Integrating Oral Health into Routine Well Care

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Disclosure

We have no present or past financial interest or involvement with any of the products/companies that will be mentioned in this presentation.

In this lecture, we will discuss the “off-label” use of an FDA-approved pharmaceutical (fluoride varnish).
Severe early childhood caries on 18 mo
Severe early childhood caries on 18 mo

This child has been to the pediatrician 5-6 times
Learning Objectives For This Session

1) Review of the 10 key concepts about dental caries and oral health

2) Discuss Bright Futures and AAP recommendations for practitioners

3) Share tips and tools for implementing oral health risk assessments into your practice
10. Caries Prevalence
The Reality

- Although dental caries (tooth decay) is largely preventable, it remains the most common chronic disease of children aged 5 to 17 years—5 times more common than asthma (59% versus 11%).
- Once established, the disease requires treatment. A cavity only grows larger and more expensive to repair the longer it remains untreated.
- Fewer than 1 in 5 Medicaid-covered children received at least one preventive dental service in a recent year; many states provide only emergency dental services to Medicaid-eligible adults.
- Poor children have nearly 12 times more restricted-activity days because of dental-related illness than children from higher-income families. Pain and suffering due to untreated tooth decay can lead to problems in eating, speaking, and attending to learning.
Caries Prevalence

Successes
- Prevalence and severity trends have changed
- 75% of kids have only 25% of the disease

Challenges
- 25% of children have 80% of the disease
- Caries Experience:
  - 11% of 2 year olds,
  - 44% of 5 year olds.

High caries experience is associated with:
- low socio-economic level/ low health literacy
- parental education level
- ethnic minorities and recent immigrants
Severe late clinical stages of Early Childhood Caries (ECC)

Overall impact of the underlying disease on general health and quality of life
9. What is dental caries?

Caries → a disease

Cavities → consequence or a sequelae of the disease
Dental caries is an infectious, transmissible disease.

Modified by dietary carbohydrates and critically regulated by saliva.

Complex and Multifactorial
Dental caries is an infectious, transmissible disease modified by dietary carbohydrates and critically regulated by saliva.

Caused by specific bacteria:

- **Mutans streptococci**: *Strep mutans*, *Strep sobrinus*
- **Lactobacilli**
- Several new species identified with ECC complex and different than regular infections
Acid producing bacteria are usually less than 1 percent of the total flora in the biofilm.
7. Dental caries is an infectious, transmissible disease modified by dietary carbohydrates and critically regulated by saliva.

- **Primarily Vertical Transmission**
  cariogenic bacteria are transmitted via saliva from mother or caretaker to child before teeth erupt and colonize the teeth shortly after their eruption.

- **Horizontal transmission** seems to be more common than previously thought in early childhood and pre-school age children.

  Parental caries status is critical.
Oral Flora: How Does Infection Occur?

- Transmitted mainly from mother or primary caregiver to infant
- Babies can be infected even before the eruption of teeth
- Earlier child colonized, the higher the risk of caries
- Maternal caries status is critical
Dental caries is an infectious, transmissible disease and critically regulated by saliva. Modified by dietary carbohydrates and critically regulated by saliva.

- Diet related
  sugars and carbohydrates (especially refined) promote bacterial growth and provide substrate for bacteria to produce acid
  Frequency of exposure is critical.
  (Vipeholm Study)

- Lifestyle dependent
  home care and hygiene practices limit the action of diet on bacteria because it is a time dependent process.
Streptococcus mutans culture showing active cell division. Sucrose leads to extracellular polysaccharides that stick the plaque together.
Substrate: You Are What You Eat

- Caries is promoted by carbohydrates, which break down to acid.
- Acid causes demineralization of enamel.
- Frequent snacking promotes frequent acid attack.
- Foods with complex carbohydrates (breads, cereals, pastas) are major sources of “hidden” sugars.
- High sugar content in sodas and “natural” sugars in juice are a major source of these substrates.
5. Dental caries is an infectious, transmissible disease modified by dietary carbohydrates and critically regulated by saliva.

