medicaid-enrolled CAH and MH clients.

When billing for direct dental services, agencies must bill their established costs, which are based on their annual cost analysis report. The MCAH Cost Analysis Report, which includes maternal and child oral health services, must be submitted to IDPH annually.

Care Coordination Funding (fee-for-service)

MH and CAH agencies must bill IDPH for allowable dental care coordination services provided to Medicaid-enrolled clients.

When billing for care coordination, agencies must bill their established costs, which are based on their annual cost analysis report. The MCAH Cost Analysis Report, which includes maternal and child oral health services, must be submitted to IDPH annually.

Other Funding Sources (CAH and MH)

MH and CAH agencies are encouraged to seek other funds (e.g. foundation funding, Early Childhood Iowa (ECI), community grants) to enhance oral health service systems. Possible use of these supplemental funds may include: reimbursing dentists for treatment of eligible clients; contracting with an agency dental hygienist or nurse to provide oral screenings and fluoride varnish for clients not enrolled on Medicaid; oral health promotion; and purchasing oral health supplies for clients.

705 – PUBLIC HEALTH SERVICES AND SYSTEMS – ORAL HEALTH

Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Section 506 [42 USC 706]
Effective Date: October 1, 2016

Overview

Public health services and systems focus on infrastructure-building activities to carry out the core public health functions of assessment, assurance, and policy development. This includes quality improvement activities; collecting, monitoring, tracking, and reporting data; engaging the public and seeking input; developing integrated systems of health care services, programs, and supports; workforce development and provider training; policy development; and population-based disease prevention and health promotion campaigns.

A population-based approach identifies groups within the community who share common health needs, especially low-income families or families with limited availability of health services. This approach allows MCAH contract agencies to consider activities for an entire group, rather than one-on-one, benefiting many people. The client's payer source is not assessed and services for individuals are not billed.

Examples

MCAH contract agencies should provide services based on community needs assessments. Examples of building services and systems and population-based activities include:

- Surveying dental offices to identify oral health care accessibility in the service area
- Establishing regular, personal contact with dentists to advocate for children, pregnant women and families
- Developing referral tracking systems with local dental offices
- Educating and training physicians on oral health
- Conducting in-service staff trainings to develop oral health education, care coordination and referral protocols
- Establishing relationships with school health staff to assure oral health education and prevention services
- Developing and presenting oral health information for the board of health
- Participating in the local Community Health Needs Assessment and Health Improvement Plan (CHNA-HIP) process
- Conducting strategic planning with local oral health coalitions and other forums to assess community oral health needs
- Planning and implementing activities with community partners, such as “Give Kids a Smile Day”
- Organizing open mouth surveys
- Providing oral health education classes for Head Start parents

- Providing oral screenings at a community event (e.g. health fair)
- Providing oral screenings for open mouth surveys
- Providing gap-filling screenings for children unable to meet the school dental screening requirement
- Providing education for a prenatal class
- Promoting oral health
- Sharing oral health information with local organizations that have interest in the health of women and children
- Meeting with child care providers to evaluate and implement oral health programs
- Coordinating the school dental screening requirement with local boards of health, schools and providers
- Promoting early oral health care through hospital delivery centers, pediatricians and/or obstetrician/gynecologists

706 – ENABLING SERVICES - ORAL HEALTH

Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Section 506 [42 USC 706]

Effective Date: October 1, 2016

Overview

Enabling services include outreach, informing, and care coordination and provide the support families need to access health care, overcome barriers to oral health care and improve health outcomes. MCAH contract agencies are responsible for providing enabling services to all child and maternal health clients regardless of payment source. This includes care coordination, referrals, translation/interpretation, transportation, outreach and enrollment assistance for public or private insurance, health education for individuals or families, health literacy, and outreach.

MH Outreach

MH agencies must assess pregnant women regarding their access to oral health care and methods to pay for dental care. Medicaid presumptive eligibility determinations are provided for pregnant women who have no health insurance.

CAH Informing

Many families may not understand the importance of early and regular oral health care by age 1. As part of informing activities, CAH contract agencies will:

- Promote the benefits of preventive oral health care
- Provide the names and locations of participating dentists
- Encourage families to establish dental homes
- Inform families about available payment sources for oral health care

MCAH Dental Care Coordination

Care coordination links pregnant women, children and families to oral health care. Billable care coordination requires personal contact (face-to-face, email, telephone call or text) with families.

Examples of dental care coordination activities include:

- Assisting clients with locating dentists
- Assisting with scheduling dentist appointments
- Reminding clients that periodic oral screenings or exams are due
- Counseling clients about the importance of keeping appointments
- Providing follow-up to assure that oral health care was received
- Arranging support services such as transportation, child care or translation/interpreter services
- Reinforcing anticipatory guidance
- Linking families to other community services (e.g., WIC)

MH “Oral Health Only” Enrollment for Pregnant Women

A woman may choose to opt out of full MH program services, yet need preventive dental services or assistance accessing dental care. In these instances, she can become enrolled in the MH program as an “oral health only” client.

Full enrollment in the MH program should always be encouraged, but in these situations described, it is not required.

“Oral health only” clients must be enrolled and also discharged on the same day, unless follow up services are needed.

707 –DIRECT DENTAL SERVICES PROVIDED BY AGENCY STAFF

Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Section 506 [42 USC 706]

Effective Date: October 1, 2016

Description

Based on local needs assessment, MCAH contract agencies may provide direct dental services for families in their service areas. These services must be gap-filling and not duplicative of services provided by dentists or other local initiatives. Examples include:

- Gap-filling oral screening and risk assessment
- Fluoride varnish applications
- Dental sealant applications
- Prophylaxes
- Radiographs
- Oral hygiene instruction
- Nutritional counseling for the control of dental disease
- Tobacco counseling for the control and prevention of oral disease

Note: An oral screening must always be done prior to the provision of fluoride varnish applications, dental sealants, prophylaxes or radiographs. Referrals for regular dental care and dental care coordination services must also be provided for women and children receiving direct dental services by MCAH contract agency staff.

