IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Oral Health in Illinois: A Focus on Pregnancy and Early Childhood

A RESOURCE GUIDE and TOOLKIT
for providers, individuals, families, and organizations that work to improve oral health in Illinois

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ORAL HEALTH IN ILLINOIS: A FOCUS ON PREGNANCY AND EARLY CHILDHOOD

A Resource Guide and Toolkit

This set of resources contains specific tools and ways to improve the oral health status of individuals of childbearing age, pregnant persons, and children from baby to child. These resources have been gathered from national, state, and local experts and have been modified for use in Illinois.

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Providers, individuals, families, and organizations
that work to improve oral heath in Illinois.

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EXECUTIVE SUMMARY

Oral health is a key component of overall health, and optimal health can be maintained or improved during the prenatal period. Pregnancy is an opportune time for health interventions and serves as a "teachable" moment when women may be motivated to adopt more healthy behaviors. Studies show that oral health services are extremely important and can be provided safely during pregnancy. However, the use of dental services among pregnant women is far below that of the rest of the population. Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) indicate that in 2018, 84% of women had dental insurance during pregnancy, but only 43% had their mouth examined and teeth cleaned. The 2018 PRAMS data also show that women enrolled in Medicaid or who belonged to a racial or ethnic minority were much less likely to obtain oral health care when pregnant compared with women from families with higher incomes, those who were privately insured,or who were non-Hispanic White.

The perinatal period begins at conception and ends two months after delivery. It is a unique time during a woman's life and is characterized by complex physiological changes that may adversely affect oral health. Several factors play a part in the oral health of women during this period, including the ability to access and utilize care; financing; knowledge, attitudes, and behaviors; and workforce preparedness and willingness to serve this population.

Physiological and behavioral changes during pregnancy may adversely affect oral health. In addition, studies report that the quality and amount of saliva declines and the levels of cariogenic oral bacteria increases during pregnancy, which elevates the risk for development and progression of tooth decay. Tooth decay during pregnancy can cause pain, nutritional deficiencies, lost workdays, and reduced employability, all of which adversely affect a woman's quality of life. Additionally, children born to mothers with poor oral health and high levels of cavity-causing bacteria are at higher risk for developing tooth decay, the most prevalent preventable chronic disease of children in the United States. In one study, fluoride varnish application on women's teeth reduced the transfer of cariogenic (caries-causing) bacteria to their children. These bacteria primarily pass from mother to child soon after birth and reducing the concentration of these bacteria in the mother's mouth before birth leads to less bacteria being transferred and a reduced potential for the development of cavities in their children.

Pregnancy and motherhood are promising times for oral health promotion, better home care practices, and professional interventions by all health care providers. These activities include education on dental disease processes (primarily dental caries and periodontal diseases); self-care for prevention; professional services, such as fluoride varnish application (dental caries prevention); and teeth cleaning (promote health and treat inflammation of the supporting structures).

Improving access to dental care for maternal and preschool child populations is a considerable task, and one that requires an interdisciplinary approach. Medical care providers see both populations frequently, so they are in a unique position to support the dentist's efforts to educate and to intervene when oral health problems are detected.

The focus of *Oral Health During Pregnancy and Early Childhood in Illinois* is to improve the health of women of childbearing age and young children. Receipt of preventive oral health care, education of the importance of effective self-care practices, and timely access to corrective treatments that address dental diseases are good for both the health of the woman and for the future oral health of their child. Access to information for primary prevention, funds for secondary prevention in the school setting, and for dental treatment has been a priority for the Illinois Title V Maternal and Child Health (MCH) Program. This has led to several prior initiatives to improve oral health among pregnant individuals and young children.

The American Congress of Obstetricians and Gynecologists states that dental treatment is safe and desirable during pregnancy.[1] Unfortunately, 2018 Illinois data show that only 42.8% of new mothers had their teeth cleaned during their pregnancy.[2] The use of dental services in children is similarly low, with only about 47.4% of Medicaid-eligible children in Illinois under the age of 21 receiving even one dental service in 2019.[3]

An early Illinois Department of Public Health (IDPH) initiative, still relevant in today's arsenal, is education directed toward pregnant women and parents of young children, the Special Supplemental Nutrition Program for Women Infants, and Children (WIC) program providers, health center primary care workers, and oral health staff. *Improving Women's and Children's Oral Health*, an in-office flip chart, was developed in response to the needs identified for bilingual oral health education materials.[4] This tool continues to deliver appropriate preventive education to at-risk populations using a systematic approach that integrates oral health into existing state services to help reduce the burden of oral disease.

In 2017, a collaboration between Illinois' Title V program and the Division of Division of Oral Health, housed in the IDPH Office of Health Promotion, allowed for the continuation of previous improvement strategies that focused on the oral health status of pregnant women and young children. This effort included an updated literature search, review of Illinois PRAMS data, hosting informational webinars, and two statewide stakeholder meetings. Illinois' oral health disease burden information and utilization data were presented, and conversations ensued with stakeholders about the challenges experiencedby MCH populations in obtaining timely access to preventive and to corrective care. Subsequently, an ad-hoc Oral Health Workgroup led by IDPH was formed to further develop opportunities for systems change, project planning, and follow-up activities.

An updated compilation of Illinois resources was identified as one such outcome. It is apparent that Illinois stakeholders are committed and ready to increase their activity so that more women, children, and families gain good health and can maintain it.

The *Oral Health in Illinois: A Focus on Pregnancy and Early Childhood - A RESOURCE GUIDE and TOOLKIT* presented here contains information from national and state sources with the addition of several resources developed by IDPH specifically for this project. The Massachusetts Department of Public Health's (MDPH) *Oral Health Practice Guidelines for Pregnancy and Early Childhood* [5] also was extensively used with permission in development of this guide and toolkit.

Oral Health in Illinois: A Focus on Pregnancy and Early Childhood contains information, resources, and tools that support opportunities for individuals and systems to change in ways that improve oral health status through collaboration, timely referral, and integration of health promotion and services. To achieve this goal, it is important to understand and address major factors contributing to poor oral health status by increasing health literacy, enhancing health promotion, stressing the importance of routine self-care practices, and increasing access to prevention and treatment services.

In addition to periodic professional assessment and care, continuous and effective self-care practices are crucial in maintaining health. Together, assessment and preventive oral health care have the power to decrease the risk and burden of oral and other chronic health conditions for all age groups and populations. Improving women's periodontal and dental health will improve the health of their children and other family members by decreasing the transmission of bacteria and adverse birth outcomes.

Effective field-tested systems change efforts increase interdisciplinary collaboration and contribute to improved health outcomes that can put the maternal-child health population on a path to a lifetime of good health. One simple strategy is to expand bi-directional initiatives that encourage health care providers to cross-refer pregnant individuals to timely and appropriate health care services to improve birth and postpartum outcomes. Integrating oral health within prenatal care supports the importance of professional oral health care during the perinatal period. Oral health care providers have the professional responsibility to accept referrals of pregnant women and to provide preventive and corrective care, relying on the best available evidence that indicates that it is safe and desirable to do so at any age, pregnancy stage, and life cycle.[2]

Differences in oral health status exist and are a result of unequal access to knowledge, to resources, and to access to corrective treatments. Therefore, *Oral Health in Illinois: A Focus on Pregnancy andEarly Childhood* seeks to inform professionals, the public, and policy makers on these topics. The intent is for these groups to take action as individuals, as families, and as communities in ways that improve overall health status with a focus on oral health.

Oral Health in Illinois: A Focus on Pregnancy and Early Childhood builds on local, state, and national efforts and summarizes information in sections to improve health outcomes by focusing on self- care, prevention, and treatment of disease. For ease of navigation and taking action, it is divided into three sections: (1) Policy, Practice Guidelines, and Recommendations and (2) Illinois Oral Health Toolkit.

The first section, Policy, Practice Guidelines, and Recommendations, is intended for prenatal, pediatric, primary care, and oral health care providers, and for caregivers. This section is subdivided into information on each of these provider types by specific activities: (a) assessment, (b) advise and educate, (c) provide care and management;, and d) refer and collaborate.

The second section is the Oral Health Toolkit. Here you will find additional online provider resources for training. This section also includes referral forms, simplified oral health services integration forms, and other tools. Patient-centered resources in this section include information on accessing oral health care in Illinois, enrolling in Illinois' Medicaid program, and lists of services, and transportation assistance for Medicaid beneficiaries. All health care providers and social support services personnel may benefit from reviewing this section.

Appendix 1 contains a listing of oral health policies and guidelines published by national organizations, societies, government agencies, and selected state programs. Appendix 2 offers a listing of oral health curriculum, risk assessment tools, and online trainings published by national organizations and experts.

Oral Diseases: The Silent Epidemic

Oral health is a key component of overall health and optimal health can be maintained or improved for all individuals by improving knowledge, nutrition, self-care practices, and timely professional care. Oral health is a growing priority for the United States. However, for many individuals and communities' receipt of timely professional care services is difficult. Healthy People 2030 has several health promotion and disease prevention goals and recognizes the importance of oral health across the lifespan. It places focus on oral health by highlighting it as one of the 10 Healthy People 2030 Leading Health Indicators. Additionally, Healthy People 2030 includes 18 other objectives related to oral health, improving oral health status, and increasing access to oral health prevention and treatment services.[6]

The Health Resources and Services Administration (HRSA) is also focused on the nation's oral health through initiatives that promote and fund medical-oral health integration.[7,8] In further support for oral health as a critical issue for the nation, the U.S. Surgeon General's Office in collaboration with the Centers for Disease Control and Prevention (CDC) and National Institutes of Health has commissioned a report on oral health with a planned 2021 release.[9] Multi-pronged efforts to address challenges to gaining and maintaining good oral health continue to be a national priority.

Many community-level factors affect oral health, including social, economic, and environmental conditions, and therefore optimal oral health cannot be achieved by brushing and flossing alone. It requires the individual's attention as well as professional intervention and largescale efforts that involve multiple systems — health care, education, publichealth, and government.

Inadequate self-care, high-risk diet, lack of knowledge, and limited access to professional care can result in uncontrolled dental caries and periodontal disease. These experiences, during gestation and early childhood, impact life-long health and wellbeing.[10] Fortunately, when approached in a risk-based manner, the two most common forms of dental disease — dental caries and periodontal disease — can be theoretically controlled in all populations and all age groups. However, the lack of timely access to care among the maternal-child health population can increase the cost to individuals and society through more hospital emergency department visits, increased medication load, pain, and stress load during gestation, and compromised employability, in addition to the cost of more extensive dental treatment.[11]

Women

Data from the 2015–2018 National Health and Nutrition Examination Survey indicate that nearly 1 in 4 women ages 20 to 44 years had at least one untreated decayed tooth surface, and this condition was more common in socioeconomically disadvantaged groups.[12] Additionally, the prevalence of gingivitis during pregnancy has been reported to range from 60 to 75%[13], and an estimated 40% of pregnant women manifest some signs of periodontitis.[14]

Systematic reviews of observational studies indicate that pregnant women with periodontal disease may be at increased risk for adverse birth outcomes, including preeclampsia, preterm delivery, or low birthweight due to the spreading of oral bacteria to the intrauterine cavity and/or systemic circulation of inflammatory factors produced in the oral cavity.[15] The first report suggesting maternal periodontal infection as a possible risk factor for preterm birth or low birthweight was published in 1996.[16]

Physical and physiological changes that occur during pregnancy can adversely affect the mouth. Although most bacterially-mediated dental diseases are highly preventable, gingivitis continues to be a common oral condition of pregnancy. Gram-negative anaerobic bacteria are the most common cause of this inflammatory condition and when left untreated, are destructive to the gingiva and may advance to infect supporting bone, resulting in periodontitis. Removal of inflammatory pathogens and necrotic tissues by debridement is effective, enabling the normal healing process to occur, and treatment for periodontal disease generally results in good outcomes. Periodontal disease is associated with several other health conditions affecting women across their lifespan. These include cardiovascular disease, diabetes, Alzheimer's disease, respiratory infections, and osteoporosis of the jaw.[17]

Other oral conditions commonly occurring during pregnancy include benign gingival tumors, increased tooth mobility, tooth erosion, and dental caries (tooth decay).[2] Pregnant women are also at high risk for dental caries due to increased exposure to gastric acid resulting from morning sickness early in pregnancy or an incompetent esophageal sphincter, and gastric pressure later in pregnancy. These acid attacks irreversibly demineralize tooth surfaces, leaving eroded or decayed areas that need restoration. Other risk factors in the development of dental caries during pregnancy include inadequate amounts of fluoride, high intake of sugary food or sweetened beverages, and a lack of oral health care.[18] Pregnant women who have dental caries may transmit caries-causing bacteria to their infants and, unfortunately, continue the cycle of preventable disease.[19, 20]

PRAMS is a CDC surveillance project with 47 state health departments participating that cover 83% of all U.S. births.[21] This survey is an annual mail and telephone-based survey used to identify factors associated with adverse birth outcomes. The survey responses are then linked with information abstracted from birth certificates. According to national PRAMS data from 2012 to 2015, only 48.3% of pregnant women nationally had a preventive dental visit during pregnancy. PRAMS data also show that women enrolled in Medicaid or belong to a racial or ethnic minority group are much less likely to obtain oral health care when pregnant compared to women from families with higher incomes, those who are privately insured, or who are non-Hispanic White. [22]

Unfortunately, oral health care remains a significant unmet health need for pregnant women and children. Improving the oral health status of the pregnant woman, not only directly helps the mother, but also improves the life course of the baby. A mother's oral health status is a good predictor of a child's risk for oral diseases, as most infants and young children acquire disease-

causing bacteria from their mother/primary caregiver.[21,23] Therefore, investments that improve the health of pregnant women continue through early childhood, school age, and adolescence and, ultimately, increase the likelihood of good oral health as an adult.[16, 21]

Children

Dental caries is one of the most common chronic conditions among children.[24] According to the 2015-2016 National Health and Nutrition Examination Survey, 45.8% of U.S. children aged 2–19 years had experienced dental caries. Prevalence increased with age, from 21.4% among children aged 2–5 years, to 50.5% among those aged 6–11 years, and 53.8% among those aged 12–19 years.[25] Insufficient access to effective preventive services and disease treating services affects children's health and education and their ability to prosper. Untreated caries may cause pain, school absences, difficulty concentrating, and poor appearance, all of which can adversely affect a child's quality of life and ability to succeed academically and socially.[26] Although a critical component of overall health, oral health care is the most common unmet health care need among children.[24] National Center for Health Statistics reports that in 2015-2018, 13.2% of children aged 5-19 years, had untreated dental caries.[13] The 2017 National Survey of Children's Health report that 24.4% of Illinois children, ages 1 through 17, had a preventive dental visit in the past year.[27]

Health Systems and Workforce

Underutilization of the oral health care system during the perinatal period may be influenced by several interrelated factors. These factors include (a) the lack of or inadequate dental insurance coverage for women with low incomes, (b) oral health professionals' unwillingness to provide care for pregnant women because of professionals' inadequate knowledge of evidence-based recommendations for perinatal oral health care, (c) shortages or maldistribution of oral health care providers and facilities, (d) women's limited opportunities for oral health advice during pregnancy, (e) inadequate workforce preparedness and willingness to serve pregnant women, and (f) women's fear about the safety of oral health care during pregnancy. Improving oral health care and status requires not just a dental visit, but a multi-modal approach that addresses disparities in disease experience, increases health literacy, promotes continuous and effective individual self-care efforts, and extends special accommodations and strategies for vulnerable populations.[28]

Many strategies may need to be implemented simultaneously to overcome barriers to care, including: (1) make dental benefits as easy to access as possible, (2) provide dental service reimbursement at fair rates to maintain adequate provider participation, (3) create incentives for providers to practice in traditionally underserved areas to ensure adequate geographic access for urban and rural populations, (4) dental insurance plans need to ensure adequate coverage to address the health needs of the covered population, (5) reduce administrative burdens on providers and balance provider and plan assurance needs, (6) create user-friendly prior authorization and appeal processes for office staff, and (7) improve dental insurers' customer service for dental health care providers and staff.[29, 30]

HEALTH INFORMATION FOR PREGNANCY AND WOMEN OF REPRODUCTIVE AGE

Every woman, fetus, and child are worthy of the opportunity to benefit from updated information, self-care, and professional measures that will improve their oral health, overall health, and health trajectory. The perinatal period represents a window of opportunity in the life course during which a pregnant woman's health and the newborn's health can interact with the health care system to improve health across the lifespan. Perinatal means the time around birth and includes both pregnancy and the postpartum period after giving birth. The impact of healthy behaviors adopted during the perinatal period can affect the child's health trajectory far beyond the first weeks of life. Policy around oral health should take advantage of this window of opportunity.

