

IMPROVING ORAL HEALTH AMONG PREGNANT WOMEN AND YOUNG CHILDREN

**Presentation of Findings
2018**



Online Focus Group

- **Included 17 dental hygienists**
 - 13 completed all questions
- Held from **June 5-7, 2018**
- Incentive: **\$100 gift card**

Screening Information

- Recruited by **RI KIDS COUNT** and its partners
- Participants:
 - Practiced in **Rhode Island.**
 - Were employed at a **General Practice** or at a **Federally Qualified Health Center (FQHC)**

Technical Information

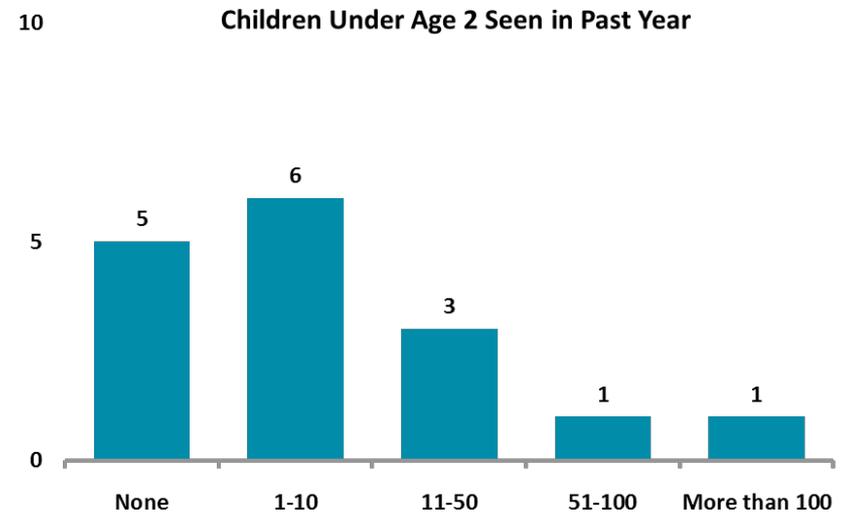
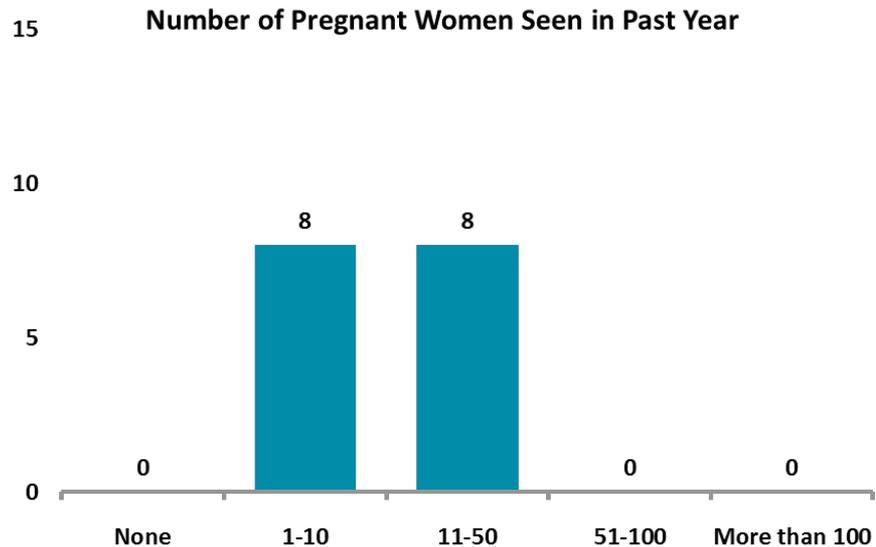
- Numeric information is included where applicable for ease in interpreting results
- Focus groups findings are **qualitative**

Experience Seeing Pregnant Women and Children Under Age 2

All the hygienists have seen pregnant women in the past year, and most have seen children under age 2 in the past year.

Those who saw <10 pregnant patients saw this as normal, and **could not think of specific barriers.**

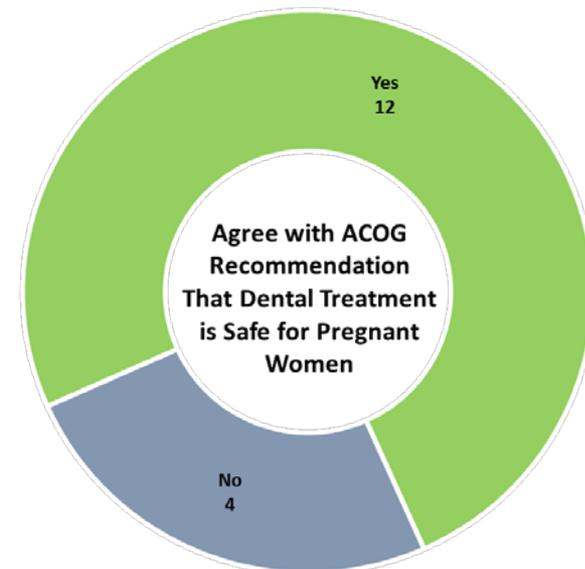
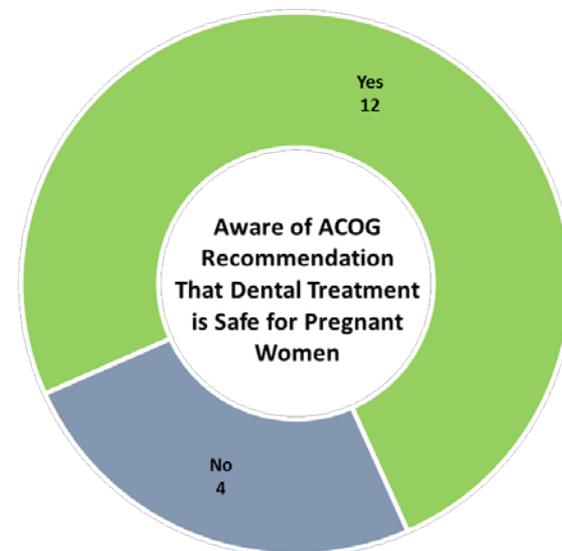
Those who saw <10 children under the age of two named **parent education**, that their practice **does not see children**, is **not tailored to children**, or **does not advertise** as a practice that sees young children.



Awareness of and Agreement with Oral Health Recommendations for Pregnant Women and Children

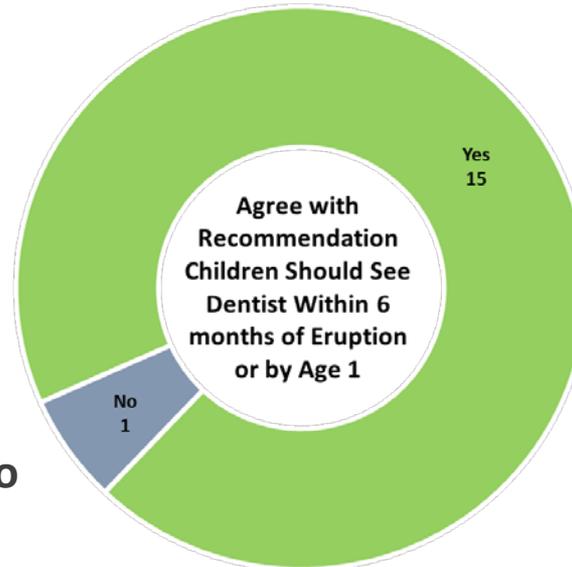
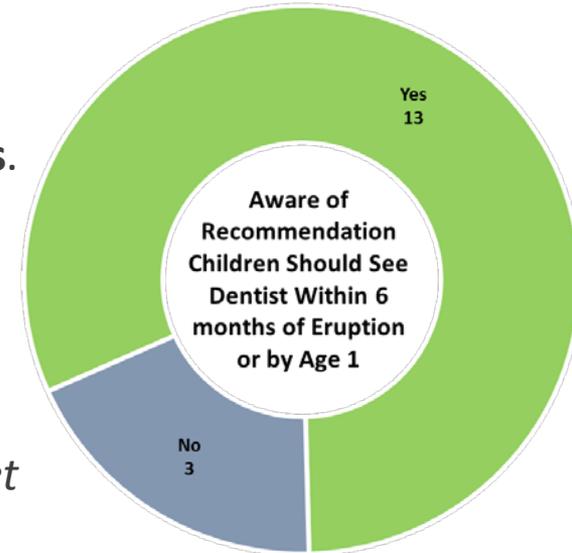
Most hygienists are aware of, and agree with the ACOG's recommendation about the safety of dental treatment for pregnant women.