Direct Service Providers

It is recommended that direct dental services be provided by a dental hygienist employed or contracted by the agency. However, based on an agency needs assessment and workforce availability, registered nurses, nurse practitioners and physician assistants who are employed or contracted by the agency may also provide direct dental services, if trained.

Training for non-dental MH and CAH agency health professionals must be provided by the CAH contract agency I-Smile™ Coordinator using IDPH-approved training materials. Documentation of the training, including a list of personnel trained, must be completed on approved forms and submitted to the IDPH Oral Health Center (OHC).

All direct dental services must be provided according to IDPH protocols and scope of practice regulations.

Refer to section 718 of this manual for information on dental hygienist supervision.

Consent for Oral Health Services

MCAH contract agencies must assure that consent is obtained prior to performing oral health services to maternal and child health clients according to the following criteria.

Active Consent

Active consent is required for:

- Fluoride varnish applications
- Dental sealants
- Prophylaxes
- Radiographs

Active consent is recommended for:

- Oral screenings

Active consent means that the client, or parent/guardian of a minor (child under age 18 and unmarried), must indicate consent for each service and must sign and date the form.

Consent forms are valid for one year. Standardized consent forms can be obtained from the OHC or agencies may develop agency-specific consent forms based on the OHC template. Consent forms that are modified must be pre-approved by the IDPH OHC staff.

Combined child health/oral health or maternal health/oral health consent forms may be used. Specific oral health services offered by the agency must be included on the combined consent forms. MCAH contract agencies must assure that all information required on the OHC consent template is captured within the client chart.

Contract agencies may accept a consent form that has been faxed or an electronic signature that has been sent via email. Phone consent is not acceptable.

Passive Consent

Passive (or “opt-out”) consent is an acceptable form of permission for oral screenings, but **is not** allowable for fluoride varnish applications, dental sealants, prophylaxes or radiographs. Passive consent is sometimes used (e.g. school settings) and allows a service to be provided, unless the parent has actively declined the service. Providers must assure that a parent or guardian has been notified about the service and did not decline the service in writing before performing an oral screening.

Note: Agencies are responsible for assuring that all required information is obtained for the purposes of data entry into the IDPH integrated data system.

MCAH contract agency staff or providers with questions about the necessity of obtaining consent, who is authorized to provide consent or the adequacy of a consent form, are encouraged to contact their private legal counsel to obtain advice on such issues.

Refer to sections 300 and 600 of this manual for additional detail on direct services and minor consent requirements.

Release of Confidential Information

Confidential information may not be shared without a *signed authorization for release*. All paper and electronic client records that include information on the identity, assessment, diagnosis, prognosis and services provided to specific individuals or families are considered confidential information.

Such records can be disclosed only under the circumstances expressly authorized under state or federal confidentiality laws, rules or regulations. MCAH contract agencies must have policies and procedures that safeguard the confidentiality of records and may be liable civilly, contractually, or criminally for unauthorized release of such information.

The authorized sharing of confidential information benefits the client as well as the MCAH program for purposes such as case management, referral, program evaluation or sharing of demographic information.

A separate release of information form and consent form are required for all oral health services provided. However, when direct dental services are provided in a school setting (parent/guardian not present), a combined consent/release of information form may be used. In this instance, two signatures must be obtained on the form – for consent and authorizing release of information.

Sample forms may be obtained from the IDPH Oral Health Center or agencies may develop agency-specific forms based on the OHC template.

708 –CHILD & ADOLESCENT HEALTH: RISK ASSESSMENT AND ORAL SCREENING

Authority: Medicaid Screening Center Provider Manual

Effective Date: October 1, 2016

Tooth decay is one of the most common chronic conditions of childhood in the United States. Untreated tooth decay can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. I-Smile™ risk assessments and oral screenings determine the level of care a child should receive through the I-Smile™ dental home. The frequency of oral screening should be determined by the client's risk level.

CAH contract agencies that provide complete EPSDT well-child exams are required to do oral screenings and risk assessments for their clients at each well-child appointment.

CAH contract agencies that do not provide complete EPSDT well-child exams may provide oral screenings and risk assessments based on a local and/or state needs assessment. The risk assessment should determine the plan of care for each client.

Oral screenings must occur at WIC clinics in every county. Oral screenings may also occur at Head Start classrooms, schools or in other public health settings.

The I-Smile™ risk assessments and oral screenings help the provider:

- Determine decay risk and prevention needs
- Identify a families' education needs
- Identify dental referral needs
- Inform dental offices of those needs when scheduling appointments for families

I-Smile™ Risk Assessment

As part of an oral screening, a risk assessment must be completed on each child. The I-Smile™ risk assessment establishes a child's level of risk for tooth decay as low, moderate or high. Based on the level of risk, the I-Smile™ Coordinator and/or CAH contract agency staff will determine one of three appropriate care plans for education, preventive services and referrals to a dentist.

Documenting the risk level (low, moderate, or high) must be done in the client paper record and in the IDPH integrated data system. The I-Smile™ Risk Assessment, including the care plan levels, is in the Forms section of the I-Smile™ Coordinator Handbook, 2nd edition.

Oral Screening

The purpose of an oral screening is to identify oral health anomalies or diseases, such as tooth decay, gum disease, soft tissue lesions or developmental problems and to help ensure individualized preventive oral health education. An oral screening includes a medical/dental history and an oral evaluation.



Medical or dental history information that cannot be obtained through an interview with the parent or guardian should be collected through the consent form. Each component of the screening, listed below, must be documented in the client paper record and IDPH integrated data system, as applicable.