Dental care is safe and important for women during pregnancy. Poor oral health in the mother is associated with preterm delivery and low birth weight babies. In addition, the mother's dental caries experience is a predictor of a child's caries risk and dental caries experience. Beyond individual-level factors, factors at the family, community, and policy level factors impact the oral health of individuals, families, and communities. This means that everyone has a role to play, individuals, family members, health care providers, policy makers, and health care payers.

Sources of health information are no longer limited to health care providers. As the health care service industry has changed and developed — sometimes forced by systemic changes, such as the Affordable Care Act and widespread online resources —a vast amount of health information is readily available to individuals at their fingertips. People report getting health information from blogs, forums, social media, online videos, and marketing arms of companies and nonprofit organizations.[31] Activated individuals are educating themselves and collaborating with providers for guidance and assistance in their decision-making. In the same era of easily available information in the public sphere, some individuals and communities are being left behind or may be misinformed. It is incumbent upon the health care system to utilize a no-wrong door approach to accessing important information and health services.

The Health of Women and Babies Includes Oral Health

Physiological and behavioral changes during pregnancy may adversely affect oral health. Changes in eating and oral hygiene practices, as well as morning sickness and/or esophageal reflux, can lead to tooth demineralization. In addition, studies report that reductions in the quality and amount of saliva and increases in caries-causing oral bacteria occur during pregnancy, which elevates the risk for development and progression of tooth decay. [11,16,19,21] Tooth decay during pregnancy can cause pain, nutritional deficiencies, lost workdays, and reduced employability, all of which adversely affect a woman's quality of life. Additionally, children born to mothers with poor oral health and high levels of cavity-causing bacteria are at higher risk for developing tooth decay, the most prevalent preventable chronic disease of children in the United States. In one study, fluoride varnish application among women was shown to contribute to a reduction in the transfer of

cariogenic (caries-causing) bacteria to their children.[32] These bacteria primarily pass from mother to child soon after birth, so lowering bacterial concentrations in the mother's mouth before birth may reduce bacterial transmission and caries risk in their children.

The perinatal period is also a critical time in the formation of a healthy face and jaw and teeth. The development of primary teeth begins at age 6 weeks in utero, and permanent molars and incisors begin to develop at around age 20 to 24 weeks in utero. Fetal distress, adverse birth outcomes, and challenges in newborn life increase the risk for craniofacial anomalies and developmental enamel defects,[33] and can also increase the risk for dental caries.

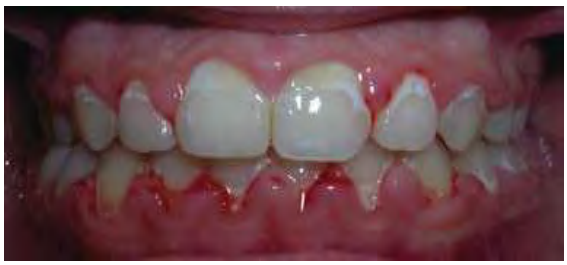


Image 1. Early dental caries with pregnancy related gingivitis.

Untreated maternal dental caries increase the odds that their children will experience caries, and a mother's beliefs, self-efficacy, and knowledge about appropriate oral health behaviors influence her child's toothbrushing habits.[21] Dental caries during early childhood (early childhood caries) impose significant comorbidities affecting children, families, and communities, including high treatment costs, lost school and work hours, psychosocial distress, and sometimes death when the appropriate intervention is delayed.[12]

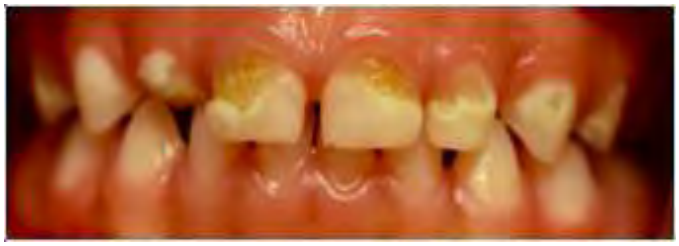


Image 2. Primary Teeth with Dental Decay at Early and Advance Stage of Treatment Need.

Role of Health Care Providers in Improving Oral Health During Pregnancy and in Young Children

Establishing and maintaining good oral health during pregnancy and early childhood requires education, coordination, and collaboration among pregnant women, children, and their families,

and prenatal care, pediatric and oral health care providers. Prenatal and pediatric health care providers, including physicians, nurses and medical assistants, can perform oral health screenings; provide oral health information, prevention, and treatment; and refer to and collaborate with oral health care providers. [6]

Typically, prenatal and pediatric providers refer to a general or pediatric dental office where patients would typically also be seen by dental hygienists or dental assistants. If indicated, those dental care practitioners might make subsequent referrals to dental specialists, such as periodontists, prosthodontists, endodontists, orthodontists, or oral and maxillofacial surgeons. Dental providers may be found in several different locations, including private practices, community health centers, dental schools, hospitals, and public health settings. Where they are available, community health workers can be a valuable resource in facilitating coordination and access to dental services for families. The practice guidelines that follow provide specific information to prenatal, pediatric, and oral health providers about how to address the oral health care needs of their pregnant patients and children.

Primary care and OB/GYN providers can utilize online training modules, such as *Smiles for Life National Oral Health Curriculum: Oral Health in Pregnancy,* to refresh themselves on the clinical presentation of oral conditions present during pregnancy.[33]

SPECIAL SECTION: PRESCRIBING OPIOIDS FOR WOMEN OF REPRODUCTIVE AGE

This section was adapted from *Prescribing Opioids for Women of Reproductive Age: Information for Dentists.*[34] Acute and episodic pain after certain dental procedures may require pharmacologic pain management. Because dental pain typically is transient, over-the-counter pain relievers, such as acetaminophen and ibuprofen, are usually adequate to reduce pain during healing. These medications, when used in conjunction, are capable of relieving pain to the same extent as opioids while reducing unwarranted side effects such as opioid dependency. However, the U.S. Food & Drug Administration recommends avoiding non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen, during pregnancy at 20 weeks or later.[35]

Prescribing opioids to women of reproductive age, warrants thorough clinical insight. Practitioners should understand the source of the patient's pain, whether acute, episodic, or chronic, and make an informed choice. If the patient's pain source is chronic, referral to their primary care provider to discuss pain management options is an appropriate choice. Extended-release, long-acting opioids are not recommended for the relief of dental pain after procedures. Anticipatory guidance regarding post-operative pain and its management is always recommended before a procedure is rendered. If a practitioner is considering an opioid prescription to manage acute, episodic pain, an in-office evaluation of the patient is necessary.

In pregnant women, prolonged use of opioids can result in neonatal opioid withdrawal syndrome (NOWS) in the newborn infant. Careful explanations regarding risks, benefits, and alternatives

should be part of the clinician's and patient's decision to use opioids during pregnancy. If warranted, opioid prescriptions to manage pain should be limited to a short duration (3 days or less) in the pregnant patient. Multimodal analgesic therapy can be a viable option to avoid opioid prescription in this demographic.

As with any patient, practitioners should check pregnant patients' opioid history by taking advantage of prescription drug monitoring programs. These programs provide insight into controlled-substance prescription histories for patients and can be useful to identify patients who are at high risk for dependency and chronic usage.

PROGRESS IN ILLINOIS

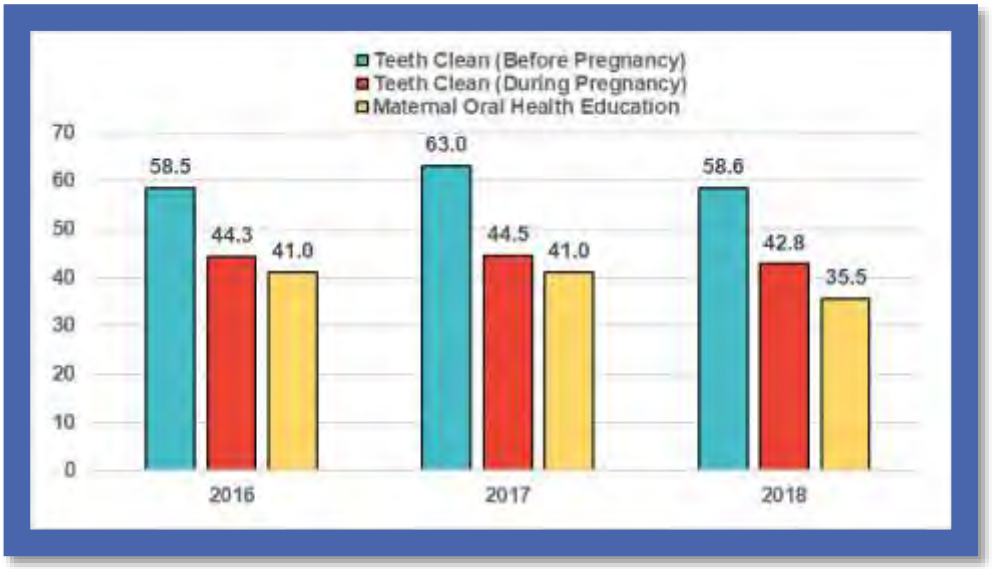
IDPH strongly believes that oral health is a vital component of overall health. Addressing oral health care among children and adults before, during, and after pregnancy is a priority area of IDPH's Division of Oral Health (DOH) and the Office of Women's Health and Family Services (OWHFS). The DOH and OWHFS work collaboratively to develop, promote, and fund several oral health initiatives. The OWHFS administers the Maternal and Child Health (MCH) Title V Block Grant, which includes a suite of National Performance Measures across various population domains. This resource is one such strategy to improve the health of these two populations.

Pregnant Women

Illinois identified improving oral health status during pregnancy as a program focus and adopted evidence-based strategies to drive improvement based on a statewide needs assessment. Illinois is using the National Performance Measure (13a: *The percent of women who had a dental visit during pregnancy*) to monitor progress using the PRAMS.

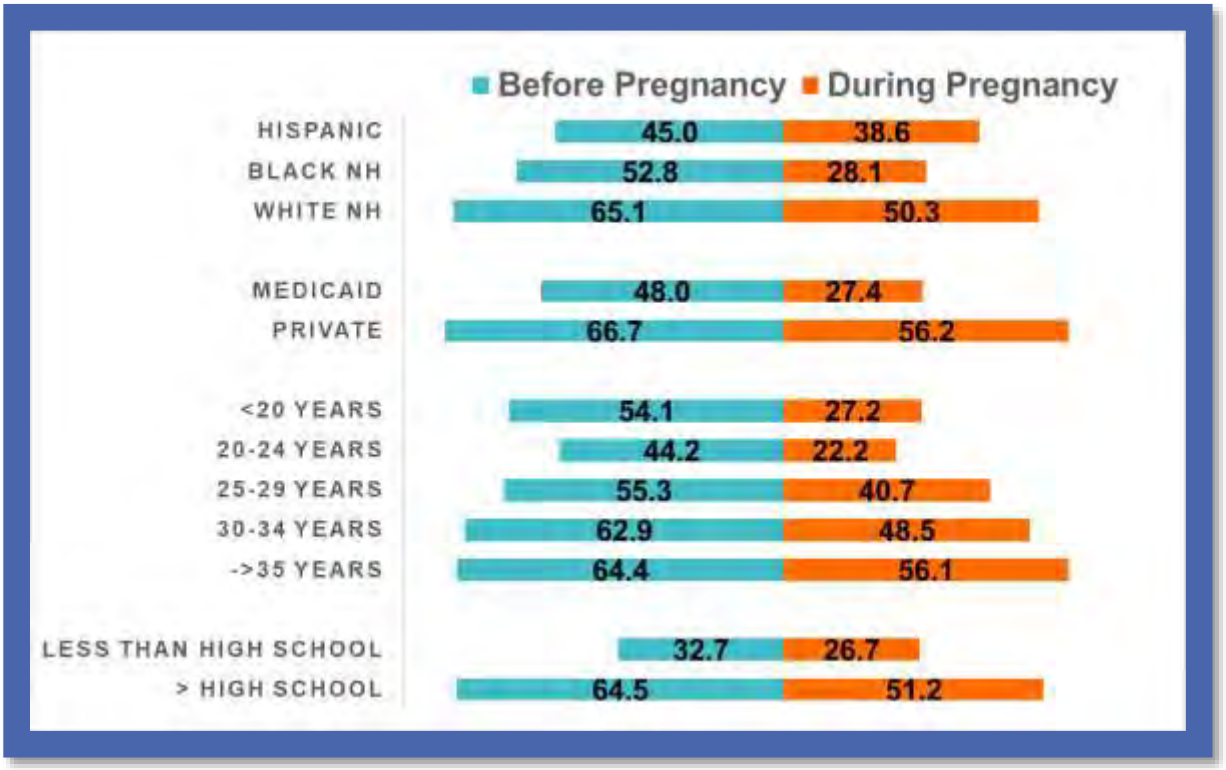
PRAMS data for 2018 to 2018 indicate that approximately two-thirds of new mothers in Illinois had their teeth cleaned in the 12 months before pregnancy. However, only 42.8% of new mothers covered by Medicaid had their teeth cleaned during their pregnancy.[3] Those data highlight opportunities to improve the oral health of pregnant women in Illinois (Figure 1). For example, health care workers provided maternal oral health education to just 41% of pregnant women in 2016 and 2017, and that prevalence declined by more than 5% in 2018.[36]

Figure 1. Mothers Who Reported Having Their Teeth Cleaning (weighted percent) Before vs. During Pregnancy, Illinois PRAMS Survey (2016 – 2018).



Perinatal oral health services varied greatly among sociodemographic groups in Illinois (Figure 2). Specifically, when compared to non-Hispanic White females, non-Hispanic Black and Hispanic women were significantly less likely to get their teeth cleaned before or during pregnancy. Women enrolled in Medicaid or with less than a high school education were significantly less likely to get teeth cleaning before or during pregnancy compared with privately insured women or those with high levels of education, respectively (data not shown). These data illustrate an opportunity to intervene with information targeting younger women who are pregnant or are considering pregnancy.

Figure 2. Percentage of Mothers Who Reported Having Their Teeth Cleaning (weighted percent), Before or During Pregnancy, by Race/Ethnicity, Insurance, Age, and Education. Illinois PRAMS Survey, 2018.



