Topics

• Prevalence of oral disease in Michigan
• Importance of oral health during perinatal period
• Breastfeeding and oral health
• Nutrition and development of tooth and oral tissues
• Teething
• Importance of primary teeth
• Early Childhood Caries
• Caries risk assessments
• Anticipatory oral health guidance
• Dental home by age one
• Fluoride
• Resources
Pregnancy Oral Health Facts

Prevalence of OH disease in pregnant women:

• According to the American Academy of Periodontology, approximately 50% of women get "pregnancy gingivitis," a disease that makes the gums sore and swollen.

• Pregnancy gingivitis usually starts around the second month of pregnancy and decreases during the ninth month.

• If the mother already had gingivitis prior to pregnancy, it will most likely get worse during pregnancy, especially without treatment.
In 2009, 41.6% (95% CI: 38.8-44.5) of Michigan women did not have their teeth cleaned during the twelve months before their pregnancy (PRAMS, 2009).

One in four (27.0%; 95% CI: 24.5-29.7) Michigan women who delivered a live birth in 2008 reported a need for dental care.

A large proportion (38.5%; 95% CI: 33.2-44.1) of the pregnant women with a dental need did not seek care.

Less than half of pregnant women reported being counseled about how to care for their teeth and gums during pregnancy (PRAMS, 2009).
Oral Care in Pregnancy
Periodontal Disease Can Affect Your Heart & Body

Emerging evidence shows a relationship between periodontal disease, cardiovascular disease and other chronic diseases — the common link is inflammation.

The presence of periodontal diseases may be associated with heart attacks, strokes, kidney disease, diabetes, preterm births and prosthetic joint complications.
Gingivitis
Periodontal Disease

Symptoms of Periodontal Disease
- Receding gums
- Tooth loosening and loss
- Bleeding, swollen gums

Healthy Gums
- Gums adherent to tooth
- Healthy bone

Periodontal Disease
- Receding gum line
- Pocket between tooth and gums
- Bone loss
- Plaque or tartar on teeth
Preterm Births/Low Birth Weights

- Research suggests that the bacteria that cause inflammation in the gums can actually get into the bloodstream and target the fetus, potentially leading to premature labor and low-birth-weight (PLBW) babies.

- One reasonable mechanism begins with the effects of endotoxins released from Gram-negative bacteria responsible for periodontal disease.
MI Perinatal Oral Health
Objectives of Perinatal OHI

**GOAL:** Create a comprehensive perinatal oral health initiative for the state of Michigan.

- **Objective I:** Develop Evidence-based Perinatal Oral Health Guidelines for the state of Michigan

- **Objective II:** Integrate oral health into the health home for women and infants

- **Objective III:** Develop interdisciplinary professional education to improve perinatal oral health

- **Objective IV:** Increase public awareness of the importance of oral health to the overall health of pregnant women and infants

- **Objective V:** Ensure a financing system to support perinatal oral health
Primary Teeth Begin To Form Between 6 And 8 Weeks In Utero.

Permanent Teeth Start To Form Around The 20th Week In Utero.
Pregnancy

- Importance of Fluoride
- Importance of Diets rich in Calcium and Phosphorus
- Importance of Oral Home Care
- Importance of Regular Dental Check ups - Guidelines for care
- Importance of Total Body Health
Transmitting Bacteria

Kissing

Sharing food and utensils

Cleaning off pacifier with parent’s saliva
Breastfeeding and Oral Health

Tongue Position While Breastfeeding

Pacifier / Bottle Nipple
Oral Abnormalities

http://www.cdc.gov/ncbddd/birthdefects/CleftLip.html
Parts of a Tooth

- Enamel
- Dentin
- Pulp
- Bone
Types of Teeth

- **Incisors** - to cut
- **Cuspids (Canines)** - to tear
- **Bicuspids (Premolars)** (Permanent teeth only) - to tear and grind
- **Molars** - to grind
Eruption Ages (Primary)

Primary Teeth Are Lettered A-T

### Baby Teeth

<table>
<thead>
<tr>
<th>Tooth Type</th>
<th>Age Tooth Comes In (months)</th>
<th>Age Tooth Is Lost (years)</th>
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<tr>
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<td>9.6</td>
<td>7.0</td>
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<td>12.4</td>
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<td>Canine (Cuspid)</td>
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<td>15.7</td>
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<tr>
<td>Central Incisor</td>
<td>7.8</td>
<td>6.0</td>
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</table>
Teething
Why are Baby Teeth So Important?