- Some had **concerns**:
 - Some would only take x-rays for patients **experiencing pain and/or infection**, or are **high-risk for oral health problems**.
 - A few prefer to **administer anesthesia until the second or third trimester**, and some **would not use anesthesia with epinephrine**.
- Those who **do not** agree said that **yearly radiographs** are not necessary; had concerns about **taking x-rays** and **administering local anesthesia** during the **first trimester**; concerns about using anesthesia with **epinephrine**; and hesitate to taking **x-rays** during pregnancy unless an absolute **emergency**.
 - *“I don't agree with doing things that are not needed during pregnancy, regardless of the recommendations.”*
- Those who were not aware **are interested in learning more**.



Hygienists have strong awareness of and agreement with the recommendation that young children should see a dentist within 6 months of eruption of their first tooth or by age 1.

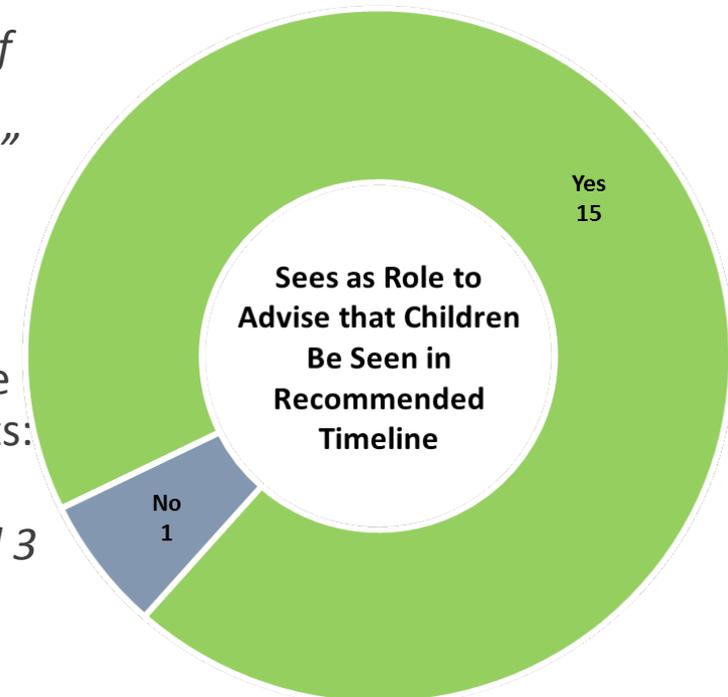
- Top benefits: **parental education** and **early exposure** to the dental office.
- Some noted this is a good opportunity to **identify any problems**.
 - *“There are several benefits at the age one visit such as becoming familiar with the dental office/dental visit routine, smells, tastes, sounds, feels of someone working in the mouth, and meeting new people. Also, detecting any gum and decay issues early on is great as well as removal of plaque/home care and going over baby bottle syndrome/diet with the parent.”*
- A few noted that **following the recommendation can be difficult**:
 - *“In theory yes I agree, but I have encountered many RDHs that say their DMD doesn't see children until 3 or 4. I think from a preventative and educational standpoint it's wonderful, we just need to keep educating DMDs, the other barrier may also be that it may not be covered for people with insurance. I had that happen in the past when I saw a pt. at age 2 it wasn't covered by the insurance.”*
- The hygienist who disagreed thought children of this age are **too young** to have their teeth cleaned, though it could be beneficial for parent education.



All but one hygienist feels that it is their role to advise that young children be seen within the recommended timeframe.

- Some think that **parents are generally unaware** of this recommendation.
- Others noted they like to **reinforce** the information:
 - *“I do in conjunction with the pediatrician. I feel like if the parents are hearing it from multiple practices they will be more likely to schedule an appointment.”*
- Even hygienists who do not see young children feel it is **their role to educate pregnant patients about the recommended timeframe.**
- One hygienist expressed frustration with her experience imparting the recommendation to her pregnant patients:
 - *“In the past I have discussed the visit by age 1 and then the DMD would come in and tell mom not until 3 when they can ‘sit for a cleaning’. This is so frustrating and undermining, and the patient will have the 3 years of age on the radar instead of 1 year!!!”*

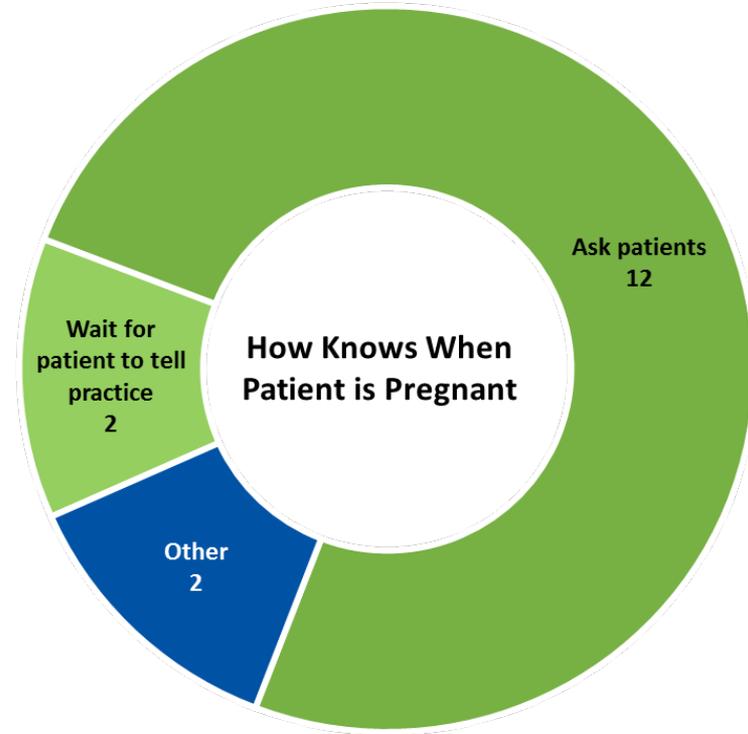
“As hygienists, we are educators.”



Dental Hygienists' Comfort and Confidence Treating Pregnant Women

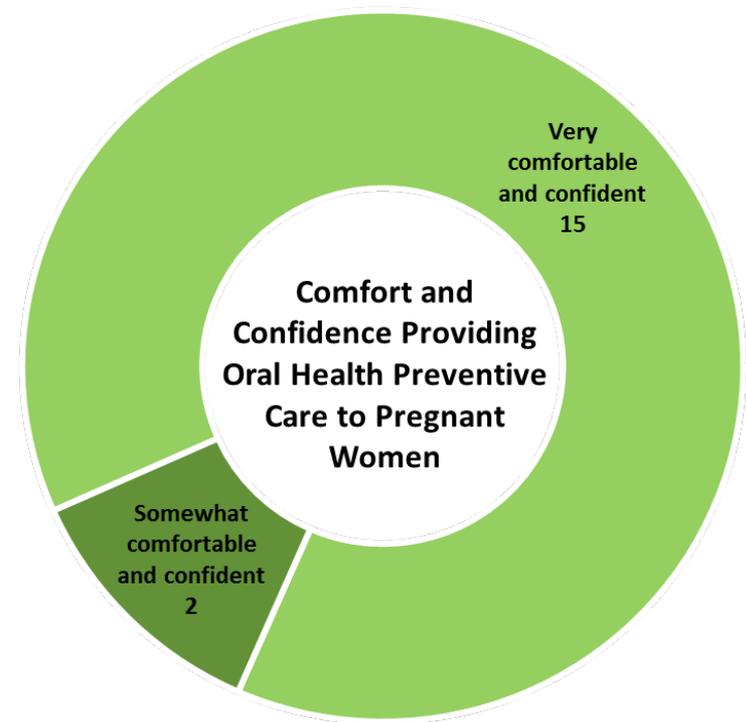
Hygienists are most likely to ask patients if they are pregnant, rather than wait for them to tell the practice.

