Potential Barriers and Suggested Ideas for Change

Key Activity: Establish a Dental Home

Rationale: Optimal oral health requires collaboration between the pediatric primary healthcare provider's office and dental provider's office to provide the patient and family with consistent and continuing care. To accomplish this, the practice needs to build partnerships with dental providers, facilitate and track dental referrals, and regularly update a dental resource guide.

Gap: Pediatric primary healthcare provider failed to refer patients to a dental home.	
Potential Barriers	**Suggested Ideas for Change**

The practice lacks understanding of the concept of a dental home and its importance.	• Review the following clinical guidelines and policy:
	  ○ Oral Health Risk Assessment Timing and Establishment of the Dental Home
	  ○ Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents 3rd Edition — Promoting
	  ○ American Academy of Pediatric Dentistry (AAPD): Policy on the Dental Home
	  ○ ADA Clinical Recommendations: Baby's First Teeth

The practice is unaware of where to find oral health education and training.	• Tap into the AAP Chapter Oral Health Advocate (COHA) to provide additional training at your institution or practice.
	• Review the following training curriculum:
	  ○ Protecting All Children's Teeth (PACT: Pediatric Oral Health Training for Physicians free online CME course
	  ○ Smiles for Life: A National Oral Health Curriculum (3rd Edition)
	• Encourage continuing education among the interdisciplinary team, including nurse practitioners, physician assistants, and allied health staff in your practice to promote standardized care.
	• Educate the entire staff on the importance of oral health to create a learned environment.
	• Appoint an office dental champion to be responsible for establishing the practice's standards and administering dental referrals.

Oral Health in Primary Care

Gap: Pediatric primary healthcare provider failed to refer patients to a dental home.	

The practice lacks access to dental homes, particularly for children under 3 years of age.	• Develop a relationship with dental providers or university dental schools within your region.
	  ○ Tip: Speak directly to the dentist and not front office staff.
	• Find the dental providers in your community who will give you confidence to refer your patients to them.
	  ○ Ask your own dentist if he or she treats young children and if not, ask why not.
	• Join your local oral health coalition.
	• Colocate a dental hygienist to your office to provide preventive dental services.
	  ○ Tip: In many states, dental hygienists can practice independently; in others, they can practice in settings outside of a dental practice.
	• Obtain local dental grant funding to improve access to dental homes in your community:
	  ○ Review funding opportunities on the AAP Children's Oral Health Web site.
	  ○ Identify local foundations and service organizations that fund projects for children or local philanthropists with interest in children's issues.
	• Identify media personalities with young children and meet with them to discuss issues, media coverage, and public service announcements.

The practice doesn't know how to access existing community dental homes.	• Find or create a resource guide listing pediatric dental providers in your area. These resources may be available from:
	  ○ State Medicaid
	  ○ State Department of Health—they will have list of Medicaid providers
	  ○ AAPD Web site
	  ○ Insure Kids Now — Connecting Kids to Coverage
	  ○ Dental schools
	  ○ State or county dental societies
	  ○ Oral health coalitions—many states have oral health coalitions that may either have a formal dental provider list or be willing to assist in creating one
	  ○ Community health clinics
	• Tap into the AAP COHA network and explore these sources:
	  ○ Federally qualified health centers (community clinics) as referrals
	  ○ Early Head Start programs

The practice lacks a protocol to refer patients to a dental home.	• Establish oral health as a part of all health supervision visits by adding dental visit prompts in the electronic medical record (EMR) for all routine visits after 6 month of age.
	• Establish age-appropriate oral health risk assessment clinical care guide.
	• Create/use a dental referral form (here is a Dental Referral Resource template):
	  ○ Ask the dentist or family to fill out and fax or send back form (in a self-stamped envelope).
	  ○ Automate the referral in EMR and include a list of pediatric dental providers.
	• Have the office care coordinator or referral coordinator follow up to see if the patient attended a dental visit.

Oral Health in Primary Care

Gap: Pediatric primary healthcare provider failed to refer patients to a dental home.	

The patient does not have dental insurance coverage.	• Help patients/families obtain dental coverage:
	  ○ Ask your benefits coordinator/enrollment officer to provide dental coverage information.
	  ○ Inform families that dental insurance is incorporated in government plans (eg, Medicaid/CHIP).
	  ○ Get involved with local advocacy and pediatric councils.
	  ▪ Employers—get involved in an advocacy group to support complete dental benefits coverage.
	  ▪ Educate families on the importance of dental insurance and oral health. Parents' dental insurance in certain states cover child dental health as well.
	• Help undocumented patients access charitable dental resources.
	  ○ Identify local sources of funding for uninsured/undocumented children.
	  ▪ State dental associations
	  ▪ United Way
	  ▪ Head Start (certain communities set aside money to care for uninsured children)
	  ▪ National Children's Oral Health Foundation

