



Topical Fluoride Recommendations for High-Risk Children *Development of Decision Support Matrix*

Recommendations from MCHB Expert Panel

October 22–23, 2007

Altarum Institute

Washington, DC

Background

While there has been a decline in the prevalence and severity of dental caries (tooth decay) in the U.S. population overall, dental caries continues to be the most common chronic childhood disease—five times more common than asthma in children ages 5–17 years.¹ Among young children, the prevalence of early childhood caries (ECC) has increased. Recent national survey data show that among all 2- to 5-year-old U.S. children, 28 percent exhibited evidence of dental caries (tooth decay), an increase from 24 percent 10 years earlier.² Despite increased prevalence rates, dental caries is largely preventable.

The use of fluoride administered both systemically and topically has been shown to be effective in preventing and controlling dental caries. Community water fluoridation is considered an important factor in the reduction of dental caries and contributes to reduced caries experience among children who live in optimally fluoridated communities.^{3,4} Although community water fluoridation is considered the foundation for sound dental caries prevention programs, there are populations of children that experience higher rates of dental caries. Research shows that 33 percent of children experience 75 percent of the dental caries burden.⁵ The highest disease burden is among low-income children and children from racial- and ethnic-minority groups, in particular American Indian/Alaska Native (AI/AN), African-American, and Latino.^{6,7,8,9} In fact, AI/AN children experience the highest dental caries rates, with 68 percent of AI/AN preschool children having decay in their primary teeth.¹⁰

Children most affected by oral health disparities could benefit from additional fluoride exposure beyond water fluoridation. A growing body of evidence supports the benefit of frequent exposure to topical fluorides and concentrated forms of topical fluoride (e.g., fluoride varnish).^{11,12} Although the use of fluoride in dental caries prevention is considered safe and effective, there are questions among health professionals and programs working with young high-risk children as to the recommended use of topical fluoride, weighing the caries-preventive benefits of fluoride with the potential risk of fluorosis.

In an effort to address these questions, the Maternal and Child Health Bureau (MCHB) convened an expert panel on October 22–23 2007, to develop a decision support matrix (Appendix A) on topical fluoride use for high-risk children. This report presents a summary of the process undertaken to develop the matrix and the expert panel's recommendations.

Expert Panel

This meeting is one of a series of meetings convened by MCHB over the past several years to address cutting-edge maternal and child oral health issues. Members of the expert panel were identified by MCHB as national experts and leaders in the areas of fluoridation, pediatric dentistry, nutrition, pediatric medicine, dental public health, primary care, oral health education, and health promotion. Additionally, these individuals brought extensive experience conducting research and working with low-income and high-risk populations, including Medicaid enrollees, migrant and seasonal farmworkers, children with special health care needs (CSHCN), and AI/ANs in a range of clinical, community, and academic settings (participant list in Appendix B).

The expert panel was tasked with:

- Reviewing the current knowledge base and professional dental guidelines regarding topical fluoride use with high-risk children
- Reviewing the concept of risk and defining high-risk children
- Identifying risk factors and settings using fluoride interventions with high-risk children
- Developing a decision support matrix to assist nondental health professionals in designing appropriate fluoride interventions for high-risk children

Members of the expert panel participated in facilitated discussions during the 2-day meeting to reach consensus on several key areas for the purpose of informing the content of the decision support matrix (agenda in Appendix C). Discussions addressed the definition of high risk, which children meet this definition, and what fluoride modalities are appropriate by age. The underlying assumption that guided discussions was that recommendations would focus on those children considered to be at high risk, with the goal of providing substantial dental caries prevention while minimizing risk of dental fluorosis. More specifically, these discussions were guided by the following questions, presented below and presented throughout the report as “guiding questions”:

- Who is the target audience for these recommendations?
- What are the informational needs of programs, such as Head Start and WIC programs that should be considered in developing our recommendations?
- Do we support population-based risk assessment for children in group settings?
- What groups of children should be considered high risk?
- How many categories of risk should we consider?
- Is it important to leave a “moderate-risk” category?
- How do we balance caries prevention with the risk of fluorosis for high-risk children?
- What are the areas of agreement among the existing professional guidelines?
- How do we stratify these guidelines by age group?

Prior to the meeting, the panel was provided with a draft decision support matrix and a background paper prepared specifically for this meeting, which provided a summary of the current knowledge base on topical fluoride and professional guidelines. In addition to a summary of the current knowledge base, the background paper also presented preliminary recommendations. It should be noted that the expert panel did not conduct a comprehensive and systematic review of available scientific evidence and instead based its recommendations on existing evidence-based clinical and expert guidelines.

