



## CONTINUING EDUCATION MATERIALS

To obtain continuing education credits for Give Kids A Smile activities you must complete the following:

- 1) Read the following four pages.
- 2) Complete the attached test.
- 3) Bring the completed test with you to the event and give to the registrant at check-in. After you complete your shift, go to volunteer check out for your CE certificate.

**OR**

- 4) Return by mail within 30 days of the event to receive a CE certificate:

Arizona Dental Foundation  
3193 N Drinkwater Blvd  
Scottsdale, AZ 85251

Phone 480-344-5777  
FAX 480-344-1442  
Email penny@azda.org

You will receive one hour of CE credit for completing the test and one hour of CE credit for each hour you volunteered. You will not receive a certificate unless we have a completed test on file.

**Private dental offices will not receive a certificate until the *Office Event/Treatment Report* has been submitted.**



## CONTINUING EDUCATION PROGRAM

Give Kids A Smile (GKAS) is a nationwide dental access program for underserved kids. Dentists, hygienists, assistants and other volunteers participate throughout the country to bring oral healthcare services to thousands of low-income children at more than 5,000 locations. The GKAS project, which was launched in 2003, was a resounding success with over \$100 million in free dental services provided. The event also brought attention to unmet dental needs.

According to the Arizona Department of Health Services Office of Oral Health 2015 Healthy Smiles healthy Bodies Survey of 3<sup>rd</sup> Grade Children, tooth decay is the number one chronic disease in Arizona children.

Currently, Arizona's statewide oral health picture is not favorable in meeting the oral health care needs of low-income children. According to the Arizona Department of Health Services, Arizona's children have more decay experience and untreated decay than the national average.

For Arizona children in third grade:

- More than 6 out of 10 are affected by tooth decay.
- Nearly 3 out of 10 need early or urgent dental care.
- 30% of these children do not have dental insurance.

The consequences of untreated decay include emergency room visits and lost time in school and emphasize the need for comprehensive prevention and restorative dental initiatives.

The Surgeon General's report in 2000 described dental disease as the "silent epidemic," especially in our nation's children and in selective populations. Since dental caries in the United States is not uniformly distributed, effective interventions and risk assessments can play a significant role in treatment of this infectious disease. Knowledge of the known risk factors will assist the practitioner in performing risk assessment within their patient populations.

Enclosed is a method of performing an oral health assessment for an infant and toddler, as well as the Caries-risk Assessment Tool (CAT) developed by The American Academy of Pediatric Dentistry. The CAT is designed as a simple screening tool for dental and non-dental health care providers in making a determination of caries probability in infants, children and adolescents.

## ORAL HEALTH ASSESSMENT

The following is a method of performing an oral health assessment for infants and toddlers:

1. Perform a visual screening
2. Determine risk
3. Develop treatment plan/recommendations

1. A visual screening can be performed using the knee-to-knee method as described below. The assistance of the child's caretaker (mother, father, guardian) is of great benefit for this process to occur successfully. The caretaker is seated in a chair holding the child face-to-face on his/her lap. The caretaker's legs are positioned so that his/her feet are in full contact with the floor. Instruct the caretaker to give the child a hug and put the child's legs around the waist of the caretaker. In this position, the caretaker's elbows can aid in stabilizing the movement of the child's legs.

The health care provider (dentist, dental hygienist, physician, nurse practitioner, etc.) is seated in a chair with his/her knees approaching those of the caretaker. The child is then gently laid down on the "table" formed by the laps of the health care provider and the caretaker. The caretaker can assist by holding the child's hands during the assessment. The child's head should be in the health care provider's lap. This non-traumatic and efficient method of performing a dental assessment on very young children can be used successfully in many settings.



### Knee-to-Knee Position

2. Determine risk by utilizing the Caries Risk Assessment Tool (CAT) found on page 3. The American Academy of Pediatric Dentistry developed CAT for both dental and non-dental personnel. The American Academy of Pediatrics states that pediatricians should use CAT to determine caries risk potential and refer to a dental provider.
3. Develop a treatment plan or make recommendations based on the findings from the visual screening, which could include:
  - instructing parents to lift the child's lip to check the upper front teeth for white spots monthly
  - applying fluoride varnish (to high-risk children)

The goal of caries risk assessment in dentistry is to deliver preventive and restorative care specific to an individual patient’s needs. First, caries risk assessment classification should be established (See # I). Second, appropriate preventive therapy should be determined based on understanding of risk indicators for the child (See # II).

