Children's Dental Strategic Plan for Humboldt County

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Final Narrative
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Dental Home: The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to a dental specialist when appropriate.

American Association of Public Health Dentistry, reaffirmed 2010

Background

The North Coast Grantmaking Partnership contracted with the California Center for Rural Policy to create a new dental strategic plan. Several factors led to this request. The Pediatric Dental Institute (PDI) in Windsor reported in spring 2011 that 142 children from Humboldt used their services at their clinic with full anesthesia (called hospital based care) within the prior year. PDI is currently facing economical challenges and now must raise $400,000 each year to continue. There is interest to reduce the number of children from Humboldt that need hospital based dental care. This very intensive and expensive treatment process is an indicator of missed opportunities for oral health education, preventive services, and early restoration. Consequently, to change the number of children needing this service, every aspect of oral health for low-income children should be reviewed and integrated into a smooth continuum of evidence-based care and education.

Dental Strategic Plan

Humboldt County has been a leader in addressing children's oral health since early 2000 with the inception of the Dental Advisory Group and the Circle of Smiles, a significant dental initiative from The California Endowment. The legacy of this work continues twelve years later. Unlike many small rural counties, Humboldt has five dental clinics that accept children with DentiCal and two hospitals that provide hospital based dental services. These institutions provide critical functions, although DentiCal may pay only some or none of the costs. Local funders recognize the vital need for coordination and preventive services and have continuously supported this work over many years. Most importantly, there is a group of committed stakeholders, including funders, providers, CBOs, and government who understand the challenges around children's oral health. Even in these times of economic cutbacks and less grant funding available, there is interest in working together to provide more effective and efficient services to improve the oral health of low-income children in Humboldt County.

Staff from the California Center for Rural Policy held personal interviews with 15 local key stakeholders and several dental agencies outside the County in June and July, 2012. Based on this information, CCRP developed a special report focusing on strengths, weaknesses, opportunities, and threats (SWOT). The first Dental Forum was held on July 26th with 23 representatives from a diverse group of stakeholders who reviewed the draft SWOT report. The group's insights were recorded and woven into the strategic plan, both narrative and work plan. This strategic plan was sent to all participants and they were invited for a final review on October 5th. There were 14 stakeholders in attendance and additional comments were collected. Several emails and personal conversations with additional stakeholders were received. The final strategic plan, consisting of this narrative and a work plan, were crafted with these final additions.

In order to work more effectively and efficiently, there is a desire to work "upstream" and put more emphasis on those most at risk of decay, use evidenced-based prevention practices, and work together to share best practices. Specifically, there are five important focus areas that create the Work Plan The five areas are 1) data, 2) oversight, coordination, and advocacy, 3) improve access to dental services for those at highest risk of dental decay, 4) create a culture shift about the importance of preventive care

through education and social marketing, and 5) increase the amount and quality of networking between new and current partners in Humboldt County and with other organizations at a state and national level.

Data

One of the biggest challenges in evaluating Humboldt County's oral health status is the lack of comprehensive dental data. There is no one place to go to for dental data. Population or surveillance data is extremely limited. The current Kindergarten Oral Health Assessment is voluntary and the return rate of the forms varies. Northcoast Children's Services has oral health assessment data on over 700 children in Head Start and Early Head Start. Process data is more readily available since programs track the reach of their work, but this information is not aggregated in any formal way across programs. Understanding that children were receiving hospital-based services at *both* SJHS and Mad River has recently come to light and the process data for these tertiary services are now shared. Outcome and performance data are the most limited, but perhaps the most important. RCAA's TOOTH program has collected pre/post data on improvements in oral health knowledge and reductions in plack levels for the preschool program for many years.

All of the FQHC dental clinics in Humboldt County have electronic dental records and this presents an opportunity to "mine" the data. Determining what to collect is a challenge. The medical field has had outcome and performance standards for many years available through the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS). Patient satisfaction surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) are also standard. Developing process and outcome standards for dental is an evolving national discussion. The Dental Quality Alliance of the American Dental Association is starting to validate the first performance and outcome measures. It is unlikely that these standards will be officially released soon. Satisfaction surveys for dental patients are not on the horizon at all. Humboldt needs are more immediate. Jared Fine, DDS, Dental Director for Alameda County, in personal conversations, recommended that Humboldt look at the number of children who completed their dental treatment plan and also received on-going preventive care. Obviously, developing a group of local data experts to determine how best to understand and use the potential data is one of the first recommended steps. Understanding where to house the community dental data and the level of access is an important discussion.

Oversight, Coordination, and Advocacy

The Dental Advisory Group has helped coordinate and improve communication among various members of the dental community. The Dental Advisory Group Coordinator has been referred to as the "glue" to keep members linked, but also provide leadership to insure best practices and engagement on state and national issues. Recently, the funding for this this vital position has been reduced so supporting personal connections is limited. The key stakeholders desire that the there is re-engagement and expansion of the connections to all the dental partners in Humboldt. Since DentiCal services are underfunded, there is a opportunity for advocacy at a higher level and inform the community as well as elected officials about the effects of limited dental services for those who are low-income.

Improve Access to Dental Services for Those at Highest Risk of Dental Decay

Dental decay is not uniform in its distribution and improving care for those at highest risk involves multiple approaches. The Well Child Dental Visit (WCDV) is an important first step in prevention and education for the youngest patients. Assuring that the WCDV is uniform and includes referral to providers for cavitated lesions should be supported across the various organizations. The Caries Risk Assessment (CAMBRA) is an important tool to help determine the appropriate level of intervention in children based on risk. Organizations providing fluoride varnish will find this risk assessment tool helpful to determine those most in need and those who need at least two applications or more of fluoride varnish. A significant risk factor is past caries or restorations. Consequently, the children who receive special services - such as hospital based dentistry, referral to a local pediatric dentist, or to PDI, should get linked back to their dental home for on-going preventive care to insure significant dental disease is not repeated. Expanding the reach of prevention in unique ways to private practice dentists, dental hygienist, dental assistants, and dental

assisting students represents opportunities to connect with and educate patients outside of a clinical setting.