The expert panel did acknowledge the challenge of translating existing guidelines into a document that can provide clear guidance for a primarily nondental audience. The panel also acknowledged that there is no one-size-fits-all approach and that while this document is intended to provide guidance, programs must balance these recommendations with specific professional guidance provided by dental partners and practitioners.

Development of Decision Support Matrix

There is greater interest in using fluoride interventions as programs and practitioners increasingly focus on prevention and the evidence for the efficacy of fluoride strengthens. As programs expand their use of fluoride, questions have arisen about the recommended usage with young children in nondental settings. In response to questions from the field, MCHB identified a need for a straightforward document that could provide guidance and elected to develop a decision support matrix that could inform programs when making decisions about a range of fluoride modalities.

The expert panel set out to develop a simplified decisionmaking tool for use in group settings that is straightforward, believing that the ease of use would facilitate oral health interventions. As such, the target audience for the decision support matrix—programs, health professionals, and paraprofessionals working with high-risk populations—was an important consideration during the 2-day meeting. The expert panel concluded that an ideal prevention model targeting high-risk children would include population-based fluoride interventions combined with individual risk assessments conducted during dental and medical appointments.

Intended Audiences and Their Role in Prevention

Guiding Questions

- *Who is the target audience for these recommendations?*
- *What are the informational needs of programs such as Head Start and WIC that should be considered in developing our recommendations?*

This matrix was developed primarily for a nondental audience—programs, paraprofessionals, and professionals without formal dental education working in public health settings (e.g., childcare centers, Head Start programs, WIC programs, primary care and pediatric clinics)—but can also be beneficial to parents. The expert panel assessed that, unlike dental professionals with the knowledge and expertise to determine appropriate use of topical fluoride based on training and existing clinically-based risk assessment tools, nondental professionals could benefit from additional guidance specific to topical fluoride that could be applied

in group settings. Increased attention on the disease burden of ECC has engaged health professionals and programs working with young high-risk children to expand oral health promotion and disease prevention efforts. The expert panel recognized the important role of these individuals in primary and secondary prevention among higher-risk populations because of their ability to reach these children at younger ages. While these individuals can play an important role in dental caries prevention, they may be reluctant to incorporate fluoride in their preventive efforts because of their concerns about fluorosis. Dental fluorosis, a discoloration of the teeth, caused when children receive excessive fluoride intake during the formation of tooth enamel, is regarded by most researchers as cosmetic in nature.¹³ The expert panel concluded that higher-risk children could benefit from an aggressive preventive approach because their risk of developing ECC outweighs their risk of mostly mild fluorosis. The guiding principle is that preventive efforts should be maximized for those at greatest risk.

The decision support matrix is intended for use by individuals working with groups of high-risk children to support the implementation of a fluoride intervention (e.g., tooth-brushing routine using fluoride toothpaste, fluoride varnish program) that is complemented by other important oral health promotion and disease prevention activities, including conducting education, providing anticipatory guidance, making dental referrals, and promoting the establishment of the dental home by the age of 1.

It is considered appropriate for programs to consult with local dental providers in the development of an oral health program using topical fluoride; to adapt these recommendations based on this consultation and individual risk assessment information; or to be in accordance with program and State guidelines.

Conceptualizing Risk Assessment

Guiding Questions

- *Do we support population-based risk assessment for children in group settings?*
- *What groups of children should be considered high risk?*

Considering the expert panel was convened to specifically address guidelines for high-risk children, participants spent a significant amount of time discussing the concept of risk and how best to categorize and assess dental caries risk relative to young children. The panel discussed a range of individual risk criteria as well as individual risk assessment tools developed by professional medical and dental organizations, primarily for use by clinicians. These tools were described as beneficial, but most panel members felt that additional work was necessary to expand the utility of such tools

to broader settings. And while an individual risk assessment was recommended, members of the panel did identify some limitations of relying solely on such a process:

- Existing risk assessment instruments and models may be too complex for a nondental audience.
- In some settings, it may not be practical or cost-effective to conduct individual risk assessments.
- In some settings, individual risk assessments may be less useful when all or most of children served can be categorized as high risk.

Although studies have indicated that a successful dental caries risk assessment approach should consider a range of factors—social, behavioral, microbiologic, environmental, and clinical—the expert panel concluded that there is a need for a population-based approach to risk assessment although this approach is not well-defined in the literature. The expert panel considered various criteria, including access to dental care, income, special health care needs, and fluoride exposures, that could be considered when assessing a child’s risk status. They also drew from research, which has cited prior dental caries experience, parental education, and socioeconomic status as the best predictors of decay in primary teeth.¹⁴ Of these, members of the panel agreed that low socioeconomic status, and specifically income, can be applied most easily to group settings, such as Head Start and WIC programs where eligibility is largely income-based (e.g., family income relative to the Federal poverty income guidelines). Several participants noted that additional definitive studies with very young high-risk children are needed.