Medical History

The medical history consists of:

- Name of child's primary care provider
- Pertinent medical conditions (e.g. heart murmur, special health needs, prematurity/low birth weight)
- Current medications used (e.g. those with sugar or those that cause dry mouth, enlarged gingiva, or bleeding)
- Allergies

Dental History

The dental history consists of:

- Name of child's dentist
- Current or recent oral health problems or injuries
- Parental concerns related to child's oral health
- Frequency of dental visits
- Home care (frequency of brushing, flossing or other oral hygiene practices)
- Feeding/snacking habits (exposure to sugar/carbohydrates)
- Use of fluoride by child (water source, use of fluoridated toothpaste or other fluoride products)
- Parent or sibling decay history (presence of untreated decay, fillings or crowns)

Soft Tissue Evaluation

The soft tissue evaluation consists of:

- Gum redness or bleeding
- Swelling or lumps
- Trauma or injury

Hard Tissue Evaluation

The hard tissue evaluation consists of:

- Suspected decay
- White spot lesions (demineralized areas) near the gumline
- Visible plaque
- Stained fissures
- Enamel defects
- Decay history (presence of fillings or crowns)
- Trauma or injury

Note: Documenting the risk level (low, moderate, or high) and presence of “decayed”, “filled”, and/or “gingivitis” must be done in the client paper record and the IDPH integrated data system.

Dental explorers cannot be used for oral screenings. A visual assessment is sufficient. Using a dental explorer may transfer decay-causing bacteria from one tooth to another or cavitate a demineralized area. The only exception to this is within school-based sealant programs; dental explorers are allowed, but not required, for screenings within a sealant program.

Education

An oral screening is an excellent opportunity to provide anticipatory guidance and oral health education to children and parents. If the parent/guardian is present, oral health education should be provided based on the finding of the oral screening and each client’s individual need. If the parent/guardian is not present, education is recommended if a child is age-appropriate. Oral health education must be documented in the client paper chart and the IDPH integrated data system. Refer to the Education section in the I-Smile™ Coordinator Handbook, 2nd edition.

Dental Referrals

All children that receive an oral screening must be referred to a dentist based on the I-Smile™ Risk Assessment and Care Plan. Follow-up should be provided to ensure that the client’s oral health needs have been met.

709 – MATERNAL HEALTH: RISK ASSESSMENT AND ORAL SCREENING

Authority: Medicaid Screening Center Provider Manual

Effective Date: October 1, 2016

A healthy mouth is essential for a healthy pregnancy. Diet and hormonal changes that occur during pregnancy may increase a woman’s risk for developing tooth decay and gum disease. Oral infections can affect the health of the mother and her baby. Agency staff can have a positive impact on improving the health of maternal health clients and their babies by including risk assessments and oral screening services.

MH contract agencies that provide full prenatal care are required to include oral screening for their clients.

- At least one screening must be completed during the prenatal visit schedule.
- If a client has not seen a dentist following the initial screening, a second screening is required and can be completed postpartum, if needed.

MH contract agencies that do not provide full prenatal care must provide oral screenings to pregnant and postpartum women at WIC clinics. They may also be provided in other public health settings.

- Oral screenings should be considered for all pregnant and postpartum women, especially those who have indicated they have problems with their teeth or gums, or if a health history indicates that the woman is at risk for tooth decay or gum disease.

A woman may choose to opt out of full MH program services, yet need preventive dental services or assistance accessing dental care. In these instances, she can become enrolled in the MH program as an “oral health only” client. Full enrollment in the MH program should always be encouraged, but in these situations described, it is not required. “Oral health only” clients must be enrolled and also discharged on the same day, unless follow up services are needed.

Maternal Oral Health Risk Assessment

As part of an oral screening, a risk assessment must be completed on each woman. Completing the Maternal Oral Health Risk Assessment will establish the level of risk for dental disease as low, moderate or high. Based on the level of risk, the I-Smile™ Coordinator and/or MH contract agency staff will determine one of three appropriate care plans for education, preventive services and referrals to a dentist.

The Maternal Oral Health Risk Assessment, including the care plan levels, is in the Forms section of the I-Smile™ Coordinator Handbook, 2nd edition.

Oral Screening

An oral screening includes a medical/dental history and a soft and hard tissue evaluation. The purpose of a screening is to identify dental anomalies or diseases, such as dental caries, gum disease or soft



tissue lesions and to ensure that preventive dental education is provided. The screening service must be documented in the IDPH integrated data system and detailed in the client chart.

Medical History

The medical history consists of:

- Name of primary care provider
- Pertinent medical conditions (e.g. pregnancy due date, prenatal care, nausea/vomiting, gestational diabetes, heart murmur)
- Current medications used (e.g. those with sugar or those known to cause dry mouth, enlarged gingiva, or bleeding)
- Allergies
- Tobacco, alcohol or drug use

Dental History

The dental history consists of:

- Name of dentist
- Current or recent oral health problems or injuries
- Frequency of dental visits
- Home care (frequency of brushing, flossing or other oral hygiene practices)
- Feeding/snacking habits (exposure to sugar/carbohydrates)
- Fluoride use (water source, use of fluoridated toothpaste or other fluoride products)

Soft Tissue Evaluation

The soft tissue evaluation consists of:

- Gum redness, bleeding or exudate
- Swelling or lumps
- Trauma or injury
- Gingival recession

Hard Tissue Evaluation

The hard tissue evaluation consists of:

- Suspected decay
- White spot lesions (demineralized areas) near the gumline
- Visible plaque, calculus (tartar) or stain
- Enamel defects
- Decay history (presence of fillings or crowns)
- Trauma or injury
- Loose or missing teeth

Note: Documenting the risk level (low, moderate, or high) and presence of “decayed”, “filled”, and/or “gingivitis” must be done in the client paper chart and IDPH integrated data system.

Dental explorers cannot be used for oral screenings. Visual assessment is sufficient. Dental explorers may transfer decay-causing bacteria from one tooth to another or cavitate a demineralized area.

