



MASSACHUSETTS
DEPARTMENT OF
PUBLIC HEALTH



**MASSACHUSETTS
ORAL HEALTH PRACTICE
GUIDELINES
FOR
PREGNANCY AND
EARLY CHILDHOOD**

MARCH 2016



**INFORMATION FOR
PROVIDERS**

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ORAL HEALTH
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EXECUTIVE SUMMARY

In 2000, the Surgeon General's report, *Oral Health in America*, identified oral diseases as the "silent epidemic" affecting millions of children and adults in the United States.¹ Since then, evidence of the effects of poor oral health on systemic health, and social and economic well-being has accumulated. Universal access to affordable dental care has been a priority for the Massachusetts Title V Maternal and Child Health Program since 2010, which has led to several initiatives to improve oral health among pregnant women and young children.

In 2013, the Title V Program, in collaboration with the Office of Oral Health at the Massachusetts Department of Public Health (MDPH), convened a statewide summit to lay a foundation for the integration of dental care into routine prenatal care. The MDPH also endorsed efforts by Massachusetts Health Quality Partners to include oral health in its 2013 Perinatal Care Recommendations. An Oral Health Advisory Committee and work groups were subsequently convened by MDPH to develop oral health care practice guidelines for providers who care for pregnant women and young children.

Massachusetts data show that women are much less likely to obtain oral health care during pregnancy than before pregnancy.² The American Congress of Obstetricians and Gynecologists emphasizes that dental treatment is safe and desirable during pregnancy.³ Obstetrical healthcare providers can educate their patients, while coordinating and collaborating with oral healthcare providers to improve women's oral health. The section on prenatal oral health care highlights information on the way that normal and pathologic aspects of pregnancy may affect oral health and oral health care. Oral health practice guidelines for prenatal providers include instructions on how to assess oral health status, advise and educate patients, and recommendations for referral and collaboration with oral healthcare providers.

Similarly, specific recommendations for oral healthcare 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 in itself should not affect the type or quality of oral health care offered to pregnant patients. However, oral healthcare providers must be aware of medications which are acceptable for use during pregnancy (See Insert 1).

Improving women's oral health will also improve the health of their children by decreasing transmission of decay causing bacteria. Dental caries (cavities) is the most prevalent chronic condition among children. All healthcare providers can cooperate to reduce caries risk for their young patients. Oral health practice guidelines for pediatric healthcare providers include recommendations for assessment of oral health among children, including those with special health care needs. Appendices include risk assessment tools, information on fluoride use, prescribing guidelines, and a listing of Massachusetts communities that benefit from community water fluoridation. Community water fluoridation is the most cost effective preventive measure for tooth decay for all ages including pregnant women and it is the foundation for better oral health.⁴ Healthcare providers may advise and educate with respect to diet and oral hygiene, and make a referral to a dental home. A dental home may be the office of a general dentist who feels comfortable treating

This document builds on state and national efforts to educate healthcare providers across professions on oral healthcare for pregnant women and young children.

pregnant women and young children or a pediatric dentist who specializes in the treatment of children (pedodontist). All healthcare providers may benefit from reviewing the appendices that include a list of perinatal oral health guidelines and tools, and resources including information on MassHealth (Medicaid).

This document builds on state and national efforts to summarize information in order to educate healthcare providers across professions for the benefit of patients. The MDPH will publish this resource and maintain it as an electronic document online. The electronic version will be the most current.

INTRODUCTION

ORAL DISEASES: THE SILENT EPIDEMIC

Oral health is essential to promote general health and well-being. In 2000, the Surgeon General's report on oral health, *Oral Health in America*, identified oral diseases as the "silent epidemic" affecting millions of children and adults in the United States.¹ In its Healthy People 2020 health promotion and disease-prevention goals and objectives, the United States Department of Health and Human Services recognized the importance of oral health across the lifespan. Oral health is one of the 26 Healthy People 2020 Leading Health Indicators – *children, adolescents and adults who visited the dentist in the past year*. Additionally, Healthy People 2020 includes 33 other objectives related to oral health, improving oral health status, and increasing access to oral health prevention and treatment services.⁵

During pregnancy, physical and physiological changes occur that can adversely affect the mouth. Gingivitis is the most common oral condition of pregnancy.⁶ Left untreated, gingivitis may progress to periodontal disease which may destroy both soft and hard tissues.⁷ Other oral conditions commonly occurring during pregnancy include benign oral gingival lesions, tooth mobility, tooth erosion and dental caries (cavities).⁸ Pregnant women are 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. Other causes of dental caries during pregnancy include inadequate amounts of fluoride, high intake of sugary food or beverages, and a lack of oral health care.⁹ Pregnant women who have caries may transmit caries-causing bacteria to their infants.⁹ Additionally, oral health disorders have been found to be associated with a number of diseases affecting women across their lifespan, including cardiovascular disease, diabetes, Alzheimer's disease, respiratory infections, and osteoporosis of the oral cavity.³

Among children, dental caries is the number one chronic condition; it is five times more prevalent than asthma.³ According to the National Health and Nutrition Examination Survey, "approximately 37% of children aged 2-8 years had experienced dental caries in primary teeth in 2011-2012" and "21% of children aged 6-11 years had experienced dental caries in permanent teeth" during 2011-2012.¹⁰ 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.¹¹ Although a critical component of overall health, oral health care is the most common unmet health care need among children.¹² According to the National Center for Health Statistics, 4.3 million U.S. children aged 2-17 years had unmet dental needs in 2010 because their families could not afford dental care.¹³ Under the Affordable Care Act (ACA), pediatric dental coverage is considered an essential benefit; the health insurance marketplaces created under the ACA must offer choice and availability of oral health coverage for everyone.¹⁴

To effectively improve oral health among pregnant women and children, it is important to understand and address two contributing factors: health literacy and

Women are at risk for oral conditions during pregnancy and across the lifespan.

Dental caries is the number one chronic condition in children; oral health care is the most common unmet health care need in children.

Improving oral health care requires:

- » Addressing disparities
- » Increasing health literacy
- » Using special accommodations and strategies

oral health disparities by race, ethnicity and income. Often, those with low levels of health literacy are found among these same vulnerable populations.^{15,16}

Children with Special Health Care Needs (CSHCN) are a group for whom oral health care can present additional challenges. These children are defined as “...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”^{17,18} About 18.3% of Massachusetts children aged 0-17 years met this definition in 2009-2010.¹⁷ These children require special accommodations and strategies to successfully receive prevention and treatment services in community settings. To address these issues across diverse, vulnerable populations, it is important for providers to understand their populations, and provide culturally and linguistically appropriate care to meet their needs.¹⁸

STATUS OF ORAL HEALTH AMONG PREGNANT WOMEN AND CHILDREN IN MASSACHUSETTS

According to data collected by MDPH using the Pregnancy Risk Assessment Monitoring System, PRAMS, there is opportunity to improve the oral health of pregnant women in Massachusetts. For example, among Massachusetts women who delivered in 2011, about two-thirds reported having a dental cleaning during the 12 months before pregnancy, but only one-half reported cleanings during pregnancy.²

Among the Massachusetts women studied, disparities in the proportion who received dental cleanings during pregnancy were observed by age, race, ethnicity, and insurance status. Women aged 30-39 years old were more likely than younger women to have their teeth cleaned during pregnancy (Figure 1). Among different racial/ethnic groups, White women were the most likely to have their teeth cleaned during pregnancy; however, only 55.8% of these women had cleanings. For Asian and other women, about one-third had cleanings during pregnancy (Figure 2). Massachusetts women with private insurance were more likely to have their teeth cleaned during pregnancy (60.4%) than those with MassHealth (Medicaid) insurance (38.2%) (Figure 3).

