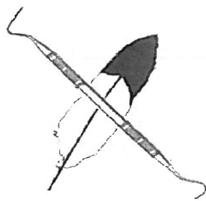

The IHS Dental Explorer

A publication of the IHS Division of Oral Health

October 2012

The IHS ECC Collaborative

At the 2009 IHS Dental Updates Meeting, a group of innovative IHS oral health professionals began the planning for a program aimed at preventing Early Childhood Caries (ECC). The ECC Initiative was launched in FY 2010. In FY 2011 it was renamed the ECC Collaborative after its successful inaugural year attracting many I/T/U community partners. Beginning in FY 2010 as a five-year collaborative, the ECC Collaborative will conclude at the end of Fiscal Year 2014 (September 30, 2014).

This edition of the IHS Dental Explorer is devoted to providing you with the latest information on one of the major IHS HQ Division of Oral Health supported dental clinical initiatives, the IHS Early Childhood Caries Collaborative.

Table of Contents

	Pages
How are we doing now?	2-4
What have we learned?	5-13
What should my clinic be doing now?	14-15

When will we know if we have made a difference?

We conducted the first nationwide Basic Screening Survey on 0-5 year-olds in FY 2010, and we plan to conduct the next one in the Fall of 2014. The FY 2010 and 2014 screenings will indicate if our interventions have made a difference in ECC prevalence.

How have we done on the ECC Collaborative?

	FY 2009 (Baseline)	FY 2010 (Year 1)	FY 2011 (Year 2)	FY 2012 (Year 3, as of 9/5/12)
0-5 year-olds accessing dental care	**53,431**	**54,327**	**55,593**	**44,065**
Sealants provided to 0-5 year-olds	**16,343**	**18,997**	**21,377**	**22,916**
0-5 year-olds receiving sealants	**4,350**	**4,852**	**5,417**	**5,395**
0-5 year-olds receiving fluoride	**39,898**	**44,125**	**47,144**	**36,790**
Fluoride applications in 0-5 year-olds	**61,790**	**69,596**	**78,501**	**60,472**
Interim therapeutic restorations in 0-5 year-olds	**3,818**	**4,670**	**7,742**	**8,062**

** Fiscal Year 2012 data is incomplete and will not be complete until November or December.*

	2009 Baseline Year	**2011 (latest complete data)**
0-5 year-old dental utilization rate	26.5%	27.6%
Sealants per 0-5 year-old patient	3.76	3.95
Fluoride applications per 0-5 year-old patient	1.55	1.67
Percentage of 0-5 year-olds accessing care receiving fluoride	74.7%	84.8%

How have we done on the ECC Collaborative?

Access to Care

- **ECC Collaborative Goal**

Increase access in 0-5 year-olds by 25% by 2014

- **So far**

We've increased by just 3%

- **What we need to do**

Increase 0-2 year-old access

Sealants

- **ECC Collaborative Goal**

Increase sealants in 0-5 year-olds by 25% by 2014

- **So far**

We've increased by 29%

- **What we need to do**

Keep it up!

Patients Receiving Fluoride

- **ECC Collaborative Goal**

Increase 0-5 year-olds receiving fluoride by 25% by 2014

- **So far**

We've increased by 14%

- **What we need to do**

Capture fluoride data from our community partners

Interim Therapeutic Restorations (ITRs)

- **ECC Collaborative Goal**

Increase ITRs in 0-5 year-olds by 50% by 2014

- **So far**

We've increased by 79%

- **What we need to do**

Keep it up!

Apply now for VLCP-2!!!

The IHS Division of Oral Health is pleased to announce the continuation of the **Virtual Learning Community Program (VLCP)**, part of the IHS Early Childhood Caries (ECC) Collaborative. This program is designed to use some of the improvement tools taught by the Improving Patient Care (IPC) initiative to enhance how we're implementing the ECC Collaborative at local IHS, Tribal, and Urban (I/T/U) dental programs. The goal of the Virtual Learning Community is to increase awareness and knowledge about ECC and ECC best practices throughout I/T/U dental programs. Dental programs that sign up to participate will participate in quarterly nationwide conference calls or webinar sessions where they will share successes from their programs and learn from one another about best practices in implementing components of the ECC Collaborative.