Pregnancy in Teen Years

According to the Centers for Disease Control and Prevention, overall teen birth rates declined from 2016 to 2017, although geographic differences persisted.[37] Pregnancy during the teenage years adds to the challenge of maintaining good health. Pregnant teenagers typically have lower levels of education and income, which poses additional challenges to healthy gestation and birth. Early intervention programs may benefit these teens who may struggle to maintain good health during gestation and yield improved birth outcomes.

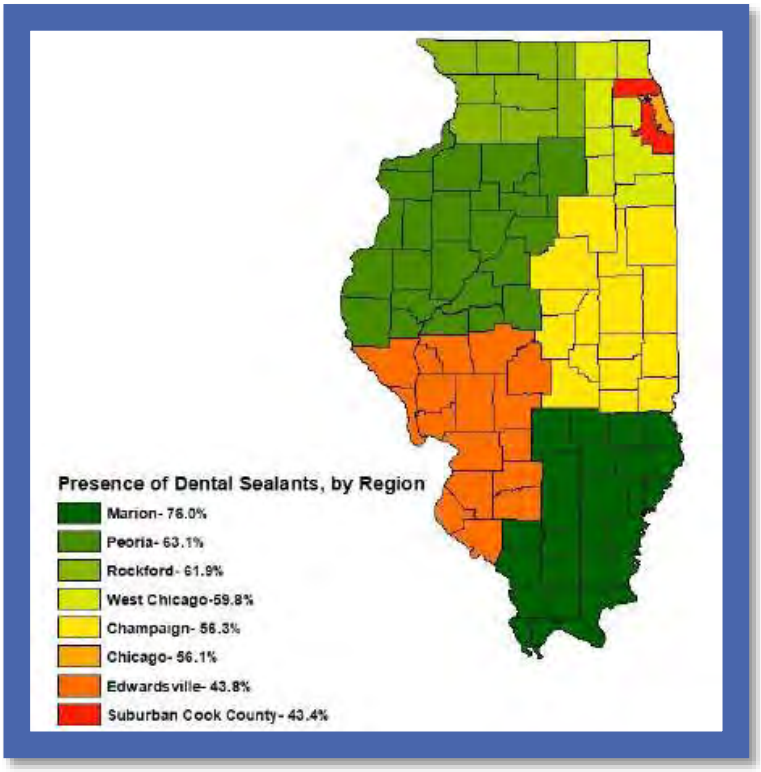
Children

Illinois is addressing oral health in children through efforts focused on the Title V Maternal and Child Health Services Block Grant National Performance Measure 13b: *The percentage of children, ages 1 through 17, who had a preventive dental visit in the past year.*

Data to track progress toward this target are from the National Survey of Children's Health (NSCH), which is conducted annually by the Health Resources & Services Administration's Maternal and Child Health Bureau. As reported earlier, the 2017 NSCH found that 75.6% of Illinois children aged 1–17 years received at least one preventive visit during the preceding 12 months.[27]

NSCH provides an opportunity to benchmark how Illinois children are faring as compared with other states and nationally. Additional disease burden and prevention efforts data are available for a subset of Illinois children through the Healthy Smiles, Healthy Growth (HSHG) basic screening survey of third grade children. IDPH collects HSHG data every five years, and this effort gives a snapshot of the trends in several oral health indicators. Oral disease burden in third grade children has been trending downward since the survey inception in 2003. Untreated decay in Illinois has decreased from 30% in 2003 to 22% in 2018. The prevalence of dental sealants (protective against dental caries) increased from 27% in 2003 to 53% in 2018.[38]

Figure 3. Dental Sealant, by IDPH Health Region. *Healthy Smiles, Healthy Growth (2018-2019).*



However, children living in suburban Cook County and the Edwardsville area have the state's lowest prevalence of this preventive service, as shown in Figure 3. Thus, rurality alone does not predict oral health status, and additional factors, such as socioeconomic status, special health care needs, and type of insurance, need to be considered when evaluating the intersectionality of oral health and disease burden.

Improving health and timely access to services are multifactorial public health issues. To overcome oral health disparities and inequities, the root causes must be addressed with a cohesive approach. Efforts in education (self-care and understanding of disease processes), health promotion (foundations of health and health behaviors), and access to professional care (evidenced-based prevention and treatment therapies) need to be the core foci of improvement efforts. Dental caries is not uniformly distributed among the population, but rather it concentrates in certain population segments, such as among those who are socioeconomically disadvantaged, are in certain racial or ethnic minority groups, or are geographically isolated.[28] Subpopulations that have limited options for education, prevention services, or corrective treatment services become disproportionately burdened by the disease.

The inequitable prevalence of untreated dental disease is attributable to social determinants of health factors, such as educational attainment, income, access to quality food, housing, and health care. In addition, different populations have limited options when it comes toresolving their oral health challenges. For maximal impact, promising strategies must include contributions by all health care professionals that reconnect oral health improvement activities to general health as poor oral health shares common risk factors with many chronic diseases: namely diabetes, obesity, and cardiovascular diseases.[40]

Access to Care and Social Determinants of Health

An individual's biological makeup, environmental, and social determinants of health — factors such as education, income, access to quality food, housing, and health care — have a significant impact on the incidence of disease and overall health outcomes. Because oral health care and the delivery system for other types of health care often operate in separate spheres, overcoming persistent challenges to optimal oral health poses a complex and difficult challenge.

The application of the best prevention science and behavior support strategies are most effective when used in cooperation with community, educational, social, and general health principles. Life-long healthy messages might be most effectively received through regular peer health contacts. Because the people with the greatest oral health needs are those least likely to be in dental offices, health promotion and disease prevention strategies might be most effectively delivered through partnerships, placement of oral health personnel, and integration of oral health activities within community, educational, social, and general health organizations.[40]

People who struggle to access dental services often need help with care coordination and dental service system navigation. They need help finding dental providers who can address their families'

unique needs, including payment methodologies, transportation, and childcare. Care providers at all levels of the health system, from home visitors and community health workers to pediatricians and OB/GYNs, can reinforce that oral health is part of overall health and serve as a vital tool and trusted messengers in providing education, prevention services, and referrals to appropriate care in a culturally and linguistically appropriate manner.

Promoting oral health and improving health care knowledge and skills of parents in the perinatal andprimary care setting during the perinatal period is an optimal approach for improved oral health. Research shows that routine oral health treatment, including periodontal therapy, during pregnancy does not increase the incidence of adverse pregnancy outcomes.[2] Yet, despite heightened oral health needs and the apparent benefit of oral health education, many women do not seek and are not provided oral health care during pregnancy.

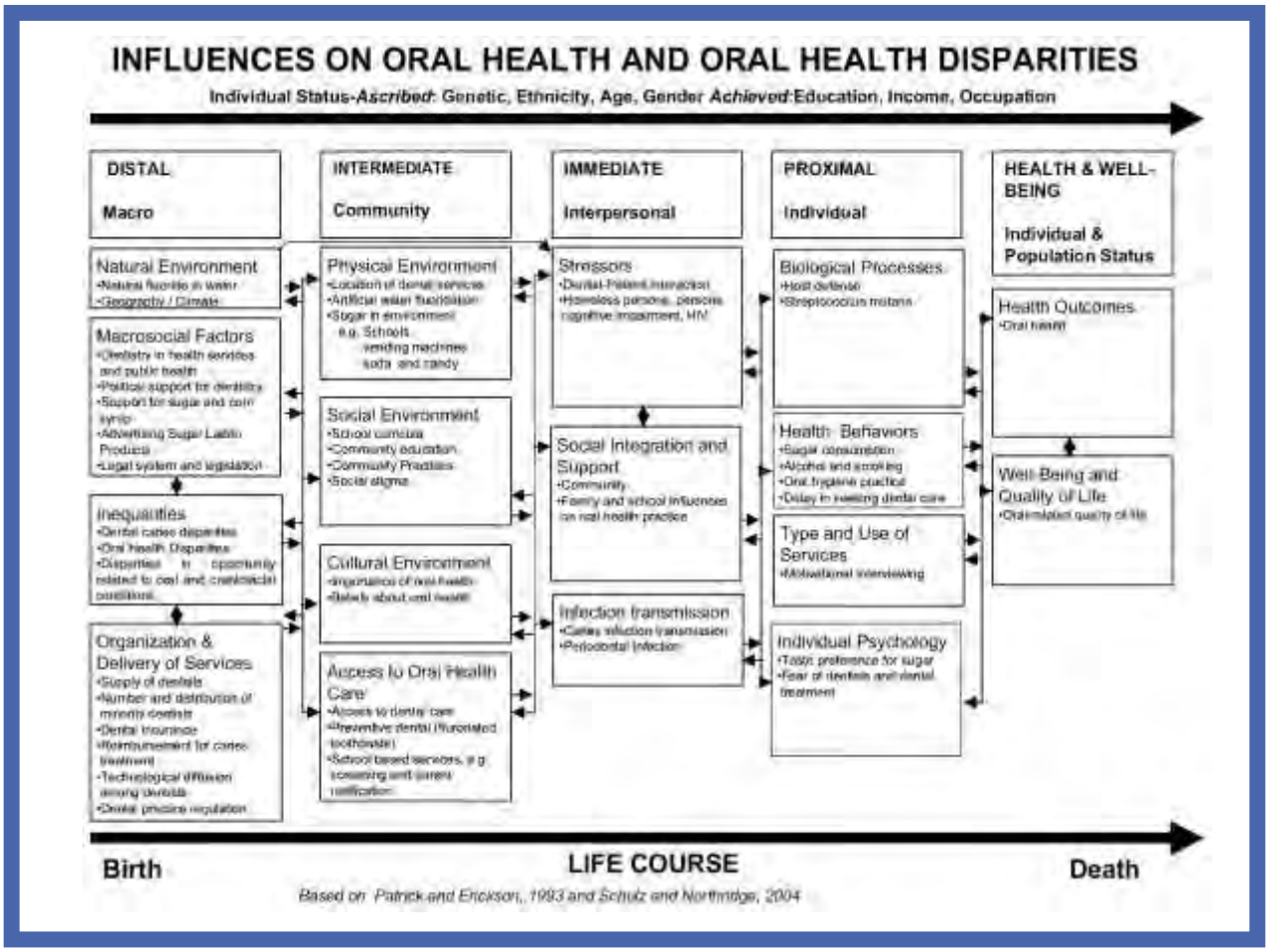


Figure 4. Multiple Factors that Impact Oral Health Status from Birth to Death. Patrick DL, Lee RSY, Nucci M, Grembowski D, Jolles CZ, Milgrom P. Reducing oral health disparities: A focus on social and cultural determinants. *BMC Oral Health*. 2006;6(SUPPL. 1). doi:10.1186/1472-6831-6-S1-S4.

Unfortunately, many populations have difficulty seeking and receiving health promotion, prevention, or treatment services for a variety of reasons. The people who care and serve the maternal and child health populations need to utilize all avenues, and the concept of the no wrong door to accessing professional health advice promotes concepts of effective self-care, evidence-based prevention, and coordination to treatment services. This resource guide lays out ideas and processes to expand the landscape of oral health promotion, prevention, and accessing treatment services.

National Efforts to Address Oral Health among Pregnant Women and Children

Many national organizations have undertaken efforts to promote oral health among pregnant women and children through the development of training, statements, guidelines, and outreach to providers. These organizations include the American Congress of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatric Dentistry (AAPD), the American Academy of Pediatrics (AAP), the American Academy of Periodontology, the American Academy of Physician Assistants (AAPA), the American College of Nurse-Midwives (ACNM), the Society of Teachers in Family Medicine (STFM), and the American Dental Association (ADA). Several states including New York, California, South Carolina, and Washington have developed statewide practice guidelines for perinatal oral health.

ACOG has issued a committee opinion to emphasize the importance and safety of dental treatment during pregnancy.[1] Despite the extensive evidence that routine dental care during pregnancy is safe and important to overall health, many pregnant women do not receive oral health care for a multitude of reasons. Oral health providers need to understand the unique challenges that pregnancy poses from nausea to hesitancy of treatment in fear of endangering the pregnancy. Oral health practitioners need to be equipped with information that address patients' concerns.

Illinois Efforts to Address Oral Health among Pregnant Women and Children

One of nine priority areas for the 2021–2025 Illinois Maternal and Child Health (MCH) Title V Action Plan is to support an intergenerational and life course approach to oral health promotion and disease prevention[41]. The information presented here can be used to expand oral health outreach to the most at-risk maternal populations by engaging WIC programs; supporting and assisting school personnel and families across Illinois to access oral health education, dental sealants, fluoride varnish, Illinois All Kids (Medicaid) enrollment, and dental home referrals; assessing the burden of oral diseases and barriers to access care for individuals during their pregnancy period; and supporting projects to integrate the interprofessional oral health core clinical competencies into primary care practice, particularly for pregnant women and adolescents.

In many Illinois communities, oral health care services are provided through standalone clinics. Referrals to and from these facilities pose additional challenges to accessing timely oral health services. All health care providers for pregnant women can prioritize effective use of social service and care coordination to help facilitate delivery of prevention and treatment services.

The practice guidelines included in the following sections are consistent with guidance from many professional organizations and state health departments. The guidelines provide detailed information about the provision of dental care, including advice and education for pregnant women. Where possible, Illinois-specific information has been added and is contained in the Tools section of the guide.

ORAL HEALTH POLICY AND PRACTICE GUIDELINES

FOR PRENATAL PROVIDERS

ORAL HEALTH POLICY AND PRACTICE GUIDELINES

Oral health practice guidelines for prenatal providers include instructions on how to assess oral health status, advise and educate patients, and collaborate with oral health care providers. Similarly, specific recommendations for oral health care providers include assessment (health history, dental history, comprehensive examination, including blood pressure and radiographs as appropriate), advice and education, and the provision of all necessary treatment. Pregnancy generally should not affect the type or quality of oral health care provided. However, oral health care providers must be aware of medications that are acceptable for use during pregnancy.

ORAL HEALTH PRACTICE GUIDELINES FOR PRENATAL PROVIDERS

Oral health is an essential component of overall health. Providing anticipatory guidance, education, and risk-based referral is within the health care framework of the prenatal and primary care provider. All patients benefit from having their health care issues assessed and receiving prevention and health promotion information that limits unnecessary complications, pain, and burden of disease. For success, those effort should fit with patient and clinic flow and deliver targeted education and referral. With this patient-centered approach, prenatal and primary health care providers can easily implement the field-tested oral health integration concepts [8, 42, 43]

Assess Risk and Oral Health Status

During the first prenatal visit, take a simple oral health history, including recent dental problems and dental care received. A sample Oral Health Assessment, Integration and Referral Form is available in the Education and Fast Facts section of this resource guide. Consider implementing such a tool into the electronic health record to document assessment of risk, services or guidance provided, and clinical findings. The immediacy of referral should be indicated on the form, which allows care coordinators to assist in obtaining timely professional care. It is important to followup on any oral health problems or referrals to ensure that the patient was connected to corrective dental care.

Once oral health screening is incorporated in the clinic flow, it only takes a few minutes to provide a brief oral examination to check the general appearance of teeth and gums. *Smiles for Life: A National Oral Health Curriculum* is a comprehensive module-based oral health curriculum targeted to medical practices and health care teams.[33] Relevant modules for the prenatal provider are Smiles for Life Course 5 – Oral Health for Women: Pregnancy and Across the Life Span, Course 6 – Caries Risk Assessment, Fluoride Varnish and Counseling, and Course 7 – The Oral Examination training materials.