Figure 1. Prevalence of Teeth Cleaning During Pregnancy by Age, PRAMS, 2011

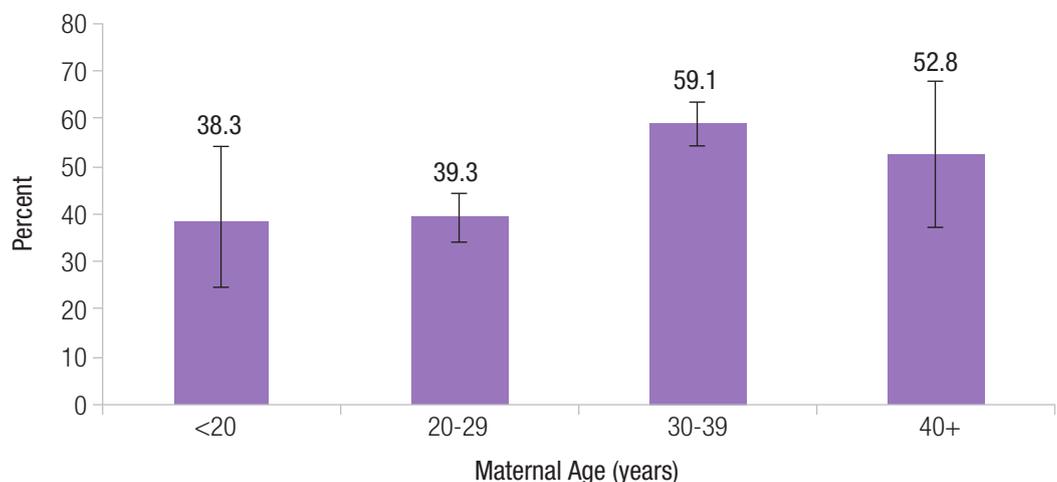


Figure 2. **Prevalence of Teeth Cleaning During Pregnancy by Race and Hispanic Ethnicity, PRAMS, 2011**

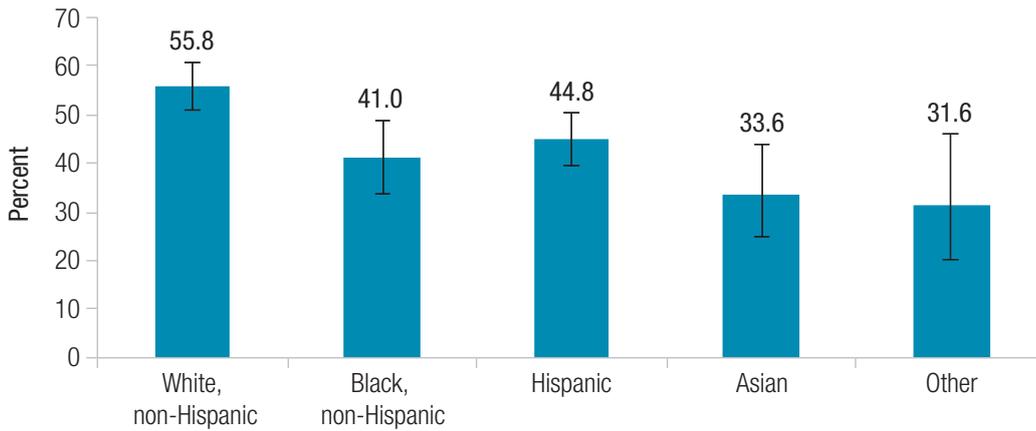
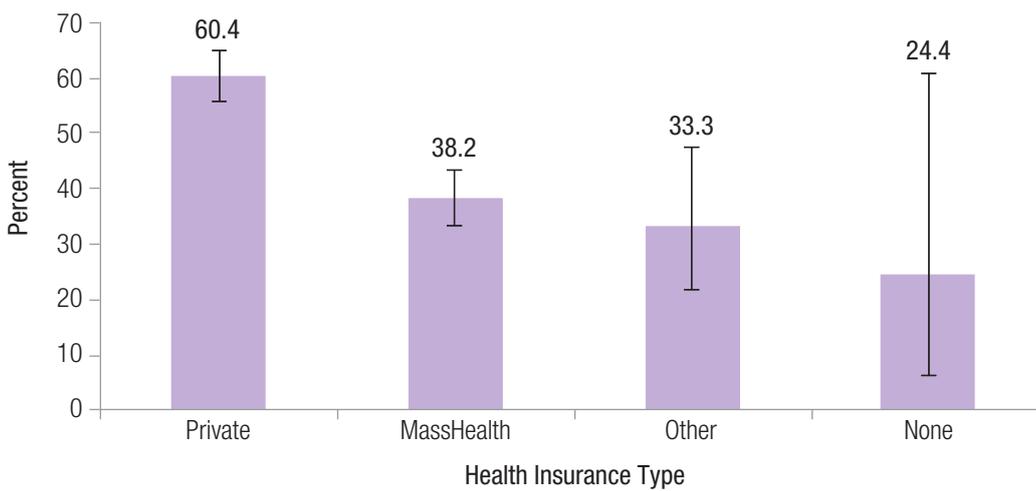


Figure 3. **Prevalence of Teeth Cleaning During Pregnancy by Insurance, PRAMS, 2011**



The oral health of Massachusetts children is better than that of children in other states, but there is opportunity for improvement. While Massachusetts ranked the second lowest in the country for the proportion of third grade students with dental caries, more than 40% of Massachusetts third graders had dental caries experience. Almost one-fifth of third grade students had untreated tooth decay.¹⁸ Additionally, there are significant oral health disparities among Massachusetts children. While 85% of White parents reported the conditions of their children’s teeth as excellent or very good, less than two-thirds of Black and Hispanic parents reported the same. Compared to children without special health care needs, Massachusetts CSHCN were found to be less likely to have teeth in excellent or very good condition (65%) than other children (73%).¹⁹

NATIONAL EFFORTS TO ADDRESS ORAL HEALTH AMONG PREGNANT WOMEN AND CHILDREN

Several national organizations have undertaken efforts to promote oral health among pregnant women and children. They developed statements, guidelines, educational materials, and tools to improve oral health. These 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).

In 2008, an expert panel convened by the U.S. Maternal and Child Health Bureau (MCHB) developed strategies for improving perinatal oral health. One strategy was to “promote the use of guidelines addressing oral health during the perinatal period and to disseminate guidelines to Maternal and Child Health and Oral Health professionals.” This led to the development of a national consensus statement in collaboration with ACOG and the ADA “Oral Health Care during Pregnancy: A National Consensus Statement,” as well as a Committee Opinion from ACOG “Oral Health Care During Pregnancy and Through the Life Span.” Several states including New York, California, South Carolina, and Washington developed statewide practice guidelines for perinatal oral health. The consensus statement and other policies and guidelines, including website links where available, are included in Appendix 1.

MASSACHUSETTS EFFORTS TO ADDRESS ORAL HEALTH FOR PREGNANT WOMEN AND CHILDREN

In 2010, the Massachusetts Title V program selected oral health as one of its priorities, specifically – “Coordinating preventive oral health measures and promoting universal access to affordable dental care.” The state’s performance measures include the “percentage of women with a recent live birth reporting that they had their teeth cleaned recently (during pregnancy and one year before or after).” Additionally, the Massachusetts Health Quality Partners, a broad-based coalition of physicians, hospitals, health plans, purchasers, patient and public representatives, academics, and government agencies working together to promote improvement in the quality of health care services, now includes oral health screening and treatment for pregnant women in its Perinatal Care Recommendations and Guidelines, which can be found at www.mhqp.org/guidelines/perinatalPDF/MHQP%202014%20Perinatal%20Guidelines.pdf and at www.mhqp.org/EmailLinks/MHQP%20Perinatal%20Preventative%20Care%20Guidelines%202016.pdf.

In order to identify opportunities for improvement in oral health care among pregnant women and children, in 2011, MDPH sent surveys to Massachusetts family medicine physicians, obstetricians-gynecologists (OB-GYNS), dentists, and dental hygienists, with a 15% response rate. The responses suggest opportunities for improvement. For example, family medicine physicians and OB-GYN respondents do not routinely refer their pregnant patients to oral healthcare professionals, and very few of these providers give their patients educational materials on oral health during pregnancy. Higher proportions of dentists and dental hygienists provide this information. The survey results also suggest that the knowledge of perinatal oral health and its relationship to diseases, such as cardiovascular disease and birth outcomes, is not consistent across providers. Subsequently, Massachusetts held an oral health summit and convened an advisory committee to develop practice guidelines for pediatric, prenatal and oral health providers for the oral health care of pregnant women and young children. A listing of the members of the Advisory Committee and its work groups is provided after the Table of Contents.