During the discussion session, the expert panel considered populations of children that experience higher levels of disease. Beyond low income status, the expert panel debated the inclusion of other groups including the category of CSHCN. MCHB defines CSHCN as children and adolescents:

...who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally.¹⁵

While the expert panel recognized that the MCHB definition of CSHCN is broad and encompasses a group of children with a range of diagnoses and functional abilities, there was agreement that specific conditions can significantly compromise oral health and increase the likelihood of developing oral disease. For example, a fact sheet produced by the National Maternal and Child Oral Health Resource Center identified the following conditions that increase risk:

- Children and adolescents with compromised immunity or certain cardiac conditions may be especially vulnerable to the effects of oral diseases.
- Children and adolescents with mental, developmental, or physical impairments who do not have the ability to understand and assume responsibility for or cooperate with preventive oral health practices may be vulnerable as well.
- Malocclusion and crowding of the teeth occur frequently in children with atypical development. Over 80 craniofacial syndromes exist that can affect oral development.
- Medications, special diets, and oral motor habits can cause oral health problems for many children and adolescents with special health care needs (e.g., tooth decay—promoting the effect of medicines with high sugar content, excessive tooth grinding with self-stimulating behaviors.)¹⁶

Even though the group of CSHCN is more difficult to define and not all children who meet the MCHB definition are at increased risk of developing dental caries, the expert panel agreed that enough children are more vulnerable to the effects of oral disease, that CSHCN could benefit from fluoride interventions and should be included in the high-risk category.

Guiding Questions

- *How many categories of risk should we consider?*
- *Is it important to leave a “moderate-risk” category?*

In defining the category of high-risk children, the group questioned whether the high-risk category was in the context of a two-tier system or a three-tier system. It was mentioned that most risk assessment models are based on a tiered system that include either two or three risk categories. For example, both the American Academy of Pediatric Dentistry (AAPD) and the American Dental Association (ADA) have developed three-tiered risk categories (low risk, moderate risk, high risk) specific to children.^{17,18} Considering the target audience for the decision support matrix, some members of the expert panel felt that a three-tiered system is overly confusing

and lacking consistent epidemiological findings to support the implementation of such a system. The panel also believed that it was unclear what would constitute moderate risk on a population-based level and ultimately decided to adopt a more liberal two-tiered model (high risk and low risk) and focus this guidance on the high-risk group.

Translating Professional Dental Guidelines into Recommendations

Guiding Questions

- *How do we balance caries prevention with the risk of fluorosis for high-risk children?*
- *What are the areas of agreement among the existing professional guidelines?*
- *How do we stratify these guidelines by age group?*

The expert panel was provided with a draft of the decision support matrix and a background paper prepared for this meeting by Jim Crall, Director of the National Oral Health Policy Center. This background paper provided a summary of professional guidelines issued by the Centers for Disease Control and Prevention (CDC),¹⁹ the AAPD,^{20,21} and the ADA.^{22,23} In addition to a summary of the current knowledge base, the background paper presented preliminary recommendations. During the meeting, members of the expert panel were led through a review and discussion of guidelines specific to each fluoride modality in the

context of high-risk children until consensus was reached. Lastly, although dietary fluoride supplements can have a topical effect, the expert panel chose not to address fluoride supplements in the matrix.

While addressing each modality, there was discussion about the age range of children that would be covered by the recommendations. Because of the focus on prevention and early intervention, the panel felt strongly about including recommendations targeting early childhood through school age, approximately age 6. There was some debate about whether this age group was too broad and should be broken down further. Throughout the discussion, most agreed that recommendations would differ by age and should distinguish very young children from other young children. The group debated whether to stratify recommendations at age 2 or 3 and felt that there was no strong evidence supporting either age as the most appropriate. Upon reflecting on other recommendations for children, the expert panel decided to be consistent with organizations, such as CDC, and develop recommendations for two groups—children under 2 years and children aged 2–6 years.

Drinking Water. Although the decision support matrix does focus on topical fluoride, members of the expert panel considered it very important to note that community water fluoridation is a part of a comprehensive population-based strategy to prevent or control dental caries in communities.²⁴

Fluoride Toothpaste. Panel members were definitive in their recommendation that all high-risk children use fluoride toothpaste and felt that the professional community has communicated inconsistent recommendations. The panel felt that it was important to communicate that high-risk children would benefit from brushing twice daily. Panel members recommended a “smear” of toothpaste for children under 2 years and a “pea-size” amount of toothpaste for children 2–6 years and suggested that photographs would be helpful in differentiating these amounts. Members spent a considerable amount of time crafting the language in this recommendation and felt that it was important to include these statements:

- Children should spit out excess toothpaste.
- Children should not rinse after brushing.