Create a Culture Shift about the Importance of Preventive Care through Education and Social Marketing

It was clear at the Dental Forum that there was interest in prevention promotion; dental disease is not "fixed" just with a filling. Good preventive oral care is critical to prevent further disease. Statewide, Latino and Native American children have some of the highest rates of untreated dental disease. Understanding what is causing these higher rates and what will increase awareness, improve prevention, and increase early restorations could provide an opportunity for culturally sensitive focus group exploration. From these, social marketing is a potential opportunity to create a cultural shift toward better preventive care.

Increase the Amount and Quality of Networking between New and Current Partners in Humboldt County and With Other Organizations at a State and National Level

Although Humboldt County has a dedicated group of key stakeholders, there is opportunity to increase the networking between them and expand the number of those who are engaged in improving children's oral health. Linking to other organization outside the county, both in California and nationally represents opportunities to work more effectively and identify funding opportunities.

Background Information on Low Income Children and Dental Disease

Oral health is a complex multi-faceted system. Teeth are a dynamic tissue that is constantly demineralizing and remineralizing. Acids from plaque, food, or beverages will demineralize the teeth and fluoride from water, toothpaste, or varnish will help remineralize the teeth. Good oral health is a positive balance to the remineralization equation. This generally requires three elements, personal habits of brushing/flossing and low carbohydrate consumption, preventive measures such as fluoridated water, topical fluoride application (fluoridated toothpaste, gels in dental offices or fluoride varnish) and restoration of caries (cavities), ideally, at an early stage of development. Oral bacteria produce acidic cariogenic plaque that erodes tooth enamel to produce caries. Since everyone has a different oral ecology, some individuals have a higher number of aggressive cariogenic bacteria (*s. mutans*) and are more susceptible to dental disease. Combining poor oral hygiene, limited preventive and restorative care, and high levels of cariogenic bacteria, leads to aggressive decay and infections.

Oral health is an integral component of overall health. Dental caries and gum disease is an infection that has significant health implications. Pain, inability to eat, sleep disturbances, and missed school or work days due to poor dental health are well reported in the literature (USDHHS, Oral Health in America, 2000). Psychosocial efforts to poor dental health include avoidance of social contact and avoiding laughing, smiling, or conversation and feeling uncomfortable when eating with other people. Infection in the mouth has been associated with increased odds for heart disease, adverse pregnancy outcomes, complications with diabetes and a number of other health issues. The idea of "putting the mouth back in the body", as an importance aspect of total health, has not been fully adopted.

Dental disease is not uniform in its distribution. Nationally, 25% of children five to 17 years have untreated caries in their permanent teeth, but 80% of untreated caries are found in 25% of children who are predominantly from low-income families and other vulnerable populations (USDHHS, *Oral Health in America*, 2000). There is a clear relationship between family income and untreated caries. In Humboldt County, 28% of children 0-5 years and 23% of children under 18 years live in poverty. Since 2003, there has been significant work to develop a caries risk assessment tool. In 2009, the California Dental Association's Caries Risk Assessment tool was validated. In fact, risk-based prevention and patient-centered disease management have been recognized as the cornerstones of modern caries management.

Dental access is a complex patchwork of services based on age, insurance status, clinic availability and other factors. Medicare does not cover dental services in those 65 years and older. Federal Medicaid states adult dental care is an optional benefit and children's dental care is a mandated benefit. In

California, dental MediCal is called DentiCal and does not cover dental services for adults, except for dental emergencies and preventive care for perinatal women. Generally, DentiCal reimburses private practice dentists less than 40% of the usual and customary fees. Consequently most of the private practice dentist offices in Humboldt County do not take DentiCal. Federally Qualified Healthcare Clinics (FQHC) receive a flat rate reimbursement for each patient they see, but it is at a higher rate than regular fee for service DentiCal. Consequently, the local FQHC clinics see most of the DentiCal insured patients. The two dental clinics that serve tribal enrolled Native Americans have additional resources from the Indian Health Services that allows them to accept adult patients who have MediCal or Medicare as well as private insurance.

There are five dental clinics in Humboldt; United Indian Health Services in Arcata (with mobile clinics in Orleans), K'ima:w Dental Clinic in Hoopa, Redwoods Rural Health Center in Redway, and Open Door Community Health Center's two clinics – Willow Creek Clinic in Willow Creek, and Burre Dental Clinic in Eureka (with mobile services to Humboldt schools).

In late 1999, an early group of stakeholder gathered to create the Dental Advisory Group (DAG) in response to the limited availability of dental services for low-income children. In 2001, *Crisis with our Children* and the *Framework for Action* were written and led to the Humboldt Area Foundation receiving significant funding from The California Endowment to support Circle of Smiles. This initiative included many funded partners which included the Oral Health Coordinator at DHHS for the DAG, Sealant Clinics at College of the Redwoods, the California Conservation Corp's TOOTH program, and, in part, the building of the Burre Dental Clinic and the enhancement of the mobile dental van. The legacy of these efforts over eleven years and in combination with additional partners and programs is a testament to the hard work and dedication of those who work to improve oral health for children in the county.

SWOT – Strengths, Weaknesses, Opportunities, and Threats

Strengths

History of collaboration with informed groups: There is a 12-year history of government, agencies, foundations and individuals committed to improve oral health for low-income children in Humboldt County. Oral health is seen as an integral part of overall health in a diverse groups who represent a continuum of care, including education, prevention, and restoration. Generally, innovation and collaboration is welcomed.

The Dental Advisory Group: The Dental Advisory Group has been an on-going forum for 12 year. It is recognized by many as an important facet of collaboration in Humboldt to address children's oral health needs.

