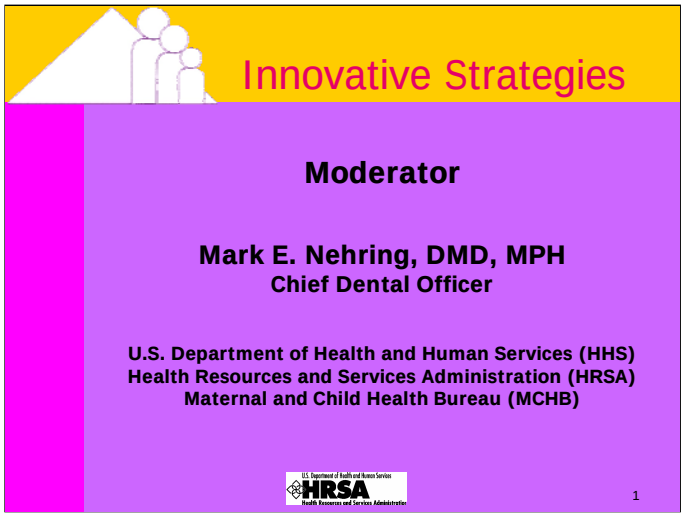


I am Mark Nehring, the Maternal and Child Health Bureau's Chief Dental Officer within the U.S. Department of Health and Human Services', Health Resources and Services Administration.

Before we get started, let me describe the ways you can use your computer interface during this webcast:

- Slides will appear in the central window on your screen and will advance automatically. The slide changes are synchronized with the speakers' presentations, so that you do not need to do anything to advance them, although you may need to adjust the timing of the slide changes to match the audio – you can do this by using the "Slide Delay" control at the top of the messaging window.
- We encourage you to pose questions for the speakers at any time during the presentation… simply type your question in the white message window on the right of the interface, select "Question for Speaker" from the drop-down menu and hit "Send." Please include your state or organization in your message so we will know from where you are participating. If time allows, the speakers will address your questions near the end of the webcast, but if there isn't sufficient time, an email response will be sent to you after the webcast. Again, we encourage you to submit questions at any time during the broadcast.
- On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider, which you can access by clicking on the loudspeaker icon.
- Those of you who selected "Accessibility Features" when you registered will see text captioning underneath the video window.
- At the end of the broadcast, the interface will close automatically and you will have the opportunity to fill out an online evaluation. Please take a couple of minutes to do so, since your responses will help us plan future broadcasts and improve our technical support.

Our webcast today will focus on projects from two grantees who are part of a larger collaborative program among several national professional membership organizations, funded by the Maternal and Child Health Bureau, both of whom are working to address oral health issues related to children and families.

These two organizations:

The American Academy of Pediatric Dentistry, and

The American Academy of Pediatrics…

participate in the Alliance for Information on MCH, the AIM Program, which is a collaborative of Maternal and Child Health Bureau Grantees.

AIM grantees are all national membership organizations representing professionals responsible for making decisions affecting the health of women, children and families. Together they include organizations of:

state and local government officials,

MCH professionals,

foundations,

legal professionals,

the health insurance industry, and

large businesses, as well as

family advocates

The purpose of the individual projects from these two grantees is to promote a two-way communication by:

- making new research findings and policy information accessible to professionals to help them make clearly-informed decisions affecting public health policies and programs for women, children and families, and
- creating a channel for professionals in the field to alert the Bureau to emerging concerns and issues they are facing

Beyond the value of the individual grants, there's an added value that comes from convening all the organizational representatives twice yearly, providing opportunities for the 16 member organizations having very different perspectives, to share expertise and concerns, and also to educate one another, as well as the Bureau, about emerging issues and promising MCH practices.

As you read the project titles from our two presenters today, you may be thinking that we mistakenly switched the titles… traditional oral health providers within dentistry talking about oral health as an integral part of pregnancy and infants, and physicians apparently taking on oral health outside the dental clinic...?? These projects are, in part, a response to a persistent health need and seen recently as an increase in oral disease in children under the age of 5. The projects are in keeping with MCHB's interest to integrate oral health into existing systems of care so that various access points for oral health services can be made available. As we come to better understand oral health as an overall health issue… that is, recognizing the infectious nature of oral disease, its systemic consequences, the need to intervene at the earliest of opportunities and to integrate existing systems of care... We begin to understand why AAPD and AAP are addressing the issue of comprehensive health from each of their unique perspectives with the purpose of improving access to oral health care even though we face looming challenges surrounding workforce, geography and the influence of poverty.

We will begin with Ms. Jessie Buerlein, Project Manager for the AAPD project "Improving Perinatal and Infant Oral Health. Following her presentation, Dr. Suzanne Boulter, a practicing pediatrician in New Hampshire and chair of AAP's Oral Health Initiative will describe AAP's work in oral health. Following both presentations, I will return for a question and answer period. Ms. Buerlein…

Improving Perinatal and Infant Oral Health

American Academy of Pediatric Dentistry and Children's Dental Health Project

Jessie Buerlein, MSW
Project Manager
April 16, 2009

Why is Perinatal Oral Health Important?

- Oral health is key to overall health and wellbeing
- Pregnancy increases women's risk for oral infections
- Research exhibits associations between periodontal disease and birth outcomes
- Perinatal oral health contributes to establishing good oral health for children

Oral health is a key component of overall health and wellbeing for women across the lifespan.

The physiological changes that occur during pregnancy may increase susceptibility to oral infections such as periodontal disease, and hinder the body's ability to repair and maintain soft tissues in the mouth-during pregnancy, inflammation of the gums or "pregnancy gingivitis" occurs in many women.

Studies show an association between periodontal disease and adverse birth outcomes, such as low birth weight, preterm birth, and gestational diabetes. While more research is pending to confirm these associations, the safety and importance of oral health care for the woman herself remains a key factor in achieving overall health and wellbeing.

Transmission of caries-causing bacteria from mother-to-child is the primary vehicle through which children first acquire the disease that causes cavities. The healthier the mother's mouth, and the longer the initial transmission of bacteria is delayed, the more likely children are to establish and maintain good oral health.

Pregnancy is an opportune time to educate women on proper oral health behaviors, nutrition, and hygiene, both for themselves and their children.

Significance

Dental care during pregnancy is important in order to:

- prevent periodontal disease
- manage tooth decay
- decrease risk of poor birth outcomes
- decrease risk of pre-eclampsia
- delay transmission of maternal oral bacteria to the infant

Definition of perinatal dental care:

The provision of oral health care and anticipatory guidance for pregnant women, mothers and infants in a coordinated, continuous fashion to promote oral and systemic health.

Prevalence

- National survey findings among 20-34 year old persons (NHANES 1999-2004):
  - Untreated caries 28%
  - Periodontal disease 4%
- Periodontal disease can be detected in 37-46% of women of reproductive age, and in up to 30% of pregnant women

Source: Kumar J, Samelson R, eds. 2006. *Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines.* Albany, NY: New York State Department of Health. http://www.health.state.ny.us/publications/0824.pdf

Perinatal Dental Care: Barriers

- Lack of national guidelines on perinatal oral health
- Reluctance among providers to treat and refer pregnant women
- Lack of awareness of relationship of oral to overall health
- Concern over safety of dental x-rays, materials, and medications during pregnancy
- Perception of oral health as unimportant or unattainable

Health professionals mat be hesitant to refer or treat pregnant women, due to inadequate training and/or concerns for liability and safety issues.

Cultural influences, prior experiences with oral health, insurance coverage, economic challenges and other factors can all impact the relevant importance place on oral health in general, and on seeking dental care during pregnancy specifically.

Do pregnant women access oral health treatment?

Dental Care

- In the US, nearly one in five women do not visit the dentist during the year before they become pregnant
- In a 2004 study, 22% of women reported that they had never accessed oral health before pregnancy
- Same 2004 study found that less than one third (30%) of women visited a dentist in the 2-9 months following the birth of their infants

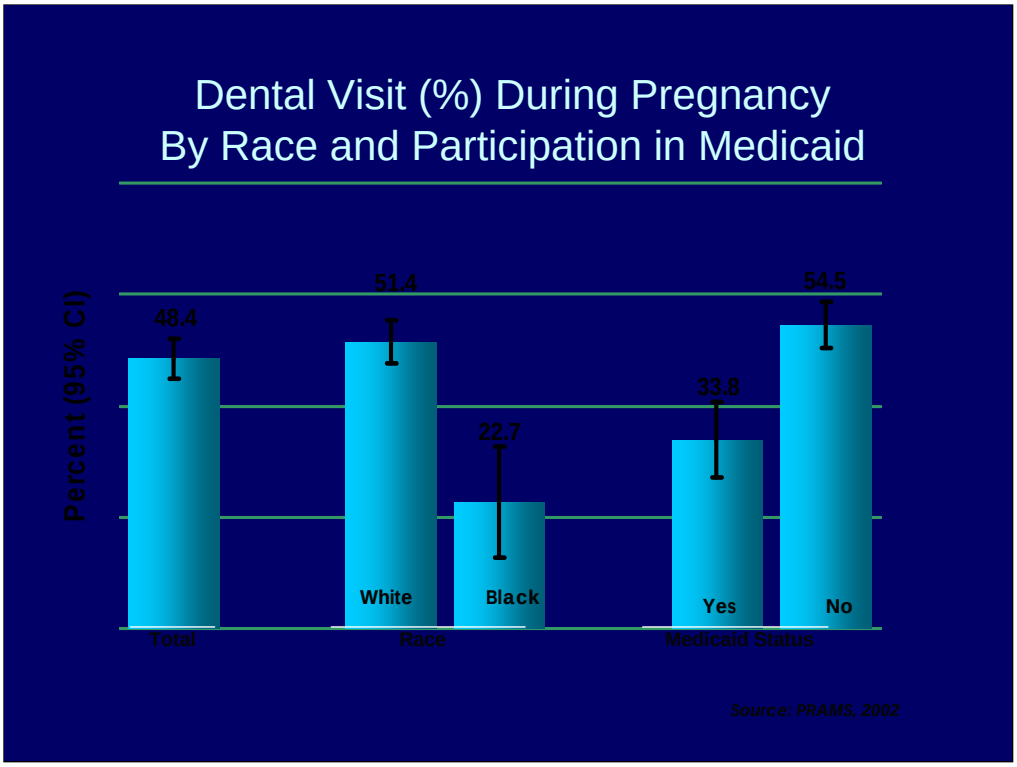
Source: D'Angelo D, Williams L, Morrow B, Cox S, Harris N, Harrison L, Posner SF, Hood JR, Zapata L. 2007. Preconception and interconception health status of women who recently gave birth to a live-born infant—Pregnancy Risk Assessment Monitoring System (PRAMS), United States, 26 Reporting Areas, 2004. Morbidity and Mortality Weekly Report Surveillance Summaries 56(SS-10):1–35. http:/www.cdc.gov/MMWR/preview/mmwrhtml/ss5610a1.htm

Dental Care

- Among pregnant women who report having oral problems, only about half seek oral health care.
- 1991 study provided free dental care to pregnant women to rule out costs of dental care:
  - 39% did not visit dentist
  - Reason for non-attendance: mothers ‘did not feel it necessary’ to visit a dentist during pregnancy

Rogers, SN. Dental attendance in a sample of pregnant women in Birmingham, UK. Community Dental Health 1991; 8(4): 361-8.

