THE TRUTH

“What it is like to provide baby dental care”

Beth Noel RDH, BS
Oral Health During Pregnancy

Good oral health for infants starts during pregnancy
The National Maternal and Child Oral Health Resource Center (OHRC) at Georgetown University announced the availability of a new resource to help professionals working in states and communities plan, develop, and implement programs to help ensure that pregnant women receive optimal oral health services.

The expert workgroup consisted of individuals with expertise in oral health and prenatal care representing the AAP, AAPD, ACOG, ACNM, ADA, ADHA, ASTDD, National Maternal and Oral Health Resource Center, Medicaid-CHIP State Dental Association and federal agencies.

Preventive, diagnostic (radiographs), and restorative dental treatment is safe throughout pregnancy and is effective in improving and maintaining oral health. Also appropriate pharmacological agents are listed in the document as indicated, contraindicated or may be used under special consideration.

All health professionals can play an important role in providing pregnant women with appropriate and timely oral health care, which includes oral health education.

This resource was developed with support from the Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA).
Oral Health Concerns During Pregnancy

Swollen or bleeding gums

Untreated tooth decay - Tooth pain that may interfere with good nutrition

Vomiting (morning sickness)
Finding a Dental Home for the Pregnant Mother

If it has been more than 6 months since the mother’s last dental check-up or if any oral health problems are identified during an assessment, the mother should be advised to schedule an appointment with a dentist as soon as possible.

- Medical professionals should establish relationships with oral health professionals, and community–based programs in the community.
- Develop a formal referral process that will allow for a timely appointment.
- Share pertinent information about pregnant women with oral health professionals, and coordinate care with oral health professionals as appropriate.
Oral Health Education During Pregnancy

- Brush 2x day with a fluoride toothpaste
- Floss 1x day
- Xylitol gum/mints which can reduce bacteria that can cause tooth decay
- Rinse after vomiting to reduce acid level and postpone brushing for 30 minutes
- Eat a variety of healthy foods (fruit, vegetables, whole grains, dairy products, proteins)
- Limit sugary foods (candy, cookies, dried fruit, soda, juice)
- Read food labels (sugar content)
- Drink more water
- Smoking cessation and avoiding alcohol and drugs
- Infant oral health (how to take care of the baby’s teeth and gums)
After the Baby is Born

- New mothers need to continue taking care of their mouth and teeth after the baby is born. (Home care and regular dental check-ups).
- Mothers should already know how to take care of the baby’s teeth and gums from day 1 (bottle use, breast-feeding, sippy cup use, cleaning the gums and teeth when they erupt, BBTD, sugary drinks and snacks).
- Ask the pediatrician to check the baby’s mouth at well baby check-ups.
- Ask the pediatrician for a referral to a dentist when the baby is 6 months of age for routine and urgent oral health care.
Infant Oral Health
During my 25 Years as a Dental Hygienist in Private Practice...

Trying to get that reluctant 3 year old into my dental chair for her first dental visit!

If I would have known then what I know now after 10 years of working in a dedicated baby dental clinic.
Age 1 Dental Visit/Dental Home Recommendation

American Academy of Pediatric Dentistry
American Dental Association
American Academy of Pediatrics

- Establish a “dental home” for preventive and routine oral health.

- Urge parents and guardians, as a child's first tooth erupts, to consult with their dentist regarding scheduling the child's first dental visit.

- It is advantageous for the first visit to occur within six months of eruption of the first tooth and no later than 12 months of age.

- Receiving oral health education based on the child's developmental needs (also known as anticipatory guidance).
Historically although the infant oral health program began in 1989, in August 2003 we designated ½ day a week for a new baby dental clinic. Today we run the baby dental clinic 5 days a week. We see up to 20 patients a day. We have a 7 month waiting list for new patients and recalls.

THE DEMAND FOR APPOINTMENTS SHOW THAT MOST PEDIATRICIANS AND PARENTS GET IT!!
So, What is Keeping You from Providing Preventive Dental Care to Children Beginning at Age 1?