- Some hygienists ask **all female patients of childbearing age** whether they are, or could be pregnant.
 - *“I ask all female patients of child bearing age.”*
- A few would **wait until the patient tells the practice**.
 - *“Unless I am taking x-rays I would not ask a patient if she was pregnant. She may have just put on a few pounds since the last cleaning. If a patient choses to tell me, I then share the information with staff by placing an alert on computer. I will tell the doctor because he sometimes likes to congratulate [the patient].”*



Hygienists are not only comfortable and confident providing oral health preventative care to pregnant women—many are excited about doing so.

- Some mentioned **their own pregnancies** as the reason for their confidence:
 - *“I have a 3 year old child and during my pregnancy I became very interested all things involved in pregnancy. I was happy that my OB asked about my oral health, but that is where the conversation ended. I began doing a bit more research into pregnancy oral health, because of this I feel very confident working with pregnant women.”*
- Others noted they have received **training**.
- A few hygienists mentioned providing preventative care to pregnant women allows them to **educate women about oral health for infants and children**:
 - *“It is a **great opportunity** to tell first time moms about the recommendations on when the babies first dental visit should be and also go over oral care for babies.”*



Comfort in providing preventative care varies by trimester, though most are moderate to very comfortable throughout a woman's pregnancy.



First Trimester

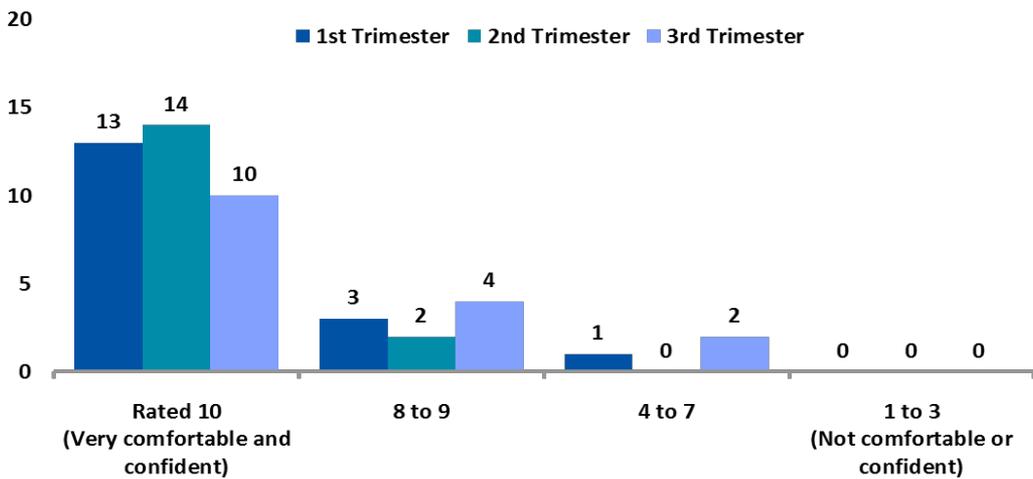
- Most are comfortable and focus on **morning sickness, pregnancy gingivitis**, and general **education** about dental care during pregnancy.
- Concerns: not wanting to give pregnant patients x-rays, fluoride, or anesthesia.

Second Trimester

- Hygienists are **most comfortable**.
- Patients are usually **feeling better** and are **more energetic**, and **feel safer** because of the reduced chance of miscarriage.
- A few were uncomfortable giving x-rays.

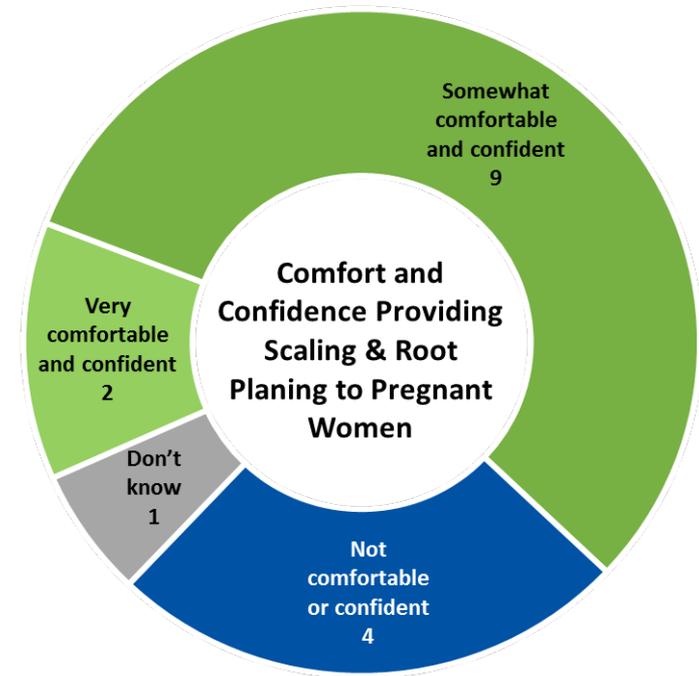
Third Trimester

- Many are concerned about the patient **comfort**.
- Some make **adjustments** like providing pillows for support, or not reclining them as far.
- A few start talking more about **home care** and **oral care for infants**.



Hygienists are less comfortable and confident providing scaling and root planing to pregnant women than they are providing preventative care.

- Some would be more comfortable if the patient had **first consulted their OB.**
- Others noted that they would use an anesthetic **without epinephrine.**
 - *“Some OBs still tend to [err] on the side of caution with their patients, so anything beyond a regular [prophylaxis] I would ask for clearance. I would use a local anesthetic without epinephrine to minimize risks although we know that epinephrine is generally safe during pregnancy and if the patient is comfortable without [epinephrine], it is one less risk I have to worry about.”*
- A few would be more comfortable during the **second trimester.**



Hygienists are most comfortable providing scaling and root planing with local anesthesia during the second trimester.

First Trimester

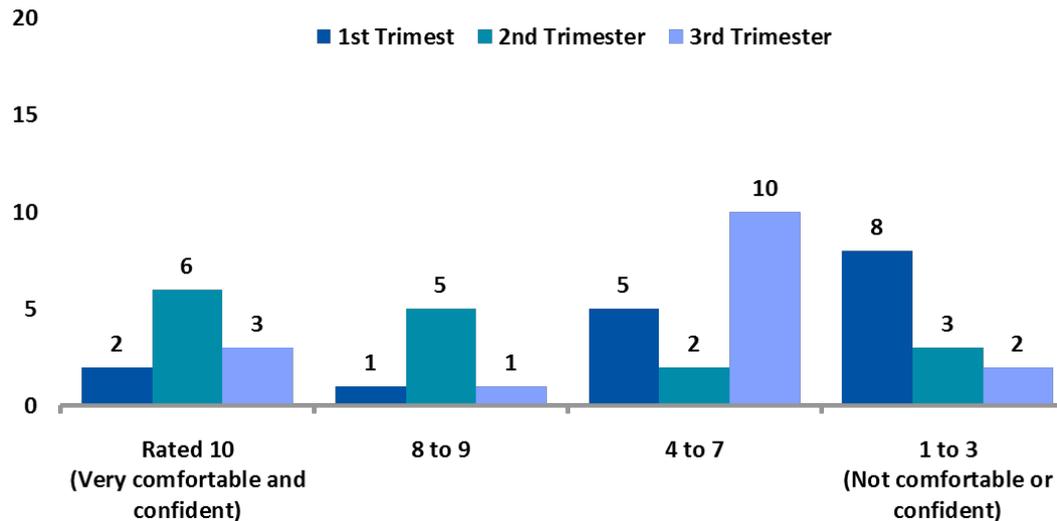
- **Least comfortable.**
- Several reiterated the need for **clearance** from patient's OB.
- A few would only use local anesthesia if absolutely necessary.

Second Trimester

- **Moderately comfortable:**
 - *"I know [scaling and root planing] is safe during pregnancy so if I were to do it in any trimester it would be this one."*
- Some would **consult the patient's OB** to use anesthesia, and a few would use an anesthetic that does not include epinephrine.

Third Trimester

- **Patient comfort** is a concern, given the length of the appointment.
- Some would rather **wait** until after delivery.



Hygienists regularly make adjustments for their pregnant patients.

