

# Child Health Program Oral Health

## Guidance Document

This document is in support of the Child Health Program, Requirements 2, 3, 10, 12, & 13 of the Ontario Public Health Standards, 2008

Standards, Programs & Community Development Branch  
Ministry of Health Promotion  
May 2010

This guidance document is intended to support boards of health, and in particular, public health dental staff. This document is not intended to provide legal advice or to be a substitute for the professional judgment of public health dental staff. Public health dental staff should consult with legal counsel as appropriate. Where there is a conflict between this guidance document and the Ontario Public Health Standards (OPHS), the Health Protection and Promotion Act (HPPA), or its regulations, the OPHS, HPPA or regulations, as the case may be, prevail.

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## Introduction

The Ontario Public Health Standards (OPHS) and incorporated protocols lay out the minimum standard for boards of health in their provision of public health programs and services. This guidance document is provided for convenience only. It is important to remember that the OPHS and protocols articulate the mandated requirements. The information provided in this document is not legally mandated or enforceable unless specified in either the program standards or the dental protocols.

The Ministry of Health Promotion has created a number of Guidance Documents to support the implementation of the four program standards for which it is responsible, e.g.:

- Child Health
- Child Health Program Oral Health
- Healthy Eating, Physical Activity and Healthy Weights
- Nutritious Food Basket
- Prevention of Injury
- Prevention of Substance Misuse
- Reproductive Health
- School Health

### **Purpose**

- To help dental staff implement the following dental components of the OPHS: Preventive oral health services; Oral health assessment and surveillance; The Children In Need Of Treatment (CINOT) program; Recording keeping and personal health information; and, community water fluoridation.
- To assist Ontario's public health dental staff to respond to existing or emerging program-specific issues using the OPHS.
- To ensure consistency in implementation (e.g., acronyms for consistency across the province) in the OPHS.

### **Objectives**

To provide:

- A summary of the dental program/service issue(s) in the OPHS to promote understanding of these issues;
- Guidance on a standardized approach and response with regard to the promotion and protection of public health as related to dental programs and services in the OPHS; and
- Information sources and to promote knowledge exchange through the availability of accessible and current resources, research, etc. related to dental programs and services.

This document has four sections, one for each of the dental protocols. Where appropriate, references to relevant legislation and regulations associated with duties and responsibilities carried out under the OPHS have been included. In addition, explanatory definitions from credible sources (e.g., World Health Organization), links to the websites of government partners (e.g., Statistics Canada), evidence from current scientific research and best practices from other jurisdictions have been included.

This document contains information on issues and questions most commonly asked by dental public health staff. It does not cover all issues or questions staff may have. As this document is updated, new or emerging issues will be included.

This document does not replace statutory or regulatory requirements, the OPHS, or health unit policy and procedure manuals. It is a supportive document only.

## Preventive Oral Health Services Protocol, 2008 (or as current)

The OPHS and incorporated protocols lay out the minimum requirements of service delivery. Staff should use their professional judgement when determining eligibility for preventive services. Your health unit's program may offer preventive services to a broader range of children than the minimum standard in the protocol.

Under the Operational Roles and Responsibilities section of the *Preventive Oral Health Services Protocol, 2008* (or as current) please note the following rationale for the requirements.

Section 2 a) *"Offer PATF to children where two or more of the following criteria apply: i) Water fluoride concentration is less than 0.3 ppm..."* Dental program managers should ensure that staff have been provided with information on local water fluoride concentrations both for municipal water sources with added fluoride and local data on naturally occurring fluoride in municipal water systems and wells.

Section 3 a) *"Offer PFS to children based on an individual caries risk assessment..."* An individual caries risk assessment should include, but not be limited to, history of decay, tooth morphology, current decay, current oral hygiene practices, water fluoridation status, diet, medical/dental history, physical disability, and dental knowledge base.

Before providing a preventive service, staff must review the signed parent/guardian consent and signed medical history. If the parent is present in the clinic or on the phone, a verbal consent and medical history may be taken by phone and recorded and signed in the child's chart.

For examples of medical history forms and information on health history, please refer to the Royal College of Dental Surgeons of Ontario (RCDSO) website [www.rcdso.org](http://www.rcdso.org) and College of Dental Hygienists of Ontario (CDHO) website [www.cdho.org](http://www.cdho.org).

All preventive services must be rendered in accordance with the standards of practice for community health settings of the practitioner providing the service(s).

**Provision of Service:** When a child qualifies for one, or more, of the listed preventive services, the board of health will offer the service and make a reasonable effort to ensure the family is informed about the benefit of the service(s) offered and make reasonable attempts to ensure the family has access to the service(s).

## Choice Of Preventive Therapies

Choice of materials should be based on the latest evidence of efficacy and effectiveness and safety considerations.

At the request of the Senior Dental Consultant, Ministry of Health and Long-Term Care, the Community Dental Health Services Research Unit (Faculty of Dentistry, University of Toronto) has provided two evidence-based reports.

The reports are:

Jokovic A, Locker D. Evidence-based recommendations for the use of pit and fissure sealants in Ontario's public dental health programs. Quality Assurance, No 21, 2001.

Hawkins R.J., Locker D. Evidence-based recommendations for the use of professionally applied topical fluorides in Ontario's public health dental programs. Quality Assurance, No 20, 2000.

## Scaling

Registered Dental Hygienists must abide by the CDHO regulations regarding self-initiation (O. Reg. 501/07, Part III Prescribed Contraindications to Scaling Teeth and Root Planing, Including Curetting Surrounding Tissue, on Member's Own Initiative <http://www.cdho.org/Home/Contraindications.pdf>. Board of Health Policy and Procedure Manuals should be written to accommodate dental hygienists who are and those who are not authorized for self initiation for their authorized act of *"scaling teeth and root planing including curetting surrounding tissue."* *Dental Hygiene Act, 1991*.

