Potential Barriers and Suggested Ideas for Change

Key Clinical Activity: Establish a Dental Home

Rationale: Optimal oral health requires collaboration between the offices of the pediatric primary healthcare and dental providers to provide the patient and family with consistent and continuing oral healthcare. To accomplish this, the pediatric practice needs to establish interprofessional relationships with dental partners, help families build partnerships with dental providers, facilitate and track dental referrals, and regularly update a dental resource guide.

Gap: Dental home are not established/discussed.

- For patients ≥12 months, a dental home has not been established.
- For patients <12 months, the importance of a dental home has not been discussed.

Potential Barriers	Suggested Ideas for Change

The practice lacks understanding of the concept of a dental home and its importance.	• Review the following guidelines and policies concerning the function and importance of the dental home:
	  ○ AAP policy statement from the Section on Oral Health, Maintaining and Improving the Oral Health of Young Children. Reaffirmed January 2019.
	  ○ AAP *Bright Futures:* Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. 2017, including the section, Promoting Oral Health and Recommendations for Preventive Healthcare - Periodicity Schedule
	  ○ AAPD 2018 Policy on the Dental Home
	• Review the resources provided for *How Should I Set Up My Practice To Include Oral Health?* on the AAP Oral Health Practice Tools Web page.

Families do not prioritize establishing a dental home, particularly before the child's permanent teeth come in.	• Offer education for families on establishment of a dental home in the form of posters or handouts—find these in resources section. • Use strength-based approach and motivational interviewing techniques to address oral health issues with families. • Discuss the impact of oral health on general health (cannot be healthy without a healthy mouth).
Families have a dental home but do not regularly visit their dental home.	• Select an oral health champion within the practice and designate support staff responsible for oral health awareness, referral tracking, outreach to dental offices to establish communication with dentists, etc. • Investigate families' barriers to seeking regular dental care.

Gap: Patients without a dental home are not referred to one.	
Potential Barriers	**Suggested Ideas for Change**
The practice lacks access to dental homes, particularly for children under 3 years of age.	• Review the resources provided for *How Do I Help Children To Find a Dental Home?* on the AAP Oral Health Practice Tools Web page. • Develop relationships with dental providers or university dental schools within your region, especially those who see young children <3 years old. ○ Tip: Speak directly to the dental provider and not front office staff. • Integrate a dental hygienist into your office to provide preventive dental services. Patients can directly access dental hygienists without a dentist in 42 states. • Identify ways to improve access to dental homes in your community, eg local foundations and service organizations that fund projects for children or local philanthropists with interest in children's issues.

The practice is struggling with access to dental homes within the community.	• Use these sources to find or create a resource list of dental providers in your area who see children and adolescents of all ages:
	  ○ Health Guide USA for state dental health programs
	  ○ Medicaid and Chip Web sites
	  ○ State Department of Health—for a list of Medicaid providers
	  ○ AAPD Web site
	  ○ Insure Kids Now — Connecting Kids to Coverage
	  ○ Dental schools
	  ○ State or county dental societies
	  ○ American Network of Oral Health Coalitions—check your state's coalition for a dental provider list or inquire whether they may be willing to assist in creating one
	  ○ Community health clinics, rural health clinics, federally qualified health centers
	  ○ AAP COHA network
	  ○ Federally qualified health centers (community clinics)—many have associated dentists
	  ○ Head Start and Early Head Start programs
	• Use the Dental Referral Resource Sheet template provided on the *How Do I Help Children To Find a Dental Home?* tab on the AAP Oral Health Practice Tools Web page to record provider information.

The practice lacks a protocol to refer patients to a dental home.	• Consider the role of the dental champion to establish a protocol for referring patients to dental homes and put systems in place to confirm, document, and retrieve records from the dental home. Click to see an example office protocol. • Use resources provided for *How Do I Help Children To Find a Dental Home?* on the AAP Oral Health Practice Tools Web page, including the Dental Referral Resource Sheet template, which can be modified for your practice, and *Questions to Ask When Calling a Dental Provider*. • Ask the dentist or family to fill out and fax/mail referral form. • Automate the referral in EMR and include a list of dental providers who see children and adolescents of all ages and children with special healthcare needs.