Advise and Educate

Document in the prenatal care record any oral health issues identified and services or education provided. These may include anticipatory nutritional counseling, care for nausea/vomiting, or assisting patients with quitting their use of tobacco, alcohol, or marijuana. Reassure patients that community water fluoridation is safe and effective for all ages, including very young children. Based on risk assessment, consider providing fluoride varnish treatment for pregnant women.

Specific additional topic areas to cover at subsequent prenatal and post-partum visits:

- ✓ Importance of oral health during pregnancy, including professional assessment and prevention visits at least every six months to control gum disease.
- ✓ Importance of adhering to the oral health providers' recommendations.
- ✓ Reassurance that dental care is safe throughout pregnancy, including X-rays, dental restorations/extractions, pain medication, and local anesthesia.

Special consideration to prevent tooth decay in pregnant individuals experiencing frequent nausea and vomiting:

- ✓ Eat small amounts of nutritious foods throughout the day.
- ✓ Use a teaspoon of baking soda (sodium bicarbonate) in a cup of water as a rinse after vomiting to neutralize the acid.
- ✓ Do not brush for one hour after vomiting because stomach acid can weaken the enamel and cause tooth hypersensitivity.
- ✓ Chew sugarless or xylitol-containing gum after eating, which prevents transmission of bacteria (*Streptococcus mutans*) to their children and reduces children's risk for tooth decay.[46]
- ✓ Use gentle brushing with a soft toothbrush and fluoride toothpaste to prevent damage to demineralized tooth surfaces.
- ✓ Include oral health in prenatal care classes.

Provide Care and Management

Consider providing in-office fluoride varnish applications for women who are at high risk for or currently have active dental caries. See *Smiles for Life* Caries Module 6 – Caries Risk Assessment, and Fluoride Varnish and Counseling for an online tutorial.

Refer and Collaborate

- ✓ Print/copy the Oral Health Assessment, Integration and Referral Form (Illinois Oral Health Toolkit) and send it with referral to the oral health provider. Include pertinent health information on the oral health referral form. Encourage women who have not seen a dentist within the last six months to schedule an appointment with their regular dentist.

- ✓ Consider developing a list of dental care resources such as area Federally Qualified Health Centers (FQHCs) and private dental offices, and a map of dental care providers in relation to the medical practice. Develop a referral list by calling area dental offices or using the Find a Dentist

function on insurekidsnow.gov. Be sure to determine whether the dental facilities accept adult Medicaid or other insurance plans and whether they have sliding fee schedules for uninsured patients. Refer patients to providers who participate in their dental plans and are comfortable caring for pregnant women. Illinois Medicaid benefits for adults include comprehensive examination, dental cleanings, treatments for periodontal disease, dental restorations (fillings), extractionof teeth, and additional services with prior authorization. A description of dental coverage and help for managed care adults and children members enrolled in Medicaid can befound on the Illinois Department of Healthcare and Family Services Dental Program webpage.

ORAL HEALTH POLICY AND PRACTICE GUIDELINES

FOR ORAL HEALTH CARE PROVIDERS TREATING PREGNANT WOMEN

GUIDELINES FOR ORAL HEALTH PROVIDERS TREATING PREGNANT WOMEN

Assess Risk and Oral Health Status

Management of oral infections, disease control, and providing corrective treatments are essential to maintaining health and well-being during pregnancy.

- ✓ For new pregnant patients, take a full medical and dental history and conduct a risk assessment.
- ✓ For existing patients, update medical and dental history when first seen during pregnancy.
- ✓ Routine dental care, including dental radiography, is safe and acceptable during all trimesters and should be provided when clinically indicated.

Oral health providers who care for pregnant women should be aware of the effects of pregnancy on oral health and systemic health. They should understand the physiologic changes throughout all three trimesters (1st – through 13 weeks gestation; 2nd – 14 weeks through 27 weeks; and 3rd – 28 weeks to birth [40 weeks +/-2 weeks]), as well as potential risks found during pregnancy. Normal physiologic changes include increased blood volume and lower blood pressure in the first trimester. Later in pregnancy, the uterus may put pressure on the vena cava so the patient may need to change position during dental treatment. [44]

About 7% of pregnant women have hypertension during pregnancy, 5–8% have pre-eclampsia, less than 1% have eclampsia, and 7% have gestational diabetes. Medications or drugs can have significant effects on the fetus, so it is important to know what medications a woman is taking, and only prescribe those that are safe. Some pregnant patients are at increased risk for pregnancy complications or adverse birth outcomes, such as teens and women older than 35 years of age, women with multiple pregnancies, and those with systemic disease, such as HIV or Hepatitis C.[6]

General information review should include primary care or OB\GYN provider's name and contact information, medications taken, the use of tobacco products, alcohol, or drugs, and chief complaint.

Collect prenatal information such as due date, whether receiving prenatal care, name and contact information of prenatal care provider, and complications (e.g., high blood pressure, diabetes, morning sickness, severe or prolonged vomiting, or bleeding disorders).

Ask about social history including employment status, education, current access to social services, cultural status, literacy level, primary language, medical and dental insurance, home stability, members of the household, and history of family/personal violence.

Take an oral health history. Plan to address acute issues at the first visit and work up a comprehensive care plan. Obtain a good understanding of self-care practices and historical access to professional oral health services. Be sure to address the patient's specific pregnancy-related questions or safety concerns. Document any special needs, including relevant medical, psychological, or physical needs during pregnancy.

Conduct a caries risk assessment with specific questions geared to understanding risk factors such as nausea and vomiting. Review diet, eating, and beverage consumption that contribute to increasing caries risk and use of fluoridated products. Community water system information can be found on the Illinois page of CDC's My Water's Fluoride.

Clinical Examination:

- ✓ Take blood pressure; immediately consult with prenatal providers for pregnant patients with high blood pressure (>140/90) to determine the need for an immediate referral.
- ✓ Perform a comprehensive oral examination; note pregnancy-specific oral issues. See Appendix 5 for an example of oral conditions seen in pregnant individuals.
- ✓ Periodontal issues - pregnancy gingivitis, chronic periodontitis, or acute exacerbation of periodontitis.
- ✓ Dental erosions - secondary to severe or prolonged vomiting or gastroesophageal reflux disease.
- ✓ Tooth mobility may be increased and is normal due to hormonal relaxation of connective tissue.
- ✓ Take radiographs as needed based on risk and evidence using ADA-FDA 2012 guidelines.

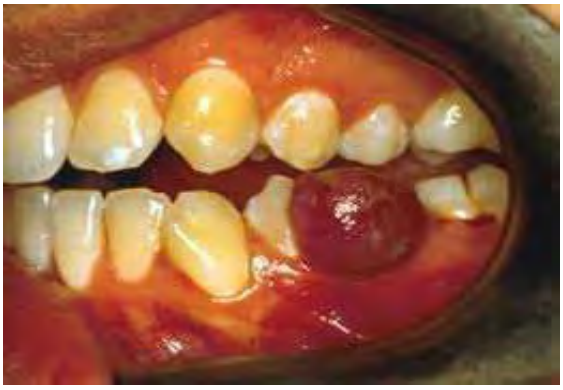


Image 3. Common pregnancy related oral conditions: Pyogenic granuloma (pregnancy tumor). Svirsky JA. Oral Pyogenic Granuloma.

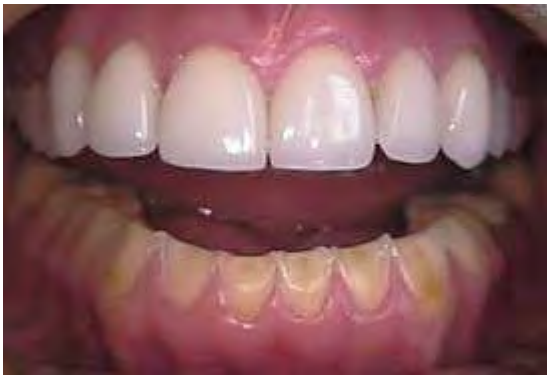


Image 4. Erosion of tooth enamel and dentin from exposure to stomach acids compounded with bruxism, warning signs of stress and acid erosion.

Advise and Educate

Reassure women on the safety of routine dental care during pregnancy, drinking optimally fluoridated water, taking of radiographs, use of local anesthesia, and restoration of dental cavities. Encourage women with caries or periodontal disease to get treatment as soon as possible.

Treatment Considerations: Sequence treatment that requires immediate treatment, such as extractions and root canals before they become urgent issues. Reinforce that routine dental treatment is safe and can occur at any time during pregnancy and delaying treatment may result in more complex problems.

Provide anticipatory information about common oral health conditions and changes during pregnancy (e.g., pregnancy gingivitis) and explain how maternal oral health affects their child's oral health (e.g., the transmission of maternal caries-causing bacteria to

infants).

Advise women to receive dental cleaning and treatment for all active dental caries. Effective disease control may require multiple or more frequent treatments to control gingival inflammation or dental caries.

Discuss health promotion and ongoing self-care practices, home oral hygiene, the use of fluoride products, appropriate diet, and nutrition, eating and drinking behaviors, andthe importance of professional assessment and preventive dental visits.

- ✓ Brush teeth twice daily with a soft-bristle toothbrush and fluoride-containing toothpaste, and floss daily to reduce gingival bleeding (some bleeding is normal during pregnancy).
- ✓ The use of fluorides in toothpaste, rinses, or water is safe when used appropriately.

Provide nutrition advice including:

- ✓ Choosing healthy foods and snacks and limiting foods containing added sugar
- ✓ Choosing water or low-fat milk; limiting juice sports drinks, sugar-sweetened beverages, and all carbonated beverages.
- ✓ If experiencing vomiting and nausea, eating small amounts of nutritious foods throughout the day.
- ✓ Encourage patients to continue dental care throughout the pregnancy and during the post-partum period.
- ✓ Encourage patients to establish a dental home for themselves and their families. Discuss the recommendation that dental visits for children should begin within six months of the eruption of the first tooth or by age 1.

Discuss other oral health topics and recommendations with women, as appropriate:

- ✓ Rinse with a cup of water with a teaspoon of baking soda after vomiting; do not brush for one hour after vomiting because stomach acid can cause loss of enamel and dentinal hypersensitivity.
- ✓ Inform women that chlorhexidine and other non-alcohol mouth rinses are acceptable during pregnancy as needed (limit chlorhexidine duration to avoid staining of teeth).
- ✓ Consider recommending xylitol gum or mints in the postpartum period (up to two years) to reduce transmission of oral bacteria to the infant.[45]
- ✓ Support prenatal health by encouraging the use of prenatal vitamins, attendance at prenatal visits, and breastfeeding.

Provide Care and Management

Develop a plan to address immediate issues and comprehensive management during and after pregnancy. Work towards establishing a regular source of oral health care.

Discuss treatment options with the patient; explain the safety of all procedures and medications during pregnancy.

Address possible barriers to oral health care during pregnancy.

- ✓ General (e.g., transportation or financial).
- ✓ Competing health issues, especially for those with special needs.
- ✓ Fear and fatalistic attitudes, such as "lose one tooth for each baby."
- ✓ Lack of awareness among other health providers about the importance and safety of oral health care during pregnancy.
- ✓ Illinois Medicaid benefits include dental examination, dental cleanings, treatments for periodontal disease, dental restorations, extraction of teeth, and additional treatments with prior authorization. A description of dental coverage and help for managed care adults and children members enrolled in Medicaid can be found on the Illinois Department of Healthcare and Family Services Adult Dental Program webpage.

Treat and control periodontitis for improved prenatal outcomes; read and follow antibiotic recommendations for pregnancy.

- ✓ Use practical tips that can help pregnant patients during visits.
- ✓ All trimesters – keep the woman's head higher than the level of her feet; use semi-reclining positions and allow for frequent position changes.
- ✓ Accommodate patient preferences for appointment times due to pregnancy-related issues, such as morning sickness.

Provide comprehensive treatment to address dental caries.

- ✓ Restoration, root canals, or extractions as needed.
- ✓ Avoid temporary material when possible because it may be difficult for pregnant and postpartum women to return in the short term.

Provide comfort during pregnancy and ongoing care during and after pregnancy. Place a pillow under the right side to position women slightly on the left side to maximize blood flow return through the vena cava, especially in the third trimester (28 weeks to birth).

- ✓ Follow up, reinforce, and provide support for effective self-care.
- ✓ Determine and schedule individualized follow-up visits.
- ✓ Complete care in a reasonable time.
- ✓ Follow up with patients that have discontinued care and address barriers.

Refer and Collaborate

- ✓ Consider collaborating with area prenatal providers through a written referral relationship.

For pregnant women with normal pregnancies, medical consultation with prenatal providers is

not needed for routine dental care. For patients without a medical home, help them make the connection to a provider.

Consider developing a list of prenatal care resources, such as area FQHCs or other OB/GYN and primary medical care practice locations. Call area offices to determine whether they accept Medicaid, other insurance plans, or have sliding fee schedules for uninsured patients. For women with Illinois Medicaid coverage, see Illinois Healthcare and Family Services webpage for Pregnant Women and Infants for contact informationto help in finding Illinois Medicaid providers.

High-Risk Patients

For high-risk patients, such as those with gestational diabetes, pre-eclampsia, or other complex health conditions, consult with prenatal providers before providing dental care. Update prenatal health care providers with pertinent dental treatment and management plans as requested or needed, especially for high-risk patients.

Collaborate with prenatal providers. For example, give a presentation on oral health topics during inter-professional rounds, do a meet-and-greet with local prenatal providers, review which insurance plans are accepted by your practice, and develop a process for sharing health information and consultation for special cases. Offer to provide information about common oral health conditions encountered during pregnancy, corrective treatment measures to be taken, and oral health care for the newborn and infant. This information can also be shared through group settings, such as prenatal classes or centering pregnancy programs, that are hosted by prenatal providers.

ORAL HEALTH POLICY AND PRACTICE GUIDELINES

FOR PEDIATRIC HEALTH CARE PROVIDERS

ORAL HEALTH PRACTICE GUIDELINES FOR PEDIATRIC PROVIDERS

To ensure a lifetime of good oral health, children need to establish good oral health habits and a dental home early in life. Initially, those steps are the responsibility of a parent or primary caregiver. The first dental visit should occur within six months of the eruption of the first tooth or by age 1 year, whichever comes first. Deciduous teeth are important for eating and speaking, and they play an essential role in socialization, nutrition, and appearance. They also hold the space for the adult teeth. Childhood oral health problems, including dental caries, may have immediate complications as well as cause a lifetime of oral health issues including pain, local and systemic infections, poor eating and growth, poor self-esteem, financial costs, missed school days, and missed work for parents.

Pediatric health care providers, in collaboration with oral health care providers, play an important rolein promoting good oral health and reducing the burden of early childhood caries, benefitting children and their families. The Oral Health Prevention Primer was developed by the American Academy of Pediatrics (AAP) and offers many resources needed to help pediatricians and other health professionals who care for children, learn, incorporate, and provide support to achieve optimal oral health. Additional information is available through online modules: Child Oral Health and Caries Risk Assessment, Fluoride Varnish, and Counseling from *Smiles for Life*, a national oral health curriculum.

The practice guidelines presented below pertain to young children. Families of children with special health care needs may require additional assistance to prepare their child for a dental visit, including communication before the appointment. Children with special health care needs (CSHCN) are children who typically require accommodations and strategies to address their specific physical, behavioral, and/or communication disabilities. Suggested accommodations and strategies may be found in the American Association of Pediatric Dentists' publication Management of Dental Patients with Special Health Care Needs.