- Overall, hygienists did not report discomfort as a major barrier.
- Only one **needed to stop treatment** due to discomfort:
 - *“I have a patient in her 3rd trimester who can not recline all the way back, I stood and was fine. By the time I was almost completed, [the patient] expressed that it was getting to be too much and we skipped polishing and flossing and was completely fine with it.”*
- Another has had patients reschedule appointments in first trimester due to **morning sickness**.

Most Common Adjustments

- Pillows and blankets for support
- Repositioning on side
- Topical anesthetic for sensitivity
- Standing to provide care to pregnant patients

Gingivitis is perceived as the most common oral health concern for pregnant women among hygienists.

Gingivitis

Hygienists mentioned gingivitis, as well as its symptoms as the most common oral health concerns among pregnant patients.

“Pregnancy gingivitis. My normally healthy patients will come in and state that their gums has been bleeding more or are tender to brushing and flossing.”

Tooth Decay

Tooth decay, especially as a result of enamel erosion due to morning sickness, was a common concern.

“Another issue is oral lesions, erosion of teeth, or increased decay (increased acid environment) because of vomiting due to nausea during pregnancy.”

Pyogenic Granulomas

A few mentioned pyogenic granulomas.

“The most common concern I've had is patients having inflammation of the gingiva or a pyogenic granuloma.”

Other concerns (mentioned by one or two hygienists)

- Low birth weight due to oral health problems
- Miscarriage due to oral health problems
- General gingival health

All hygienists have given anticipatory guidance to pregnant patients, and it is generally well-received.

HOME CARE

- Most likely to bring up **home care** with pregnant patients.
 - *“I spend a lot of time on home care and offering alternatives for flossing (soft picks, rubber tip, proxybrush, sulcabrush, etc). The majority are interested and will willingly try (in the chair) any products I give them.”*
- A few give guidance for oral health home care when experiencing **morning sickness**.

PATIENT EDUCATION

- A few stress the **importance** of good oral health during pregnancy, and the potential **impact of their oral health on their baby**.
 - *“I always educate them about the link between gum disease and premature and under weight births. I explain the change in hormones will tend to cause an increase in bleeding, inflammation and tooth decay. They often respond positively to the information.”*
- Others educate patients about **what to expect** during pregnancy, with some mentioning pregnancy gingivitis.
 - *“Whenever I have a pregnant woman in my chair especially a first time mom I like to touch on a couple of ways that their oral cavity may change over the course of their pregnancy. I usually start with pregnancy gingivitis and tell them to expect some changes in their gums and not to worry if they experience things like pyogenic granulomas. I mention that poor oral health has been linked to premature births and stress the importance of maintaining a clean oral cavity throughout their pregnancy.”*

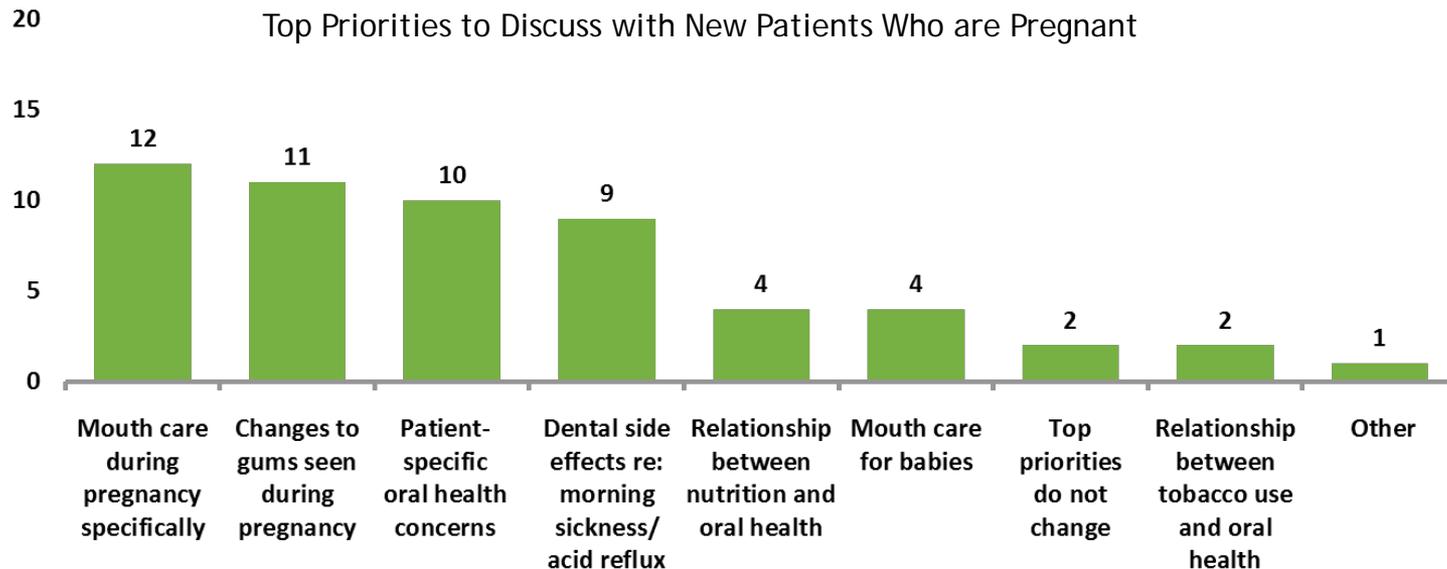
OTHER GUIDANCE

- Some hygienists also discuss **oral health and home care for babies**, and the importance of **nutrition** for their oral health.

Hygienists emphasized the need to educate pregnant women about the importance of oral health and the potential impact on their baby.

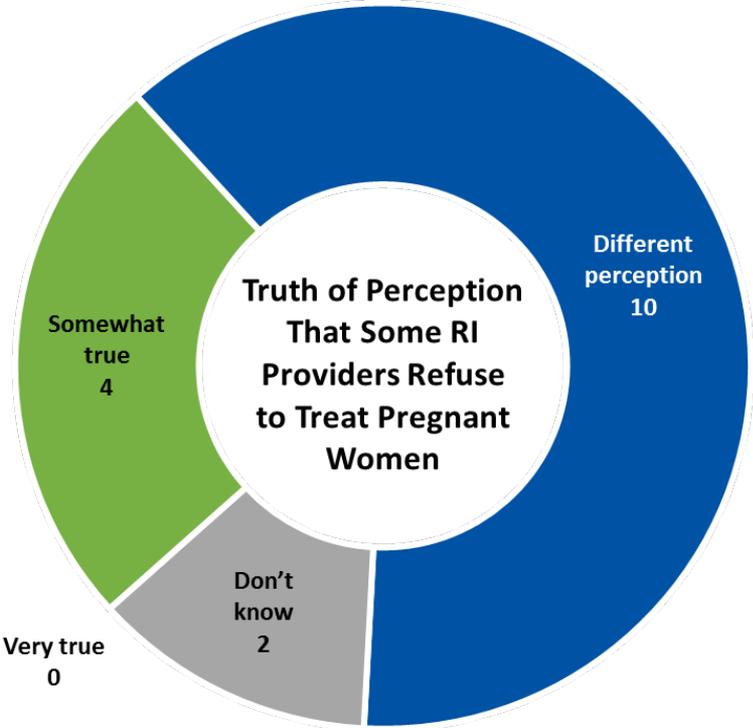
“In my experience, OB/GYNs do not discuss oral care with patients, and often they have a lot of questions. I use their pregnancy as another opportunity to emphasize the importance of good oral hygiene and especially as it relates to their health during pregnancy.”

“I try to treat pregnant patients the same as non-pregnant patients but I tend to try to educate the pregnant women more. Most women for example are not aware of the effects vomiting from morning sickness can have on the enamel. I try to find out what the patient does and doesn't know and base my patient education on this. Basically at this appointment the patient education segment is primarily focused on the pregnancy.”



Most hygienists have not heard of providers refusing to treat pregnant women, and none of them have experienced this.