Resources available: There are resources for low-income children to address dental needs. Some supply services, some provide payment for services, others provide education. Many rural counties have significantly less opportunities. These engaged local resources include:

- 5 dental clinics that accept DentiCal
- Head Start/Early Head Start
- Well Child Dental Visit at WIC, Burre, UIHS, and Mobile Medical (still?)
- TOOTH program in preschools and elementary schools
- Burre Dental Van in elementary schools
- Hospital Based Dentistry at St Joseph Hospital in Eureka, Mad River Hospital in Arcata, and Pediatric Dental Institute in Windsor

Water fluoridation: This is considered one of the ten best public health achievements because it reduces caries by 30% to 60% in primary teeth and 20% to 40% in adult dentition (ADA, *Fluoridation Facts*). The city of Eureka, Scotia, Hoopa, and Arcata/Jacoby Creek water area have fluoridated water.

Weaknesses

Data: There is limited oral health surveillance data in Humboldt and for the data that does exist, it is not coordinated or shared in any significant way. It is impossible to document improvements in children's oral health unless there is baseline and on-going assessment. The following are important sources of local oral health data (* not confirmed data is readily available):

- Kindergarten Oral Health Assessment
- Northcoast Children's Services' Head Start and Early Head Start
- Hospital Based Dentistry Coordinator
- DHHS's Well Child Dental Visit at WIC
- CHDP's dental summary*
- RCAA' TOOTH preschool and elementary school programs
- Burre's Mobile Dental Van*
- Population based data from all the FQHC clinics*
- Emergency department and urgent care utilization due to dental disease
- Aggregated results of pediatrian's oral health assessments*

Access: Based on personal interviews, neither Burre nor UIHS dental clinics have the capacity to give every currently insured patient an appointment. The FQHC clinics are different than private practice dental offices. The balance of need and access has been a challenge for many years for all the clinics. Consequently each has developed specific strategies towards care. Currently Burre is focusing on the serving Open Door Community Health Centers' patients to insure a full circle of care, although no child will be denied services. Consequently there is reluctance to create new referral systems from other agencies such as "hotlines" for appointment for children with active dental disease. UIHS has focused on those in pain or walk-in appointment.

The typical dental clinic patient has a complex and extensive dental treatment plan. Rarely does a patient come in cavity-free. This is significantly different than a private practice dental office whose patient's primarily come in for preventive services. For clinic patients that have completed their treatment plans, Burre sets up either three or six month recall appointments for preventive services to prevent more caries from developing. Getting patients to come to these appointments is challenging. Dr Wright, Dental Director for Open Door Community Health System believes the value of prevention is not recognized by many patients. He also estimates that if all the patients completed their treatment plan and the clinic could focus on prevention, the clinic capacity would quadruple.

Limits to specialty dental care: There is extremely limited access to pediatric dentists or other specialty services, such as oral surgeons for low-income children. The three pediatric dental practices have made limited commitments with specific agencies, such as Head Start or UIHS to see a small number of children on a fee for service basis. The ULHF Dental Angel Fund pays specialists and private practice dentists a fee for service to treat a limited number of children for specific treatment plans.

Need to insure aggressive prevention for all low-income children who have restored caries: Since filling caries does not prevent future caries from developing and low-income children with fillings are at very high risk of infection, every effort should be taken to make sure these children receive aggressive, consistent and on-going preventive care and education with support of the parent of care-giver. This is especially important for DentiCal children who are receiving just restorative care on a special fee-for-service basis from a pediatric, private practice, or hospital-based dentist. Once the restorations are complete, these children need to be looped back to a general dental clinic and have preventive appointments. Some hospital-based programs report up to a 40% return rate for their patient. Insuring education and prevention are an essential element to address this cycle of decay.

Perinatal women on DentiCal are only covered for preventive services: Perinatal women often have a high need for dental services. Due to hormone changes, pregnant women are more susceptible to dental decay. In addition, periodontal disease has been linked to poor pregnancy outcomes, such as low birth weight babies. Generally the oral flora of a baby's caregiver is transferred to the baby within the first year. If the caregiver is the mother and she has a particularly aggressive oral bacteria, the baby will be at high

risk of early dental disease – early childhood caries, some of the most difficult dental disease to treat. When perinatal women receive preventive care, they do not continue to get the restorative work done because of the cost.

Dental Professional Shortage/Recruitment and Retention: There is a significant dental professional shortage in Humboldt. Based on the 2010 report, *Specialty Access on the North Coast: Mental, Dental, and Medical Access* (Bonser-Bishop), there were 41 adjusted FTE general dentists, but only 5.2 FTE dentists to serve low-income patients. This leaves a ration of 4,808 low-income patients per dentist. This ratio led to Dental Health Professional Shortage Area designation and the local clinics are eligible for National or State Health Service Corp Loan Repayment programs. It also leads to a level of transiency to the dental workforce. In addition, Burre has a number of 4th year dental students and interns in rotations throughout the year. This also leads to variation in clinic capacity. This was particularly evident in early 2012 when UIHS had just one dentist and only 4% of patients requesting a dental appointment got one; currently with three dentists the rate is 48%. They are expecting one more dentist to come aboard in the near future, so the rate is expected to rise to the high 60%.

Use of caries risk assessment is critical: The use of a standardized caries risk assessment tool is critical to insure the children who need services actually get services. In times of limited resources, population based services should be ranked to serve those with the greatest risk first.

Dental Advisory Group lacks cohesion and consistency of partners: The Dental Advisory Group (DAG) has been challenged with limited funding for the coordinator; currently it is only a 0.4 FTE position. This does not provide the staff time to support strong relationship with community partners and outreach to state and national agencies. Consequently, the agenda items for the DAG in the last year have primarily focused on the work within DHHS. The representation from the various partner organizations has also been varied or not existent. These partners also commented in stakeholder interviews, that they want clarity on the goal of the DAG meetings and to better understand their role. If the Dental Advisory Group is to be a focus point of collaboration within the county, the diverse stakeholders need to develop a process to achieve this ambitious goal.

