Plan de Salud del Valle
(Valley Health Plan)
1115 Second Street Ft. Lupton, Colorado 80621 857-2771 Metro 892-0004

June 24, 1986

Dear Fellow Dental Directors,

On June 18, 1986, the latest DRAFT copy of proposed dental policy for Community and Migrant Health Centers was distributed for review and comment. This occurred at the combined National Health Service Corps' Dental-In-Service Conference and the National Association of Community Health Center's Clinical Directors Conference held in Philadelphia, Pennsylvania. If you attended that meeting, you received a copy and know the importance of responding.

The purpose of this letter is to inform those of you who did not attend the Philadelphia meeting about the draft. Dental directors who attended the meeting agreed that it is important to obtain the imput of as many dental directors as possible. Therefore, I am requesting that you respond to the draft immediately. This can be done in two ways. First, you may respond to Dr. Donald Weaver as stated in the draft. And second, I am requesting that you send your comments, or a copy of your comments, to me for the following actions:

First, I will collate your responses and send them to several dental directors for review and synthesis. (Aug 1, 1986).

Second, these several dental directors will return their review and synthesis comments to me and I will collate them into a final document. (September 1, 1986.)

Third, this document will be sent to the Clinical Task Force of the National Association of Community Health Centers and finally to the Division of Primary Care Services. (October 1, 1986).

The most important part of this process is that you send your comments to me so that I receive them by August 1, 1986. This is not very much time, so please read the policy draft, think about how it will effect your program and if or if not you can acheive the draft's intentions and goals, then send your comments to me. Please realize that if you do not respond, the draft could go into effect as is.

PLEASE RESPOND TO ME BY AUGUST 1, 1986. YOUR IMPUT IS VERY IMPORTANT. THANK YOU IN ADVANCE FOR YOUR HELP.

Sincerely,

John W. McFarland
Director of Dental Services
Plan de Salud del Valle
1115 East 2nd
Ft. Lupton, Co. 80621

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Memorandum

Date

From Acting Director

Subject Draft Dental Policy - Regional Program Guidance Memorandum 86-

To Regional Health Administrators, PHS
Regions I-X

I. Purpose:

The purpose of this document is to establish Bureau of Health Care Delivery and Assistance (BHCDA) policy regarding provision of dental services by community and migrant health centers (C/MHCs) funded under section 329 for migrant health, and section 330 for community health centers, of the Public Health Service Act.

The C/MHC legislation requires that these centers provide preventive dental services to the populations they serve. In addition, the Public Health Service (PHS) can determine based on need and performance that it will provide funds for support of "supplemental" dental services.

Currently, many C/MHCs offer a wide range of dental services, including many that are considered supplemental under the statue, and may not be of sufficient high priority for funding within the limited funds available. This policy will address the priority for required dental preventive services, and priorities for investing limited section 329 and 330 resources in dental programs.

II. Definitions of Preventive and Levels of Dental Services.

A. Emergency Dental Services (Level I)

All centers are expected to provide or arrange for treatment of dental emergencies. Dental emergency treatment is limited to treatment of an acute episode of pain, infection or hemorrhage.

B. Primary Prevention (Level II)

All centers are expected to provide or arrange for the provision of primary preventive services for their target population. Required primary preventive dental services are:

Community water fluoridation.[1]

- School water fluoridation, where appropriate.[1]

Supplemental fluoride therapy (tablets and drops)[2], as appropriate.

Topical fluoride therapy, either self applied or operator applied[3] as appropriate.

Fit and Fissure sealants, as appropriate.[3]

Oral cancer detection and prevention.[2]

Trauma prevention i.e., use of child restraints and seat belts.

Oral hygiene instructions, including self prophylaxis

Oral health education and dietary counseling

To determine compliance with the provision of dental prevention services, centers should meet 1 and 2 below.

1. Target the child and adolescent lifecycles for the provision of primary preventive services. Targeting of dental preventive services is successful when 70 percent of the users of the center under age 21 are receiving the dental preventive services offered by the center.