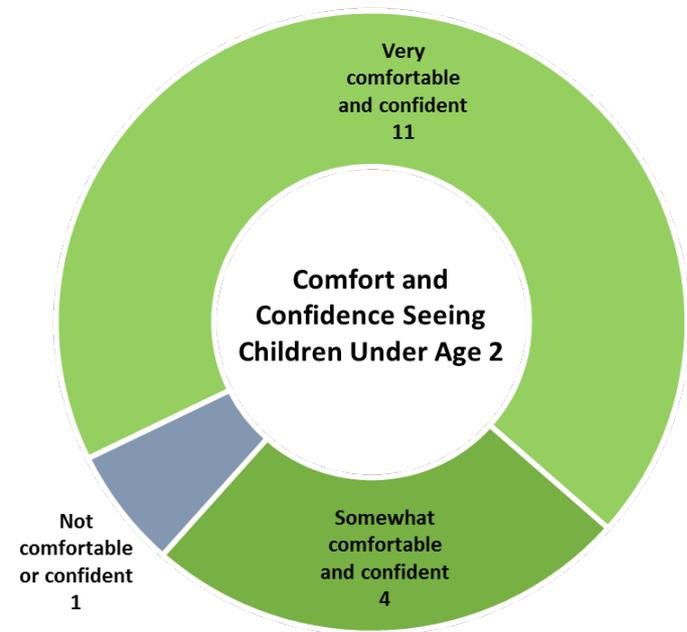
- Some noted treatment may be **modified** or non-emergency treatments may be **postponed**.
 - *“My experience working in Public Health, pregnant women are encouraged to seek non-invasive and monitored dental treatment during pregnancy. In my experience I have never heard of refusal of treatment due to pregnancy.”*
- A few have heard of this, but have not experienced it:
 - *“At my practice, I find this not to be true, but I have heard of other practices that do not want to treat pregnant women. I think the fear is that if their is a health issue with the baby, or a miscarriage, the dental practice may be blamed. Educating patients and dentists would be key to breaking this belief.”*



Dental Hygienists' Comfort and Confidence Treating Young Children

Most hygienists are comfortable and confident seeing children under age two.

- Those who are *very comfortable and confident* cite **prior experience** as the reason for their confidence.
- Some acknowledged it as a **challenging population**.
 - *“Although seeing children before the age of 1 is challenging, it is important for parents to understand the importance of good oral care. This will help set up positive goals for the future.”*
- A few mentioned the importance of early appointments for **educating parents**, and for the child to get **comfortable** with the dental office.
- Those who are less comfortable and confident have **little or no experience** treating young children, or their comfort depends on the child.
- One hygienist was concerned that she might **create a negative association with dental offices** if a child has a bad experience.



*“This is **one of my favorite patient populations**. I am very confident, above all I strive to make the visit fun. I think the most important part of these visits is parent education. I only do what the child allows and what the child is willing to do, some times, its just a quick look around and FI Varnish, other times a full prophy. I always tell parents that its best to do less and have a positive experience then force a child. Overtime I am able to do more and more until the child is happy and excited to come to the office.”*

Eight hygienists report seeing children for their age one dental visit, and eight do not.

“Generally I see the child first and then the dentist comes in for a quick exam.”

Several noted that though they sometimes see children for age one visits, this is **relatively infrequent**.

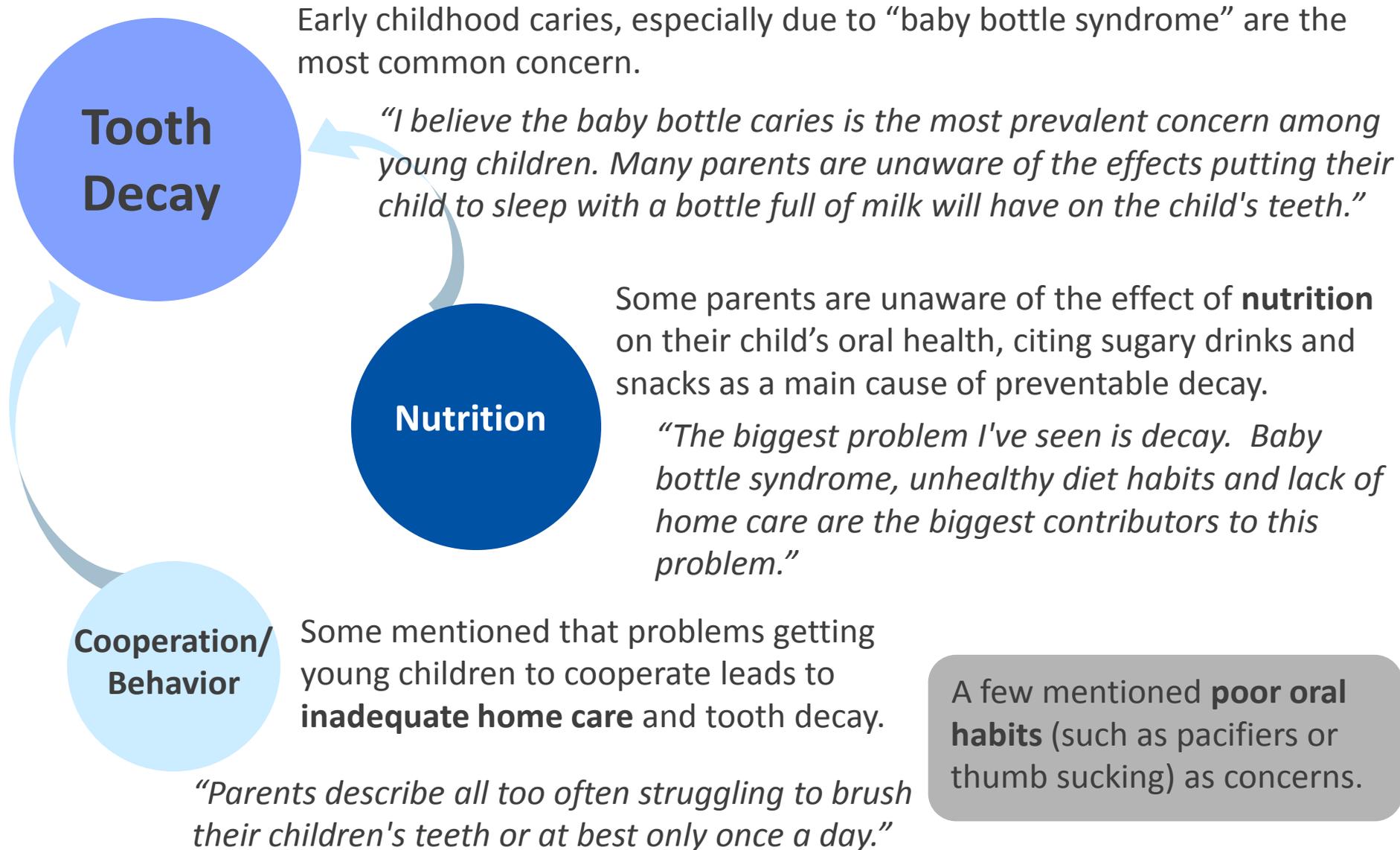
“I do, but in the 5 years of practice I have maybe seen 1 or 2 patients that young. Despite recommendations, I think a lot of parents wait until they think their child can somewhat cooperate.”

“Our office policy is [age] 3- cooperation and time. The doctor wants to be able to bill for full services- prophyl, exam, fluoride treatment.”

Those who do not mainly said that their practice **does not accept patients of that age**, a few noting starting to see patients at age three. Some also mentioned that children **only see the dentist** for this first visit.

“Children under age one are always scheduled with dentist first.”

Tooth decay is the most common oral health concern among young children.



Most hygienists have given anticipatory guidance to parents about their young children's oral health.

NUTRITION

- Many stress the **importance of good nutrition**.
- Some mention **limiting their child's juice intake**, and making sure parents know **not to send their baby or toddler to bed with a milk bottle**.

HOME CARE

- Hygienists go over the **basics of good home care**, such as good brushing and flossing techniques, making sure to check the child's mouth if they let them brush independently, and tips to improve cooperation.

OTHER TOPICS

- A few mentioned discussing tooth **eruption patterns**, and some go over what stage of eruption their child is in at the time of their visit.