The panel chose to emphasize the role of adults, particularly parents, in supervising or assisting children with tooth brushing and encouraged programs to provide parents and caregivers with education on proper toothpaste use.

Fluoride Varnish. The panel quickly agreed that fluoride varnish should be recommended for high-risk children but debated the issue of frequency. There was discussion about existing periodicity schedules and guidelines, including the ADA recommendation that fluoride varnish be applied at 3- to 6-month intervals for higher-risk children. The consensus among panel members was that fluoride varnish should be applied at least every 6 months, but some members preferred to specify at 3- to 4-month intervals. After some debate, the group decided to adopt the ADA recommendation that fluoride varnish be applied every 3–6 months.

Mouth Rinses, Gel, or Foam. The group reached quick consensus that rinses, gels, or foams not be recommended for children under 6 years, because the ability to control the swallowing reflex is not fully developed in preschool-aged children, increasing the likelihood that children younger than 6 years of age can inadvertently ingest excess fluoride.²⁵

Conclusion And Next Steps

MCHB plans to develop a dissemination strategy to share the decision support matrix effectively with programs and practitioners and other important target audiences. The panel discussed several next steps, which included sharing the decision support matrix with association members from organizations such as the American Academy of Pediatrics, the ADA, the AAPD, and the Association of State and Territorial Dental Directors, by including a description of the matrix in association newsletters, presenting at professional conferences, and/or submitting articles to relevant peer-reviewed journals. There was also discussion about soliciting feedback on the matrix from relevant professional dental and medical organizations and possibly pursuing formal endorsements from these organizations.



Appendix A: Decision Support Matrix
Topical Fluoride Recommendations

Topical Fluoride Recommendations For High-Risk Children Under Age 6 Years

Decision Support Matrix

Population-Based Risk Factors

- Low-income children (e.g., enrolled in Head Start, WIC, free/reduced lunch program, Medicaid or SCHIP eligible, or other programs serving low-income children)
- Children with special health care needs

Fluoride Modality

Age

Children Under 2 Years

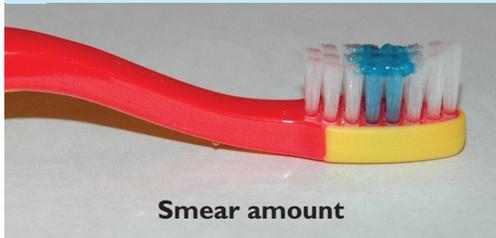
Children 2-6 Years

Toothpaste

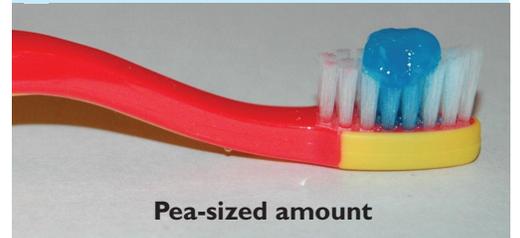


- Encourage parents and caregivers to take an active role in brushing their children's teeth once the first tooth erupts
- Educate parents and caregivers on proper fluoride toothpaste use
- Brush children's teeth with fluoride toothpaste twice daily
- Use a smear of fluoride toothpaste

- Encourage parents and caregivers to take an active role in brushing their children's teeth
- Educate parents and caregivers on proper fluoride toothpaste use
- Brush children's teeth with fluoride toothpaste, or assist children with toothbrushing, twice a day
- Use no more than a pea-sized amount of fluoride toothpaste



Smear amount



Pea-sized amount

- Do not rinse after brushing

- Children should spit out excess toothpaste
- Do not rinse after brushing

Varnish

- Apply every 3-6 months

- Apply every 3-6 months

Mouth rinses, gel, or foam

- Not recommended

- Not recommended

Introduction

Although community water fluoridation is considered the foundation for sound dental caries prevention programs, there are populations of children that experience higher rates of dental caries (tooth decay) and could benefit from additional fluoride exposure. Although the use of fluoride in dental caries prevention is considered safe and effective, there are questions among health professionals and programs working with young children at high risk of developing dental caries, as to the recommended use of topical fluoride. In an effort to address these questions the Maternal and Child Health Bureau (MCHB) convened an expert panel on October 22–23, 2007 to develop a decision support matrix on topical fluoride use for high-risk children. This matrix was developed primarily for a nondental audience—programs, paraprofessionals, and professionals without formal dental education working with higher-risk children in public health settings (e.g., childcare centers, Head Start programs, WIC programs, primary care clinics) but could also be useful to parents and caregivers.