## Financial Eligibility

### **Ontario Child Benefit**

The information below was retrieved from the Ministry of Community and Social Services on July 24, 2009.

It is also available on the Children and Youth Services website:

<http://www.children.gov.on.ca/htdocs/English/programs/ocb/index.aspx>.

### **What is the Ontario Child Benefit?**

The Ontario Child Benefit is financial support that low-income families can receive to help provide for their children.

About 465,000 families with 960,000 children receive an Ontario Child Benefit payment each month of up to \$1,100 per child this year. When the program is fully implemented, more than 600,000 low-income families will receive up to \$1,310 per child annually.

### **Am I eligible?**

Your eligibility is based on the number of children under age 18 in your family and your family net income. You may be eligible for the Ontario Child Benefit if you:

- Have a child under 18 years old and are in a low-income family;
- Have filed your income tax return and so has your spouse or common-law partner;
- Are registered for the federal Canada Child Tax Benefit; and
- Are a resident of Ontario.

**What is family net income?**

For the purposes of determining your entitlement for the Ontario Child Benefit, family net income is defined as: The net income amount on line 236 of the Canada Revenue Agency personal income tax form for both you (and your spouse/common-law partner if applicable) minus any federal Universal Child Care Benefit payments.

**I have not yet filed my tax return. How can I apply for the Ontario Child Benefit?**

To receive the Ontario Child Benefit, you must file an income tax return for the previous year and register for the Canada Child Tax Benefit. The Canada Revenue Agency will automatically review your eligibility for the benefit once your return is assessed. To find out more about the tax-filing process, visit the Canada Revenue Agency.

**I am an Aboriginal person living on reserve and I'm not required to file an income tax return. How do I become eligible for the Ontario Child Benefit?**

The process to receive the Ontario Child Benefit is the same for all Ontario families. You and your spouse or common-law partner must file an income tax return and submit a Canada Child Tax Benefit Application to be eligible for the Ontario Child Benefit.

Even if you are not usually required to file an income tax return, you must do so to be eligible for the Ontario Child Benefit. To continue receiving the Ontario Child Benefit, you and your spouse or common-law partner must file an income tax return each year.

**Where can I call for more information?**

For general information about the Ontario Child Benefit program, please contact Service Ontario at 1-866-821-7770.

**How can I confirm that the child's family is receiving the Ontario Child Benefit?**

The Ontario Child Benefit will show up on the "Child Tax Benefit and Ontario Child Benefit Notice" provided to clients by the Canada Revenue Agency in July. This notice will have both the Government of Canada and Government of Ontario logos at the top of the page, either side of the heading "Canada Child Tax Benefit and Ontario Child Benefit Notice." A description of the Ontario Child Benefit (OCB) will appear underneath the description of the Canada Child Tax Benefit (CCTB). In the body of the notice, the names and birth dates of the eligible children will appear as well as the term "OCB."

For families on direct deposit and for families who receive a monthly cheque, the Ontario Child Benefit appears on their cheque stub. This notice will have both the Government of Canada and Government of Ontario logos at the top of the page, either side of the heading "Canada Child Tax Benefit and Ontario Child Benefit Notice." In the body of the notice, the names and birth dates of the eligible children will appear as well as the term "OCB."

### Statistics Canada, Low Income Cut-Offs (LICOs)

The Low Income Cut-Off (LICOs) are income amounts, determined by the Federal Government, to denote a family with low income.

The information below was retrieved from Statistics Canada's website on October 21, 2008.

For more information, please consultant Statistics Canada, LICO Main Product Page:

<http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=13-551-XIB&lang=eng>

*"Low Income Cut-Offs (LICOs) are income thresholds, determined by analyzing family expenditure data, below which families will devote a larger share of income to the necessities of food, shelter and clothing than the average family would. To reflect differences in the costs of necessities among different community and family sizes, LICOs are defined for five categories of community size and seven of family size.*

*Low Income Measures (LIMs), on the other hand, are strictly relative measures of low income, set at 50% of adjusted median family income. These measures are categorized according to the number of adults and children present in families, reflecting the economies of scale inherent in family size and composition. This publication incorporates a detailed description of the methods used to arrive at both measurements. It also explains how base years are defined and how LICOs are updated using the Consumer Price Index."*

Statistics Canada, Catalogue no. 75F0002M – No. 004, ISBN 978-0-662-48901-6

Low Income Cut-offs for 2007 and Low Income Measures for 2006

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Table 2: Low Income Cut-Offs (1992 base) **after tax** (continued)

	Community Size				
	Rural areas	Urban areas			
		Less than 30,000 <sup>1</sup>	30,000 to 99,999	100,000 to 499,999	500,000 and over
Size of family unit	dollars				
2007					
1 person	11,745	13,441	14,994	15,184	17,954
2 persons	14,295	16,360	18,250	18,480	21,851
3 persons	17,800	20,370	22,725	23,011	27,210
4 persons	22,206	25,414	28,352	28,709	33,946
5 persons	25,287	28,940	32,285	32,691	38,655
6 persons	28,044	32,095	35,805	36,225	42,869
7 or more persons	38,801	35,250	39,324	39,819	47,084

<sup>1</sup> Includes cities with a population between 15,000 and 30,000 and small urban areas (under 15,000)

Table 2: Low Income Cut-Offs (1992 base) **before tax** (continued)

	Community Size				
	Rural areas	Urban areas			
		Less than 30,000 <sup>1</sup>	30,000 to 99,999	100,000 to 499,999	500,000 and over
Size of family unit	dollars				
2007					
1 person	14,914	16,968	18,544	18,659	21,666
2 persons	18,567	21,123	23,084	23,228	26,972
3 persons	22,826	25,968	28,379	28,556	33,159
4 persons	27,714	31,529	34,457	34,671	40,259
5 persons	31,432	35,760	39,081	39,322	45,662
6 persons	35,452	40,331	44,077	44,350	51,498
7 or more persons	39,470	44,903	49,073	49,377	57,336