This study found that although the majority of mothers (95.5%) were aware that dental care was free, the high non-attendance rate was because mothers ‘did not feel it necessary’ to visit. Therefore the removal of the financial deterrent did little to promote dental attendance during pregnancy.



Studies indicate that some groups of women are significantly less likely to access oral health care during pregnancy than others. Women who have low incomes, belong to racial or ethnic minority groups, or participate in Medicaid are half as likely to receive oral health care while pregnant compared with women who have higher incomes, are white, or are privately insured.

Gaffield ML, Gilbert BJ, Malvitz DM, Romaguera R. 2001. Oral health during pregnancy: An analysis of information

collected by the pregnancy risk assessment monitoring system. *Journal of the American Dental Association* 132(7):1009–1016.

Idaho Department of Health and Welfare. 2005. *Dental Care During Pregnancy: 2005 Idaho Pregnancy Risk Assessment Tracking System.* Boise, ID: Idaho Department of Health and Welfare.

Barak S, Oettinger-Barak O, Oettinger M, Machtei EE, Peled M, Ohel G. 2003. Common oral manifestations

during pregnancy: A review. *Obstetrical and Gynecological Survey* 58(9): 624–628.

Are providers aware of the importance and safety of oral health care during pregnancy?

Dental Providers

1994 survey of general dental practitioners (Shrout et al.):

- 12%: routine care should not be provided during pregnancy
- 81% did not expose pregnant patients to radiographs
- Majority excluded routine care during first trimester

2009 survey of general dentists in Oregon (Huebner et al.):

- Most respondents (91.7 %) agreed that dental treatment should be part of prenatal care
- 2/3 of respondents (67.7%) were interested in receiving continuing dental education (CDE) regarding care for pregnant patients
- Comparisons of self-reported knowledge with professional guidelines revealed several points of difference
- Conclusion: dentists need education to provide up-to-date preventive and curative care to pregnant patients. Specific skills and misinformation could be addressed through CDE.

Shrout MK, Potter BJ, Comer RW, Powell BJ. Treatment of the pregnant dental patient: a survey of general dental practitioners. Gen Dent. 1994 Mar-Apr;42(2):164-7.

Huebner CE, Milgrom P, Conrad D, Lee RS. Providing dental care to pregnant patients: a survey of Oregon general dentists. J Am Dent Assoc. 2009 Feb;140(2):211-22.

Survey of obstetricians

Survey of obstetricians in Ohio revealed that a small number integrated oral health into practice:

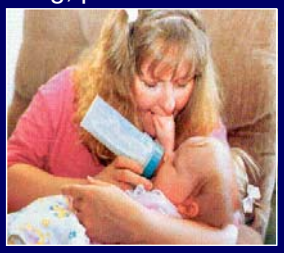
- 29% performed a visual mouth inspection during prenatal care
- 20% used oral health screening questions
- 6% referred patients to a dentist
- BUT 64% agreed that oral health screening should be part of prenatal care

Source: Access to Oral Health Care During the Perinatal Period. A Policy Brief

How does perinatal oral health impact infant oral health?

Transmission from Caregivers

- Dental caries is an infectious, transmissible disease process established by age 2
- Dental caries is *initiated* by bacteria transmitted through saliva from caregiver to child (spoon sharing, pacifier cleaning, hand-in-mouth)
- Degree of transmission varies by several factors (level of bacteria, frequency of exposure, etc.)



- The earlier the caries process is initiated, typically the more severe and rapidly progressing it will be

The primary goal of perinatal oral health care, with regard to caries transmission, is to lower the numbers of cariogenic bacteria in an expectant mother's mouth so that colonization of Mutans Streptococci (MS) in the infant can be delayed as long as possible.

Impact of Mothers' Oral Health

- Periodontal disease is associated with adverse birth outcomes: preterm birth, low birth weight, and gestational diabetes
- Children whose mothers have poor oral health are 5 times more likely to have oral health problems
- Children whose mothers have poor oral health are at greater risk for having oral infections at young ages and for developing dental caries

Source: Access to Oral Health Care During the Perinatal Period. A Policy Brief

Advancements in Perinatal Oral Health

- Increased awareness of the link between oral and systemic health, and the role of pregnancy
- Evidence has emerged documenting an association between periodontal disease and adverse pregnancy outcomes, including preterm birth and low birth weight in infants
- Research has also confirmed the safety of oral health care during the perinatal period

Research on the association between periodontal disease and preterm birth has not established a direct cause-effect relationship. Most of the peer reviewed evidence to date, however, does indicate that there is an association between poor periodontal health and adverse birth outcomes. It is important to remember that there is no known downside risk to addressing inflammatory periodontal disease in pregnant women, while there is potentially tremendous upside benefit to addressing this association. Studies show that periodontal therapy during pregnancy is not only safe, but may also improve pregnancy outcomes. Research suggests that preventing periodontal disease, even in healthy individuals, may improve pregnancy outcomes.

The safety of dental care during pregnancy is scientifically accepted, and increasing numbers of research efforts have confirmed the safety of accessing care during pregnancy.

Program and Policy Developments

- Perinatal professional guidance: ADA, AAP, ACOG, AAPD, Bright Futures
- 2006 New York State Guidelines
- 2006 and 2008 MCHB-sponsored perinatal oral health forums
- 2007 Maternal and Child Health Bureau Perinatal Oral Health Workgroup
- National Maternal and Child Oral Health Resource Center materials

The American Dental Association, the American Academy of Periodontology, the American College of Obstetricians and Gynecologists, and AAPD have issued statements and recommendations for improving perinatal oral health.

2006: MCHB sponsored the Research to Policy and Practice Forum: Periodontal Health and Birth Outcomes- a meeting of maternal, child, and oral health experts to address the role of perinatal oral health in improving maternal and infant health.

2008: Improving Perinatal Oral Health: Moving Forward- MCHB sponsored this meeting to build partnerships to improve the oral health status of pregnant women- to identify areas of collaboration and discuss innovative approaches.

New York State Guidelines

- New York State Department of Health, 2006: *Oral Health Care During Pregnancy and Early Childhood Practice Guidelines*- only state-level guidelines
- Recommendations for prenatal, oral health, and child health professionals
- To facilitate change in the health care delivery system and improve standards of care
  http://www.health.state.ny.us/prevention/dental/oral_health_care_pregnancy_early_childhood.htm

In 2006 the New York State Department of Health convened an expert panel of health professionals to review literature, identify existing guidelines, practices, and interventions, assess issues of concern, and develop recommendations – these guidelines provide general guidance for the purpose of bringing about changes in the health care delivery system and improving the overall standard of care, and are currently the only state-level clinical guidelines for perinatal and early childhood oral health.

AAPD Improving Perinatal and Infant Oral Health Project

Goals:

- Expand availability of prenatal oral health care
- Expand availability of infant oral health care
- Raise awareness regarding dental care for pregnant women and infants

Improving Perinatal and Infant Oral Health Activities

- Communication:
  - -to AAPD membership through Pediatric Dentistry Today
  - -to parents and the public through nontraditional partnerships
  - -to policymakers
- Education:
  - - to providers through dissemination of NY, MCHB, and AAPD perinatal guidelines
  - - promoting inclusion of perinatal and infant oral health in dental education and training curricula
  - - to caregivers and maternal and child health audiences
  - -through the TEACH program
  - - through consumer documents
- Training:
  - - committee members provide professional trainings to pediatric and general dentist audiences

The TEACH program is collaborative effort of Healthy Smiles, Healthy Children, the Foundation of AAPD, and Henry Schein, Inc. The study investigated whether incorporating oral health kits into provider interactions with parents would increase providers' awareness of early childhood oral health, likelihood of adopting oral health counseling as part of subsequent well-child visits, and perception that the intervention will positively affect caregivers' oral health behavior for themselves and their children.

Activities

- Incorporation of oral health into AIM partner initiatives, including the American Bar Association and the National Business Group on Health
- Pre-doctoral dental school survey of infant and toddler oral health curricula
- Research and education on expanded coverage of oral health care for pregnant women
- Parent education events- including the House and Senate Child Care Centers
- MCHB Perinatal Oral Health Workgroup

MCHB Perinatal Oral Health Workgroup

- Health Resources and Services Administrations' Maternal and Child Health Bureau (chair)
- Health Resources and Services Administrations' Office of Women's Health
- Altarum Institute
- American Academy of Pediatric Dentistry
- American College of Obstetricians and Gynecologists
- American Dental Association
- American Dental Education Association
- Association of Maternal and Child Health Programs
- Children's Dental Health Project
- National Maternal and Child Oral Health Resource Center
- National Oral Health Policy Center
- University of California at Los Angeles

Pregnancy and Oral Health Workgroup Strategies

- Conduct environmental scan of materials for health professionals and consumers and develop resources for providers, policymakers, and the public
- Promote guidelines and other materials
- Expand education of health professionals
- Integrate perinatal health and oral health (education, referral, and follow-up as part of routine perinatal care)
- Educate women and their families
- Improve financing of perinatal oral health care

Oral Health Care During Pregnancy
A Summary of Practice Guidelines

- Summarizes the New York Department of Health's publication, *Oral Health Care During Pregnancy and Early Childhood Practice Guidelines*
- Intended to improve the standard of care for pregnant women
- Explains why oral health care during pregnancy is important

Provides information for all health professionals, prenatal care professionals, and oral health professionals.

Offers guidance to share with families during pregnancy and postpartum.

Oral Health Care During Pregnancy
A Summary of Practice Guidelines

Role of all health professionals:

- Explain why oral health care during pregnancy is important
- Explain that oral health care during pregnancy is safe and effective
- Inform that diagnosis (including necessary dental X-rays) and treatment are safe during the first trimester of pregnancy
- Inform women that treatment can be provided throughout pregnancy, however 14th – 20th week of pregnancy is best
- Advise that delaying treatment could result in risk to the mother and indirectly to the fetus

Additionally, the guidelines encourage all health professionals to: provide information about oral hygiene and oral health care by including topics in prenatal classes, provide a list of dentists in the community, and to provide referrals as needed.

Oral Health Care During Pregnancy
A Summary of Practice Guidelines

Role of prenatal health professionals:

- Assess pregnant women's oral health status
- Integrate oral health topics into prenatal care classes
- Make available educational materials that are written at appropriate reading levels
- Counsel women to adhere to their dentist's recommendations for treatment or follow-up

Oral Health Care During Pregnancy
A Summary of Practice Guidelines

Role of oral health professionals:

- Improve access to oral health services
- Conduct a health history, risk assessment, and oral examination
- Use when clinically indicated: X-rays, local anesthetic with epinephrine, appropriate analgesics and/or antibiotics, and dental amalgam
- Assist pregnant women with disease management

Oral Health Care During Pregnancy
A Summary of Practice Guidelines

Guidance to share with families (during pregnancy):

- Brush teeth with fluoridated toothpaste twice a day, and floss once a day
- Limit foods containing sugar to mealtimes only
- Drink water or milk. Avoid carbonated beverages (pop or soda).
- Obtain necessary oral treatment before delivery

This document was disseminated by the National Maternal and Child Oral Health Resource Center to:

national, regional, and state provider organizations; MCHB-funded grantees; universities; local programs; Head Start grantees; and others.