The expert panel set out to develop a simplified decisionmaking tool for use in group settings that is straightforward, believing that the ease of use would facilitate oral health interventions. This matrix provides recommendations on the use of topical fluoride for higher-risk children aged 6 years and younger. This matrix focuses on topical fluoride—toothpaste, varnish, mouth rinses, gel, and foam. Lastly, although dietary fluoride supplements can have a topical effect, the expert panel chose not to address fluoride supplements in the matrix.

While this matrix is targeted at group interventions, the expert panel agreed that an ideal prevention model targeting high-risk children would include population-based fluoride interventions and individual risk assessments conducted during dental and medical appointments.

Topical Fluoride Recommendations For High-Risk Children Under Age 6 Years			
Decision Support Matrix			
Population-Based Risk Factors			
<p>1. Low-income children (e.g., enrolled in Head Start, WIC, free/reduced lunch program, Medicaid or SCHIP eligible, or other programs serving low-income children)</p> <ul style="list-style-type: none"> Children with special health care needs 			
Age	Children Under 2 Years	Children 2-6 Years	
Fluoride Modality	<p>2. Toothpaste</p>  <ul style="list-style-type: none"> Encourage parents and caregivers to take an active role in brushing their children's teeth once the first tooth erupts Educate parents and caregivers on proper fluoride toothpaste use Brush children's teeth with fluoride toothpaste twice daily Use a smear of fluoride toothpaste  <p>Smear amount</p> <ul style="list-style-type: none"> Do not rinse after brushing 	 <ul style="list-style-type: none"> Encourage parents and caregivers to take an active role in brushing their children's teeth Educate parents and caregivers on proper fluoride toothpaste use Brush children's teeth with fluoride toothpaste, or assist children with toothbrushing, twice a day Use no more than a pea-sized amount of fluoride toothpaste  <p>Pea-sized amount</p> <ul style="list-style-type: none"> Children should spit out excess toothpaste Do not rinse after brushing 	
	3. Varnish	<ul style="list-style-type: none"> Apply every 3-6 months 	<ul style="list-style-type: none"> Apply every 3-6 months
	4. Mouth rinses, gel, or foam	<ul style="list-style-type: none"> Not recommended 	<ul style="list-style-type: none"> Not recommended
	Decision Support Matrix developed by MCHB Expert Panel on Topical Fluoride, October 2007		

I. Definition of High-Risk Children

There were two groups of children identified by the expert panel as high-risk populations. These groups are described below:

Low-Income Children

This category includes children that are enrolled in programs where they must meet income eligibility requirements. This category includes children enrolled in Early Head Start, Head Start, WIC, National School Lunch Program, Medicaid, and the State Children's Health Insurance Program (SCHIP).

Children with Special Health Care Needs (CSHCN)

MCHB defines CSHCN as children and adolescents: *who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally.*²⁶

The expert panel acknowledged that some CSHCN experience higher rates of disease due to specific conditions that can significantly compromise their oral health and increase the likelihood of developing oral disease.

Description of Fluoride Recommendations By Modality

Members of the expert panel reviewed existing professional dental guidelines on fluoride issued by the Centers for Disease Control and Prevention (CDC),²⁷ the American Academy of Pediatric Dentistry (AAPD),²⁸ and American Dental Association (ADA)^{29,30} to develop the recommendations that follow.

2. Toothpaste. Unless otherwise instructed by a health professional, the expert panel recommended that all children at high risk should use fluoride toothpaste and provided specific guidance to accompany this recommendation. The panel recommended that children under 2 years of age use a “smear” of toothpaste while children aged 2–6 years use a slightly larger “pea-sized” amount of toothpaste. The recommendation differed by age because children under 2 years are not able to spit out excess toothpaste and are more likely to inadvertently swallow toothpaste. Children should not rinse after brushing. The panel also emphasized the role of adults and parents because tooth brushing is more effective when young children are supervised or assisted by an adult.

3. Fluoride Varnish. The expert panel was in agreement that fluoride varnish is an effective preventive measure with higher risk populations. The consensus among panel members was that fluoride varnish should be applied *at least* every 6 months, but some members preferred to specify at 3- to 4-month intervals. After some debate, the group decided to adopt the recommendation that fluoride varnish be applied every 3–6 months.

4. Mouth Rinses, Gel, or Foam. The group reached quick consensus that rinses, gels, or foams not be recommended for children under 6 years, because the ability to control the swallowing reflex is not fully developed in preschool-aged children, increasing the likelihood that children under 6 years of age inadvertently ingest excess fluoride.