2. Document that at least 50 percent of adult users are receiving primary dental preventive services.

In addition, all centers should attempt to offer these services to all users of the center.

C. Supplemental Dental Services, Level III and Level IV

As part of their annual application, centers may request funds for Level III and limited Level IV services. Regional office review of those requests will consider availability of funds, need for the services, and efficiency and effectiveness of existing or proposed

1/ Support and initiate to extent possible, generally not to be funded with section 329 and 330 funds.

2/ Can only be provided by prescription or action of physician or dentist.

3/ Can only be provided in accordance with State dental practice Acts.

dental program. Emphasis must continue to be on the provision of those services which have the most long-term prevention potential.

1. Level III: Basic Dental Services or primarily services that contain the disease process. Examples of Level III services are:

   a. Restorative dental services.

   b. Basic endodontic services.

   c. Occasional single crowns.

   d. Basic Periodontal services.

   e. Basic oral surgery services (routine extractions).

   f. Space Maintenance.

2. Level IV: Rehabilitative Dental Services or those services which restore oral structure (lowest priority).

   a. Removable prosthetic services.

   b. Fixed prosthetic services (bridges and multiple crowns).

   c. Oral surgery services (elective or complicated).

III. Management Review of Dental Services Cost Center

A. Criteria for Considering the Provision of Level III and IV Dental Services

Only after a 330/329 supported dental program fulfills the requirement of a preventive dental service program (outlined above), will consideration be given to investing 330/329 resources in Level III services if: (1) there is a well documented need, (2) there is an assurance that revenue will cover at least a majority of the costs, and (3) dental department capacity can be made available. A parallel review is necessary should a project also propose providing level IV services.

B. Dental Needs/Demand

As part of the need/demand assessment and the development of the annual health care plan, all C/MHCs including those not now providing dental services must address the need for dental services for their current user population. For applications with funding start dates after January 1, 1987 needs/demand information should

reflect the pattern of dental disease in the community, identify all providers of dental services in the community, and provide an estimate of the gap, if any, of need and supply.

C. Cost/Revenue

The C/MHC must for the Dental Department:

- o Track revenue and expense separately from other components of the center, including a reasonable share of the center's overload;
- o Charge for all services provided (including Level I and II services) in an amount consistent with the cost of the services.
- o Maximize revenues from all sources for which reimbursement or payment is available.
- o Establish and collect minimum fees from all patients, including fees that cover all laboratory costs for Level III and IV services.
- o Generate revenues for Level IV which cover the majority of the costs of providing those services and which cover a significant portion of Level III.

D. Facility

When onsite dental services are offered, the dental facility should contain at least two operatories for every dentist employed. In addition, the number of operatories should increase by one for every hygienist employed.

E. Staffing

Staffing patterns must be reflective of a program which has as its priority function the provision of preventive services, must meet all applicable State laws, and can be justified by a cost/revenue analysis. Staffing models are expected to incorporate dental auxiliary utilization principles, the ratio of auxiliaries to dentists being approximately 1.5 to 1.

F. Reporting

Bureau of Common Reporting Requirements (BCRR) is required, all encounters and users by age and sex cells should be completed. One dentist can reasonably be expected to generate 3,000 encounters per year.

In addition, the following information is not required to be submitted in formal reports; however, items listed below should be assembled on an ongoing basis and utilized by center directors and dental managers, and be available for review or upon request.

As part of the annual ZBA process regional offices will review dental productivity. Grantees may submit productivity documentation, in addition to those required on the BCRR, in their annual renewal application i.e., number and type of services provided by level of services i.e., Level I, II, III, or IV; total number of all services provided; or relative value units, by level of service.

G. Quality Assurance

All centers are expected to have in place a dental quality assurance program which assures a continuum of quality dental services and parallels the centers' medical quality assurance activities.

IV. Implementation/Timeline

As part of the next grant continuation review all C/MHCs should include a dental section as part of the overall needs/demand analysis, and at a minimum:

- Establish effective dates for emergency dental services and primary dental preventive services
- Submit justification for existing dental programs as outlined in section II. A-C.
- Regional office project officers should be contacted to arrange for dental consultation, if necessary, in developing or refining the dental program.