Oral Health Best Practices

Gap: Patients without a dental home are not referred to one.	
Potential Barriers	**Suggested Ideas for Change**

The patient does not have dental insurance coverage.	• Create and share a list of public dental providers who provide free or low-cost care, eg, community health centers, county health departments, and dental van services.
	• 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 to support complete dental benefits coverage.
	• 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
	  □ Free clinics

The practice does not see this as a responsibility of the medical home.	• As described in Row 1 of this grid, review guidelines and policies concerning the function and importance of the dental home.
	• Consider identifying an oral health champion within the practice and designating supporting staff members responsible for oral health awareness, communication, referral tracking, documentation, follow-up, etc.
	• In a team meeting, discuss obstacles for confirming the establishment of a dental home and the retrieval of dental records and brainstorm ways to overcome them. Implement the best ideas through Plan-Do-Study-Act (PDSA) cycles.
	• Investigate and become familiar with training opportunities and other oral health resources available from your AAP Chapter Oral Health Advocates (COHA). Following are some additional training resources:
	  • Smiles for Life National Oral Health Curriculum and Resources (Includes Training Videos)
	  • Cavity-Free at Three
	• Add prompts to electronic health records (EHR) to confirm the establishment of the dental home and to retrieve dental records. Click to see suggested prompts to include in the EHR for oral health.

Gap: The reason patients lack a dental home is unknown or not documented.	
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.
	• Allay fear in patient and family:
	  ○ Reassure 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 (message: can't be healthy without a healthy mouth).
	  ○ Use motivational interviewing techniques to help the patient/family identify the thoughts and feelings that cause fear of dentists.
	  ○ Use strength-based approach to build on patient/family strengths to 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 your local or state Area Health Education Center (AHEC) for local cultural competency training and state-specific grants.
	• Use case managers, practice navigators, and community health workers to help families get to their appointments and address language and cultural barriers; both publicly and privately insured children have access to a case manager.
	• Have local bus schedules and taxi services schedule and contact information available.

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)* as a reminder and place 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 that asks if the child has a dentist and the date of last dental visit and contact information. Consider having translation services available or using multilingual questionnaires to obtain this history. • Click to see suggested prompts to include in the EHR for oral health.

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 is a responsibility of the pediatric primary healthcare provider who can identify factors that contribute to dental caries. Education for providers, patients, and families is fundamental in controlling dental caries and should continue throughout a child's life.

Gap: Oral health risk assessment was not completed at recommended intervals
(at the last recommended health supervision visit for patients ≤6 years or within the last 12 months for patients >6).

Potential Barriers	Suggested Ideas for Change

The practice is unaware of current oral health recommendations concerning risk assessment or provider's responsibilities.	• Review oral health policies and guidelines concerning oral health risk assessment:
	  ○ AAP policy statement from the Section on Oral Health, Maintaining and Improving the Oral Health of Young Children. Reaffirmed January 2019.
	  ○ AAP Oral Health Practice Tools
	  ○ AAP *Bright Futures:* Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. 2017, including the section, Promoting Oral Health and Recommendations for Preventive Healthcare – Periodicity Schedule
	• Oral health risk assessment includes injury prevention. Review:
	  ○ AAP 2014 Clinical Report, Management of Dental Trauma in a Primary Care Setting

The practice is unaware of the recommended frequency for oral health risk assessments.	• Review and incorporate timely recommendations from:
	  ○ American Academy of Pediatric Dentistry (AAPD) 2018 Best Practices, Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment For Infants, Children, And Adolescents
	  ○ Bright Futures Recommendations for Preventive Healthcare – Periodicity Schedule
	  ○ *How and When Do I Provide an Oral Exam and Risk Assessment?* on the AAP Oral Health Practice Tools Web page.