Appendix B: Participant List

Jay Anderson, DMD, MHSA

Chief Dental Officer
Bureau of Primary Health Care,
Office of Quality and Data
HRSA
5600 Fishers Lane 15C 26
Rockville, MD 20857
Phone: 301-594-4295
Email: janderson@hrsa.gov

Cynthia Barron

Project Director
Educational Outreach
Sesame Street Workshop
One Lincoln Plaza
New York, NY 10034
Phone: 212-875-6527
Fax: 212-875-6155
Email: cynthia.barron@sesameworkshop.org

Harry W. Bickel, DMD, MPH

Health Consultant
Training and Technical Assistance Services
College of Education
Western Kentucky University
2212 Dearing Court
Louisville, KY 40204
Phone: 502-456-6312
Fax: 502-456-9459
Email: hbickel@insightbb.com

Patrick Blahut, DDS, MPH

Director, IHS Health Promotion/
Disease Prevention Program
Division of Oral Health
Indian Health Service
801 Thompson Avenue, Suite 300
Rockville, MD 20852
Phone: 301-443-4323
Email: patrick.blahut@ihs.gov

Robin Brocato, MHS

Program Specialist
Office of Head Start
Administration for Children and Families
U.S. Department of Health and Human Services
1250 Maryland Avenue SW, Eighth Floor
Washington, DC 20024
Phone: 202-205-9903
Fax: 202-401-5916
Email: robin.brocato@acf.hhs.gov

Bonnie Bruerd, DrPH

Oral Health Consultant, Region XI
2552 Arroyo Ridge Ct. NW
Salem, OR 97304
Phone: 503-363-6770
Email: bonnie.bruerd@comcast.net

James J. Crall, DDS, ScD

Director
National Oral Health Policy Center
Center for Healthier Children, Families, and Communities
Professor and Chair of Pediatric Dentistry
School of Dentistry
University of California, Los Angeles
1100 Glendon Avenue, Suite 850
Los Angeles, CA 90024
Phone: 310-794-0982
Fax: 310-794-2728
Email: jcrall@dent.ucla.edu

Julie C. Frantsve-Hawley, RDH, PhD

Director, Research Institute and Center for
Evidence-based Dentistry Science
American Dental Association (ADA)
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2519
Fax: 312-440-2536
Email: frantsvej@ada.org

Rani Simon Gereige, MD, MPH

American Academy of Pediatrics (AAP) Representative
Associate Professor, University of South Florida Pediatrics
General Academic Pediatrics
University of South Florida (on behalf of AAP)
All Children's Hospital, 801 6th Street South
Box 6960
St. Petersburg, FL 33701
Phone: 727-767-4106
Fax: 727-767-8804
Email: rgereige@health.usf.edu

Rocio Gonzalez-Beristain, MS, MPH

Dental Department
MAYA Project
San Ysidro Health Center
4004 Beyer Avenue
San Ysidro, CA 92173
Phone: 619-662-4193
Fax: 619-662-4117
Email: rogonzalez@syhc.org

Rebecca S. King, DDS, MPH

Association of State and Territorial Dental Directors
(ASTDD) Representative
Section Chief, Oral Health Section
Department of Health and Human Services
Division of Public Health North Carolina
1910 MSC, 5505 Six Forks Road
Raleigh, NC 27699-1910
Phone: 919-707-5487
Fax: 919-870-4805
Email: rebecca.king@ncmail.net

Lewis N. Lampiris, DDS, MPH

Director
Council on Access, Prevention and
Interprofessional Relations
Dental Practice/Professional Affairs
American Dental Association (ADA)
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2751 ext. 2751
Fax: 312-440-4640
Email: lampirisl@ada.org

Steven Levy, DDS, MPH

Professor
University of Iowa, College of Dentistry
N 328 DSB, University of Iowa
Iowa City, IA 52242
Phone: 319-335-7185
Fax: 319-335-7187
Email: steven-levy@uiowa.edu

Reginald Louie, DDS, MPH

The Regional Head Start Oral Health Consultant
DHHS
Office of Head Start
Region IX - San Francisco
2760 Pineridge Road
Castro Valley, CA 94546
Phone: 510-583-8120
Email: reglouie@sbcglobal.net

William Maas, DDS, MPH

Director
Division of Oral Health
Centers for Disease Control and Prevention
4470 Buford Highway, MS F-10
Atlanta, GA 30341
Phone: 770-488-6054
Fax: 770-488-6080
Email: wmass@cdc.gov

Peter Milgrom, DDS

Professor
Dental Public Health Sciences
University of Washington
Box 3574475
Seattle, WA 98195-7475
Phone: 206-685-4183
Fax: 206-685-4258
Email: dfrc@u.washington.edu

Patti L. Mitchell, MPH, RD

Senior Program Analyst
Supplement Food Programs Division (WIC)
Food and Nutrition Service
U.S. Department of Agriculture
3101 Park Center Drive, Suite 528
Alexandria, VA 22304
Phone: 703-305-2692
Fax: 703-305-2196
Email: patti.mitchell@fns.usda.gov