- Facial Development
- Chewing
- Talking
- Smiling
- Self-esteem
- Place-holders for permanent teeth
Michigan Oral Health Facts

- 34% of 0-5 year old Michigan Head Start children had signs of ECC in 2009
- 29.3% of Michigan parents send their child to bed with a bottle of juice
- 37% of Michigan residents live in non-fluoridated communities
- Dental care for all children is included in ACA, optional
Prevalence of Dental Decay in Very Young Children

Dental decay is the most common chronic disease of childhood.

- 6% of 1 year olds
- 22% of 2 year olds
- 35% of 3 year olds
- 48% of 4 year olds

- 5 times more common than asthma
- 7 times more common than hay fever
Effects of Decay

- Nutritional problems
- Sleeping issues
- Pain
- Swelling
- Tired or grouchy due to systemic infection

- Not wanting to smile
- Inability to focus
- Missed school days
- Poor school performance
- Poor self-esteem
- Impaired speech
Oral Disease

CHILDHOOD ORAL DISEASE

Early Childhood Caries

(Baby Bottle Mouth, Nursing Caries)
Caries vs. Cavities

- Caries is a process
- Caries is singular (no such thing as a cary)
- Cavities are a visual symptomatic endpoint of the caries process
- The Objective is to control the process to prevent the symptom.
Early Childhood Caries

- Is an **INFECTIOUS BACTERIAL** Disease
- Transmitted mainly from mother or primary caregiver to infant
- Window of infectivity is first 2 years of life
- Earlier child colonized, the higher the risk of caries
Early Childhood Caries (ECC)

• Dental decay found on any ONE surface of a tooth in a child less than 71 months of age is called Early Childhood Caries (ECC).

• This includes noncavitated (white spot lesions) as well as cavities, or holes in the teeth.
Progression of Early Childhood Caries

Progress of Early Decay

Healthy primary (baby) teeth

Mild decay

Moderate decay

Severe (rampant) decay
Severe ECC
Abscess = Infection
Caries Risk Assessment
AAP Oral Health Policy

“Pediatricians and pediatric health care professionals should develop the knowledge base to perform oral health risk assessments on all patients beginning at 6 months of age.”

“Patients who have been determined to be at risk of development of dental caries or who fall into recognized risk groups should be directed to establish a dental home 6 months after the first tooth erupts or by 1 year of age (whichever comes first).”

(AAP website Jan 2011)
## Recommendations for Preventive Pediatric Health Care

**Bright Futures/American Academy of Pediatrics**

Each child and family is unique; therefore, these recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, in the absence of manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Additional visits may become necessary if circumstances suggest deviations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive data visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

### Key Change

- The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Medical care, taking into account individual circumstances, may be appropriate.

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### Table of Recommendations

<table>
<thead>
<tr>
<th>AGE</th>
<th>INFANCY</th>
<th>EARLY CHILDHOOD</th>
<th>MIDDLE CHILDHOOD</th>
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<td></td>
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<td>STI Screening</td>
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<td>ANTIMICROBIAL GUIDANCE</td>
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### Table Notes

- Newborn Metabolic/Hemoglobin Screening: At birth and within 2-4 weeks postpartum.
- Immunization: According to the Advisory Committee on Immunization Practices (ACIP).
- Hematocrit or Hemoglobin: At birth and at 6-12 months.
- Lead Screening: At 9-12 months.
- Tuberculin Test: At birth and at 12 months.
- Cystic Fibrosis Screening: At birth.
- STI Screening: At 11-13 years.
- Cervical Dysplasia Screening: At 13-15 years.

### Table Key

- NEW: New measurement to be performed.
- NEW: New recommendation to be performed, with appropriate action to follow within 2-4 weeks.
- NEW: Range during which a visit may be provided, with symbol indicating the preferred age.
Who is at Risk?