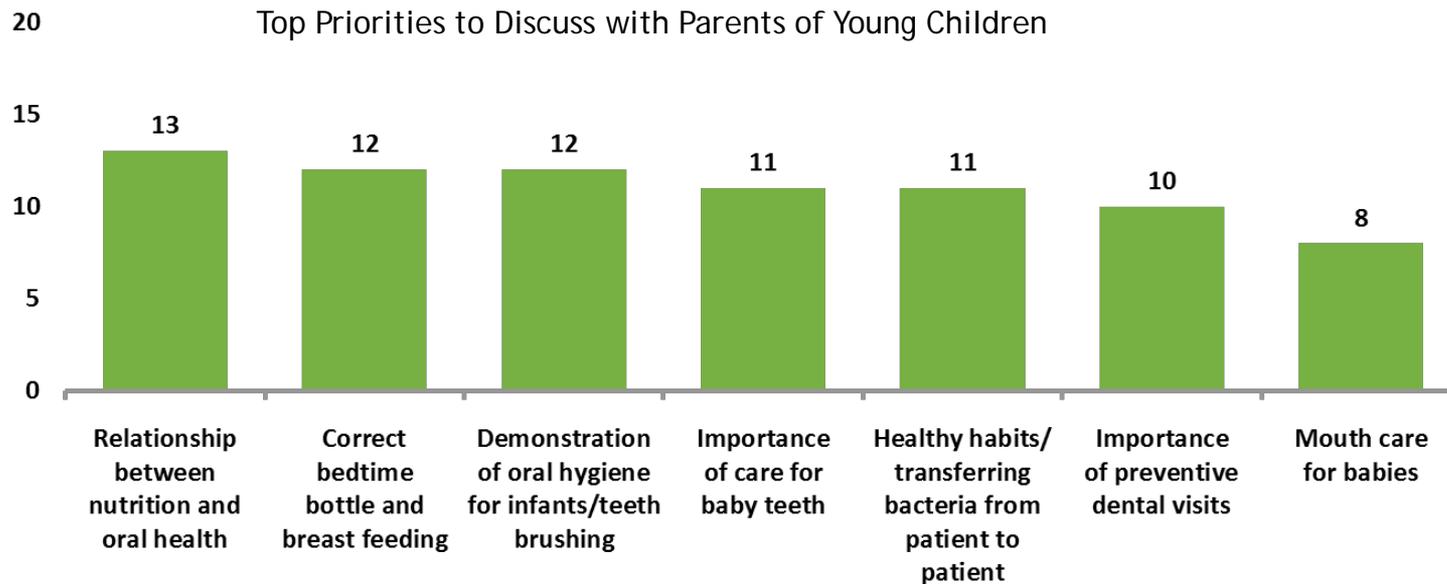
Though most parents are receptive to anticipatory guidance, a couple have experienced parents who are defensive about their child's oral health, or concerns that a parent will not follow through with their recommendations—especially relating to nutrition.

“Most of the parents are very receptive and are appreciative to have this new knowledge that will help them care for their child's teeth. I do however have a number of parents who have the attitude that ‘a little sugar won't hurt anybody’ and do not fully understand the effects that cariogenic foods will have on their child's dentition. I also have parents who will say they didn't follow any advice with previous children and they turned out fine.”

Almost all of the topics are high priorities for hygienists to discuss with parents of young children.

“Proper homecare should be discussed always with every patient. It is extremely important to discuss nutritional habits because I have been surprised at how many patients are unaware that their baby or toddler should not be going to bed with juice, or even drinking juice at all. I spend most of my time discussing homecare and nutritional habits.”

“I believe these are all top priorities. Especially for first time parents it is important that they are educated on how to keep the oral cavity clean from the time they are an infant and how to change the way they are caring as they get older. I also think a lot of parents have the attitude that the baby teeth don't need to be taken care of as seriously as adult teeth because they will be replaced eventually.”

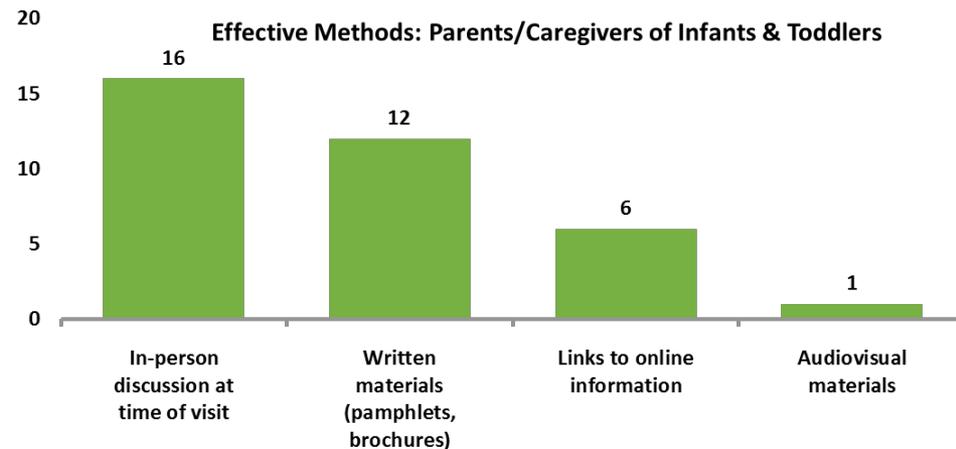
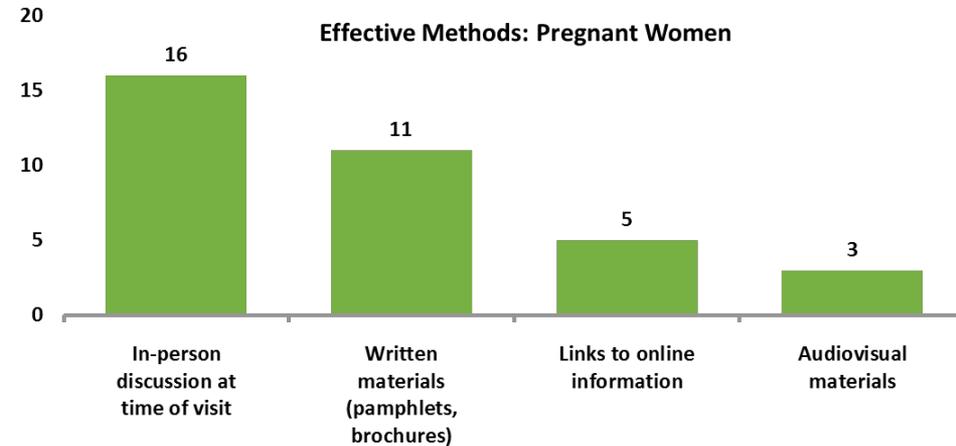


Hygienists use a combination of in-person discussions and written materials to provide oral health education to pregnant patients and parents of young children.

- Written materials are **especially effective** to **reinforce** and remind patients of in-person discussions:

- *“Presenting the information verbally/in-person allows for two-way communication. Information can be presented in a way that is catered to the individual. Following up with brochures and web links, allows the patient to have a synopsis of the subject (brochures) and a means to gather additional information, at his/her own pace (websites). Using a variety of methods reinforces the information, so that it can be retained.”*

- Hygienists find these methods **equally effective** for pregnant patients, and for parents/caregivers of infants and toddlers.



Barriers to Care

Hygienists perceive cost to be the biggest barrier to pregnant women obtaining appropriate oral health care.

"I find even well educated patients are not sure if they should come in for dental care during pregnancy."

Cost

"I feel as though many pregnant women do not seek dental care during their pregnancy due to lack of insurance and income."