The provider's perception is that there is not enough visit time and that there are competing family/provider priorities.	• Have support staff initiate the oral health screening process using the Oral Health Previsit Questionnaire created for this course to help identify risk factors for dental caries and collect information about dental services provided by others. Using this questionnaire can save time and help with documentation. • Delegate responsibilities to staff, such as educating families about healthy eating/drinking practices or daily oral care routines. • Have educational materials for families preprinted and readily available and/or on the practice Web site.
The practice does not have a protocol in place for proper oral health documentation.	• Consider establishing an oral health champion who will review and institute oral health documentation practices that suit the needs of the practice and patient flow. (Click to see a sample oral health protocol.) • Use age-appropriate Bright Futures Visit Forms to remind providers to record oral health information. • Enhance or create encounter forms with appropriate questions and a place to document results.

Oral Health Best Practices

Gap: Oral health risks for patients <6 years was not completed using a formal assessment tool.	
Potential Barriers	**Suggested Ideas for Change**
The practice is uncertain of which risk assessment tool to use.	• Consider the AAP Oral Risk Assessment Tools located on the *How and When Do I Provide an Oral Exam and Risk Assessment?* on the AAP Oral Health Practice Tools Web page, which includes tools in English and Spanish. • Contact your AAP Chapter Oral Health Advocates (COHA) to determine if there are state-specific tools available for use.
The provider is concerned that using a formal tool will take too much time.	• Be aware that risk assessments using available tools can be performed quickly. Tools are available on paper, which can be printed before visits, or can be incorporated in the EMR. The Smiles for Life Oral Health App, which is free of charge, can be refreshed with each patient encounter.

Gap: Clinical examination of patients' teeth and gums was not performed at the last health supervision visit.	
Potential Barriers	**Suggested Ideas for Change**
The provider lacks the training and/or ability to interpret exam findings and triage. Or, there is a perceived barrier of poor child compliance.	• Utilize oral health training programs to gain skill in oral health assessment such as the Smiles for Life Oral Health Curriculum. • Utilize your AAP Chapter Oral Health Advocates (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. • While examining the child's throat, also look at the teeth and gums. The exam becomes easier with practice.

Gap: Patients' eating/drinking habits that put them at risk for dental caries was not assessed at the last health supervision visit.	
Potential Barriers	**Suggested Ideas for Change**
The practice has no protocol to ask pertinent behavioral oral health questions for feeding, eating, and drinking.	• Follow Bright Futures recommendations concerning oral health anticipatory guidance, which spell out questions to ask patients/families for optimal oral health, including patients' eating/drinking habits. See the content and barriers/ideas grid for KCA 3, Provide Anticipatory Oral Health Guidance, for more information. • Educate physicians, staff members, and patients about the importance of good oral hygiene through simple practices such as cleaning an infant's mouth with damp cloth after feeding, offering fluoridated tap water after ingestion of sugar-containing foods and beverages, brushing with fluoride toothpaste twice daily, and flossing. • Encourage continuing education among all health staff in your practice to promote standardized care. • Be aware that the questions for obesity prevention concerning excessive sugar consumption that are already being asked mirror those for oral health.

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 responsibilities to staff, such as educating families about healthy feeding/drinking practices, to address time constraints. • Recall that the questions/guidance for oral health mirror those for obesity prevention except for adding the discussion of brushing/flossing.

Gap: Patients' daily oral healthcare routine was not assessed at the last health supervision visit.	
Potential Barriers	**Suggested Ideas for Change**
The practice has no protocol to ask pertinent behavioral oral health questions about daily care routine.	• Like the suggested ideas for the previous gap, follow Bright Futures recommendations concerning oral health anticipatory guidance, which spells out questions to ask patients/families for optimal oral health, including daily oral healthcare routine. See the content and barriers/ideas grid for KCA 3, Provide Anticipatory Oral Health Guidance, for more information. • Use a strength-based approach and motivational interviewing techniques to address oral health issues. Discuss the impact of oral health on general health (cannot be healthy without a healthy mouth).

Gaps: Patients' daily intake of systemic fluoride was not assessed. Patients' sources of topical fluoride was not assessed.	
Potential Barriers	**Suggested Ideas for Change**
The provider does not make assessments concerning fluoride intake due to: ○ Confusion about fluoride guidelines/policies ○ Unsure of differences between systemic/topical use ○ Lack of knowledge about fluoridation in local water supply	• Review *How Much Fluoride Do My Patients Need? and What Do I Need To Apply Fluoride Varnish in My Office?* on the AAP Oral Health Practice Tools Web page. • 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 the 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, including the AAP 2020 Clinical Report, Fluoride Use in Caries Prevention in the Primary Care Setting ○ The fluoride debate and review reliable resources about fluoride to aid in the discussion ○ Age-appropriate oral health anticipatory guidance concerning topical fluoride sources and use ○ The fluoridation in local water supplies by visiting the CDC's Find Water System Information and search by state and county • See the content and barriers/ideas grid for KCA 4, Apply Fluoride Varnish.

