CONDUCTING AN ORAL EXAM AND SCORING THE PRIMARY CARE ASSESSMENT TOOL (PCOAT)

Introduction

This section contains information on how to conduct an oral health risk assessment using the Primary Care Oral Health Assessment Tool or PCOAT. PCOAT forms for people under and over six years old are included, as are English and Spanish interview protocols that may be used by patients to answer the questions on the PCOAT form. (Note that these questions may be asked by a staff member of the provider's office or completed by the patient and then entered onto the PCOAT form).

Primary Care Oral Health Assessment Using the Primary Care Oral Assessment Tool (PCOAT)

Introduction

The purpose of the Primary Care Oral Assessment Tool (PCOAT) is to document the oral health portion of prenatal and well child clinical visits. It includes key patient dental and medical history and a screening oral exam. Together, these determine the oral health *risk level.* The PCOAT documents specific elements of the patient's care plan including patient self-management goals (see Tab Four), treatment recommendations (see Tab Five), and dental care referrals (see Tab Six).

The (PCOAT) is a clinical decision support tool that provides a format to:

- Guide and document oral health screening (history and oral physical exam);
- Establish an oral disease risk level (Low, High, Extreme) from screening findings;
- Guide the patient oral health management plan based on risk level; and
- Document the oral health plan of care including patient self-management goals

How to Use the PCOAT

There are two PCOAT forms that follow these instructions - one for Primary (baby) teeth and a second for Permanent Teeth PCOAT.

- If the patient is an adult use the Permanent teeth PCOAT unless they have full dentures. Ask the adult patient if they have full or partial dentures. If the patient has dentures; ask if they have **any** of their own natural teeth. If patient has ANY natural teeth, use the Permanent teeth PCOAT.

- If the patient is a child use the Primary (baby) teeth PCOAT from the time their first baby tooth comes in until they get their first permanent (adult) tooth.

Ask the parent of a very young child patient if they have any teeth yet. If the young child has no teeth; use NO PCOAT. If the young child has any teeth, use the Primary (baby) teeth PCOAT

- Ask the parent of pre-school and school age children (usually 6 and over) if they have gotten any adult teeth yet. If the child has**:**

  - no permanent (adult) teeth use the Primary (baby) Teeth PCOAT
  - any permanent teeth (even just one) use the Permanent Teeth PCOAT
  - no teeth because they were pulled, use NO PCOAT

- If parents do not know if their child has permanent (adult) teeth yet, provide both PCOAT forms for the provider who will determine this by exam.

How to Fill Out the History and Oral Exam Parts of the PCOAT Form

There are two parts on the PCOAT form: the Patient Questions and Health Care Provider History and Oral Exam. Usually both parts are filled out in the same patient visit. However:

- Filling out the "Patient Questions" Section can be done in a couple of ways by a health worker.

  - **Interview:** a health care worker can ask the questions to the patient, parent or caregiver. The health care worker checks or circles the answers. (Depending on your site, it could be paper form, a computerized form, or part of an electronic health record).

  - **Patient Fills Out:** the patient, parent or caregiver answers the questions on the paper and pencil form**.** (A PCOAT Patient Questions Form is provided at the end of this section).

- Filling out the "Health Care Provider History and Oral Exam" is done by the health care provider. A provider checks the answers based on their findings based on history and oral exam.

How to Determine and Document the Oral Disease Risk Level on the PCOAT Form

After the Patient Questions and Health Care Provider History and Oral exam sections are completed, an overall oral disease risk level of Low, High, or Extreme is determined from the answers recorded on the form.

1. Look at the three columns that contain checked answer boxes.

2. Locate the checked answer box that is farthest to the right.

3. Look down the column that contains the farthest right checked box to find the RISK level (Low, High or Extreme).

4. Check the oral health risk level (Low, High or Extreme).

How to Determine and Order Referral to Dental Care Based on Patient Need on the PCOAT Form

1. Find the Referral to Dental Care Box on the top of the far right hand column**.**

2. Check **Not Indicated** if patient is low risk and has a dental provider.

3. Check **Routine** if patient is low risk but does not have an established dental provider or is at high risk.

4. Check **Expedited** if the patient is Extreme Risk OR is at any risk level and shows an urgent need for dental care determined by health care provider.