Gap: Pediatric primary healthcare provider did not ask if the patient has a dental home and makes annual dental visit.	
Potential Barriers	**Suggested Ideas for Change**

Lack of time: The practice does not deem this as an important focus of the medical visit; the practice's perception is that the family will not want to discuss this or is simply overlooking the matter.	• Have the office support staff initiate the oral health screening process with an oral health previsit questionnaire (parent or adolescent).
	• Establish oral health as a part of all health supervision visits by adding dental visit prompts in the EMR for all routine visits after 6 month of age.
	• Educate staff on the importance of oral health to create a learned environment:
	  ○ Appoint an office dental champion.
	  ○ Encourage continuing education among nurses and allied health staff in your practice to promote standardized care.
	• Create a list of public providers for low-cost dental care, eg, community health centers, county health departments, and dental van services.
	• Use strength-based approach/motivational interviewing technique to address oral health issues.
	  ○ Discuss the impact of oral health on general health (can't be healthy without a healthy mouth).

Families could not recall the last visit to a dentist.	• Create/use a dental referral form (here is a Dental Referral Resource template):
	  ○ Ask the dentist or family to fill out and fax or send back form (in a self-stamped envelope).
	  ○ Automate the referral in EMR and include list of pediatric dental providers.
	• Have the office care coordinator or referral coordinator follow up to see if patient attended dental visit.

Oral Health in Primary Care

Gap: Pediatric primary healthcare provider did not document dental home information.	
Potential Barriers	**Suggested Ideas for Change**
The practice lacks a dedicated place in the medical record to document dental home information.	• Use the age-appropriate Bright Futures Visit Forms *(scroll down from the Web page and click on title to reveal forms)* for a place to record and as a way to remind providers to record dental home information. • Create encounter form documentation to flag providers that the dental home information needs to be recorded and prompt appropriate questions with a place to document results. • Use an oral health previsit questionnaire (parent or adolescent) that asks if the child has a dentist and the date of last dental visit and contact information. ○ Make translation services available or have multilingual questionnaires when necessary for obtaining this history. • Establish oral health as a part of all health supervision visits by adding dental visit prompts or risk assessment tool into the EMR for all routine visits after 6 months of age.

Gap: Provider did not document reason dental home was not established.	
Potential Barriers	**Suggested Ideas for Change**

The provider felt uncomfortable with how to respond to:
 	
• Cost of dental care
• Patient fears
• Access issues (ie, transportation, language, and cultural barriers)
	• Explain to families that early childhood caries can lead to lost school days—requiring families to stay home to care for their child and incur expensive dental restorations, which can lead to higher costs.
	• See concerns for dental coverage above.
	• Allay fear in patient and family:
	  ○ Tell them that the dental provider and their staff members will foster a positive relationship with children, especially on their first visit.
	  ○ Discuss the impact of preventive dental care and oral health on general health (can't be healthy without a healthy mouth).
	• Use strength-based approach/motivational interviewing technique to build on the patient and family's strengths against fear and facilitate successful referrals.
	• Investigate cultural competency training such as the National Center for Cultural Competence for the following:
	  ○ Dental Initiative 1—Rationale for Cultural Competence in Health Care
	  ○ Dental Initiative 2—A Definition of Linguistic Competence
	  ○ Dental Initiative 3—Dental Care Utilization/Population Data
	  ○ Dental Initiative 4—Selected Findings from Literature Review
	• Contact Area Health Education Center (AHEC) for local cultural competency training and state-specific grants.
	• Have the office care coordinator or referral coordinator follow up to see if the patient attended dental visit and close the referral loop.
	• Use case managers to help families get to their appointments and address language and cultural barriers.
	  ○ Tip: Both publicly and privately insured children have access to a case manager.
	• Have local bus schedules and taxi services contact information available.

Potential Barriers and Suggested Ideas for Change

Key Activity: Perform Oral Health Risk Assessment
Rationale: Early childhood primary tooth caries is a leading risk factor for caries in permanent teeth. Oral health risk assessment, a responsibility of the pediatric primary healthcare provider, can identify contributing factors that lead to dental caries. Education for providers, patients, and families is a key factor in controlling dental caries and should continue throughout a child's life.