Education

Oral health education should be provided and based on the findings of the oral screening and each MH client’s individual need. Education should include infant oral health care. Oral health education must be documented in the client paper chart and the IDPH integrated data system, as applicable. Refer to the Education section in the I-Smile™ Coordinator Handbook, 2nd edition.

Dental Referrals

Dental referrals for MH clients should be based on the Maternal Oral Health Risk Assessment and Care Plan. At a minimum, a MH client should visit the dentist at least once while pregnant. Follow-up should be provided to ensure completion of the referral.

710 – DENTAL REFERRALS

Authority: Medicaid Provider Manuals (Screening Center & Maternal Health Center)

Effective Date: October 1, 2016

Child Health Referrals

An important goal of the I-Smile™ program is assisting families to obtain necessary oral health care for their children. All children must be referred for a dental exam within 6 months of the eruption of the first tooth, or by age 1, and continue periodically as indicated by the client's I-Smile™ Risk Assessment and Care Plan.

These early and regular visits are important for prevention and early diagnosis of tooth decay and for anticipatory guidance for parents.

Children identified with an oral health problem, such as suspected decay, injury, pain, gum inflammation, or abscess, must be referred to a dentist for treatment.

All CAH clients must be referred to a dentist, at a minimum, for routine and regular care.

Maternal Health Referrals

Dental care is safe and effective during pregnancy. Ensuring that mothers have direct access to preventive care and treatment is significant for improving both the mother's and child's oral health and overall health.

Dental referrals for MH clients should be based on the Maternal Oral Health Risk Assessment and Care Plan. At a minimum, a MH client should visit the dentist at least once while pregnant. A dental visit should be scheduled as soon as possible if the client has any of the following conditions:

- No dental visit within the past year
- Suspected or obvious decay
- Gum inflammation or abscess
- Pain or injury
- Other abnormalities

Needed treatment can be provided throughout pregnancy.

Documenting Referrals

Dental referrals must be documented in the IPDH integrated data system and the client's chart, as applicable. Follow-up should be provided to all clients to ensure completion of the referral.

711 – FLUORIDE VARNISH

Authority: Not Applicable

Effective Date: October 1, 2016

Overview

Fluoride varnish is highly effective in preventing decay and re-mineralizing white spot lesions. It is recommended for use on at-risk children as soon as teeth begin to erupt. It can also be highly effective for preventing tooth decay in pregnant women.

The benefits of fluoride varnish make it extremely useful within public health programs. When applied to teeth, fluoride varnish sets upon contact with saliva. The hardened layer of fluoride is then absorbed into enamel. If not brushed off the teeth, it will continue to be absorbed for several hours. The absorption time is much longer than for traditional fluoride gels and foams. Fluoride varnish application is recommended three to four times a year.

Because of the rapid hardening of the varnish and small amount used, the risk of ingestion and toxicity of fluoride varnish is extremely low, making it safe for very young children and pregnant women.

Criteria

The criteria for application of fluoride varnish include:

- Presence of suspected tooth decay
- Presence of white spot lesions
- Presence of visible plaque
- History of decay (fillings or crowns)
- Low socio-economic status

Fluoride varnish application must only be done in conjunction with an oral screening and must be provided according to the IDPH fluoride varnish protocol. Fluoride varnish application must be documented in the IDPH integrated data system and the client record. The client paper record must include the product used and fluoride concentration.

Reference the IDPH website for fluoride varnish protocol: <http://idph.iowa.gov/ohds/oral-health-center/fluoride>

712 –DENTAL SEALANTS

Authority: Iowa Administrative Code 650 IAC 10

Effective Date: October 1, 2016

Overview

Dental sealants are an important preventive service for low-income, uninsured and/or underinsured children and adolescents, particularly when placed on permanent molar teeth. Most CAH agencies will provide sealants as part of the I-Smile™ @ School program.

The teeth most at risk of decay, and therefore most in need of sealants, are the first and second permanent molars. These teeth should be a priority on all children and adolescents and should be sealed as soon as possible after eruption. This would include children ages 6-8 years and 12-14 years. The permanent premolars may also benefit and sealant application on those teeth can be determined on an individual basis. Although sealing primary molars is a Medicaid-billable service, this should be limited to children whose age and behavior will allow an optimal application procedure to ensure sealant retention.

Clients who receive sealants provided by MCAH contract agencies within direct care clinics and/or school-based settings must be referred for regular dental care and are eligible for dental care coordination services.

Information on the school-based sealant program and the School-Based Dental Sealant Program Manual can be found at: <http://idph.iowa.gov/ohds/oral-health-center/school-based>

Provider Qualifications

A client must first have an exam or an oral screening to determine which teeth will benefit from the application of dental sealants. The following professionals are able to do this:

- Exam: Iowa-licensed dentist
- Screening: Iowa-licensed dental hygienist practicing under public health supervision, with a collaborative agreement that includes sealant screenings

Based on the findings from the exam or screening, a dentist or dental hygienist may apply dental sealants. A dental hygienist must practice under public health supervision, with a collaborative agreement that includes sealant application.

Dental assistants are recommended to be used to assist dentists and/or dental hygienists with sealant application. Dental assistants must be registered with the Iowa Dental Board and practice under public health supervision. Other primary care providers (e.g. nurses) or laypersons (e.g. parent volunteer) are not eligible to serve in this role, per Iowa Dental Board rules.

Periodic retention checks are recommended for quality assurance, according to IDPH protocols.

Documenting Services



Sealant application must be documented in the IDPH integrated data system and the client record. The client paper record must include the sealant product used, tooth number and tooth surface.

Services and data for all school-based sealant programs must be submitted to IDPH using the department's Sealant Data Recording System.