ROLE OF HEALTH CARE PROVIDERS IN IMPROVING ORAL HEALTH FOR PREGNANT WOMEN AND CHILDREN

Establishing and maintaining good oral health during pregnancy and early childhood offers both opportunities and challenges. It requires education, coordination and collaboration among pregnant women, children and their families, and their prenatal care, pediatric and oral health care providers. Prenatal and pediatric providers, including physicians, nurses and medical assistants, can perform oral health screenings; provide oral health information, including prevention and treatment; and refer to and collaborate with a number of different types of oral health providers.

Typically, prenatal and pediatric providers refer to a general or pediatric dentist where the patients would also be seen by dental hygienists or dental assistants. These dental practitioners might then make subsequent referrals to dental specialists, such as periodontists, prosthodontists, endodontists, orthodontists, and oral and maxillofacial surgeons. Dental providers may be found in a number of 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 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.





ORAL HEALTH PRACTICE GUIDELINES FOR PROVIDERS OF PREGNANT WOMEN

Despite the evidence that dental care during pregnancy, including prevention and treatment, is safe and important to overall health, many pregnant women do not receive oral health care. ACOG has issued a Committee Opinion to emphasize the importance and safety of dental treatment during pregnancy.³

The practice guidelines included in this section are consistent with guidance from professional organizations. The guidelines provide detailed information about the provision of dental care, including advice and education to pregnant women. In addition to these practice guidelines, there are a number of additional policies and guidelines provided in Appendix 1.

It is important for oral health providers who care for pregnant women to be aware of the effects of pregnancy on oral health and systemic health. It is necessary to 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 necessitating that the patient change position during dental treatment.

About 7% of pregnant women have hypertension during pregnancy, 5-8% have preeclampsia, less than 1% have eclampsia and 7% have gestational diabetes.²⁰⁻²² Medications/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. A listing of safe/not safe antibiotics, analgesics, and anesthetics can be found in Insert 1. Certain populations, such as teens and women older than 35 years of age, women with multiple pregnancies, and those with systemic disease, such as HIV and Hepatitis C, are at increased risk for pregnancy complications or adverse birth outcomes.

Oral health and prenatal providers should work together as needed to provide coordinated prevention and treatment services.

GUIDELINES FOR PRENATAL PROVIDERS

ASSESS ORAL HEALTH STATUS

- During the first prenatal visit, take an oral health history, including recent dental problems and dental care received. Sample questions for the oral health history include:
 - Do you have swollen or bleeding gums, a toothache, problems eating or chewing food, or other problems in your mouth?
 - When was your last dental appointment?
 - What was the purpose of your last dental appointment?
 - Do you need help finding a dentist?
- Provide a brief oral examination by checking teeth and gums. For training in proper oral examination, see Appendix 2 for links to the Smiles for Life Course 5 – Oral Health and the Pregnant Patient, and Course 7 – The Oral Examination training materials.
- Follow-up on any oral health problems, as needed, in subsequent prenatal and post-partum visits.
- Document in the prenatal care record any oral health issues identified; status of smoking, alcohol and marijuana use; and history of dental services received.

ADVISE AND EDUCATE

- Reassurance that fluoridation in community water is safe and effective.
- Counsel pregnant women about the following during prenatal visits:
 - Importance of oral health during pregnancy, including visits at least every 6 months.
 - Importance of adhering to the oral health providers' recommendations.
 - Reassurance that dental care throughout pregnancy, including x-rays, dental restorations/extractions, pain medication and local anesthesia, is safe.
 - Suggestions about ways to prevent tooth decay in pregnant women experiencing frequent nausea and vomiting:
 - » Eat small amounts of nutritious foods throughout the day. See Inserts 4 and 5 for a list of suggested foods.
 - » Use a teaspoon of baking soda (sodium bicarbonate) in a cup of water as a rinse after vomiting to neutralize acid.
 - » Do not brush for one hour after vomiting as stomach acid can weaken the enamel and cause hypersensitivity.
 - » Chew sugarless or xylitol-containing gum after eating, which prevents transmission of bacteria (*Strep mutans*) to their children reducing children's risk of tooth decay.²³
 - » Use gentle brushing with soft tooth brush and fluoride toothpaste to prevent damage to demineralized tooth surfaces.
- Include oral health in prenatal care classes offered to pregnant women.

Community water

fluoridation is the most cost effective preventive measure for tooth decay for all ages, including pregnant women, and it is the foundation for better oral health.

REFER AND COLLABORATE

- Refer women with identified oral health problems in the first or subsequent visits to oral health providers immediately.
- Develop referral procedures to oral health professional offices to facilitate timely appointments.
- Complete a referral form for the oral health providers. A sample form adapted from California Dental Society is the provided in Insert 2 (See Appendix 1 for a link to California Dental Association Foundation guidelines).
 - Include pertinent health information on the oral health referral form.
 - Include a list of medications that are safe to take during pregnancy. A list of medications that are safe to take as well as those to use with caution or avoid during pregnancy is provided in Insert 1.
- Encourage women who have not seen a dentist in the last 6 months to schedule an appointment with their regular dentist. For women who do not have a regular source of dental care (“dental home”), assist them in locating a dental home in their communities.
 - When assisting patients to locate a dental home, determine the women’s dental insurance coverage, and refer them to providers who participate in their dental plans and are comfortable caring for pregnant women.
- For women with MassHealth coverage, see Appendix 3 for a description of MassHealth coverage and contact information to help in finding MassHealth dental providers.

GUIDELINES FOR ORAL HEALTH PROVIDERS

ASSESS ORAL HEALTH STATUS

- For new pregnant patients, take a full medical history and risk assessment. For existing patients, update when first seen during pregnancy. Include the following:
 - Reason for visit, chief concern.
 - General health information, including: primary care provider's name and contact information, medications taken, the use of tobacco products, alcohol and drugs.
 - Prenatal information, including: due date, whether receiving prenatal care, name and contact information of prenatal care provider, and complications (high blood pressure, diabetes, morning sickness, severe or prolonged vomiting, bleeding disorders).
 - Social history, ideally including: socio-economic status, employment status, education, current access to social services, cultural status, literacy level, primary language, medical and dental insurance, home stability, members of household and history of family/personal violence.
 - Special needs, including: medical, psychological and physical needs.
- Take an oral health history:
 - Dental issues: acute and non-acute.
 - Professional dental care received in the past.
 - Home dental care practices.
 - Past or current caries.
 - Caries risk assessment. See a sample tool at www.ada.org/~media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx.
 - Diet: use and frequency of sugary foods and drinks.
 - Whether the woman lives in a fluoridated or non-fluoridated community and has a history of fluoride treatment. (See Appendix 4 for a list of fluoridated communities in Massachusetts.)
 - Other supplemental oral care tools such as calcium phosphate paste.
 - Woman's concerns/questions about oral care and treatment during pregnancy.
- Conduct examination:
 - Take blood pressure; immediately consult with prenatal providers for pregnant patients with high blood pressure (>140/90) to determine need for immediate referral or to continue dental care plan for the visit.
 - Perform a comprehensive oral examination; note pregnancy-specific oral issues. See Appendix 5 for example of oral conditions seen in pregnant women.
 - » Periodontal issues – pregnancy gingivitis, periodontitis exacerbation.
 - » Dental erosions – secondary to severe or prolonged vomiting, gastroesophageal reflux disease.
 - » Common pregnancy related oral conditions
 - › Pyogenic granuloma (pregnancy tumor)
 - › Tooth mobility (may be normal due to hormonal relaxation of connective tissue).
- Take radiographs, as needed, based on risk and evidence using ADA-FDA 2012 guidelines. (See Appendix 1 for a link to the guidelines.)
 - Dental radiography is safe and acceptable during all trimesters when clinically indicated to complete a thorough examination, diagnosis, and treatment plan.