This document was written by Jayanth Kumar and Hiroko Iida of the New York Department of Health, coordinated by the Children's Dental Health Project, and produced by the National Maternal and Child Oral Health Resource Center. It is available from the National Maternal and Child Oral Health Resource Center at: http://www.mchoralhealth.org/

Coming soon: AAPD Guideline on Perinatal Oral Health Care

Proposes recommendations for perinatal oral healthcare, including:

- caries risk assessment
- anticipatory guidance
- preventive strategies
- appropriate therapeutic interventions

These guidelines are intended to provide clinical information to stakeholders in perinatal and pediatric oral health. They will be available after May 2009 at AAPD's website: www.aapd.org.

Proposed outcomes

- Increased knowledge among prenatal and oral health providers
- Increased coordination and referrals among providers
- Increased awareness among pregnant women and demand for care
- Increased access to, utilization, and quality of dental care during pregnancy

The guidelines will assist health professionals in working as a team to improve quality of care provided to pregnant women. Ideally, these efforts will result in improved health outcomes for women.

Infant Oral Health

Promoting Simultaneous Approaches:

- Access to systems of care: the dental home and the age one dental visit
- Individual and family behaviors

Early Childhood is:

A time of significant growth and development

A time for functional capacity development

A key period for building the cornerstone for lifelong health and wellbeing

This period is as important for the mouth as for other parts of the body

Dental care during infancy is important for several reasons:

Dental disease can be consequential to growth, function, learning, and self image

Dental pain inhibits eating, speaking, and distracts children from learning

The disease process that leads to cavities is typically established by age 2

Dental caries is progressive and infectious, but it is preventable

CDC reports that for the period of 1999-2004, 28% of 2-5 year olds had visible caries experience. This represents a 15 percent increase among U.S. toddlers and preschoolers over the period 1988-1994, indicating that more than one in four pre-school age children have experienced the disease. An estimated 1.12 million preschoolers have visible signs of ECC experience. The study also found that 74 percent of young children – an estimated 840,000 children- who have experienced tooth decay are in need of dental repair (Centers for Disease Control and Prevention. National Health and Nutrition Examination Survey. Dental examiners procedure manual. Accessed 9/15/08 at: http://www.cdc.gov/ nchs/data/nhanes/oh-e.pdf).

Data from the National Health and Nutrition Examination Survey reveals the progression of caries experience by age, as 1-in-10 two year olds are reported to have cavities, growing to 2-in-5 among children of age five. (Hiroko L, Auinger P, Billings R, Witzman M. Association between infant breastfeeding and early childhood caries in the United States. Pediatrics 2007; 120(4): 944-952).

Individual and Family Behaviors

- Fluoride exposure (in water, toothpaste, supplements)
- Oral hygiene (to reduce transmission from caregiver; appropriate brushing for infants and children)
- Nutrition (healthy, balanced diet with calcium-rich foods)
- Eating habits (bottle and sippy cup use, frequency of snacking, exposure to sugar)

Risk for early childhood caries (ECC) increases with the frequency of sugar-containing diet exposures that a young child experiences throughout the day and night. The caries process, once initiated after acquisition of cariogenic bacteria, is stimulated and exacerbated by the frequency of sugar exposure.

As with other forms of caries, ECC is modulated by the presence of frequent low-levels of topical fluorides which reduce mutans acid production, secondarily disrupt plaque integrity, stabilize enamel crystals, and promote remineralization of caries-damaged enamel.

Promoting a *Dental Home for all children*

- The dental home is a source for accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent care

The dental home provides a place for regular care and prevention, a place for parents to turn to in emergencies, and a place for questions, that is accepting of child and family special needs and allows for the development of a relationship before painful procedures are needed.

Nowak, AJ and Casamassimo, PS. The dental home: A primary care oral health concept. JADA 2002; 133: 93-98.

Evidence supports the advantages of receiving early professional dental care and intervention that are complemented by anticipatory guidance for parents, as well as periodic supervision visits based on the child's risk of dental disease. The dental home embraces the importance of early intervention with optimal preventive strategies chosen based on the risk of the patient and would encourage the first dental visit by approximately 1 year of age. An important feature of a dental home is to provide anticipatory guidance to the parents so

that they are aware of their children's growth and development, as well as possible risk factors that occur as children age.

Professional Guidelines: Age One Visit

- The American Academy of Pediatrics, American Dental Association, American Academy of Pediatric Dentistry, American Academy of Family Physicians, Bright Futures, and numerous other children's health organizations recommend establishment of the dental home by one year of age.

Tooth decay in the primary teeth is the most reliable predictor of caries in permanent teeth. An eight-year study of children ages 3-5 found that children having tooth decay in their primary teeth were three times more likely to develop decay in their permanent teeth (Li Y, Wang W. Predicting caries in permanent teeth from caries in primary teeth: An eight year cohort study. Journal of Dental Research 2002; 81: 561-6).

Failure to prevent early childhood caries has long-term consequences that can be costly in terms of disease progression and function. It can also be costly in terms of dollars. The cost of preventive dental care is low compared to treatment once the disease is established.

Low-income children who have their first preventive dental visit by age one are not only less likely to have subsequent restorative or emergency room visits, but their average dentally related costs are almost 40% lower ($263 compared to $447) over a five year period than children who receive their first preventive visit after age one (Savage MF, Lee JY, Kotch JB, Vann WF. Early preventive dental visits: Effects on subsequent utilization and costs. Pediatrics 2004; 114(4): 418-423).

Key Project Activities

- Trainings to pediatric dentists and general dentists on treating infants and young children, and on the importance of perinatal oral health
- Training and education to health professionals and child care providers on preventing and managing dental disease in infants
- Promoting the dental home and age one dental visit to the public
- Promoting awareness of the infectious and preventable nature of dental caries to the public

Survey of general and pediatric dentists and pediatricians in VA found:

100% of pediatric dentists treated infants and were more likely to recommend age one visit

45% of general dentists treated infants, and only 12% referred for age one visit Source: Brickhouse, TH, Unkel JH, Kancitis I, Best AM, Davis RD. Infant oral health care: a survey of general dentists, pediatric dentists, and pediatricians in Virginia. Pediatric Dentistry 2008; 30(2): 147-53.

Collaborative Activities

- National Healthy Start Association
- Parents Magazine
- ASTDD- Best Practices Project
- American Bar Association
- Pediatric Dentistry Today
- Family Voices
- MCHB
- House and Senate Child Care Centers
- Today's Child Magazine
- National Maternal and Child Oral Health Resource Center

Coming Soon- ASTDD's Best Practices report on Early Childhood Oral Health, to be released late 2009/early 2010.

ASTDD Proven and Promising Best Practices for State and Community Oral Health Programs:
http://www.astdd.org/index.php

Take Home Messages

- Dental caries is infectious and transmissible, but preventable
- Primary prevention: pregnant women
- Early risk assessment: infants
- Importance of educating caregivers on prevention and disease management

This Project addresses the need to intervene at the earliest opportunity, with a priority on prevention of dental caries, and promotes the integration of existing systems of care. It reflects a growing recognition of the importance of addressing oral health for the family, and the inability to separate perinatal health from infant and family health.

AAPD Committee on Perinatal and Infant Oral Health

- Ned L. Savide, DDS, Chair
- Paul Casamassimo, DDS, MS
- Yasmi Crystal, DDS
- Sara Filstrup, DDS
- Mike Ignelzi, DDS, PhD, PA
- Jessica Lee, DDS, MPH, PhD
- ManWai Ng, DDS, MPH
- Rocio Quinonez, DMD, MS, MPH
- Francisco Ramos-Gomez, DDS, MS, MPH
- John Rutkauskas, DDS, MBA, CAE
- Burton Edelstein, DDS, MPH
- Jan Connelly, MSW
- Scott Litch, Esquire, CAE

Thank you!

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The Oral Health Initiative (OHI) began at the American Academy of Pediatrics (AAP) in 2001 in response to the Surgeon General's Report on the State of Oral Health in America.

With funding from the federal Maternal and Child Health Bureau (MCHB) the Partnership to Reduce Oral Health Disparities in Early Childhood (PROHD) program was established. The project works to address children's oral health issues through the development of training materials, providing communication outlets related to pediatric oral health, and developing educational programs.

Dr Boulter is chair of the OHI Steering Committee which is composed of pediatricians and pediatric dentists who have a particular interest in identifying and developing tools to support the promotion of good oral health among children and their families. The group has been focusing on the development of training materials to support pediatric health care professionals in assessing the oral health risks of their patients (eg presentations, tool kit), providing communication outlets (eg listserv®, Web site) related to pediatric oral health, and developing educational programs to promote an understanding of oral health issues for children.

Because pediatricians and other child health professionals are far more likely to encounter new mothers and infants than are dentists, it is essential that they be aware of the infectious pathophysiology and associated risk factors of early childhood dental caries to make appropriate decisions regarding timely and effective intervention. Dental decay can be well advanced by 3 years of age.

- Seeing children early and regularly: Pediatricians and other child health professionals can have a major impact on health outcomes for children because of the opportunities provided by early intervention. When tracking immunization rates data suppports that 74% of poor children 19-35 months of age received all immunization. In addition, we know that 89% of poor children have a usual source of care.
- Being experts in prevention: Prevention is an essential part of pediatric care. Pediatricians already provide anticipatory guidance in many areas related to oral health: diet, feeding habits, fluoride supplementation, and injury prevention. In addition, pediatricians can identify early oral disease, provide preventive measures, and refer children to a dental home for further monitoring and care.
- Being advocates for child health: Pediatricians and other child health professionals advocate for child's health issues and oral health is a part of overall health. Oral diseases have an impact on overall health and well-being of children and adults through pain, time lost from school/work, spread of infection, and other oral systemic interactions

Dental caries is the most common chronic disease affecting children in the United States. It is 5 times more common than asthma and 7 times more common than hay fever.*

Research indicates that the prevalence rate of caries increases steadily across the human life span. The frequency of caries in children is

- 18% in children aged 2 to 4
- 52% in children aged 6 to 8
- 67% in children aged 12 to 17

Prevalence rates vary by ethnicity as well as socioeconomic status. African American and Hispanic children have higher rates of caries at all ages, compared with white non-Hispanic children. Data indicate that American Indian/Alaska Native children have among the highest rates of caries. There is inadequate data on children with special health care needs, but as a group they are at increased risk for coexisting morbidities such as caries.

* US Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.