Assess Risk and Oral Health Status

Perform an oral health risk assessment. Ideally, the assessment should include an evaluation of risk factors, such as maternal (or primary caregiver) oral health status, bottle use after the age of 1 year, use of a sippy cup with fluids other than water, frequent snacking, and special healthcare needs. The American Academy of Pediatrics has developed an Oral Health Risk AssessmentTool in English and Spanish that may be useful to providers.

Take oral health history and note findings regarding:

- ✓ Habits: digit sucking, pacifier use, bruxism.
- ✓ Issues to date, including current acute issues.
- ✓ Professional dental care and home care received to date.

- ✓ Survey parents on beverage consumption, including use of tap or bottled water.
- ✓ Perform a caries risk assessment. See https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf for a sample tool.
- ✓ Past or current caries experience of siblings, parents, and other household members.

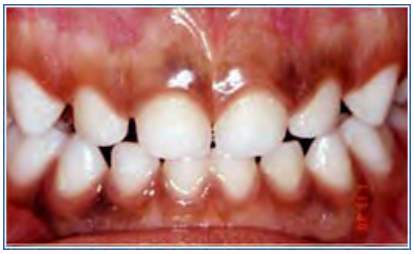
Discuss additional oral health topics/recommendations, as appropriate:

- ✓ Discuss the recommendation that dental visits for children should begin within six months of the eruption of the first tooth or by age 1.
- ✓ Encourage patients to establish a dental home for themselves and their young children.
- ✓ Help the parent/caregiver identify a dental home for themselves and their child at 12 months of age or sooner if dental caries exists or the patient is at high risk for caries.
- ✓ Answer caregivers' questions or concerns about dental treatment.

For children under age 3 years, consider offering a quick knee-to-knee oral screening to look for white spots or visible decalcifications on teeth, obvious decay (dark or discolored tooth surfaces or missing tooth structure), restorations (fillings), visible plaque accumulation, and gingivitis (swollen or bleeding gums).

Image 5. Knee-to-knee dental examination for use with young children.

Image 6. Healthy Teeth and Gums



Joanna Douglass, BDS, DDS

Advise and Educate

Advise and educate parents/caregivers about the importance of healthy eating and beverage consumption habits.

- ✓ Choose age-appropriate healthy foods and snacks during planned meals and snacks; limit foods containing added sugar.
- ✓ Use and frequency of sugary food and drinks, nighttime feedings of anything except water.

- ✓ Fluoride exposure, including fluoride varnish in other settings, systemic and topical fluoride, and community water fluoridation.
- ✓ Encourage fruits and vegetables, other healthy snack options, and dairy products (milk, cheese, cottage cheese, unsweetened yogurt) for snacks.
- ✓ Avoid sugary and sticky foods, such as candy, sugared-based gum, cookies, cakes, fruit roll-ups, and raisins. Foods like crackers and chips tend to get stuck on teeth and lead to cavities, so limit these snacks.
- ✓ Choose water between meals. Drinks low in sugar (such as white milk) should be limited to less than 4 ounces once a day with a meal.
- ✓ Advise and educate parents/caregivers about maintaining good oral health for themselves to preventtooth decay in their infants and children.
- ✓ Do NOT put infants to sleep with a bottle, sippy cup, or no-spill cup with formula, milk, orjuice products. Do not breastfeed to sleep past the eruption of the first tooth.
- ✓ Do NOT feed infants with a propped-up bottle.
- ✓ Offer only water from a sippy or no-spill cup.
- ✓ Only offer juice at mealtime; infants should not consume more than 4 ounces of 100% juice daily. Juice is not necessary for a balanced diet and whole fruit should be prioritized.
- ✓ Wean infants from the bottle by their first birthday.
- ✓ The ADA suggests that powdered formula be reconstituted with optimally fluoridated drinking water.
- ✓ If using honey at bedtime for the treatment of cough in young children, advise parents to wipe or clean mouth before bedtime.

Reinforce *Protective Benefits of Fluoride*

The mineral fluoride occurs naturally on earth and is released from rocks into the soil, water, and air. Fluoride protects teeth from decay. All water contains some fluoride but, in many communities, the fluoride level in water is not enough to prevent tooth decay. Consumption of fluoride through water and foods is important for the growing child. During tooth development, fluoride is incorporated into the developing tooth and strengthens the primary and permanent dentitions. Community water fluoridation, available to more than 95% of the Illinois population, is the process of adjusting the amount of fluoride found in water to achieve optimal prevention of tooth decay.

As summarized by the CDC Community Water Fluoridation program,[46] fluoride benefits children and adults throughout their lives and irrespective of income, race, or ethnicity Because of the widespread adoption of community water fluoridation in Illinois, that benefit extends across geographic regions of the state. For children younger than age 8, fluoride helps in the development of stronger secondary teeth. For adults, drinking water bathes teeth with low levels of fluoride that helps prevent cavities from forming and supports remineralization of tooth enamel.[46] The optimal fluoride concentration indrinking water, as established by the U.S. Public Health Service, is 0.7 parts per million. In 2018,the CDC reported that 98.2% of Illinois' 12.8 million residents on 1,800 community water systems receive fluoridated drinking water.

It is important to educate adults and children on the importance of drinking fluoridated water and determine whether they live in a fluoridated or non-fluoridated community. This is important because living in a non-fluoridated community may increase the risk of dental caries. Fluoride concentration of specific water systems information by county can be found on the Illinois page of CDC's My Water's Fluoride.

The International Bottled Water Association maintains a list of bottled water brands containing fluoride. However, most bottled waters contain a less-than-optimal concentration of fluoride, and the fluoride content varies among brands. Bottled-water products that are marketed as "purified," "distilled," "deionized," "demineralized," or "produced through reverse osmosis" typically have concentrations of fluoride much lower than those of products marketed without these claims. For children living in areas without optimal levels of fluoride in their community drinking water, consider the child's ingestion of water from other sources from the home such as at school, day care, or other sources and encourage drinking of water supplied by their local water system.

Primary care-office fluoride varnish application for high-risk children

For children under 6 years of age, apply fluoride varnish to the primary teeth starting at the age of primary tooth eruption regardless of the levels of fluoride in their water. Fluoride varnish is recommended by the U.S. Preventive Services Task Force for children through the age of 5, and, therefore, is a mandated service covered by insurers.[47] Based on risk, discuss, and provide an

application of fluoride varnish every three to six months. The following non-oral health providers should consider adding the use of fluoride varnish to their clinical practice:

- Dentists
- Dental Hygienists
- Dental Assistants (with dentist supervision)
- Physicians
- Physician Assistants
- Nurse Practitioners
- Registered Nurses
- Licensed Practical Nurses
- Medical Assistants

The Illinois Department of Healthcare and Family Services reimburses physician providers for applying fluoride varnish. Although physicians must perform the oral health assessment themselves, fluoride varnish application maybe delegated to ancillary medical staff that has been trained to provide the services. This effort reaches high-risk children up to 3 years of age in primary care settings. Refer to Handbook for Providers of Healthy Kids Services, Procedures for Health Care for Children Chapter HK-200for detailed protocol.[48]

Image 7. Fluoride Varnish Application Unit.

M. Van Kanegan

Home Care

Discuss health promotion and self-care practices, home oral hygiene, decreasing the risk of dental disease using fluoride, appropriate diet, and nutrition, eating and sugar-sweetened beverage drinking behaviors, and the importance of professional preventive dental visits. Remember to emphasize that bacteria from untreated dental caries from caregiver/parent can pass on to the baby

through sharing toothbrushes, pre-chewing food, and cleaning a pacifier with caregiver/parent saliva.These bacteria then can start the caries process in the child.

For baby and caregiver/parent

- ✓ Wipe gums/teeth twice daily with a soft cloth or baby toothbrush.
- ✓ The use of fluorides in toothpaste, rinses, or water is safe when used appropriately.
- ✓ Limit food and utensil sharing between caregivers and infants/children to reduce the transmission of bacteria that can cause dental caries.
- ✓ Encourage parents/caregivers to practice and set an example of good oral health habits like flossing and brushing.
- ✓ Avoid cleaning a dropped pacifier or toy with the caregiver's mouth. This will transmit bacteria between caregiver and child.
- ✓ Do not dip the pacifier in sweetened foods, such as honey, syrup, or sugar.
- ✓ Do not ingest any food or beverages other than water after the nighttime brushing.
- ✓ Encourage caregivers to brush their children's teeth with the appropriate amount of toothpaste until age 7 or 8 years, depending on the maturity of the child.
- ✓ Advise parents on oral health protective factors, including establishing a dental home, fluoride usage (toothpaste, drinking water), low cariogenic diet, and twice-daily tooth brushing.
- ✓ Advise parents on age-appropriate prevention of oral-facial injuries (e.g., mouth guards).

Image 8. Do not load pacifier with honey.

Stacey Ballweg

In addition to providing advice on tooth brushing and flossing, evaluate the child's sources and estimated levels of fluoride intake. Although fluoride provides protection against dental caries, ingestion of higher than recommended levels of fluoride is associated with increases in mild dental fluorosis in developing permanent teeth. Encourage caregivers to have children avoid rinsing with water after using toothpaste at night to leave some protective fluoride on teeth.

Provide Care and Management

Health care providers should develop a comprehensive management plan including assistance in establishing a dental home, a source for ongoing prevention and treatment. In addition, trained primary care providers can assess risk in young children and apply fluoride varnish to prevent and control the dental caries process. Providers are also encouraged to talk with parents/caregivers to access the barriers to oral health care for young children. Ask about:

- ✓ Transportation and financial issues.
- ✓ Competing health issues, especially for those with special needs.
- ✓ Fear and fatalistic attitudes, such as "they are only baby teeth."
- ✓ Health providers' awareness of the recommendation to begin dental visits by age 1.

It is important to document and follow-up on recommendations. Parents listen to what you have to say, and the recommendations you make, so use your influence to motivate and to institute health behaviors at home and to promote professional care.

Refer and Collaborate

Pediatricians must work with oral health care providers to establish effective oral health care for infants and children. According to the AAP policy statement, pediatricians should support families in identifying a dental home for all children. A dental home should be identified within six months of the eruption of the first tooth and before their first birthday.

- ✓ For children who do not have a dental home, help the family to locate one in their community. Develop a referral list by calling area dental offices or by using the Find a Dentist function on insurekidsnow.gov. Be sure to determine whether they accept adult Medicaid and other insurance plans or have sliding fee schedules for uninsured patients.
- ✓ Establish relationships with oral health professionals who see children in the community to facilitate your referrals. Consider developing a formal referral process with oral health professional offices to facilitate timely appointments.
- ✓ Consider providing to the parent/caregiver a written referral to collaborating oral health care provider.
- ✓ Consult with oral health providers for patients with high-risk conditions, including those with heart disease, complex medical conditions, or taking multiple medications.

- ✓ As needed, make referrals to other health professionals, such as nutritionists.
- ✓ Assist families with applications for insurance or other sources of coverage, social and nutrition services, or other needs such as transportation and translation.

Important Oral Health Topics

- ✓ Discourage saliva-sharing behaviors between parent and child, such as sharing of spoons and cleaning pacifiers in the mouth. Inform parent/caregiver that such behaviors are the source of cariogenic bacteria in the baby's mouth.
- ✓ Discuss teething remedies, such as cold teething rings and the use of acetaminophen/ibuprofen only as needed; discourage topical anesthetic products due to the risk of toxicity and ease of overdose.
- ✓ Discuss non-nutritive oral habits, such as a digit, pacifier, or toy sucking; bruxism; or abnormal tongue thrust. Although most children stop these behaviors on their own between ages 2 and 4, they should be weaned from these habits by age 5 to prevent long-term dental effects.
- ✓ Provide age-appropriate injury prevention counseling (e.g., mouth guards, childproofing home).

Useful Medications for Pediatric Oral Conditions: The American Academy of Pediatric Dentistry has produced a guideline on useful medications to address pediatric oral health concerns, which is available at: https://www.aapd.org/globalassets/media/policies_guidelines/r_usefulmeds.pdf.

ORAL HEALTH POLICY AND PRACTICE GUIDELINES

FOR ORAL HEALTH CARE PROVIDERS TREATING PEDIATRIC PATIENTS

GUIDELINES FOR ORAL HEALTH PROVIDERS TREATING PEDIATRIC PATIENTS

Assess Risk and Oral Health Status

In the knee-to-knee examination (pictured below), the parent and dental care provider sit facing each other, with knees nearly touching. The young child sits on the parent's lap and leans backward so the child's head is in the lap of the dental provider, who can then examine the child's mouth while the child can see their parent and hold the parent's hands. This positioning is beneficial and reassuring to the child as he/she can see their parent. The provider, child, and parent all wear eye protection. The provider also wears a face mask, gown, and gloves. Through this process, the provider can assess growth and development, eruption sequence, hard and soft tissue (extra-oral and intra-oral) injuries, and signs of child abuse or neglect.

Image 9. Knee-to Knee Examination allows for optimal positioning of child, parent and dental provider.

Advise and Educate

In general, be willing to be an ongoing source of care for children 12 months of age or younger. Maintain a dental record starting at age 12 months with yearly updates addressing the child's oral health needs to include any special instructions given to the parent/caregiver. Encourage child and family-centered healthy eating and beverage consumption habits.

- ✓ Choose age-appropriate healthy foods and snacks during planned meals and snacks; limit foods containing added sugar to decrease caries risk.
- ✓ Limit use and frequency of sugary food and drinks, and night-time feedings of anything except water.
- ✓ Assess fluoride exposure, including fluoride varnish applied in other settings, systemic and topical fluoride, and community water fluoridation.
- ✓ Encourage fruits and vegetables, or other healthy snack options and dairy products (milk, cheese, cottage cheese, unsweetened yogurt) for snacks.

- ✓ Avoid sugary and sticky foods, such as candy, sugared-based gum, cookies, cakes, fruit roll-ups, and raisins. Foods like crackers and chips tend to get stuck in the biting surfaces of teeth and lead to cavities, so limit these snacks.
- ✓ Drink water between meals. Drinks high in sugar (such as chocolate milk, juices) should be limited to less than 4 ounces once a day and be consumed with a meal.
- ✓ Advise and educate parents/caregivers about practicing good oral hygiene to prevent tooth decay for infants and children.
- ✓ Do NOT put infants to sleep with a bottle, sippy cup, or no-spill cup with formula, milk, or juice products. Do not breastfeed to sleep past the eruption of the first tooth.
- ✓ Do NOT feed infants with a propped-up bottle.
- ✓ Offer only water from a sippy or no-spill cup.
- ✓ Only offer juice at mealtime; infants should not consume more than 4 ounces of 100% juice daily. Juice is not necessary for a balanced diet and whole fruit should be prioritized.
- ✓ Wean infants from the bottle by 12 months of age.

Home Care

Discuss health promotion and self-care practices, home oral hygiene, the use of fluoride, appropriate diet, and nutrition, eating and sugar-sweetened beverage drinking behaviors, and the importance of professional preventive dental visits. Remember to emphasize that bacteria from untreated dental caries in a caregiver/parent can be transmitted to the baby through sharing a toothbrush, pre-chewing food, and cleaning a pacifier with caregiver/parent saliva. These bacteria then can start the caries process in the child.

For baby and caregiver/parent

- ✓ Wipe gums/teeth twice daily with a soft cloth or baby toothbrush.
- ✓ The use of fluorides in toothpaste, rinses, and water is safe when used appropriately.
- ✓ Limit food and utensil sharing between caregivers and infants/children to reduce the transmission of bacteria that can cause dental caries.
- ✓ Encourage parents/caregivers to practice and to set an example of good oral health habits like flossing and brushing.
- ✓ Avoid cleaning a dropped pacifier or toy with the caregiver's mouth. This will transmit bacteria from caregiver to child.
- ✓ Do not dip the pacifier in sweetened foods, such as honey, syrup, or sugar.