Mark Nehring, DMD, MPH

Chief Dental Officer
Oral Health Program
Division of Child, Adolescent, and Family Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Department of Health and Human Services
5600 Fishers Lane, 18A-30
Rockville, MD 20857
Phone: 301-443-2449
Email: mnehring@hrsa.gov

Howard F. Pollick, BDS, MPH

Clinical Professor
Preventive & Restorative Dental Sciences
Oral Epidemiology & Dental Public Health
School of Dentistry, University of California San Francisco
707 Parnassus Avenue, Box 0758
San Francisco, CA 94143-0758
Phone: 415-476-9872
Fax: 415-476-0858
Email: howard.pollick@ucsf.edu

John Rossetti, DDS, MPH

Lead Head Start Oral Health Consultant
Maternal and Child Health Bureau
Health Resources and Services Administration
Department of Health and Human Services
14669 Mustang Path
Glenwood, MD 21738
Phone: 301-443-3177
Fax: 301-443-1296
Email: jrossetti@hrsa.gov

Sandra Silva, MM

Senior Policy Associate
Altarum Institute
1200 18th St NW, Suite 700
Washington, DC 20036
Phone: 202-776-5163
Fax: 202-728-9469
Email: sandra.silva@altarum.org

Steven Strobe MD, MEd, MPH

American Academy of Family Physicians (AAFP)
Representative
Associate Professor
Regional Programs
University of Arkansas for Medical Sciences
4301 west Markham, #599 A
Little Rock, AR 72205
Phone: 501-686-2590
Fax: 501-686-5992
Email: strodestevenw@uams.edu

Norman Tinanoff, DDS, MS

Professor and Chair
Health Promotion and Policy
University of Maryland Dental School
650 W. Baltimore Street
Baltimore, MD 21201
Phone: 410-706-7970
Fax: 410-706-4031
Email: ntinanoff@umaryland.edu



Appendix C: Meeting Agenda



Meeting Objectives:

- Review populations at highest risk for dental caries and the process for assessing risk in group settings
- Review professional dental guidelines within the context of high-risk children
- Translate guidelines and recommendations into a decision-support matrix that can provide guidance to practitioners and programs in designing appropriate topical fluoride interventions

Agenda
Monday, October 22nd

- 8:30 – 9:00 **Continental Breakfast**
- 9:00 – 9:30 **Welcome and Introductions**
Remarks by:
▪ Mark Nehring, DMD, MPH, Chief Dental Officer, MCHB
- 9:30 – 10:00 **Meeting Overview**
Presented by:
▪ John Rossetti, DDS, MPH, Lead Oral Health Consultant, MCHB
- 10:00 – 11:00 **Review of Background Paper**
Presentation by:
▪ Jim Crall, DDS, ScD, Director, National Oral Health Policy Center, UCLA
- 11:00 – 12:00 **Participant Questions and Comments**
- 12:00 – 1:30 **Lunch on Your Own (not provided)**
- 1:30 – 2:00 **Defining and Assessing Caries Risk in Group Settings**
Presentation by:
▪ Bonnie Bruerd, DrPH, Region XI Oral Health Consultant
- 2:00 – 3:30 **Defining and Assessing Caries Risk in Group Settings (continued)**
Facilitated Discussion Led by:
▪ Bonnie Bruerd, DrPH, Region XI Oral Health Consultant
- 3:30 – 3:45 **BREAK**
- 3:45 – 5:15 **A Review of Professional Dental Guidelines by Fluoride Modality**
Facilitated Discussion Led by:
▪ Julie Frantsve-Hawley, RDH, PhD, Director, Research Institute and Center for Evidence-based Dentistry Science, American Dental Association
- 5:15 – 5:30 **Preview of Day 2**
Remarks by:
▪ John Rossetti, DDS, MPH, Lead Oral Health Consultant, MCHB



Agenda
Tuesday, October 23rd

- 8:30 – 9:00 Continental Breakfast**
- 9:00 – 10:00 Review of Preliminary Recommendations from Background Paper**
Facilitated Discussion Led by:
 - Jim Crall, DDS, ScD, Director, National Oral Health Policy Center, UCLA
- 10:00-11:00 Translating Recommendations Into Decision-Support Matrix**
Facilitated Discussion Led by:
 - Patti L. Mitchell, MPH, RD, Senior Program Analyst, Supplement Food Programs Division (WIC), Food and Nutrition Service, U.S. Department of Agriculture
 - Jim Crall, DDS, ScD, Director, National Oral Health Policy Center, UCLA
- 11:00 – 11:15 BREAK**
- 11:15 – 12:30 Translating Recommendations Into Decision-Support Matrix (continued)**
Facilitated Discussion Led by:
 - Patti L. Mitchell, MPH, RD, Senior Program Analyst, Supplement Food Programs Division (WIC), Food and Nutrition Service, U.S. Department of Agriculture
 - Jim Crall, DDS, ScD, Director, National Oral Health Policy Center, UCLA
- 12:30 – 1:00 Final Remarks and Next Steps**
Closing Remarks by:
 - John Rossetti, DDS, MPH, Lead Oral Health Consultant, MCHB