Gap: Pediatric primary healthcare provider did not perform oral health risk assessment.	
Potential Barriers	**Suggested Ideas for Change**
The practice is unaware of what an oral health risk assessment is.	• Learn about oral health risk assessment by reading the AAP Policy statement, Maintaining and Improving the Oral Health of Young Children. • Review the AAP Bright Futures Oral Health Risk Assessment Tool and Guidance. • Review the American Academy of Pediatric Dentistry Caries-Risk Assessment Tool (CAT). • Review the Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition regarding oral health risk assessment. • Review American Academy of Pediatric Dentistry (AAPD) and American Dental Association (ADA) policy statements regarding the Age One Dental visit. • Review the Academic Pediatrics Special Issue on Children's Oral Health that explains the importance of and strategies for improving children's oral health.
The practice is uncertain of which risk assessment tool to use.	• Identify a list of tools to use such as the AAP Bright Futures Oral Health Risk Assessment Tool and Guidance. • Ensure that an oral health protocol is created and implemented and is done at all ages (routine visits). Here is an example of what a protocol might look like. • Contact your AAP Chapter Oral Health Advocate (COHA) to determine if there are state-specific tools.

The provider's perception is that there is not enough visit time and that there are competing family/provider priorities.	• Create encounter form documentation to flag providers that the assessment needs to be completed and prompt appropriate questions with a place to document results.
	Have the office support staff initiate the oral health screening process with an oral health previsit questionnaire (parent and adolescent).
	• Educate staff on the importance of oral health and create an oral health team:
	  ○ Recruit an office dental champion.
	  ○ Establish an oral health team to discuss strategies for implementation of oral health assessments and education so everyone feels empowered.
	  ○ Encourage continuing education among all health staff in your practice to promote standardized care.

Gap: Pediatric primary healthcare provider did not document oral health risk assessment.	
Potential Barriers	**Suggested Ideas for Change**
The practice does not have a protocol in place for proper documentation	• Use the age-appropriate Bright Futures Visit Forms to remind providers to record oral health information. • Create encounter form documentation to flag providers that the assessment needs to be completed, with prompt appropriate questions with a place to document results. • Have the office support staff initiate the oral health screening process with an oral health previsit questionnaire (parent and adolescent). • Establish oral health as a part of all health supervision visits by adding dental visit prompts or risk assessment tool into the EMR for all routine visits after 6 months of age.

Gap: Pediatric primary healthcare provider did not document assessment of the teeth and gums.	
Potential Barriers	**Suggested Ideas for Change**

The provider lacks the training and/or ability to interpret exam findings and triage.	• Utilize oral health training programs to gain skill in oral health assessment:
	  ○ PACT
	  ○ Smiles for Life
	• Utilize your COHA for additional training at your institution, practice, or the AAP chapter meeting.
	• Begin regularly examining and documenting in a select subset of patients such as infants, and then include the older children as your comfort level with oral assessments increase.

There is a perceived barrier of poor child compliance and insufficient visit time.	• While examining the throat, also look at the teeth and gums. ○ The exam becomes easier with practice.

Gap: Pediatric primary healthcare provider did not ask if the child has a dental home and makes an annual dental visit.	
Potential Barriers	**Suggested Ideas for Change**

Time constraints: the practice does not deem this an important focus of the medical visit; the practice perceives that the family will not want to discuss this or they simply overlook the matter.	Have the office support staff initiate the oral health screening process with an oral health previsit questionnaire (parent and adolescent).
	• Establish oral health as a part of all health supervision visits by adding dental visit prompts in the EMR for all routine visits after 6 month of age.
	• Educate staff on the importance of oral health to create a learned environment:
	  ○ Recruit an office dental champion.
	  ○ Encourage continuing education among nurses and allied health staff in your practice to promote standardized care.
	• Use strength-based approach/motivational interviewing to address oral health issues.
	  ○ Discuss the impact of oral health on general health (can't be healthy without a healthy mouth).

Gap: Pediatric primary healthcare provider did not ask if the child has a dental home and makes an annual dental visit.	

There is a lack of knowledge about the AAP and Bright Futures guidelines regarding the importance of dental home establishment.	• Suggest that the pediatric primary healthcare provider review the following clinical guidelines and policy:
	  ○ Maintaining and Improving the Oral Health of Young Children
	  ○ Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents 3rd Edition—Promoting Oral Health

There is no dental home available to send the child to (ie, low number of available providers and/or lack of formal resource guide).	• Find or create a resource guide listing pediatric dental providers in your area. These resources may be available from the following sources:
	  ○ State Medicaid
	  ○ State Department of Health—may have a list of providers who accept Medicaid
	  ○ AAPD Web site
	  ○ Insure Kids Now
	  ○ Dental schools
	  ○ State or county dental societies
	  ○ Oral health coalitions—many states have oral health coalitions that may either have a formal dental provider list or be willing to assist in creating one
	  ○ Community health clinics
	• Develop a relationship with dental providers or university dental schools within your region.
	  ○ Talk directly to the dentist, not the front desk staff.
	• Find the dental providers in your community who will give you confidence in referring your patients to them by asking your own dentist if he or she treats young children. If not, ask why not.
	• Tap into the AAP COHA network and explore these sources:
	  ○ Federally qualified health centers (community clinics) as referral resource
	  ○ Early Head Start programs for a list of pediatric dental services providers
	• Co-locate dental hygienists in your office to provide preventive dental services. In many states, dental hygienists can practice independently and in others, they can practice outside of a dental practice setting. Pediatric primary healthcare providers should ensure they learn their state's rules for independent dental hygiene practice.