- ✓ Do not ingest any food or beverages other than water after the nighttime brushing

Habits

Infants should NOT be put to sleep with a bottle, sippy, or no-spill cup with formula, milk, or juice products. Only water should be offered in such drinking vessels. Children should be weaned from the breast, the bottle, and the pacifier after one year. The pacifier should never be dipped in sweetened foods such as honey, syrup, and sugar.

Limit food and utensil sharing between mothers or primary caregivers and infants/children to reduce the transmission of tooth-specific bacteria that can cause dental caries. Avoid cleaning a dropped pacifier or toy with saliva. This can transmit bacteria from caregiver to child.

The eruptive process can be a source of stress and pain for children and can be alleviated with age/weight adjusted dose of Motrin or Tylenol. Avoid using topical benzocaine for children under the age of 2 years old due to its toxic properties.

For infants and toddlers from birth to 3 years

Brushing: Wipe gums with a clean, soft child-size toothbrush or washcloth, after each feeding to establish early good oral health habits before the eruption of the first tooth. Regular cleaning of gums and use of a toothbrush before the eruption of teeth will introduce a baby to the sensation of a toothbrush and make the acceptance easier once the teeth erupt.

Upon eruption of teeth, brush teeth gently with a ‘smear’ of fluoridated toothpaste twice daily - morning and night. There is no need to rinse after brushing when using such a small amount of toothpaste. For children under age 3, a smear amount is used and is about “rice-sized.” This is

much less than the widely recognized “pea-size” amount previously recommended. This amount limits swallowing but helps with the uptake of fluoride.

Image 10. Amounts of fluoridated toothpaste “smear” on yellow/orange brush for 3 years and younger, “pea sized” on blue/green toothbrush for children 3-6 years of age. Clear brush shows amount of toothpaste for 7 years and older.

M. Van Kanegan

Image 11. Floss String, Tape, and Flossers. Several types of floss and flossing aids are available, some of them pictured here.

M. Van Kanegan

Flossing: Begin flossing when any two teeth touch. Again, the idea here is to get the child accustomed to the feeling of cleaning in between teeth. Early practice with flossing will lay a habit-forming acceptance and behavior.

For children from 3 to 6 years of age

Children do not have the dexterity to brush and floss effectively until they can tie their shoes at approximately 6–8 years of age. Always brush or help brush the child’s teeth with a pea-sized drop of fluoridated toothpaste in the morning and at night and floss the child’s teeth, especially those that touch.

- ✓ Teach the child to spit out - NOT swallow - the fluoridated toothpaste.
- ✓ Schedule a dental appointment every six months for cleaning/routine care (more often if indicated by the dental team).
- ✓ Encourage caregivers to supervise children’s brushing, including the use of the appropriate

amount of toothpaste, until age 7 or 8 years old or older depending on the maturity of the child.

- ✓ Advise parents on protective factors of oral health care, including establishing a dental home, consistent source of fluoride (toothpaste, drinking water), low cariogenic diet, and twice-daily tooth brushing.
- ✓ Advise parents on age-appropriate injury prevention counseling, such as mouth guards, use of car seats, strapped in while in a stroller, and a child-proofed home environment.

Provide Care and Management

Oral health care providers should develop a comprehensive management plan by providing a dental home for their patients. Beginning after the eruption of the first primary tooth or by age 1, provide oral preventive care as recommended by caries risk assessment.

Assess the barriers to oral health care for young children.

- ✓ Transportation or financial issues.
- ✓ Competing health issues, especially for those with special needs.
- ✓ Fear and fatalistic attitudes, such as “they are only baby teeth.”

Comprehensive treatment of caries.

- ✓ Restoration or extractions as needed.
- ✓ Amalgam or composite restorations are acceptable.
- ✓ Use of a rubber dam and high-volume evacuation is recommended.

Follow up – have office staff check that patient is following through with home care, schedule follow-up visits and referrals if provided.

Refer and Collaborate

- ✓ Consult with child’s pediatrician for children with high-risk conditions, including those with heart disease, complex medical conditions, or taking multiple medications.
- ✓ For children without a regular source of medical care, assist them in finding a medical home. Maintain current listing of all sources of local medical care.
- ✓ Coordinate fluoride prescription with child’s pediatric provider, as appropriate.
- ✓ Communicate with area pediatricians about available oral health services at your practice for children and area offices that are accessible to physically impaired children.
- ✓ Consider collaborating with pediatric health care providers who gives a written referral form for oral health care to the parent/caregiver.

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

ORAL HEALTH RECOMMENDATIONS

FOR MOTHERS AND PRIMARY CAREGIVERS WITH YOUNG CHILDREN

RECOMMEDNATIONS FOR MOTHERS AND PRIMARY CAREGIVERS WITH YOUNG CHILDREN

Tooth decay (dental cavities) is one of the most common chronic diseases of childhood in the United States. Untreated tooth decay can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. Compared with children who have good oral health, those who have poor oral health often miss more school and receive lower grades.[49] Good oral health supports life-long health and achievements in education, employment, and social relationships.

The good news is that tooth decay is preventable. The best protection against tooth decay is good oral home care, regular access to professional care, a healthy diet of low sugar food and beverages, use of fluorides, and dental sealants. Mothers and primary caregivers play a critical role in good oral health practices and the prevention of tooth decay in young children. Your child should see a dentist when their first tooth erupts, or at age 1, whichever comes first.

When liquids or food that contain sugar are left in a baby's or a young child's mouth for a long time, the sugar breaks down into acid that can remove minerals from the teeth, causing cavities to form. Common high sugar food or drink sources are sugar-sweetened beverages, fruit-based and milk-based sweetened drinks, 100% fruit juices, pureed baby food pouches, cakes, cookies, sweetened cereals, sweet desserts, candy, honey, and syrups. Breast milk and formula also contain sugar.

Why are baby teeth important?
Baby teeth are needed for chewing food and for permanent tooth development. They provide a nice smile and promote a good self-image for children. They are needed to speak clearly. If baby teeth are lost too early, permanent teeth can come in crowded and out of alignment.

Children aged 2 years or younger

Mouth Care: The parent or primary caregiver should brush the child's teeth with a soft toothbrush and a tiny smear of fluoridated toothpaste twice daily, once in the morning and then before bedtime. Children should not have access to toothpaste after toothbrushing time. The parent or caregiver should also wipe the child's mouth with a wet cloth after feedings or meals. In particular, be sure to wipe plaque from their upper front teeth.

Eating and Drinking: Children should be eating healthy, age-appropriate foods and should not be given sugary drinks, such as fruit juices. Meals and snacks should include no-sugar-added yogurts, fruits, vegetables, nuts (if not allergic), sources of protein, and cheeses. Avoid sugary and sticky foods, including candy, cookies, cakes, fruit roll-ups, raisins, fruit leathers, or dried fruits. Foods high in carbohydrates, such as crackers, chips, and dried fruit tend to get stuck on the teeth and lead to tooth decay.

Children should be given only water to drink between meals. Juice should only be allowed at mealtime, and infants should not consume more than 4 ounces of 100% juice daily. Juice is not necessary for a balanced diet and whole fruit should be prioritized.

Habits: Infants should NOT be put to sleep with a bottle, sippy cup, or no-spill cup with formula, milk, or juice products. Nighttime, on-demand breastfeeding should be curtailed as much as possible. Children should be weaned from the bottle, and the pacifier after one year. Pacifiers should never be dipped in sweetened foods such as honey, syrup, or sugar.

Limit food and utensil sharing between mothers or primary caregivers and infants or children to reduce the transmission of bacteria that can cause dental caries. Do not clean a dropped pacifier or toy with saliva, which can transmit bacteria from the caregiver to the child.

Development: The bottom front baby teeth (central incisors) are often the first teeth to come into the mouth, usually between 6 to 8 months of age. Generally, four teeth erupt for every six months of life after the development of the first teeth into the mouth. The upper jaw center teeth (central incisors) often erupt after the lower central incisors and a total of 30 primary teeth should have come into the mouth by 3 years of age.

The teeth eruptive process can be a source of stress and pain for children, and it can, be alleviated by biting on cold teething rings or other soft teething aids. Teeth must always be brushed and properly cared for, even at such a young age, because primary teeth have permanent teeth successors.

Image 12. Encourage drinking water from a monitored and fluoridated source.

Rose Mutzbauer

Children aged 2 to 5 years

Mouth Care: The parent or caregiver should brush the child's teeth with a soft toothbrush and a tiny smear of fluoridated toothpaste for children under the age of 3 years and a pea-sized amount of toothpaste for children between 3 and 5 years old. Children should not have access to toothpaste after toothbrushing time. The toothbrushing routine should be repeated twice a day. Start using dental floss daily when teeth are in contact, particularly between the back teeth. Tooth brushing together with parents and older siblings can be incorporated as a fun family activity.

Eating and Drinking: Children should be eating healthy, age-appropriate foods and should not be given sugary drinks or fruit juices. Meals and snacks should include no-sugar-added yogurts,fruits, vegetables, nuts (if not allergic), sources of protein, and cheeses. Avoid sugary and sticky foods, including candy, cookies, cakes, fruit roll-ups, raisins, fruit leathers, or dried fruits. Foods high in carbohydrates, such as crackers, chips, and dried fruit tend to get stuck in the bitingsurfaces of teeth and lead to cavities. Limit these snacks.

Children should be given only fluoridated water to drink between meals. Juice should only be allowed at mealtime; infants should not consume more than 4 ounces of 100% juice daily. Juice is not necessary for a balanced diet and whole fruit should be prioritized.

Habits: Children should be discouraged from thumb sucking, finger biting, or nail chewing.

Development: When baby teeth become loose, which could happen as early as 5 years of age, children should be encouraged to "wiggle" the teeth to help them come out. The lower front teeth (central incisors) are usually the first teeth to fall out, at around age 5 to 7 years.

The first permanent molars, which begin development at birth, most frequently come into the mouth around age 5 to 6 years. Extra care must be taken with toothbrushing to properly clean these new permanent teeth and the surrounding soft tissue, which is often inflamed following tooth eruption. This process can be a source of pain for children, and it can be alleviated with age/weight adjusted dose of Motrin or Tylenol.

Children aged 6 to 8 years

Oral Hygiene: Fluoride's mechanism of action suggests it would be best to have a high fluoride level in surface enamel and plaque before an acid challenge. It makes more sense to brush before breakfast and before going to sleep. Caregivers should brush the child's teeth until they are confident that the child is brushing effectively (usually around age 7 or 8) and not swallowing toothpaste. A child who can tie their shoes has the dexterity to brush and floss effectively. Lift the child's lip to inspect the teeth and gums after the child brushes. Parents or caregiver should closely monitor toothbrushing habits through age 8 years. Similarly, dental floss should be used by the parents or caregivers when the child's adjacent teeth touch each other. Gently work the dental floss between teeth to avoid injuring the gums.

Eating and Drinking: Children should be eating healthy, age-appropriate foods and should not be given sugary drinks or fruit juices. Meals and snacks should include no-sugar-added yogurts,fruits, vegetables, nuts (if not allergic), sources of protein, and cheeses. Avoid sugary and sticky foods, including candy, cookies, cakes, fruit roll-ups, raisins, fruit leathers, or dried fruits. Foods high in carbohydrates, such as crackers, chips, and dried fruit tend to get stuck on teeth and may lead to tooth decay.

Children should be given only water to drink between meals. Juice should only be allowed at mealtime; infants should not consume more than 4 ounces of 100% juice daily. Juice is not necessary for a balanced diet and whole fruit should be prioritized.

Habits: Children should be discouraged from thumb sucking, finger biting, or nail chewing.

Development: When teeth become loose, which could happen as early as 5 years of age, children should be encouraged to "wiggle" the teeth to exfoliate or fall out. The primary lower jaw incisor teeth are often the first teeth to fall out of the mouth between 5 and 7 years of age. The upper jaw incisor teeth are often the next teeth to fall out.

The first permanent molars (FPMs), which begin development at birth, most frequently come into the oral cavity between 5 and 6 years old. Extra care must be taken in toothbrushing regimensto properly clean these new permanent teeth and the surrounding soft tissue, which is often inflamed following a tooth eruption. This process can be a source of pain for children, and it can,therefore, be alleviated with Motrin or Tylenol. Dental sealants, a thin protective plastic coating, are generally recommended for FPMs as a caries prevention technique.

Children aged 9 to 12 years

Oral Hygiene: Fluoride's mechanism of action suggests it would be best to have a high fluoride level in surface enamel and plaque before an acid challenge. It makes more sense to brush before breakfast and before going to sleep. Similarly, flossing techniques should be implemented before nightly toothbrushing. Mouthwash should only be considered as an additional oral hygiene technique, as opposed to a replacement for regular toothbrush and flossing care.

Eating and Drinking: Children should be eating healthy, age-appropriate foods and should not be given sugary drinks or fruit juices. Meals and snacks should include no-sugar-added yogurts,fruits, vegetables, nuts (if not allergic), sources of protein, and cheeses. Avoid sugary and sticky foods, including candy, cookies, cakes, fruit roll-ups, raisins, and fruit leathers or dried fruits. Foods high in carbohydrates, such as crackers, chips, and dried fruit, tend to get stuck on teeth and lead to cavities. Limit these snacks.

Older children and pre-teens should drink only water between meals. Otherwise, drinks low in sugar, such as plain milk or 100% juice, should be consumed very infrequently, as neither is necessary for a balanced diet.

Habits: Older children and preteens should not have to be reminded to brush their teeth or floss. Regardless, parents or primary caregivers should emphasize the importance of a routine because children aged 9 to 12 years may tend to stay up late and fall asleep in front of the television without properly attending to their oral hygiene. Consequently, they may wake up too late for school to follow through with their morning oral hygiene regimen. The trap of this cycle should be discouraged.

Development: Most primary (baby) teeth should have fallen out naturally, and the successor permanent teeth should come into the mouth during the preteen years. The second permanent molars frequently emerge at about age 12. Extra care must be taken in toothbrushing regimens to properly clean these new permanent teeth and the surrounding soft tissue, which is often inflamed following a tooth eruption.

The preteen years also present a crucial window for growth and alignment of the permanent teeth, as well as possible evaluation by an orthodontist.

Cancer Prevention: The human papillomavirus (HPV) vaccine is recommended for all children aged 11 or 12 years. It is important that the two doses of the HPV vaccine be administered 6 to 12 months apart to prevent HPV infection.

