

MCHB/Oral Health Webcast

Engaging Providers to Improve Perinatal and Infant Oral Health: Innovative Strategies

April 16, 2009

MARK NEHRING: Good afternoon and thank you for joining us today for focusing on early oral health interventions, especially preventing disease, assessing risk and increasing access to services by engaging providers to improve perinatal and infant oral health. Next slide, I'm Mark Nehring from the Health Resources and Services Administration.

Before we get started let me describe the ways you can use your computer interface during this webcast. Slides will appear in the central window on your screen and will advance automatically. The slide changes are synchronized with the speaker's presentations so you do not need to do anything to advance them. Although you may need to adjust the timing of the slight to changes match the audio. You can do this by using the slide delay control at the top of the messaging window.

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Our webcast today will focus on projects from two grantees who are part of a larger collaborative program among several national professional membership organizations funded by the Maternal and Child Health Bureau. Both of whom are working to address oral health issues related to children and families.

Next slide, please. These two organizations the American Academy of pediatric dentistry and the American Academy of pediatrics participate in the alliance for machines on MCH, the AIM program a collaborative of Maternal and Child Health Bureau grantees. AIM grantees are national membership organizations representing professionals responsible for making decisions affecting the health of women, children and families. Together they include organizations of state and local government officials, MCH professionals, foundations, legal professionals, the health insurance industry and large businesses as well as family advocates.

Next slide. The purpose of the individual projects from these two grantees is to promote a two-way communication by making new research finding and policy information accessible

to professionals to help them make clearly informed decisions affecting public health policies and programs for women, children and families. And creating a channel for professionals in the field to alert the bureau to emerging concerns and issues they are facing. Beyond the value of the individual grants, there is an added value that comes from convening all the organizational representatives twice yearly, providing opportunities for the 16-member organizations having very different perspectives to share expertise and concerns, and also to educate one another. As well as the bureau about emerging issues and promising MCH practices.

Slide five, please. As you read the project titles from our two presenters today, you may be thinking that we mistakenly switched the titles. Traditional oral health providers within dentistry talking about oral health as an integral part of pregnancy and infants and physicians apparently taking on oral health outside the dental clinic. These projects are, in part, a response to the persistent health need and seeing recently as an increase in oral disease in children under the age of five. The projects are in keeping with MCHB's interest to integrate oral health into existing systems of care so various access points for oral health services can be made available. As we come to better understand oral health as an overall health issue, that is recognizing the infectious nature of oral disease, its systemic consequences, the need to intervene at the earliest of opportunities and integrate existing systems of care we begin to understand why the American Academy of pediatric dentistry and the American Academy of pediatrics are addressing the issue of comprehensive health from each of their unique perspectives with the purpose of improving access to oral healthcare even though they face looming challenges surrounding workforce, geography and the influence of poverty. It is worth mentioning as you see these first few slides we indicated there is an improper date in the lower left-hand corner. It wasn't something that was developed in February of 2002. Those slides

indications will be updated for the archive. But it's also worth mentioning that at this point each of our presenters have much more information than we really have time to share in this next hour. So as we archive these slides, be mindful that when you access these Power Point slides in the future, you will be able to access the presenters' narrative comments but in more detail than what you'll hear today for additional information that we feel would make our presentations too long. I'll mention that at the end of our presentation today again as a reminder. We will begin with Ms. Jessie Buerlein the project manager, improving infant oral health. Following her presentation Dr. Suzanne Boulter, a practicing pediatrician in New Hampshire and chair of the Oral Health Initiative will describe the American Academy of pediatrics in oral health and then I'll return for a question and answer period.

JESSIE BUERLEIN: Thanks, Mark. I'm Jessie Buerlein with children's oral health project and the improving perinatal and infant oral health project. A joint initiative of the American Academy of pediatric dentistry and Children's Dental Health Project. I'll be giving an overview today of the importance of perinatal oral health, of some recent advancements in perinatal oral health and along with our key efforts and messages in promoting infant oral health. So thank you for attending today's webcast.

Next slide, please. For my first initial slides I'll be providing general overview of why perinatal oral health is important and providing information on prevalence and access issues in this area. I apologize if some of these messages might be familiar to you. Bear with me for a few slides. Why is it important? Oral health is a key component of overall health and well-being for women across the life span. We know that the physiological changes that occur during pregnancy can increase susceptible to oral infections such as periodontal disease and inflammation of the gums or pregnancy gingivitis. Recent studies

show an association between periodontal disease and adverse birth outcomes. Low birth weight and just gestation diabetes. More research is pending to confirm this we know the safety and importance of oral healthcare for the woman herself is a key factor in achieving overall health and well-being. We know that perinatal oral health continues to establishing good oral health for children. The transmission of cavity causing bacteria from mother to child is the primary vehicle by which children first get the disease that causes cavities. The healthier the mother's mouth, the longer that initial transmission of bacteria is delayed, the more likely children are to establish and to maintain good oral health. We also know that pregnancy is an great time to educate women on oral health behaviors, nutrition and hygiene both for themselves and their children and families.

