Integrating Risk Assessment as Standard of Care

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Why Oral Health?

- Surgeon General's report on oral health
  - "Silent Epidemic"
  - Prevalence
  - Effects of oral disease on health
  - Access to care
  - Cost
  - Oral health disease is largely preventable

Oral health in America. A Report of the Surgeon General; 2000.

Why Pediatricians?

- The dental community is overloaded and decreasing in capacity
  - Only 3% of practicing dentists are pedodontists
- 25% of poor children do not see a dentist by age 5
  - >100 million Americans have no dental insurance
  - <20% of children eligible for dental care under Medicaid receive regular care.

Why Us?

- Primary Prevention – all of our goal
- Need more manpower
- Need consistent family and child messaging that “baby teeth matter”
  - Media, school, doctors office, dentist...

Routine Visits

- Oral Health Risk Assessment
  - AAP policy 2003: “Every child should begin to receive oral health risk assessments by 6 months of age…”
- Anticipatory guidance - diet, hygiene
- Referral to a dental home
  - High-risk infants should be referred for establishment of a dental home no later than 6 months after the first tooth erupts or by 12 months of age
  - “Ideal approach” to ECC prevention is early establishment of a dental home

Dental Update: Fluoride Varnish Applications Covered for Children up to Seven Years of Age

- October 1, 2009
- Maximum of four (4) annual fluoride varnish applications covered for children from birth until 7 years of age
- Physicians, Dentists, and Nurse Practitioners treating Medicaid fee-for-service beneficiaries will be reimbursed up to $30.00 per application.
- Procedure code "D1206" should be used by all Provider types
- http://www.health.state.ny.us/health_care/medicaid/program/update/2009/2009-09.htm#den

Figure 2: State Medicaid Programs Paying Primary Care Providers for Preventive Oral Health Services, 2012