This is really doable!
All you need is to welcome these little ones, a hygienist, a room and 2 chairs!
No Child is Too Young to have Healthy Teeth and Gums

- Age 3 is too late to start preventive dental care

- It only takes 15-20 minutes to do the risk assessment, oral exam and fluoride varnish application

- You don’t need any special equipment or a dental chair

- Early intervention at age 1/lower risk that child is going to get a cavity/prevent referral to pediatric dentist (family dental home)

- Great use of hygienist time/nice change of pace/minimal training to see 1 year olds

- Arrange baby appointments at the beginning of the day

- Infant oral health care services are billable {oral exam (periodic, comprehensive), fluoride application, toothbrush prophylaxis}
What Do We See In The Baby Dental Clinic?
But We Also See White Spot Lesions and Small Incipient Caries

With aggressive fluoride therapy, more frequent recalls and well supported home care, these early lesions can be maintained or reversed with the assistance of a dental home.
We Also See Simple Anomalies Like...

- Fused teeth
- Aphthous ulcer
- Low frenum attachment
- Eruption cyst
- Incisal chipped tooth
- Delayed eruption/teething
- Iron Supplement Stain
- Thrush
- Oral Habits

That are easy for you to explain to the parent
Consequences and Risks of Waiting Until Age 3 for First Dental Visit

- Different lifestyle: This is not the 1960’s when most mothers stayed home with the kids
- Americans eat roughly 570 calories more per day than they did in the 1970s.
- Well meaning parents are very remorseful that they were not educated earlier about sugar in natural fruit juice or milk, inadequate brushing habits, lack of adequate fluoride exposure was contributing to their risk for cavities. REALIZATION THAT IT WAS PREVENTABLE!!
- Parents not knowing that just because cavities run in the family it doesn’t mean that you can’t prevent them from ever starting. (soft teeth)
- Environmental risks: stress, smoking, inadequate access to nutritious food, etc.
- Parents wait 6-9 months for an appointment at NCH, drive 2-3 hours to come here for a 30 minute appointment to find out that their 2 year old needs to come back next month for sedation or general anesthesia. That sometimes means a day off work, cost of gas, cost of food and the reality that they will have to turn around and do it again in a month.
- Children with cavities that now associate the dentist with pain and anxiety.
Consequences $$ of Waiting Until Age 3 for the First Dental Visit

• Total cost for regular preventive care from age 1-3 (oral exam, fluoride, toothbrush prophy) **750.00** *(typically covered by Medicaid and Private Insurance)*

• Average cost of general anesthesia (average cost) **$5000** plus associated risks
Baby Dental Visit

1. Small room with 2 chairs/or dental chair and chair-side seat (knee-to-knee)
2. Antimicrobial hand cleaner/gown/gloves/mask/safety glasses
3. Mirror and explorer
4. Age appropriate toothbrush and toothpaste
5. Gauze
6. Fluoride varnish
7. Educational posters and handouts
You **want** the Parent to Come Back with the Child...

Both you and the parent have a common goal to prevent cavities and promote the oral health of the child!!
Risk Assessment

Identifying the cause of disease through the assessment of risk factors for each individual patient and then managing those risk factors through behavioral, chemical and minimally invasive procedures.

CAMBRA Risk Assessment Tool (Caries Management By Risk Assessment) AAPD Caries Risk Assessment Form for children age 0-5

The goal of CAMBRA is to educate and motivate patients to improve their behaviors and give them strategies and products to attain and maintain a healthy oral environment.

Goal with risk assessment is to gather information:
- Brushing habits
- Fluoride exposure (toothpaste, water)
- Sippy cup/bottle habit
- Going to bed with sugary drink
- Sugary drinks throughout the day
- Snacking

*Decide if they are low, medium or high risk (behaviors)*
ECC Visit # — RISK ASSESSMENT FORM
(Visit # & Risk Assessment must be completed by ECC PROJECT PERSONNEL only)

Initial Questions to Parent (please write down parent’s replies verbatim):
1. Do you remember the 2 main caries-control goals we gave you at the last appointment?