Next slide. A general definition of perinatal dental care would be the provision of oral healthcare and guidance for pregnant women, mothers and infants in a coordinated, continuous fashion to promote oral and systemic health. Dental care during pregnancy is important to prevent periodontal disease, to manage existing tooth decay. To reduce the risk of adverse birth outcomes and delay transmission of maternal oral bacteria to the infant.

Next slide. What is the prevalence of caries and periodontal disease in women of reproductive age? Data shows that among individuals age 20 to 34 untreated caries has been found in about 30% of that population and periodontal disease and about 4%. Other studies show that periodontal disease can be detected in upwards of 40% of women of reproductive age and in about 30% of pregnant women.

Next slide. There are several key barriers to accessing dental care during the perinatal period. Primarily a lack of national guidelines on perinatal oral health for health

professionals. Some health professionals may be hesitant to refer or to treat pregnant women due to inadequate training in this area and concerns of liability and safety issues. Women themselves may have a lack of awareness of the relationship of oral to overall health, cultural influences, lack of insurance coverage, economic challenges and many other factors that impact the importance placed on oral health in general and on seeking dental care during pregnancy specifically, especially when that comes to concerns over the safety of care including X-rays during pregnancy.

Next slide. So what do we know about whether pregnant women are accessing oral health treatment?

Next slide again. We do know that nearly one in five women do not visit the dentist during the year before they become pregnant. 2004 study showed that 22% of women reported that they had never accessed oral health before pregnancy and the same study showed that less than 1/3 visited a dentist immediately following the birth of their infants.

Next slide, please. Data shows that among pregnant women who actually report having oral health problems, only about half seek oral healthcare. A study was done to try to determine the reasons for this. So it provided free dental care to pregnant women to rule out cost as a barrier. The study still found that about 40% did not visit a dentist during pregnancy. The primary reason was that mothers do not feel it necessary to visit a dentist during pregnancy. The removal of the financial deterrent did little to promote dental attendance during the perinatal period.

Next slide. Studies also show that some groups of women are significantly less likely to access oral healthcare during pregnancy than others. Women who have low incomes,

who belong to racial or ethnic minority groups or who participate in medicare are about half as likely to receive oral healthcare while pregnant compared with women who have higher incomes, are white or are privately insured.

Next slide. So we've discussed the consumer side of the coin. But on the other side of the coin are providers aware of the importance and the safety of providing oral healthcare during pregnancy?

Next slide. In a survey done of general practitioners in 1994 the results showed that 12% did not feel that routine care should be provided at all during pregnancy. About 80% did not expose their patients to radio graphs and the majority excluded care during the first trimester. In a much more recent survey of general dentists in Oregon the authors found that most respondents agreed that dental treatment should be part of prenatal care. 2/3 were also interested in receiving further professional education regarding providing care to pregnant patients. But comparisons of their self-reported knowledge with the New York State practice guidelines did reveal some key points of difference. So the authors concluded that dentists do need more educational opportunities to provide up to date care to pregnant patients to develop specific skills and address any areas of misinformation.

Next slide. In terms of prenatal care providers, a survey of obstetricians in Ohio found that a small number integrated oral health into practice. About 1/3 performed a visual mouth inspection, 20% used oral health screening questions. Only 6% referred patients to a dentist but over half did agree that oral health screening should be part of prenatal care.

Next slide. So we've talked about the importance of perinatal oral health for the woman herself but I want to be sure to mention the impact that it does have on infants' oral health.

Dental caries is a transmitted disease that's usually established by age 2. It is initiated by bacteria that's transmitted through saliva from the caregiver to the child. So the primary goal of perinatal oral healthcare with regard to caries transmission is to lower the numbers of the caries-causing bacteria in an expectant mother's mouth so that the transmission of that bacteria can be delayed as long as possible.

Next slide. Again and besides the issue of transmission of bacteria, studies show that children whose mothers have poor oral health are five times more likely to have oral health problems themselves and are also at a greater risk for having oral infections at younger ages and for developing dental caries than do children of mothers who have good oral health.

Next slide. There have been several advancements in perinatal oral health in recent years. There is a growing awareness of the link between oral and systemic health and the role that pregnancy plays in impacting oral health among providers, policymakers and the public. As mentioned before, there is growing evidence documenting an association between periodontal disease and adverse pregnancy outcomes. But also the safety of dental care during pregnancy is scientifically accepted and there are increasing numbers of research studies that have confirmed the safety of accessing care during pregnancy.

Next slide, please. There have been a number of program and policy developments on the state and national level as well. The American Dental Association, the American Academy of periodontists and the American College of obstetricians and gynecologists have issued statements and recommendation to their membership for improving perinatal oral health. The New York State Department of Health developed practice guidelines for prenatal health. I'll describe it in greater detail in a few minutes. In 2006 and 2008 the

Maternal and Child Health Bureau sponsored perinatal oral health national forums. In 2006 this forum was the research to policy and practice forum. A meeting of maternal, child and oral health experts to address the health and improving maternal and infant oral health. And there was a moving forward health forum designed to build partnerships to improve the oral health status of pregnant women and identify new areas of collaboration and innovative approaches in this area. In 2007 MCHB formed the perinatal oral health workgroup that I'll describe in further detail which has worked to advance perinatal oral health on the national level. In the national Maternal and Child Health Resource Center has developed many materials promoting perinatal oral health that target consumers and providers.