- Saliva’s flow and composition alter the caries process on the tooth surface.
- Has a major impact on biofilm, plaque, and bacterial colonization.
- Saliva flow is greatly reduced at night.
Diet - Not Just What You Eat, But How Often

- Acids produced by bacteria after sugar intake persist for 20 to 40 minutes.
- Frequency of sugar ingestion is more important than quantity.
Protective Factors

Calcium phosphates

Enamel Plaque/saliva

Calcium phosphates

Demineralization

Remineralization

Acid pH

Neutral pH
Caries is a dynamic process and reversible up to a specific point.

The Caries Balance

- **Pathological Factors**
  - Acid-producing bacteria
  - Frequent eating/drinking of fermentable carbohydrates
  - Sub-normal saliva flow and function

- **Protective Factors**
  - Saliva flow and components
  - Fluoride - remineralization
  - Antibacterials: chlorhexidine, xylitol, new?

- **No Caries**

- **Caries**

JDB Featherstone
When protective factors prevail the result is remineralization.

When harmful factors prevail the result is further demineralization that quickly progresses into cavitation which is irreversible.
Once the enamel breaks, the process is irreversible and progressive.
Treatment gets progressively more invasive, expensive....

cavities only get larger, and fast
...and complicated
3. Fluoride works primarily via topical (surface) mechanisms

- **Fluoride inhibits demineralization**
  by adsorbing from solution onto tooth mineral crystal surfaces

- **Fluoride enhances remineralization**
  combining with calcium and phosphate to make a low solubility veneer of fluorapatite-like mineral.

- **Fluoride can inhibit plaque bacteria**:
  interferes with enzymes in the cell
Protective Factors

- Calcium phosphates
- Enamel Plaque/saliva

Neutral pH

Fluoride speeds up remineralization -> less soluble mineral

Acid pH
Fluoride: Evaluate all sources

- Check on water fluoridation, and testing well water
- Fluoride prescriptions, giving optimal instructions for timing and form.
- Fluoride Water
- Counsel on toothpaste as a source of fluoride.
- Encourage on use of tap water when the water is fluoridated.
- Cultural Considerations
Systemic F - Prescription Supplements

- Available from physician or dentist
- *Determine water fluoride level before writing prescription!*
- Multiple sources of F make prescribing challenging!
- Recommended for patients at *high risk* who have no F in tap water starting at 6 months*
  - *JADA 2010;141;1480-1489*
Making a shared decision

**Considerations**

Is reconstituted infant formula the main source of nutrition for the infant?

What type of formula is the infant consuming – powder or liquid concentrate or ready-to-feed?*

Does the child consume milk or soy based formula?*

How long will the child continue to consume formula?

What is the level of fluoride in the water being used to reconstitute formula?*

**Discussion**

Fluoride from reconstituted infant formula may add to the chance of developing fluorosis.

It is difficult to isolate the risk of developing fluorosis specifically from reconstituted formula.

Children are exposed to multiple sources of fluoride during the tooth development period.

Reducing fluoride intake from reconstituted infant formula alone will not eliminate the risk of fluorosis development.

**Decision**

Provide information to the parents or caregivers and make a shared decision.

Examples of dental fluorosis.†

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*In general, liquid concentrate mixed with water has less fluoride than powder concentrate mixed with water. Ready-to-feed has the lowest concentration of fluoride compared to reconstituted formulas.

*Soy-based formulas have slightly greater fluoride content than milk-based formulas.

†You can learn the fluoride content of your tap water by contacting your local water supplier, the local/county/state health department or online at http://apps.nccd.cdc.gov/MWF/index.aspx

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ADA American Dental Association®
America’s leading advocate for oral health

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Making a shared decision

Determine balance between need for caries prevention and risk of fluorosis

**Fluoride Exposure**
Consider all sources of fluoride intake including bottled water.
Contact local, county and/or state health departments about local water fluoride content or test water sample.