<sup>1</sup> Includes cities with a population between 15,000 and 30,000 and small urban areas (under 15,000)

20% added to the LICOs

Low Income Cut-Offs (1992 base) **after tax + 20%**

	Community Size				
	Rural areas	Urban areas			
		Less than 30,000 <sup>1</sup>	30,000 to 99,999	100,000 to 499,999	500,000 and over
Size of family unit	dollars				
2007					
1 person	14,094	16,129	17,993	18,221	21,545
2 persons	17,154	19,632	21,900	22,176	26,221
3 persons	21,360	24,444	27,270	27,613	32,652
4 persons	26,647	30,497	34,022	34,451	40,735
5 persons	30,344	34,728	38,742	39,229	46,386
6 persons	33,653	38,514	42,966	43,470	51,443
7 or more persons	46,561	42,300	47,189	47,783	56,501

<sup>1</sup> Includes cities with a population between 15,000 and 30,000 and small urban areas (under 15,000)

Low Income Cut-Offs (1992 base) **before tax + 20%**

	Community Size				
	Rural areas	Urban areas			
		Less than 30,000 <sup>1</sup>	30,000 to 99,999	100,000 to 499,999	500,000 and over
Size of family unit	dollars				
2007					
1 person	17,897	20,362	22,253	22,391	25,999
2 persons	22,280	25,348	27,701	27,874	32,366
3 persons	27,391	31,162	34,055	34,267	39,791
4 persons	33,257	37,835	41,348	41,605	48,311
5 persons	37,718	42,912	46,897	47,186	54,794
6 persons	42,542	48,397	52,892	53,220	61,798
7 or more persons	47,364	53,884	58,888	59,252	68,803

<sup>1</sup>: Includes cities with a population between 15,000 and 30,000 and small urban areas (under 15,000)

### **Protocol References**

Guide to Community Preventive Services, Systematic Reviews and Evidence Based Recommendations. Centres for Disease Prevention and Control, Economic Evaluations: Cost Effectiveness ratio (CER) or Program Cost Per Averted Decayed, Missing or Filled Tooth Surfaces (DMFS). Published in the American Journal of Preventive Medicine, July 2002 supplement (Am J Prev Med. 2002: 23 (1S) – Evidence, findings and expert commentaries. See [www.thecommunityguide.org/oral/](http://www.thecommunityguide.org/oral/) for individual articles.

For evidence-based research to inform decision making go to: <http://health-evidence.ca/>

From MMWR, August 17, 2001, "Recommendations for Using Fluoride to Prevent and Control Dental Caries in the United States" <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm>

*"All other things being equal, fluoride modalities are most cost-effective for persons at high risk for dental caries. Because persons at low risk develop little dental caries, limited benefit is gained by adding caries-preventive modalities to water fluoridation and fluoride toothpaste, even though demonstrated to be effective among populations at high risk."*

CDC Guide to Community Preventive Services, Systematic Reviews and Evidence-Based Recommendations  
<http://www.thecommunityguide.org/oral/>

School-based/school-linked pit and fissure sealant delivery programs showed a 60% median decrease in occlusal caries in posterior teeth of children aged 6-17 years. The economic analysis tables show the cost per averted DMFS (1997 US \$70-\$139) compared to the cost to provide fissure sealants per person (including personnel, overhead, capital equipment and sealant material)(1981 US \$22.82)

*Health Partners Dental Group and Clinics' Caries* guidelines. Provides recommendations on evaluation, risk assessment, and intervention processes for childhood caries. The guidelines provide a summary of recommended treatments and related statistical information:

[http://www.guideline.gov/summary/summary.aspx?view\\_id=1&doc\\_id=12538](http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=12538)

The American Dental Association Council on Scientific Affairs published Evidence-Based Clinical Recommendations for the Use of Pit-and-Fissure Sealants. A Report of the American Dental Association Council on Scientific Affairs. Published in the J Am Dent Assoc, Vol 139, No 3, 257-268. <http://jada.ada.org/cgi/content/short/139/3/257>.

The guidelines provide a critical evaluation, summary of the scientific evidence and recommendations to inform clinical practice decisions regarding pit-and-fissure sealants in an easy to follow chart:

[http://www.guideline.gov/summary/summary.aspx?view\\_id=1&doc\\_id=12991](http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=12991)

Professionally applied topical fluoride, Evidence-based clinical recommendations, American Dental Association Council on Scientific Affairs. Published in JADA, Vol. 137, page 1151, August, 2006.

[http://www.ada.org/prof/resources/pubs/jada/reports/report\\_fluoride.pdf](http://www.ada.org/prof/resources/pubs/jada/reports/report_fluoride.pdf)

## Oral Health Assessment and Surveillance Protocol, 2008 (or as current)

Health units should use their discretion in deciding whether to modify screening protocols to accommodate situations including, but not limited to, middle schools (where there is no Grade 2 to determine risk level), and small private schools.

When health unit staff is denied access to a school setting, reasonable attempts should be made to inform families about health unit programs/services and how to access them. This could be done through a combination of communication strategies including, but not limited to, website postings, newsletters, media, mailings and posters.

Access to clients between the ages of 14 and 17 years may be difficult. Because routine screening in high schools is not mandated under the OPHS, other strategies as outlined above will need to be considered.

### **Glossary**

A “non-school entry point” is a location other than a school, where dental screening could occur. For example, Ontario Early Years Centre, Food Bank, Health Unit Clinic, etc.

Section 2 d) *“Perform an oral health screening on all Grade 2 students in every school annually. This screening shall include the noting of ‘d + D’...”* and e) *“Apply the following definitions....”* The Grade 2 ‘d+D’ result from the previous school year, or the current school year, can be used at the discretion of the health unit. Where the previous year’s statistic is used and the current statistic reveals the school is now high risk, consideration should be given to conducting additional screening if health unit resources permit and additional parent notification has been given.