ADVISE AND EDUCATE

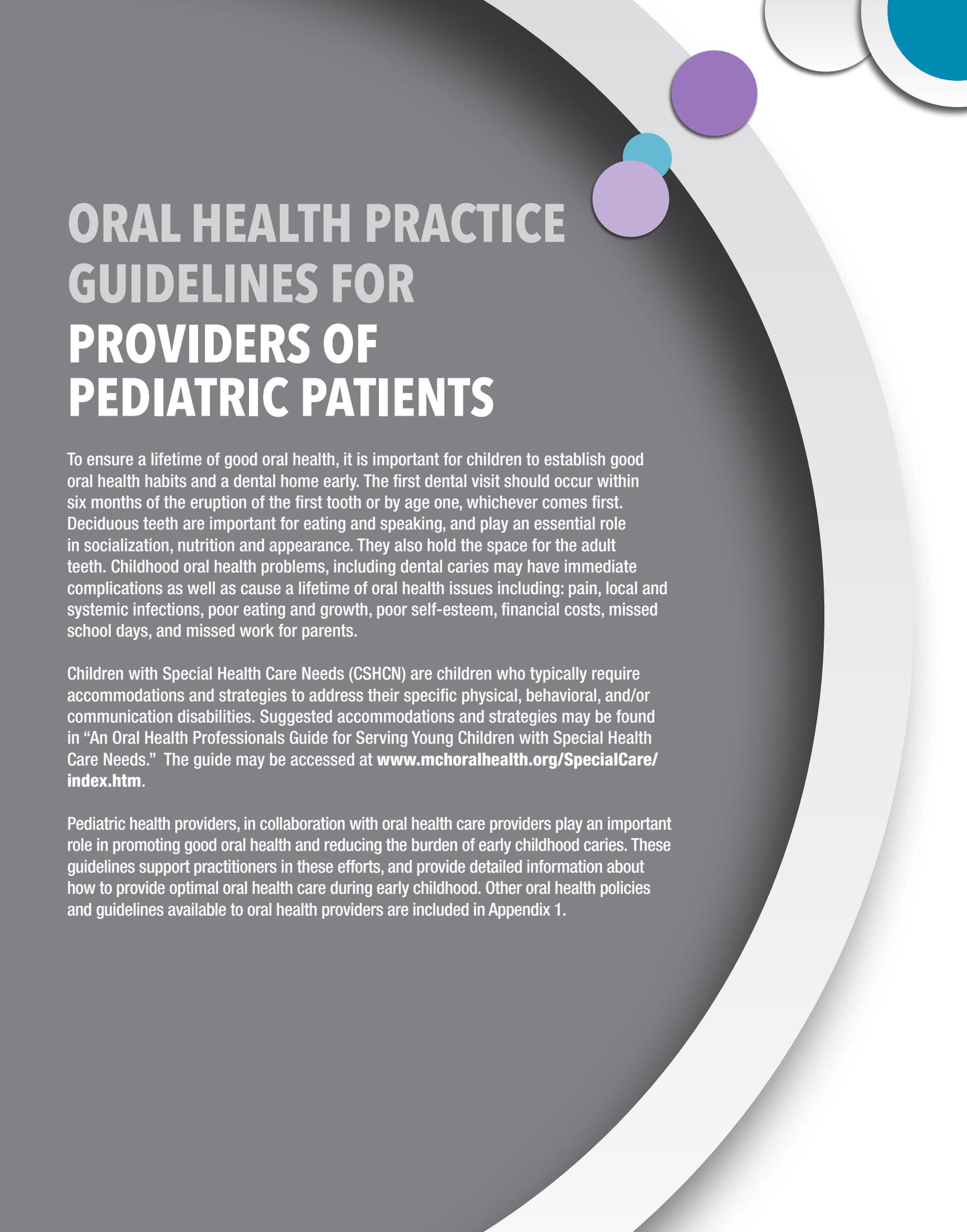
- Reassure women on the safety of dental care during pregnancy, community water fluoridation and restoration (both amalgam and composite) of untreated caries. Encourage women with caries to get treatment as soon as possible.
- Inform women of conditions that require immediate treatment, such as extractions and root canals.
- Reassure women that these treatments can be managed safely at any time during pregnancy, and that delaying treatment may result in more complex problems. (See Appendix 1 for references/links to *Oral Health Care During Pregnancy: A National Consensus Statement—Summary of an Expert Workgroup Meeting*; to the ACOG Committee opinion on oral health: *Oral Health Care During Pregnancy and Through The Lifespan*; and to other state guidelines – for example, California and New Jersey.)
- Provide information to your patients about common oral health conditions and changes during pregnancy (for example, pregnancy gingivitis) and how maternal oral health affects their child’s oral health (for example, the transmission of maternal caries bacteria to infants).
- Advise women to have a dental cleaning by an oral healthcare provider every six months or more often as required.
- Discuss oral hygiene, fluoride, diet and nutrition, and dental visits with your patients.
 - Advise women to 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).
 - Discuss fluoride, fluoride toothpaste, and fluoride rinses, and their safety during pregnancy when used properly; include the safety of community water fluoridation if applicable.
 - Provide nutrition advice including:
 - » Choosing healthy foods and snacks; limiting foods containing added sugar to avoid gaining excessive weight.
 - » Choosing water or low fat milk; limiting juice, sport drinks, and all carbonated beverages.
 - » If experiencing vomiting and nausea, eating small amounts of nutritious foods throughout the day. See Inserts 4 and 5 for lists of healthy snacks.
 - 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 one.
- Discuss other oral health topics/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 as stomach acid can cause loss of enamel and 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.²³
- Support prenatal health by encouraging the use of prenatal vitamins, attendance at prenatal visits, breastfeeding, etc.

PROVIDE TREATMENT AND MANAGEMENT

- Develop a comprehensive management plan during pregnancy and provide a dental home for patients.
 - Discuss treatment options with the patient; explain the safety of all procedures and medications during pregnancy. See Insert 1 for list of safe medications.
 - Discuss possible barriers for oral health care during pregnancy.
 - » General (transportation, financial, etc.).
 - » 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.
- Communicate with prenatal providers; this is advisable, but not required, for routine care.
- Provide comprehensive treatment to address caries.
 - Restoration, root canals, extractions as needed.
 - Avoid temporary material when possible (as it may be difficult for pregnant and postpartum women to return in the short term).
- Perform all necessary treatments for periodontitis for possible improved prenatal outcomes; read and follow antibiotic recommendations for pregnancy.
- Use practical tips that can help pregnant patients during visits:
 - All trimesters – keep 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.
 - Third trimester (28 weeks to birth) – place a pillow under right flank to position women slightly on the left side to maximize blood flow return through the vena cava.
- Ideally follow up with patients to check that they are carrying through with home care.
- Schedule follow up visits with patients.
- Documentation is important: consider modifying electronic system to track comprehensive oral health issues in pregnant patients.

COLLABORATION

- For patients without a medical home, help them make the connection to a provider.
- Consult with prenatal providers for high risk patients, such as those with gestational diabetes or pre-eclampsia; the need for general anesthesia; and complex medical conditions, as needed.
- Update prenatal health providers with pertinent management plans, especially for high risk patients, as needed.
- Collaborate with prenatal providers, e.g., give inter-professional rounds, do a meet-and-greet with local prenatal providers, as possible.



ORAL HEALTH PRACTICE GUIDELINES FOR PROVIDERS OF PEDIATRIC PATIENTS

To ensure a lifetime of good oral health, it is important for children to establish good oral health habits and a dental home early. The first dental visit should occur within six months of the eruption of the first tooth or by age one, whichever comes first. Deciduous teeth are important for eating and speaking, and 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.

Children with Special Health Care Needs (SHCN) 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 “An Oral Health Professionals Guide for Serving Young Children with Special Health Care Needs.” The guide may be accessed at www.mchoralhealth.org/SpecialCare/index.htm.

Pediatric health providers, in collaboration with oral health care providers play an important role in promoting good oral health and reducing the burden of early childhood caries. These guidelines support practitioners in these efforts, and provide detailed information about how to provide optimal oral health care during early childhood. Other oral health policies and guidelines available to oral health providers are included in Appendix 1.

GUIDELINES FOR PEDIATRIC PROVIDERS

The practice guidelines presented below pertain to young children. Families of children with special health care needs may require additional assistance in preparing their child for a dental visit, including communication prior to the appointment.