**Caries Prevention**
Repeat caries risk assessment at frequent intervals because risk status can change.
Caries risk assessment tools are available for dentists* and physicians.**

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**Comply with prescription**
Use dietary fluoride supplements as directed to maximize the caries prevention benefit.
Chew tablets or suck lozenges for 1–2 minutes before swallowing to maximize topical effect.
For infants, supplements are available as a liquid and used with a dropper.

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**The Clinician**

&

**The Patient**
• Fluoride concentrations are up to .7 or .8 ppm
• 8 oz bottles contain approx. .20 mg F ion
Professionally applied Fluorides
By Pediatrician, family practitioner, or dentist
when children at high risk
Brushing twice daily with a FLUORIDE containing dentifrice is one of the MOST effective ways to control dental decay.

Evaluate each child before recommending training toothpaste.
Supervised use of fluoride toothpaste

Curnow, Pine, et al, 2002 reported 56% reduction with supervised brushing twice daily

Cochrane review 2003 reports 24% caries reduction with twice daily brushing
Primary preventive procedure. Twice daily use has greater benefits than once daily.

Counsel: child’s caries risk, dispensing right volume of toothpaste onto soft, age-appropriate sized toothbrush, frequency of brushing, and performing/assisting brushing on young children.

A “smear” of fluoridated toothpaste for children less than 2 years of age

A “pea-size” amount for children ages 2 to 5

2. Caries is an entirely preventable disease

Early identification of risk is crucial
Health providers should work as a team
Fluoride Varnish Efficacy in Preventing Early Childhood Caries

INTRODUCTION
Early childhood caries is a public health problem sometimes seen in young children almost as soon as their teeth erupt. In some cases, pediatric dental services may require anesthesia in the operation of teeth. Services often unavailable, especially for low-income families, and urgent tooth extraction. Excellent clinical outcome was achieved with a wide array of fluoride varnish products and six follow-up telephone calls.

Results. After one year, children in the MI

ABSTRACT
To determine the efficacy of fluoride varnish (5% NaF, Duraphat®, Colgate) added to caregiver counseling to prevent early childhood caries, we conducted a two-year randomized, dental center trial. The fluoride varnish aids in preventing further decay and remineralizing incipient lesions on some children
On reducing caries rates:

Behavior modification is just as important as fluoride varnish or restorative treatment.

Motivating parents to prevent caries in their young children

One-year findings

PHILIP WEINSTEIN, Ph.D.; ROSAMUND HARRISON, D.M.D., M.S.; TONYA BENTON, M.A.

Background. The authors conducted a study to compare the effect of a motivational interviewing counseling treatment with that of traditional health education on parents of young children at high risk of developing dental caries.

Overview. The authors enrolled in the study parents of 240 infants aged 6 to 18 months and randomly assigned them to either a motivational interviewing, or MI, group or a traditional health education (control) group. Parents in the control group received a pamphlet and watched a video. Parents in the MI group also received the pamphlet and watched the video; in addition, they received a personalized MI counseling session and six follow-up telephone calls.

Results. After one year, children in the MI
Efficacy of an oral health promotion intervention in the prevention of early childhood caries

Behavior modification ideally should start with the mothers.
It is important to control the disease process early because:

- 40 percent of Early Childhood Caries (ECC) patients treated for restoration under General Anesthesia (GA) relapsed, experiencing tooth decay within the first year after dental surgery. (Berkowitz RJ, Ca Dent Assoc 2003)

- An eight-year study of children ages three to five 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, J Dent Res 2002)
Higher caries experience is associated with:

- Mothers who have high caries experience
- Lower socio-economic status and lack of dental home
- Ethnicity
- Parental education level

However,

- Poverty alone (or being on Medicaid) is not an indicator of high risk
- Belonging to a racial minority or being a recent immigrant does not automatically place a child on high risk
Caries Activity vs. Caries Risk

