Connecticut Dental Health Partnership

Children's Oral Health Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Periodicity Schedule

The Connecticut Department of Social Services HUSKY Health dental program, known as the Connecticut Dental Health Partnership, follows the American Academy of Pediatric Dentistry's guidelines for periodicity of examination and preventive dental services, anticipatory guidance and treatment for infants, children, teenagers and young adults up to the age of twenty-one. Continuity of care is based upon each child's unique needs and should be performed at an established dental home. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal.

	6 - 12 Months	12 - 24 Months	2 - 6 Years	6 - 12 Years	12 - <21 Years
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and Topical Fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance / counseling [6]	•	•	•	•	•
Oral Hygiene Counseling [3,7]	Parent	Parent	Patient / Parent	Patient / Parent	Patient
Dietary Counseling [3,8]	•	•	•	•	•
Counseling for nonnutritive oral habits [9]	•	•	•	•	•
Injury prevention and safety counseling [10]	•	•	•	•	•
Assess speech / language development [11]	•	•	•		
Assessment developing occlusion [12]			•	•	•
Assessment for pit and fissure sealants [13]			•	•	•
Periodontal risk assessment [3, 14]			•	•	•
Counseling for tobacco, vaping and substance misuse				•	•
Counseling for human papilloma virus / vaccine				•	•
Provide counseling on intraoral piercings				•	•
Assess third molars					•
Transition to adult dental care					•

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status / susceptability to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, types and frequency determined by child's history, clinical findings, and susceptability to oral disease.
5. Consider when systematic fluoride exposure is suboptimal. Up to at least 16 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent, as child matures, jointly with the parent, then, when indicated, only child
8. At every appointment, initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age 2.
9. At first, discuss the need for nonnutritive sucking: digits vs. pacifiers; then the need to wean from the habit malloclusion or deleterious effect on the dentofacial complex occurs. For school aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching or bruxism.
10. Initially, pacifiers, car seats, play objects, electric cords, secondhand smoke, when learning to walk, with sports and routine playing, including the importance of mouthguards, then motor vehicles and high-speed activities.
11. Observation for age appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.
12. Identify, transverse, vertical and sagittal growth patterns; asymmetry; occusal disharmonies; functional status including temporomandibular joint dysfuntion (TMD), esthetic influences on self-image and emotional development
13. For caries susceptible primary molars, permanent molars, premolars and anterior teeth with deep pits and fissures, placed as soon as possible after eruption.
14. Periodontal probing should be added to the risk assessment process after the eruption of the first permanent molars.