ASSESS 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, continual bottle or sippy cup use with fluids other than water, frequent snacking and special health care needs. The AAP has developed an oral health risk assessment tool in English and Spanish that may be useful to providers. The tool may be accessed at www2.aap.org/oralhealth/riskassessmenttool.html (it is also included in Appendix 2).
 - Determine if the child lives in a fluoridated or non-fluoridated community, and whether the child drinks the community water. This is important because living in a non-fluoridated community may increase the risk of dental caries. See Appendix 4 for a list of fluoridated communities in Massachusetts.
- Perform an oral examination to look for white spots or visible decalcifications, obvious decay, restorations (fillings), visible plaque accumulation and gingivitis (swollen/bleeding gums).
 - Smiles for Life course on performing an oral health examination may be accessed at www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=585&pagekey=64650&cbreceipt=0.
 - The AAP has instructions for performing an examination and fluoride varnish at <http://illinois.aap.org/2010/08/bright-smiles-from-birth-training-video/>.
 - Additional links are included in Appendix 2.

ADVISE AND EDUCATE

- Advise and educate parents/caregivers about the importance of eating healthy foods and avoiding sugary drinks:
 - Serve age-appropriate healthy foods during planned meals and snacks.
 - » Encourage fruits and vegetables, or other healthy snack options, such as grain products (for example, whole grain crackers) and dairy products (milk, cheese, cottage cheese, un-sweetened yogurt) for snacks.
 - » Avoid sugary and sticky foods, such as candy, sugared-based gum, cookies, cakes, fruit roll-ups, and raisins.
 - » Choose water and milk between meals, and drinks low in sugar should be limited to less than 4 ounces with meals.
- Advise and educate parents/caregivers about practicing good oral health care to prevent tooth decay for infants and children:
 - Do NOT put infants to sleep with a bottle, sippy or no-spill cup.
 - » At age 6 months or older, only use water in a bottle if something is needed.
 - » 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 four ounces of 100% juice daily.
- Wean infants from the bottle by about 12 months.
- Advise and educate parents/caregivers about the importance of practicing good oral hygiene:
 - Limit food and utensil sharing between caregivers and infants/children to reduce the transmission of tooth specific 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 their mouth.
 - Do not dip the pacifier in sweetened foods such as honey, syrup and sugar.
- For infants and toddlers from birth to 3 years:
 - Wipe gums with a clean, soft washcloth after each feeding to establish early good oral health habits.
 - Once the teeth erupt, brush teeth gently with a soft child size toothbrush 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.
 - Begin flossing when any two teeth touch.
 - Offer only water at bedtime after brushing.
 - Identify a dental home no later than 12 months of age, sooner if dental caries exist.
 - 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.
- For children from 3 to 6 years of age:
 - Always brush or help brush the child’s teeth with a pea-sized smear of fluoridated toothpaste in the morning and at night and help the child floss.
 - Teach the child to spit out – NOT swallow – the fluoridated toothpaste.
 - Schedule a dental appointment every 6 months for a cleaning/routine care (more often if indicated by 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.
- Advise parents on protective factors of oral health care, including establishing a dental home, consistent source of fluoride, low cariogenic diet and twice daily teeth brushing.
- Advise parents on age appropriate injury prevention counseling (e.g., mouth guards) for oral facial trauma.

PROVIDE FLUORIDE ADVICE AND/OR TREATMENT

- In addition to the advice on brushing provided above, evaluate the child’s sources and estimated levels of fluoride.
 - While fluoride provides protection against dental caries, ingestion of higher than recommended levels of fluoride is associated with increases in mild dental fluorosis in developing, un-erupted permanent teeth.
- Encourage caregivers to have their children avoid rinsing after using toothpaste at night, and spit only (to leave some protective fluoride on teeth overnight).
- 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.²⁴
- Several educational resources to assist pediatric providers in acquiring the supplies and skills to apply fluoride varnish in the office (for example, Smiles for Life), are provided in Appendix 2.
- MassHealth (Medicaid) currently reimburses medical providers to apply fluoride varnish up to the 21st birthday.
- Encourage the drinking of fluoridated water.
 - The optimal fluoride concentration in drinking water, as established by the U.S. Public Health Service, is 0.7 parts per million.²⁵ In 2012, the CDC reported that more than 70% of Massachusetts residents have access to fluoridated drinking water. For public water supplies, the fluoride level can be verified by local or state boards of health.
 - 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, provide oral fluoride supplementation, and encourage long-term daily use of the supplements.
 - Use the ADA approved dosage schedule below.
 - Tablets are preferable for children old enough to chew because they gain an additional topical benefit to the teeth through chewing.
 - Liquid supplements are recommended for younger children and should be added to water or put directly into the child’s mouth.
 - Addition of the fluoride supplement to milk or formula is not recommended because of the reduced absorption of fluoride in the presence of calcium.²⁶
 - Additional fluoride resources are provided in Appendix 4.

Recommended Fluoride Dosages for Children by Age Group			
Age	Fluoride Ion Level in Drinking Water (PPM)*		
	<0.3	0.3-0.6	>0.6
Birth-6 months	None	None	None
6 months-3 years	0.25 mg/day**	None	None
3-6 years	0.50 mg/day	0.25 mg/day**	None
6-16 years	1.0 mg/day	0.50 mg/day	None
*1.0 part per million (ppm) = 1 milligram per liter (mg/l)			
** 2.2 mg sodium fluoride contains 1 mg fluoride ion			

Source: Approved by the American Dental Association Council on Scientific Affairs²⁷

REFER AND COLLABORATE

- It is essential that pediatricians work with oral health professionals 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. See Appendix 1 for reference and link. A dental home should be identified within 6 months of the eruption of the first tooth and before the first birthday. For children who do not have a dental home, assist the family to locate one in their community.
- In assisting patients to locate a dental home, determine the child's type of dental coverage and refer her/him to a participating provider (e.g., MassHealth).
- Establish relationships with oral health professionals who see children in the community to facilitate referrals.
- Consult with oral health providers for high risk situations; including those with heart disease, complex medical conditions, and patients on multiple medications.
- Develop a formal referral processes with oral health professional offices to facilitate timely appointments.
- Complete a referral form for the oral health providers. A sample referral form may be found in Insert 3.
- Make referrals to other health professionals, such as nutritionists, as needed.
- Assist the families with applications for insurance or other sources of coverage, social and nutrition services, or other needs such as transportation and translation, to the extent possible.

GUIDELINES FOR ORAL HEALTH PROVIDERS

ASSESS ORAL HEALTH STATUS

- Take a full history and assess for risks.
 - Reason for visit, chief concern.
 - General health information including primary care provider's name and contact information, medications, including their sugar content and whether they cause xerostomia, and tobacco exposure (including second hand smoke and smokeless tobacco products).
 - Social history, ideally including: socio-economic status, parental employment status and education, current access to social services, cultural status, literacy level, primary language, medical and dental insurance, home stability, members of household, child's caretakers, presence of family/personal violence, substance use exposure, and child's school/day environment.
 - Take oral health history:
 - » Habits: digit sucking, pacifier use, bruxism.
 - » Issues to date, including current acute issues.
 - » Professional dental care and home care received to date.
 - » Perform a caries risk assessment. See www2.aap.org/oralhealth/riskassessmenttool.html for a sample tool.
 - » Past or current caries experience of siblings, parents and other household members.
 - » Diet: Use and frequency of sugary food and drinks, night time feeding of anything except water.
 - » Fluoride exposure, including fluoride varnish in other settings, systemic and topical fluoride and community water fluoridation. See Appendix 4 for a list of fluoridated communities in Massachusetts.
- Perform examination.
 - Knee-to-knee examination, as appropriate:



Photo courtesy of Dr. John Zdanowicz, DMD

- Assess growth and development, eruption sequence, hard and soft tissue (extra-oral and intra-oral) injuries, and signs of child abuse or neglect.

- Take radiographs as needed.
- Answer concerns/questions about treatments raised by the caregivers.

ADVISE AND EDUCATE

A child who is able to tie his/her own shoes has the dexterity to brush and floss effectively.