Section 3 a) *“OHISS or other method specified by the ministry”*. This means the current Oral Health Information Support System (OHISS) database or any other software the Ministry may develop in future years to replace/ supplement OHISS.

For health units who collect data on the OHISS screening module in schools, data will be uploaded to the central server at the earliest opportunity. Ideally, this will be no more than one day, but may be longer in the remote areas where staff is physically away from all office locations for longer periods.

### **What needs to be included in the parent notification sent home prior to a health unit entering a school to conduct school-based dental screening as outlined in Child Health Requirement 10?**

Parent notification must be made annually and the parent should be advised of the process they can use to exclude or include their child for dental screening. This should include appropriate contact information for the parent to use. Notification should also include information that the health unit will notify the parent if the child has an urgent dental condition or may qualify for a preventive service outlined in the Ontario Public Health Standards.

## Fluorosis Index

Note: To print this page separately, [click here](#)

NB: This is an optional field.

One digit field. Fluorosis appears bilaterally in pairs of teeth that develop at the same time (e.g., 11 and 21). Both teeth of a pair must be affected in the same manner to be fluorosis. Score the worst bilateral pair of homologous permanent teeth. Fluorosis is a defect in enamel formation produced by high concentrations of fluoride during tooth development. The clinical manifestations of fluorosis ranges from almost invisible white flecks (at low levels of fluoride ingestion) to gross loss of outer enamel (at high concentrations).

There are, however, other causes of enamel hypoplasia (e.g., trauma, metabolic disturbances, etc.). It may be difficult, in mild cases to achieve a differential diagnosis, especially if a clear history of fluoride exposure cannot be established. Severe cases are usually much easier to distinguish.

Non-fluoride opacities are usually centered in smooth surfaces of singularly affected teeth. They are often round or oval and clearly demarcated from adjacent normal enamel. Any tooth may be involved, but only a few teeth are usually affected (e.g., one to three). Lesions are common in deciduous teeth and on the labial surfaces of lower incisors. The enamel surface may be rough on probing. Lesions are normally most visible in strong light, especially when viewed slightly perpendicular to the tooth surface.

Fluoride lesions often affect the tips of cusps or incisal edges; the lesions often appear as lines which follow the incremental lines in enamel and shade imperceptibly into the surrounding normal enamel. Bilateral pairs of teeth are affected (e.g., 11 and 21). Cuspids, bicuspid second and third molars are most commonly affected. It is rarely observed on lower incisors and almost never in the primary dentition. The mild lesions are commonly described as having papery white appearance. The enamel surface is smooth to an explorer. Marks are often invisible under strong light.

Because differential diagnosis of fluorosis is difficult in the mildest cases, **if in doubt, score 0**. If you are convinced that the lesions you are viewing are truly due to fluoride, score according to the **worst bilateral pair of homologous teeth that you can see**. If only one tooth (not a pair of teeth) is involved, do not score as a fluorotic lesion.

0 = None

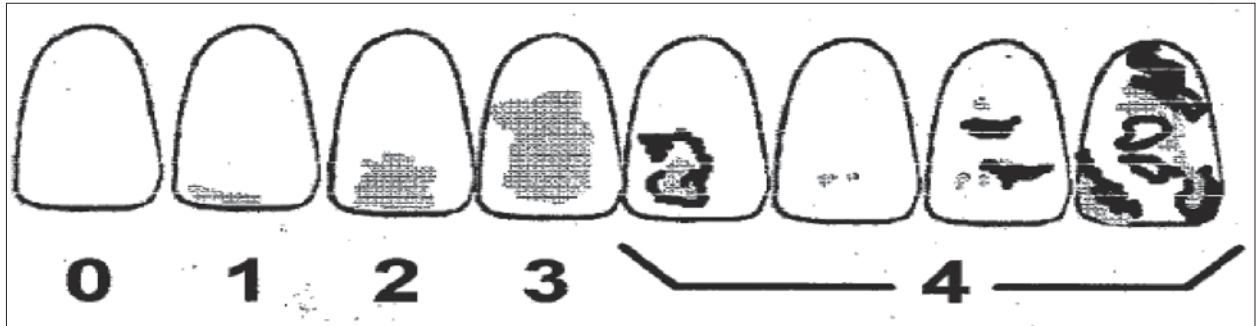
1 = Parchment white colour on less than 1/3 of enamel surface

2 = Parchment white colour on 1/3 but less than 2/3 of enamel surface

3 = Parchment white colour on 2/3 or more of the enamel surface

4 = Staining and/or pitting in conjunction with 1, 2 or 3

### Diagram for Scoring Fluorosis Index



### Gingivitis

NB: This is an optional field.

Visual inspection only – no probing. This one digit field is to be used to score whether gingivitis is present around two or more teeth.

0 = None

1 = Yes (well defined inflammation, redness, puffiness, loss of texture around two or more teeth)

9 = Missing value (default value automatically inserted by OHISS unless you enter 0 or 1)

### deft/DMFT

NB: The "d+D" component of this index is compulsory. The "e+M" and "f+F" components are optional.

Use of explorers: Dental Hygienists use explorers selectively, and for specific uses. No sub-gingival probing takes place. Explorers are not used to probe (with force) the tooth surface.

The Dental Hygienist should use a blunt explorer for the following purposes only:

- To remove food debris that is obscuring a tooth surface;
- To use the back of the explorer to show the child large plaque deposits (education);
- To determine if clear sealants are present and to determine sealant eligibility (tactile);
- To determine if a composite resin restoration has been placed (tactile); and
- To conduct the CINOT/OW quality assurance.

A blunt sterilized explorer should be the only probe used during the deft/DMFT assessment. Only gentle pressure will be used to diagnose caries. 'Gentle' pressure is defined as pressure comparable to the tip of the explorer touching a fingernail and the examiner applying pressure without causing blanching of the area beneath the nail.