- Caries Activity describes the status of the caries process (remin/demin) on an individual tooth surface.
- Caries Risk describes the status of the whole patient, defined as the likelihood of the patient of getting a new cavitation.
Risk assessment.

use a form to aid in identification of risk factors and follow-up

<table>
<thead>
<tr>
<th>RISK FACTORS</th>
<th>PROTECTIVE FACTORS</th>
<th>CLINICAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ Mother or primary caregiver had active decay in the past 12 months Yes □ No □</td>
<td>▲ Existing dental home Yes □ No □</td>
<td>▲ White spots or visible decalcifications in the past 12 months Yes □ No □</td>
</tr>
<tr>
<td>▲ Mother or primary caregiver does not have a dentist Yes □ No □</td>
<td>▲ Drinks fluoridated water or takes fluoride supplements Yes □ No □</td>
<td>▲ Obvious decay Yes □ No □</td>
</tr>
<tr>
<td>▲ Continual bottle/sippy cup use with fluid other than water Yes □ No □</td>
<td>▲ Fluoride varnish in the last 6 months Yes □ No □</td>
<td>▲ Restorations (fillings) present Yes □ No □</td>
</tr>
<tr>
<td>▲ Frequent snacking Yes □ No □</td>
<td>▲ Has teeth brushed daily Yes □ No □</td>
<td>▲ Visible plaque accumulation Yes □ No □</td>
</tr>
<tr>
<td>▲ Special health care needs Yes □ No □</td>
<td></td>
<td>▲ Gingivitis (swollen/bleeding gums) Yes □ No □</td>
</tr>
<tr>
<td>▲ Medicaid eligible Yes □ No □</td>
<td></td>
<td>▲ Teeth present Yes □ No □</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▲ Healthy teeth Yes □ No □</td>
</tr>
</tbody>
</table>

Caries Risk: □ Low □ High
Completed: □ Anticipatory Guidance □ Fluoride Varnish □ Dental Referral
Diet Recommendations

- Transition from the breastfeeding / bottle starting at 9 mo. age
- Bottle can be used with only water at nights
- Sippy cup can be used with regular beverages during meals or water only between meals
- Watch for hidden sugars in starches and beverages (apple juice and rice)
- Sticky sweets are the most dangerous
Targeted counseling: directed towards modifying the individual’s specific risk factors.

Not only for caries

obesity/diabetes
Fight risk factors:

- Instruct parents about vertical transmission and frequency of sugar intake
- Discourage frequent snacking
- Discourage frequent consumption of sweet drinks. Bottle, sippy cup?

*Not only for caries, obesity/diabetes*
Oral Hygiene Recommendations

- Start tooth brushing as soon as the first tooth erupts. Even better, have the baby do the teething with a frozen toothbrush.
- Use a smear of fluoridated toothpaste as soon as the first tooth erupts on high risk children.
- Supervised vs. unsupervised brushing.
- Children should brush alone at age…
- Recommend flossing asap if there are no spaces between the teeth. Or when the first tooth gets loose if there are spaces.
Promote Protective Factors:

- Encourage supervised brushing with fluoride toothpaste
- Encourage drinking of fluoridated water
- Recommend healthy snacks

8 oz bottles contain approx. .20 mg F ion
1. Dental Home

AAP Oral Health Policy. May, 2003
AAPD and ADA Policies

Infants should have a dental home by age 1 or 6 months after the eruption of the first tooth.
AAP Policy Statement
Oral Health Risk Assessment Timing and Establishment of the Dental Home”
(2003, policy reaffirmed in 2009)
and
“Preventive Oral Health Intervention for Pediatricians” (2008)

- Assess mother/caregivers oral health status
- Assess oral health risk in infants and children
- Recognize signs and symptoms of dental caries
- Make timely referral to a dental home
AAP policy statements......