Lack of connection to and advocacy with other professionals outside Humboldt: There needs to be consistent connections to organizations in other counties and at the state and federal level to learn about and advocate for new opportunities. By working at a higher level, Humboldt can advocate for important changes in oral health services. These agencies are not limited to, but include:

- Alameda County Dental Health Program
- UCSF Dental School
- California Dental Association
- California Department of Health Services
- Oral Health Foundation
- Association of State and Territorial Dental Directors
- National Alliance for Oral Health
- American Association of Public Health Dentistry
- Centers for Disease Control

A change in the public perception and culture of oral health: There needs to be increased oral health literacy. The old paradigm of seeking dental care just to fill cavities or to get rid of toothaches needs to be changed to understanding the value of preventive care for all, but especially children. This is extremely difficult when services for low-income adults are virtually non-existent. Information from the California Health Interview Survey (2001) shows that 45.9% of American Indian and 44.1% of Latino children ages 2 – 5 years in California have never had a dental visit. This culture shift to prevention including a well child dental visit by the age of one has profound preventive effects. The medical “check-up”, essentially a preventive medical visit, is generally well understood and valued by parents. This concept could be extended to the dental visit with a “dental check-up”. Focus groups with American Indian and Latin parents would help frame the right and effective interventions.

Change policymaker's perception: Inform policymakers and administrators at local, state and federal levels of the results of oral health research and programs and of the oral health status of their constituencies. Develop concise and relevant messages for the policymakers. Document the health and quality of life outcomes that result from the inclusions (or exclusion) of oral health services in programs and reimbursement schedules.

Limited focus on children leaves others out: The current focus on low-income children's dental needs ignores significant other populations with high dental needs; low-income adults, working families without dental insurance, college students, seniors, and residents of skilled nursing facilities.

Opportunities

FQHC contract with local providers: According to a policy analyst at the California Dental Association, FQHCs can now legally contract with other medical providers with the enhanced FQHC rate. Due to the complications of the issues, it is not expected that many FQHCs will do this until guidelines and toolkits have been developed by CDA and CPCA.

Opportunities of the RDHAP: The Registered Dental Hygienist in Alternative Practice (RDHAP) was created in 1998. The purpose of this new license category was to deliver dental hygiene care and preventive services to special populations in alternative settings where people live or frequent, rather than the traditional dental office or clinic. An RDHAP may be able to meet many of the needs of residents of residential care facilities and schools. More importantly, the RDHAP can help develop critical prevention strategies. Preventing or minimizing oral problems can be achievable for many residents, saving staff time and reducing pain, suffering, and loss of self esteem.

Potential to design cultural awareness in oral health awareness campaign: There are some agencies in the County that have the expertise to support a culturally competent oral health awareness campaign to raise awareness and start a culture shift toward preventive care.

Threats

Alternate dental models: Dental service corporations, such as Western Dental entice individuals with low income or no dental insurance with low-cost cleaning, x-ray, and prevention. Then the patient is signed up with a dental credit card to pay for expensive dental restorations. Since the corporation provides a reduced reimbursement rate to the dentist, they tend to attract very young dentists and oversight can be limited. Perhaps a locally created Co-op to support this sort of home-grown insurance would be more suitable

Healthcare Reform Transition: Healthy Families contracts with private practice dentists. In 2014, these children will roll into MediCal in phases and approximately 2,000 to 3,000 children will most likely not continue with their current private provider and need to become patients of record at an FQHC clinic. Although this is a big enrollment number, most of the children are probably in fairly good oral health status.

Insurance exchange: Children's dental benefits are federally mandated and are part of the 10 essential health benefits that must be offered in the exchange. The challenge is to create an insurance package with a high enough reimbursement level to be favorable to private practice dentist, but not so highly priced that families and individuals cannot afford it.

Limit of hospital based dental services: As mentioned at the beginning of this report, Pediatric Dental Institute in Windsor California provides dental services for children under anthesthesia. Last year, they reported 142 children from Humboldt County receiving services. Currently, they are under significant fiscal challenges. They need to raise approximately $400,000 annually to provide services. It is unknown what this means for our community. PDI may ask Humboldt foundations to help with this challenge and thus put other dental programs who receive local funding at-risk. If PDI closes or limits access for Humboldt children, these children may not have anywhere to go for services.

Oral Health Focus Area #1 - Data collection, evaluation, and dissemination to understand the oral health status of Humboldt County's children and the effectiveness of partner programs				
Strategy 1A: Convene a dental data group to aggregate existing data and develop collection plan to determine the oral health status of Humboldt's children.				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	**Timeline/ Funding Source**
1) Gather existing data from: a. FQHC clinics' electronic health database b. Well Child Dental Visit data		Burre and Willow Creek Clinics - (ODCHC) UIHS Clinic, Redwoods Rural, Head Start, TOOTH, DHHS	The four FQHC clinics have electronic medical records that can be mined for oral health data. Similar data should be collected and compared across all the clinics.	
2) Identify other data – locally, regionally or nationally that adds to the understanding of the oral health status in Humboldt.		DAG	CHIS, MediCal data, CDC, Identify other data – locally, regionally or nationally that adds to the understanding of the oral health status in Humboldt.	
3) Create a Data Collection Plan-- Determine additional resources needed to collect the data, aggregate or evaluate		DAG. First 5 evaluation framework included. Data Commons (HAF & CCRP) use this data as pilot program. PDI data Hospital data. Claims data for public insurance.	There is other local data including: HCOE's Kindergarten Oral Health Assessment, SJHS Emergency Department & Urgent Care data, Pediatric Dental Institute's data on Hospital-based dental services in Windsor, NCCN and Darla Dale's Hospital-	