Workforce Barriers to Access

Dentist to population ratio is declining

- 154,000 dentists in US
- 3,600 pediatric dentists

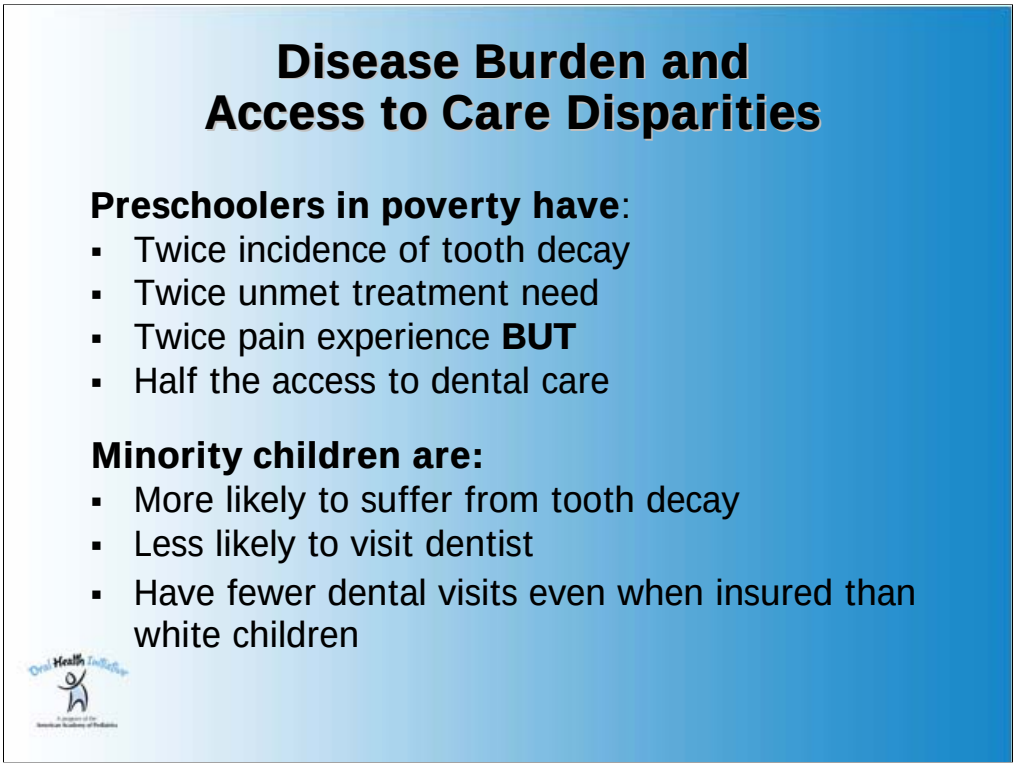
General dentists often do not have training in seeing infants and small children

Oral Health in America: A Report of the Surgeon General (2000) states that the ratio of dentists to population is declining: in 1996 there were approximately 58.4 professionally active dentists per 100,000 people in the United States, down from 59.1 in 1990.

Dental Work Force Strategies During a Period of Change and Uncertainty

J Dent Educ. **65(12): 1404-1416 2001**

Among factors shaping the demand for dental care are changing disease patterns, shifting population demographics, the extent and features of third-party payment, and growth of the economy and the population. The capacity of the dental work force to provide care is influenced by enhancements of productivity and numbers of dental health personnel, as well as their demographic and practice characteristics. The full impact of these changes is difficult to predict. The dentist-to-population ratio does not reflect all the factors that must be considered to develop an effective dental work force policy. Nationally, the dental work force is likely to be adequate for the next several years, but regional work force imbalances appear to exist and may get worse. Against this backdrop of change and uncertainty, future dental work force strategies should strive for short-term responsiveness while avoiding long-term inflexibility. Trends in the work force must be continually monitored. Thorough analysis is required, and action should be taken when necessary.

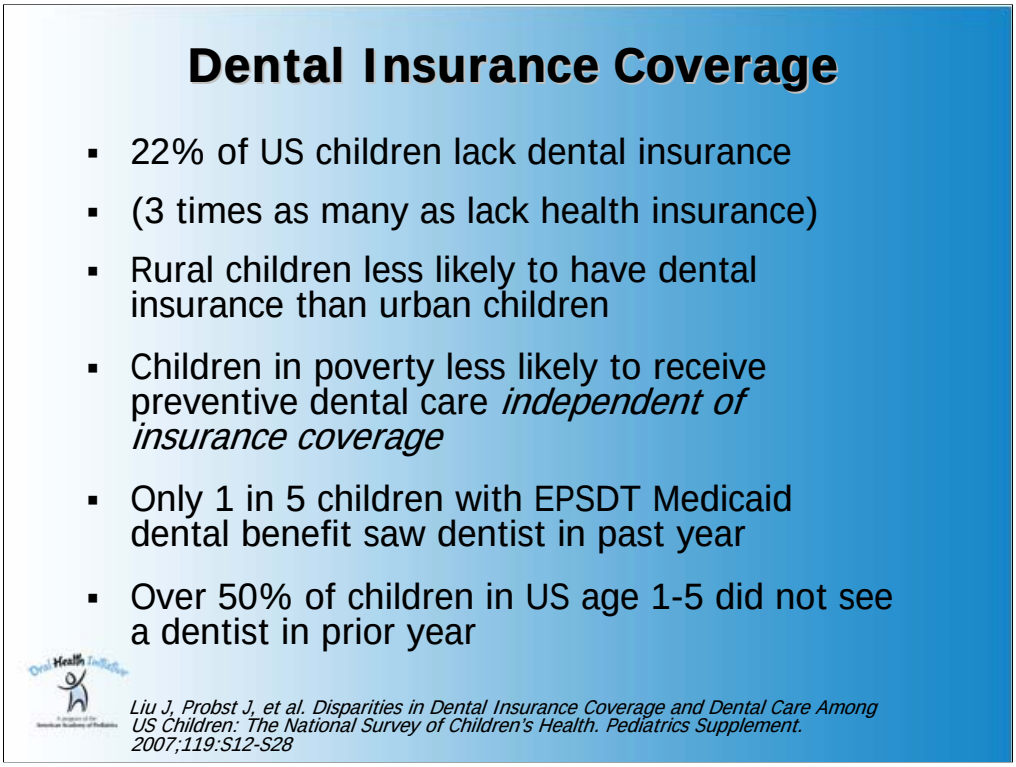


Disparities exist between majority and minority/rich and poor in disease burden and access to dental care for a completely preventable disease.

Preschoolers who live in poverty have twice the odds of having tooth decay, twice the extent of decay, twice the unmet treatment need, twice the pain experience, **but** 1/2 the access to dental care than their more affluent peers.

Native American children have the highest rate of dental caries in the US

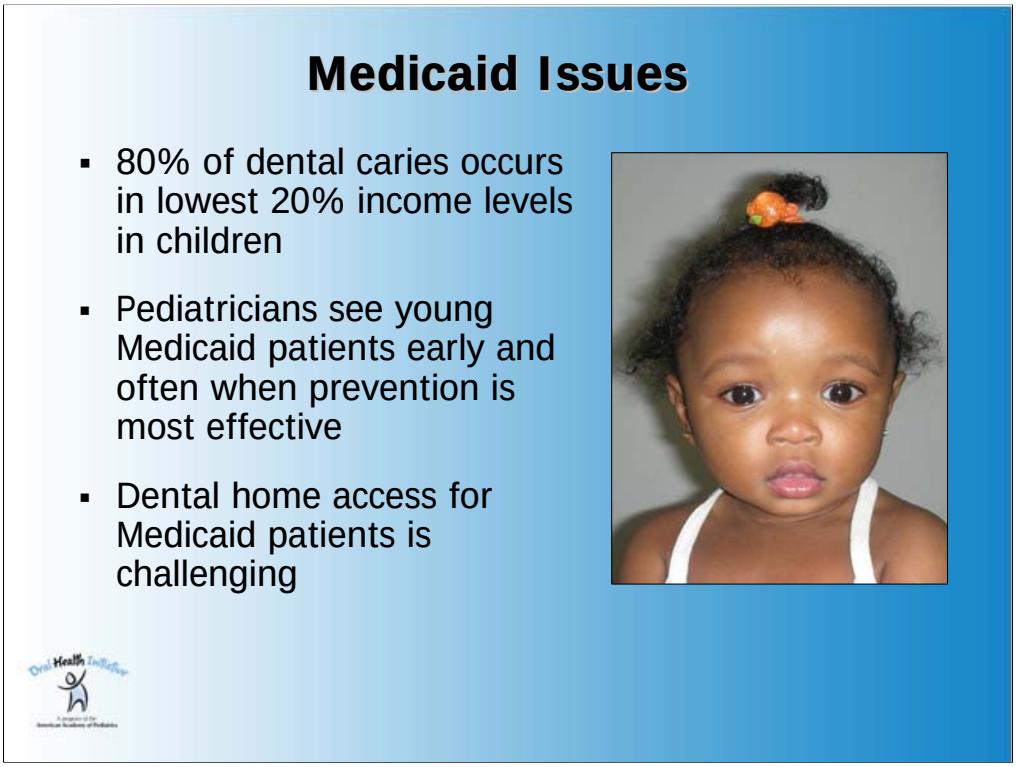
Minority children are more likely to suffer from tooth decay, are less likely to visit dentist, and have fewer visits when they do access care than white children



Disparities in Dental Insurance Coverage and Dental Care Among US Children: The National Survey of Children's Health

(PEDIATRICS Vol. 119 Supplement February 2007, pp. S12-S21)

A total of 22.1% of US children lacked parentally reported dental insurance coverage in the preceding year, 26.9% did not have a routine preventive dental visit, and 5.1% had parentally perceived unmet need for preventive dental care. US-born minority children were less likely to lack dental insurance than US-born white children; however, foreign-born Hispanic children were more likely to be uninsured. Rural children were more likely to be uninsured than urban children. Children with health insurance were more likely to have dental coverage. Children who lacked dental insurance were less likely to have received preventive care and more likely to have unmet need for care. Compared with US-born white children, all minority children were less likely to receive preventive care. These disparities were exacerbated among foreign-born children. Fewer race-based disparities were found for unmet need for dental care. Only black children, both US- and foreign-born, had higher odds of unmet need for preventive services than US-born white children. Poor dental health was strongly associated with unmet need. Disparities in dental insurance coverage and dental care are also evident by family socioeconomic status. Article is available online at: http://pediatrics.aappublications.org/cgi/content/full/119/Supplement_1/S12.