• Provide anticipatory guidance and instruction on proper brushing and flossing as well as proper nutrition and dietary practices.

• Make timely referral to a dental home (6 months after the first tooth erupts or by 12 months of age, whichever comes first)

• Assess child’s exposure to fluoride and administration of all fluoride modalities based on an individual’s caries risk.
Why do we recommend fluoride varnish for very young children?

- 41% of US children 2 to 11 have had caries in their primary teeth
- To prevent dental caries and in some cases reverse early dental caries
- Children with early childhood decay are more likely to get more decay
- In addition to pain and infection:
  - Affects their speech
  - Affects their ability to eat
  - Affects their ability to learn
  - Affects the way they feel about themselves
Possible Barriers to Implementation of Oral Health Risk Assessment Tool and Fluoride Varnish Program during well child care visits

• Attitudes
• Education
• Lack of time in a routine well care visit
• Lack of insurance payment for procedure
• Lack of manpower (assistants) in the office to help with the assessments and varnish procedure.
Tools to Implement Preventive Oral Health Program in Primary Care Practice Setting

- Printed forms for you to keep valuable resources
- AAP/NJ website – www.aapnj.org
- Oral Health training modules online:  
  - Smiles for Life (endorsed by the AAP)
Risk assessment.

use a form to visualize the caries balance weighing in risk factors vs. protective factors from parent interview to complement the clinical findings.

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<td>Mother/primary caregiver has active decay in the past 12 months</td>
<td>Existing dental home</td>
<td><strong>Pathological Factors</strong></td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>坚硬度, 流动性与成分</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Fluoride - remineralization</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Antibacterials:</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Chlorhexidine, xylitol, new?</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td><strong>Protective Factors</strong></td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>White spots or visible decalcifications in the past 12 months</td>
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<td>Yes</td>
<td>Sub-normal saliva flow and function</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Teeth present</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Healthy teeth</td>
</tr>
</tbody>
</table>

- Parent or caregiver with recent or current caries
- White spots
- Obvious decay

= high risk
Risk assessment facts:

- Parent or caregiver with recent or current caries
- White spots
- Obvious decay

= High risk

Belonging to a low socioeconomic level does NOT make a child high risk

Use risk factors recorded as basis for counseling and anticipatory guidance
Supplies Needed to Perform Fluoride Varnish Procedure

- Varnish
- Disposable mirrors
- Exam gloves
- Gauze
- Light source/ head lamp
Cost of Supplies

- Fluoride varnish kit-approx. $0.86-$2.00/application
- Disposable mirrors- $0.19-$0.22/each
- 2” x 2” gauze- $1.12/pk of 200
- Head lamp (bicycle)- $10.00-$15.00
- Disposable gloves- $0.17/pair
  (PVC exam gloves)

CAN EASILY BE DONE FOR LESS THAN $2.00/PATIENT
Fluoride Varnish Application

Clean and Dry Teeth
Apply Varnish with small brush

covering anterior and posterior teeth
Fluoride Varnish Application

- The varnish hardens quickly after application as a yellow film
- The child can have a drink of water
Post application instructions for parents

- Varnish will set on contact with saliva.
- Child can eat or drink right after application but avoid hot beverages and hard or crunchy foods for 4 hours.
- Do not brush your child’s teeth tonight. Start brushing them tomorrow morning.
Anticipatory Guidance

- Infectious process - vertical transmission
- Diet - healthy snacks, avoid frequent snacking, avoid sugary drinks, use of sippy cup (only for water), bottle use,
- Brushing - when first tooth erupts
- Flossing - when 2 teeth touch
- Need to see a dentist by 1 year of age
- Fluoride sources - smear of toothpaste on small brush under 2 years; pea-sized amount for ages 2-5 years.
- Use flip-chart
Dietary Fluoride Supplements: Evidence-based Clinical Recommendations

Levels of evidence and strength of recommendations: Each recommendation is based on the best available evidence. Lower levels of evidence do not mean the recommendation should not be applied for patient treatment.