Next slide, please. The New York State guidelines, in 2006 the New York State Department of Health convened an expert panel of health professionals to identify existing guidelines, practices and interventions and to develop recommendations for prenatal oral health and child health professionals in promoting oral health. These guidelines serve as general guidance for bringing about changes in the healthcare delivery system and for improving the overall standard of care for perinatal and infant populations. Currently they're the only state-level clinical guidelines for perinatal. Other states are in the process of developing their own guidelines. And these guidelines can be accessed at the website provided in the slide.

Next slide, please. So that brings us to describing some of the activities of the AAPD improving perinatal and infant oral health project. The project has three overarching goals that include expanding availability of prenatal oral healthcare. Expanding infant oral healthcare and raising awareness involving dental care for pregnant women and infants among diverse audiences.

Next slide. Some key project activities can be broken into three different categories. The first would be communication. Communication is undertaken to the AAPD membership through the membership newsletter. Through continuing education courses, conferences through and other venues. Incorporating perinatal and oral health components into practice and provide the skills and tools to enable providers to do so. Also communication is undertaken with parents and the public through non-traditional partnerships including parenting magazines, Maternal and Child Health and parent organizations. Also to policymakers both professional health providers and also public policymakers on the importance of adequate coverage for pregnant women and infants in terms of oral health. Activities under education include providing clinical information to diverse providers through disseminating the New York guidelines, the Maternal and Child Health Bureau guidelines and the AAPD perinatal guidelines. I'll discuss those in a few moments. Through promoting the inclusion of perinatal and infant oral health components in dental education, training curricula, education is provided to caregivers and Maternal and Child Health audiences. Those who come in contact with pregnant women and young children that caries is preventable and infectious. Education is also provided and gained through the teach program, a collaborative effort of the foundation of the American Academy of pediatric dentistry, it's a study investigating whether incorporating oral health kits into pediatric provider interactions with parents will increase provider's oral health and it is being completed and a report available later this year. Consumer documents targeting vertical transmission and on behaviors that parents and families can do at home to prevent and manage dental caries and through professional training. Providing training to general and pediatric dentists and using it in practice. A few specific activities. We try to incorporate oral health into our AIM partner activities. The AIM initiative that Dr. Nehring discussed earlier. One example is the American bar association completed a bench book

for judges on promoting healthy infant and toddlers in the child welfare system. We've integrated information on promoting a home for those children. The national business group on health has developed an employer toolkit for investing in Maternal and Child Health. The project undertook a general school survey of infant and oral health curricula to identify gaps to inform future advocacy efforts. We're looking at which state offered oral health benefit for pregnant women in order to -- we also provide parent education events including at the health and Senate childcare centers. One way to educate policymakers and their staff on perinatal and infant oral health. Another activity is our involvement with the Maternal and Child Health workgroup which I'm going to go into further detail on in the next slide.

Next slide, please. The Maternal and Child Health Bureau convenes the perinatal oral health workgroup in 2007. As you can see from the list of participants they represent diverse providers and also general education associations.

Next slide. There were several strategies for this workgroup. Initially to conduct an environmental scan of existing materials for health professionals and also consumers in the area of perinatal oral health to promote existing guidelines and materials, developed by the workgroup which will expand the education of health professionals and also to educate women and their families. All of this was undertaken with the goal of really integrating perinatal health and oral health so that oral health is seen as a very integral part of routine perinatal care.

Next slide. One of the materials developed by the workgroup they did develop several documents that were disseminated nationally but I'll be focusing on the abridged version of the New York State oral healthcare during pregnancy and early childhood practice

guidelines. This document was intended to improve the standard of care for pregnant women and explains why oral healthcare during pregnancy is important, provides information for three different groups of professionals, all health professionals inclusively, then separately prenatal care professionals and finally oral health professionals and offers guidance to share with families during pregnancy and postpartum.

The next slide. I just want to share some of the information provided in this document.

The role of all health professionals as outlined in the abridged version of the New York guidelines, as you can see is to explain why oral healthcare during pregnancy is important to explain that oral healthcare during pregnancy is safe and effective, to inform patients that diagnosis and treatment is safe during the first trimester of pregnancy, to specifically inform women that treatment can be provided throughout pregnancy but that between the 14th and 20th weeks of pregnancy is best. Also to advise patients that delay in treatment could result in significant risk to the mother and indirectly to the fetus. Additionally the guidelines encourage all health professionals to provide information about oral hygiene and oral health, to provide a list of dentists in the community including dentists who do accept patients enrolled in Medicaid and to provide referrals as needed.

Next slide. The role of all prenatal health professionals as recommended by the guidelines are to assess the pregnant woman's oral health status, to integrate oral health topics into prenatal care classes. To make educational materials available to patients and to counsel women to follow their dentist's recommendations for treatment or follow up. This document includes a referral form for prenatal providers and includes a dentist report form for the oral health provider to report back to the prenatal provider on the care that was given so it's really supporting the integration and collaboration of these two types of providers.