An announcement was sent out on Friday, September 14th with the application packet attached. If you did not receive this e-mail and would like to participate in the VLCP-2, or if you have further questions about the VLCP, please e-mail ECCCollaborative@ihs.gov.

The deadline for applications is Monday, October 1, 2012.

How did VLCP programs perform in FY 2012?

Objective	VLCP-1 Sites % Increase (n=39)	Non-VLCP Sites % Increase (n=273)
Access, 0-2	-3.4%	-6.8%
Access, 3-5	32.5%	17.1%
Sealants, 0-2	56.9%	46.6%
Sealants, 3-5	145.8%	25.8%
Fluoride Patients, 0-2	9.7%	5.7%
Fluoride Patients, 3-5	56.6%	27.5%
ITRs, 0-2	98.6%	196.0%
ITRs, 3-5	199.0%	73.1%

Summary of best practices to prevent ECC

Case Management: Assign one person to generate lists of children and provide exams, fluoride varnish, sealants, and ITRs. This person also becomes the "go to" person for families whose children need more dental treatment, often setting up appointments and arranging transportation. Be sure to provide follow-up after dental treatment is completed.

Collaboration: Work with WIC, medical staff, IPC committees, and other community programs like daycare centers and Head Start.

Local Champions: This might be a dental staff member, a public health nurse, a Tribal Council member, or someone else in the community that is committed to the prevention of ECC.

Training: Make sure dental staff are comfortable treating young children and know how to use glass ionomer products for sealants and restorations on primary teeth.

Teamwork: Make the ECC Collaborative objectives a priority in your dental program. Consider providing open access for 0-2 year olds.

There are many ways to build effective ECC programs.

Which model will work in YOUR community?

ECC Collaborative: best practices

Through the Virtual Learning Community 2011-2012, some simple yet powerful strategies to meet the objectives of the ECC Collaborative have emerged. The solutions are unique to each dental program and community, yet they share threads of wisdom that can be adopted by other dental programs.

Components of Successful Dental Programs

- Knee to knee screenings for 0-2 year olds
- Dental exams for 3-5 year olds
- Fluoride Varnish 3-4 times a year
- Glass ionomer and resin sealants on primary molars
- ITRs with glass ionomer on primary teeth
- Family education that includes daily brushing with fluoride toothpaste beginning with eruption of the first primary tooth
- Collaboration with medical and community partners

Key elements to success: what works?

Organization

- An effective ECC Program requires a high level of organization and attention to details, especially in the development stage. The more organized you are initially, the smoother the program will run later on.

Commitment

- Your goal is to achieve a solid commitment from your own dental staff and also your medical and community partners. Find those champions in your own community who will commit themselves to the prevention of ECC.

Communication

- Good communication between the dental staff, medical staff, and community partners is essential. Furthermore, if you effectively market your ECC program to the families you serve, you can more effectively get them to join you as partners in the prevention of ECC.

Creativitiy

- Successful dental programs have been very creative. They have increased access through mailings, health fairs, and various other strategies. Instead of complaining that nothing works, the programs featured in this document have found new ways to address problems, often by thinking outside of the box.

Best practices to increase 0-2 year-old dental access

Objective #1: *Increase dental access for 0-5 year old AI/AN children by 25% in five years.*

Challenge: *Increase access for* ***0-2 year olds*** *because only then will we prevent the onset of ECC.*

.**Seminole Dental Program (Nashville Area)**

What: Increased dental access over 50% in a three month period.

How: The Tribal Daycare requires a dental exam before the children are enrolled. This policy resulted in more families seeking dental exams for their 0-2 year olds.

Collaboration and policy changes that really made a difference.

Ft Peck Dental Program (Billings Area)

What: Increased dental access for 0-2 year olds by 103% in a three month period.

How: "Go where the babies are." We worked with WIC and well-child staff. An oral health assessment has become an expected part of a well-child visit.

The dental hygienist serves as a "case manager," making sure families follow through if more dental treatment is needed. The RDH also keeps a spreadsheet of 0-2 year old children so that she can keep track of their visits. It takes a significant commitment to send the dental hygienist out of the clinic two days a week to attend well-child clinics.