The child does not have dental coverage.	• Help patients/families obtain dental coverage:
	  ○ Ask your benefits coordinator/enrollment officer to provide dental coverage information.
	  ○ Inform families that dental insurance may be incorporated in government plans (eg, Medicaid/CHIP).
	  ○ Get involved with local advocacy and pediatric councils:
	  ▪ Employers—get involved in advocacy group to support complete dental benefit coverage.
	  ▪ Educate families on the importance of dental insurance and oral health. Parents' dental insurance in certain states cover child dental health as well.
	• Undocumented patients:
	  ○ Identify local sources of funding for uninsured/undocumented children:
	  ▪ United Way
	  ▪ Head Start (certain communities set aside money to care for uninsured children)
	  ▪ National Children's Oral Health Foundation

Oral Health in Primary Care

Gap: Pediatric primary healthcare provider did not ask if the child has a dental home and makes an annual dental visit.	

Families could not recall the last visit to a dentist.	• Create/use a dental referral form (here is a Dental Referral Resource template):
	  ○ Ask dentist or family to fill out and fax or send back form (in a self-stamped envelope).
	  ○ Automate the referral in EMR and include list of pediatric dental providers.
	• Have the office care coordinator or referral coordinator follow up to see if patient attended the dental visit.

There is no set place in the medical record to record a dental home.	• Have the office support staff initiate the oral health screening process with an oral health previsit questionnaire (parent and adolescent). • Add prompts to the EMR for all health supervision visits after 6 months of age to record the dental home information. ○ Brainstorm with your oral health team what dental home information should be documented in the medical record. • Utilize Pediatric Care Plan form to coordinate care.

Gap: Pediatric primary healthcare provider did not ask about or document the families' oral health status.	
Potential Barriers	**Suggested Ideas for Change**

The provider overlooked this matter.	• Regularly perform oral health risk assessments using a standardized form that contained maternal oral health questions.
	• Conduct front-desk screening using a previsit questionnaire (in case the mother is not present for the visit):
	  ○ Use a family history documentation form that includes family dental health history.
	  ○ Implement use of a prompting sheet, which allows quick review of the oral health risk assessment results.

The provider felt they did not have enough time and had competing priorities.	• Establish priorities for health supervision visits (oral health becomes part of all health supervision visits).
	• Delegate some of the education (hygiene, varnish, etc.) and varnish application to address time issue:
	  ○ Implement a previsit questionnaire that asks about the families' oral health.
	  ○ Don't give up—persistence will increase efficiency in practice.

The provider has a lack of knowledge that such questions are important.	• Educate physicians, staff members, and patients as to why oral health for families and the child is important:
	  ○ Explain why you are asking about oral health.
	  ○ Perform regular quality-improvement audits and remind staff to ask the mother's/primary caregiver's oral health status.
	  ○ Encourage continuing education among all health staff in your practice to promote standardized care.

The provider feels uncomfortable asking about the mother's health and not focusing on the child/patient or the family is not present for questions.	• Patient education—use strength-based approach/motivational interviewing technique to address oral health issues.
	  ○ Discuss the impact of oral health on general health (can't be healthy without a healthy mouth).
	• Conduct front-desk screening using a previsit questionnaire (in case the mother is not present for the visit).
	  ○ Use a family history documentation form that includes family dental health history.

Gap: Pediatric primary healthcare provider did not ask about or document the families' oral health status.	
There is no system in place to document the responses.	Include families' oral health history as a part of all health supervision visits for all routine visits after 6 months of age with paper documentation forms or EMR prompts.