			based dental coordination, NCS Head Start's dental data for both Early Head Start & Head Start, Union Labor Health Foundations' Dental Angel Fund, Redwood Coast Community Action's TOOTH program.	
4) Develop appropriate outcome measures (including performance and quality measures).		Burre and (Willow Creek Clinics – when dental clinic is open) - (ODCHC) UIHS Clinic. Redwoods Rural Head Start, TOOTH	Currently the Dental Quality Alliance of the ADA is working on national performance and quality standards. Until national measures are set, our discussion might involve the number of patients completing treatment plan and receiving preventive care and clinic efficiencies (number of patients who could not get an appointment, no shows, etc).	
5) Update data annually			Data will need to be maintained annually. This should be built into the initial planning.	
6) Develop Data Warehouse			Identify where the collected dental data should be stored and level of accessibility. The option of a community dental website and who is to maintain the site is a critical	

			part of the discussions	

Strategy 1B: Map and analyze the Pediatric Dental Institute's Hospital-based dental services for Humboldt County				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Status Notes**	**Timeline/ Funding Source**
1) Analyze the data from PDI by age, geography, race and ethnicity to better understand the typical hospital-based patient	CCRP	PDI		
2) Map the data to better understand the geography and regionality of children's oral health needs in Humboldt County	CCRP	Funders DAG		
Oral Health Focus Area #2 – Develop Stronger Oversight, Coordination and Advocacy for all the Oral Health Activities in the County				
Strategy 2A: Expand the role of Oral Health Analyst to encompass greater leadership and policy activities which might include two coordinated positions - one at DHHS and one at a community based partner organization - each providing specific oral health responsibilities.				
Project	**Leaders/ Resource**	**Stakeholder Organizations**	**Status Notes**	**Timeline/ Funding**

	People			**Source**
1) Develop a job description for a the two Oral Health Coordinator/Analyst positions:		To be determined Ideally develop a linked position at both a 501c3 and DHHS since both have strengths and weaknesses. Policy and building political alliances is not easy in a public agency, but is linked to ACA funding and can draw down funds. A 501c3 can to do the policy/advocacy work and be nimble. There needs to be a move toward prevention and this will be emphasized in ACA funding. DHHS is moving to prevention activities and funding community and family involvement activities for this and needs a liaison position outside of agency. CSBG will receive ACA funding: monies will go through CDC	Ideas for the Oral Health Analyst already suggested include: • Support for the evolving workgroups (data, ACA, social marketing campaign, etc) • Take lead in funding opportunities • Develop partnerships with all members of the DAG, especially with all clinical dental directors and project leads • Develop partnerships with other dental and medical professionals to expand oral health services • Outreach to community members and all elected officials to inform about the oral health status of children in Humboldt • Understand the value of supporting local efforts with best practices and supporting evidence-based practices. • Develop connections to and working relationships with agencies outside of Humboldt, such as CDA,	

		and we need to track 2014 sources.	ASTDD, AAPHD, ADA, CDC, and others • Revitalize the DAG through appropriate evaluations and recommendations	
Oral Health Focus Area #3 - Improve Access to Dental Services for Those at Highest Risk of Dental Decay				
Strategy 3A: Standardize Well Child Dental Visit protocols				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	**Timeline/ Funding Source**
1) Share best practices and resources for the parent education component		DHHS, Burre Dental, UIHS, TOOTH		
2) Link caries risk assessment to determine appropriate number of fluoride varnishes for each child		All above	Use same caries risk assessment each time. Educate parent. Use forms easy for parents to understand. Share successful tools and forms among WCDV providers.	.
3) Identify ways to insure that children with caries are referred to and **receive** appropriate dental care		All above	If there appears to be frank caries, immediate referral is necessary.	

Strategy 3B – For community based organizations providing fluoride varnish, use a risk assessment to determine the group most at risk and provide evidenced-based care at an efficacious level.				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	
1) For organizations providing fluoride varnish, determine how at least two applications or optimally three will be performed on the same child each year.		TOOTH DHHS (WIC and Mobile Engagement Vehicle)	American Dental Association (2006), *Evidence-Based Clinical Recommendations for Professionally Applied Topical Fluoride (JADA 2006;137(8):1151-9).*	
2) Explore ways to track fluoride varnishes		TOOTH DHHS All FQHC dental clinics	Determine how to best do this. Does this involve a registry, a card based on the immunization model (not successful in prior years), a HMIS family-based model or something else? Potentially pilot in Loleta	
3) Determine how to insure appropriate referral to dental services for children identified with caries. Insure no HIPPA violations and not "diagnosing"		TOOTH DHHS Family Resource Centers/Healthy Start partnerships First 5 Schools	California Dental Association may be able to give advice about how to work through this.	
4) Link community based dental services to schools with high		TOOTH Humboldt County Office of Education	Currently many schools with high free/reduced lunch either declining or not getting oral	

percent of children receiving free and reduced school lunches		Superintendents for school districts with high free/reduced school lunches Local funders CCRP working on data	health services. Need support from school system at every level. In partnership with DAG partners, start with Superintendent, Gary Eagles and then go to principals with data (kindergarten oral health evaluation and map, etc) and stories of how dental care changes lives. McLean Foundation interested in producing video. Stipend for school to provide additional help for school secretary to support dental activities is advised.	
5) Determine if there are at-risk children who are not being reached with preventive or restorative services and try to determine best way to reach them.		DAG		
Strategy 3C – For every child who received special restorative dental services (such as hospital-based services or special appointments with a dental specialist), an equal level of case management effort must be made to insure that he/she has a dental home and receives aggressive and on-going preventive services				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	