- Children with:
  - Special health care needs
  - Existing decay or caries experience
  - Inadequate exposure to fluoride
  - Inability to maintain good oral hygiene
  - Prolonged, regular exposure to liquids, foods and medications containing sugar - this includes milk

- Children in families of low-income status

- Past caries experience of mother, primary caregiver, or siblings
One risk factor is a high cavity rate in the mother.

- Mothers with a high decay rate or high levels of decay causing bacteria can transmit these bacteria to their babies.

- We are not recommending mothers stop kissing their babies. Mothers should be informed of the transmissibility of the bacteria.
Risk Factor of Early Childhood Caries (ECC)

Dietary Habits

- Prolonged exposure of the child’s teeth to liquids other than water.
- Putting baby to bed with a bottle containing:
  - Formula
  - Milk (including breast milk)
  - Fruit juices
  - Sodas
  - Other sweet liquids (sugar water)
Risk Factor of Early Childhood Caries (ECC)

Continuous use of bottle/sippy cup containing anything other than water, including milk and juice.
Risk Factor of Early Childhood Caries (ECC)

Giving child pacifier dipped in sugary substance
Risk Factor of Early Childhood Caries (ECC)

Frequent snacks containing fermentable carbohydrates including snacks like crackers and chips

Some medications containing fructose/sugar
Caries Progression and Diet

After consumption of carbohydrates the pH level drops to 5.5 within 20 minutes of eating and causes enamel demineralization.

Re-mineralization occurs when the acid is buffered by saliva.

Hence not just WHAT you eat; but HOW OFTEN you eat can determine caries progression.
Indicators of High Caries Risk

Child’s history:

* Special needs child
* Medications
* Dry mouth
* In-frequent dental visits
* Frequency of decay
* Parent and sibling decay
* Pre-mature birth
* Congenital diseases
* Enamel defects

Low socioeconomic status

Behavioral issues

Dietary exposure to sugars/carbohydrates

* Use of bottle or sippy cup containing liquids other than water
* Between meal snacks
* Use of sweetened medications
Indicators of High Caries Risk

**Use of fluoride**
- No or low fluoridated drinking water

**Poor oral hygiene**
- How often are teeth brushed
- Who is brushing teeth

**Clinical evaluation**
- Plaque present
- Gum tissue red, puffy
- Decay present
Assess Maternal Oral Health

• Ask about caries in mother/caregivers previous and active

• Ask about toothaches or extractions

• Ask about source of regular dental care

• Provide oral health anticipatory guidance
Caries Risk Assessment Tools
<table>
<thead>
<tr>
<th>Factors</th>
<th>High Risk</th>
<th>Low Risk</th>
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<tbody>
<tr>
<td>Biological</td>
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<tr>
<td>Mother/primary caregiver has active cavities</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Parent/caregiver has low socioeconomic status</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has &gt;3 between meal sugar-containing snacks or beverages per day</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child is put to bed with a bottle containing natural or added sugar</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has special health care needs</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child is a recent immigrant</td>
<td>Yes</td>
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<tr>
<td>Protective</td>
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<tr>
<td>Child receives optimally-fluoridated drinking water or fluoride supplements</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Child has teeth brushed daily with fluoridated toothpaste</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Child receives topical fluoride from health professional</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Child has dental home/regular dental care</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Clinical Findings</td>
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<tr>
<td>Child has white spot lesions or enamel defects</td>
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<td>Yes</td>
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<tr>
<td>Child has visible cavities or fillings</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Child has plaque on teeth</td>
<td>Yes</td>
<td>Yes</td>
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</table>

Circling those conditions that apply to a specific patient helps the health care worker and parent understand the factors that contribute to or protect from caries. Risk assessment categorization of low or high is based on preponderance of factors for the individual. However, clinical judgment may justify the use of one factor (e.g., frequent exposure to sugar containing snacks or beverages, visible cavities) in determining overall risk.

Overall assessment of the child’s dental caries risk: High ☐ Low ☐
Oral Health Risk Assessment Tool Guidance

Timing of Risk Assessment
The Bright Futures/AAP (Recommendations for Preventive Pediatric Health Care) (its, Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright Futures/AAP Periodicity Schedule—http://www.bright futures. aap.org/practice.htm.