Next slide. Finally, the role of oral health professionals as instructed in the guidelines is to improve access to oral health services by removing practice level barriers and by encouraging providers to accept patients who are enrolled in Medicaid, to conduct a health history, risk assessment and oral exam, to use appropriate treatment when clinically indicated and to assist pregnant women with disease management.

Next slide, please. The guidance given to share with families relates to proper hygiene and nutrition during pregnancy. Just encourages women to obtain necessary oral treatment before delivery. This document was disseminated by the national Maternal and Child Health Resource Center to national regional and state provider organizations to MCHB funded grantees, to universities, local programs and Head Start grantees and other audiences in fall of 2008. These and other materials are available on the Resource Center's website.

Next slide. Coming soon the AAPD has developed their own guideline on perinatal oral healthcare. The guidelines are intended to provide clinical information to stakeholders in perinatal and pediatric oral health. They include recommendations related to caries assessment, participatory guidance, preventive strategies and appropriate therapeutic interventions. These guidelines will be available after may and they'll be available on AAPD's website. Check the website for then they'll be provided. I want to point out this guideline is very significant. It reflects a growing recognition that perinatal oral health is a foundation on which children's oral health is built and also because it recognizes the dentists, pediatricians, physicians, prenatal and other health providers should all work as partners to promote the optimal health of children.

Next slide. The ideal outcomes for the AADP oral health guidelines for the MCHB guidelines and the New York State guidelines are to increase knowledge and skills among prenatal and oral health providers, to increase coordination and referrals among providers but simultaneously to increase the awareness among pregnant women of the importance of oral health and their demand for care, which will lead to increased access utilization and quality of care during pregnancy.

Next slide. Since the title of this project is improving perinatal and infant oral health we want to focus today on our perinatal activities but I'll briefly describe our key efforts and messages related to infant oral health so we do know that early childhood is a time of significant growth and development that is as important for the mouth as it is for other parts of the body. As I mentioned before, general disease is usually established by age 2 and progressive and infectious which is why it's so important to start with prevention as early as possible. Ideally with the infant population. So the project really promotes a simultaneous approach to promoting oral health for infants. Which is access to systems of care such as establishing a general home and the age 1 dental visit while also providing information on individual and family behaviors that can be done to prevent and manage dental caries at home.

Next slide, please. So some of the individual and family behaviors that we provided indication on relate to fluoride exposure to oral hygiene, nutrition and eating habits. We try to educate families and providers and other organizations that come in contact with families on again what they can do at home to prevent and manage this disease and to keep it from progressing.

Next slide. Again a key project message and initiative is promoting a general home for all children. Evidence supports the advantages of receiving early dental care and intervention that's complimented by anticipatory guidance to parents. It embraces the importance of early intervention and encourages a first dental visit by about one year of age.

Next slide. On the age one dental visit is endorsed by many different health organizations and it is important because tooth decay in primary teeth is the most reliable predictor of caries in permanent teeth. Also failure to prevent early childhood caries has long term consequences not only in terms of disease progression for the child but also in terms of dollars. A study has shown that low income children who have their first preventive dental visit by age one are not only less likely to have subsequent emergency room visits but their average dental-related costs are about 40% lower over a five-year period than for the children who receive their first preventive visit after age one. Preventing caries from progressing is important in promoting the optimal health for the child but it is also cost effective.

Next slide, please. So I just wanted to share some of our key project activities including infant oral health which includes providing trainings to pediatric dentists and general dentists on how to treat infants and young children and the importance of integrating messages on perinatal oral health while doing so. Providing training and education to health professionals and childcare providers on how to prevent and manage dental disease and also on avoiding vertical transmission as a key message. Promoting the importance of the dental home and the age one dental visit to the public and also again promoting awareness of the infectious and preventable nature of dental caries.

Next slide. I've just listed some of our collaborative partners including parent organizations such as national healthy start association, publications like parents magazine, today's child magazine, American bar association, family voices, recently we collaborated with the association of state and territorial general directors to develop a report on early childhood oral health and that will be on our website stimulate 2009, early 2010. I encourage you to visit their website to access that report and the website is provided in the pages of these slides.

Next slide, please. So the take-home message for today is that dental caries is preventable. We promote that prevention should start as early as possible so ideally with pregnant women both for their health and the health of their children and families that early risk assessment should be provided to infants in order to prevent caries from progressing at the earliest opportunity in a child's life. Also simultaneously that it's important to educate caregivers and other professionals who come in contact with children and families on ways to prevent and manage disease. On what can be done at home to promote oral health. This project overall addresses the need to intervene at the earliest opportunity prioritizing prevention and promotes integrating existing systems of care. It reflects a growing recognition of the importance of addressing oral health for the entire family and of the inability to separate perinatal health from infant and family health in general.

Next slide. The AAPD committee on perinatal and infant oral health oversees the implementation of the infant and perinatal oral health project and the committee members represent different universities and professional organizations and associations are listed there.