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Illinois Oral Health Toolkit

for providers, individuals, families, and organizations that work to improve oral health in Illinois

PROVIDER CENTERED INFORMATION

Smiles for Life: A National Oral Health Curriculum has developed modalities for primary care providers to learn and feel more comfortable providing anticipatory guidance and risk factor assessment to patients. The curriculum can be accessed through the following link: https://www.smilesforlifeoralhealth.org

Relevant modules for the maternal and child populations are:

Course 1 - The Relationship of Oral and Systemic Health
Course 2 - Child Oral Health
Course 5 - Pregnancy and Women's Oral Health
Course 6 - Caries Risk Assessment, Fluoride Varnish, and Counseling
Course 7 - The Oral Examination

Easy Messaging Flipchart and PowerPoint Presentation

Illinois Department of Public Health. Improving Women's and Children's Oral Health, 2005. https://dph.illinois.gov/sites/default/files/Improving%20Womens%20and%20Childrens%20Oral%20Health.pdf

The Improving Women's and Children's Oral Health flipchart reviews oral health topics and oral health instructions. This is an excellent combined English and Spanish educational tool for use by any program promoting oral health to mothers, infants, and children. For more information, contact the IDPH Division of Oral Health at 217-785-4899, 800-547-4899 TTY (hearing impaired), or at DPH.oralhealth@Illinois.gov

Boston Children's Hospital, Department of Dentistry
2013 PowerPoint Presentation

https://oralhealthsupport.ucsf.edu/sites/g/files/tkssra861/f/wysiwyg/oralhealthed/Boston%20Children%27s%20Hospital%20Flipchart%20Dentisty04-23-13.pdf

Additional Fast Facts on Oral Health at the IDPH Division of Oral Health

https://dph.illinois.gov/topics-services/prevention-wellness/oral-health/fast-facts-oral-health

Oral Health Assessment, Integration and Referral Form A

Oral Health Assessment, Integration and Referral

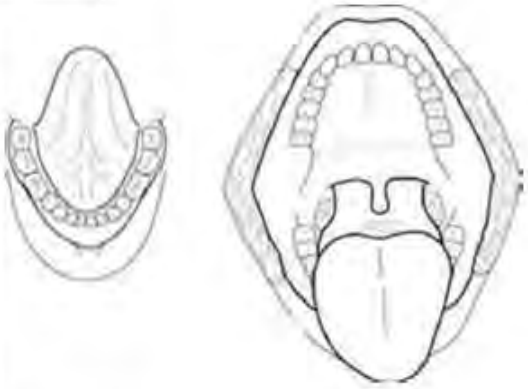
Medical Record #: _____ Service Date: _____

Population of Interest			
Pediatric under age 3	_____	Pediatric 3-6 years	_____
Pregnant women	_____	Adolescent age 12-20	_____

Contributing Conditions			
Dental home Last dental visit: _____	Yes ☐	No ☐	Unknown ☐
Dental pain (If yes, immediate referral)	Yes ☐	No ☐	
Fluoride exposure (through drinking tap water, toothpaste, professional applications, supplements)	Yes ☐	No ☐	Unknown ☐
Sugary foods or drinks between meals (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Yes ☐	No ☐	
Flosses daily	Yes ☐	No ☐	
Current smoker	Yes ☐	No ☐	
For Patients Under Age 6			
Untreated dental caries in mother, caregiver and /or other siblings	Yes ☐	No ☐	
Brushes teeth twice a day with fluoridated toothpaste	Yes ☐	No ☐	
Provider Signature:			

Anticipatory Guidance		
Oral health education	Yes ☐	No ☐
Nutritional counseling	Yes ☐	No ☐
Tobacco cessation counseling	Yes ☐	No ☐
Oral hygiene kit provided	Yes ☐	No ☐
Services Provided		
Toothbrush prophylaxis	Yes ☐	No ☐
Fluoride Varnish	Yes ☐	No ☐
Other: _____	Yes ☐	No ☐

Clinical Findings (Note in diagram on right)			
Cavitated or white spot lesions	Yes ☐ (1-2 teeth)	Yes ☐ (3 or more teeth)	No ☐
Inflamed /bleeding gums	Yes ☐	No ☐	
Visible dental plaque	Yes ☐	No ☐	
Severe dry mouth	Yes ☐	No ☐	
Other lesions (please describe here and note location in diagram): If present for more than 2 weeks, immediate referral to dentist.			
Provider Signature:			



Referral (Check all that apply)	
☐ Immediate within 24-48 hours - to dentist for pain, abscess, swelling or fever	☐ Made appointment today
☐ Within 2 weeks / will follow up with dentist for routine treatment for caries, periodontal disease, broken asymptomatic teeth, dry mouth, suspicious lesion	☐ Patient has a dental home
Insurance Type:	
Case Manager Signature:	

Oral Health Assessment, Integration and Referral Form B

Oral Health Assessment and Integration

Client Initials: _____ DOB: _____ Service Date: _____

Population of Interest
Pregnant Woman _____
Postpartum Woman _____

Contributing Conditions			
Dental home **Last dental visit:** _____	Yes ☐	No ☐	Unknown ☐
Dental pain (If yes, immediate referral)	Yes ☐	No ☐	
Fluoride exposure (through drinking tap water, toothpaste, professional applications, supplements)	Yes ☐	No ☐	Unknown ☐
Sugary foods or drinks between meals (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Yes ☐	No ☐	
Flosses daily	Yes ☐	No ☐	
Current smoker	Yes ☐	No ☐	

Anticipatory Guidance		
Oral health education	Yes ☐	No ☐
Nutritional counseling	Yes ☐	No ☐
Tobacco cessation counseling	Yes ☐	No ☐
Oral hygiene kit provided	Yes ☐	No ☐
Services Provided		
Fluoride Varnish	Yes ☐	No ☐
Other: _____	Yes ☐	No ☐

	Referral (Check all that apply)
☐ Immediate within 24-48 hours - to dentist for pain, abscess, swelling or fever	☐ Made appointment today
☐ Within 2 weeks / will follow up with dentist for routine treatment for caries, periodontal disease, broken asymptomatic teeth, dry mouth, suspicious lesion	☐ Patient has a dental home
Insurance Type:	
Staff Signature:	

Primary Caregivers and Providers - Quick Tip - The importance of primary teeth

Primary teeth play an important role in the health and development of children. Primary teeth guide speech development and are functionally used to chew foods and are socially relevant in terms of smile and development of self-confidence.

Primary teeth begin eruption between 4 months and 12 months of age and continue until full primary dentition is established around 3 years of age. There are 20 teeth in the primary dentition. Sequentially, the eruption pattern is usually Mandibular: central incisor, lateral incisor, primary first molar, canine, and primary 2nd molar; Maxillary: central incisor, lateral incisor, primary 1st molar, canine, and primary 2nd molar. This eruption pattern can vary from child to child.The primary incisors exfoliate about 6 to 7 years of age and the primary molars and canines are retained until 12 years of age. Early and adequate hygiene is essential to help retain these teeth until their normal exfoliation timeline. Early loss of primary molars and canines can result in space loss for the eruption of permanent teeth. If space loss occurs, permanent teeth may become impacted (retained under the gums) and require surgical procedures to guide eruption and complex orthodontic treatment plans. The best space maintainer to guide the development of the permanent dentition is the primary tooth, and every effort should be made to retain and restore them if cavities are evident.

Not only are primary teeth important to guide eruption of the permanent teeth, but trauma and infection in primary teeth can cause developmental defects in the permanent dentition. Traumatic injuries to primary teeth should be evaluated by a dentist within 24 hours, if possible, to ensure the health of the developing permanent dentition. Permanent teeth develop just below the root of primary teeth and infection can interrupt the process. Dental infections must be treated to prevent systemic complications and to preserve the permanent tooth. This treatment may include pulpotomy or pulpectomy (removal of the inflamed or necrotic pulp tissue) or extraction of the tooth.

Children depend on adult caregivers to ensure the health of their teeth and mouth. It is important to establish a daily hygiene routine early and consistently. Toothpaste with fluoride should be used upon eruption of the first tooth. The amount of toothpaste should minimize swallowing but allow the topical uptake of fluoride to the teeth. A smear of toothpaste (less than a grain of rice) is recommended for children ages 0–2. Once children learn to spit, toothpaste can be increased to a pea-size amount for ages 2–5 and larger than a pea-size amount for children age 6 and older. Tooth brushing should be completed by the caregiver until age 8 years, when the child's dexterity and maturity enable adequate hygiene techniques.

Pediatric Provider Guidance - Quick Tip: Dental Caries and High-Risk Patients

Dental caries is not uniformly distributed in the population. This chronic and progressive disease is disproportionately concentrated among children of low socioeconomic status and among racial and ethnic minorities. It is important to identify risk factors and intervene in the disease process for these children.

The AAPD and APP provide recommendations to address early childhood caries in these high-risk populations, but multiple factors may limit their access to dental care. Anticipatory guidance and recommendations throughout the health care system will help to reduce these disparities.

Fluoride varnish is an effective preventive measure for children at elevated risk for dental caries. Varnish can be applied up to four times per year (twice per medical provider and twice per dental provider) and is covered by Illinois Medicaid. However, fluoride varnish alone is not enough to prevent the establishment or progression of the disease. Follow-up and referral to oral health providers can help mitigate this disease process.

Fluoride Varnish Program for Young Children

Illinois Department of Healthcare and Family Services supports early, risk-based intervention with fluoride varnish application.

The current protocol for reimbursement for fluoride varnish application by non-oral health medical staff can be found in the 203.8 section of the Illinois Department of Healthcare and Family Services Handbook for Providers of Healthy Kids Services, March 2017. (https://www.illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf)

HK-203.8 Oral Health Screening/Fluoride Varnish

Beginning at the 6-month visit, physicians should counsel caregivers on oral health, perform a dental screening for visual signs of decay and assess the child's oral health, and provide anticipatory guidance. Physicians should refer children to a dental home for routine and periodic preventive dental care within six months of the eruption of the first tooth or by age 1, as per recommendations by the American Academy of Pediatrics (AAP), the American Dental Association (ADA), and the American Academy of Pediatric Dentists (AAPD). The AAP's *Bright Futures, 4th Ed.* recommends oral health assessments begin at 6 months of age and continue at well child visits at 9, 12, 18, 24, 30, 36-months, and 6 years.

Physicians must be trained in an Illinois Department of Healthcare and Family Services (HFS)-approved training program to be eligible for reimbursement for applying fluoride varnish. Providers complete training in the HFS-approved *Bright Smiles from Birth* program and provide their Medicaid license number for enrollment in the program. Reimbursement is $26 per fluoride application up to three times a year on children under 36 months of age. The procedure code for application of varnish is D1206. Information about HFS's reimbursement rates is available on the HFS Fee Schedule website. The *Bright Smiles from Birth* training program can be found on the American Academy of Pediatrics Illinois Chapter website.

Physicians trained in the program must perform the oral health assessment themselves. The fluoride varnish application may be delegated to ancillary medical staff that have been either trained in an HFS-approved training program themselves or trained by another provider who has been trained through the program.

An oral health screening is part of the physical examination but does not replace referral to a dentist. Medicaid dental benefits for children include services for treatment of early childhood caries, relief of pain and infections, restoration of teeth, dental sealants, prophylaxis, and maintenance of dental health, including instruction in self-care oral hygiene procedures. Dental care for children is **not** limited to emergency services, by federal law. Medicaid in every state must cover "all medically necessary" dental care for enrolled children. For assistance in finding a dentist for referral, contact DentaQuest of Illinois or the child's managed care organization for referral options.

An alternative to *Bright Smiles from Birth* is the national oral health curriculum developed by *Smiles for Life*, which has several trainings for primary providers addressing anticipatory guidance, risk factor assessment, and training for fluoride varnish application for young patients. This information can be found in Course 6 - Caries Risk Assessment, Fluoride Varnish, and Counseling.

Fluoride Resources

Illinois Fluoridated Cities/Towns and Resources

Illinois county, city, and town information on public water fluoridation, naturally occurring fluoridated water sources can be accessed through the CDC My Water's Fluoride website, link below. This website will be useful to determine patient fluoridation status.

https://nccd.cdc.gov/doh_mwf/default/default.aspx

American Dental Association – Fluoride in Water
https://www.ada.org/en/public-programs/advocating-for-the-public/fluoride-and-fluoridation

Campaign for Dental Health (an alliance of health professionals and scientists)
www.ilikemyteeth.org/

Centers for Disease Control and Prevention - available in multiple languages
www.cdc.gov/fluoridation/

For additional information call: IDPH - Division of Oral Health 217-782-3300 or visit
http://www.dph.illinois.gov/topics-services/prevention-wellness/oral-health

PERSON CENTERED INFORMATION

Accessing Oral Health Care in Illinois

Oral health is more than just healthy teeth. Oral refers to the mouth, which includes the teeth, gums, and supporting tissues. Oral health is an important part of overall health, well-being, and directly affects your quality of life. Diseases and disorders that can affect oral health include:

- Tooth decay and periodontal or gum disease.
- Viral infections, including cold and canker sores.
- Birth defects, such as cleft lip and palate, or missing all or most teeth.
- Chronic oral-facial pain that can result from disorders of the jaw joints and chewing muscles, such as temporomandibular joint (TMJ) dysfunction or craniomandibular dysfunction.
- Mouth and throat cancers.

Changes in the mouth often are the first signs of problems elsewhere in the body. Dentists and dental hygienists play an important role in evaluating, diagnosing, preventing, or treating oral diseases, which can affect systemic health. Poor oral health also may increase diseases and health conditions, such as diabetes, immune disorders, heart disease, and having pre-term low birth weight babies. These health conditions may result in poor health outcomes when your oral health is not good.

If you are having problems finding oral health care, there are several ways to find access to care. Check out the resources listed below to help locate oral health care services in your community. But first, some things to consider when choosing a dental home.

- Is the office easy to get to from your home or job?
- Do they have convenient office hours for you?
- If you have dental benefits, is this dentist in your network?
- Doctor-patient communication is important. Will you need translation or interpreter services?

These resources are searchable by your home ZIP code.

- "Find a Dentist" for Illinois State Dental Society (ISDS) member dentist directory: https://www.isds.org/for-the-public/find-a-dentist
- "Find a Dental Clinic" resource on the ISDS website: https://www.isds.org/for-the-public/find-a-dental-clinic. This is a listing of clinics for people with limited financial ability.
- Illinois' Federally Qualified Health Centers: https://findahealthcenter.hrsa.gov. These centers are for people who are low income, uninsured, or are undocumented residents.
- For Medicaid members, use the Find a Dentistfunction on insurekidsnow.gov to find a community dentist enrolled in Illinois' Medicaid program.

Also consider below sources to obtain oral health care.

- Local health department dental clinics.
- Dental schools and dental hygiene programs.
- Check with your medical insurance plan to see if dental insurance is included and, if it is, contact customer service and ask for list of participating dentists.

- Consider purchasing a dental insurance plan.

Illinois Medicaid Dental Program Information

Illinois Medicaid oversees enrollment and eligibility of individuals and families utilizing state and federal rules. Individuals and families can access an application package as well as assistance with completing the forms by calling the Application for Benefits Eligibility (ABE). I Applications can be submitted at ABE.Illinois.gov or by calling the ABE hotline at 1-800-843-6154.
https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/about.aspx

Illinois Medicaid benefits cover examination, dental cleanings, treatments for periodontal disease, dental caries, extraction of teeth, and additional treatments with prior authorization. A description of dental coverage and help for managed care adults and children members enrolled in Medicaid can be found on the Illinois Department of Healthcare and Family Services Dental Program webpage.