- Reassure parents about the importance and safety of oral health prevention and treatment in early childhood and throughout life.
- Remind parents of the importance of a medical home and refer when necessary.
- Discuss oral hygiene, water fluoridation, fluoride treatment, good diet and nutrition, and dental visits.
 - Oral hygiene considerations:
 - » Instruct the parent to lift the child’s lip to inspect the teeth and gums at the time that the child brushes.
 - » Brush teeth with fluoride toothpaste after breakfast and before going to sleep.
 - » Caregivers should brush child’s teeth until they are confident that child is brushing effectively (age 7-8) and not swallowing toothpaste.
 - » Recommend flossing when proximal tooth surfaces are in contact, only after parent has been trained to do so correctly (to avoid gingival trauma). Initially, the care provider should floss the child’s teeth. As the child matures, supervise flossing until the child masters the skill.
 - » Confirm availability of a soft toothbrush, fluoride toothpaste, and clean water.
 - Discuss fluoride:
 - » Discuss safety and benefits of community water fluoridation.
 - » Encourage drinking optimally fluoridated tap or bottled water.
 - » If access to fluoridated water is not possible, prescribe fluoride drops or tablets supplements for children in sub-optimally fluoridated communities.²⁷
 - » For infants less than 6 months of age who are not breastfed, discuss mixing powdered or concentrated infant formula with non-fluoridated water to decrease the possibility of a child developing questionable or very mild fluorosis.
 - › The ADA suggests that powdered formula continue to be reconstituted with optimally fluoridated drinking water, but for caregivers who are concerned with the potential for fluorosis, ready-to-feed formula or reconstituting formula using fluoride-free water can be suggested. Fluoride-free water is water that is labeled as “purified,” “demineralized,” “deionized,” “distilled,” or “produced through reverse-osmosis.”²⁸
 - » Supervise use of fluoride toothpaste on toothbrush, a smear from eruption of the first tooth to age 3 and a pea size amount until age 6.^{29,30}
 - » Discuss the application of fluoride varnish every three to six months.
 - › Varnish is the only professionally applied topical fluoride recommended for use on children from eruption of the first tooth to the age of six years. The following providers can apply varnish with the appropriate training:
 - Dentists
 - Dental Hygienists
 - Dental Assistants
 - Physicians
 - Physicians Assistants
 - Nurse Practitioners

- Registered Nurses
- Licensed Practical Nurses
- Medical Assistants
- › Fluoride varnish is recommended by the U.S. Preventive Services Task Force for children through the age of 5, and is a mandated service covered by insurance.
- › MassHealth (Medicaid) reimburses fluoride varnish services up to the 21st birthday. See Appendix 3 for MassHealth coverage.
- Nutrition:
 - » Support breastfeeding.
 - » Diet recommendations.
 - › Only breast milk or formula during the first 6 months.
 - › After 6 months, only fill bottles with breast milk, formula or water.
 - › Ideally a bottle should not be used for sleeping; if necessary, fill the bottle with water only.
 - › Recommend planned meal and snack times; avoid sugary snacks and drinks.
 - » American Academy of Pediatrics does not recommend any juice before age 1 and no more than 4-6 ounces after age 1. If juice is consumed, it should be from an open cup ideally as part of a meal.
- Dental visits:
 - » Establish a dental home with the first dental visit occurring within 6 months of the eruption of the first tooth or by age one, whichever occurs first. Continue regular preventive oral health visits as recommended by ADA and AAPD.
- Other oral health topics:
 - » Discourage saliva sharing behaviors between parent and child, such as sharing of spoons and cleaning pacifiers in the mouth.
 - » Discuss teething remedies such as cold teething rings and the use of acetaminophen/ibuprofen only as needed; discourage topical anesthetic products due to risk of toxicity.
 - » Discuss non-nutritive oral habits such as digit, pacifier or toy sucking, bruxism and abnormal tongue thrust; infants should be weaned from these habits before malocclusion occurs.
 - » Provide age-appropriate injury prevention counseling (e.g., mouth guards, childproofing home).

PROVIDE TREATMENT AND MANAGEMENT

- Develop a comprehensive management plan by providing a dental home for your patients.
 - Beginning 6 months after the eruption of first primary tooth or by age one, provide oral preventative care as recommended by caries risk assessment.
 - Assess the barriers for oral health care for young children.
 - » General, such as 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.
 - Comprehensive treatment of caries.

- » Restoration, extractions as needed.
 - › Amalgam and composite are both 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.
- Documentation of the above is important. Modify record keeping system to include all of the above.
- Make your office accessible to the physically impaired.

COLLABORATION

- For patients without a medical home, assist them in finding a medical home.
- For children who need fluoride prescription, coordinate the prescription with the pediatric provider.
- Consult with medical providers for high risk situations, including those with heart disease, complex medical conditions, and patients on multiple medications.
- Update child health providers with pertinent management plans especially for high risk patients, as needed.
- Communicate with pediatric health providers about available oral health services for children. Collaborate with community providers as possible. For example, by presenting at inter-professional rounds, or by giving a talk to a local medical office.

APPENDICES

APPENDIX 1

ORAL HEALTH POLICIES AND GUIDELINES

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

Massachusetts Health Quality Partners (MHQP)-Perinatal Care Recommendations. 2014. Available at: www.mhqp.org/guidelines/perinatalPDF/MHQP%202014%20Perinatal%20Guidelines.pdf

Massachusetts 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: <http://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

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: <http://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/commpepd/ochs/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

APPENDIX 3



MASSHEALTH DENTAL PROGRAM FACT SHEET

Enrollment

MassHealth 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 MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled).

ID Cards

MassHealth directly issues all ID cards to members. When ID cards are received by members demonstrating their eligibility they can use them immediately. Please note that the possession of a MassHealth ID card does not guarantee eligibility for services. You must continue to verify eligibility on the date of service via the MassHealth Provider web portal at www.masshealth-dental.net.

Replacement card requests and address changes can be reported to MassHealth via their customer service number at 1-800-841-2900.

Transportation (MassHealth)

Members may be eligible for transportation to a dental appointment for MassHealth covered services.

To determine if a member is eligible for transportation and access a provider request form contact the DentaQuest MassHealth Customer Service at 1-800-207-5019.

Transportation always requires approval by MassHealth directly prior via a provider request form (PT-1 form).

Providers may fax PT-1 forms to MassHealth Customer Service at either of the following fax numbers: 617-988-2925 or 617-988-2927

Preventive Service Coverage (October 2014)

Under 21 Benefits	
Service	Coverage
Cleaning (Prophylaxis) (Ages 14-20)	Two of (D1110) per 1 Calendar year(s) per patient.
Cleaning (Prophylaxis) (Ages 0-13)	Two of (D1120) per 1 Calendar year(s) per patient.
Topical application of flouride varnish (Ages 0-20)	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location.

Adult Regular Benefits	
Service	Coverage
Cleaning (Prophylaxis)	Two of (D1110) per 1 Calendar year(s) per patient.
Topical application of flouride varnish	One of (D1208) per 90 Day(s) per provider OR location. Only allowed for members 21 & older who have medical/dental conditions that significantly interrupt the flow of saliva.

MassHealth Board of Hearings

Members have 30 days after they receive a decision about their benefits to file an appeal with the Massachusetts Board of Hearings. Only members can submit appeals to the Board of Hearings.

A fair hearing request form can be found on the MassHealth web portal at **www.masshealth-dental.net** (general public, documents and member forms).

Complaints & Grievances

Members can submit complaints and grievances directly to the MassHealth team at DentaQuest via phone at 1-800-207-5019 or through mail at the below address.

DentaQuest
 MassHealth Dental Program
 Attn: Complaints and Grievances
 12121 North Corporate Parkway
 Mequon, WI 53092

Customer Service

Members can access the MassHealth customer service team at DentaQuest from 8am-6pm Monday-Friday to answer questions regarding benefits and claim inquiries. Our Member Intervention Specialist is also available for assistance finding a dental provider, plan information requests and to help resolve concerns. Customer Service and our Member Intervention Specialist can be reached at 1-800-207-5019.

In addition, members can access their member dental benefits booklet, member complaint form, request for fair hearing form, dental fact sheets and education pieces on the non-secure member side of the web portal at **www.masshealth-dental.net**.

Provider Network

Members must see a MassHealth participating dental provider in order to receive coverage for services.

To determine if a dentist is in the MassHealth Dental Program, visit the MassHealth web portal at **www.masshealth-dental.net**, and click the “Find a Provider” link.