Next slide. Thank you very much for attending this webcast and if you have any questions, feel free to ask them at the end of the presentation or to contact me at the information provided here.

>> Next slide, please. Thank you very much, Marc, for your introduction and Jessie for your comprehensive review of addressing oral health factors in pregnancy. As Mark Nehring noted I'm a practicing pediatrician from New Hampshire and currently serving as chair of the American Academy of pediatrics Oral Health Initiative. My remarks today will talk about the State of oral health in early childhood and the role of the pediatrician in trying to expand access to the 0 to 3-year-old population. Particularly those who are poor, uninsured or are of minority status.

Next slide, please. You might ask, why is oral health important for pediatricians? Because when pediatricians by and large first heard that oral health was important for them they asked this question. Well, we as pediatricians see children early and we see them regularly. We see 12 well child visits in kids from the ages of 0 to 3 so we have 12 opportunities during well visits and other opportunities during illness visits to address oral health. Also, as pediatricians we're experts in prevention strategies. Think about immunizations as prevention. But also in the oral health area, we can talk about nutrition, fluoride and injury as good preventive strategies to attain good oral health. And also pediatricians always have and always will advocate for child health and oral health is just part of good child health.

Next slide, please. I don't have to tell people on the call that oral disease is consequential and it's very common and we've all heard the numbers. Oral disease is five times more common than asthma and seven times more common than hay fever and it is

unconscionable to here that 24 to 28% of our 2 to 4-year-olds in the United States have dental caries. Dental caries leads to hospitalization, to surgical intervention and even to deaths. We all know what happened to the child who lived in Maryland and was unable to access care for his abscess and ended up dying. Oral disease also results in missed work and missed school and estimates are that 51 million hours are lost by children who are in pain from being in school. And oral disease can also provide a distraction for kids from their normal activities, mainly learning, and can lead to issues with growth and with speech and eating dysfunction.

Next slide, please. So what about the workforce issue and access to care? Well, we know that the dentist to the population ratio is declining and that is especially true of the pediatric dentist population. There is a little over 150,000 practicing dentists in the United States and only 3,600 practicing pediatric dentists and we've found that general dentists right now do not generally have training in or feel comfortable with seeing small children.

Next slide, please. We also know that there is a lot of disparities in accessing oral healthcare. And some of the factors are that preschoolers who are poor have twice as much tooth decay, twice as much unmet treatment needs, twice as much pain, but yet they only have half the access to care. And minority children are also much more likely to suffer from tooth decay, are less likely to visit the dentist, and even when they are insured they have fewer dental visits than white children. Just think about if you're both a preschooler and a minority. In fact, Native American children have the very highest rate of dental caries in the United States.

Next slide, please. So what about insurance coverage? Aren't kids insured? Well, about 22% of children in the United States lack dental insurance. And that's three times as high

as those who lack medical insurance. Rural children we know are less likely to have insurance than urban children. And kids who live in poverty are less likely to receive preventive dental care independent of insurance coverage. So even if they have the card they're less likely to receive the care. It is shameful that only about 20% of children with Medicaid dental benefit saw a dentist in the past year. And, in fact, over half of all our children in the U.S. ages one to five had not seen a dentist in the prior year in a recent survey.

Next slide, please. It's probably no surprise that it's kids on Medicaid that have the biggest burden of caries. 80% of dental caries occurs in the lowest 20% income levels. And as pediatricians, our doors are generally wide open to Medicaid patients. We see them early and we see them often when prevention is most effective. But getting Medicaid patients into a dental home can be challenging.

Next slide, please. So that's a rationale for why pediatricians should be interested and involved. However, do pediatricians have an adequate background in oral health?

Next slide, please. We know from surveys that medical school education on oral health is lacking and there are two studies that are cited on your slide, one from 1997 and one from 2000 showing that still a large percentage of people graduating from medical school have received little to no dental health instruction.

Next slide, please. So you can ask are they getting it in residency? Well, in 2006 the American Academy of pediatrics did a residence survey. Here are the results. Two thirds of graduating residents felt that pediatricians should conduct oral health risk assessments. One-third of the residents surveyed had received no oral health training of any kind during

residency. And of those who had received some training, 3/4 had had less than three hours of training. And only 14% had had clinical observation time with a dentist. As a result, the majority of residents stated in this survey that they would like more oral health training.

Next slide, please. So you might ask about practicing pediatricians, those folks that have been out for a while. So in 2008, the AAP survey, which was similar to the one that had been done with the residents two years prior, came up with these results. Only 13% of pediatricians said that they had received any training in oral health during med school. A little more than that, 16%, had received a bit of training in residency. 22% said that they've had training after residency. And of those who had had some training, 69% said that their training had been less than three hours. And only 6% had had clinical observation time with a dentist. Almost half reported that their training had been from journal articles.

Next slide, please. So understanding that pediatricians are lacking and need more background in oral health –

next slide, please -- three forces brought oral health to the radar screen of the American Academy of Pediatrics. First the section on pediatric dentistry, secondly the 2000 Surgeon General's report on oral health in America and thirdly the Maternal and Child Health Bureau grant.