How to Locate and Apply Management Guidelines for Patient Risk Level on the PCOAT Form

1. Refer to Section Five of this Manual, Treatment Recommendations.

2. Find management guidelines for each risk level (Low, High, Extreme) in the far right hand column.

3. Find the management guideline for this patient's risk level.

4. Choose the parts of the management guideline suited to the individual patient need. Consult Section Five*, Treatment Recommendations, for additional specifics on patient care.*

5. Place a check before those parts of guidelines that were started with the patient today.

How to Record Self-Management Goals Agreed to by the Patient

1. Find Self-Management Goals box on bottom of the form.

2. Place a check before the diet and oral hygiene changes that patient is ready to try.

Patients with Dentures

1. Ask patient to remove full or partial dentures or other removable appliances.

2. Perform oral exam to observe for: (a) Oral lesions (malignancy, poor denture fit) and (b) Oral candidiasis.

3. Document oral exam results and plan, if needed.

Permanent Teeth PCOAT

(Primary Care Oral Assessment Tool – for patients age ≥ 6 years)

Date: _____ Patient Name: _____ Date of Birth: _____

Patient Questions:

Do you have a dentist where you go to get your teeth cleaned and taken care of? If yes, who/where:_____	☐ Yes– seen within the last six months	☐ No ☐ Yes-seen more than six months ago	
Have you had any cavities or fillings in the last 12 months?	☐ No	☐ Yes	
Have you ever been told you have gum disease?	☐ No	☐ Yes	
Have you had any teeth removed in past 36 months?	☐ No	☐ Yes	
When do you eat sugary or starchy foods outside of meal time? (candy, pretzels, chips, bread, tortillas)	☐ Mostly at meal - times	☐ Outside of meal - times	
When do you drink sugary beverages outside of meal time? (sweet coffee/tea, juice, soda pop, energy/sport drinks, cocktails, wine, beer)	☐ Mostly at meal - times	☐ Outside of meal - times	
How often do you brush your teeth?	☐ Twice or more a day	☐ Once daily or less	

Health Care Provider History and Oral Exam:

Exposure to fluoride (toothpaste, rinse, Rx)	☐ Yes	☐ No	
Physical, behavioral or cognitive factors interfering with oral care (special needs, drug/alcohol overuse, tobacco use)	☐ No	☐ Yes	
Frequent vomiting/acid reflux (daily)	☐ No		☐ Yes
EXAM: Dry mouth/Xerostomia (reported or observed OR risk from Rx/radiation treatments)	☐ No		☐ Yes
Visible, heavy plaque on teeth	☐ No	☐ Yes	
Visible cavities (including white spot lesions)	☐ No	☐ Yes	
Gingivitis	☐ No	☐ Yes	
Fillings, crowns, retainers, braces, removable appliances	☐ No	☐ Yes	
Suspicious lesion on buccal mucosa, gingiva, tongue	☐ No		☐ Yes
	☐ Low	☐ High	☐ Extreme

Management Guidelines: ☐ Applied Fluoride Varnish

Referral to Dental Care:

☐ Not Indicated ☐ Routine ☐ Expedited

Low Risk

- ☐ Reinforce routine dental care
- ☐ Set diet and oral hygiene management goals
- ☐ Use OTC fluoride toothpaste twice daily
- ☐ Recommend gum with xylitol as first ingredient

High Risk

- ☐ Set diet and oral hygiene management goals
- ☐ Instruct on OTC or prescription fluoride tooth - paste
  - ☐ Prescribe high fluoride toothpaste for decay
- ☐ Gum with xylitol as the first ingredient
- ☐ Prescribe antibacterial mouth rinse to decrease oral bacteria

Extreme Risk

- ☐ Set diet and oral hygiene self-management goals
- ☐ Recommend (see guidelines)
  - ☐ Oral moisturizer for dry mouth
  - ☐ pH neutralizing rinse for vomiting
  - ☐ Fluoridated mouth rinse for decay

  Prescribe (see guidelines)
  - ☐ Anti-bacterial rinse to decrease oral bacteria
  - ☐ High fluoride toothpaste for decay
- ☐ Gum with xylitol as first ingredient
- ☐ Topical fluoride every 3 months
- ☐ Evaluate medications to modify xerostomia