Endnotes

- 1 Centers for Disease Control and Prevention. Preventing Chronic Diseases: Investing Wisely in Health. Atlanta: CDC; November 25, 2005. Available at: <http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/oh.htm>. Accessed May 20, 2008.
- 2 Beltrán-Aguilar ED, Barker LK, Canto MT, et al. Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel fluorosis – United States, 1988–1994 and 1999–2002. *MMWR*. August 26, 2005;54:1–44.
- 3 Centers for Disease Control and Prevention. Recommendations for using fluoride to prevent and control dental caries in the United States. *MMWR*. August 17, 2001;50(RR14):1–42.
- 4 Centers for Disease Control and Prevention. Preventing Chronic Diseases: Investing Wisely in Health. Atlanta: CDC; November 25, 2005. Available at: <http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/oh.htm>. Accessed May 20, 2008.
- 5 Fisher-Owens SA, Barker JC, Adams S, Chung LH, Gansky SA, Hyde S, Weintraub JA. Giving policy some teeth: routes to reducing disparities in oral health. *Health Affairs*. 2008;27(2):404–412.
- 6 U.S. Department of Health and Human Services (DHHS). *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: DHHS. 2000.
- 7 Vargas CM, Crall JJ, Schneider DA. Sociodemographic distribution of pediatric dental caries: NHANES III, 1988–1994. *Journal of the American Dental Association*. 1998;129:1229–1238.
- 8 Beltrán-Aguilar et al. Surveillance.
- 9 Holve S. 2006. Fluoride Varnish Applied at Well Child Care Visits Can Reduce Early Childhood Caries. The IHS Primary Care Provider. 2006;31(10):243–245.
- 10 Ibid.
- 11 Fejerskov O. Changing paradigms in concepts on dental caries: consequences for oral health care. *Caries Research*. 2004;38:182–191.
- 12 Centers for Disease Control and Prevention. Recommendations.
- 13 American Dental Association; Council on Access, Prevention, and Interprofessional Relations. *Fluoridation Facts*. 2005. Available at: http://www.ada.org/public/topics/fluoride/facts/fluoridation_facts.pdf. Accessed May 20, 2008.
- 14 American Academy of Pediatric Dentistry (AAPD). Policy on use of a caries-risk assessment tool (CAT) for infants, children and adolescents. Chicago: AAPD; 2006. Available at: www.aapd.org/media/policies_guidelines/p_cariesriskassess.pdf. Accessed May 20, 2008.
- 15 McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck PW, Perrin JM, Shonkoff JP, Strickland B. A new definition of children with special health care needs. *Pediatrics*. 1998;102(1):137–140.
- 16 Georgetown University, National Maternal and Child Oral Health Resource Center. *Oral Health for Children and Adolescents with Special Health Care Needs: Challenges and Opportunities*. Washington: Georgetown University; 2005. Available at: <http://www.mchoralhealth.org/PDFs/SHCNfactsheet.pdf>. Accessed May 20, 2008.
- 17 American Academy of Pediatric Dentistry. Policy.
- 18 American Dental Association, Council on Scientific Affairs. Professionally applied topical fluoride: evidence-based clinical recommendations. *Journal of the American Dental Association*. 2006;137:1151–1159.
- 19 Centers for Disease Control and Prevention. Recommendations.
- 20 American Academy of Pediatric Dentistry. Policy.
- 21 Adair S. Evidence-based use of fluoride in pediatric dental practice. *Pediatric Dentistry*. 2006;28:133–142.
- 22 American Dental Association (ADA). ADA positions & statements: interim guidance on fluoride intake for infants and young children. Chicago: ADA; November 8, 2006. Available at: www.ada.org/prof/resources/positions/statements/fluoride_infants.asp. Accessed May 20, 2008.
- 23 American Dental Association Council on Scientific Affairs. Professionally.
- 24 Centers for Disease Control and Prevention. Recommendations.
- 25 Ibid.
- 26 McPherson M et al. A new definition.
- 27 Centers for Disease Control and Prevention. Recommendations.
- 28 American Academy of Pediatric Dentistry. Policy.
- 29 American Dental Association. ADA positions.
- 30 American Dental Association, Council on Scientific Affairs. Professionally.