APPENDIX 4

LIST OF MASSACHUSETTS FLUORIDATED CITIES/TOWNS AND RESOURCES

120 Fully Fluoridated and 18 Partially Fluoridated Communities (September 2015)			
0.7 PART FLUORIDE PER MILLION PARTS WATER (PPM) OR MG/L			
Fully Fluoridated			
ACTON	1970	HAVERHILL	1971
ACUSHNET	2007	HINGHAM	1953
AMHERST	1987	HOLDEN	1995
ANDOVER	1969	HOLLISTON	1970
ARLINGTON*	1978	HOLYOKE	1970
ASHBURNHAM	1958	HUDSON	1985
ATHOL	1952	HULL	1953
ATTLEBORO	1973	IPSWICH	1971
BEDFORD*	1978	LAWRENCE	1983
BELMONT*	1978	LEXINGTON*	1978
BEVERLY	1952	LINCOLN	1971
BILLERICA	1992	LONGMEADOW	1989
BOSTON*	1978	LOWELL	1982
BROOKLINE*	1978	LYNN	1983
BURLINGTON	1993	LYNNFIELD *	1959/1972
CAMBRIDGE *	1974	MALDEN*	1978
CANTON*	1978	MANCHESTER BY SEA	1983
CHELSEA*	1978	MANSFIELD	1997
COHASSET	1956	MARBLEHEAD*	1978
CONCORD	1970	MARLBOROUGH*	1982
DANVERS	1951	MEDFORD*	1978
DARTMOUTH	2007	MEDWAY	1953
DEDHAM*	1977	MELROSE*	1978
DRACUT	1982	MIDDLETON	1951
DUXBURY	1987	MILLIS	1988
ESSEX	1970	MILTON*	1978
EVERETT*	1978	NAHANT*	1978
FALL RIVER	1973	NATICK	1997
FITCHBURG	1975	NEEDHAM *	1971
FRAMINGHAM *	1970	NEW BEDFORD	2007
FRANKLIN	1970	NEWBURYPORT	1969
FREETOWN***	1978/2007	NEWTON *	1963
GARDNER	1987	NORTH ANDOVER	1975
GLOUCESTER	1981	NORTH ATTLEBORO	2002
GROVELAND	1995	NORTHBOROUGH*	2001
HAMILTON	1956	NORTH READING	1971

NORWOOD*	1978	SWANSEA	1969
OAK BLUFFS	1991	TAUNTON	1981
OXFORD	1987	TEMPLETON	1951
PEABODY*	1983	TEWKSBURY	1983
PEMBROKE	1969	TOPSFIELD	1953
QUINCY*	1978	TYNGSBOROUGH	1987
READING*	1970	WAKEFIELD*	1978
REVERE*	1978	WALPOLE	1977
ROCKPORT**	1984	WALTHAM*	1978
RUTLAND	1985	WATERTOWN *	1971
SALEM	1952	WAYLAND	2000
SAUGUS*	1978	WELLESLEY*	1987
SCITUATE	1954	WENHAM	1967
SEEKONK	1952	WESTBOROUGH	1974
SHARON	1953	WESTFORD	1994
SHREWSBURY	1953	WESTMINSTER	1968
SOMERSET	1969	WEST NEWBURY	1969
SOMERVILLE*	1978	WESTON*	1973
SOUTHBOROUGH*	1996	WESTWOOD*	1977
SOUTHBRIDGE	1971	WEYMOUTH	1972
STONEHAM*	1978	WINCHENDON	1958
STURBRIDGE	1990	WINCHESTER *	1956
SUDBURY	1960	WINTHROP*	1978
SWAMPSCOTT*	1978	WOBURN*	1978/2008
Partially Fluoridated			
AQUINNAH	1996	HARDWICK **	
BELCHERTOWN		MARSHFIELD	1987
BOURNE (OTIS ANG)	1960	NEWBURY	1969
BRIDGEWATER(MCI)	1989	NORFOLK	1977
CARLISLE		PELHAM	1987
CHARLTON **	1996	ROYALSTON (SRIC)**	
DIGHTON	1971	WESTPORT	1975
DOVER	1997	WILMINGTON	2009
DUDLEY **		WORCESTER	1995

Prepared by: Massachusetts Department of Public Health, Office of Oral Health. For additional information email Oral.Health@state.ma.us or go to www.mass.gov/dph/oralhealth.

*Members of the Massachusetts Water Resources Authority (MWRA) fluoridated in 1978 (old MDC).

**Naturally fluoridated at .7 or higher ppm.

***Public water system which began receiving fluoridated water in two different years.

Fluoride Resources:

American Dental Association:

www.ada.org/en/public-programs/%20advocating-for-the-public/fluoride-and-fluoridation/ada-fluoridation-resources

Campaign for Dental Health (alliance of health professionals and scientists):

www.ilikemyteeth.org

Centers of Disease Control and Prevention – available in multiple languages:

www.cdc.gov/fluoridation

APPENDIX 5

PYOGENIC GRANULOMA AND GINGIVITIS DURING PREGNANCY

FIGURE 1

Pregnancy oral tumor (pyogenic granuloma)



Photo courtesy of Drs. Douglass, Douglass and Silk, A Practical Guide to Infant Oral Health, American Family Physician, 2004 Dec 1;Vol 70(11):2113-2020

FIGURE 2

Gingivitis

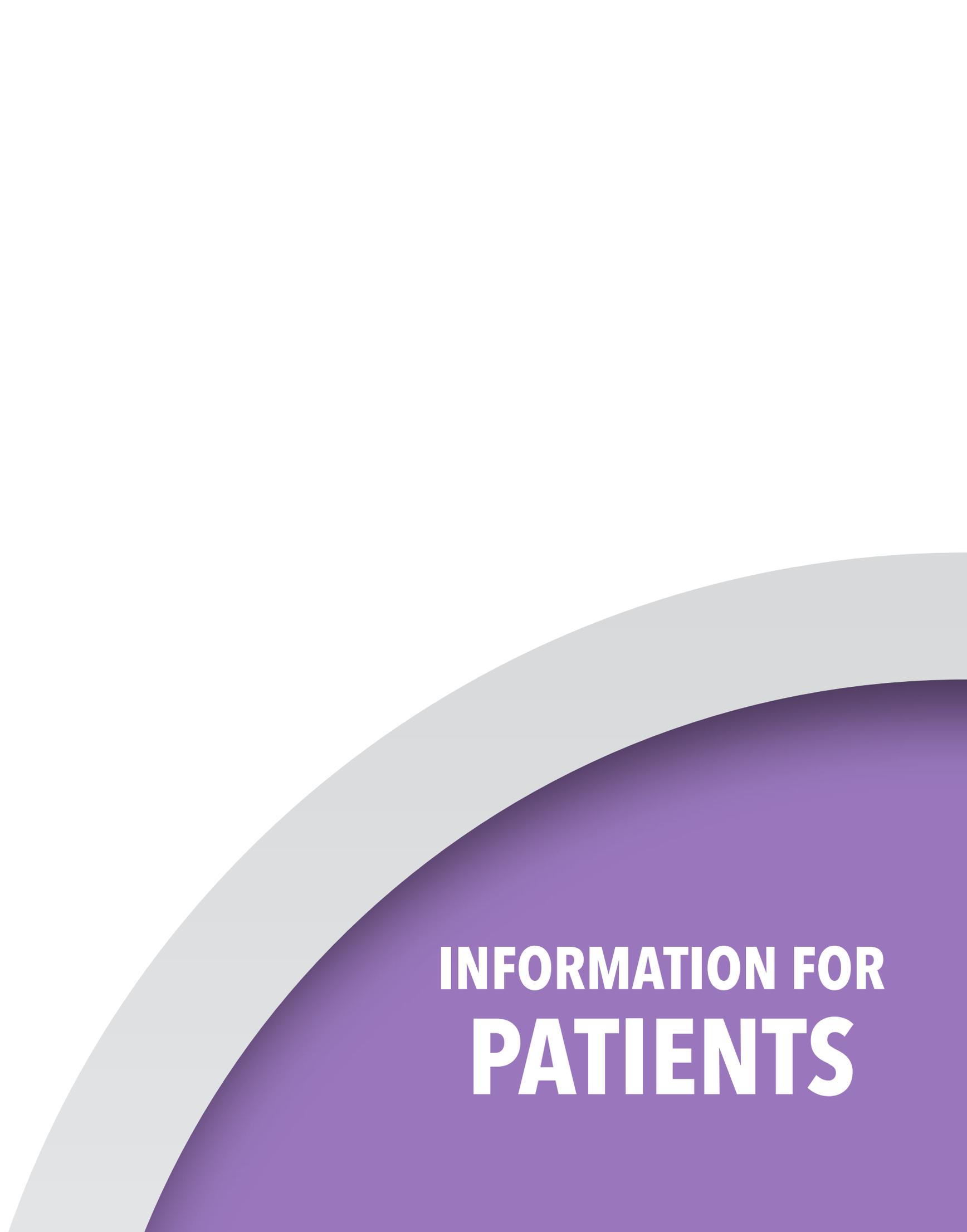


Photo courtesy of Dr. Joanna Douglass, DDS, BDS

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**INFORMATION FOR
PATIENTS**