**Barriers to
Obtaining
Appropriate
Care: Pregnant
Women**

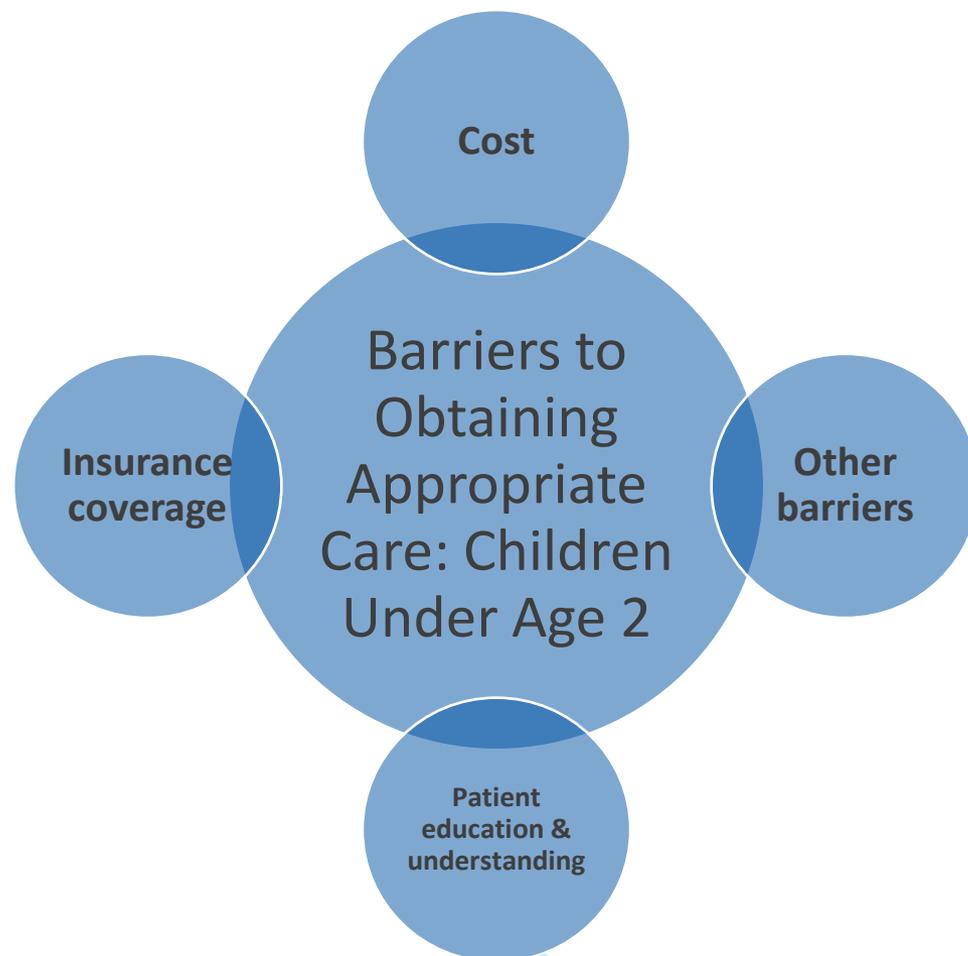
**Patient
education &
understanding**

**Other
barriers**

"[The] majority of my pregnant patients have other young children and they don't have, or have a hard time finding care for them, so they end up missing appointments."

- Several mentioned **lack of understanding** of the importance of dental care during pregnancy, and **safety concerns** or misconceptions.
- Individuals mentioned **physical discomfort**; difficulty getting a **timely appointment**; difficulty finding **childcare**; and **having trouble getting time off of work**, due to the number of medical appointments women have throughout their pregnancy.
- Most suggestions related to **educating patients when possible**.

Cost and insurance coverage are perceived as the most significant barriers for obtaining appropriate oral health care for children under age 2.



- Some patients **have trouble finding providers** who accept state insurance.
- Some practices **do not see young children**.
- **Patient education.**
- Other barriers include difficulty **finding childcare; compliance and behavioral issues**; and worrying that their **child will be fearful** at the dentists' office.

"I think many parents are uneducated in regards to when the child should be seen."

Though hygienists do not report significant cultural barriers, about half have experience with language barriers among their patients.

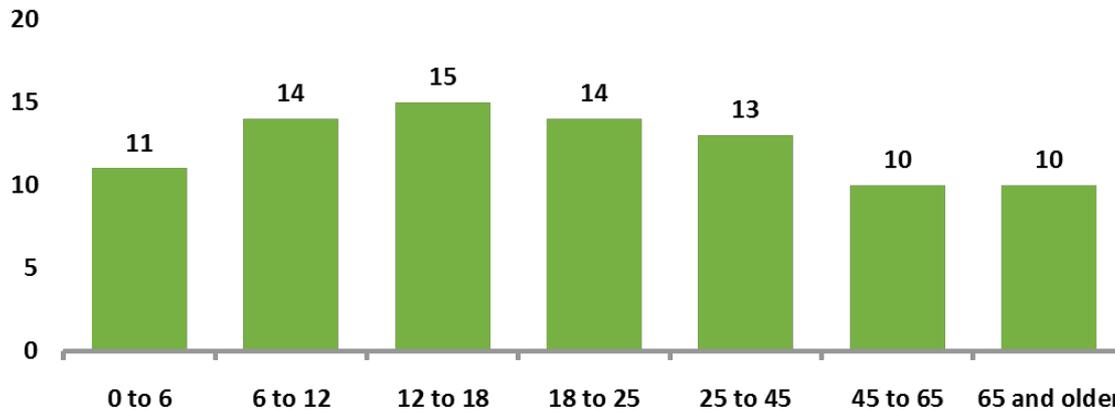
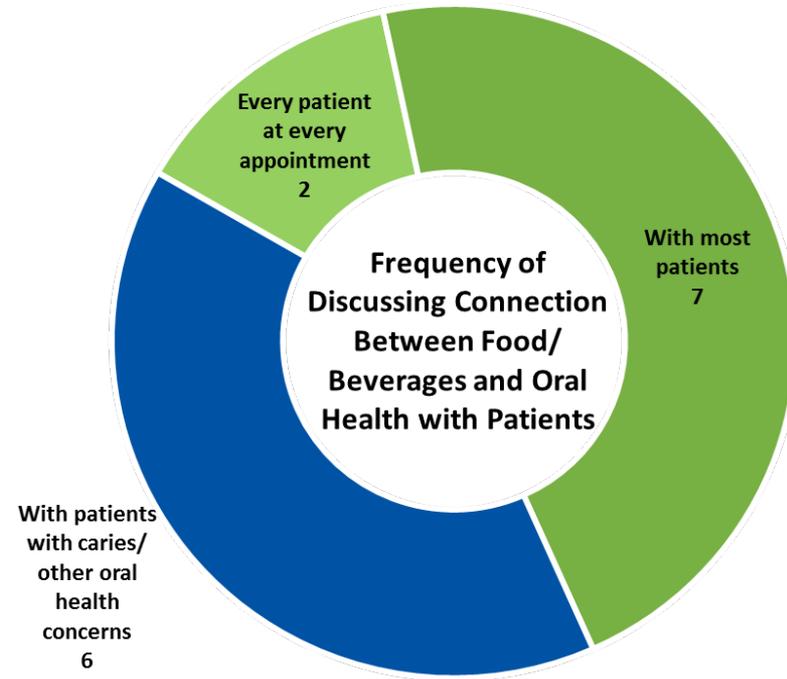
- A few have experienced cultural barriers:
 - *“I find many different cultures don't value early dentistry and often only bring their children in because school or preschool requires it. Often times these patients have ECC and it goes untreated, many parents don't understand that primary teeth are important too. I see this in my Chinese patients and my Middle Eastern patients the most.”*
 - *“I have found that in the Jewish community most of the parents are not as receptive to the advice on oral care that I give. The children come time after time again stating that they are not brushing their teeth and nothing I do can seem to get through to them.”*
- Hygienists suggested **relying on visual aids** when educating patients; having materials **translated into multiple languages**; and having **someone in the office to translate** if possible.

*“The main barrier for myself is a language barrier that I sometimes encounter. I see many Hispanic patients, and although the children usually speak English, the parents barely do. I always like to explain necessary treatment and recommendations to both child (even if a teenager) and parent, and there is a huge barrier when the parent does not speak English. The child can translate, but **I am unaware if everything is being relayed.**”*

Specific Oral Health Topics

All hygienists report discussing nutrition with their patients.