1) Expand UIHS's model of intensive education and prevention with the use of a contract for children receiving hospital-based care.	Dr. Greg Jaso Carla Creason	Burre Redwood Rural	Attachment #1- UIHS contract process for Hospital based Dental care.	
2) Identify ways to insure that children establish a dental home and receive aggressive preventive care after funding for special care (such as Darla's HBS, ULHF Dental Fund and Head Start).		Darla Dr. Epperson Amy Jester Linda Shepard	Families that receive hospital based dentistry (especially Spanish-speaking) often ease up on prevention since they know these intensive services exist. Need to find a way that helps people take more care with prevention. Insure Latino community is involved in developing these systems to ramp up outreach and support and overcome barriers. . . UIHS uses a contract with hospital-based care, and the parents must understand and agrees to these steps to get treatment. The contract is not punitive, but encourages responsibility. For those that support children's access to specialty dentists (such as ULHF Angel Fund), the person who submits the application needs to insure the child has an appointment	

			with a local dentist for on-going prevention. Unfortunately, there are not enough local Spanish bilingual/bicultural case workers for follow-up. Since many children or their siblings have repeat extensive treatment plans, families should treated as a whole at the same Dental home. There should be more emphasis on the Dental home: First 5 encourages medical home, integrate these. Open Door provides both. Stop putting in silos. Look at school-based dental care (Lake County has it!). Component of affordable care act. CHDP has oral health as performance measure. They track dentists who accept Medi-cal. Look at health assess guidelines and encourage pediatrician to look at mouth before 6 months. There is a shortage of dentists and specialty dentists, such as pediodontists and oral	

			surgeons. It is difficult to get children in for care and Medi-Cal is virtually not accepted by specialty dentists. Economic development approach: Doctors and dentists as businesses that are vital to economic development. Possibly create a revolving fund that compensates dentists until Medi-Cal reimburses and support a subsidy to increase rates (need to check legality). Going to Headwaters as an economic development approach is a possibility. Could have more dentists if more revenue were possible. Incentives to bring in more dental offices contributes dramatically to community via payroll. Legal issue? Work around, separate the link. Target for number of children served. Use the Summer lunch program as model. Funders came in to cover gap between the federal money. 1. Subsidize another pediatric dentist with guaranteed income level	

			2. Incentivize current dentist to accept low income pts. 3. Subsidize support people/intro to dental care for very young children, less $ than dentist. Non-technical aspects of dental care intro. 4. Cultural competency in dental offices.	
Strategy 3D – Support and encourage pediatrician's to provide a Well Child Dental exam and appropriate referral for dental care				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	
1) Support pediatricians to provide an oral health assessment, fluoride varnish and create a workgroup to work through challenges with referral process.	John Sullivan, MD Elesha Hernandez	Require ongoing conversations and workgroup. Pediatricians need dental offices to refer to. Eureka Pediatrics feels it has places to refer (Darla and PDI). Also trying to take an educational approach with Well Child visits to include brushing and varnishes etc.	Attachment #2 - Bright Futures/AAP attached	

		They would like to target referral coordinators with plan and get feedback as to what transpired.		
2) Provide continuing education and engagement on oral health issues		DAG		
Strategy 3E – Support plans to enlist families in understanding and receiving on-going preventive care.				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	
1) Identify successful protocols and or contracts that are used in the various dental clinics		Burre, Willow Creek, UIHS, Redwoods Rural FRC's DHHS		
2) Insure best practices are shared between clinics		All above		
Strategy 3F – Explore the use of dental sealants, xylitol, high fluoride dental products and other preventive measures				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	
1) For community partners that work in		DAG Changing Tides	Changing Tides staff goes to childcare providers that support	

a non-clinic setting, explore the use of xylitol gum in schools and rinses in other unique settings		Northcoast Children's Services/Head Start TOOTH HCOE First 5	1000 children. This is an outreach opportunity to support use of xylitol gum or rinses and tie in with nutritional information. Reach out to other childcare centers that are not Head Start funded.	
2) Identify the benefits and barriers to community based dental sealants. Identify other options, if necessary.		DAG College of the Redwoods		
3) Support dental clinics in the use of dental sealants, xylitol, high fluoride products, and other preventive measures.		DAG Dental Clinics		
Strategy 3G – Explore ways to increase the number of dental professionals to help improve oral health in Humboldt				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	
1) See Strategy 5B				
2) Explore ways to insure build a quality recruitment system for dental professionals for the FQHC dental clinics;		DAG Burre, Willow Creek, UIHS, Redwoods Rural, K'ima:w	Understand the on-going recruitment efforts and gaps. Are recruitment efforts coordinated between organizations or medical/dental? The primary	

potentially look at the Workforce Collaborative Project to include dental professionals.			recruiter for medical is the hospital. Recruiting is very expensive, approximately $60,000 for a doctor to interview. Loan forgiveness is an incentive, but also creates a revolving door of providers once term is completed. Look at increasing capacity of the current workforce through CME credits, a little pro bono, a little Medi-Cal, in exchange for learning to deal with small children with a limited finite commitment.	
Oral Health Focus Area #4 – Create a culture shift about the importance of preventive care through education and social marketing				
Strategy 4A: Develop a community wide social marketing campaign with several messages for specific target audiences.				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	
1) Review literature for effective community campaigns to raise awareness about oral health and increase oral health literacy.		DAG Humboldt CAN Paso a Paso Northern Cal Indian Development Council MAC Center Healthy Kids Humboldt Northcoast Children's Services/Head Start	Need to bring the mouth back into health care and the body. The community marketing needs to be for patients and providers. Review existing campaigns for effectiveness. Invest in public messaging – whole health. Dental health literacy.	