Illinois Medicaid Dental Services

Covered Services Comparison for Children and Adults

	Children (< age 21)	Adults (> age 20)	Pregnant Women
Diagnostic Services (Exams)			
Oral Exams (child - one per six months in office setting, and one per 12 months in a school setting; adult - one per 12 months; pregnant women - one per six months)	X	X	X
X-rays	X	X	X
Preventive Services			
Cleanings (child - one per six months; adult - one per 12 months; pregnant women - one per six months)	X	X	X
Sealants (child - one per lifetime per tooth)	X		
Topical Fluoride (child - [0-2] three per 12 months, [3-20] one per six months)	X		
Silver Diamine Fluoride (six per one lifetime per tooth, other limits apply)	X	X	X
Space Maintenance	X		
Restorative Services (Fillings)			
Amalgam restorations (some limits apply)	X	X	X
Composite restorations (some limits apply)	X	X	X
Crowns	**X**	**X**	**X**
Protective Restoration	X	X	X
Endodontic Services (Root Canals)			
Pulpotomy - pulp removal	X		
Root Canal Treatment	X	X	X
Apexification/Recalcification	**X**		
Periodontal Services (for Gum Disease)			
Gingivectomy - gum removal	**X**	X	X
Bone Replacement Grafts	**X**	X	X
Scaling and Root Planing	X	X	X
Full Mouth Debridement	X	X	X
Removable Prosthodontic Services (Denture Services)			
Complete Denture (upper and lower)	**X**	**X**	**X**
Immediate Denture (upper and lower)	**X**	**X**	**X**
Partial Denture (upper and lower)	**X**		
Denture Repair	X	X	X
Denture Relines	**X**	**X**	**X**
Maxillofacial Prosthetics	**X**	**X**	**X**
Fixed Prosthetic Services			
Bridgework	**X**		
Oral and Maxillofacial Services (Removal of tooth/teeth)			
Extractions – removal of tooth/teeth	X	X	X
Surgical Extractions	**X**	**X**	**X**
Alveoloplasty – pre-prosthetic procedure on jawbone	**X**	**X**	**X**
Removal of Odontogenic Cyst or Tumor	**X**	**X**	**X**
Addition services with prior approval	**X**	**X**	**X**
Orthodontic Services (Braces)			
Orthodontia (coverage limited to children meeting or exceeding a score of 28 points. Handicapping Labio-Lingual Deviation (HLD) Index or meeting criteria for medical necessity)	**X**		
Adjunctive General Services (Other)			
Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)	X	X	X
General Anesthesia	**X**	**X**	**X**
Intravenous (IV) Sedation	**X**	**X**	**X**
Nitrous Oxide Analgesia	X	X	X
Conscious Sedation	**X**	**X**	**X**
Therapeutic Drug Injection	**X**	**X**	**X**

X's in bold red may require prior authorization before services can be performed.
Consult your dental provider.

Additional Dental Services by Managed Care Plan

Blue Cross Community Health Plans

1-877-860-2837
TTY: Illinois Relay
at 7-1-1
or 1-800-526-0844
bcchpil.com

Serviced by:
DentaQuest*
1-888-291-3763

For members under age 21:
- Exams and cleanings
- One (1) fluoride treatment per year
- Sealants
- Fillings
- Crowns
- Root Canals
- Dentures
- Extractions

For members over 21:
- Two (2) cleanings per year
- Two (2) exams per year
- One (1) set of preventive X-rays per year

All covered for emergency dental services

aetna Aetna Better Health of Illinois

Members should call
Aetna Better Health
for dental services at
1-866-329-4701
TTY: Illinois Relay
at 7-1-1

https://www.aetnabetterhealth.com/illinois-medicaid/index.html

For members under age 21:
- Dental services provided in school dental programs
- Oral exams (1 per year)
- Fluoride treatments (1 per year)
- Oral surgeons
- Dental cleanings (2 times per year)

For members over 21:
- Limited and comprehensive exams
- Restorations
- Complete dentures
- Extractions
- Sedation

All covered for emergency dental services

meridianhealth

1-866-606-3700
TTY: Illinois Relay
at 7-1-1
or 1-866-606-3700
or
memberservices.il
@mhplan.com
corp.mhplan.com

For members under age 21:
- Exams, cleanings, and X-rays
- One (1) fluoride treatment per year
- Sealants
- Fillings
- Crowns
- Root Canals
- Dentures
- Extractions

For members over 21:
- Two (2) cleanings per year
- Two (2) exams per year
- One (1) set of preventive X-rays per year

All covered for emergency dental services

MOLINA HEALTHCARE

1-855-687-7861
TTY: Illinois
Relayat 7-1-1
or 1-800-526-0844
molinahealthcare.com

Members should
callMolina for
dental services at
1-888-858-2156

CountyCare HEALTH PLAN

1-855-444-1661
TTY: Illinois Relay
at 7-1-1
or 1-855-444-1661
countycare.com

Serviced by:
DentaQuest*
1-888-291-3763

For members under age 21:
- One dental exam and one cleaning every six months.
- X-rays, sealants, fillings, oral surgery, crowns, root canals, dentures, braces, and extractions.

For members over 21:
- Some routine and medically necessary dental services, including X-rays, fillings,crowns, root canals (front teeth only), oral surgery, extractions, dentures, and denture repairs.
- Regular exams and cleanings every six months.

All covered for emergency dental services

Some dental services require prior approval. For those services, you must have approval before getting treatment. Without approval, you will have to pay for those services.
****Questions about services? Contact your managed care plan****

Need Help Finding a Dentist?

Managed Care Members will need to contact the phone number on the back on the membership card to receive help with finding a dentist enrolled in their Managed Care Plan. You can also use the "Find a Dentist" function at insurekidsnow.gov.

Adults and children enrolled in Medicaid, but not enrolled in a Managed Care Plan, will need tovisit *DentaQuest (http://bit.ly/FindDentistIL) or call 1-888-286-2447 (TTY 1-800-466-7566) for help finding a dentist.

ACCESSING TRANSPORTATION BENEFITS IN ILLINOIS MEDICAID

Illinois Medicaid Managed Care Organizations (MCO): Transportation Services

Additional plan information can be found at: https://www2.illinois.gov/hfs/MedicalClients/ManagedCare/Pages/default.aspx

**Transportation services are provide by a 3rd party transportation service company

MCO	Customer Service #	Transportation Request #	Hours of Operation (when appointment can be made)	Information Needed to Schedule Transportation	Days Notice	Mileage	Use of Service Limits	Unaccompanied Minor	Confirmation of Service	Extra info
YouthCare (Serves DCFS Youth in Care only)	844-289-2264 or visit medicaltrip.net to schedule	Member Services press 2 then press 1 for transportation	7a-6p and overnight staffing as well	Member ID number or member date of birth, phone number, and address; addess of provider to be seen and pickup location	3 calendar days	N/A	Services and members must reside in IL; if outside the state then authorization needed	must be 18, no exception for emancipated, and must have adult over 18+ regardless of age.	Trips are set up by MCO provider and the third party with call 1 hour before appointment time; some companies do not call so it is recommended that the transportation is confirmed for the member in the event they don't call.	Recommendation: have the member call the day before to confirm transporation.
County Care - Cook County Only	312-864-8200	Press 3 for members then 5	7a-7p M-F and 9a-1p Sa-Sun		72 hours notice	Cook County Only	https://countycare.com/wp-content/uploads/NEMTforCCCMembersFlyerFTPublic_2021.pdf	Anyone under 18 must have an adult; whever they need picked up.	They will get a confirmation call a day before to know exactly who is picking them up.	Request public transportation passes (CTA and Pace) 2 weeks before your appointment by calling Member Services at 312-864-8200/ 855-444-1661 (toll-free)/ 711 (TDD/TTY).
Meridian	866-606-3700 or visit medicaltrip.net to schedule	Press 3 for member services then 1	8a-6p standard 7/days week; emergency 24/7		3 calendar days	Varies based on type of Medicaid;	no ride of choice; could be denied if not called with 72; eligiblity will be determined by health plan	16 years or older or emanciapted minor can ride alone; otherwise accompanied by adult 16+; exception for memebrs under 16 to family planning, pregnancy related appointments, and behavioral health treatments.	After scheduling the member will receive a 'trip number' and someone will reach out to the member to confirm appointment and ETA.	Any type of mile restriction or out of state will require Provider Approval; and CCR will inform member what is needed to get approved.
Molina	855-687-7861 or visit medicaltrip.net to schedule	Call Molina transpotation directly 8446446354	24/7		2 calendar	Trips over 100 one way miles require prior authorization from Molina - 1 exception; discharge from hospital or urgent care no	Be aware of days notice	16 years or older or emanciapted minor can ride alone; otherwise accompanied by adult 16+; exception for memebrs under 16 to family planning, pregnancy related appointments, and behavioral health treatments	Drivers will call members to confirm; day before and day of 1-hour before.	Recommendation: Have the member call the day before to confirm transporation and to follow-up for all short notice requests.
Aetna Better Health (Formerly Illinicare Health)	866-329-4701	Press 2 for member then press 1	8a-5p m-f longer hold times on Monday; lower in afternoon and end of week		2 business days	50 miles one way; anything over will need authorization		Requires minor release form; once on file they can proceed 12+; allow 2 escorts.	When a member calls in, they schedule, once finished can be provided with trip number and once appotment scheduled provider will reach out to member to confirm appointment and ETA.	Mileage reimbursement is available if you use your own car or get a ride from someone. You have seven days after your appointment to ask for mileage reimbursement. Call Member Services at 1-866-600-2139 (TTY: 711) for assistance.
Blue Cross Community Family Health Plan	877-831-3148	Press 1 for member then follow prompts	8a-6p m-f		3 days	Prior authorization required to see a provider more than 40 miles away.	https://www.bcbsil.com/bcchp/benefits-and-coverage/transportation-services	Request, as needed.	Will be provided with reservation number. Be ready for your ride one hour before your visit. Your driver will honk, knock, ring the bell, or call you and will only wait 5 minutes. A parent or caregiver may ride with children or members with special needs. If you are a member who is a single caregiver, and you have more than one minor child in your care, you can ask Member Services to approve transportation for additional minor children. Caregivers or other children must be approved by BCCHP when the ride is scheduled.	You may pre-schedule a return ride if you know what time you will be done. If you pre-schedule your return ride, the driver should come within 30 minutes. If you do not have a pre-scheduled pick up time, call ModivCare at 1-877-831-3148 when you are done with your visit. The driver should come within an hour of the call.

Notes:

Illinois Medicaid and DHS member services number: **800-843-6154; best times to call Tues-Thurs @800a *when line opens***

Give an additional days notice when setting up services for the first time

All services will call day of when en route to pick up member

Exceptions for single caregivers and pregnant women are offered

The Oral Health Forum

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APPENDIX 1: ORAL HEALTH POLICIES AND GUIDELINES FROM NATIONAL ORGANIZATIONS AND SELECTED STATES

All resources include clickable links for direct access to each resource.

Oral Health Care During Pregnancy Expert Workgroup. 2012. *Oral Health Care During Pregnancy: A National Consensus Statement-Summary of an Expert Workgroup Meeting*. Washington, DC: National Maternal and Child Health Oral Health Resource Center.

American College of Obstetricians and Gynecologists. Committee Opinion 569. Oral Health Care during Pregnancy and Through the Lifespan. August 2013. Available at: www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Oral-Health-Care-During-Pregnancy-and-Through-the-Lifespan

American Academy of Pediatric Dentistry. 2014. Guideline on Caries-Risk Assessment and Management for Infants, Children, and Adolescents. *Reference Manual* 36(6):123-130. Available at: www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf

American Academy of Pediatric Dentistry. 2014. Guideline on Infant Oral Health Care. *Reference Manual* 36(6):137-141. Available at: www.aapd.org/media/Policies_Guidelines/G_InfantOralHealthCare.pdf

American Academy of Pediatric Dentistry. 2014. Policy on Early Childhood Caries (ECC): Classifications, Consequences, and Preventative Strategies 14. *Reference Manual* 36(6):50-52. Available at: www.aapd.org/media/Policies_Guidelines/P_ECCClassifications.pdf

American Academy of Pediatric Dentistry.2011. Guidelines on Perinatal Oral Health Care. Available at: www.aapd.org/media/Policies_Guidelines/G_PerinatalOralHealthCare.pdf

American Academy of Pediatric Dentistry. 2013. Guidelines on Periodicity of Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral treatment for Infants, Children, and Adolescents. Available at: www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf

American Academy of Pediatric Dentistry. 2012. Guidelines on Management of Dental Patients with Special Health Care Needs. Available at: www.aapd.org/media/Policies_Guidelines/G_SHCN.pdf.

American Academy of Pediatrics. 2013. Brushing Up on Oral Health. Never Too Early to Start. Available at: www.healthychildren.org/English/healthy-living/oral-health/Pages/Brushing-Up-on-Oral-Health-Never-Too-Early-to-Start.aspx

American Academy of Pediatrics. 2003. Policy statement: Oral Health Risk Assessment Timing and Establishment of a Dental Home. Available at: pediatrics.aappublications.org/content/111/5/1113.full.pdf

American Dental Association-Food and Drug Administration. 2012 Recommendations for Prescribing Dental Radiographs. Available at: www.fda.gov/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/MedicalX-Rays/ucm116504.htm

California Dental Association Foundation. Oral health during Pregnancy and Early Childhood: Evidenced-based Guidelines for Health Professionals. February 2010. Available at: www.cdafoundation.org/Portals/0/pdfs/poh_guidelines.pdf

Centers for Disease Control and Prevention. Children's Oral Health. Available at: www.cdc.gov/oralhealth/children_adults/child.htm

Centers for Disease Control and Prevention. Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers at a Glance. Available at: www.cdc.gov/NCCDPHP/publications/AAG/pdf/doh.pdf

Illinois Health Quality Partners (MHQP)-Perinatal Care Recommendations. 2014. Available at : http://www.mhqp.org/guidelines/perinatalPDF/MHQP%202014%20Perinatal%20Guidelines.pdf
Illinois Health Quality Partners (MHQP)-Perinatal Care Guidelines. 2016. Available at : http://www.mhqp.org/EmailLinks/MHQP%20Perinatal%20Preventative%20Care%20Guidelines%202016.pdf

National Maternal & Child Oral Health Resource Center. Oral Health Professionals Guide for Serving Young Children with Special Health Care Needs. Available at: www.mchoralhealth.org/SpecialCare/index.htm

New York State Department of Public Health. Oral Health Care during Pregnancy and Early Childhood.2006. Available at: www.health.ny.gov/publications/0824.pdf

South Carolina Oral Health Advisory Council and Coalition. Oral Health Care for Pregnant Women. Available at: www.scdhec.gov/library/cr-009437.pdf

APPENDIX 2: ORAL HEALTH CURRICULA AND TOOLS

All resources include clickable links for direct access to each resource.

American Academy of Pediatrics. Bright Futures Oral Health Resources: Promoting Oral Health Guidelines. Available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/8-Promoting_Oral_Health.pdf

American Academy of Pediatrics. Bright Smiles from Birth Training Video. Available at: illinoisaap.org/2010/08/bright-smiles-from-birth-training-video/

American Academy of Pediatrics. Section on Oral Health: Education and Training Materials. Available at: www2.aap.org/commpeds/dochs/oralhealth/EducationAndTraining.html.

American Academy of Pediatrics. Oral Health Risk Assessment Tool. Available at: www2.aap.org/oralhealth/riskassessmenttool.html

American Dental Association. CAMBRA Caries Risk Assessment Form for >6 years of age. Available at: www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx

National Maternal & Child Oral Health Resource Center. Bright Futures in Practice: Oral Health Pocket Guide. Pregnancy through adolescence plus Caries Risk Assessment Tools. Available at: www.mchoralhealth.org/pocket/index.html

Smiles for Life: A National Oral Health Curriculum. Available at : www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=555&pagekey=62948&cbreceipt=0

Smiles for Life: Child Oral Health Course 2. Available at: www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=557&pagekey=61354&cbreceipt=0

Smiles for Life: Oral Health and the Pregnant Patient Course 5. Available at: www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=560&pagekey=61366&cbreceipt=0

Smiles for Life: Caries Risk Assessment, Fluoride Varnish, and Counseling Course 6. Available at: www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbreceipt=0

Smiles for Life: The Oral Examination Course 7. Available at: www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=585&pagekey=64650&cbreceipt=0