Competency Assessment Checklist for Provider Staff Performing Well-Child Screenings

Health Plan of San Joaquin

Mountain Valley Health Plan

TOPICAL FLUORIDE/DENTAL SCREENING

	COMPETENCY	MET	NOT MET
I. KNOWLEDGE			
1.	Describes the importance of Fluoride varnish application.	☐	☐
2.	Enumerates some risk factors for developing dental cavities.	☐	☐
3.	Verbalizes frequency of Fluoride application per AAP guidelines.	☐	☐
4.	Enumerates the contraindications for Fluoride varnish application.	☐	☐
II. SKILLS			
A. Pre Fluoride Application			
1.	Prepares the materials needed (paper gauze, towel, trash can, and fluoride packet).	☐	☐
2.	Explains the procedure to the patient.	☐	☐
B. Actual Fluoride Varnish Application			
1.	Positions the patient on the exam table/chair or allow the child to stand depending on patient's ability to cooperate with the procedure.	☐	☐
2.	Tilts the patient's head.	☐	☐
3.	Dries teeth (use cotton 2x2 or 4x4).	☐	☐
4.	Paints biting/outside surfaces of lower teeth first.	☐	☐
5.	Repeats on upper arch.	☐	☐
6.	Allows the patient to spit.	☐	☐
C. Post Fluoride Varnish Application			
1.	Provides instructions to avoid foods or drinks that can rub, pull, or melt fluoride off the teeth three to four hours after application.	☐	☐
2.	May skip brushing the night of the application but will need to brush the teeth the following morning.	☐	☐
3.	Reminds the patient to follow up with the provider/dentist after three to six months for reapplication or as instructed.	☐	☐

D. DOCUMENTATION			
1.	Documents in the patient's chart the following risk factors: a. Dental home and last dental check up b. Last fluoride varnish application c. If taking any fluoride products (supplements, toothpaste, water, etc.) d. Other risk factors or dental issues	☐	☐
2.	Documents in the chart the fluoride varnish application and any instructions given to the patient.	☐	☐
3.	Documents any patient/parent refusal for varnish application.	☐	☐
		TOTAL ITEMS MET:	
		Total Possible Points:	18 points
		Passing Score (80%):	14 points

*If score is below 14, please review the training module and retest.**

Name: _____ **Designation:** _____

Email of Employee: _____

Date of Evaluation: _____

Name of Evaluator: _____ **Designation:** _____

Signature of Evaluator: _____

Email of Evaluator: _____

INSTRUCTIONS FOR SUBMISSION

1. If you have completed the CHILD training module on Topical Fluoride/Dental Screening, kindly have your **Clinical office manager/trainer/provider** or designee complete this checklist with you.
2. Once required score is met, the office manager/trainer/provider or designee will upload the checklist via the CHILD attestation page: 

   The completed checklist can also be sent directly to the FSR team at **fsrteam@hpsj.com**.
3. Once verified by the FSR Team, you will be issued a certificate of completion. The certificate of completion will be **valid for 4 years** unless revoked by the health plan.

For any questions or assistance needed, please reach out to the health plan's FSR team at **fsrteam@hpsj.com**.