Risk Factors

Maternal Oral Health
Studies have shown that children with mothers or primary caregivers who have had active decay in the past 12 months are at greater risk to develop caries. This child is high risk.

Maternal Access to Dental Care
Studies have shown that children with mothers or primary caregivers who do not have a regular source of dental care are at a greater risk to develop caries. A follow-up question may be: "If this child has a dentist?"

Continual Bottle/Sippy Cup Use
Children who drink juice, sodas, and other liquids that are not water from a bottle or sippy cup continually throughout the day or at night are at increased risk of caries. The frequent intake of sugar does not allow for the acid to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on reducing the frequency of sugar-containing beverages in the child's diet.

Frequent Snacking
Frequent snacking, especially at an increased risk of caries. The frequent intake of sugar-free snacks does not allow for the acid to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce the frequency of sugar-containing snacks such as, snacks, vegetables, and fruit.

Special Health Care Needs
Children with special health care needs are at an increased risk for cavities due to their diet, xerostomia (dryness of the mouth, sometimes due to asthma or allergy medication use), difficulty performing oral hygiene, seizures, gastrointestinal reflux disease and vomiting, attention deficit hyperactivity disorder, and periodontal disease or overgrowth of teeth. Premature babies also may experience oral health problems.

Protective Factors

Dental Home
According to the American Academy of Pediatric Dentistry (AAPD), the dental home is oral health care for the child that is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. The AAP and the AAPD recommend that a dental home be established by age 1. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the pediatrician should continue to do oral health risk assessment at every well-child visit.

Fluoridated Water/Supplements
Fluoridated water provides a child with systemic and topical fluoride exposure, a proven caries reduction intervention. Fluoride supplements may be prescribed by the pediatrician or dentist if needed. View fluoride resources on the Oral Health Practice Tools Website http://www.teachershealth.org/practiceTools.htm.

Fluoride Varnish in the Last 6 Months

Tooth Brushing and Oral Hygiene
Pediatricians can reinforce good oral hygiene by teaching parents and children simple practices. Parents should have their children brush twice a day. For children under the age of 2 it may be inappropriate to recommend a smear of fluoride toothpaste if the child is at high risk for caries, but recommendations vary. Children older than 2 years old should use a pea-sized amount of fluoride toothpaste twice a day. View fluoride resources in the AAP Protecting All Children's Teeth Curriculum fluoride module http://www.aap.org/oralhealth/early/fluoride/fluoride.pdf.

Clinical Findings

White Spots/Decalciifications
This child is high risk. White spot decalciifications present—immediately place the child in the high-risk category.

Obvious Decay
This child is high risk. Obvious decay present—immediately place the child in the high-risk category.

Restorations (Fillings) Present
This child is high risk. Restorations (Fillings) present—immediately place the child in the high-risk category.

Visible Plaque Accumulation
Plaque is the soft and sticky substance that accumulates on the teeth from food debris and bacteria. Pediatricians can teach parents how to remove plaque from the child's teeth by brushing and flossing.

Gingivitis
Gingivitis is the inflammation of the gums. Pediatricians can teach parents good oral hygiene skills to reduce the inflammation.

Healthy Teeth
Children with healthy teeth have no signs of early childhood caries and no other clinical findings. They are also experiencing normal tooth and mouth development and spacing.

For more information about the AAP's oral health activities email oralhealth@aap.org or visit www.aap.org/oralhealth.
Similar questions can be easily incorporated into the child’s medical assessment form the parent fills out.

Key points to include in an assessment:

- Mother’s previous oral history
- Use of bottle
- Use of fluorides
- Special needs child
- Socio economic status
Anticipatory Guidance and Oral Health Education for Parents

Key Points to share with parents:
- Age 1 dental visit recommendation
- Transmission of bacteria
- Prevention is crucial to overall health
- Home care for child’s teeth
- Bottle and sippy cup use
- Role of diet in oral health
- Role of fluorides
- Establishing a dental home
- Application of varnish fluoride is not a replacement for routine dental care
“As an effective way to begin a lifelong program of preventive dentistry, the American Academy of Pediatric Dentistry (AAPD) recommends:

“The first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age.”
Age 1 Dental Visit

Studies show that the dental costs for children who have their first dental visit before age one are 40% lower in the first five years than for those who do not see a dentist prior to their first birthday. (aapd)
Establishing a Dental Home

Care providers and parents should help every child establish a Dental Home by 12 months of age.

