Medical Home Telephone Conference
June 28, 2005

Lisa Samson-Fang, Dr. Duane Yamashiro director of PCMC dental program and the Lend program
Dental Issues for CSHCN and resources.

Dr. Yamashiro began with giving a brief overview of dental services in general. Dr. Yamashiro has been at PCMC for about 20 years after completing residency in 1979. He is a Pediatric Dentist and Orthodontist. He is also part of the Craniofacial Program for congenital anomalies as well as acquired problems of head and jaws.

The goal of the Pediatric dental program is to structure a layered provider network working with pediatric dentists in the community. Most services are based in the Wasatch front. There are three levels of services:

1- **Primary**: the pediatric dentist in community. Most pediatricians have a working relationship with them. No problem on Wasatch front
2- **Secondary**: the pediatric dentist on staff with either an outpatient surgical center or hospital. The hospitals are set up different. He is familiar with PCMC, AltaView and one of the residents is setting up with Dixie.
3- **Tertiary**: When you have Co-morbidity (cardiology, neurology or other similar things) they try and get this layer of patient to go to PCMC. The majority of time this is something that the pediatrician and sub-specialists following the patient agree with.

One of the problems the dentist has is having referrals done at age appropriate times. The AAPD (American Academy of Pediatric Dentists) and the AAP (American Academy of Pediatrics) have made some recommendations that are sometimes at odds as far as recommendations go and some of the concerns are addressed in the Medical Home Newsletter that Barbara Ward is sending out (see newsletter for more information).

Dr. Yamashiro asks: Has there been any concerns or comments about how the providers are accessing care at these three levels?
Lisa asks: Lets start with the first level, the pediatric dentist in the community. How many accept Medicaid and who is taking new patients? Is there somewhere where Dentists register that they take Medicaid?
Reply: Some dentists that accept Medicaid do not want to be put on a list so you can access a specific dentist. However you can go to the Utah Oral Health Program website and there you will find a list of clinics that is statewide that tells you who is taking Medicaid/Chip or donating dental services and it lists the hygiene schools. Barbara will email out the website. The next newsletter is on oral health and she will put in a handout of all the clinics.

Lisa asks; Moving to the next level if, you have pts that need sedation for procedures, besides PCMC, are there other programs that you have been accessing fairly regularly?

Replay: Dr. Tereashima indicated he usually goes through PCMC because he doesn't know of any others but would like to know if there is another referral source.

Lisa asks; Dr Yamashiro, could you remind us of other programs that could put uncomplicated kids to sleep?

By uncomplicated that means they are ASA1's and ASA2's. The ones that I am aware of are Salt Lake Surgical which can do ASA1's and some 2's and Alta View (we worked with them to set up their program). Chief of anesthesia at Alta View can handle 2's (low acuity) but anything above should go to PCMC. Southtown has facilities. That is a relatively new service so I can't comment on their abilities. (Who he relies on for information and feedback is from anesthesia or pediatric dentists going out to the facilities.) What I found is that most of the offices that have pediatric dentists who are on staff PCMC are good about doing their assessments and triages to where they take their patients for procedures. Any of the local providers that are on staff at PCMC (20) are good about triage. Outside of Salt Lake, Utah valley is set-up to do their own cases. MCDee and Ogden surgical center do low acuity cases. High 2"s and 3"s come to PCMC.

Two to three months ago we worked with the sedation team at PCM (the nurse practitioners and chief of sedation services) so we have his team doing sedation here at PCMC for patients needing sedation but at this point we are not making this available to outside providers. But for pts. referred into the hospital program they do have that option where we have the nurse practitioners or staff to do the sedations here safely. In the offices in the community they do have nurse anesthetists who do come in and provide that service for the lower acuity patients. Most of the dentists on staff at PCMC do offer that service for low acuity needs. Most pediatric dentists are in the community but also on staff at PCMC and are listed on PCMC website under the medical staff. They are active staff and some have appointments at the University.

Lisa Asks: Some may not be familiar with the terms ASA1 and ASA2. I understand that is a level of anesthesia risk. Can you give us an example of what an ASA2 and a 3 might look like?

ASA1's are usually considered your typical child. ASA2's are children with things like a ASD or VSD. When you get into children with special needs child with significant developmental delays and genetic syndromes, with heart and underlying neurological problems, then we look at a high two or three. When you talk about level 4 you are usually talking about a child that has had a bone marrow transplant. You can use the 10 foot rule to see what level a child may be

in. The 10 foot rule is when you look at a child from 10 feet away and you notice a super small jaw or a retreated face this indicates that there is a possibility the child has airway problems and you can classify them as a level 2.