Potential Barriers and Suggested Ideas for Change

Key Activity: Provide Oral Health Anticipatory Guidance

Rationale: Provide relevant information to patients and families that promotes the well-being of patients concerning the prevention of tooth decay, reduction of mouth injuries, and promotion of oral health. Anticipatory guidance includes, but is not limited to, nutritional counseling, behavioral issues, fluoride exposure, culturally sensitive oral healthcare habits, injury prevention, and promotion of a dental home.

Gap: Age-appropriate oral health anticipatory guidance was not offered at the last health supervision visit.

Potential Barriers	Suggested Ideas for Change

Practice lacks knowledge on basic principles for providing oral health anticipatory guidance.	• Review the following policies and guidelines:
	  ○ AAP policy statement from the Section on Oral Health, Maintaining and Improving the Oral Health of Young Children. Reaffirmed January 2019.
	  ○ AAP *Bright Futures:* Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. 2017, including the section, Promoting Oral Health and Recommendations for Preventive Healthcare – Periodicity Schedule
	  ○ For anticipatory guidance on injury prevention, review the AAP 2014 Clinical Report, Management of Dental Trauma in a Primary Care Setting
	• Be aware of AAP age-appropriate oral health anticipatory guidance recommendations.
	• Review and share with staff resources provided on the AAP Oral Health Practice Tools Web page, including those on the *How Can I Educate Families?* tab.

The practice does not have a system for providing oral health anticipatory guidance during a health supervision visit.	• Develop a systematic, practice-wide approach to provide age-appropriate anticipatory guidance at every health supervision visit. Doing the following will facilitate your efforts:
	  ○ 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 to discuss strategies for implementation of oral health assessments and education.
	  ○ Implement the use of Bright Futures Visit Forms as a prompt for anticipatory guidance discussion topics.
	  ○ Ensure that the guidance recommendations to be covered during the visit are easily accessible to providers.
	  ▪ Keep a Bright Futures Oral Health Pocket Guide in all exam rooms.
	  ▪ Keep a Smiles for Life Child Oral Health Pocket Card in all exam rooms.
	  ○ Consider how you will document oral health discussions and materials provided.
	  ○ Be mindful of keeping open dialogues with families by employing motivational interviewing techniques and using a strength-based approach when discussing oral health concerns.
	• Keep family handouts and a list of Web sites (as described in the next row of this grid) accessible to providers.
	• Train and encourage staff to provide guidance to families regarding the importance of twice-daily brushing (flossing if indicated) beginning with appearance of the first tooth, the dental home, the importance and longevity of primary teeth, and how improper nutrition, suboptimal oral hygiene, inadequate exposure to fluoride, and the contribution of bottles and sippy cups to dental caries. Include guidance on injury prevention and dental emergencies. The Smiles For Life Oral Emergencies Pocket Card is a good resource for preparing staff.

Oral Health Best Practices

Gap: Age-appropriate oral health anticipatory guidance was not offered at the last health supervision visit.	
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 exam rooms 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 family handouts and Web sites such as the following: ○ AAPD Parent Resources ○ Cavity Free at Three Resources Page ○ CDC Children's Oral Health Web site ○ HealthyChildren.org parent resources: Brushing Up on Oral Health: Never Too Early to Start FAQ: Fluoride and Children Dental Emergencies: What Parents Need to Know ○ Healthy Teeth Healthy Children, a program of the PA Chapter; click on Resources tab for low literacy resources in multiple languages ○ Smiles for Life Oral Health Curriculum Patient Education: Fluoride varnish and patient information posters and handouts in English and Spanish ○ Campaign for Dental Health videos with pediatricians discussing the benefits of drinking fluoridated water and protecting teeth with fluoride varnish. Community water fluoridation works Drinking tap water protects kids' teeth Fluoride: An easy way to protect your teeth Los beneficios de agua del grifo ○ How Can I Educate Families? on the AAP Oral Health Practice Tools Web page
There are competing priorities with all the facets of anticipatory guidance and not enough time.	• Use information from the Oral Health Previsit Questionnaire to help identify possible concerns and prioritize discussion topics. • Consider sending an e-mail informing the family of recommendations for oral health. See a customizable email template that can be sent before the child's 6-month visit that introduces the importance of a dental home. • Consider adding oral health topics in practice newsletters to families.