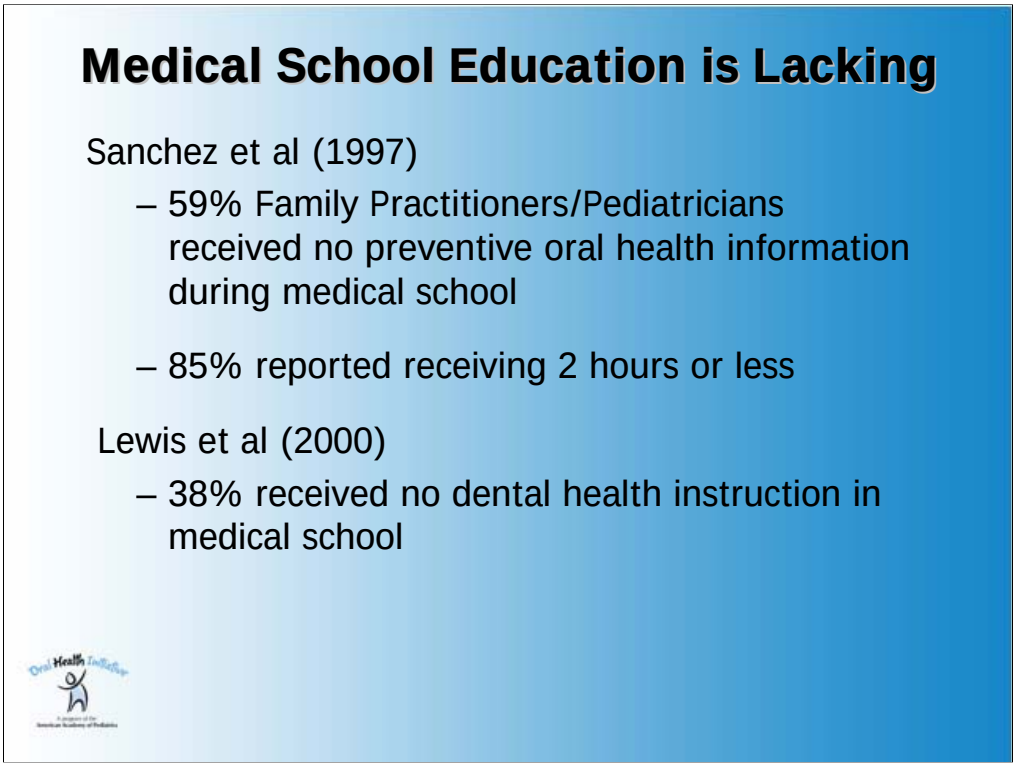


Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay (GOA Report September 2008)

The information provided by nationally representative surveys regarding the oral health of our nation's low-income children in Medicaid raises serious concerns. Measures of access to dental care for this population, such as children's dental visits, have improved somewhat in recent surveys, but remain far below national health goals. Of even greater concern are data that show that dental disease is prevalent among children in Medicaid, and is not decreasing. Millions of children in Medicaid are estimated to have dental disease in need of treatment; in many cases this need is urgent. Given this unacceptable condition, it is important that those involved in providing dental care to children in Medicaid—the federal government, states, providers, and others—address the need to improve the oral health condition of these children and to achieve national oral health goals.

Access report online at:
http://www.cdhp.org/downloads/Oct2008_GAO%20Report.pdf.

But do Pediatricians have an adequate background in oral health?



Physicians' Views On Pediatric Preventive Dental Care (Sanchez et al)

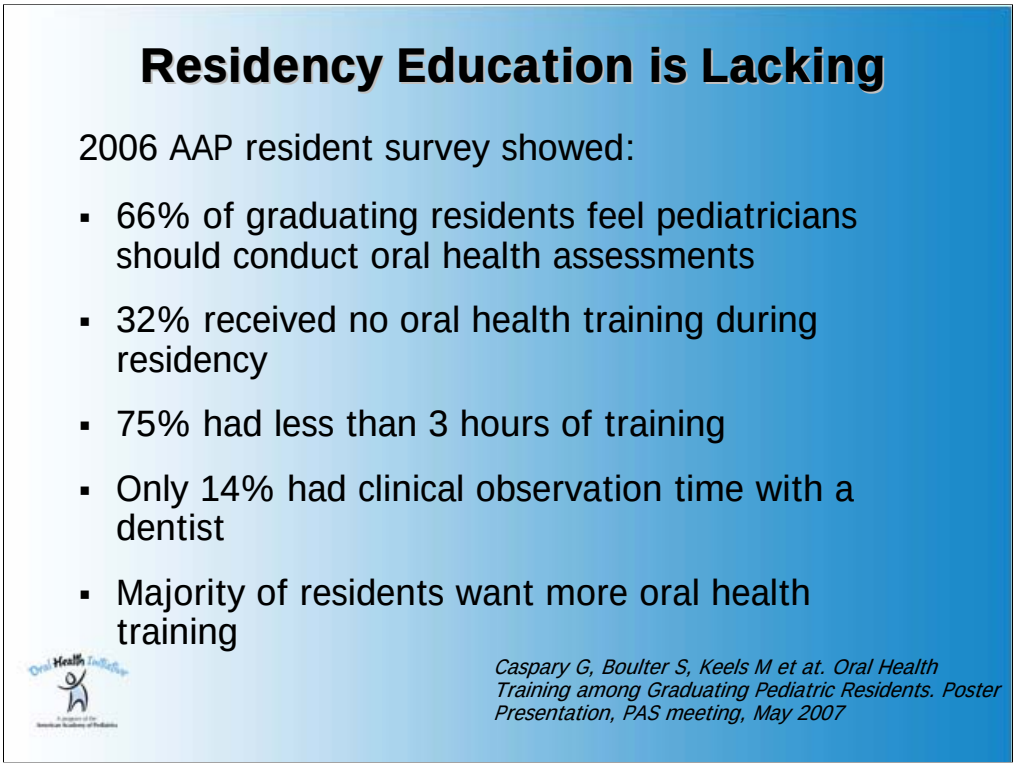
The purpose of this study was to assess the knowledge, attitudes, and beliefs of pediatricians and family physicians toward preventive dental care in children. A questionnaire was mailed to 398 pediatricians and 632 family physicians licensed to practice in the state of Alabama.

Information is available online at: http://www.ncbi.nlm.nih.gov/pubmed/9348601.

The Role of the Pediatrician in the Oral Health of Children: A National Survey (Lewis et al):

This survey took a national sample of 1600 pediatricians randomly selected from the American Medical Association Master File to assess their knowledge, current practice, and opinion on their role in the promotion of oral health; experience with dental decay among patients and in referring patients for professional dental care; and willingness to apply fluoride varnish.

The full text is available online at:
http://pediatrics.aappublications.org/cgi/reprint/106/6/e84.pdf

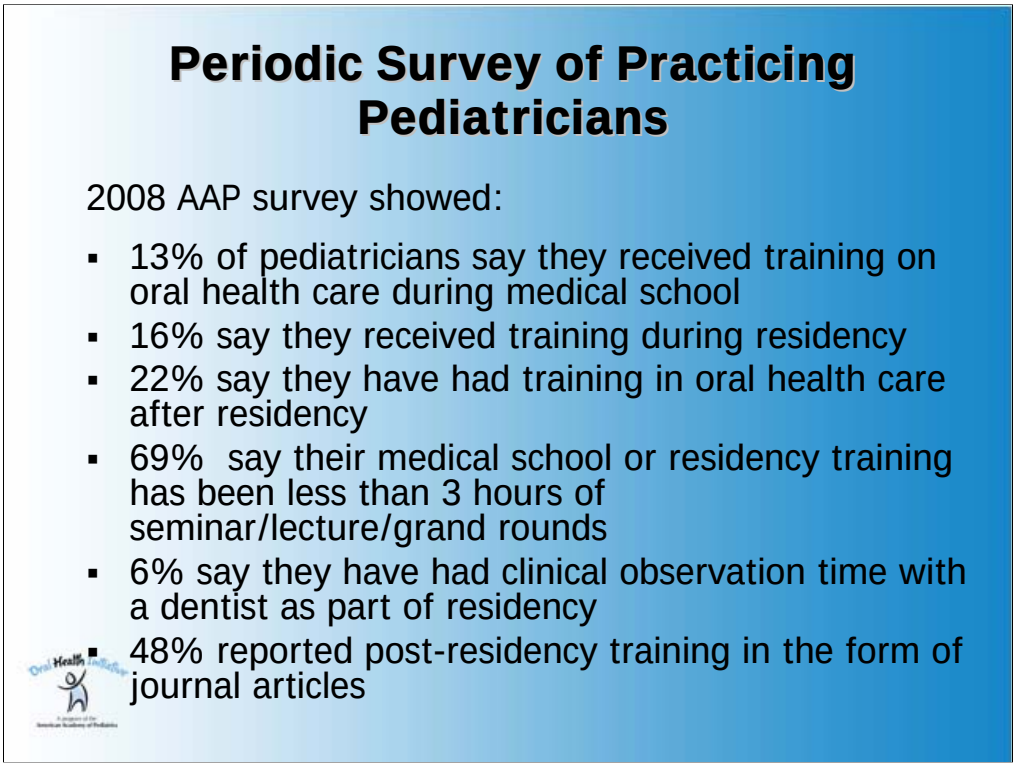


AAP Graduating Residents Survey

This is an annual, randomly sampled national survey of graduating pediatric residents. The 2006 GRS surveyed 1,000 residents and examined their residency training on oral health and their attitudes about performing oral health assessment tasks.

Survey Conclusion:

Most graduating pediatric residents believe that they should be conducting oral health care assessments, but many feel that they lack the skills to do so, and report that they would have liked to have had more training in oral health care assessment during residency. While we recognize that there are many demands on residents' time, this study suggests as little as three or more hours of oral health care training can have a large impact on the self-efficacy pediatricians feel in their ability to perform oral health assessment tasks, compared to those with less or no training. Oral health care assessments performed by pediatricians could have a substantial positive effect on the oral and overall health of American children, particularly among those at most risk.



Periodic Survey of Pediatric Fellows

This was an eight-page self-administered questionnaire sent to a random sample of 1,618 active US members of the AAP. The original mailing and six follow-up mailings to recontact nonrespondents were conducted from October 2007 to March 2008. After seven mailings a total of 1103 completed questionnaires were received for a response rate of 68%.

One-fourth of pediatricians (24%) say they are very interested in a continuing medical education (CME) course on pediatric oral health and 41% are moderately interested; 29% are slightly interested while only 7% say they are not interested.

Most pediatricians (57%) think there are too few dentists who see infants and children to meet the needs of infants and children in their practice; 38% think there are about the right number of such dentists.