Gap: Pediatric primary healthcare provider failed to document patient systemic and topical fluoride exposure.	
Potential Barriers	**Suggested Ideas for Change**
The provider is unaware that these questions are important to improve oral health, or the provider is unsure what guidance to provide due to: ○ Confusion about fluoride guidelines/policies ○ Unsure of differences between systemic/topical use ○ Unsure of what anticipatory guidance to provide regarding brushing, toothpaste, and supervision	• Learn the fluoride levels of local water supplies for your patient population on My Water's Fluoride, the CDC Web site listing of city and water district fluoridation status. ○ What is the fluoride status of the drinking water? ○ Learn where to get information about water fluoridation if it is not posted on CDC Web site. • Educate yourself about: ○ The benefits of fluoride in topical and systemic form ○ The fluoride policies on the ADA, AAPD, AAP, and Pew Web sites ○ The fluoride debate and review reliable resources about fluoride to aid in the discussion ○ Anticipatory guidance regarding topical fluoride sources and use by age
The families are hesitant regarding fluoride, either debating or refusing its use.	• Determine specific issues regarding families' concern: ○ Excessive fluoride exposure (distinguish systemic vs topical) ○ Adverse health effects ○ Skeletal fluorosis ○ Enamel fluorosis—tooth discoloration • Provide reassurance that concerns are not surprising in light of the amount of misinformation on the media: ○ Focus education on specific issues identified by the patient and families. ○ Provide patients and families with a written list of reliable resources. • Emphasize the importance and proven benefits of fluoride. ○ Keep the discussion open during future visits if families continue to be hesitant.
There is no system in place to document the response.	• Establish fluoride questions as a part of all health supervision visits with paper or EMR prompts. • Utilize the EMR more effectively by adding fluoride prompts for all routine visits and use a template to document it, such as a formal oral health risk assessment tool that contains questions regarding fluoride.

Gap: Pediatric primary healthcare provider did not document the assessment of feeding/drinking risks for oral health.	
Potential Barriers	**Suggested Ideas for Change**
The provider felt they did not have enough time and had competing priorities.	• Establish priorities for health supervision visits (oral health becomes part of all health supervision visits). • Delegate some of the responsibilities to staff, such as educating families about healthy feeding/drinking practice, to address any time issue.
The provider has a lack of knowledge that such questions are important.	• Educate physicians, staff members, and patients about the importance of good oral hygiene through simple practices such as cleaning infant's mouth with damp cloth after feeding. • Encourage continuing education among all health staff in your practice to promote standardized care.

The practice has no protocol to ask pertinent behavioral oral health questions for feeding, eating, and drinking.	• Use age-appropriate oral health anticipatory guidance. For example:
	  ○ For infants: Ask if the family props the bottle or puts the baby to sleep with a bottle of formula, milk, or juice. Offer information on foods to avoid (ie, foods that stick to the teeth) or if given, wash the teeth after feeding.
	  ○ For toddlers and older children: Create awareness about foods that stick to the teeth (ie, candies such as gummy bears, fruit roll-ups, or raisins).
	• Review the AAP Policy Statement: Maintaining and Improving the Oral Health of Young Children
	• Utilize existing educational materials found in:
	  ○ AAPD patient education brochures and parent resource center
	  ○ National Institute of Dental and Craniofacial Research (NIDCR)
	  ○ Health Resources and Services Administration (HRSA) Oral Health Web site
	  ○ National Maternal and Child Oral Health Resource Center consumer brochures (English and Spanish)
	• Provide education and anticipatory guidance to families regarding the importance and longevity of primary teeth and how poor nutrition, bottles, and sippy cups can contribute to dental caries. Helpful materials include:
	  ○ How to Prevent Tooth Decay in Your Baby
	  ○ First Steps to a Healthy Smile
	  ○ Thumbs, Fingers, and Pacifiers
	  ○ A Guide to Children's Dental Health

There is no system in place to document the response.	• Have the office support staff initiate the oral health screening process with an oral health previsit questionnaire (parent and adolescent). • Establish questions about feeding/drinking habits (ie, sippy cups, bottle to bed, etc.) as a part of all health supervision visits with paper or EMR prompts.

Potential Barriers and Suggested Ideas for Change

Key Activity: Provide Oral Health Anticipatory Guidance and Education
Rationale: Provide specific, preventative information to patients and families to promote the well-being of patients by preventing tooth decay, reducing mouth injuries, and promoting oral health. Anticipatory guidance includes, but is not limited to, nutritional counseling, behavioral issues, fluoride exposure, culturally sensitive oral health care habits, injury prevention, and promotion of a dental home.

Gap: Pediatric primary healthcare provider did not provide oral health education/anticipatory guidance.	
Potential Barriers	**Suggested Ideas for Change**
Provider lacks the knowledge on basic principles for providing oral health anticipatory guidance.	• Review Bright Futures Guidelines for Health Supervision, 3rd Edition on promoting oral health. • Post the Bright Futures Handout to educate staff about the importance of promoting oral health. • Review the AAP Bright Futures Oral Health Risk Assessment Tool and Guidance • Review the American Academy of Pediatric Dentistry (AAPD) Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents • Educate clinical staff in practices by encouraging continuing education.

The practice lacks resources for providing anticipatory guidance.	• Have staff and office dental champion create a centralized information area in the waiting area and in each exam room that is devoted to oral health education for families, including discussion prompts like "*Don't forget to ask about oral health care."* or *"When did your child last see the dentist?"*.
	• Utilize existing oral health handouts (Cavity Free at Three, National Institute of Dental Craniofacial Research [NIDCR]).
	• Provide information from HealthyChildren.org Web site, such as:
	  ○ First Steps to a Healthy Smile
	  ○ Preventing Tooth Decay in Children
	  ○ Preventing Tooth Decay
	  ○ Brushing Up on Oral Health: Never Too Early to Start
	  ○ A Guide To Children's Dental Health
	  ○ Pacifiers and Thumb Sucking
	• Review AAPD Emergency Care Q&A.
	• Promote AAP Brush, Book, Bed Program.