We had to use a mix of WIC and medical staff because neither strategy worked at all of the sites.

Rosebud Dental Program (Aberdeen Area)

What: Increased dental access for 3-5 year olds by 47% in a three month period.

How: Completed exams, prophies, fluoride varnish, GI sealants, and interim therapeutic restorations (ITRs) at the Head Start Center 3 days/week in February. We used 1 dentist

This is a great way to increase access, fluoride, sealants, and ITRs all at the same

White Earth Dental Program (Bemidji Area)

What: During the first 2 ½ years of the ECC Collaborative, this program increased access for 0-2 year olds by 197 percent, from 31 to 92 children a year.

How: The dental staff trained the pediatrician and medical staff to provide screenings and fluoride varnish. This information is entered in the EHR and a special template allows the information to be printed and reviewed in dental.. They also provide screening and fluoride varnish at daycare centers. The medical and community screenings and fluoride varnish are entered in the EDR for better tracking of these children and services.

Yukon-Kuskokwim Dental Program (Alaska Area)

What: This program went from seeing zero 0-2 year olds during the first quarter of 2012 to seeing seventy-three 0-2 year olds in the second quarter.

How: Before we travel to the villages, we print out a list of 0-5 year olds. When we get to the village, we try to see most of these children, beginning with the youngest and working up. Entire families often come to dental appointments in the villages and we make sure we see any babies that are with them.

Printing lists of children and contacting their families is an example of case management.

One dentist in Bethel is double-booked each week with 0-5 year olds. These children receive exams, fluoride varnish, and sealants during these appointments.

More best practices to increase dental access

Yakama Dental Program (Portland Area)

> *In a large community, an RDH Case Manger can be self-sustaining.*

What: This program has sustained high access for 0-2 year olds over the past 10 years, seeing over 350 0-2 year olds each year.

How: A dental hygienist, hired by the tribal WIC program, works as a case manager for young children, providing screening, family education, fluoride varnish, sealants, and ITRs as needed. She also works with families on referrals if further dental treatment is needed. This RDH
position is self-sustaining through Medicaid reimbursements.

A dentist/RDH team routinely goes to the well-child clinic to provide exams, fluoride varnish, and nutrition education. Once a month, the dental program has a "Children's Dental Health Day" where they see children ages 0-18 and provide exams, fluoride varnish, sealants, and cleanings.

Chinle Dental Program (Navajo Area)

What: This program is saw 457 0-2 year olds in one fiscal year.

How:
Presentation and application of fluoride varnish at WIC clinics, presentation to IPC committee which increased referrals from medical staff, and disseminated "Your Baby's Teeth" flyer at the pediatric clinic to encourage referrals

Cherokee Dental Program (Nashville Area)

> *A simple intervention that really worked.*

What: Increased access for 0-2 year olds by 24% in one quarter.

How: The local tribal newsletter ran an article about asthma. The pediatric dentist wrote a follow-up article about ECC and the fact that it is more prevalent than asthma. Many families brought their children to the dental clinic after reading the article.

Best practices to increase fluoride varnish

Objective #2: *Increase the number of children 0-5 years old who received a fluoride varnish treatment by 25% in five years.*

Challenge: *It is important to implement a certain level of case management to be sure that young children return for 3-4 yearly fluoride varnish treatments.*

Kyle Dental Program (Aberdeen Area)

What: Increased fluoride varnish treatments applied by medical staff by 125 applications in a three-month period.

How: A public health nurse championed a "Paint to Prevent" program. We recently recruited two more public health nurses to work on this initiative.

Find a local Champion.

TIP

Successful programs have found that if they increase dental access, they automatically increase fluoride varnishes and sealants by providing these services all at the first appointment.

Best practices to increase sealants

Objective #3: *Increase the number of sealants among children 0-5 years old by 25% in five years.*

Challenge: *Dental staff need to adopt the concept of applying sealants to primary molars soon after they erupt, often using a glass ionomer (GI) sealant on primary molars. Our oral survey data demonstrated that many AI/AN children have erupted first permanent molars at five years of age, so be sure to provide sealants for children soon after their first molars erupt. If a permanent molar is partially erupted, try to put a GI sealant on it. You can place a resin sealant later.*

Menominee Dental Program (Nashville Area)

What: Increased dental sealants on primary molars from 0 to 90 during the summer of 2012.