Additionally in the survey of pediatricians named the following as "moderate" to "significant" barriers to providing oral health assessments/counseling during health supervision visits with patients birth to 3 years:

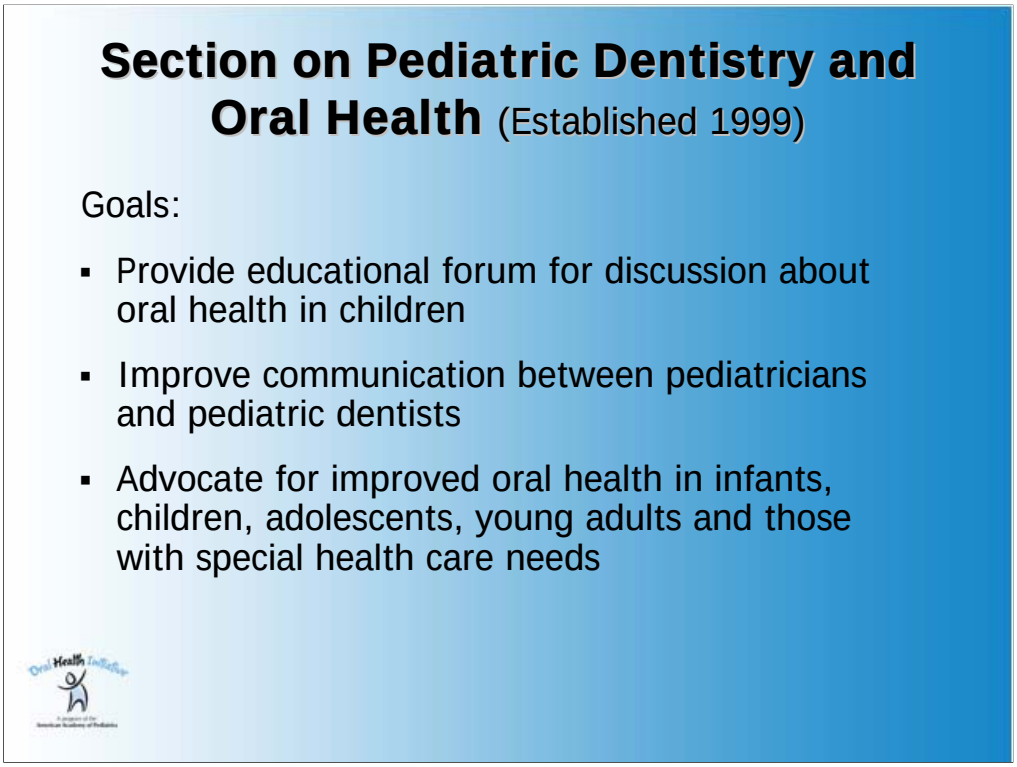
- lack of professional training in oral health care (41%)
- inadequate time during health supervision visits (35%)
- lack of ability to bill separately for oral health assessments and/or counseling on preventive oral hygiene (34%).
- only 31% of pediatricians offer fluoride varnish; among these pediatricians, 47% say lack of ability to bill separately for application of fluoride varnish is a "moderate" to "significant" barrier

Understanding pediatricians need more background in oral health…

Oral Health at AAP

Three forces bring oral health to the AAP radar screen:

- Section on Pediatric Dentistry
- 2000 *Oral Health in America: A Report of the Surgeon General* leads to development of AAP Policy Statement
- Maternal and Child Health Bureau Grant



Initially the Section was composed of only pediatric dentists however in 2006 the name was changed to the Section on Pediatric Dentistry **and Oral Health** (SOPDOH) to include both pediatric dentist and pediatrician members. Membership is currently at 235 members.

The Sections bylaws have further changed to include so others interested in children's oral health (eg general dentists, RDH, RN, PA, etc) can join as affiliate members. Information about how to join can be found online:

Associate Membership:
http://www.aap.org/sections/peddentist/Associatemembership.htm

Affiliate Membership:

http://www.aap.org/member/SectionMbrreq.htm

Oral Health Policy Statement

Oral Health Risk Assessment Timing and Establishment of the Dental Home

- Explains the scientific evidence behind dental caries
- Identifies risk groups
- Describes Oral Health Risk Assessment
- Outlines anticipatory guidance and prevention strategies
- Defines the Dental Home

Recommendations of the Policy Statement include:

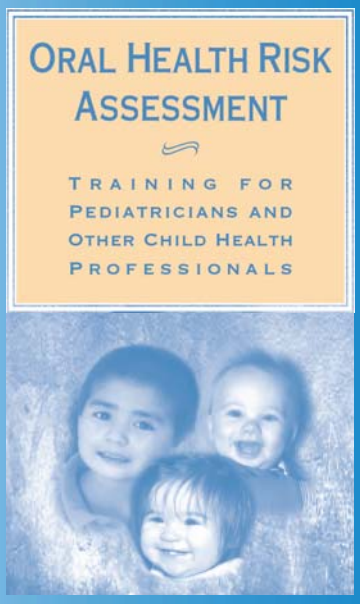
1. Early childhood caries is an infectious and preventable disease that is vertically transmitted from mothers or other intimate caregivers to infants. All health care professionals who serve mothers and infants should integrate parent and caregiver education into their practices that instruct effective methods of prevention of early childhood caries.
2. The infectious and transmissible nature of bacteria that cause early childhood caries and methods of oral health risk assessment, anticipatory guidance, and early intervention should be included in the curriculum of all pediatric medical residency programs and postgraduate continuing medical education curricula at an appropriate time.
3. Every child should begin to receive oral health risk assessments by 6 months of age from a pediatrician or a qualified pediatric health care professional.
4. Pediatricians, family practitioners, and pediatric nurse practitioners and physician assistants should be trained to perform an oral health risk assessment on all children beginning by 6 months of age to identify known risk factors for early childhood dental caries.
5. Infants identified as having significant risk of caries or assessed to be within 1 of the risk groups listed in this statement should be entered into an aggressive anticipatory guidance and intervention program provided by a dentist between 6 and 12 months of age.
6. Pediatricians should support the concept of the identification of a dental home as an ideal for all children in the early toddler years.

Oral Health was one of 5 topic areas addressed the Pediatric Collaborative Care Grant (PedsCare) along with Child Care, Community Pediatrics Special Interest Groups, International Health, and Mental Health. PedsCare was a partnership program between the AAP and MCHB and providers, to promote improved child health by providing pediatricians with the tools and support they need to provide community-based, collaborative care within a medical home.

During the 2 years of oral health activities under the grant, the Oral Health Initiative convened a work group composed of pediatricians, pediatric dentists, and oral hygienists who had a particular interest in identifying and developing tools to support the promotion of good oral health among children and their families. The work group focused on the development of training materials to support pediatric health care professionals in assessing the oral health risks of their patients (eg presentations, tool kit), providing communication outlets (eg listserv®, Web site) related to pediatric oral health, and developing educational programs to promote an understanding of oral health issues for children. In addition, the Oral Health Initiative provides technical support for Community Access to Child Health (CATCH) and Healthy Tomorrows Partnership for Children Program grants related to oral health, and the Training Oral Health Risk Assessment Preceptorship Program.

Oral Health Risk Assessment Training

- 14,000 Speaker Kits produced and distributed to medical and dental providers
- Training available online in a PDF format
- Available online for FREE CME (medical) and CERP (dental) Continuing Education hours



Training Content:

- Understand the role of the child health professional in assessing children's oral health
- Understand the pathogenesis of caries
- Conduct an oral health risk assessment
- Identify prevention strategies
- Understand the need for establishing a dental home
- Provide appropriate oral health education to families

The training has been available for FREE CME since February 2008—to date over 600 individuals have taken the course.

The training can be found online at: www.aap.org/oralhealth/cme.

AAP Recommendations for an Oral Health Risk Assessment

- Assess mothers's/caregiver's oral health
- Assess oral health risk of infants and children
- Recognize signs and symptoms of caries
- Assess child's exposure to fluoride
- Provide anticipatory guidance including oral hygiene instructions
- Make timely referral to a dental home

The AAP recommends that pediatricians include an Oral Health Risk Assessment as part of well-child visits. It suggests that every child begin to receive an oral health risk assessment within 6 months of the eruption of the first primary tooth but by no later than 12 months of age by a qualified pediatrician or a pediatric health care professional.

Anticipatory Guidance

- Minimize risk of infection
- Optimize oral hygiene
- Reduce dietary sugars
- Remove existing dental decay
- Administer fluorides judiciously

Parents need to be counseled on ways they can reduce the risk of dental caries.

The chronic management of dental caries is aimed at enhancing the level of non-cariogenic bacteria while reducing the levels of cariogenic bacteria. This strategy is called “reduce cariogenic bacterial colonization.”

Management for reducing cariogenic bacterial colonization includes

- Removing the source of cariogenic bacteria (the decay)
- Reducing the dietary sugars and carbohydrates, which promote growth of cariogenic bacteria
- Maintaining good oral hygiene and optimizing fluoride

Oral Health Strategic Plan

Proposed outcomes:

- Increased oral health knowledge and practices among pediatricians as outlined in the Oral Health Policy Risk Assessment Tool through specific training strategies
- Increase education on oral health *for providers, parents and children*
- Increase collaboration between dentists, pediatric dentists and pediatricians
- Increase access to fluoride

The strategic plan of the AAP has two primary components:

1. The statement of mission/vision/values

   Mission: *Attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. To accomplish this mission, the Academy shall support the professional needs of its members.*

   Vision: *Children have optimal health and well-being and are valued by society. Academy members practice the highest quality health care and experience professional satisfaction and personal well-being.*

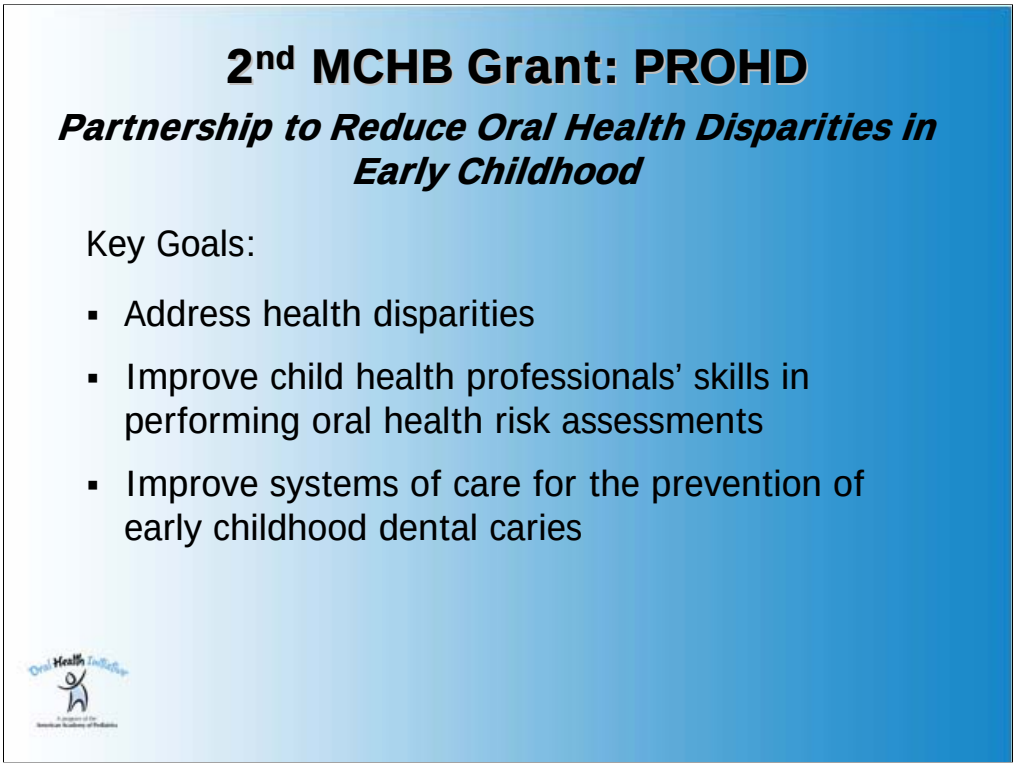
   Core Values: *We believe:*

   - *In the inherent worth of all children*
   - *Children are our most enduring and vulnerable legacy*
   - *Children deserve optimal health and the highest quality health care.*
   - *Pediatricians are the best qualified to provide child health care.*
   - *The AAP is the organization to advance child health and well-being.*

2. The current strategic priorities, which have been captured both graphically, and in text, for the purpose of communicating with various stakeholders of the AAP.