Lisa asks: Then controlled asthma and minor heart defects are generally ASA 2 ?. That is correct.

Lisa asks Dr. Yamashiro: Are there times that you say to yourself that you wish pediatricians knew X about these kids or would refer them in for this or you say to yourself "I wish we could get the word out about this"?

The Pediatric community here is one of the most educated and I can only compare to those on the west coast (he trained in CA and HI). As far as recognizing oral conditions and appropriate referrals, those here are much more proactive and educated in recognizing oral conditions than the west coast. On the east coast I can only rely on conversations. A lot of the issues they are dealing with, we don't have here. I can't speak to why this community is proactive, only make some conjectures one of them being Karen Ortiz, Karen Buchi and Lisa being involved in a resident level which exposes them to looking at the oral cavity. In Iowa pediatricians also have a good handle on that probably because of the relationship their pediatricians have with the University. Dr. Clark commented on that.

One of areas that could be improved is when a child has a transplant or chemotherapy or something similar. What we find is that there is reasonably significant dental disease to the point where it would compromise the overall health of a child with a suppressed or absent immune system. For those populations it would be best that the pediatrician refers the child to a Pediatric Dental Specialist rather than a regular dentist to rule out any kind of pathology before chemotherapy. This would prevent their acuity from being bumped up and having their care provided in a hospital as opposed to having their prep done in the community close to home and having someone who is familiar with their case.

Another area is the airway kids. Over the years more children are being seen with skeletal involvement; micronathy, children with small jaws or midface involvement. Typically these are the kids with chromosome abnormalities where the airway is compromised because of small bones, These referrals are typically made by the pediatrician's office. Down syndrome is well recognized and that is something we see on a regular basis. We are talking about kids with distinctive facies. We look at these children and say "something is small or something is not quite right" Children with facial asymmetry are usually referred by the pediatrician's office rather than another dentist. (He thinks it is because they are seeing the kids younger than the other dental providers.)
A lot of these children are watch and see cases; however, a small percentage of them can be helped with a small procedure while they are young rather than

having a larger procedure done on them when they are in their teens. We are seeing a big difference in how their face looks when they become a teenager requiring some reconstruction but by starting early we can use newer procedures causing less morbidity than the traditional wait and fix procedures.

Pediatricians seem to be doing a good job of picking up early childhood caries and bottle mouth that is probably one of the more fixable problems. Oral surgery at primary is good with problems such as teeth knocked out so residents coming through here are good about knowing how to handle those types of things.

The question was asked if a child comes in with a weak jaw, how do you know if you need to refer the child? First look at things like soft tissues, if they have 3 plus tonsils (if they stick their tongue out and the tonsils are not quite touching or are touching), if the child snores at night, restless sleep, night terrors, bedwetting, etc. Then check for daytime alertness, if the child falls asleep at school, etc… Looking at all of this can help you make an appropriate referral or raise a red flag for a kid at risk for an airway obstruction. The typical kid that we see will have a very small jaw or have an increase in secretions that look like they have a weak jaw but there is some soft tissue component or they have a soft palate. To examine them hold the kid upside down on your lap with the legs in the caregivers lap and look. In addition to looking inside their mouth, listen to their airway and if the kids sound a little loud or moist ,if the kids are gagging and their soft palate just stays there flaccid, those are the pickups that I start asking questions. Listening to the airway can also help determine appropriate referrals.

What if the child is unfunded where can they get care? What is current status of Primary Pennies?

That could be a huge topic for another call. Medicaid access is a problem and the pediatric dentists that I know of do take Medicaid up to age 5 and that just has to do with taking care of young kids with no other resource or safety net. Primary Pennies has become a little more restrictive. If the services are available in other areas such as third world countries or out of state they want those kids to get service there. If they absolutely cannot access services there, then they can come here. We do a fair number of primary service cases and we walk a fine line between turning away kids that really need care but could be served in other areas and that's very uncomfortable sometimes. But they can apply and if they don't qualify other resources such as church charities. We have had radio stations pick up services but that is certainly a challenge. I would say that between Medicaid and Primary services the majority do access care. These are for the young children with special needs or co-morbid medical conditions. In the newsletter that is coming out there are other resources you can access.
Both the minutes and the newsletter will be posted on the web.
How to access Dr. Yamashiro 588-3620

Next Phone Conference: Tuesday July 26, 2005, Jocelyn Taylor State Office of Education to talk about what services the school system has to offer particularly children with autism.

Attendees: Lisa Samson-Fang, Barbara Ward, Grace Baugh, Mary, Lisa Lee, Chuck Norlin, Diane Behl, Robert Terashima, Val Jones, Donna, Fred, Lois, Duane Yamashiro.

(Transcript was edited for readability).