713 – PROPHYLAXES AND RADIOGRAPHS

Authority: Iowa Administrative Code 650 IAC 10

Effective Date: October 1, 2016

Prophylaxes

Based on a community needs assessment, MCAH contract agencies may provide prophylaxes (professional cleanings that include scaling and polishing teeth) as a gap-filling service for clients. If a prophylaxis is provided, a periodontal assessment must be part of this service. The documentation for this assessment should include charting that details an evaluation of the teeth, gingiva and periodontium.

A prophylaxis may only be provided by a dentist or a dental hygienist. Dental hygienists must work under public health supervision and the collaborative agreement must include the guidelines for prophylaxis services.

Due to the threat of bleeding associated with prophylaxis, a detailed medical history must be completed to evaluate a client's risk for bacterial endocarditis or other blood-related conditions. This would include, but not be limited to, a client who has a heart murmur, takes anti-coagulant medications, or is immune-suppressed.

Contractors must document provision of prophylaxes in the IDPH integrated data system and the client record.

Radiographs

In partnership with local dentists, MCAH contract agencies may provide radiographs to assist with client referrals for dental treatment.

Radiographs may be provided by dental hygienists working under public health supervision. The public health supervision collaborative agreement must include guidelines for radiograph services.

Standing orders must be in place with a specific dentist who will read the client's radiographs, provide an exam and establish a treatment plan.

Contractors must document radiographs in the IDPH integrated data system and the client record. The client paper record must include the type of radiograph, number taken and tooth number, if applicable.

714 – GUIDELINES FOR CLIENT ORAL HEALTH EDUCATION

Authority: Iowa Administrative Code 650 IAC 10

Effective Date: October 1, 2016

Overview

Oral health education is an integral component of the services provided by MCAH contract agencies. It is important that MCAH clients understand that healthy teeth and gums impact overall health, proper nutrition, appearance and speech for both mother and child.

Child & Adolescent Health Guidelines

Parents/caregivers must be educated about a range of age-appropriate oral health topics such as:

- Importance of baby teeth
- First dental visit by age 1 and periodic visits based on client's risk assessment
- Proper daily cleaning and monthly "Lift the Lip" techniques
- Risks associated with certain foods and beverages, including bottle and sippy cup habits
- Importance of topical fluoride exposure
- Non-nutritive sucking (fingers or pacifier)
- Teething/eruption patterns
- Risks associated with certain medications (e.g. seizure medications, those that cause dry mouth, or sugary cough syrups used for an extended time)
- Oral piercing
- Tobacco use

Maternal Health Guidelines

Comprehensive services provided by a MH contract agency must include oral health education as an essential part of total health maintenance. Specific oral health issues that may require counseling include:

- Home care
- Dietary habits, including inappropriate snacking and soda pop consumption
- Pregnancy gingivitis
- Morning sickness
- Risks of periodontal disease and link to pre-term labor
- Systemic implications of oral diseases
- Fluoride
- Transfer of decay-causing bacteria from mother to child
- Infant oral health care

Educational Resources

MCAH contract agency staff providing oral health education must be trained by the I-Smile™ Coordinator to assure that a consistent message is given to all clients and families.

Agencies should provide anticipatory guidance and oral health education to individuals as well as groups to promote optimal oral health. Client education should be individualized and based on the findings of the oral screening and risk assessment. For child health clients, the parent or caregiver should be included in the education and demonstration of brushing and flossing.

The IDPH Oral Health Center provides educational brochures and the OHC website includes information to guide development of individual education plans, group curriculum or to provide background information.

The publication, *Bright Futures in Practice: Oral Health* also provides the tools and strategies needed to promote a lifelong foundation for oral health. It is published by the National Center for Education in Maternal and Child Health and may be ordered from: www.brightfutures.org.

For specific education resources, refer to the Oral Health Center website:

<http://idph.iowa.gov/ohds/oral-health-center/resources>

or the I-Smile™ website: www.ismiledentalhome.iowa.gov/

715 – DOCUMENTATION OF ORAL HEALTH SERVICES

Authority: Iowa Administrative Code 441 IAC 84; 42CFR 441.B

Effective Date: October 1, 2016

Documenting Services

Direct dental services and care coordination must be documented in the client's health record, including the IDPH integrated data system. Service documentation must include:

- Name of client
- Date of birth
- Medicaid number, if applicable
- Date of service
- Place of service
- Medical and dental history
- Findings from the oral screening
- Direct services provided
- Time in/time out for time-sensitive services (e.g. education, care coordination)
- Oral health education provided, including with whom you spoke
- Dental care coordination, including written and verbal dental referrals and referral follow-up
- Products recommended or dispensed
- Client plan of care
- First and last name of provider and credentials
- Signature/signature log

The IDPH integrated data system serves as both permanent dental health record and data system. Information is analyzed and used to meet federal reporting requirements, for program planning and evaluation and quality assurance evaluation.

Additional Records

A paper chart for each client may also be necessary to assure a comprehensive client health record. The IDPH Oral Health Center has developed template oral screening forms for MH and CAH clients which MCAH contract agencies may use as part of a paper chart.

All child health and maternal health records (hard copy and/or electronic) are the property of IDPH. Refer to section 600 of this manual for more information on record maintenance and storage.

For more specific information on CARES refer to the CARES User Manual:

www.idph.state.ia.us/hpcdp/common/pdf/CARES_manual.pdf

For more specific information on WHIS, refer to the WHIS User Manual:

www.idph.state.ia.us/hpcdp/common/pdf/family_health/womans_health_system_manual.pdf



716 – MEDICAID BILLABLE ORAL HEALTH SERVICES

Authority: Iowa Administrative Code 441 IAC 84; 42CFR 441.B

Effective Date: October 1, 2016

Billing Medicaid

As part of the interagency agreement between IDPH and the Department of Human Services, MCAH agencies are designated as Medicaid Maternal Health and Child Health Screening Centers. Through this collaboration, MCAH agencies coordinate health care and bill Medicaid for certain services provided to women, infants, children and adolescents who are enrolled in the Medicaid program.