2. Why do you think ……………….. (child’s name) has cavities?

3. How many regular care-givers does your child have and who are they? (daycare, grandparent, etc.)

<table>
<thead>
<tr>
<th>DIET &amp; DRINK:</th>
<th>TOOTH BRUSHING:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the child have a bottle or sippy cup at night or between meals?</td>
<td>Does anyone cleans/brushes the child’s mouth yet?</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>What do they drink at night?</td>
<td>Who brushes child’s teeth: Parent/Child/Both</td>
</tr>
<tr>
<td></td>
<td>How often are the teeth brushed?</td>
</tr>
<tr>
<td></td>
<td>Weekly/most days/once a day, multiple times per day</td>
</tr>
<tr>
<td>Does the child use a bottle or sippy cup with fluid other than water?</td>
<td>When are the child’s teeth brushed?</td>
</tr>
<tr>
<td>Yes</td>
<td>Morning/Afternoon/Bedtime</td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does the child have a bottle or sippy cup with fluid other than water?</td>
<td>Does the child cooperate with parental brushing?</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes/No</td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Types (frequency) of snacks: Fruit/starch/Dairy/Meats/Sugary/Veggies</td>
<td>FLUORIDE EXPOSURE:</td>
</tr>
<tr>
<td>Yes</td>
<td>What type of toothpaste is used for child?</td>
</tr>
<tr>
<td>No</td>
<td>None/Flouride/Non-flouride</td>
</tr>
<tr>
<td>FAMILY HISTORY:</td>
<td>Drinking water – Public/Well/Bottled/Reverse Osmosis</td>
</tr>
<tr>
<td>Active caries in Mother/Or Siblings – or neither –</td>
<td>Fluoridated</td>
</tr>
</tbody>
</table>

RISK FACTORS & DISEASE INDICATORS

☐ Existing non-cavitated white spots or Carious lesions
☐ High frequency carbohydrates
☐ Drinking water not fluoridated
☐ Not using fluoride toothpaste
☐ Heavy plaque or gingivitis
☐ Other

INDICATORS OF IMPROVED RISK:

☐ Meeting Self-management Goals
☐ Motivation level for change
☐ Improved oral hygiene

REVISED SELF-MANAGEMENT GOALS:

1. ……………………………………………………………………………………………………………………………

2. ……………………………………………………………………………………………………………………………

Overall Risk

Low

Medium

High

NV for High Risk ECC: ___ Months from today for Disease Management if ☐ GA or ☐ Sedation Referral

☐ Restorations (☐ Baby Op / ☐ CC)

NV for Low or Moderate Risk: 6 Months from Baseline Visit for Recall

08.18.2011
Knee-to-Knee Exam
Knee-to-Knee Exam

Instruct the parent to lift the lip and brush along the gumline.

Demo brushing the teeth, gums and tongue

Point out plaque, bleeding gums, non-cavitated white spot lesions, deep pit and grooves in posterior teeth, or possible cavitation's

Apply fluoride varnish

Decide if they are low, medium or high risk (clinical risk)
**Charting Form**

**ECC - EARLY CHILDHOOD CARIES**

**PATIENT DATA FORM**

**ECC Visit #**

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Baseline</th>
<th>Disease Management (1-4 months)</th>
<th>6-month recall</th>
<th>Baby OP</th>
<th>CC</th>
<th>Sedation</th>
<th>OR</th>
</tr>
</thead>
</table>

Please complete □ 1-2 WEEKS prior to treatment, if any.

1. Examine & label each tooth surface per diagnosis:
   - W - White spot
   - C - Caries
   - R - Remineralizing or arrested
   - F - Filling (restoration) & crown

2. □ Deep pits or fissures & □ Enamel defects/hypoplasia

3. Visible plaque: □ No □ Yes - □ Light □ Mod. □ Heavy

4. Gingivitis: □ No □ Yes - □ Mild □ Moderate □ Severe

   Affected area: □ Localized □ Generalized

5. Pain/Sensitivity due to Untreated Caries: □ Yes □ No

   Which tooth/teeth?