Potential Barriers and Suggested Ideas for Change

Key Activity: Apply Fluoride Varnish
Rationale: Fluoride varnish is a highly concentrated dose of fluoride that is professionally applied to all tooth surfaces and does not cause fluorosis. 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 on preventive measures (including brushing and fluoridated water), fluoride varnish has been shown to reduce cavities. Fluoride varnish should be applied in the pediatric office for infants and children starting at the age of primary tooth eruption if not otherwise applied by a trained professional.

Gap: Fluoride varnish was not applied in the pediatric office for patients <6 years once teeth have erupted.	
Potential Barriers	**Suggested Ideas for Change**

The practice does not consider fluoride varnish application to be their responsibility.	• Review recommendations for fluoride varnish application in the following:
	  ○ AAP policy statement from the Section on Oral Health, Maintaining and Improving the Oral Health of Young Children. Reaffirmed January 2019.
	  ○ AAP 2020 clinical report, Fluoride Use in Caries Prevention in the Primary Care Setting
	  ○ 2014 Prevention of Dental Caries in Children From Birth Through Age 5 Years: US Preventive Services Task Force Recommendation Statement
	• Educate staff that preventive oral health is a responsibility of primary care and includes applying fluoride varnish. Share resources such as *How Much Fluoride Do My Patients Need?* and *What Do I Need To Apply Fluoride Varnish in My Office?* on the AAP Oral Health Practice Tools Web page.

Oral Health Best Practices

Gap: Fluoride varnish was not applied in the pediatric office for patients <6 years once teeth have erupted.	

The practice feels applying fluoride varnish in the office would be:
☐ Burdensome
☐ Time-consuming
☐ Difficult to document
	• Review the following literature:
	  ○ American Dental Association, ADA Professionally Applied Topical Fluoride: Evidence-Based Clinical Recommendations chart
	  ○ Article, Fluoride Varnish Use in Primary Care: What Do Providers Think?
	  ○ Association of State and Territorial Dental Directors (ASTDD). Fluoride Varnish Policy Statement. Updated October 2015
	  ○ 2020 AAP clinical report, Fluoride Use in Caries Prevention in the Primary Care Setting.
	• Establish oral health as part of all health supervision visits and prepare as if you would provide 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.

	• Work with the dental champion to delegate to trained staff some of the education (hygiene, varnish) and varnish applications to address time issues and increase efficiency, but be sure that clinicians are examining the teeth as they look into the mouth. • Some electronic health records systems can document fluoride varnish as a medication, as well as to whom and when it was applied, to aid in documentation. Others can include it as a procedure with CPT code 99188. • Remind clinicians and staff about the impact poor oral health has on the child, family, and society, including increasing disease burden, poor school performance/learning, pain, lost days in school, and possible increased severity or risk of complications with SARS-CoV-2 infections (*British Dental Journal*, 2020). • Realize that reimbursement for fluoride varnish can provide significant additional revenue to the practice while improving the health of patients. Costs for applying the varnish are less than $2 in supplies plus your time to apply it. (See reimbursement information by state on the information and resources map on the AAP Section on Oral Health Web page.) • Recognize that the application of fluoride varnish is a part of the Bright Futures recommendations for pediatric preventive care and, therefore, is not optional.

The provider lacks the training and feels uncomfortable applying fluoride varnish.
 	