Correlate these colors with the text and table below.

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation based on higher levels of evidence</td>
<td></td>
<td></td>
<td>Recommendations based on lower levels of evidence or expert opinion</td>
</tr>
</tbody>
</table>

Practitioners are encouraged to evaluate all potential fluoride sources and conduct a caries risk assessment before prescribing fluoride supplements.

For children at low caries risk, dietary fluoride supplements are not recommended and other sources of fluoride should be considered as a caries preventive intervention. (D)

For children at high caries risk, dietary fluoride supplements are recommended according to the schedule presented in the following table. (D)

When fluoride supplements are prescribed, they should be taken daily to maximize the caries prevention benefit. (D)

### ADA dietary fluoride supplement schedule for children at high caries risk

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>Fluoride Concentration in Drinking Water (ppm)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;0.3</td>
</tr>
<tr>
<td>Birth to 6 months</td>
<td>None (D)</td>
</tr>
<tr>
<td>6 months to 3 years</td>
<td>0.25 mg/day (B)</td>
</tr>
<tr>
<td>3 to 6 years</td>
<td>0.50 mg/day (B)</td>
</tr>
<tr>
<td>6 to 16 years</td>
<td>1.0 mg/day (B)</td>
</tr>
</tbody>
</table>

*1.0 ppm = 1 mg/liter

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1. Rozier, et al. Evidence-based clinical recommendations on the prescription of dietary fluoride supplements for caries prevention: a report of the ADA Council on Scientific Affairs. Evidence-based clinical recommendations on the prescription of dietary fluoride supplements for caries prevention. JADA 2010; 141:1480–1489. Copyright © 2010 American Dental Association, All rights reserved. Adapted with permission. To see the full text of this article, please go to http://jada.ada.org/cgi/reprint/141/12/1480.

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Follow up from dentist

- Standardized referral form/card that is sent with patient to dentist and returned to primary care provider
- EHR- template available on oral health website
- Telephone communication between local dentist and pediatrician
Medicaid Reimbursement in NJ/billing and coding

• Range for payment for fluoride varnish application in NJ is $15 (Horizon) to $25 (United HC). All Medicaid HMOs as of January 2012 must participate.

• Currently no payment for oral health risk assessment

• Can delegate procedure to NP’s or PA’s

• Coding: 99420 DA (CPT)

• ???Private insurances to follow?
Example

• Mary is in your office for a 18 month well child visit
• Height and weight have progressed well and she is now in the 45th% for length and the 50th% for weight
Risk Assessment

• Mary has 12 teeth and has some enamel hypoplasia secondary to her prematurity

• The family’s home is in a trailer park with water from a well

• Her mother has decay in her teeth and she does not currently have a dentist
Risk Factors

- History reveals that Mary drinks sugar containing beverages from both a bottle and sippy cup and she is unable to sleep without her bottle.

- Mary’s diet is rich in simple and complex carbohydrates.
Protective Factors

• As her pediatrician you had put F varnish on her teeth at her 1 year old and 18 month old visits and referred her to a dental home

• Mary has Medicaid with dental insurance but mother was unable to find a participating dentist

• Mother has been following your advice by brushing with a smear of fluoride toothpaste twice a day
Risk Status

- Is Mary low or high risk for early childhood caries?
- What are her risk factors?
- Is Mary a candidate for F supplements?
- How can you find out if the well water contains F?
- Can you help find a dental home for Mary and how?

= High risk
Summary of Recommendations

- Begin the oral hygiene conversation with family before first tooth erupts
- Use risk assessment tool starting at 6 month well visit
- Prescribe fluoride supplements based on patient risk level and all fluoride sources
- Promote protective factors:
  - Tooth brushing
  - Fluoridated water
  - Healthy snacks
- Fluoride varnish application for high risk patients
- Refer to dental home by age one or at eruption of first tooth
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