Charles D. Baker
Governor

Karyn E. Polito
Lieutenant Governor

Marylou Sudders
Secretary, Executive Office of Health and Human Services

Monica Bharel, MD, MPH
Commissioner, Massachusetts Department of Public Health

Ron Benham
Director, Bureau of Family Health and Nutrition

Hafsatou Diop, MD, MPH
Director, Office of Data Translation

Medications		
Acceptable	Use Caution	Avoid
Antibiotics Amoxicillin Cephalosporins Clindamycin Metronidazole Penicillin	Antibiotics Sulfas (Avoid 1st and 3rd trimesters)	Antibiotics Ciprofloxacin Clarithromycin Levofloxacin Moxifloxacin Tetracycline
Analgesics Acetaminophen Codeine* Hydrocodone* Morphine* Oxycodone*	Analgesics Avoid 1st and 3rd trimesters. Limit use to 48 to 72 hours. Aspirin Ibuprofen Naproxen	
Anesthetics Local anesthetics with epinephrine (e.g., bupivacaine, lidocaine, mepivacaine)	Anesthetics Limit use. Ideally consult with prenatal care provider prior to use. Nitrous oxide – 30% Intravenous sedation General anesthesia	
*Use caution with opioids (including codeine, hydrocodone, morphine and oxycodone) in 3rd trimester due to risk for dependency by fetus.		

SAMPLE REFERRAL FORM FOR PREGNANT WOMEN TO ORAL HEALTH PROVIDERS

Referral Form for Pregnant Women to Recieve Oral Health Care

Referred To: _____ Date: _____

Patient Name (Last/First): _____

Date of Birth: _____ Estimated Delivery Date: _____ Week of Gestation Today: _____

Known Allergies: _____

Precautions: None Specify (if any): _____

Reason(s) for Referral: _____

This patient may have routine dental care, including but not limited to: oral health examination, prophylaxis, scaling and root planning, extraction, dental x-ray with abdominal and neck shield, local anesthesia with epinephrine, root canal and restorations (amalgam or composite).

The patient may have: (Check all that apply)

Acetaminophen with codeine for pain control

Alternative pain control medication: (Specify) _____

Penicillin

Amoxicillin

Clindamycin

Cephalosporins

Erythromycin (not estolate form)

Prenatal Care Provider: _____ Phone: _____

Signature: _____ Date: _____

DO NOT HESITATE TO CALL WITH QUESTIONS

Dentist's Report for the Prenatal Care Provider

Diagnosis: _____

Treatment Plan: _____

Name: _____ Date: _____ Phone: _____

Signature of Dentist: _____

INSERT 3:

SAMPLE REFERRAL FORM FOR CHILDREN TO ORAL HEALTH PROVIDERS

Referral Form for Children to Recieve Oral Health Care

Referred To: _____ Date: _____

Patient Name (Last/First): _____

Guradian's Name (Last/First): _____

Child's Date of Birth: _____

Known Allergies: _____

Reason(s) for Referral: _____

Special Considerations: _____

Pediatric Provider: _____ Phone: _____

Signature: _____ Date: _____

DO NOT HESITATE TO CALL WITH QUESTIONS

Dentist's Report for the Pediatric Provider

Diagnosis: _____

Treatment Plan: _____

Name: _____ Date: _____ Phone: _____

Signature of Dentist: _____

How much should you eat each day when you're pregnant? Here are some guidelines:



Grains

Eat 6 ounces per day in the first trimester, 7 ounces in the second trimester and 8 ounces in the third trimester. Make half of your grains each day whole grains.

1 ounce of grains is equal to:

- 1 slice bread
- 1 cup ready-to-eat cereal
- ½ cup cooked rice, pasta or cereal
- 1 small pancake (4 ½ inches in diameter)
- 1 small tortilla (6 inches in diameter)



Vegetables

Eat 2 ½ cups per day in the first trimester and 3 cups per day in the second and third trimesters.

1 cup of vegetables is equal to:

- 1 cup raw or cooked vegetables
- 1 cup vegetable juice
- 2 cups raw, leafy greens
- 1 medium baked potato



Fruits

Eat 1 ½ to 2 cups per day in the first trimester and 2 cups per day in the second and third trimesters.

½ cup of fruit is equal to:

- ½ cup 100% fruit juice
- ½ cup fresh, frozen or canned fruit
- ½ a fruit (small orange, apple or banana)
- 16 grapes



Dairy Products

Eat 3 cups per day all throughout pregnancy. Low-fat or skim is best.

1 cup of milk product is equal to:

- 1 cup milk
- 1 cup yogurt
- 2 small slices of cheese
- ½ cup shredded cheese



Proteins

Eat 5 ounces per day in the first trimester, 6 ounces in the second trimester and 6 ½ in the third trimester.

1 ounce of protein is equal to:

- 1 tablespoon peanut butter
- ¼ cup cooked beans or tofu
- 1 ounce lean meat, poultry or fish
- 1 egg
- ½ ounce nuts (12 almonds or 24 pistachios)

Knowing how big each of these serving sizes is can be tricky. Here are some everyday items that can help:

1 CUP is about the size of a baseball.



1/3 CUP is about as much as you can fit in your hand (a rounded or full handful).



1/2 CUP is about the size of 1/2 a baseball.



1/4 CUP is about the size of a golf ball.



1 TABLESPOON is about the size of 1/2 a ping-pong ball.



1 OUNCE of meat (chicken, pork, beef, fish, etc.) is about the size of two thumbs.



3 OUNCES of meat is about the size of a deck of cards or the palm of your hand.



A SMALL FRUIT (orange or apple) is about the size of a tennis ball.



It's important to eat healthy foods during pregnancy, and in the right amounts. Here are some tips:

How many calories do you need per day when you're pregnant?

Most pregnant women only need about 300 extra calories per day. The exact amount depends on your weight before pregnancy. If you're underweight before pregnancy, you may need more calories. If you're overweight before pregnancy, you may need less. Talk to your health care provider about what's right for you.

Is it OK to eat fish when you're pregnant?

Yes, as long as you eat the right kinds! Most fish are low in fat and high in protein and other nutrients your body needs.

Why are some fish not safe for pregnant women to eat?

Some fish contain mercury, a metal that can harm your baby's health. Fish get mercury from water they swim in and from eating other fish that have mercury in them. If you eat fish that have a lot of mercury in them, you can pass the metal to your baby during pregnancy.

If you're pregnant, thinking about getting pregnant or breastfeeding, you can eat 8 to 12 ounces each week of fish that are low in mercury. These include:

- Shrimp
- Salmon
- Pollock
- Catfish
- Canned light tuna
- Albacore (white) tuna – Don't have more than 6 ounces of this type of tuna in 1 week.

How can you make sure you're making healthy meals?

Use these tips when planning your meals:

- Eat foods from the five food groups at every meal.
- Choose whole-grain bread and pasta, low-fat or skim milk and lean meat, like chicken, fish and pork.
- Try to make half of your plate fruits and vegetables. Put as much color on your plate as you can.
- Try eating four to six smaller meals a day instead of three bigger ones. This can help relieve heartburn and discomfort you may feel as your baby gets bigger.
- Make sure your whole meal fits on one plate. Don't make huge portions.
- Drink six to eight glasses of water every day.
- Take a prenatal vitamin each day. This is a multivitamin made just for pregnant women.

Foods to avoid:

- Unpasteurized milk or juice
- Soft cheeses like feta and Brie
- Unheated deli meats and hot dogs
- Refrigerated, smoked seafood
- Undercooked poultry, meat or seafood