Oral Health in Primary Care

Gap: Pediatric primary healthcare provider did not provide oral health education/anticipatory guidance.	

The practice does not have a system for providing anticipatory guidance during a health supervision visit.	• Develop a systematic, practice-wide approach to provide anticipatory guidance at every health supervision visit.
	  ○ Establish an oral health team.
	  ○ Recruit an office dental champion (a nurse, medical assistant, or other staff member).
	  ○ Determine if there is a Chapter Oral Health Advocate (COHA) in your state who can facilitate a Lunch-and-Learn session for employees to discuss strategies for implementation of oral health assessments and education so everyone is empowered as part of the oral health office team.
	  ○ Implement the use of Bright Futures Visit Forms as a prompt for anticipatory guidance discussion topics.
	  ○ Ensure that the Age-appropriate Anticipatory Guidance Recommendations to be covered at the visit are easily accessible to providers.
	  ▪ Keep a Bright Futures Oral Health Pocket Guide in all exam rooms.
	  ▪ Keep a Child Oral Health Pocket Card in all exam rooms.
	• Ensure the system includes anticipatory guidance and education to families regarding eating/feeding/drinking oral health risks, including injuries. For example:
	  ○ For infants: Ask if the family props the bottle or puts the baby to sleep with a bottle of formula, milk, or juice. Review strategies with the family regarding how to help the child not sleep with a bottle and/or encourage only water in the bed bottle.
	  ○ Offer information on foods to avoid (ie, avoid sugary and/or sticky foods), or if given, brush the teeth with fluoridated tooth paste after feeding.
	  ○ For toddlers and older children: Create awareness about foods that stick to the teeth (ie, candies such as gummy bears, fruit roll-ups, or raisins) and the impact of frequent snacking. Educate families regarding how frequent snacking with sugary drinks or sugary and sticky foods can lead to cavities.
	  ○ Teach families to brush their child's teeth with fluoridated toothpaste beginning with the eruption of the first tooth, using a smear of toothpaste before 2 years age and a pea-size amount of toothpaste after 2 years.
	• Review the AAP Policy Statement on Preventive Oral Health Intervention for Pediatricians
	• Utilize existing educational materials found in:
	  ○ AAPD patient education brochures and parent resource center
	  ○ National Institute of Dental and Craniofacial Research (NIDCR)
	  ○ HRSA funded free oral health brochures (English and Spanish)
	  ○ National Maternal and Child Oral Health Resource Center consumer brochures (English and Spanish)
	  ○ Qualis Health Oral Health Integration in the Patient-Centered Medical Home
	• Provide education and anticipatory guidance to families regarding the importance and longevity of primary teeth and improper nutrition, suboptimal oral hygiene, inadequate exposure or fluoride, bottles, and sippy cups contribute to dental caries. Materials that are helpful include:
	  ○ How to Prevent Tooth Decay in Your Baby
	  ○ First Steps to a Healthy Smile
	  ○ Thumbs, Fingers, and Pacifiers
	  ○ A Guide to Children's Dental Health
	• Be sure to include age-appropriate injury prevention counseling
	  ○ Review the ADA dental emergency procedures

Oral Health in Primary Care

Gap: Pediatric primary healthcare provider did not provide oral health education/anticipatory guidance.	

The provider does not feel comfortable discussing oral health topics with families.	• Develop an open dialogue using motivational interviewing/strength-based approach when discussing oral health concerns with patient and families.
	  ○ Educate the patient/family regarding the relationship between oral health and systemic health.
	  ○ Advise the family against pretasting, prechewing, sharing of utensils with their children, and cleaning pacifier in their mouth to avoid the vertical transmission of harmful bacteria through saliva.
	  ○ Discuss with a pregnant woman or new mother about changes in the teeth or the gums, oral hygiene practices, fluoride use, infections, and medications.
	  ○ Use an oral health risk assessment tool to direct education and anticipatory guidance.
	• Reach out to the patients through various methods of education and resources.
	  ○ Utilize office staff, handouts, waiting room media, practice Web site, etc., to get the word out.
	  ○ Deliver messages over various visits: structure the education so that at each of the following health care visits oral health is assessed and age appropriate oral health education is provided.
	• Address brushing and flossing for any child who has at least 2 teeth touching.
	  ○ Families should perform and supervise brushing teeth by first brushing the child's teeth, then allowing the child to practice by himself or herself. Typically, children younger than 6–8 years of age do not have the manual dexterity to brush alone. When children can tie their shoes, they have the manual dexterity to brush their own teeth.
	  ○ Electric toothbrushes can be used before 4 years of age (and after 4 years of age). There is no difference in the effectiveness of electric toothbrush or manual toothbrush if children are taught how to brush properly. The optimal brushing time is 2 minutes. Children should brush at least twice a day (more if they are eating/drinking frequent sugary and/or sticky snacks or sugaring drinks.
	  ○ Discuss various strategies to motivate child to want to brush.
	  ▪ Sing a song through brushing.
	  ▪ Brush in various parts of house that are convenient
	  ▪ Model brushing by brushing as a family.
	  ▪ Use a 2-minute egg timer or listen to a 2-minute song to help know when to stop brushing.
	• Consider cultural sensitivity for families from different cultural backgrounds such as language, household decision maker, and the practice of food sharing.