Or, members of the practice/staff have concerns about the necessity and
	• Review training materials, including:
	  ○ YouTube Video, Fluoride Varnish Application by NYCHealth
	  ○ Smiles for Life Fluoride Varnish and Counseling Course
	• Contact Chapter Oral Health Advocate (COHA) for training at your institution, practice, or AAP chapter meeting.
	• Realize that fluoride varnish does not cause fluorosis.
	• Research and discuss fluoride safety data with providers and staff. Studies show that urine fluoride levels are the same or lower following varnish application compared to routine brushing with fluoridated toothpaste.[1]

Oral Health Best Practices

Gap: Fluoride varnish was not applied in the pediatric office for patients <6 years once teeth have erupted.	
safety of fluoride varnish application.	[1] Association of State and Territorial Dental Directors Fluoride Committee. Fluoride varnish: an evidence-based approach. *Research Brief.* September 2007. https://www.astdd.org/docs/Sept2007FINALFlvarnishpaper.pdf. Accessed December 21, 2020. NOTE: This *Research Brief* was updated in March 2014: https://www.astdd.org/www/docs/fl-varnish-research-brief.pdf

There is family hesitancy regarding fluoride, either debating or refusing its use.	• Determine specific issues regarding families' concern with empathy, then address their specific concerns:
	  ○ Excessive fluoride exposure (distinguish systemic vs topical)
	  ○ Adverse health effects
	  ○ Skeletal fluorosis
	  ○ Enamel fluorosis—tooth discoloration
	  ○ Families may question why fluoride varnish is necessary because they 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.
	• Emphasize the importance and proven benefits of fluoride. Share reliable educational material. For example, these videos from the Campaign for Dental Health feature pediatricians discussing the benefits of drinking fluoridated water and protecting teeth with fluoride varnish.
	  ○ Community water fluoridation works
	  ○ Drinking tap water protects kids' teeth
	  ○ Fluoride: An easy way to protect your teeth (Spanish: Los beneficios de agua del grifo)
	  ○ Fluoride for Children: FAQs
	• Foster open dialogues with families using motivational interviewing techniques, employing a strength-based approach to discussions, and being culturally sensitive. Keep the discussion open for future visits if families continue to be hesitant.
	• Address patient's discomfort or pine nuts allergy issue (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. (Search for colophony-free fluoride varnish on the Web for products.)
	• Post fluoride varnish posters such as the Healthy Teeth Healthy Children *What is Fluoride Varnish?* available in English or Spanish or the Smiles for Life Child Fluoride Varnish Posters available in several languages to prompt interest in varnish application and explain the benefits.
	• Offer the American Fluoridation Society link to the family for further research.

Oral Health Best Practices

Gap: Fluoride varnish was not applied in the pediatric office for patients <6 years once teeth have erupted.	
The provider lacks understanding of patient's eligibility for varnish application. Or, the practice fears inadequate reimbursement.	• Be aware that all patients from tooth eruption through age 5 are eligible; state Medicaid programs reimburse in all 50 states. Commercial insurances should pay for fluoride varnish as it is required by Bright Futures and is a USPSTF Class B recommendation. (Note: Use the Contest Non-payment for Fluoride Varnish Application template letter if you encounter carriers who deny coverage.) • Consult the AAP Oral Health Advocacy Web page, which includes a link for Preventive Oral Health Services by state, including payment details, reimbursement rates, and codes. Also see reimbursement information by state on the information and resources map on the AAP Section on Oral Health Web page. • See 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 Preventive Oral Health Services 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. • For specific coding questions, e-mail aapcodinghotline@aap.org. • 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.

The provider is unable to obtain fluoride or keep up with fluoride expiration.	• See *What Do I Need To Apply Fluoride Varnish in My Office?* on the AAP Oral Health Practice Tools Web page.
	• Identify a point person for fluoride ordering (delegate responsibility to staff member).
	• 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. Shelf life is typically 2 years and does not require refrigeration.
	  ○ Varnish expiration dates are generally more than 1 to 2 years. Varnish can be ordered in quantities as low as 32 per box, but is less expensive if ordered in larger quantities.

Also see the Perform Oral Health Risk Assessment grid for potential barriers and suggested ideas for change concerning the following related gaps:

- ***Patients' daily intake of systemic fluoride was not assessed.***
- ***Patients' sources of topical fluoride was not assessed.***