The World Health Organization's definition for determining if a carious lesion is present:

*"Caries is recorded as present when a lesion in a pit or fissure, or on a smooth tooth surface, has an unmistakable cavity, undermined enamel, or a detectably softened floor or wall. A tooth with a temporary filling, or one which is sealed...but also decayed, should also be included in this category. In cases where the crown has been destroyed by caries and only the root is left, the caries is judged to have originated in the crown and therefore scored as crown caries only... Where any doubt exists, caries should not be recorded as present."*  
[World Health Organization. *Oral Health Surveys, Basic Methods*. 4th Edition, 1997, p41].

### **Screening Terminology**

To ensure consistency in record keeping, use of short forms and acronyms is acceptable as long as they are commonly acceptable terminology which will be understandable to staff in all health units. Please refer to the acceptable terminology listed below.

**Federation Dentaire Internationale Nomenclature (FDI)**

Upper Right	17 16 15 14 13 12 11	21 22 23 24 25 26 27	Upper Left
	55 54 53 52 51	61 62 63 64 65	
	85 84 83 82 81	71 72 73 74 75	
Lower Right	47 46 45 44 43 42 41	31 32 33 34 35 36 37	Lower Left

Thus, tooth

- 17 = the second permanent molar in the first, or upper right, quadrant
- 16 = the first permanent molar in the first, or upper right, quadrant
- 15 = the second permanent premolar in the first, or upper right, quadrant
- 14 = the first permanent premolar in the first, or upper right, quadrant
- 13 = the permanent maxillary canine in the first, or upper right, quadrant
- 12 = the permanent maxillary lateral incisor in the first, or upper right, quadrant
- 11 = the permanent maxillary central incisor in the first, or upper right, quadrant

- 75 = the second primary molar in the seventh, or lower left, quadrant
- 74 = the first primary molar in the seventh, or lower left, quadrant
- 73 = the primary canine in the seventh, or lower left, quadrant
- 72 = the primary mandibular lateral incisor in the seventh, or lower left, quadrant
- 71 = the primary mandibular central incisor in the seventh, or lower left, quadrant

Definitions for the purpose of using OHISS:

- Case – is the individual child who has been identified as age and dentally eligible for CINOT and entered into OHISS for follow-up.
- Claim – reflects entry of data on the claim forms received from practitioners for specific treatment rendered for a case.

**Examples of Commonly Used Charting Guidelines (for consistency across health units)**

Abscess = ABS

Absent = Abs

Acute necrotizing ulcerative gingivitis = ANUG

Amalgam = Ag

Assistance for Children with Severe Disabilities = ACSD

Buccal (see vestibular)

Bitewing radiograph = BW

Calculus = Calc

Cephalometric radiograph = CEPH

Certified Dental Assistant = CDA

Chief complaint = CC

Child Urgent Care (age + dentally eligible for CINOT). Financial eligibility remains to be determined = CUC

Children's Aid Society = CAS

Children In Need Of Treatment Program = CINOT

College of Dental Hygienists of Ontario = CDHO

Complete lower denture = CLD

Complete upper denture = CUD

Composite resin = Comp

Consent = cons

CINOT Claim Form = CCF

Crown = CR

Decayed/Missing/Filled permanent teeth = DMFT

decayed/extracted/filled primary teeth = deft

the total number of decayed, extracted and filled primary teeth + the total number of decayed, missing (due to decay) and filled permanent teeth = deft+DMFT

Dental Special Care Plan = DSCP (for eligible social assistance recipients)

Distal surface = D

Doctor of Dental Surgery = DDS (can also be used for BDS and DMD)

Does Not Qualify = DNQ

Early Childhood Caries = ECC (this is the preferred acronym for ECTD or Early Childhood Tooth Decay)

Enamel defect = ED

Extra oral (e.g., as in exams) = EO

Filled = F

Fluoride = FL

Fluorosis = FI

Full denture = FD

Gingivitis = Gng

Health Protection and Promotion Act = HPPA

Incisal = I

Intra oral (e.g., as in exams) = IO

Labial (see vestibular)

Large = lg

Left voice message = LVM

Lingual = L

Mandibular = Md

Maxillary = Mx

Mesial surface = M (used in the context of tooth anatomy)

Mobile/Mobility = I, II, or III

Ministry of Children and Youth Services = MCYS

Ministry of Community and Social Services = MCSS

Ministry of Health and Long-Term Care = MOHLTC

Ministry of Health Promotion = MHP

Missing = M (used in the context of DMFT for decayed, missing and filled teeth)

No care required (no treatment or preventive care) = NCR

No change in medical history = NCMH

Non-urgent = Non-u

No significant findings = NSF

Occlusal surface = O

Oral Health Information Support System = OHISS

Ontario Disabilities Support Program = ODSP

Ontario Early Years Centres = OEYCs

Ontario Public Health Standards = OPHS

Ontario Works = OW

Oral Hygiene Instruction = OHI

Periapical (could refer to radiograph or the periapical region) = PA

Palatal (see Lingual)

Panoramic radiograph = PAN

Professionally applied topical fluoride = PATF

Pit and fissure sealant = PFS

Parent Notification Form (CINOT) = PNF

Partial denture = PD

Periodontal or periodontology = perio

Pre-school = Pre-s

Prescription = Rx

Prophylaxis = prophy

Preventive Services Only = PSO

Quadrant = 1, 2, 3, or 4 for the permanent dentition and 5, 6, 7 and 8 for the primary dentition

Registered Dental Hygienist = RDH

Root canal treatment = RCT

Royal College of Dental Surgeons of Ontario = RCDSO

Scaling = Sc

Screened = S

Stainless steel crown = SSC

Supernumerary tooth = 99

Telephone call = TC

To be extracted = TBX

To call back = TCB

Treatment = Tx

Tender to percussion = TTP

Temporary restoration = Temp

Vestibular surface (in place of B for buccal, L for labial and F for facial) = V

Voice mail = VM

Will call back = WCB

Within normal limits = WNL

### **Protocol References**

At the request of the Senior Dental Consultant, Ministry of Health and Long-Term Care, the Community Dental Health Services Research Unit (Faculty of Dentistry, University of Toronto) has developed and tested a paediatric screening tool to be used by parents/caregivers to determine if a child has dental problems.