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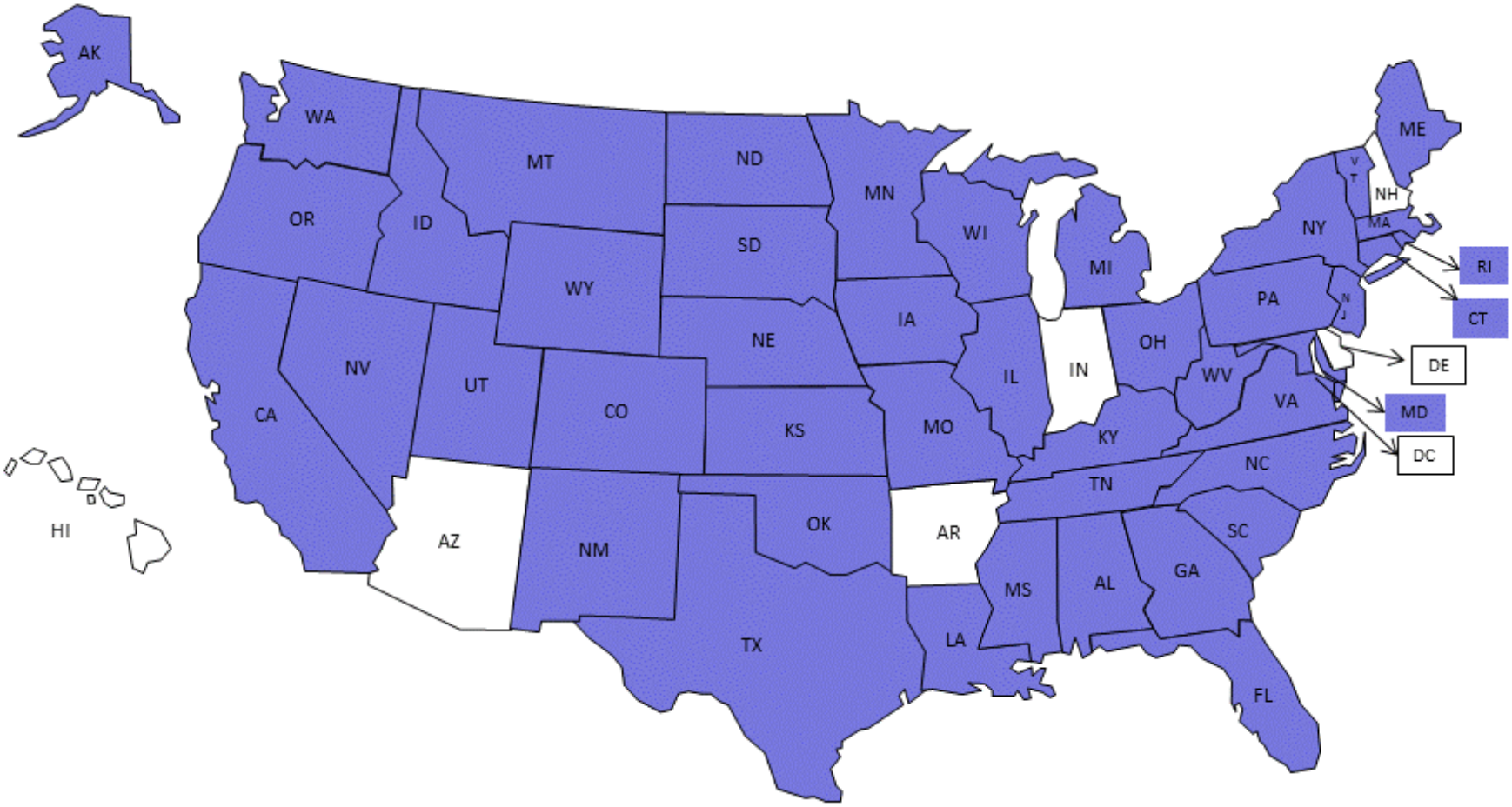
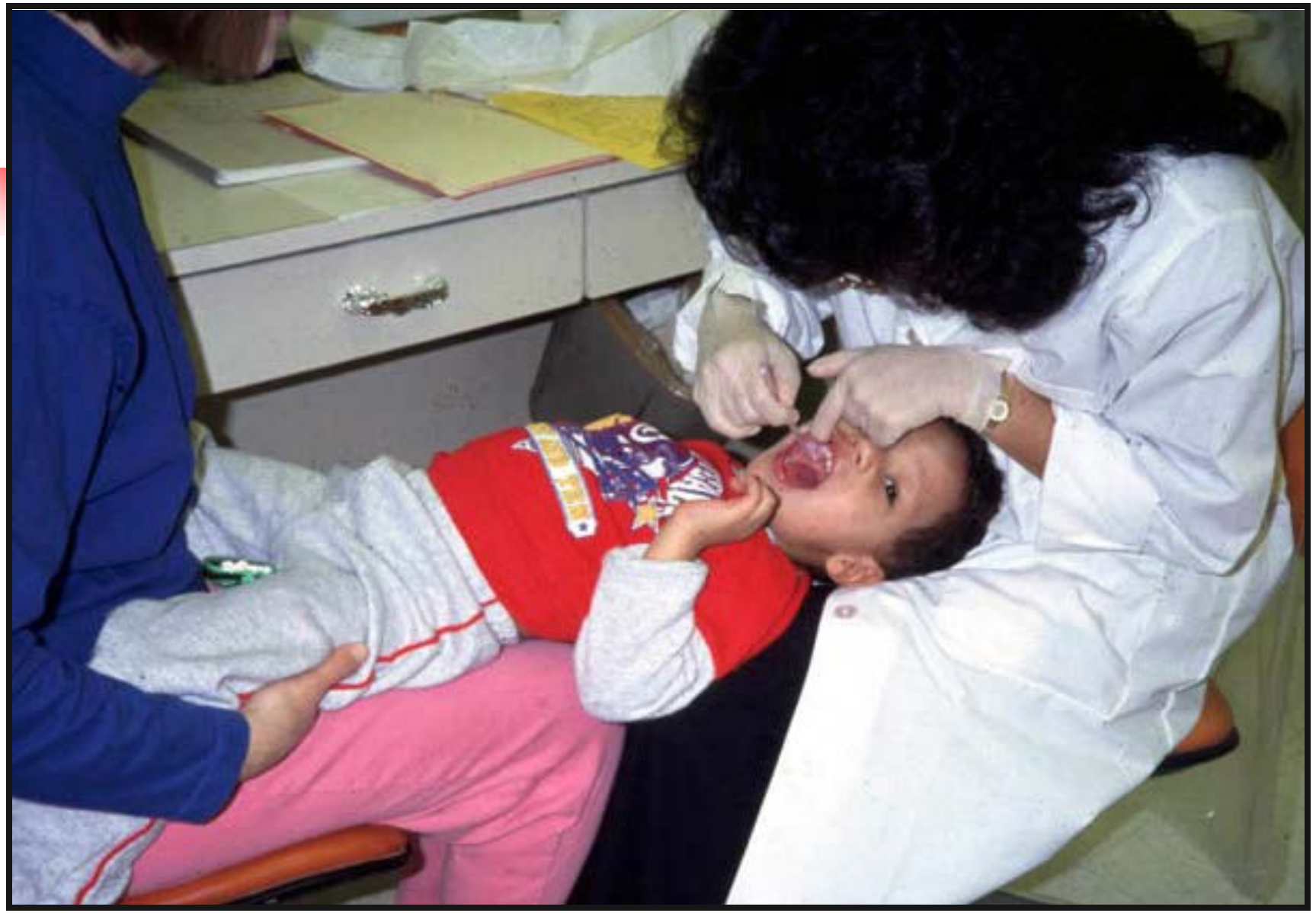


This information was collected through a survey of the 50 states and DC by the American Academy of Pediatrics in Spring, 2012 based on a survey originated by Amos Deinard, MD, MPH.

What does this entail?

- Oral Health Risk Assessment
  - AAP policy 2003: “Every child should begin to receive oral health risk assessments by 6 months of age…”
  - Risk Assessment = Standard of Care
- Anticipatory guidance
- Fluoride Varnish if high risk
- Referral to a dental home



Barriers

- Time
  - Fast
  - Important: Most common chronic disease
- Disinterest
  - Immediate and future impact of neglect
  - Obesity message and caries nutrition messages parallel
- Someone else's job
  - Bright Futures, AAP
- Not getting paid
  - Start billing
- Will it matter?
  - Burden of disease and relative impact of interventions
- Families do not want to hear it - messaging

Messages

- Discuss oral health early and often
- Discuss the bacteria, not just the hygiene
  - Cannot just treat holes, infection still present
    - Analogy to stopping abx course early
    - Matter of “slime + time”
  - Address “baby teeth don’t matter” myth
  - Shift blame to something evil we can target
- Healthy eating
  - Choose foods that look like something found in nature
- Concentrate on a single change each visit

Next steps

- Interprofessional medical focus
- Bridge the silos
- Media messaging
- School focus on oral health
  - Dental health certificates
- Public health efforts