Oral Health in Primary Care

Gap: Pediatric primary healthcare provider did not provide oral health education/anticipatory guidance.	

There are competing priorities with many facets of anticipatory guidance and not enough time.	• Use an oral health pre-visit questionnaire (parent or adolescent) to identify concerns and help prioritize discussion topics.
	• Send out an e-mail informing the family of the recommendations regarding dental home by age 1 year as well as other anticipatory guidance information. See a customizable email template here.
	• Establish oral health as part of all health supervision visits.
	• Establish critical times visit to implement primary prevention strategies for oral health anticipatory guidance. For example:
	  ○ Newborn—advise against the parent putting thing in his/her mouth and then to the infant's mouth (eg, cleaning a pacifier or putting the pacifier in the mother's mouth and then putting it in the newborn's mouth) to prevent vertical transmission of *Streptococcus mutans.*
	  ○ Four to 6 months—advise against tasting the food and then feeding it to the baby.
	  ○ Twelve months—offer first fluoride varnish application in the primary care office and offer oral health anticipatory guidance.
	  ○ After 12 months—assess if the child has a dental home and the date of the last dental visit. Offer fluoride varnish at up to 4 times a year for children at increased risk for dental caries and up to 2 times a year for children at low risk for dental caries.
	  ○ Delegate some of the education (hygiene, varnish, education) and varnish application to address the time issue. Create standard workflows to delegate tasks to various members of the care team and ensure the work gets done.
	  ○ Don't give up—persistence will increase efficiency in practice.
	  ○ Ask your (COHA) for ideas.

Gap: Pediatric primary healthcare provider did not document oral health education/anticipatory guidance.	
Potential Barriers	**Suggested Ideas for Change**

The practice does not have a system in place to document oral health discussions and materials provided.	• Have families complete oral health pre-visit questionnaire (parent or adolescent) either at home or in the waiting room.
	  ○ Include areas in the questionnaire to document the education and materials provided.
	• Include dentists in your list of specialist referrals.
	• Create a list with contact information for other providers (dentists, subspecialists, etc.) to coordinate care.
	  ○ Have a place for patients to update the information either on a paper form or via a kiosk/tablet device/ patient portal.
	  ○ Build EMR prompts and places to document regarding oral health risk assessment, delivery of anticipatory guidance and educational materials (handouts, videos, etc.), and delivery of care (include preventive oral health in previsit planning).

Potential Barriers and Suggested Ideas for Change

Key Activity: Ensure Fluoride Varnish Application for Patients

Rationale: Fluoride varnish is a highly concentrated dose of fluoride that is professionally applied to all tooth surfaces. The varnish is proven to adhere to each tooth surface for a longer period than other concentrated fluoride products. In combination with the risk assessment and anticipatory guidance, fluoride varnish has been shown to reduce cavities. Because fluoride varnish can be applied only by a professional, there are some options for providers who want to incorporate this into their practice.

Gap: Pediatric primary healthcare provider did not apply fluoride varnish in office.	
Potential Barriers	**Suggested Ideas for Change**

The practice does not deem this function as their responsibility.	• Review the AAP Policy Statement:
	  ○ Maintaining and Improving the Oral Health of Young Children.
	  ○ Fluoride Use Caries Prevention in the Primary Care Setting
	• Educate staff that preventive oral health is a responsibility of primary care and that includes applying fluoride varnish.

The practice feels applying fluoride varnish in the office would be:
• Burdensome
• Time-consuming
• Difficult to document
	• Review AAP *Pediatrics* article: Fluoride Varnish Use in Primary Care: What Do Providers Think?
	• Establish oral health as part of all health supervision visits.
	• Prepare each visit as if you would be providing fluoride varnish—a "be prepared" concept:
	  ○ Lay out handouts for 6-month check-ups and fluoride varnish supplies.
	  ○ Set up EMR to automatically prompt nursing staff to have fluoride varnish supplies that are stored in an easily accessible plastic box available for visits—these prompts also can be programmed according to the schedule set up by the practice.
	• Delegate to staff some of the education (hygiene, varnish) and varnish applications to address time issues and increase efficiency.
	• Some EMR systems can document fluoride varnish as a medication, as well as to whom and when it was applied, to aid in documentation.