Prakash P, Jokovic A, Locker D. Development and validation of a pediatric dental screening instrument. Health Measurement and Epidemiology report no 22, Toronto, ON: University of Toronto, Community Dental Health Services Research Unit, 2006. Available on the OHISS Collaboration Site.

The research unit has also provided three screening program evaluation reports:

Locker D., et al. Evaluation of Ontario's dental screening program for schoolchildren. Program Evaluation, report no 7, Toronto, ON: University of Toronto, Community Dental Health Services Research Unit, 2001.

Locker D. Evaluation of Ontario's dental screening program for schoolchildren. Program Evaluation report no 5, Toronto, ON: University of Toronto, Community Dental Health Services Research Unit, 2001.

Locker D. Evaluation of Ontario's dental screening program for schoolchildren. Program Evaluation, report no 4, Toronto, ON: University of Toronto, Community Dental Health Services Research Unit, 2001.

# Children In Need Of Treatment (CINOT) Program Protocol, 2008 (or as current)

## Determining Financial Hardship for the Purposes of Accessing the CINOT Program

The following information is provided to clarify the meaning of 'financial hardship'. It is intended for use by health units when:

- Explaining to parents/guardians/advocacy groups, etc. the intent of the CINOT Program and whom it covers;
- Answering a question about what is meant by the term 'financial hardship' on the Parent Notification Form (PNF); and/or
- Dealing with a complaint about a parent/guardian using the CINOT program when they are not able to pay for treatment.

The intent of the CINOT program is to prevent "financial hardship" for a family when one, or more, of their children require urgent dental care. For the purposes of the program, a family would suffer "financial hardship" if providing the necessary dental care (for the child with a CINOT-eligible condition, identified by a health unit staff member) would result in any one of the following:

- Inability to pay rent in the month the dental treatment is sought;
- Inability to pay for household bills in the month the dental treatment is sought;
- Inability to buy groceries for the family in the month the dental treatment is sought; and/or
- The family will be required to seek help from a food bank in order to provide food in the month the dental treatment is sought.

In the event that: (a) a family inquires what is meant by the term "financial hardship" or (b) a complaint is made that a family receiving CINOT services may be able to afford to pay for treatment (i.e., an investigation of a CINOT client is required), the following are sample questions that you may consider asking the child's parent or guardian to help you establish the child's financial eligibility:

1. **Explanation for the parent/guardian:** Your child has been identified, by a health unit dental hygienist, as having an urgent dental condition, or a dental condition that may cause pain in the near future. The CINOT program was designed to prevent "financial hardship" for a family when one, or more, of their children requires urgent dental care. To understand what we mean by "financial hardship", we have some simple questions that will allow you to determine, for yourself, whether you qualify for the program.
2. **Sample Questions** (health unit staff can select questions based on the situation)
  1. Would paying for dental care for your child mean that you could not pay your rent or mortgage this month?
  2. Would paying for dental care for your child mean that you could not pay your household bills (e.g., heating, groceries, hydro) this month?
  3. Would paying for dental care for your child mean that you would have to go to a food bank for help to feed your family this month?
  4. Would paying for dental care for your child mean that you would not be able to pay your household living expenses (e.g., winter jackets, winter boots, school clothes)?

5. If the child attends a private school: Is your child on a scholarship/bursary? Is the fee charge adjusted to your income? Is a family member or other individual paying for your child to attend this school?
6. Are you leaving Ontario for any reason in the next six months?

If the answer to one, or more, of the first five questions is “yes”, then you should indicate to the family that the CINOT program was designed to help in situations like theirs.

If the answer to all of the first five questions is “no” and/or the answer to the last question is “yes”, then you can either:

1. Indicate to the family that the CINOT program may not have been designed to help families in their particular situation and that they should discuss payment options with family dental care provider; or
2. Tell the family they do not qualify for assistance through CINOT. Advise them to talk with their family dental care provider, to see if payment options are available.

### **Recordkeeping**

Keeping detailed, accurate records of interactions with clients is one of the most important aspects of one’s duties under the oral health component of the OPHS. The Oral Health Information Support System (OHISS) software allows staff to make detailed notes regarding conversations with clients, parents/guardians and other dental professionals involved in their care. Good records are a professional, ethical and legal responsibility for oral health professionals. They help to ensure the safe treatment of patients, continuity of dental care and protection of the care provider. Both the Royal College of Dental Surgeons of Ontario (RCDSO) and the College of Dental Hygienists of Ontario (CDHO) have record keeping guidelines which should be used to ensure that all of the records kept are complete and accurate.

## **Personal Health Information**

The information below has been reproduced from pages 9 and 10 of *Personal Health Information Protection Act, 2004*, An Overview for Health Information Custodians, Ministry of Health and Long-Term Care, August 2004. All references to section numbers refer to sections of the *Personal Health Information Protection Act (PHIPA)*.

### **What is “Personal Health Information”?**

“Personal health information” is defined as identifying information about an individual whether oral or recorded, if the information:

- Relates to the physical or mental health of the individual, including information that consists of the individual’s family health history,
- Relates to the providing of health care of the individual, including the identification of a person as a provider of health care of the individual,
- Is a plan of service within the meaning of the *Long-Term Care Act, 1994* of the individual,
- Relates to payments or eligibility for health care in respect of the individual,
- Relates to the donation by the individual of any body part or bodily substance, or is derived from testing of such body part or substance,
- Is the individual’s health number, or
- Identifies the individual’s substitute decision-maker: s.4(1).