Have a referral system set up for families so they have somewhere to go. Establish dental networks in the community.
“Points of Light” is a Michigan based program teaming medical and dental professionals to work together as a referral team.

http://www.pointsoflightonline.org/
Anticipatory Guidance - Home Care for a Child's Teeth

• Parents need to help children brush

• Use of a wet washcloth or gauze will also help to clean teeth
Anticipatory Guidance - Home Care for a Child's Teeth

• Wide spacing is normal in children

• Flossing should be recommended if teeth are close together
Anticipatory Guidance - Bottle and Sippy Cup Use

Prolonged use of a bottle or sippy cup with anything except water can lead to decay

Milk, breast milk and fruit juices continually bathing the teeth will cause decay

Encourage transitioning to drinking from a regular cup by age 1
Anticipatory Guidance-
Diet and Infant’s Oral Health

Carbohydrates or sugars can produce an acid that attacks tooth enamel within 20 minutes of eating. Continual snacking = continuous acid attack.
Anticipatory Guidance - Fluorides

- Parents need to be made aware of the effectiveness of fluorides in preventing decay.

- Community water fluoridation, fluoride supplements and topical fluorides including fluoride varnish can all help reduce and arrest decay.

- If toothpaste is recommended for high-risk children under 2 years of age only a tiny smear is used. Only a very small pea size of toothpaste should be used for children 2 and over.
Fluoride Supplements

- Fluoride supplements are determined after the drinking water fluoride levels and other fluoride usage is determined.

- 0.7 ppm of fluoride in a water supply is optimal for increased oral health benefits.

- Water source testing kits are available through local public health departments, the Michigan Department of Community Health or through the Centers for Disease Control and Prevention (CDC) at [http://apps.nccd.cdc.gov/MWF/Index.asp](http://apps.nccd.cdc.gov/MWF/Index.asp)

**Systemic Fluoride Supplements: Recommended Dosage**

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<th>Age</th>
<th>Fluoride Ion Level in Drinking Water</th>
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<tr>
<td>6 months-3 years</td>
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<td>3-6 years</td>
<td>0.50 mg/day</td>
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<tr>
<td>6-16 years</td>
<td>1.0 mg/day</td>
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</table>

1.0 ppm = 1mg/L
2.2 mg sodium fluoride contains 1mg fluoride ion
ADA Statement on Fluoride and Infant Formula
Continue use of powdered or liquid concentrate infant formulas reconstituted with optimally fluoridated drinking water while being cognizant of the potential risks of enamel fluorosis development.

Dental Fluorosis
The Food and Nutrition Board at the Institute of Medicine recommends the following dietary intake for fluoride:

**Infants**
0 - 6 months: 0.01 milligrams per day (mg/day)
7 - 12 months: 0.5 mg/day

**Children**
1 - 3 years: 0.7 mg/day
4 - 8 years: 1.0 mg/day
9 - 13 years: 2.0 mg/day

**Adolescents and Adults**
Males ages 14 to 18 years: 3.0 mg/day
Males over 18 years: 4.0 mg/day
Females over 14 years: 3.0 mg/day
What is Fluoride Varnish?

• Most fluoride varnishes are lacquers containing 5% sodium fluoride

• Fluoride varnish provides a highly concentrated, temporary dose of fluoride to the tooth surface

• A very small amount is applied (2.3 to 5.0 mg)

• For primary teeth the .25 ml dose pack is sufficient for all teeth

• The varnish hardens on the tooth as soon as it contacts saliva

• This is a much longer exposure compared to other high-dose topical fluorides such as gels or foams, which is typically 4 to 15 minutes
Fluoride Varnish Facts...

Fluoride varnish is a protective topical fluoride that is painted on teeth.