Self Management Goals

☐ Regular dental visits	☐ Water between meals
☐ Brush twice daily	☐ Quit plan for tobacco
☐ Use Rx Fl- toothpaste	☐ Less junk food/candy
☐ Fluoride mouth rinse	☐ No soda
☐ Less/no sweet drinks/alcohol	☐ Healthy snacks
☐ Drink water with flouride	☐ Floss daily

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Permanent Teeth PCOAT
(Primary Care Oral Assessment Tool – for patients age > 6 years)
Patient Questions

Date: _____ Patient Name: _____ Date of Birth: _____

Do you have a dentist where you go to get your teeth cleaned and taken care of? If yes, who/where:	❑ **Yes, within the last six months** ❑ **Yes, seen more than six months ago** ❑ **No**	
Have you had any cavities or fillings in the last 12 months?	❑ **No**	❑ **Yes**
Have you ever been told you have gum disease?	❑ **No**	❑ **Yes**
Have you had any teeth removed in the past 36 months?	❑ **No**	❑ **Yes**
When do you eat sugary or starchy foods outside of meal time (candy, pretzels, chips, bread, tortillas)?	❑ **Mostly at meal times**	❑ **Outside of meal Times**
When do you drink sugary beverages outside of meal time (sweet coffee/tea, juice, soda pop, energy/sport drinks, cocktails, wine, beer)?	❑ **Mostly at meal times**	❑ **Outside of meal Times**
How often do you brush your teeth?	❑ **Twice or more a day**	❑ **Once daily or less**
Do you have vomiting or acid indigestion often?	❑ **No**	❑ **Yes**

Dientes Permanente PCOAT
(Herramienta de Evaluación Oral de la Atención Primaria para la Salud - para los pacientes de 6 años y más)
Preguntas para los Pacientes

Fecha: _____ Nombre del Paciente:_____ Fecha de Nacimiento: _____

¿Tiene usted un dentista adonde va para que le limpien sus dientes y cuidado dental? Si respondió sí, quién y adónde:	❑ **Si, dentro de los últimos seis meses** ❑ **Si, me vieron hace más de seis meses** ❑ **No**	
¿Ha tenido usted caries o rellenos en los dientes en los últimos 12 meses?	❑ **No**	❑ **Si**
¿Le han dicho que usted tiene enfermedad de las encías?	❑ **No**	❑ **Si**
¿Le han removido cualquier dientes en los pasados 36 meses?	❑ **No**	❑ **Si**
¿Cuando es que usted come comidas azucaradas o con almidón afuera de las comidas regulares (dulce, galletas saladas, papas, pan, tortillas)?	❑ **Mayormente durante las comidas regulares**	❑ **Afuera de las comidas regulares**
¿Cuando es que usted toma bebidas azucaradas afuera de las comidas regulares (café o té dulce, jugos, sodas, bebidas deportivas o para la energía, bebidas alcohólicas, vino, cerveza)?	❑ **Mayormente durante las comidas regulares**	❑ **Afuera de las comidas regulares**
¿Qué tan seguido usted se cepilla los dientes?	❑ **Dos veces o mas al dia**	❑ **Una vez al día o menos**
¿Usted sufre de vómito o acidez por la indigestión (agruras o reflujo) seguidamente?	❑ **No**	❑ **Si**

Primary (baby) Teeth PCOAT

(Primary Care Oral Assessment Tool – for patients age ≤ 6 years)

Date: _____ Patient Name: _____ Date of Birth: _____

Mother or Caregiver Questions:

Does your family have a dentist where you go to get your teeth cleaned and taken care of? If yes, who/where:_____		☐ Yes	☐ No	
When was the last time your child went to the dentist?	☐ N/A due to age	☐ Within the last six months	☐ More than six months ago	
Do you (parent or caregiver) have a cavity now or have you had a filling in the past three years?		☐ No	☐ Yes	
Have brothers or sisters had cavities?		☐ No	☐ Yes	
When was your child's last cavity?	☐ N/A due to age	☐ No cavities in last year	☐ Cavities in last year	
Does your child drink anything other than water in between meals?		☐ No	☐ Yes	
Does your child drink anything other than water while in bed?		☐ No	☐ Yes	
Does your child drink water with flouride?	☐ Don't know ☐ No water at all	☐ Yes	☐ No	
How often are your child's teeth brushed with fluoride toothpaste?		☐ At least daily	☐ Less than daily	