MCAH contract agencies must bill for oral health services provided to Medicaid-enrolled clients. All services except care coordination must be billed directly to Medicaid. (Dental care coordination services for Medicaid-enrolled clients are billed to IDPH.)

Direct dental services must be gap-filling. MCAH contract agency staff providing direct dental services must assure they are not duplicating services provided by dentists.

Note: For Medicaid clients, the Medicaid Eligibility Verification System (ELVS) is available to verify services and should be used when providing those services (e.g. prophylaxis) that have provider frequency restrictions.

Refer to sections 400 and 600 of this manual for more information on billing and the EPSDT Informing and Care Coordination Handbook for additional care coordination information.

Service Providers

All services listed in the following tables may be provided by dental hygienists. With the exception of radiographs, prophylaxes and sealants, these services may also be provided by registered nurses, advanced registered nurse practitioners or physician assistants. Dietitians are eligible to provide nutritional counseling.

Refer to section 300 of this manual for information about eligible providers of care coordination.

All non-dental personnel must be trained by the I-Smile™ Coordinator in the service area using an IDPH-approved training before providing and billing for the listed direct dental services. Documentation of the training, including courses provided and names of the non-dental providers trained, must be furnished to the OHC before services are provided and/or billed to Medicaid through an MCAH contract agency.

Cost Analysis

MCAH contract agencies must bill their actual cost for providing direct dental services and care coordination, as delineated in the following table. Reimbursement will be paid at the cost for services or at the maximum allowable Medicaid rate, whichever is lower. MCAH cost analysis reports must be completed and provided to IDPH each year.



Questions regarding cost analysis reports, forms needed, or billing Medicaid for direct dental services should be directed to the IDPH Oral Health Center at 1-866-528-4020.

Medicaid-Billable Oral Health Services Table For Medicaid-Enrolled

Code and Service Description	Modifier	Frequency
D0120 Periodic oral evaluation by a dentist.	None	Every 6 months; limited to those patients whose caretaker indicates child has not seen a dentist within previous six months
D0145 Oral evaluation and counseling with primary caregiver for patient younger than 3 years of age. Must include recording of the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver. (CH programs only)	DA Also add TD when provided by RN, ARNP, PA	Every 6 months Do not use for initial screening.
D0150 Initial oral evaluation by a dentist	None	1 time per patient; also allowed when provider has not seen patient within a 3-year period
D0190 (with CC modifier) Initial oral screening by <u>non</u> -dentist	CC Also add TD when provided by RN, ARNP, PA	1 time per patient Also allowed when provider has not seen patient within a 3-year period.
D0190 Periodic oral screening by a <u>non</u> -dentist.	TD when provided by RN, ARNP, PA	Every 6 months; limited to those patients whose caretaker indicates they have not had a screening within the previous 6 months
D0601 Caries risk assessment and documentation, with a finding of low risk by a dentist, dental hygienist or nurse	TD when provided by RN, ARNP, PA	Every 6 months with screening/evaluation
D0602 Caries risk assessment and documentation, with a finding of moderate risk by a dentist, dental hygienist or nurse	TD when provided by RN, ARNP, PA	Every 6 months with screening/evaluation
D0603 Caries risk assessment and documentation, with a finding of high risk by a dentist, dental hygienist or nurse	TD when provided by RN, ARNP, PA	Every 6 months with screening/evaluation
D0270 Bitewing radiograph – single film (RDH only)	none	1 time in 12-month period
D0272 Bitewing radiograph – two films (RDH only)	none	1 time in 12-month period
D0274 Bitewing radiograph – four films (RDH only)	none	1 time in a 12-month period



Code and Service Description	Modifier	Frequency
D1110 Prophylaxis – adult (age 13 and older) (RDH only)	none	Every 6 months
D1120 Prophylaxis – child (age 12 and younger) (RDH only)	none	Every 6 months
D1206 Topical fluoride varnish – therapeutic application for moderate to high caries risk patients. Risk determined using I-Smile™ Risk Assessment.	TD when provided by RN, ARNP, PA	4 times a year, at least 90 days apart
D1310 Nutritional counseling for the control and prevention of oral disease	TD when provided by RN, ARNP, PA	Every 6 months per 15 minutes, minimum of 8 minutes
D1320 Tobacco counseling for the control and prevention of oral disease (MH programs only)	TD when provided by RN, ARNP, PA	Every 6 months per 15 minutes, minimum of 8 minutes
D1330 Oral hygiene instruction. Hands-on demonstration of individualized home care techniques to age-appropriate client or parent/guardian.	TD when provided by RN, ARNP, PA	Every 6 months per 15 minutes, minimum of 8 minutes
D1351 Sealant - per tooth (RDH only)	None	1 time per tooth; (Replacement sealants may be covered when the patient record documents medical necessity); permanent premolars, molars, and primary molars; children through 18 years of age or those with a physical or mental disability

IDPH-billable oral health services table for Medicaid-enrolled

Code and Service Description	Modifier	Frequency
T1016 Dental care coordination for Medicaid-enrolled clients	none	Based on documented time-in/time-out. Cannot be billed on the same day as a Medicaid-billable direct dental service.