Next slide, please. The section on pediatric dentistry was established in 1999 as a section within the larger group of the American Academy of Pediatrics and the goals were to provide educational forum for discussion of oral health in children, to improve

communication between pediatricians and pediatric dentists and to advocate for improved health. The name was changed to the section on pediatric dentistry and oral health just a couple years ago because we're trying to get more pediatrician members. Currently membership is at 235. And a recent by laws change is allowing general dentists, dental hygienists, RNs and anyone else interested in oral health to become an affiliate member. Anyone on the call that's not a member that would like to be, please consider joining.

Next slide, please. In May of 2003 the academy published its first oral health policy statement. This was authored by members of the section on pediatric dentistry. So for the first time pediatricians were advised that they needed to incorporate oral health as part of their practice. The oral health policy statement explains and went into the background of some of the scientific behind caries, described an overall risk assessment that was recommended for us to do, outlined anticipatory guidelines and talked about the dental home.

Next slide, please. The first Maternal and Child Health Bureau grant that allowed us to look at oral health was a grant called the PedsCare grant. The oral health section of that grant brought together a workgroup comprised of pediatricians, pediatric dentists and dental hygienists and a lot of things were accomplished. The AAP oral health website was started, the monthly children's oral health newsletter was begun. We started to offer oral health training preceptorships and we also developed the oral health risk assessment training.

Next slide, please. That training has been quite successful. There were 14,000 kits produced and distributed to medical and dental health providers. The training is available now online in a PDF format and one can get free CME or continuing education hours by

taking it. It's only been up on our website since February of 2008 and already over 600 individuals have taken the course and received credit for it.

Next slide, please. Here are the recommendations that were addressed by the first oral health risk assessment policy statement. Again, published in pediatrics in May of 2003. For the first time it was recommended that pediatricians ask about mothers or other caretakers' oral health, assess the oral health risk of infants and children, recognize the signs and symptoms of early caries, assess the child's exposure to fluoride modalities, provide anticipatory guidance including oral hygiene instructions and then, very important, make a timely referral to a dental home which now as you have already heard is at one year of age.

Next slide, please. So anticipatory guidance is something that pediatricians always do and there are always things that are being added to our list. But these are the areas that we are recommending pediatricians address regarding oral health. Optimizing oral hygiene, strategies on minimizing the spread of infection as you've already heard from parent or caregiver to child, reducing dietary sugars, and then removing dental decay which only happens after referral to the dental home, hopefully we can prevent it so it doesn't have to be removed and administering fluorides judiciously.

Next slide, please. Those of you who aren't members of the American Academy of pediatrics and may not be familiar with the AAP agenda for children, it gets updated every year. And oral health is actually one of the strategic areas now on the strategic plan. And because it's on the strategic plan, many pediatricians are now really paying a lot more attention to oral health issues, which is one of our main projected outcomes.

Next slide, please. The Maternal and Child Health Bureau kindly awarded the AAP a second grant, and this grant is called the PROHD grant that stands for Partnership to Reduce Oral Health Disparities in early childhood. There are three key goals. One is to address health disparities in oral health, two, to improve child health professional skills in performing oral health risk assessments. And lastly, to improve systems of care for the prevention of early childhood caries.

Next slide, please. These are the PROHD grant activities currently going on as a result of the grant. And you can see that many of them built on the first grant, which was the PedsCare program grant. There is a monthly pediatric oral health electronic newsletter. There is a website on the AAP website and incredibly enough there are about 100,000 hits on that per month. So it is widely accessed. Also we serve as the AAP clearinghouse for any pediatric oral health information and materials are developed related to pediatric oral health. The second big category is that we support the oral health grant programs. And there are several of these. The healthy tomorrows grants, the Healthy People 2010 grants and the oral health preceptorship program grants. I'll speak a little more about these three in a minute. We also have the clearinghouse for the educational programs. NCE stands for national conference and exhibition and that's the meeting where something like 10 or 11,000 people come once a year and there are four to six different sessions on oral health at that meeting that people can choose to go to. We give a lot of oral health conferences at major national and local meetings. To other CME products and are participating very closely with Bright Futures that has as one of its ten deliverable for each visit an assessment of oral health. You can see how nice our new oral health website is, so please go to the AAP.org and click on oral health website.

Next slide, please. There is a new educational training model called protecting all children's teeth. This will be available on the oral health website of the academy for 11CME units and it is free. There are 13 modules in this curriculum and it is very, very exciting. There is a lot of different topics.

Next slide, please. So the oral health grantees that have already been mentioned, the grants tend to be smallish grants given to community pediatricians that see a need in their community or to residents that are interested in community pediatrics. And about 30 of them have been awarded specific to oral health. The healthy tomorrow's grants are a partnership between the Maternal and Child Health Bureau and the American Academy of Pediatrics. They're larger grants that go on for four to five years and involve more dollars. There have been about 20 specific to oral health. And then the oral health preceptorship awards. 42 of them have been given out and we accept about ten awards per year. And in this awardee category it provides a mentor to go to a site and do a visit and sometimes give Grand Rounds and oftentimes do clinical trials and observations and show participants how to do the oral health assessment in the office setting.