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**Radiographic Findings (if applicable):**

- List of teeth with deep, pulpal decay:
- Periapical or furcation radiolucency:

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**AFTER treatment, please complete.** □ 1-4:

1. □ Fluoride Varnish application at end of appt.

2. □ Behavior Rating: [ ] - [ ]

3. □ Name of Clinician & Provider #: ________________________

4. □ Caries Counseling by ________________________

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Any change in insurance/phone number/address: □ Yes □ No

Any change in health history: □ Yes □ No

Restorations completed today (if applicable): ________________________
Motivational Interviewing/Anticipatory Guidance

MI is a tricky business and the most difficult part of the appointment.

How to motivate a parent who may have had very limited access to dental care over their lifetime, may have tooth decay and isn’t motivated to take care of their own teeth.

I hear all kinds of excuses/scenarios: (parents of 0-3 year olds)

- Susie won’t let me brush her teeth so I let her brush by herself
- Johnny cries when I brush his teeth and I don’t want him to cry
- I can’t get his mouth open
- He won’t let me brush so I let his 7 year old sister brush his teeth
- He falls asleep before I can brush
- His gums bleed when I brush so I stopped because I thought I was hurting him
- If I take the bottle away at night he will cry all night long
- Since the new baby arrived Johnny wants a bottle too
- If he wants pop I am not going to deny him
- He has soft teeth like his dad’s side of the family
MI Video
Motivational Interviewing/Anticipatory Guidance

- Age specific (age 0-5), individualized oral health instruction that is doable not heroic.
- Use motivational interviewing to help the caregiver to make *small steps of change* to improve the oral health of the child.
- Educate the caregiver about what specific habits are putting the child’s teeth at risk for decay and how that relates to what you are seeing in his mouth.
- Have the caregiver make the decision what 1-2 changes they want to make at home.

*Provider will make the decision based on [behavioral](#) and [clinical](#) risks when the child should be seen again for a dental check-up.*

The standard of care in our dental clinic is:

- **Low** risk patients be seen every 6 months
- **Medium** risk patients be seen every 3-6 months
- **High** risk patients should be seen every 1-3 months
## AAPD Caries Management Protocol for 1-2 Year Olds

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Diagnostics</th>
<th>Interventions</th>
<th>Restorative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low risk</strong></td>
<td>– Recall every 6-12 months</td>
<td>2x daily brushing</td>
<td>Counseling</td>
</tr>
<tr>
<td><strong>Moderate risk</strong></td>
<td>Recall every 6 months</td>
<td>2x daily brushing with fl. toothpaste</td>
<td>Counseling</td>
</tr>
<tr>
<td>parent engaged</td>
<td></td>
<td>– Fl. water</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Professional topical treatment every 6 months</td>
<td></td>
</tr>
<tr>
<td><strong>Moderate risk</strong></td>
<td>Recall every 6 months</td>
<td>2x daily brushing with fl. toothpaste</td>
<td>Counseling, with limited expectations</td>
</tr>
<tr>
<td>parent not engaged</td>
<td></td>
<td>– Fl. water</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Professional topical treatment every 6 months</td>
<td></td>
</tr>
<tr>
<td><strong>High risk</strong></td>
<td>Recall every 3 months</td>
<td>2x daily brushing with fluoridated toothpaste b</td>
<td>Counseling</td>
</tr>
<tr>
<td>parent engaged</td>
<td></td>
<td>– Fluoride water</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Professional topical treatment every 3 months</td>
<td></td>
</tr>
<tr>
<td><strong>High risk</strong></td>
<td>Recall every 3 months</td>
<td>2x daily brushing with fluoridated toothpaste</td>
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<tr>
<td>parent not engaged</td>
<td></td>
<td>– Professional topical treatment every 3 months</td>
<td></td>
</tr>
</tbody>
</table>

*Fl.* indicates fluoridated.
AAPD Guideline on Fluoride Therapy

- Children at moderate caries risk should receive a professional fluoride treatment at least every 6 months.

- Those children with high caries risk should receive greater frequency of professional fluoride applications (ie, every 3-6 months).

- Ideally, this would occur as part of a comprehensive preventive program in a dental home.