For Medicaid claim forms the following diagnosis codes must be included:

Procedure Codes	Result	Suggested ICD-10
Initial dental exam by a dentist (D0150)	No abnormality	Z01.20 – dental exam, no abnormal findings
Periodic dental exam by a dentist (D0120)	Decay	Z01.21 – dental exam, with abnormal findings K02.9 Dental Caries
	Demineralization	Z01.21 – dental exam, with abnormal findings
Initial dental screening by a non-dentist (D0190 + CC modifier)		
Recall dental screening by a non-dentist (D0190)		<ul style="list-style-type: none"> • K02.61 Smooth surface limited to enamel
Oral evaluation and counseling provided by a dentist, dental hygienist or nurse (D0145 + DA modifier) (TD modifier is used with any service provided by a nurse)	Trauma to tooth	Z01.21 – dental exam, with abnormal findings <ul style="list-style-type: none"> • K03.9 Diseases of hard tissue of teeth, unspecified
	Apical abscess	Z01.21 – dental exam, with abnormal findings <ul style="list-style-type: none"> • K04.90 Other and unspecified disease of pulp and periapical tissue
	Gingivitis	Z01.21 – dental exam, with abnormal findings <ul style="list-style-type: none"> • K05.10 chronic gingivitis (desquamative, hyperplastic, simple marginal, ulcerative)
	Periodontal disease	Z01.21 – dental exam, with abnormal findings <ul style="list-style-type: none"> • K05.6 Periodontal disease, unspecified
	Trauma to gingiva	Z01.21 – dental exam, with abnormal findings <ul style="list-style-type: none"> • K06.2 Trauma to gingival tissue

Procedure Codes	Result	Suggested ICD-10
<p>Caries risk assessment</p> <ul style="list-style-type: none"> • low risk (D0601) • moderate risk (D0602) • high risk (D0603) <p>(TD modifier is used with any service provided by a nurse)</p>	NA	<p>Use the original diagnosis code (above)</p> <p>Add procedure code</p>
<p>Singe bitewing (D0270), Two bitewing (D0272), Four bitewing (D0274) radiographs</p>	NA	<p>Use the original diagnosis code (above)</p> <p>Add procedure code</p>
<p>Adult prophylaxis (D1110), Child prophylaxis (D1120)</p>	NA	<p>Use the original diagnosis code (above)</p> <p>Add procedure code</p>
<p>Fluoride varnish (D1206)</p> <p>(TD modifier is used with any service provided by a nurse)</p>	NA	<p>Use the original diagnosis code (above)</p> <p>Add procedure code</p>
<p>Nutritional counseling (D1310)</p> <p>(TD modifier is used with any service provided by a nurse)</p>	NA	<p>Use the original diagnosis code (above) but if no screening occurred:</p> <p>Z71 - Persons encountering health services for other counseling and medical advice, not elsewhere classified</p> <p>Add procedure code</p>
<p>Tobacco counseling (D1320)</p> <p>(TD modifier is used with any service provided by a nurse)</p>	NA	<p>Use the original diagnosis code (above) but if no screening occurred:</p> <p>Z71 - Persons encountering health services for other counseling and medical advice, not elsewhere classified</p> <p>Add procedure code</p>

Procedure Codes	Result	Suggested ICD-10
<p>Oral hygiene instruction (D1330)</p> <p>(TD modifier is used with any service provided by a nurse)</p>	NA	<p>Use the original diagnosis code (above) but if no screening occurred:</p> <p>Z71 - Persons encountering health services for other counseling and medical advice, not elsewhere classified</p> <p>Add procedure code</p>
<p>Maternal Health Clients Only – receiving any dental service</p>	<p>First pregnancy; must specify the trimester</p>	<p>Z34.00 encounter for supervision of normal first pregnancy, unspecified trimester</p> <p>Z34.01 – 1st Trimester</p> <p>Z34.02 – 2nd Trimester</p> <p>Z34.03 – 3rd Trimester</p>
<p>Maternal Health Clients Only – receiving any dental service</p>	<p>Subsequent pregnancy; must specify the trimester</p>	<p>Z34.80 encounter for supervision of other normal pregnancy, unspecified trimester</p> <p>Z34.81 – 1st Trimester</p> <p>Z34.82 – 2nd Trimester</p> <p>Z34.83 – 3rd Trimester</p>

717 –SCHOOL DENTAL SCREENING REQUIREMENT

Authority: Iowa Administrative Code 641 IAC 51(135)

Effective Date: October 1, 2016

Overview

All children newly enrolling in an Iowa public or accredited non-public elementary or high school must show provide the school with proof of a dental screening using IDPH-approved forms. This includes students entering kindergarten and ninth grade.

The purpose of the dental screening requirement is to improve the oral health of Iowa's children. The dental screenings:

- Facilitate early detection and referral for treatment of dental disease
- Reduce the incidence, impact and cost of dental disease
- Inform parents and guardians of their children's dental problems
- Encourage the establishment of effective oral health practices early in life
- Promote the importance of oral health as an integral component of preparation for school and learning
- Contribute to statewide surveillance of oral health

The dental screenings enhance the I-Smile™ dental home concepts of prevention, education, care coordination and treatment and provide a critical step in closing the gap in access to dental care for underserved children.

CAH Contract Agency Responsibility

I-Smile™ Coordinators within each CAH contract agency must assist schools, families and local boards of health to assure compliance with the dental screening requirement. Activities include:

- Distributing forms and dental screening information to schools and dental offices and at community outreach events
- Building partnerships with area dentists and providing care coordination to help children who do not have a dentist
- Training non-dental health care professionals how to provide screenings
- Ensuring provision of dental screenings in schools and other public health settings as a gap-filling service for children who are unable to receive a screening from a dentist
- Working with schools and local board(s) of health to audit dental screening records

Additional information about the school dental screening requirement is available at

<http://idph.iowa.gov/ohds/oral-health-center/school-screenings>



718 – SUPERVISION OF DENTAL HYGIENISTS WORKING IN PUBLIC HEALTH

Authority: Iowa Administrative Code 650 IAC 10

Effective Date: October 1, 2016

Overview

Dental hygienists providing direct dental services in Iowa must work under the supervision of a dentist.

Public Health Supervision

All dental hygienists providing direct dental services through MCAH contract agencies must use public health supervision. This allows hygienists to provide services in designated public health settings without the patient first being examined by a dentist.

A hygienist must have an Iowa license and a minimum of three years of clinical experience to work under public health supervision. A collaborative agreement between a dentist and a hygienist is required. The agreement delegates what services can be provided, where services will be provided and standing orders for the services. Dentists providing public health supervision are not required to provide future dental treatment to patients served by the hygienist.