More effective in cavity prevention, ease of application, and safety than other topical fluoride methods.

All fluorides act to slow demineralization and boost re-mineralization.
Fluoride Varnish Facts...

- **Fluoride varnish is extremely cost effective**
- **Caries reductions of up to 37% when applied 2x yearly**
- **The superior topical fluoride agent for young children**
- **Less chance for swallowing solution**

Fluoride Varnish Advantages

- Quick and easy to apply
- Releases fluoride over extended period of time.
- Does not have a bad taste
- Dries quickly once it encounters saliva (less mess)
- The application is painless
- Does not require a professional dental cleaning prior to application
- Requires minimal training to place
- Is inexpensive
## 2014 US Task Force Recommendation

### Prevention of Dental Caries in Children from Birth Through Age 5 Years

#### Clinical Summary of U.S. Preventive Services Task Force Recommendation

<table>
<thead>
<tr>
<th>Population</th>
<th>Children age 5 years and younger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>Prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. Grade: B</td>
</tr>
<tr>
<td>Routine oral screening examinations:</td>
<td>No recommendation. Grade: I statement</td>
</tr>
</tbody>
</table>

#### Risk Assessment

All children are at potential risk for dental caries; those whose primary water supply is deficient in fluoride (defined as <0.6 ppm F) are at particular risk. While there are no validated multivariate screening tools to determine which children are at higher risk for dental caries, there are a number of individual factors that elevate risk, such as low socioeconomic status, being an ethnic minority, frequent sugar exposure or snacking, inappropriate bottle feeding, developmental defects of the tooth enamel, dry mouth, history of previous caries (in the child, a sibling, or mother), lack of access to dental care, and inadequate preventive measures (such as failure to use fluoride toothpaste).

#### Preventive Medications

Oral fluoride supplementation prevents dental caries in children with inadequate water fluoridation. All children with erupted primary teeth can benefit from the periodic application of fluoride varnish, regardless of the levels of fluoride in their water.

#### Balance of Benefits and Harms

- There is a moderate net benefit of providing oral fluoride supplementation at recommended doses in children older than age 6 months who reside in communities with inadequate water fluoride.
- There is a moderate net benefit of providing fluoride varnish application to all children starting at the age of eruption of primary teeth to age 5 years.
- The evidence on performing routine oral screening examinations for dental caries in children from birth to age 5 years is insufficient, and the balance of benefits and harms cannot be determined.

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to [http://www.uspreventiveservicestaskforce.org/](http://www.uspreventiveservicestaskforce.org/).
To encourage Medicaid (WIC) medical providers to incorporate oral screenings and apply fluoride varnish to infant and toddler teeth at well baby, EPSDT exams.
Steps for WIC

• Smiles for Life Module 6: including supervising physician
• Determine staff to participate
• Babies Too! training if participating for free fluoride varnish
• Directive to nurses to apply varnish
• Billing information from Medicaid (using certified provider NPI#?)
• Supplies
www.smilesforlifeoralhealth.org
Babies Too!

- Incentive to participate
- Additional training required
- Free varnish for first two years
- Screening/data collection
- Fluoride varnish application
- Education to parent
- Dental home by age 1
Oral Screening

Basic Screening Survey
Developed by ASTDD
Adapted for MDCH
Healthy Mouth
Steps for Oral Screening

- Discuss caries risk assessment with caregiver
- Oral health education and anticipatory guidance
- Position child - knee-to-knee
- Screen child and record findings
- Apply fluoride varnish (if applicable)
Positioning the Child
Age 0-3

- Position child in caregiver’s lap facing caregiver with an appropriate light source for intra-oral viewing nearby
- Sit with knees touching caregiver’s knees
- With tri fold or patient bib across lap lower child’s head on top of barrier
- Caregiver assists with child

Visibility is increased and the child feels more secure with a caregiver holding them.
# 2014-15 VARNISH! MICHIGAN- Babies Too