		Changing Tides Humboldt Housing & Homeless Coalition Family Resource Centers/Healthy Families	Homeless population- as transitioning out of shelters	
2) Hold separate focus groups in appropriate languages with highest risk groups, including Latino, Native American, and recipients of the ULHF's Dental Angel Fund and hospital-based services to understand the challenges and barriers to better oral health and the value of prevention.				
3) Based on focus group results, develop culturally and linguistically appropriate messages for the specific target audiences. Re-test with focus groups.				
4) Understand the best medium to reach the target audience (TV,				

print, radio, etc) and determine length of time for campaign.				
5) Link campaign messages to other targeted communication opportunities, such as Changing Tides newsletters, Food Bank, First 5 Playgroups, pediatric appointments, and other DAG partners.				
6) Share focus group results and campaign messages with dental clinics and all DAG partners to help reach target populations more effectively. Bring campaign messages in to the dental clinics.				
Strategy 4B – Insure that interventions and actions emphasize the importance of preventive care at home				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	
1) For all Well Child Dental Visits,		DHHS, Burre, UIHS, NCS Head Start	Create a digital story. Lou Mourner is a good	

consider having the parent show how she brushes her child's teeth. Provide advice on how to hold a squirmy crying child and improvement on brushing techniques.		TOOTH	resource.	
2) For all appointments and Well Child Dental Visits, determine how to incorporate oral health goals and provide tracker sheet for parents		All above		
Strategy 4C: Raise community awareness about the lack of dental services and promote policy change				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Notes**	
Creating community awareness about the limited resources for oral health certain segments of the population		DAG	Create a community health Vital Sign for oral health. People with development disabilities are a high- risk group for dental disease.	
Oral Health Focus Area # 5 – Increase the amount and quality of networking between new and current partners in Humboldt County and with other organizations at a state and national level				
Strategy #5A – Develop a working group to address the upcoming changes, challenges and				

opportunities with ACA implementation in 2014				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Status Notes**	
1) Understand the combined dental clinics projected capacity and the impact of ACA	Herrmann Spetzler CDA	DAG Dental Clinics		
2) Explore the opportunities to apply for ACA grants that support expanded dental force (RDHAP) or Disease Prevention and Oral Health Literacy		To be determined	See: *Key Oral Health Provisions Contained in the Final Health Reform Bill*	
Strategy #5B – Develop ways to engage other dental health and medical professionals in the area to support the efforts to improve oral health in Humboldt				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Status Notes**	
1) Reach out to private practice dentists to volunteer for limited hours, such as school oral health screenings. Approach the Humboldt – Del Norte Dental Society	George Epperson Michael Belluscio	TOOTH DHHS	www.hdnds.org	

for donations of time, supplies, or funding.				
2) Extend connections to the local RDH professional society for support with health fairs, oral health education, and fluoride varnish applications.	Darla Dale Shirley at Dr. Johansen's in McKinleyville	TOOTH DHHS		
3) Make connections to College of the Redwoods' Dental Assisting program. Identify projects to benefit the community, CR, and the students	Pat Girczyc Hillary Reed	TOOTH DHHS Dental Clinics		
4) Identify ways Public Health Nursing can provide support or follow up on oral health programs in the community.	Susan Buckley	Dental Clinics	Present to public health nurses. Focus of nurses can be to help family go to dental office. Help people experience how to make phone call, explain problem, etc. Families are often intimidated by institutions and PH nurses can help them through the experiences.	
5) Reach out to the County Medical Officer and insure that he is up to date on the challenges with oral health for the		DAG Dr. Donald I. Baird		

children of Humboldt.				
6) Maintain good working relationships with these organizations and individuals so as policy issues come up, the dental/medical workforce for Humboldt can be mobilized.		DAG		
Strategy 5C – Make connections to elected officials, other professional organizations and the community to support public health dentistry				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Status Notes**	
1) Insure that every elected official (city, county, state) understands the challenges of Humboldt County's oral health status and the importance of dental policy. Maintain connections to insure oral health policy				
2) Have memberships or remain up to date on the activities of key				

organizations, such as CDA, AAPHD, and others				
3) Identify ways to encourage or incentive schools with a high percent Free and Reduced School Lunches to support the Burre Dental Van and other dental opportunities.	Barbara Davis ODCHC	School Districts DAG	Elevate work/importance of group to organizations and schools. Go out and meet with principals, elected school board, and teachers. Increase impact.	
Strategy 5D – Insure all dental partners/projects are not working in isolation. Share resources, provide training, and best practices				
Project	**Leaders/ Resource People**	**Stakeholder Organizations**	**Status Notes**	
1) Continue the discussion about Burre loaning its dental van to UIHS for remote site schools that are in both organizations' territory.	Burre Dental Van	Burre and UIHS	ODCHC – a new dental van is a priority. Need to replace the current dental van. Assessment of capital equip/needs is critical. They are saving money in advance of equipment collapse.	
2) Discuss the links between Burre and the TOOTH program		Burre TOOTH		

and insure efficiencies				
3) Discuss the opportunity of the Burre Dental Van going to Head Start sites	Burre Barbara Davis	NCS Linda Shepard		
4) Train additional dentists for hospital-based services and get hospital privileges.	Mad River Hospital St Joseph Hospital	Local dentists		

UIHS Dental Services
Hospital Program Informational Facts

Eligibility requirements of the Hospital Program are as follows:

- **Registered Indian client as UIHS**
- **Living in the service areas of Humboldt and Del Norte counties**
- **Clients must be between one (1) and six (6) years of age or;**
- **Lacking maturity to tolerate treatment in a clinical setting or;**
- **Mentally or physically compromised and unable to tolerate treatment in a clinical setting.**
- **Untreated teeth that will lead to compromised general health**
- **Has attended two consecutive family orientation appointments in Dental Services and one family nutrition counseling visit.**

Please initial that you have read and understand the following informational facts:

_____ **I understand the eligibility requirements of the Hospital Program.**

_____ **I understand that before my child is accepted for hospital treatment I am required to attend two appointments with my dental provider for orientation and Oral Hygiene Instruction (OHI).**