While the collaborative agreement allows the supervising dentist and hygienist to list the location of dental records, it is expected that all dental hygienists (employed or contracted) providing services through MCAH contract agencies will maintain clinical records within the agency and not at a separate location. All records of patients receiving services associated with a MCAH contract agency are the property of IDPH. Refer to section 600 of this manual for additional detail about client records.

Detailed rules about dental hygiene services and supervision requirements may be found on the Iowa Dental Board website:

<http://www.dentalboard.iowa.gov/practitioners/hygienists/public-health-supervision.html>.

A current template for public health supervision agreements may be found on the IDPH/OHC website:

<http://idph.iowa.gov/ohds/oral-health-center/resources>.

A copy of the collaborative agreement must be on file with the IDPH Oral Health Center (OHC). Each dental hygienist and dentist is responsible for reviewing the agreement biennially to assure that information is current. If updates are needed, a revised agreement must be sent to the OHC. An addendum may be requested to add sites to the agreement on file.

A report of services provided under public health supervision for the calendar year must be filed annually with the IDPH Oral Health Center. OHC staff will provide instructions and a report form to be used each year.

719 – SUPERVISION OF DENTAL ASSISTANTS WORKING IN PUBLIC HEALTH

Authority: Iowa Administrative Code 650 IAC 10

Effective Date: October 1, 2016

Dental assistants working in public health in Iowa must work under the supervision of a dentist.

IDPH requires that all dental assistants employed or contracted by Title V MCAH agencies have public health supervision. This allows assistants to provide services in designated public health settings.

An assistant must be registered in Iowa and have a minimum of one year of clinical practice experience to work under public health supervision. A collaborative agreement between a dentist and assistant is required. The agreement must detail what services can be provided, where services will be provided, and standing orders for the services.

A copy of the collaborative agreement must be on file with the IDPH Oral Health Center (OHC) and the Iowa Dental Board. Each dental assistant and dentist is responsible for reviewing the agreement biennially to assure that information is current. If updates are needed, a revised agreement must be sent to the OHC and the Iowa Dental Board. An addendum may be requested to add sites to the agreement on file.

A report of services provided under public health supervision for the calendar year must be filed at least annually with the IDPH Oral Health Center. OHC staff will provide instructions and a report form to be used each year.

Detailed rules about public health supervision for dental assistants can be found in Iowa Administrative code:

<https://www.legis.iowa.gov/law/administrativeRules/rules?agency=650&chapter=20&pubDate=08-03-2016>.

A current template for public health supervision agreements may be found on the IDPH/OHC website:

<http://idph.iowa.gov/ohds/oral-health-center/resources>.

720 – CHILD HEALTH: DENTAL TREATMENT PROVIDED BY DENTISTS

Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Sec 506 [42 USC 706]

Effective Date: October 1, 2016

Reimbursing Dentists

CH-Dental funds may be used to reimburse dentists for a limited number of basic preventive and restorative dental services, at Title XIX approved rates, for CAH clients. CH-Dental funding may not be used to support direct care services provided within FQHC dental clinics.

Client Eligibility

Criteria for eligibility are that a child:

- is age 0 – 21 years,
- is not eligible for the Title XIX Program,
- is uninsured or underinsured for dental coverage, and
- has a family income that meets guidelines as established by Iowa's Title XXI program

Dental Provider Agreements

CAH contract agencies that use CH-Dental funds to reimburse dentists for services are required to have a written agreement with those providers.

Recommended information to include in the agreement includes:

- List of the reimbursable dental procedures and the reimbursement amounts for those procedures
- Maximum amount allowed per child without prior authorization
- Information on how a dental office may request an “exception” to pay for procedures not currently on the list
- Clarification that reimbursement from Title V is accepted as payment in full and the family is not responsible for additional costs
- I-Smile™ Coordinator contact information

Dental Vouchers

CAH contract agencies may create a “dental voucher” system for eligible clients. The family can be given a voucher to provide to a participating dental office, indicating that the CAH contract agency will reimburse the dental office for allowable treatment costs (using CH-Dental funds).

Dental vouchers may not be used to pay for direct care services provided within FQHC dental clinics.



For any client receiving care from a dentist reimbursed with CH-Dental funds, “dental voucher” must be indicated as a service in the IDPH integrated data system.

Dental Treatment Coverage

The IDPH Oral Health Center (OHC) annually provides CAH contract agencies an updated list of pre-authorized codes and reimbursement levels. Reimbursement for services is based on the most current Title XIX fee schedule.

Payment frequency for examinations, prophylaxes, fluoride varnish applications, and sealants should be made according to Medicaid guidelines and agency protocol. Refer to Section 716 for details about Medicaid billable oral health services.

Exceptions to use CH-Dental funds for dental services that are not on the pre-authorized list of codes must be requested in writing. The written request must be sent to the IDPH Oral Health Consultant and contain the following components:

- Reason for requesting the exception to policy
- Age of child
- Details relating to the case requiring additional treatment
- Dental code and Medicaid reimbursement rate for requested procedure

The State Dental Director will make the final decision on the request. The Oral Health Consultant will notify the I-Smile™ Coordinator of the decision. Each request for an exception to policy is handled on a case by case basis.

Quarterly Reporting

CAH contract agencies are required to submit quarterly Dental Data Reports to the Oral Health Center the 30th of the month following the end of each fiscal quarter (January 30, April 30, July 30 and October 30). Information collected includes the number of children who saw a dentist using CH-Dental funds, the number of dental procedures provided and the total amount of treatment dollars reimbursed to dentists per quarter. The Dental Data Report is completed through iowagrants.gov.

Notes



Oral Health Center

Iowa Department of Public Health
321 E 12th Street
Des Moines, IA 50319

www.facebook.com/ISmileDentalHomeInitiative
<http://idph.iowa.gov/ohds/oral-health-center>