Information is “identifying” when it identifies an individual or when it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify the individual: s. 4(2). It is not necessary for the individual to be actually named for the information to be considered personal health information.

“Personal health information” also includes other identifying information that is contained in the same record with the information described above: s.4(3). This is referred to as a “mixed record”.

Generally, “personal health information” does not include identifying information held by health information custodians as employers, i.e. personal health information relating to an employee maintained primarily for a purpose other than the provision of health care to the employee: s.4(4). For example, information contained in the hospital human resources file of a nurse employed by the hospital would not be considered personal health information, even if it contained identifying health information about the nurse or anyone else (e.g., for the purposes of accommodating a disability, providing sick leave, or monitoring the employee’s performance in delivering health care to patients). If that employee/nurse was treated as a patient in the hospital however, information in the employee’s medical file would be considered personal health information.

It should be noted that PHIPA does not apply to personal health information about an individual after the earlier of 120 years after the record was created, or 50 years after the death of the individual: s.9(1).

### **Protocol Resources**

*Child and Family Services Act, 1990*

*Regulated Health Professions Act, 1991*

*Dental Hygiene Act, 1991*

*Dentistry Act, 1991*

Qualifications of Boards of Health Staff O.Reg. 566 (under the *Health Protection and Promotion Act*)

*Personal Health Information Protection Act, 2004*

*Municipal Freedom of Information and Protection of Privacy Act, 1990*

Royal College of Dental Surgeons of Ontario [www.rcdso.org/](http://www.rcdso.org/) and the College of Dental Hygienists of Ontario <http://www.cdho.org/> have information regarding professions standards of practice (e.g., recording keeping, informed consent, infection control, etc.) on their websites.

## Protocol for the Monitoring of Community Water Fluoride Levels, 2008 (or as current)

Under the Operational Roles and Responsibilities section of the *Protocol for the Monitoring of Community Water Fluoride Levels, 2008* (or as current), please note the following interpretations of the requirements.

Regarding section 2 ii) Notification – notification would include use of your health unit's regular communication channels (e.g., website, practitioner newsletters, media releases, etc.).

The rationale for waiting 90 days before notifying practitioners and the community of fluoride levels below the therapeutic range is to cover outages caused by scheduled maintenance of fluoridation equipment and unexpected maintenance that is required when a piece of equipment breaks or fluoride supply is unavailable.

Hydrofluorosilicic Acid, also known as HFSA, is a transparent, colourless (water white to straw yellow) aqueous solution that is used in a variety of applications, including the major end-use, water treatment for fluoridation. (Definition retrieved from National Sanitation Foundation [NSF], The Public Health and Safety Company's website [http://www.nsf.org/business/water\\_distribution/pdf/NSF\\_Fact\\_Sheet.pdf](http://www.nsf.org/business/water_distribution/pdf/NSF_Fact_Sheet.pdf) on December 8, 2008)

Under the *Safe Drinking Water Act, 2002*, O. Reg. 170/03, Drinking Water Systems (available on e-laws at <http://www.e-laws.gov.on.ca>), the following terms have been defined:

- Large municipal residential systems;
- Small municipal residential systems;
- Large municipal non-residential systems;
- Small municipal non-residential systems;
- Non-municipal year-round residential systems;
- Non-municipal seasonal residential systems;
- Large non-municipal non-residential systems; and
- Small non-municipal non-residential systems.

The "Ontario Drinking Water Quality Standards" are Ontario Regulation 169/03.

Relevant sections for dental staff include: Schedule 7, Operational Checks (7.4 refers to fluoridation); Schedule 13, Chemical Sampling and Testing (13-9 refers to fluoridation); Schedule 15, Chemical Sampling and Testing (15-6 refers to fluoride); and, Schedule 16, Reporting Adverse Test Results and Other Problems (16-1 refers to fluoride exceeding 1.5 mg/L).

### **Protocol Resources**

Technical Support Document for Ontario Drinking Water Standards, Objectives and Guidelines, June 2003 (revised June 2006) (or as current)

*Safe Drinking Water Act, 2002*

Ontario Drinking-Water Quality Standards, O.Reg. 169/03, (under the *Safe Drinking Water Act, 2002*).

Drinking Water Systems. O.Reg. 170/03 (under the *Safe Drinking Water Act, 2002*).

Drinking Water Testing Services, O.Reg. 248/03 (under the *Safe Drinking Water Act, 2002*).

***For further information on fluoride (e.g., supplements, toothpaste, water fluoridation), please refer to the following websites:***

Canadian Dental Association (Fluoride FAQs)

Health Canada, Office of the Chief Dental Officer

Health Canada (It's Your Health)

Department of Health and Human Services, Centers for Disease Control and Prevention – Water Fluoridation (background, selected reports and journal articles, cost effectiveness, systematic and evidence-based reviews, Surgeon's General Statements on Community Water Fluoridation)

# Appendix 1

## **Glossary of Terms related to the requirements and protocols**

- “Case management” – the process of identifying a child through to treatment completion or referring the family to CAS.
- “Geographic isolation” – where attending a health unit screening location is impractical due to distance, weather, transportation, or other access to care barriers.
- “When no treatment has been initiated” – when the child has not attended the office of an oral health care provider for an examination and/or treatment.
- “When treatment has been initiated” – a Section A has been received and/or the dental office has confirmed the child has been seen and/or an invoice for CINOT treatment has been received.
- “Visa student” – the son/daughter of an international student studying at an Ontario university/college.
- “Offering a screening appointment within 5 working days” – when a parent/guardian calls to have a child screened, the health unit offers a screening appointment at a screening location within five business days of the date of contact. The location could be a health unit clinic, Early Years Centre or other location where screening is scheduled. If the parent/guardian declines the appointment offered, the health unit can then re-offer an appointment outside of the five day window.