Next slide, please. There is also Healthy People 2010 chapter grants. In 2006 the academy of Pediatrics district vice chairs decided that oral health was the topic for that year so that five grants were given. California, Kansas, Kentucky, Maine and Tennessee.

Next slide, please. The goals that all of these grant programs have in common are educating providers and patients about oral health, increasing access to care, providing direct service so some of them involve schools, medical and dental clinics. Providing screenings to young children. Linking patients to a dental home and reducing disparities.

Next slide, please. Oral health and Bright Futures, as I've already mentioned, the recommendations in oral health now are that this is one of the ten areas that pediatricians need to pay attention to. And the recommendations are that pediatricians provide risk assessment screening and provide anticipatory for dietary recommendations and top call fluoride supplementation depending on risk and important referral to a dental home.

Next slide, please. There is now a second oral health policy statement that came out in pediatrics in December 2008. It is called "preventive oral health intervention for pediatricians" and it builds on the original policy statement and expands. It clarifies the scientific basis of early childhood caries, it expands on our role in anticipatory guidance. It recommends preventive and interventional strategies and it provides strategies for improving the connection of the medical and dental homes.

Next slide, please. What about physicians payment for oral health preventive services? Why are we talking about this? Well, oral health adds yet another item to the long list of assessments addressed by pediatricians during the visits. The visits aren't getting any longer in length but we have to incorporate a lot more preventive information into each one of them. So preventive services do need to involve oral health risk assessment, guidance and application of fluoride varnish but it is felt strongly that we will only attain that goal if an extra reimbursement is offered for doing the oral health preventive services.

Next slide, please. Medicaid, in fact, is giving an extra reimbursement to pediatricians and other child health providers in more than half the states in the U.S. right now. And efforts are underway in the states that don't have reimbursement to try and obtain that to act as a driver for physicians to do more in oral health risk assessment.

Next slide, please. We also have something called the chapter advocate training on oral health going on. And this is being funded by a grant from the American Dental Association foundation. So what is happening is that each chapter of the American Academy of pediatrics, there are 66 of them, is identifying an oral health advocate and that advocate will be receiving an intensive day and a half of training in oral health and then expected to go back to their own chapter and disseminate the information.

Next slide, please. So what does that training involve? It involves a scientific basis of caries and preventive strategies, how to do oral health risk assessment, how to give guidance, payment options, fluoride modalities, oral health messaging and building collaborative relationships back in the community.

Next slide, please. So just to summarize what the American Academy of pediatrics is doing in the area of oral health, we're doing a lot on communication with the monthly E-newsletter, the website and acting as a clearinghouse for pediatric oral health information. We're supporting the grant programs on oral health. We're developing and disseminating and giving a lot of educational programs in different venues and we've got a lot of energy going into training programs. The oral health risk assessment training and now the new one, protecting all children's teeth. And we are also addressing payment issues.

Next slide, please. I would like to thank everyone very much and I look forward to your questions. And the person at the American Academy of Pediatric who would be more than happy to answer question and on the call as well Wendy Nelson. The manager of the Oral Health Initiative at the academy and you have her contact information on the last slide.

Thank you.

>> I want to thank both of our presenters today. There was a lot of information. I know more than an hour has gone by since we began talking to you. So I appreciate those of you on the other end of the receiving of this webcast for your patience and all. We actually have received only one question. So while I describe what that is, I'll encourage again folks to send in any additional questions you may have in the remaining few minutes to us. And -- but first I will address the question, if I read it directly to you, what about care during the postnatal period and breastfeeding? I'm going to assume the care that's being questioned here is what about oral healthcare and I'm also going to assume it is for the mother during the postnatal period and breast feeding. I'll just make my initial reaction and comment in that we're hopeful that women who seek care will have a routine source of care and a regular source of care and that would be something that would all -- would -- that's all that would be expected, I think, in the postnatal period is a woman who is not experiencing any particular health -- oral health issue would just continue on with regular follow-up. And there should be no special needs or special circumstances or special clinical considerations to diagnose in that period. I'll invite our speakers as well as Wendy to make any further comment if they'd like.

>> This is Jessie. I would just reiterate what you said, Dr. Nehring. Hopefully if a woman hadn't already established a dental home for herself in the prenatal period that she would do so and just continue to access care afterwards at regular intervals.

>> This is Susie. And I think we as pediatricians also could do more to question whether the mother, when she brings the infant into the office, has a dental home. And that's something that we haven't really done in the past. Pediatricians really confine what they do to the pediatric patient and not to the caregiver. So it's a little bit of a leap for us but I think because the policy statement, both the first and the second one strongly recommend

that we assess the mother's oral health as does Bright Futures, that we're hoping that pediatricians will feel that that is on their radar screen and that's their responsibility. Because the data show that if a mother has a dental home it is much more likely that a child, as they get older, will have a dental home.