- Fluoride varnishes can prevent or reverse enamel demineralization.
Educational Posters

**SUGAR IN DRINKS**

- 1 cup (8 oz) = 11 grams of sugar
- 1 cup = 26 g

- 1 juice box of 8 oz serving = around 25 grams of sugar
- One 12 oz serving = around 25 grams of sugar
- 12 oz can = around 39 grams of sugar

**SUGAR IN SNACKS**

Sugar Content per Serving Size

- 15 grams of sugar in serving
- 4 grams of sugar in serving

1 Sugar Cube = 1 teaspoon of sugar = 4 - 5 grams of sugar
SELF MANAGEMENT GOALS for Caregivers

Patient Name: ___________________________

Your child has been assessed to have the following risk for caries (cavities):

☐ High  ☐ Moderate  ☐ Low

Please focus on the following GOALS between today and the next appointment:

- Healthy snacks ≤3 times daily.
- No soda!
- Drink water and milk only with meals 5-6 oz daily at age 4.
- Plan a special “sweet treat” time occasionally & only if you can brush teeth right away.
- Wear off baby bottle by 1 year. Introduce 100% fruit juice at 6 months preferably in a cup.
- Watermelon in Sippy cup sippy cup with straw is safe. Stop off completely to regular cup by 14-18 months.
- Drink water that has fluoride in it. Drink only water between meals - avoid juice/milk/sugary drinks.
- Floss teeth.
- Use a small amount of fluoride toothpaste and brush twice AM and bedtime. Brush close to gumline, managing the gums. Do not rinse mouth after brushing.
- We will apply fluoride again on.

Clinician’s Comments:

Healthy Snacks— Fruit, cheese, yogurt, meats, vegetables and non-sweetened whole grain crackers/cereal. Snacking between meals should be restricted to less than 3 times daily to control decay.

- Soda has no nutritional value and it’s best to avoid soda completely. All sodas contain sugar and acid that attack teeth. Bacteria that cause cavities love soda since they help to double the damage to teeth.

- Juicy and milk contain sugar. Drink juice and milk at mealtime only to reduce the acid level and damage to teeth. AAP & AHA recommends not more than 4-6 oz. of 100% juice from 6 months of age till 6 years. 7 years and older—limit to a maximum of 8-12 oz of juice daily.

- Candy/cookies and most sweet treats contain a lot of sugar and often stick to teeth. Limit use to special occasions only and brush teeth immediately afterwards to reduce damage to teeth.

Getting your child to give up their bottle may be difficult, but it is important to wean your child off their bottle by age 18 months. Begin weaning at 1 year and replace a bottle for a cup in stages to make the transition smooth. Most children can use a cup by 12-14 months.

If your child prefers a sippy cup, remember to only serve water in it. Sippy cups with straws are better for teeth – regular sippy cups allow the juice or milk to bathe the teeth for longer periods of time.

Fluoridated water helps prevent cavities—drink plenty of water for good health!

Floss your child's teeth daily if you don't see spaces between teeth. Flossers with handles work well for young children.

For 1-2 year old, use a smear

Remember to lead by example - brush your teeth AM&PM, floss daily and visit your dentist regularly. These self-management goals are recommended for the whole family!
Final Words of Encouragement

- Remember that early childhood caries is the single most prevalent chronic childhood disease and you have the opportunity to prevent it today.
- By providing an oral health assessment in babies and young children and educating your parents, you can dramatically improve the health of children in Ohio.
- Getting children off to the right start, healthy and ready to learn will promote a better quality of life now and for their future.
- AAP, AAPD, and the ADA strongly recommend a child’s 1st dental visit should occur by age 1 or when the first tooth erupts.
- Treating young children is easier than you might think.
- Most of the procedures are billable through private and Medicaid insurers.
- Most of what you will need to treat young children will already be in your dental office.
- Bringing in young children and families may help your practice grow.
Challenge

- Set aside one morning to see young children, just a couple of hours.
- Prepare your team in advance and the parents in advance
- Treat the children and then debrief with your team
- You will see how important it is to educate the parents and caregivers
- You will see the positive impact you are making on the children’s lives.