Health Care Provider History and Oral Exam:

History of topical fluoride varnish application		☐ Yes	☐ No	
Physical, behavioral or cognitive factors interfering with oral care (special needs)		☐ No		☐ Yes
EXAM:	Gingivitis (reported or observed OR risk from Rx/disease)	☐ No	☐ Yes	
	Dry mouth/ Xerostomia (reported or observed OR risk from Rx/disease)	☐ No		☐ Yes
	White spots lesions or tooth decay	☐ No	☐ Yes	
	Fillings or crowns present	☐ No	☐ Yes	
	Visible plaque on teeth	☐ No	☐ Yes	
	Oral candidiasis	☐ No	☐ Yes	
		☐ Low	☐ High	☐ Extreme

Self Management Goals

- ☐ Regular dental visits
- ☐ Brush twice daily
- ☐ Use Fl- toothpaste
- ☐ Dental treatment for parents
- ☐ Water between meals
- ☐ Xylitol gum/mints
- ☐ Less junk food/candy
- ☐ No soda
- ☐ Healthy snacks
- ☐ Drink water with flouride
- ☐ Less junk food/candy
- ☐ Wean off bottle
- ☐ Only water in nighttime bottle or cup

Management Guidelines:

Applied Fluoride Varnish: ☐

Referral to Dental Care: ☐ **Not Indicated** ☐ **Routine** ☐ **Expedited**

0 - 2 Years

	Clinical Management	Oral Health Instructions
Low	☐ Oral health assessment every 6 months by primary care provider ☐ Dental care by 1 year	☐ Twice daily brushing with OTC fluoridated toothpaste the size of a grain of rice ☐ Avoid saliva sharing activities ☐ Healthy teeth for speech development and nutrition ☐ Set diet and oral hygiene self-management goals
High	☐ Oral health assessment every 6 months by primary care provider ☐ Dental care by 1 year ☐ Topical fluoride varnish every 6mos. ☐ Family dental care referral	
Extreme	☐ Oral health assessment every 3 months by primary care provider ☐ Expedited dental referral ☐ Family dental care referral ☐ PCP/Dental co-management with care coordination	

3 - 6 Years

	Clinical Management	Oral Health Instructions
Low	☐ Oral health assessment every 12 months by primary care provider ☐ Assure dental home	☐ Twice daily supervised brushing with OTC fluoridated toothpaste the size of a pea ☐ Limit carbohydrates to mealtimes ☐ Healthy teeth for speech development and nutrition ☐ Set diet and oral hy - giene self-management goals
High	☐ Oral health assessment every 6 mos. w/ dental and every 12 mos. w/ PCP ☐ Topical fluoride varnish every 6 months ☐ Fluoride rinse 2x/day for decay ☐ Prescribe antibacterial rinse to de - crease oral bacteria	
Extreme	☐ Oral health assessment every 3 mos. w/ dental and every 12 mos. w/ PCP ☐ Expedited dental referral ☐ Topical fluoride varnish every 3 mos. (PCP or Dental) ☐ Fluoride rinse 2x/day for decay ☐ Prescribe antibacterial rinse to de - crease oral bacteria ☐ PCP/Dental co-management with care coordination.	

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Primary (baby) Teeth PCOAT

(Primary Care Oral Assessment Tool- for patients age ≤ 6 years)
Mother or Caregiver Questions:

Date: _____ Patient Name: _____ Date of Birth: _____

Does your family have a dentist where you go to get your teeth cleaned and taken care of? If yes, who/where:_____		☐ Yes	☐ No	
When was the last time your child went to the dentist?	☐ N/A due to age	☐ Within the last six months	☐ More than six months ago	
Do you (parent or caregiver) have a cavity now or have you had a filling in the past three years?		☐ No	☐ Yes	
Have brothers or sisters had cavities?		☐ No	☐ Yes	
When was your child's last cavity?	☐ N/A due to age	☐ No cavities in last year	☐ Cavities in last year	
Does your child drink anything other than water in between meals?		☐ No	☐ Yes	
Does your child drink anything other than water while in bed?		☐ No	☐ Yes	
Does your child drink water with fluoride?	☐ Don't know ☐ No water at all	☐ Yes	☐ No	
How often are your child's teeth brushed with fluoride toothpaste?		☐ At least daily	☐ Less than daily	