_____ **I understand and acknowledge the importance of my child being present at all necessary appointments <u>prior to hospital treatment</u> (i.e., orientation, OHI, history & physical appointment with physician).**

_____ **I understand and acknowledge the importance of my child being present for all follow-up appointments <u>after hospital treatment.</u>**

_____ **I understand there are fees associated with my child's treatment and I will assume all financial responsibility.**

_____ **Since general anesthesia requires an empty stomach I understand that my child must not eat or drink anything after midnight, prior to the day of their hospital appointment.**

_____ **I understand that if my child eats or drinks anything prior to their hospital appointment the hospital anesthesiologist <u>will refuse treatment.</u>**

Orientation Appointments **(Pre-operative)**	**2 appointments** **1 appointment**		**Orientation/Oral Hygiene Instruction Family/Child** **Nutrition Counseling Family/Child**
History & Physical Appointment	**1 appointment** **1 week prior to hospital trt.**		**Medical Physical – Family/Child**
Hospital Treatment Appointment	**1 appointment**		**Restorative treatment at hospital – Family/Child**
Follow-up Appointments **(Post-operative)**	**1 appointment – 1 week**		**Oral Hygiene Instruction – Family/Child**

	1 appointment – 1 month		**Oral Hygiene Instruction – Family/Child**
	1 appointment – 3 month		**Dental cleaning – Family/Child** **Oral Hygiene Instruction**
	1 appointment – 6 month		**Dental cleaning/exam – Family/Child** **Oral Hygiene Instruction**
	1 appointment – 6 month		**Dental cleaning recall/exam**

Client Name_____DOB_____HR#_____

_____ I understand that the hospital will have there own Consent to Treatment forms for my child's hospital treatment including the administration of general anesthesia outlining the risks associated with it.

_____ I understand it is my responsibility to contact Dental Services for all required appointments including orientation, follow-up and my child's history & physical appointments.

_____ I have had the opportunity to discuss my child's treatment considerations and risks with my child's Dental Care Provider and they have clarified any areas I do not understand about hospital treatment.

_____ I acknowledge that I have received adequate information about the Hospital Program from my Dental Care Provider.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____

RELATIONSHIP TO CLIENT

_____ _____

DENTIST'S SIGNATURE **DATE**

_____ _____

DENTAL CLINICAL SITE COORDINATOR **DATE**

Client Name_____DOB_____HR#_____

Original – Clients record Copy – To client

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care.**

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	PRENATAL[2]	NEWBORN[3]	3–5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 m	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[5]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision		★	★	★	★	★	★	★	★	★	★	★	★	●[6]	●	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing		●[7]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																
Developmental Screening[8]								●			●		●																			
Autism Screening[9]											●	●																				
Developmental Surveillance[8]		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment																						★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAMINATION[10]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[11]																																
Newborn Metabolic/Hemoglobin Screening[12]		◄	●	►																												
Immunization[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[14]						★			●		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[15]							★	★	●or★[16]		★	●or★[16]		★	★	★	★															
Tuberculin Test[17]				★			★		★		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[18]												★			★		★		★		★	★	★	★	★	★	★	★	◄	●	►
STI Screening[19]																						★	★	★	★	★	★	★	★	★	★	★
Cervical Dysplasia Screening[20]																						★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH[21]							★	★	●or★[21]		●or★[21]	●or★[21]	●or★[21]	●[22]			●[22]															
ANTICIPATORY GUIDANCE[23]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (2001) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/6/1456].
3. Every infant should have a newborn evaluation after birth, breastfeeding encouraged, and instruction and support offered.
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/2/496]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement "Hospital Stay for Healthy Term Newborns" (2004) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434].
5. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
6. If the patient is uncooperative, rescreen within 6 months per the AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (2007) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/4/902].
7. All newborns should be screened per AAP statement "Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs " (2000) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/798]. Joint Committee on Infant Hearing. Year 2007 position statement: principles and guidelines for early hearing detection and intervention programs. *Pediatrics.* 2007;120:898–921.
8. AAP Council on Children With Disabilities, AAP Section on Developmental Behavioral Pediatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics.* 2006;118:405–420 [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405].
9. Gupta VB, Hyman SL, Johnson CP, et al. Identifying children with autism early? *Pediatrics.* 2007;119:152–153 [URL: http://pediatrics.aappublications.org/cgi/content/full/119/1/152].
10. At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
11. These may be modified, depending on entry point into schedule and individual need.
12. Newborn metabolic and hemoglobinopathy screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.
13. Schedules per the Committee on Infectious Diseases, published annually in the January issue of *Pediatrics.* Every visit should be an opportunity to update and complete a child's immunizations.
14. See AAP *Pediatric Nutrition Handbook,* 5th Edition (2003) for a discussion of universal and selective screening options. See also Recommendations to prevent and control iron deficiency in the United States. *MMWR.* 1998;47(RR-3):1–36.
15. For children at risk of lead exposure, consult the AAP statement "Lead Exposure in Children: Prevention, Detection, and Management" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/4/1036]. Additionally, screening should be done in accordance with state law where applicable.
16. Perform risk assessments or screens as appropriate, based on universal screening requirements for patients with Medicaid or high prevalence areas.
17. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases.* Testing should be done on recognition of high-risk factors.
18. "Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report" (2002) [URL: http://circ.ahajournals.org/cgi/content/full/106/25/3143] and "The Expert Committee Recommendations on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity." Supplement to *Pediatrics.* In press.
19. All sexually active patients should be screened for sexually transmitted infections (STIs).
20. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first).
21. Referral to dental home, if available. Otherwise, administer oral health risk assessment. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
22. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
23. Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.)

KEY

●= to be performed ★= risk assessment to be performed, with appropriate action to follow, if positive ◄—●—► = range during which a service may be provided, with the symbol indicating the preferred age