Please share this draft policy with grantees, State primary care associations, and agencies with cooperative agreements. Questions on this memorandum and comments should be directed to Dr. Donald Weaver, Director, Clinical Support Staff, Division of Primary Care Services. Comments should be forwarded to Dr. Weaver by July 11, 1986.

Vince L. Hutchins, M.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION
BUREAU OF HEALTH CARE DELIVERY AND ASSISTANCE

Public Health Service

Memorandum

Date MAR 19 1987

From Director

Subject Dental Policy - Regional Program Guidance Memorandum 87-8

To Regional Health Administrators, PHS
Regions I-X

The purpose of this document is to establish Bureau of Health Care Delivery and Assistance (BHCDA) policy regarding provision of dental services by Community and Migrant Health Centers (C/MHC) funded under Sections 330 (CHC) and 329 (MHC) of the Public Health Service Act (PHS).

The C/MHC legislation provides that all centers must provide preventive dental services for their patients and may provide, if appropriate, supplemental dental services. The legislative mandate of the C/MHC program, therefore, is to provide preventive dental services at all centers and supplemental services only if personnel and financial resources are available.

Each C/MHC must do a dental needs/demand which takes into account all private dentists practicing in the center's community and service area. The subsequent planning, development and implementation of dental programs must be done in conjunction with local dentists.

The dental health status of underserved populations served by C/MHC can be improved significantly by effective preventive public health programs. The C/MHC have opportunities to practice dental public health and to cooperate with State and local dental public health programs. To conform to dental public health principles, children and adolescents should be a priority focus for preventive services.

Since all centers will have to look at their dental programs — some to establish preventive care capability and others to evaluate the efficiency and effectiveness of their current services — the following guidelines have been formulated to assist in this effort:

I. Definitions of Levels of Dental Services.

A. Level I — Emergency Dental Services (Mandatory)

All centers must provide or arrange for treatment of dental emergencies. Dental emergency treatment is limited to diagnosi and treatment of an acute episode of pain, infection, swelling, hemorrhage or trauma.

B. Level II — Primary Prevention (Mandatory)

All centers must provide or arrange for the provision of primary preventive services appropriate for their target population. Required primary preventive dental services are:

1. Oral Health Education
   a. Oral Hygiene Instructions
   b. Dietary Counseling
   c. Trauma prevention - child restraints and seat belts
   d. Fluoridation
2. Periodontal prophylaxis[1]/and self-prophylaxis
3. Topical application of fluoride
4. Supplemental fluoride therapy (tablets and drops)[2]/
   a. Community and school water fluoridation assessment
5. Physicals, medical examinations and dental examination must incorporate oral cancer detection and prevention principles.
6. Pit and fissure sealants as appropriate[1]/,[3]/

C. Level III: Basic dental services or services that primarily contain the disease process. (Optional) Examples include:

1. Restorative dental services
2. Basic endodontic services

1/ Can only be provided in accordance with State dental practice acts. Centers without inhouse dental departments should pursue innovative consultative arrangements with other C/MHC for this capability.

2/ Can only be provided by prescription or action of physician or dentist.

3/ Regional Program Guidance Memorandum 85-4, January 30, 1985 HP/DP Dental Caries Prevention; Required of C/MHC with onsite dental components and 10,000 medical users or 5,000 dental users.

3. Occasional single crowns

4. Basic periodontal services

5. Basic oral surgery services (routine extractions)

6. Space maintenance

D. Level IV: Rehabilitative Dental Services or those services which primarily restore oral structure (Optional). Examples include:

1. Removable prosthetic services

2. Fixed prosthetic services (bridges and multiple crowns)

3. Oral surgery services (elective or complicated)

4. Other than routine specialty services

II. Dental Policy Compliance for Primary Prevention Services

The C/MHC are to provide:

A. Primary dental preventive services to 80 percent of the routine[4/] medical users under age 19. This goal may be phased in over a 4-year period with a target of at least 20 percent added each year.

B. Primary preventive services to 90 percent of the routine dental users of the center under age 19. This goal may be phased in over a 1-year period.

C. Primary preventive services to at least 40 percent of adult routine medical users. This goal may be phased in over a 4-year period beginning with at least 10 percent additional each year.

D. Primary preventive services to at least 90 percent of adult routine dental users. This goal may be phased in over a 1-year period.

III. Funding and Management of the Dental Services Cost Center

As part of their annual application, centers are expected to describe the need for dental services in their service areas, their system for providing dental services and their request for C/MHC

4/ nonepisodic patients

funds to support some of the costs of their system. Centers may request Federal support for all types of dental services (Levels I, II, and III and limited Level IV services) in order to achieve a continuum of care with a strong emphasis on prevention. Regional office (RO) review of those requests will consider need for the services, efficiency and effectiveness of existing or proposed dental program and availability of funds. Emphasis will be on the provision of those services which have the most long-term prevention potential.

A. Criteria for Considering the Provision of Level III and IV Dental Services

When a 330/329 supported dental program has filled the requirements for a primary preventive program (outlined above), the PHS will consider funding Level III services if (1) there is a documented need, (2) dental department capacity can be made available and (3) a financial analysis with income projections indicates that significant revenue will be generated. Similarly, limited Level IV services may be provided if revenue will cover a majority of the costs of those services.

B. Dental Needs/Demand

As part of the needs/demand assessment and the development of the annual health care plan, all C/MHC must address the need for dental services for their current user population. All applications for 329 and/or 330 funding in Fiscal Year (FY) 1988 must submit needs/demand information that shows the pattern of dental disease in the community, identifies all providers of dental services in the community, and provides an estimate of the gap, if any, of need and supply.

C. Cost/Revenue

As part of the annual Zero-Based Assessment (ZBA) process, dental departments of the centers must:

1. Treat the department as a separate cost center, tracking all expenses including an appropriate allocation of overhead as well as revenue;

2. Charge for all services provided (including Levels I and II) in an amount consistent with the cost of the services, and bill in accordance with the center's sliding fee scales;

3. Maximize revenues from all sources for which reimbursement or payment is available, particularly Medicaid;

4. Establish and collect minimum fees from all patients, including fees that cover all laboratory and supply costs for Level III and IV services;

5. Generate revenues for Level IV which cover a majority of the costs of providing those services and which cover a significant percentage of the costs of providing Level III services.

D. Facility

When onsite dental services are offered, the dental facility should contain two operatories for every dentist. There should be one additional operatory for every hygienist employed.

Programs that do not meet the facility and staffing criteria will be reviewed during the grant application renewal process to determine the appropriate course of action which may include consideration for an exception.

E. Staffing

Staffing patterns must: reflect a preventive services program; meet all applicable State laws and be justified by a cost/revenue analysis. Staffing models are expected to incorporate dental auxiliary utilization principles, the minimum ratio of dental chairside auxiliaries to dentists being approximately 1.5 to 1.

F. Reporting

The BHCDA Bureau Common Reporting Requirements (BCRR) must be submitted. All encounters, by provider type, and users by age and sex cells should be completed and be available on request. Each full-time equivalent dentist should generate approximately 2,300 encounters per year; a dental hygienist, 1,400. It is expected that productivity will exceed this level as the program becomes more efficient.

As part of the annual ZBA process, the RO will review dental financial information and productivity. Grantees may submit productivity documentation in addition to BCRR requirements in their annual renewal application. Aggregate totals of dental services provided by type and level of service should be maintained, utilized for management purposes, and be available upon request.

The use of a relative value unit (RVU) system is a practical means of measuring total dental productivity and productivity by level of service. RVU reporting is not required, but use of an RVU system for management purposes is encouraged.

G. Quality Assurance

All centers must have in place a dental quality assurance program which assures a continuum of quality dental services and parallels the center's medical quality assurance activities.

IV. Implementation/Timeline

As part of the grant continuation reviews for FY 1988, all C/MHC must include a dental section as part of the overall needs/demand analysis and at a minimum:

A. Establish effective dates for emergency dental services and primary dental preventive services. Centers are encouraged to design ways to provide preventive services in innovative, low-cost manners.

B. Submit justification for existing dental programs as outlined in section III. A-C.

C. Contact RO project officers to arrange for dental consultation, if necessary, in developing or refining the dental program.

Organizations still applying for FY 1987 funds are encouraged to include this information in this year's application.

Although many C/MHC have offered dental services for some time, a dental policy has never been promulgated. In the absence of a policy, different types of C/MHC dental programs have been established, many of which could be affected by this policy. Recently, the BHCDA awarded a contract to study the best dental practices in C/MHC. As part of this contract an ad hoc dental committee of C/MHC dental directors and other dental resource people has been established. The findings of this study will be available near the end of FY 1987.

The findings of the study and the effects of this policy on C/MHC dental programs will be evaluated by the BHCDA in conjunction with the ad hoc committee. This policy should be considered dynamic, and subject to modification, as our dental data base of information increases.

Edward D. Martin, M.D.
Assistant Surgeon General

DENTAL PREVENTION PROTOCOLS

FOR COMMUNITY AND MIGRANT HEALTH CENTERS

SUBMITTED BY

JOHN W. MCFARLAND, D.D.S.

TREATING THE COMMUNITY

I. COMMUNITY FLUORIDE PROTOCOL

Evaluate fluoride concentration in the community and:

A. If Inadequate

1. Attempt to get community water supply optimally fluoridated.

2. Attempt to get school supply fluoridated to 4.5 times optimum if you can't get community water fluoridated.

3. If unable to do community or school water supply, then school based programs of fluoride tablets or fluoride rinses.

4. To individual level.

B. If adequate

1. Monitor and maintain

2. Fluoride surveilance system to maintain proper fluoride level.

C. If excessive (if 2 x optimum according to EPA) (If 4 x optimum according to Public Health Dentists

1. Change water source

2. Attempt to reduce fluoride concentration to proper levels

II. COMMUNITY DENTAL HEALTH EDUCATION PROTOCOL

A. School Visitations

B. Social Group Presentations

C. Health Fairs -- County Fairs

IV. COMMUNITY DENTAL HEALTH LEGISLATION

A. Smokeless Tobacco - Push for Legislation Which Would:

1. Prohibit sales to minors

2. Ban radio and T.V. advertising

3. Package warnings

B. Strengthen Reporting Requirements and Penalties for Child Abuse and neglect

PREVENTION PROTOCOLS BY LIFE CYCLES

Prenatal (Mother and Fetus)

Non-Fluoride	Fluoride
1. Emergency care	1. Emergency care
2. Fluoride toothpaste	2. Fluoride toothpaste
3. Supplemental systemic fluorides (for mom at least)	3. No supplemental systemic fluorides unless high caries incidence
4. Professionally applied topical fluoride	4. Professionally applied topical fluoride
5. For high caries [after age 6] activity, fluoride rinses or topical application of fluoride	5. For high caries [after age 6] activity, fluoride rinses or topical application of fluoride
6. Selected use of sealants	6. Selected use of sealants
7. Disease containment Treatment necessary - To include prophylaxis Prudent utilization of dental radiography Medications kept to absolute minimum	7. Disease containment Treatment necessary - To include prophylaxis Prudent utilization of dental radiography Medications kept to absolute minimum
8. Home care counseling	8. Home care counseling
9. Diet counseling Balanced diet, reduce sucrose amounts and frequency	9. Diet counseling Balanced diet, reduce sucrose amounts and frequency
10. Counseling mother re newborn a. Bottle mouth syndrome b. Avoid tetracyclines c. Alcohol and tobacco avoidance d. Home care for child During infancy, parent brushes until child can do it (age 6) then supervises	10. Counseling mother re newborn a. Bottle mouth syndrome b. Avoid tetracyclines c. Alcohol and tobacco avoidance d. Home care for child During infancy, parent brushes until child can do it (age 6) then supervises
11. Appropriate recall	11. Appropriate recall

PEDIATRICS (BIRTH - 14)

Non-Fluoride	Fluoride
1. Emergency care	1. Emergency care
2. Fluoride toothpaste	2. Fluoride toothpaste
3. Supplemental systemic fluorides a. Birth to 2 years - drops b. 2-3 years - drops or tabs c. 3-13 years - tabs	3. No supplemental systemic fluorides
4. Professionally applied topical fluoride	4. Professionally applied topical fluoride
5. For high caries activity, fluoride rinses or topical application of fluoride	5. For high caries activity, fluoride rinses or topical application of fluoride
6. Sealants According to clinical judgment including deciduous molars, permanent molars, bicuspids	6. Sealants According to clinical judgment including deciduous molars, permanent molars, bicuspids
7. Disease containment (Prudent use of x-rays)	7. Disease containment (Prudent use of x-rays)
8. Home care counseling	8. Home care counseling
9. Diet counseling	9. Diet counseling
10. Counseling mother as appropriate for age group	10. Counseling mother as appropriate for age group
11. Trauma prevention, i.e. mouth guard	11. Trauma prevention, i.e. mouth guard
12. Recognition and reporting of child abuse and neglect	12. Recognition and reporting of child abuse and neglect
13. Appropriate recall	13. Appropriate recall

Adolescents (15-19)

Non-Fluoride	Fluoride
1. Emergency care	1. Emergency care
2. Fluoride toothpaste	2. Fluoride toothpaste
3. Supplemental systemic fluorides a. Tabs b. Rinses	3. No supplemental systemic fluorides
4. Professionally applied topical fluoride	4. Professionally applied topical fluoride
5. For high caries activity, fluoride rinses or topical application of fluoride	5. For high caries activity, fluoride rinses or topical application of fluoride
6. Sealants	6. Sealants
7. Disease containment (Prudent use of x-rays)	7. Disease containment (Prudent use of x-rays)
8. Home care/perio-counseling	8. Home care/perio-counseling
9. Diet counseling	9. Diet counseling
10. Tobacco and alcohol use counseling	10. Tobacco and alcohol use counseling
11. Tauma prevention	11. Trauma prevention
12. Recognition and reporting of child abuse and neglect	12. Recognition and reporting of child abuse and neglect
13. Appropriate recall	13. Appropriate recall

ADULTS (20-62)

Non-Fluoride	Fluoride
1. Emergency care	1. Emergency care
2. Fluoride toothpaste	2. Fluoride toothpaste
3. Supplemental systemic fluorides	3. No supplemental systemic fluorides
4. Professionally applied topical fluoride	
5. For high caries activity, fluoride rinses or topical application of fluoride	4. For high caries activity, fluoride rinses or topical application of fluoride
6. Selected use of sealants	5. Selected use of sealants
7. Disease containment	6. Disease containment
8. Home care counseling	7. Home care counseling
9. Perio evaluation, counseling and treatment	8. Perio evaluation, counseling and treatment
10. Diet counseling	9. Diet counseling
11. Tobacco and alcohol counseling	10. Tobacco and alcohol counseling
12. Cancer screening	11. Cancer screening
13. Appropriate recall	12. Appropriate recall

GERIATRICS (63 and over)

Non-Fluoride	Fluoride
1. Emergency care	1. Emergency care
2. Fluoride toothpaste	2. Fluoride toothpaste
3. Supplemental systemic fluorides	
4. Professionally applied topical fluoride	
5. For high caries activity, fluoride rinses or topical application of fluoride	3. For high caries activity, fluoride rinses or topical application of fluoride
6. Extremely selective use of sealants	4. Extremely selective use of sealants
7. Disease containment	5. Disease containment
8. Home care a. Counseling on abrasion, erosion and recession b. Counseling re altered salivary flow	6. Home care a. Counseling on abrasion, erosion and recession b. Counseling re altered salivary flow
9. Perio-counseling and treatment	7. Perio-counseling and treatment
10. Diet counseling	8. Diet counseling
11. Tobacco and alcohol counseling	9. Tobacco and alcohol counseling
12. Cancer screening	10. Cancer screening
13. Evaluate existing prosthesis and/or need for prosthesis	11. Evaluate existing prosthesis and/or need for prosthesis
14. Appropriate recall	12. Appropriate recall

ATTACHMENT 1

Definition of Types of Dental Services

1) Prevention (services to prevent the onset of disease
   a. Fluoride therapies (e.g., mouthrinse, topical, supplements)
   b. Sealants
   c. Dietary counseling
   d. Prophy
   e. Plaque removal
   f. Oral hygiene instruction
   g. Interdental cleaning
   h. Oral health education
   i. Other (e.g., chemical agents, mouth protector/mouthguard)
   j. Examination and radiographs

2) Emergency Care (services for the relief of emergency and acute conditions including pain, bleeding, and infection) especially pain)
   a. Examination and radiographs
   b. Sedative filling
   c. Endodontic access
   d. Prosthodontic repairs
   e. Extraction
   f. Incision and drainage
   g. Gross debridement (such as ANUG)

3) Disease Containment
   a. Diagnostic services including examinations and radiographs
   b. Amalgam and composite restorations
   c. Stainless steel crown space maintainers
   d. Periodontal scaling
   e. Treatment for gingivitis and early periodontitis
   f. Surgical excision of small oral tumors
   g. Endodontic therapy
   h. Prosthodontics - tissue conditioning and prosthetic relines

SCHEDULE OF SYSTEMIC SUPPLEMENTAL FLUORIDE DROPS AND TABLETS FOR CHILDREN, as recommended by the American Dental Association and the American Academy of Pediatrics (in mg. of fluoride per day).

Parts per million Fluoride in Water Supply

Age of Child	Less than 0.3ppm Fl	0.3 to 0.7 ppm	More than 0.7 ppm	Type of Preparation
Birth to 2 yrs.	0.25mgFl/day	0	0	Drops
2 to 3 yrs.	0.50mgFl/day	0.25mgFl/day	0	Drops/Tablets
3 to 13 yrs. (at least).	1.00mgFl/day	0.50mgFl/day	0	Tablets

SAMPLES OF SYSTEMIC FLUORIDE PRESCRIPTIONS

Age 18 mos.

Rx Sodium Fluoride 0.25gm
Distilled water to make 114 ml
Disp: in plastic dropper bottle that delivers 20 drops per ml.
Sig. Use 5 drops for 0.25mg fluoride. Place drops inside cheek once a day. Refill 1 time in one year
Caution: Keep out of reach of children
Cost: Retail $5.27.(Takes 113 tabs of 2.2mg NaFl)

Age 7 yrs.

Rx Sodium Fluoride Tablets
2.2mg (1mg.Fl) Disp. 120
Sig. One tablet should be chewed, swished, and swallowed daily after brushing and flossing at bedtime. Refill 3 times in one year.
Caution: Keep out of reach of children
Cost: Wholesale is $5.95/1000 tabs and retail is $8.93/1000

FLUORIDATED WATER FROM DISTILLED WATER

Add 4mg of fluoride (or 8.8mg of sodium fluoride) per gallon of distilled water. This would equate to adding four 1mg fluoride (2.2mg sodium fluoride) tablets to a gallon of water.

Note: Optimum level is 1mg fluoride/liter of water. There are 3.79 liters per gallon or approximately 4 liters per gallon.

Cost: Wholesale is $5.95/1000 and retail is 8.93/1000. Per gallon retail would be 4 cents per gallon.

COMMERCIAL SYSTEMIC FLUORIDE TABLETS AND DROPS
Example - Luride drops or tablets by Colgate-Hoyt
Colgate-Hoyt Laboratories
575 University Ave.,
Norwood, Ma 02092
1-800-225-3756

Luride Drops

Description: Each ml. (18 drops) contains 2.25mg fluoride ion from 4.97 mg sodium fluoride, which is approximately 0.125 mg fluoride per drop. Supplied in squeez bottles of 30 ml. Cost

Cost: Wholesale is $4.40, and retail is $7.15.

Luride Tablets

Luride 0.25mg F Lozi-Tabs. 120 tablets per bottle
Description: Each tablet contains 0.25 mg fluoride from 0.55 mg sodium fluoride.
Cost; Wholesale is $4.20, and retail is $6.95.

Luride 0.50mg F Lozi-Tabs. 120 tablets per bottle
Description: Each tablet contains 0.50 mg fluoride from 1.1 mg sodium fluoride.
Cost: Wholesale is $4.53, and retail is $7.28.

Luride 1.0mg F Lozi-Tabs. 120 tablets per bottle
Description: Each tablet contains 1.00 mg fluoride from 2.2 mg sodium fluoride.
Cost: Wholesale is $4.45, and retail is $7.20.

Luride Dosage and Administration

Fluoride Content of Drinking Water	Daily Dosage (Fluoride Ion)		
	Birth to Age 2	Age 2-3	Age 3 and over
Less than 0.3 ppm	0.25 mg tab or 2 drops	0.5 mg tab or 4 drops	1.0 mg tab or 8 drops
0.3 to 0.7 ppm	one half above dosage		
Over 0.7 ppm	Fluoride dietary supplements contraindicated		

Lethal And Safe Dosages Of Fluoride For Selected Ages

Age	Weight (lbs)	Certainly Lethal Dose (CDL) (mg)	Safely Tolerated Dose (STD) (mg)
2	22	320	80
4	29	422	106
6	37	538	135
8	45	655	164
10	53	771	193
12	64	931	233
14	83	1206	301
16	92	1338	334
18	95	1382	346
Adult	154	5000 to 10000	1250 to 2500

PRIMARY DENTAL CARIES PREVENTION

PROPOSED MEDICAL PLAN

I. Determine the fluoride level of the patient's water source.

A. Determine the patient's residence and the fluoride level of the patient's community water supply (most communities served by Salud have optimally fluoridated water supplies). If the patient is using the community water supply for drinking and cooking, write down the fluoride level for that community. The optimal fluoride level is 1.0 parts per million (expressed as 1.0 ppm or 1.0mg/liter).

B. If the patient is using alternate water sources, find out the source and note fluoride content. (Example: patients drinking most commercial bottled water receive optimally fluoridated water. Patients drinking distilled water, such as the water obtained from the "Windmill" dispensers, do not contain fluoride.)

C. If uncertain, have patient bring water source, and we will test in dental. (Example: Patient is modifying the community water supply with a home filtration system with an unknown effect on fluoride concentration).

II. Provide Caries Prevention Counseling

A. Fluoride Counseling

1. If the patient lives in an area with an adequate community fluoridated water supply, and the patient is using that water for drinking and cooking, and;
   a. Caries not evident - recommend a fluoride toothpaste.
   b. Caries evident - recommend a fluoride toothpaste and, if the child is six years of age or older, a fluoride rinse (like Fluorigard or Act). Fluoride rinses should not be prescribed for children five years of age and under.
2. If the patient lives in an area with inadequate fluoride, or the patient is using an alternate water source which is not fluoridated;
   a. Recommend systemic fluoride supplements (see Schedule of Systemic Fluoride Drops and Tablets for Children). Maximum number of tablets prescribed should not exceed 120 tabs.
   b. Caries not evident - recommend a fluoride toothpaste.

c. Caries evident - recommend a fluoride toothpaste and, if the child is six years of age or older, a fluoride rinse (like Fluorigard or Act). Fluoride rinses should not be prescribed for children five years of age and under.

3. If fluoride level unknown, we can test and develop a plan based on findings.
4. If the patient shows a high caries incidence;
   a. Recommend a fluoride toothpaste.
   b. Recommend a fluoride rinse.
   c. Refer to dental.
   d. If water supply is inadequate in fluoride, recommend systemic fluoride supplements (will give detail on this later

B. Sealant Counseling - Recommend sealants for protection against pit and fissure cavities.

III. Review written referral procedures between medical and dental.

IV. Have dental continue to provide in-service sessions for medical providers.

V. Example of a stamp which might facilitate recording prevention couseling.

Fluoride Status
Prevention Counseling
Fluoride Supplements
Dental Referral