## Oral Health Screening/Varnish Form

**Date:** __________  
**Agency Name:** __________  
**Site:** __________

**Child’s Name:** __________  
**M/F:** __________  
**Child’s DOB:** __________

**First**  
**Middle**  
**Last**

---

**Has child seen a dental provider in last 12 months?**  
Yes [ ]  
No [ ]

**Medical history reviewed/no allergies to pine sap:** [ ]

**Parent/guardian consent:** __________  
**Date:** __________

---

<table>
<thead>
<tr>
<th>Sex</th>
<th>Child’s Race/Ethnicity</th>
<th>Primary Language</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>White: Caucasian</td>
<td>English</td>
<td>Is your child limited in any way in any activities because of physical, mental, or emotional problems?</td>
</tr>
</tbody>
</table>
| Female       | Black: African Americans| Spanish          |     Yes [ ]  
|              | Hispanic/Latino         | possibilities     |     No [ ]  
|              | Middle Eastern/Arab     | Don’t know/insure |     Refused [ ]  
|              | Native American/Alaskan Native/Asian/Pacific Islander | Other            | If yes, check all that apply |
|              | Other                   |                  | Physical [ ]  

**ORAL SCREENING**

**Examiner Initials:** __________

**Number of Teeth Present:** __________

**Previous Caries:** (fillings, crowns, extractions from decay)  
---

**# of treated teeth:** __________

**Untreated Decay:**  
---

**# of teeth w/un treated decay:** __________

**White Spot Lesions:** Circle yes or no  
---

**Yes**  
**No**

**Early Childhood Caries:**  
---

**Yes**  
**No**

**Treatment Urgency:**  
---

**Circle number**  
---

0= No obvious problems  
1= Early dental care  
2= Urgent care

**Caries Risk Assessment today:**  
---

**Yes**  
**No**

**Fluoride varnish applied today:**  
---

**Circle yes or no**  
---

**Yes**  
**No**

**Child referred for dental treatment:**  
---

**Yes**  
**No**

**To:** __________

---

**Comments:**
Previous Treatment for Decay

- Amalgam filling
- Composite filling
- Stainless steel crown
- Extraction sites
White Spot Lesions

“Lift the Lip” to see

Usually found along gum line of upper front teeth

Can encircle the affected teeth - look on insides/backs of teeth also
Early Signs of ECC: White Spots Lesions
Untreated Decay

Areas of darkness where the enamel looks involved.

Areas of white spot lesions that have broken through the enamel.

If you can’t tell if it’s decay or stain, consider it decay. Then refer to a dentist for further follow-up.
Applying Fluoride Varnish
Contra-Indications

- Parent/guardian refuses care

- Medical history:
  - A known allergic reaction to colophony (colophonium) (Pine sap)
  - Possible allergy to pine nuts
  - Caution in patients with asthma
  - Possibly contact dermatitis

- Cold sore (herpes simplex), sores in mouth

- Totally decayed teeth that varnish would not help

**Care must be exercised by applying fluoride sparingly and preventing children from swallowing the excess product during applications**
Dental Assistance Programs

Assistance Application (DHS-1171)
Michigan Assistance and Referral Service (MARS)
http://www.michigan.gov/dhs

Healthy Kids Dental
Medicaid Billing

• Code D1206 for fluoride varnish-4 x/yr
• Code D0190 for oral screening- 1 per 6 mo
Medicaid Billing for Medical Professionals

- Fluoride varnish code D1206 for children age 0-2. (Up to age 3).
- Four (4) fluoride varnishes are allowed in a 12 month period.
- Current reimbursement is $9.00/varnish application
- D 0190: $14.89/oral screening; 1x every 6 mo
- Application of the fluoride varnish is part of the EPSDT and/or a well child exam oral screening and determination of caries risk.
Medicaid Provider Information

For Medical Providers:

www.michigan.gov/mdch - Providers

For additional assistance providers may contact Provider Support at 1-800-292-2550 or ProviderSupport@michigan.gov
WIC OH Resources

“Providing Preventive Oral Health Care to Infants and Young Children in Women, Infants, and Children (WIC), Early Head Start, and Primary Care Settings”


http://www.wichealth.org/

WIC: Early Entry into Dental Care Guidebook

Questions?

Susan Deming, RDH, RDA, B.S.
Education and Fluoride Coordinator
Michigan Department of Community Health
demings@michigan.gov