The provider lacks the training and feels uncomfortable performing this function.	• Review the Children's Oral Health Initiative Pediatric Guide to Oral Health Flip Chart and Reference Guide (in English and Spanish) that assists pediatric primary healthcare providers in counseling patients about oral health and applying fluoride varnish.
	• Review videos of fluoride varnish application and positioning of child:
	  ○ Bright Smiles from Birth
	  ○ Smiles for Life
	• Contact Chapter Oral Health Advocate (COHA) for training at your institution, practice, or the AAP chapter meeting.
	• Visit the Oral Health Initiative Web site for resources:
	  ○ Take the Smiles for Life Course #6: Fluoride Varnish to learn the benefits, appropriate safety precautions, and dosing for fluoride, as well as how to apply fluoride varnish and provide adequate follow-up care.

Oral Health in Primary Care

Gap: Pediatric primary healthcare provider did not apply fluoride varnish in office.	
The practice does not know how to get started.	• Go to the AAP Oral Health Initiative Web site: What Do I Need To Apply Fluoride Varnish in My Office? • Review the Smiles for Life Fluoride Varnish Manual for Medical Clinicians.
The practice fears inadequate reimbursement.	• Study the State Medicaid Payment Map from PEW, which identifies the states that pay and the states where advocacy efforts are taking place, to enact this policy change. • Review the State Medicaid Payment Information table, which explains the requirements related to payment, including payment codes, age limits of children eligible for services, frequency of annual varnish application, required training, and delegation, if allowed. • Review the Oral Health Coding Fact Sheet for Primary Care Physicians. • If services are not yet covered, become active in your pediatric council or state AAP chapter to advocate for payment for primary care prevention services.
Office staff has conflicting opinions about the necessity and safety of fluoride varnish application.	• Recruit an office dental champion to educate staff on the importance of oral health care. • Create an environment for open discussion to work toward consensus and achieve standardized care. ○ Support your discussion by quoting fluoride safety data. Studies show that urine fluoride levels are the same or lower following varnish application compared to routine brushing with fluoridated toothpaste.[1] • Review the Academic Pediatrics Special Issue on Children's Oral Health that explains the importance of improving children's oral health and strategies to do so. [1] Association of State and Territorial Dental Directors Fluoride Committee. Fluoride varnish: An evidence-based approach. *Research Brief.* September 2007. http://www.astdd.org/docs/Sept2007FINALFlvarnishpaper.pdf Accessed February 11, 2016

There is family hesitancy regarding fluoride or fluoride refusal.	• Open a dialogue regarding family hesitancy using motivational interviewing/strength-based approach to allay concerns by presenting data about fluoride varnish and about being culturally sensitive.
	  ○ Families may question why fluoride varnish is necessary when they already get fluoride from supplement and fluoridated toothpaste.
	  ○ Families may be willing to pay if it is not a covered service once they understand the importance of the fluoride varnish.
	• Address patient's discomfort or pine nuts allergy issue (other nut allergies, including peanuts, are not an issue) by referring patient to the dental home for a gel or foam treatment. Colophony-free varnish is available for purchase.
	• Provide education as to why fluoride varnish is important for the physician, staff, and patient.
	  ○ Use your dental champion and your oral health team to provide education.
	  ○ Educate nurses and allied health staff in practices and encourage continuing education.
	  ○ Post the Smiles for Life Fluoride Varnish Posters in English and Spanish to show families why and how it is applied and to prompt interest.

The provider lacks understanding of patient's eligibility.	• All patients from tooth eruption through age 5 are eligible, state Medicaid programs reimburse in 49 of 50 states. • Review the AAP Bright Futures Oral Health Risk Assessment Tool and Guidance. • Review *Oral Health Risk Assessment Barrier Grids* for the Suggested Ideas for Change.

Oral Health in Primary Care

Gap: Pediatric primary healthcare provider did not apply fluoride varnish in office.	

The provider is unable to obtain fluoride or keep up with fluoride expiration.	• Identify a point person for fluoride ordering (delegate responsibility to staff member).
	• Review the Fluoride Varnish Product List and Dental Supply Companies.
	• Expand your process for ordering medical supplies to include fluoride varnish.
	  ○ NOTE: Remember fluoride varnish should be treated as any other medication; inventory, handling, storage, and expiration dates should be monitored regularly.
	  ○ Some EMR systems can help track the supply and expiration date.