   At any given time, the AAP is working on dozens of critical child health and member issues. The Board actively seeks out issues for the strategic plan that are national in scope and can make a significant, measurable, contribution to the mission of the AAP. Each of these issues has unique qualities, they vary with regard to the breadth and depth of response required, and they often interact, or align, with one another. Currently Oral Health is one of the Child health issues.

   A further explanation of the AAP's Strategic Plan can be found online at: http://www.aap.org/sections/ypn/r/resident/pdfs/general_aap/AAPStrategicPlan06-07.pdf.



The Goals and Objectives of the Grant are to:

Facilitate communication and collaboration between the AAP and MCHB to address health disparities

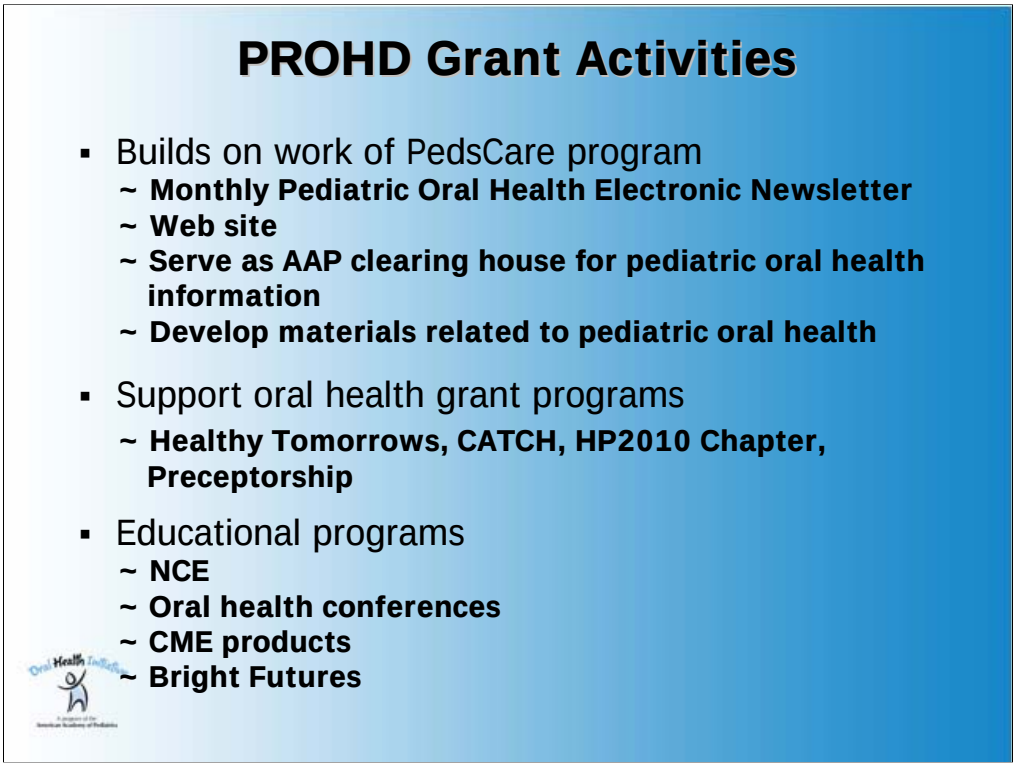
- Improve information exchange between the MCHB and AAP membership by creating at least dissemination mechanisms by the end of Year 5.
- Improve communication and collaboration on health disparities within the AAP.

Improve child health professionals' skills in performing oral health risk assessments in the medical home

- Provide education and training opportunities/resources to pediatricians and other child health professionals on early childhood dental caries.
- Evaluate pediatricians' and other child health professionals' knowledge of early childhood caries and their comfort level in performing oral health risk assessments.
- Provide support to states and communities to improve oral health practices and programs.

Improve systems of care for the prevention of early childhood dental caries and referral to a dental home

- Facilitate collaboration between at least 4 key national organizations.
- Explore the feasibility of incorporating oral health content into residency training programs.
- Develop and disseminate educational resources for parents related to the prevention of early childhood dental caries and the importance of establishing a dental home.



Monthly E-News:

Currently there are over 1,000 registered subscribers though we know it is passed on in turn to numerous residency programs, public health bureaus, and other agencies.

Web site:

On average there are 100,000 hits per month.

Members of the Project Advisory Committee include:

- American Academy of Family Physicians
- American Academy of Pediatric Dentists
- American Association of Public Health Dentistry
- American Dental Association
- American Dental Hygienist Association
- Association of Pediatric Program Directors
- Association of State and Territory Dental Directors
- Center for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Children's Dental Health Project
- Family Voices
- Head Start/Early Head Start
- Hispanic Dental Association
- Indian Health Service
- Maternal and Child Health Bureau
- Medicaid/SCHIP Dental Association
- National Association of Pediatric Nurse Practitioners
- National WIC Association

Oral Health Web site

Protecting All Children's Teeth: A Pediatric Oral Health Training for Physicians (PACT)

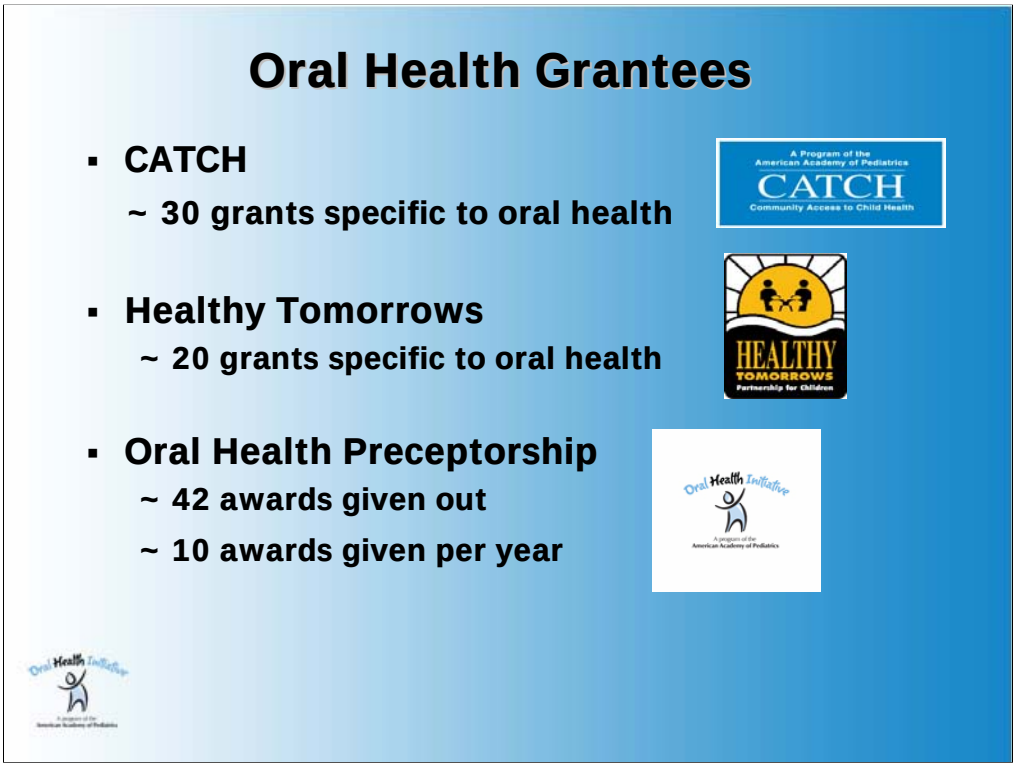
The goal of the PACT curriculum is to train pediatricians to become more knowledgeable about child oral health, more competent in providing oral health guidance and preventive care, and more comfortable sharing the responsibility of oral health with dental colleagues. The 13 modules curriculum is designed specifically to cover all the APA Educational Guidelines for Pediatric Residency Training in oral health.

The chapters can be done individually or in succession, but each can stand alone for purposes of returning to the module

Module topics include: Basic oral structures, Oral Development, Oral Health Screening, Early Childhood Caries, Preventative Oral Health Care, Nutrition/Feeding Practices, Fluoride, Special Needs Considerations, Oral Habits, Common Oral Pathology, Oral Injury, Oral Findings, and Adolescent Oral Health.

The training contains individual chapter photo galleries, a main photo gallery, a glossary, and a reference section.

The training will be available on the Oral Health Web site for FREE CME (11 units) beginning May 2009 (http://www.aap.org/commpeds/dochs/oralhealth/pact.cfm).



CATCH Grants:

The Community Access To Child Health (CATCH) Program is a national program of the AAP that increases children's access to medical homes or specific health services supporting pediatricians and communities who are involved in community-based efforts for children. The CATCH Program provides pediatricians with training, technical assistance and resources, peer support and networking opportunities, and funding opportunities

Healthy Tomorrows Grants:

The Healthy Tomorrows Partnership for Children Program (HTPCP) is a collaborative grant program of MCHB and AAP. The goal of HTPCP is to improve the health status of mothers, infants, children, and adolescents by increasing their access to health services at the local level by providing guidance and funding for community-based initiatives. Healthy Tomorrows projects target low-income populations and address 4 key areas of access to health care, community-based health care, preventive health care, and service coordination.

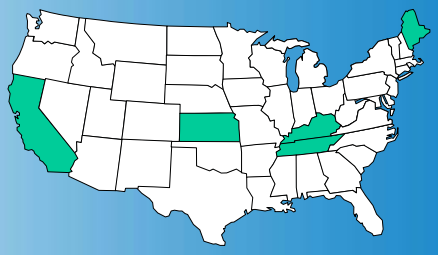
Oral Health Preceptorship:

The AAP Oral Health Preceptorship program was initiated to provide pediatricians interested in implementing oral health assessments in their practice with mentorship support. The purpose of the award is to provide individualized one-on-one training in performing oral health risk assessments, maternal/ caretaker oral assessment interviews, and to learn to apply
fluoride varnishes.

HP 2010 Chapter Grants

- The AAP District Vice Chairs determined that the 2006 round of chapter grants should focus on programs addressing children's oral health
- Five chapters were awarded $20,000 each to develop innovative programs to accomplish pediatric objectives specifically focusing on children's oral health:

~ California Chpt 4
~ Kansas
~ Kentucky
~ Maine
~ Tennessee



Grantee Goals:

California Chapter 4: Raise OH awareness among pregnant teens, encourage teen moms to visit dentists, educate pediatric health care provider on identification and prevention of oral disease, assess change in attitude and practice of pediatric providers.

Kansas Chapter: Through its Bright Smiles for Kansas Kids program, developed a fluoride varnish online educational course.

Kentucky Chapter: Provide a practical training model for primary care clinicians to include OHRA and application of fluoride varnish, and look at reimbursement issues.

Maine Chapter: Train pediatricians on OHRA and to provide outreach to Early Head Start personnel.

Tennessee Chapter: Develop model of peds, dentists, community organizations and businesses in rural areas to work together to increase awareness of OH needs of children.