How: We identified 185 patients that were eligible for our program to provide sealants for primary teeth. Most of these children under three years of age. One of the dental staff attempted to call every one of these patients. She was able to get 16 children in and we placed 90 sealants on primary teeth.

TIP!

This is another example of case management. Don't wait until 0-3 year old children "show up." Use RPMS or your EDR to generate lists of these children and contact them by mail or phone!

Best practices to increase ITRs

***Objective #4**: Increase the number of Interim Therapeutic Restorations (ITRs) provided for children ages 0-5 by 50% in five years.*

***Challenge**: Getting the dental staff on board. When the dental staff is on board, the families will be on board too.*

Blackfeet Dental Program (Billings Area)

What: Increased the number of ITRs placed for 0-2 AND 3-5 year olds by over 1000% in a three-month period.

How: Added ITRs to Early Childhood Center general consent form and made a presentation about the procedure to center staff.

In Sept., we provided all children at the center who were 0-3 years old, screenings, FV, sealants, and ITR's as needed.

In January, ITRs applied in September were still in place. This encouraged the dental staff to begin routinely providing ITRs in the dental clinic.

"We all built confidence in applying ITRs on young children."

Hopi Dental Program (Navajo Area)

What: Increased Interim Therapeutic Restorations by 295% (269% in 0-2 year-olds, 319% in 3-5 year-olds) in a three-month period.

How: At initial operative or pre-OR visit, ITRs were provided because many of these children may not receive their dental treatment in a timely manner. We Encouraged general dentists to provide ITRs at exams as often as possible.

Head Start: an ECC Collaborative partner

The IHS Head Start Program serves over 25,000 AI/AN children in 26 states. Head Start is involved in daily tooth brushing with fluoride toothpaste, application of fluoride varnish 3-4 times a year, child and family education, and completion of dental exams and treatment. You can help Head Start by meeting with them to discuss dental access, blocking out time for dental exams and treatment, and providing sealants and ITRs when possible to avoid expensive and difficult referrals.

Head Start is a committed partner in the ECC Collaborative. To learn more, go to http://www.ihs.gov/headstart/

Key Partners

- Head Start or Early Head Start
- Daycare Centers
- Physicians and nurses
- WIC staff
- Community Health Representatives

Contact one of your key medical or community health partners THIS WEEK!

How to download and order educational materials

To order ECC Collaborative education materials, go to

www.ihs.gov/doh/ecc

- Download and print the revised ECC Packet. You can print one or all of the pages. Use them when you are speaking to collaborative partners.
- Download and print the 4 new flyers/posters. These can be printed as single flyers or enlarged for posters.
- Mighty Mouth stickers can be ordered by contacting Dr. Tim Ricks at tim.ricks@ihs.gov.

The IHS ECC Collaborative Steering Committee

- Dr. Tim Ricks, IHS National Dental Public Health Consultant, *Co-Chair*
- Dr. Bonnie Bruerd, IHS Head Start Program, Oral Health Consultant, *Co-Chair*
- Dr. Tim Lozon, Acting Director, IHS Division of Oral Health, *Ex-Officio*
- Dr. Mary Beth Kinney, Director, Dental Continuing Education Program
- Dr. Jim Schaeffer, Deputy Director, IHS Division of Oral Health
- Dr. Patrick Blahut, IHS Oral Health Promotion/Disease Prevention Coordinator
- Dr. Craig Bruce, IHS National Pediatric Dental Consultant
- Bob Bialis, IHS National Head Start Consultant
- Dr. Gary Pannabecker, Dental Chief, Blackfeet
- Dr. Rick Champany, Navajo Area Dental Officer
- Dr. Brandy Larson, Chief Dentist, Cass Lake Dental Program
- John Shutze, MPH, Nashville Area Quality Improvement Coordinator

Newsletter Editor: Dr. Tim Ricks

Contributors: Dr. Tim Ricks, Dr. Bonnie Bruerd

Reviewers: Dr. Tim Lozon, Dr. Patrick Blahut, Dr. Jim Schaeffer

Published by the IHS Division of Oral Health