CINOT was designed so that no child need suffer from urgent or emergency dental conditions because the parent/guardian has no dental insurance and cannot afford to pay for the treatment.

Emergency and Essential – as defined in the Children In Need Of Treatment (CINOT) *Schedule of Dental Services and Fees*. “Definitions for the purpose of determining CINOT dental eligibility” section.

Urgent – refers to a child who is eligible for CINOT based on the dental condition they present with. See definition for “Essential” in CINOT *Schedule of Dental Services and Fees*.

Non-urgent – refers to a child who has a dental condition(s) which does not meet the criteria for emergency or essential conditions as defined in the Children In Need Of Treatment (CINOT) *Schedule of Dental Services and Fees*. A child may have one or more dental conditions that do not qualify for CINOT but the dental care provider may recommend be treated. This is outside the scope of CINOT. Program staff should advise the parent that the fact that CINOT does not cover the recommended care does not mean that the treatment is not needed, just that it is not eligible for CINOT coverage.

Hydrofluorosilicic Acid is the most commonly used form of fluoride to fluoridate water. Check with your local water treatment plant to confirm the type of fluoride used in your area.

PATF = professionally applied topical fluoride








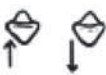



















PFS = pit and fissure sealants

## Appendix 2

### Standardized Charting

Special thanks to the University of Toronto, Faculty of Dentistry for permission to use the following content.

### Explanation of Charting Symbols

Missing		Unerupted Impacted		Partially erupted	
Distoang Impaction		Overeruption		Drifting	
Rotated teeth		Tipped teeth		Hypocal	
Abrasion or Abfraction		Erosion		Attrition	
Open contact		Loose contact		Hypoplasia	
Restoration (eg. Am, CR)		Crown (eg. PBM)		Bridge	
Caries		Implant		Overhang	
Recession		Crown fracture		Furcation Involvement	
Root canal filling		Root canal radiogr. short		Periapical radiolucency	

MAXILLA

AMOUNT OF ATTACHED GINGIVA

Chart #: \_\_\_\_\_

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Date

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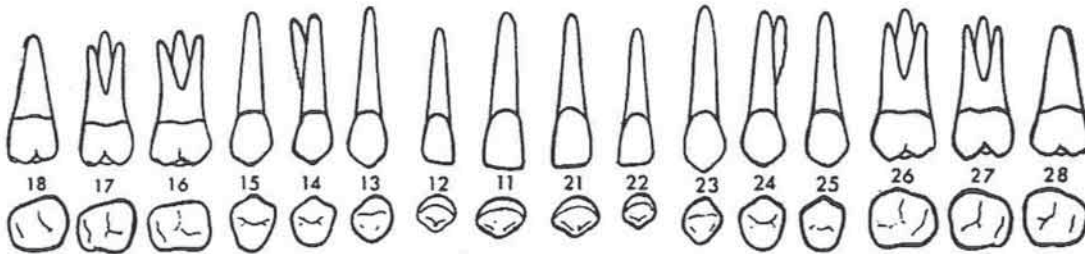
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BLEEDING ON PROBING

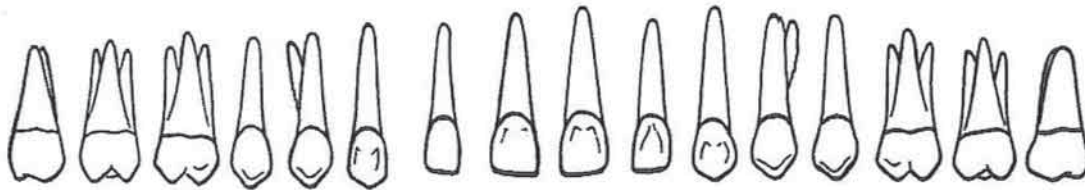
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PROBING DEPTH

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Date



F A C I A L



P A L A T A L

PROBING DEPTH

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Date

BLEEDING ON PROBING

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RECESSION

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MOBILITY (0-3)

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**MANDIBLE**

Chart #: \_\_\_\_\_

MOBILITY (0-3)															Date	
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

RECESSION

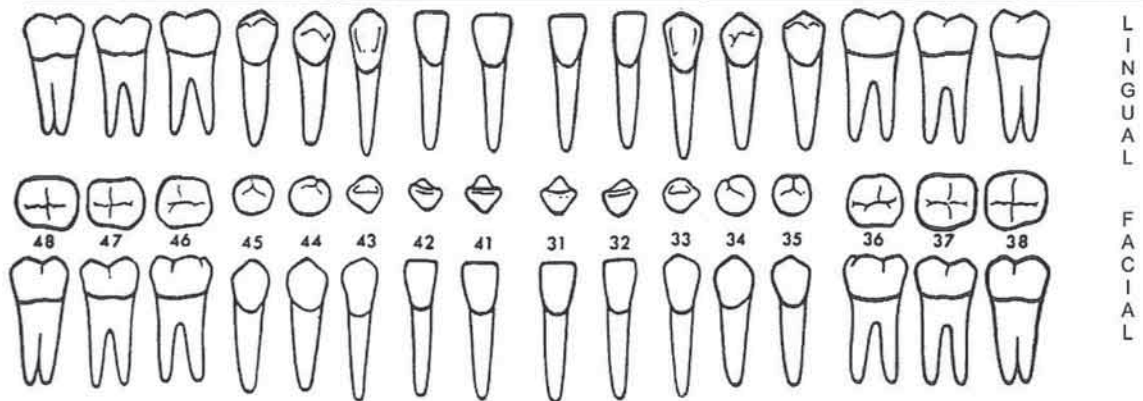
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BLEEDING ON PROBING

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PROBING DEPTH

48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Date



PROBING DEPTH

48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Date

BLEEDING ON PROBING

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RECESSION

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AMOUNT OF ATTACHED GINGIVA

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Date:	Signature: