

Oral Health Supervision Guidelines



Oral health supervision involves regular, periodic health intervention by a dental professional. The dental professional performs a risk assessment, diagnoses existing conditions, and provides anticipatory guidance in order to promote oral health.

Optimal oral health supervision occurs when there is a therapeutic alliance between the dental professional and the family—beginning between the dental professional and the parents during the prenatal period or early in the child’s life, progressing between the dental professional and the growing child, and continuing to grow between the dental professional and the adolescent. Early in the alliance, parents assume responsibility for preventive and oral health procedures, but the child gradually assumes greater responsibility. This alliance creates a relationship based on familiarity, trust, and a shared history that supports health.

Oral health supervision occurs over time. The frequency of intervention should be keyed to the individual’s needs and developmental milestones. The interval between health supervision visits must be short enough to take advantage of change, because it is important to intercept incipient disease and to maximize opportunities for anticipatory guidance. Traditionally, a period of six months has been the interval for oral health supervision, but this guide strongly encourages assessing each child’s individual risk, in order to address normal growth and development issues (such as nonnutritive sucking and the need for dental sealants) and to provide care more efficiently. Some children will need more frequent dental



visits if they are at higher risk; children with low risk, stable environments, and demonstrated wellness habits may need less oral health supervision. Past experience and current oral health status may be a key to determining appropriate intervals for a child.

The success of oral health supervision depends to a large degree on the relationship or alliance between the family, dental professional, and other health professionals. Successful oral health supervision also depends on the systematic assessment of risk; the prevalence of protective factors; the consideration of community, familial, economic, cultural, and social factors; and the integration of oral health with general health initiatives for the child.

Components of Oral Health Supervision

Family Preparation

Just as the dental health professional prepares for oral health supervision, families need to prepare, too. Families can gather health information, prepare questions, and complete forms in anticipation of the health supervision visit. This step is an essential component of oral health supervision, and the dental professional should guide the family in how to prepare. Between health supervision visits, the child and the family might assess how well the child is complying with recommendations, and then determine how the self-assessment compares to the dental professional's assessment of the child's performance.

Periodicity and Services

The periodicity of services included in these guidelines is based on what most infants, children, and adolescents need. The periodicity listed under the term "health professional" refers to the general preventive care the child or adolescent receives, usually from a nurse or physician. (The recommended periodicity listed in this guide is the same as that listed in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.) This periodicity is not meant to suggest supplemental visits to health professionals specifically for oral health; rather, within the context of health supervision visits with children and adolescents, health professionals can reinforce the oral health messages provided by a dental professional. All health professionals have an important role in educating and screening children to ensure that they are receiving the oral health care they need.

The periodicity listed under “dental professional” refers to preventive and health-promoting services provided by an appropriately trained dental professional. In addition to educating children and families, the dental professional examines the child or adolescent and uses oral health risk assessment to decide on appropriate interventions and guidance. The first dental visit is recommended by age one, with the aim of intervening early and providing appropriate counseling before the caries process develops.

Health Supervision Interview

The goal of the interview is to ascertain key issues that should be addressed in the health supervision visit. The interview needs to address information gleaned from previous health supervision visits, as well as issues specific to the age and development of the child. The dental professional needs to assess whether the child or family has assumed personal responsibility for oral health and demonstrates a sense of mastery and consistent use of preventive oral health care. As the child matures and becomes more responsible, the dental professional should discuss these issues directly with the child or adolescent.

During the interview, it is important to listen to the family members in order to learn what they want and expect and how they view oral health. Do the parents believe it is realistic for their child to have a healthy mouth, free from dental caries? Do the parents feel empowered to teach their child good oral health practices? Does the child think it is possible to have healthy teeth with no decay? How does the adolescent feel about dental visits? About the appearance of her teeth and smile? Trigger questions, which address age-specific oral health issues and risk factors that are relevant to

the child and family, can help guide the interview. Cultural, economic, social, and environmental factors influencing the family and child should be considered.

Observation of Parent-Child Interaction

Since parents are the child’s primary teachers of healthy habits, interactions within the family can have a major impact on oral health. Watching parents with their children in the dental setting provides clues to learning strategies, potential behaviors, and difficulties (and, in the extreme, parental child abuse and neglect situations). If children are clinging to the parents, especially at three to six years of age, their parents may need extra support to encourage independence. Detached and depressed children who are afraid of parental and other adult reactions may signal an abusive home situation.

Observing how parents communicate with and motivate their child at early ages can indicate the



strengths and difficulties parents may have in guiding oral hygiene efforts. Later, in middle childhood and adolescence, the dynamics between parent and adolescent when discussing habits and behaviors is also revealing. It can indicate difficulties or strengths in the relationship that will affect the adolescent's compliance with anticipatory guidance suggestions.

Oral Exam and Diagnostic Procedures

While physical risk factors can be noted during general screenings by other health professionals, an oral exam by a dentist is a vital part of health supervision because it provides evidence about the condition of the gums, teeth, and occlusion. It is an empirical way to measure oral health, the success of preventive interventions and treatments, and attainment of good oral health outcomes.

Traditionally, the goal of the oral exam has been to identify disease. In the context of developmentally based health supervision, another critical goal is to identify risk factors. In addition to gaining information about the progress of disease, dentists should use the oral exam to thoroughly evaluate the child's or adolescent's physical risk factors and perform a risk assessment. Particularly with children under age three who may have no obvious disease, assessment of physical risk factors such as plaque can be done only with information gained through a thorough exam. In the adolescent, visual signs of tobacco use discovered in the oral exam can predict more serious problems later.

Dentists may also need radiographs, if indicated, to assist in diagnosis, though radiographs are not used as a routine part of the exam. Other less common diagnostic procedures can include saliva tests or cultures of caries-causing bacteria, such as mutans streptococci.

Risk Assessment

Risk assessment provides the dental professional with the opportunity to tailor periodicity and oral health supervision to the individual's level of risk for specific diseases, conditions, and injuries. This assessment involves identifying risk factors that may negatively impact a child's oral health, and protective factors that promote oral health. Risk assessment allows health professionals to individualize intervention by focusing resources and education on specific components of oral health according to a child's risk and protective factors. The risk and protective factors are organized according to four major dental problems: dental caries, periodontal disease, malocclusion, and injury. The guidelines indicate which factors can be an issue for all ages of children, and which are most common at a particular developmental period. Risk assessment is discussed in more detail in Section II.

Anticipatory Guidance

Anticipatory guidance refers to the information provided to the child and family about the child's current oral health and what to expect as the child enters the next developmental phase. The guidance should be modified based on the risk assessment. The dental professional, for example, can not only remind an 11 year old and his family about the importance of wearing a mouth guard while playing soccer, but can also discuss how dental sealants will protect the second permanent molars, which should erupt in a year or two. Through advance discussion of dental sealants, the family learns about the procedure before the next dental visit, considers its benefits, and is better prepared to ask more informed questions of the dental professional.

When providing anticipatory guidance, the dental professional is encouraged to discuss age-related risk and protective factors. The health professional can explain to families, for example, that inappropriate use of the baby bottle can produce baby bottle tooth decay (BBTD) in infancy and early childhood, increasing the risk of caries later in childhood. Discussing tobacco use as a risk factor for oral soft tissue problems becomes important to the middle-school child and the adolescent. It is also important for the dental professional to reinforce the key messages of anticipatory guidance in subsequent oral health supervision visits.

Review

As the need for accountability in health care increases, utilization review, outcomes assessment, and continuous quality improvement—new terms for many dental professionals—become more important. Additionally, individualized risk assessment, which requires more sophisticated tracking



of individual progress and community risk profiles, needs automated and organized data. The review section suggests several sources of information that could indicate whether oral health supervision has been provided appropriately. This section, rather than being all-inclusive, describes the range of sources of information that can be adapted and used for utilization review, outcomes assessment, and continuous quality improvement.

Outcomes

The success of oral health supervision can be measured by whether the child or adolescent has achieved certain outcomes. Measured outcomes will also help guide the dental professional in determining the necessary periodicity for subsequent visits, and in providing the appropriate anticipatory guidance.

The guidelines include a list of general outcomes that are comprehensive, achievable, attainable, and measurable. They are organized as educational, behavioral, and physical outcomes, since sustainable health promotion requires knowledge and effort as well as the ability to achieve a certain health status. The outcomes are keyed to developmental stages and thus represent clear and useful tools to determine intervals for oral health supervision, particularly when risk is low. These general outcomes can be refined for each individual child. Since defining and measuring outcomes are critical components of oral health supervision, they are discussed in more detail in Section III.