>> Thank you both. That was helpful. In the absence of additional questions, and I will continue to monitor the message board here, I want you to understand there is an evaluation that will be automatically displayed in a separate window at the end of the webcast and this information will help us better to serve you with the future webcasts so please take the opportunity to fill out that evaluation for help to us. I think again I had mentioned earlier with my initial comments that I want those of you especially who have joined later through this broadcast to understand that these presentations will be archived and then the archives will be available, the power point slides that you've seen will be available for you to view as notes pages and as a note document you will see a more complete narrative of what was presented today with some additional details. So please be mindful of that. I believe from other broadcasts that have happened within the past month the message back to the public has been in those that are anxious to get their hands on the power points and review them again have been told that the archives will be provided no earlier than one week after today. Maybe a few days longer. So I will just say to you now that within the next couple of weeks you should expect that the archives will be available for viewing in other formats and also to monitor that you can go to www.mchcom.com and you'll be able to access those webcasts. You'll be able to not only view past webcasts, but you will also be able to see a list of upcoming webcasts on a variety of other topics. I'm going to look at the message board here. I have a couple more messages. One is from someone in another country and indicates that -- it's a county. None of the pediatric dentists in our county accept the Medicaid insurance. Is there any

campaign to bring them into the effort? And again in the immediate off the top of my head response to that I think that's in keeping for the reason for the webcasts is to let people know as both speakers have done so well to give you an idea of the lack of access that exists out there, that there are new venues and access points that are developing through medical and dental providers and that we recognize that there is a problem that we want to address further. So I guess another way to answer that is we are making every effort within the Maternal and Child Health Bureau and our various partners to try to -- with especially now new legislation. State healthcare programs for children under the new legislation that was just signed by the current administration to bring additional access points for children by increasing the workforce and the providers that are able to provide care to those children, especially those that are preventive in nature. I also have a question here, can you address specifically the payment issues. I'm not clear on what you mean about the payment issues. There are reimbursements for providers through the Medicaid system. Each state has its own coverages and its own practice acts under which providers practice. And that those coverages may well be reimbursed to selected providers in a given state, at different reimbursement rates. Another new CHIPRA legislation it's my understanding at this point in time that a national minimum payment across every given state for reimbursement of certain procedures is not on the radar screen, so to speak. I understand that states will still have their ability to make their independent decisions based upon the need in their states and their assessment of how they are going to meet the clinical needs of the population. So it's a difficult question to address specifically. There are a range of things, again, I think with the work groups, whether they're at the state level, through some efforts with the likelihood of health reform where the public is invited to comment about issues that they are concerned about for healthcare in America, and then again partners with Maternal and Child Health Bureau being at the table to recognize that there are these issues that we face in trying to improve

services and quality of services for women and children. I believe that we need to be at the table to recognize those things and to be able to speak to them as well. Would our presenters like to make any comment on that which I've already spent time?

>> This is Susie. I'm wondering whether the question came from a pediatrician or a dentist. If the question came from a pediatrician, WWW.AAP.org, which is the AAP website, has oral health that you can click on and we have a lot of information on our website about what states do have reimbursement and how much the reimbursement is from state to state for pediatricians who are seeing Medicaid children in their offices. So if it's a pediatrician that is asking that question, that's the place that I would send that person.

>> This is Wendy from the initiative. I would add, though, if you're going to go to the website it's [www.AAP.org/oral health](http://www.AAP.org/oral%20health). We have downloaded and did a survey of states and it indicates what states are reimbursing, the amount that they're reimbursing for non-dentist providing some of these preventive services.

>> Thank you. I have received over the message board that I use as a moderator that there are a couple more questions. One now is a statement rather than a question. I think it's worth mentioning and reading to our audience. And it says from Debra, I want to applaud the AAP for all their efforts to improve the oral health of children and partner with the oral health folks. It is clear that access and intervention to this population is best done through the medical -- the pediatric medical community. I think that's the point of our presentation today is to recognize there is what I -- a term I use oftentimes here, there is a medical/dental interface at work here and the word interface for me implies that there is at least the opportunity, if not an existing opportunity for communication and I think it's that

opportunity for communication and leveraging our individual abilities and access to populations that for the greater good for both professions and for the population benefits the oral health of those that we're trying to improve. And I will ask in the absence of seeing any more messages for any concluding remarks from either of the presenters. In the absence of that, and I will make my closing remarks and I'll open it back to the presenters. Do you have any closing remarks?

>> This is Susie. I just want to say that without the support, the grant support specifically of the Maternal and Child Health Bureau, we would not have been able to accomplish what we have accomplished by funding us to move oral health to the front of the radar screen of pediatricians across the United States. And it has just been a remarkable journey. And the fact that it's one of the big main initiatives this year and last year and next year of the academy shows how much importance the academy is giving to oral health and with the ultimate goal of the potential for eliminating -- I'm an optimist -- early childhood caries, that's a pretty awesome goal. Thank you.

>> Well, thank you, Dr. Boulter and I also want to thank Ms. Buerlein and Ms. Nelson for being available through this and their presentations and their words of wisdom. Everyone in the audience, thank you for your kind attendance today. We hope this has been worthwhile and hope to continue to provide such forums to address other issues within oral health, in particular for the needs of women and children in this country. Thank you again.