### I. AAPD Caries-Risk Assessment Tool (CAT)\*

Caries-risk Indicators	Low risk	Moderate risk	High risk
<b>Clinical Conditions</b>	• No carious teeth in past 24 mos.	• Carious teeth in past 24 mos.	• Carious teeth in past 12 mos.
	• No enamel demineralization	• 1 area of enamel demineralization	• More than 1 area enamel Demineralization (enamel caries “white-spot lesion”)
	• No visible plaque; no gingivitis	• Gingivitis	• Visible plaque on anterior (front) teeth
			• Radiographic enamel caries
			• High titers of mutans Streptococci
• Wearing dental or orthodontic appliances			
		• Enamel hypoplasia	
<b>Environmental Characteristics</b>	• Optimal systemic and topical fluoride exposure	• Suboptimal systemic fluoride exposure with optimal topical exposure	• Suboptimal topical fluoride exposure
	• Consumption of simple sugars or foods strongly associated with caries initiation primarily at meal times.	• Occasional (i.e., 1-2) between-meal exposures to simple sugars or foods strongly associated with caries	• Frequent (i.e., 3 or more) between-meal exposures to simple sugars or foods strongly associated with caries
	• High caregiver socioeconomic status	• Midlevel caregiver socioeconomic status (i.e. eligible for school lunch program or SCHIP)	• Low-level caregiver socioeconomic status (i.e., eligible for Medicaid – AHCCCS)
	• Regular use of dental care in an established dental home	• Irregular use of dental services	• No usual source of dental care
• Active caries present in the mother			
<b>General Health Conditions</b>			• Children with special health care needs
			• Conditions impairing saliva composition/flow

## II. Caries Prevention & Management Appropriateness of Therapies Based on Risk Level\*\*

<b>Therapy</b>	<b>Low Risk No caries and No Risk Factors</b>	<b>Moderate Risk Incipient Caries and/or Some Risk Factors</b>	<b>High Risk Active Caries</b>
<b>Recall interval for caries</b>	1-2 years	6-12 months	3-6 months
<b>Dental sealants</b>	At risk teeth	At risk teeth	All pits and fissures
<b>Fluoride toothpaste</b>	2-3 times per day	2-3 times per day	2-3 times per day
<b>Fluoride varnish / gel</b>		2+ times per year	4-6 times per year
<b>Fluoride mouthrinse</b>		1+ times per day	1+ times per day (encourage F gel)
<b>Prescription F gel</b>			1+ times per day
<b>Fluoride supplements</b>			Once per day
<b>Baking soda rinse</b>			Rinse & Spit throughout day
<b>Xylitol gum/candy</b>		3-5 times per day	3-5 times per day
<b>Chlorhexidine rinse</b>			1-2 times per day for 2 weeks – repeat in 6 months if needed <i>(may irritate oral tissue in Xerostomic patients)</i>
<b>Dietary counseling</b>		As needed	As needed

- Encourage fluoride exposure about every 4 hours. Encourage fluoride exposure at mid-day – mouthrinse and supplements may be more acceptable to patients at this time of day.
- Recommend that patients use CHX and prescription gels before bed. If using a fluoride gel at bedtime, make sure that they have two other exposures to fluoride toothpaste.
- Do not use fluoride gels (in office or prescription), fluoride mouthrinse or chlorhexidine mouthrinse in children under 6 years of age.

\*AAPD, Council on Clinical Affairs, [www.aapd.org/pdf/policycariesriskassessment tool.pdf](http://www.aapd.org/pdf/policycariesriskassessment%20tool.pdf)

\*\*Farewell to Fillings: A Rational Approach to Caries Prevention in Clinical Practice 2003, Dr. Kathy Phipps, [www.kathy\\_Phipps@class.OregonVOS.net](mailto:www.kathy_Phipps@class.OregonVOS.net)