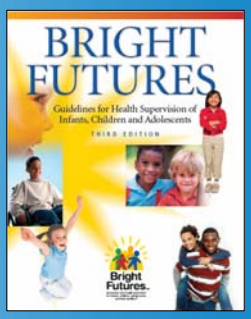
Grantee Goals in Common

- Educating providers and patients about oral health
- Increasing access to care
- Providing direct service – schools, dental clinics, medical clinics
- Providing oral health screening to young children
- Linking patients to a dental home
- Reducing disparities

Oral Health in Bright Futures

Recommendations

- Provide Risk Assessment
- Provide Anticipatory Guidance
  ~ Oral hygiene recommendations
  ~ Diet
  ~ Caregiver oral health
  ~ Appropriate systemic and topical fluoride supplements depending on risk.
- Refer to a Dental Home



Examples of Oral Health Anticipatory Guidance in the 3rd Edition Guidelines

- Assess fluoride exposure/prescribe supplements as needed
- Soft toothbrush and parent brushes teeth twice a day
- Avoidance of bottle in bed
- Stop bottle by 1 year of age
- Recommend diet low in sugars
- Oral Hygiene in older children
- Avoid use of tobacco products
- Injury prevention - mouth guards

How Pediatricians Can Get This Done in Practice:

- Use previsit questionnaire
- Use nurse, medical assistant, or other office staff ask the questions
- Have prompts on documentation form or electronic health records
- Have a practice staff person who is “in charge of oral health”
- Keep track of dental home referrals with a registry
- Measure progress and report back to the whole practice or clinic
- Use as a quality improvement activity for your recertification or residents practice based learning ACGME requirement
- Co-locate an oral health educator in practice

Second Oral Health Policy Statement

Preventive Oral Health Intervention for Pediatricians (2008)

- Clarifies scientific bases of early childhood caries
- Expands on anticipatory guidance for young children
- Recommends preventive and interventional strategies
- Provides strategies for improving the connection of the medical and dental homes

Recommendations of the Policy Statement include:

1. Oral health risk-assessment training should be recommended for medical practitioners who are in training programs and those who currently administer care to children.
2. Dietary counseling for optimal oral health should be an intrinsic component of general health counseling.
3. An oral health risk assessment should be administered periodically to all children.
4. Anticipatory guidance for oral health should be an integral part of comprehensive patient counseling.
5. Administration of all fluoride modalities should be based on an individual's caries risk. Patients who have a high risk of caries are candidates for consideration of more intensive fluoride exposure after dietary counseling and oral hygiene instruction as compared with patients with a lower risk of caries
6. Supervised use of fluoride toothpaste is recommended for all children with teeth.
7. The application of fluoride varnish by the medical practitioner is appropriate for patients with significant risk of dental caries who are unable to establish a dental home.
8. Every child should have a dental home established by 1 year of age.
9. Collaborative relationships with local dentists should be established

Available online at:
http://aappolicy.aappublications.org/cgi/reprint/pediatrics;122/6/1387.pdf.

Physician Payment for Oral Health Preventive Services

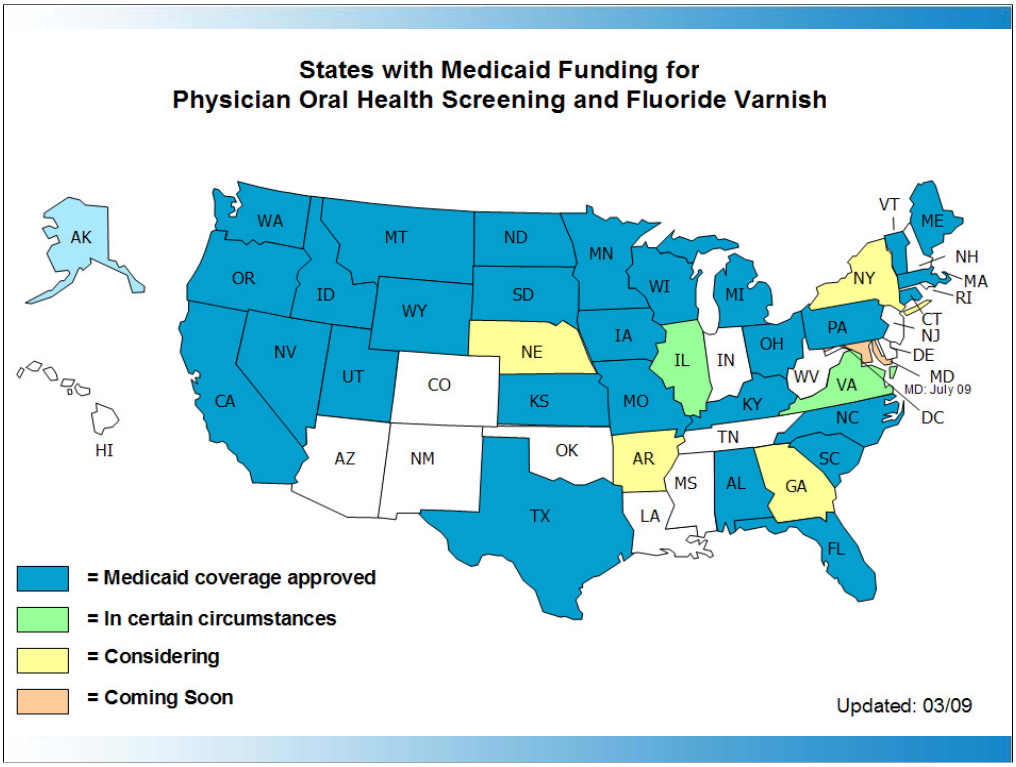
Why?

Including oral health adds yet another item to the long list of assessments addressed by pediatricians during well child visits.

Preventive services should include risk assessment, anticipatory guidance and the application of fluoride varnish where appropriate.

While training pediatricians to do oral health assessments is central to the initiative, it is understood that payment is a key component to having these assessments implemented into practice. Since 2005 the Oral Health Initiative has been assembling information from each state about Medicaid payment for oral health services provided by pediatricians and other non-dental professionals. State specific information can be found on the Web site at: http://www.aap.org/commpeds/dochs/oralhealth/fluoride.cfm.

A chart including what providers can be paid for, procedure code, age limits, number of annual varnishes, training required, delegates allowed, barriers, and payors is updated monthly and can be found online at. http://www.aap.org/commpeds/dochs/oralhealth/pdf/OH-Reimbursement-Chart.pdf


States with Medicaid Funding for
Physician Oral Health Screening and Fluoride Varnish
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NC
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PA
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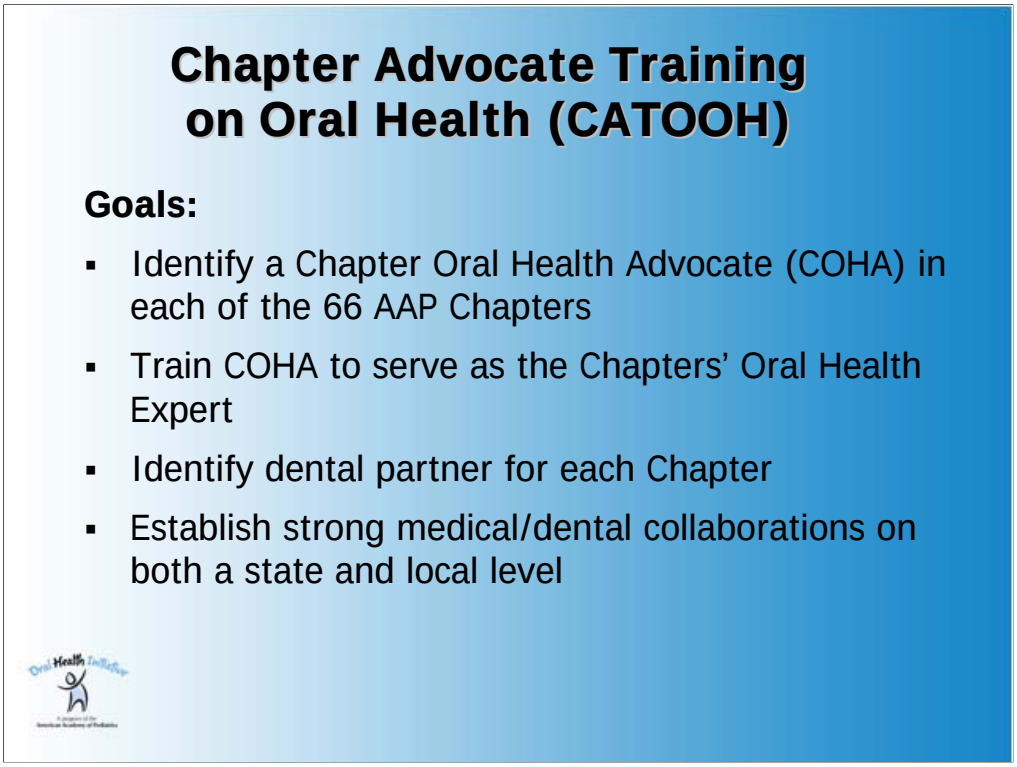
DC
= Medicaid coverage approved
= In certain circumstances
= Considering
= Coming Soon
Updated: 03/09



CATOOH Training Schedule

2008

AL, DE, DC, GA, IN, LA, MA, MD, ME, MI, NJ, NY, OH, Ontario, PA, RI, VT, and WV and Uniformed Services East

2009

IA, IL, KS, KY, MN, MO, ND,NC, NE, NH, SC, SD, TN, VA, WI, and Canadian Chapters

2010

AK, AR, AZ, CA, CO, FL, HI, ID, MS, MT, NM, NV, OK, OR, Puerto Rico, TX, UT, WA, WY, Canadian Chapters, and Uniformed Services West

Chapter Oral Health Advocate Duties to include:

- Serve as Chapter "Point Person" when questions arise related to children's oral health.
- Promote physician education on pediatric oral health within their Chapter. Serve as a speaker on the topic of pediatric oral health wherever possible.
- Develop/maintain relationships with area dental colleagues; encourage pediatrician in their Chapters to develop relationships with state dental societies, health departments, & other organizations that have a stake in pediatric oral health.
- Work with dental community on increasing children's access to oral health services; work to support reimbursement to pediatricians and other non-dental professionals for oral health services
- Write articles about pediatric oral health for the local Chapter, community, and state Newsletters.
- Work with local experts to disseminate the AAP policies and resources to pediatricians interested in pediatric oral health.

Summary: Oral Health Activities

- Communication services
  - ~ Monthly E-Newsletter
  - ~ Web site: *www.aap.org/oralhealth*
  - ~ Serve as AAP clearing house for pediatric oral health information
- Support oral health grant programs
  - ~ Healthy Tomorrows, CATCH, HP2010 Chapter
- Educational programs
  - ~ Professional venues
  - ~ Oral health conferences
  - ~ CME products/PREP Audio
  - ~ Bright Futures
- Training programs
  - ~ Oral Health Risk Assessment Training
  - ~ Protecting All Children's Teeth
  - ~ Chapter Advocate Training on Oral Health
  - ~ Preceptorship Program
- Addresses Payment Issues

For information about AAP Oral Health Programs contact:

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Web site: **www.aap.org/oralhealth**