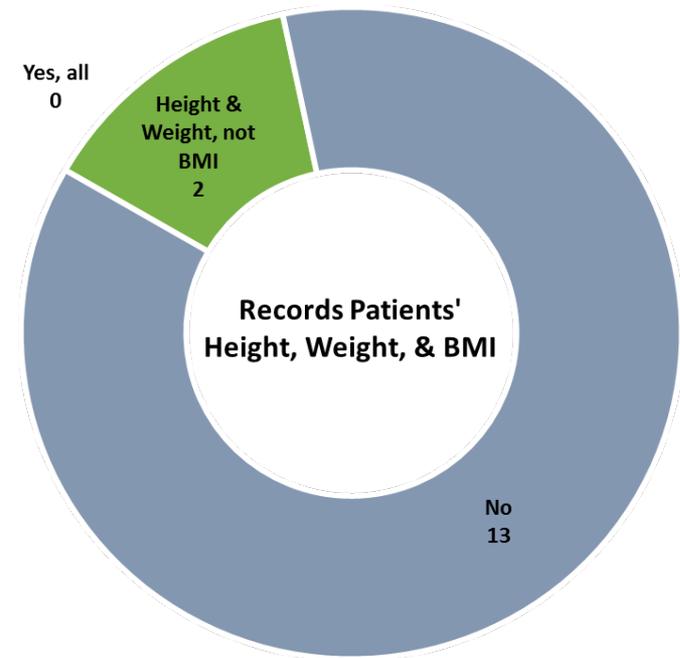
- Hygienists **do not limit these discussions** to sugary beverages, sports drinks, and coffee. Hygienists focus on foods that are **sugary or acidic**.
- Some are especially concerned with educating **younger patients** to help them develop healthy habits.
- Others **tailor the information** to each patient, depending on their age and conditions.



Hygienists discuss nutrition with patients across a variety of age groups.

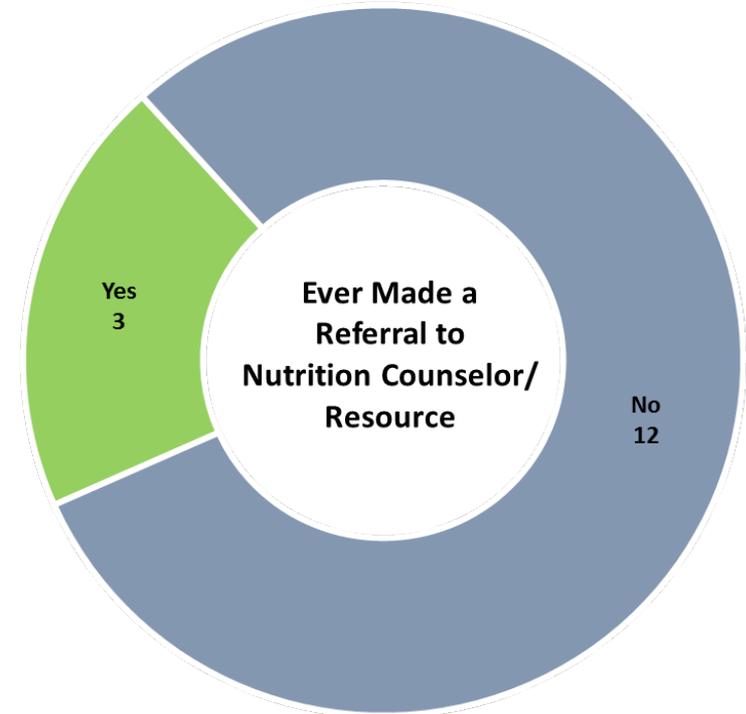
The majority of hygienists do not record patients' height and weight.

- Several **do not think it is their responsibility**.
- A few would feel **uncomfortable** collecting this information.
 - *“I personally don't know if I would feel comfortable recording this because I do not feel it is my expertise and I have noticed a lot of times patients are scolded in the medical field at every visit with their PCP to lose weight. I feel like this would give patients another reason to not enjoy coming to the dentist.”*
- Others do not have **time** or **equipment** to measure height and weight.
- Those who collect this information ask patients to **self-report** their height and weight on their new patient/medical history paperwork.



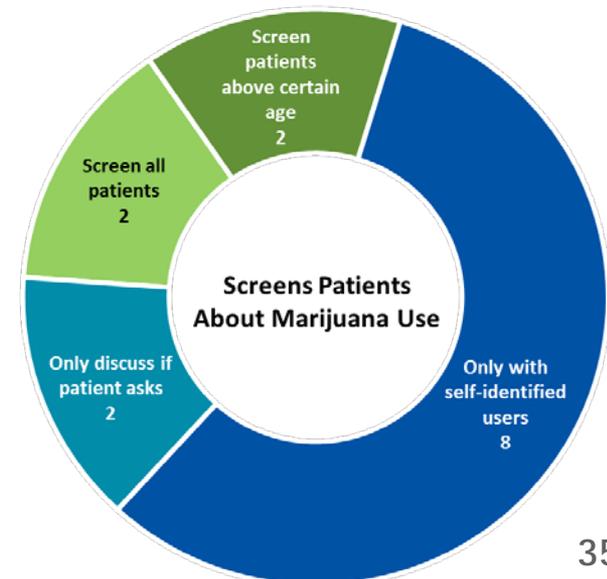
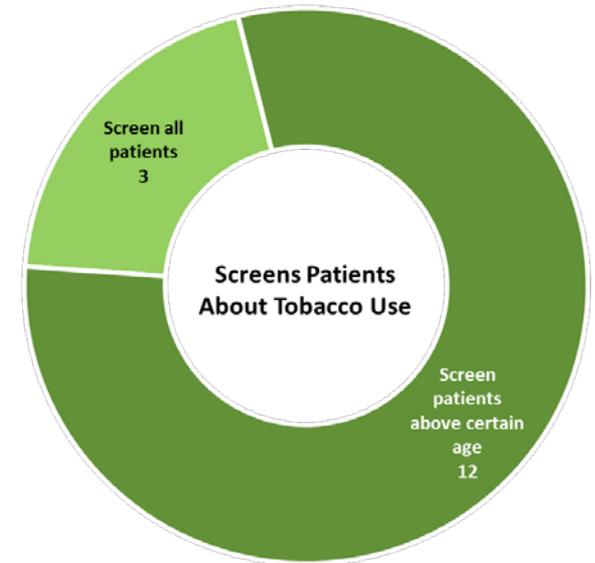
Most hygienists have not made a referral to a nutrition counselor or resource.

- Some have had no experience referring to nutritionists, and would feel more comfortable **if they knew where to refer patients.**
 - *“No I have not ever made a referral but if I have the right resources and some training on when to do so I would gladly refer so the patient can learn more about nutrition.”*
- One makes referrals to a nutritionist, who is a patient of their practice:
 - *“One of our patients is a nutritionist and she asked if we wouldn't mind referring our patient with uncontrollable caries to her so she is who we mainly use but we didn't refer before then. I do feel this is important and beneficial.”*
- The other two who indicated they have made referrals **did not do so formally**, but suggested that some of their patients seek out specific nutrition resources.



Screening for tobacco use is common, but hygienists are more likely to discuss marijuana use among self-identified users.

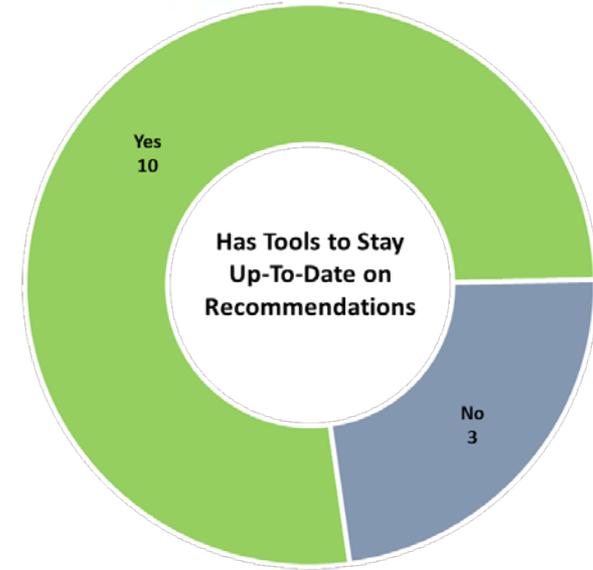
- The majority talk about **smoking cessation**:
 - *“The practice does stress tobacco cessation and offers a program the patient can participate in at no cost to the patient. We offer resources/information and a number they can call.”*
- A couple said the conversation about tobacco use is **different for pregnant patients**:
 - *“If the patient is pregnant then the conversation is very different and I'll explain the risks of SIDS and birth defects to the pregnant patient.”*
- Hygienists are **less likely to screen for marijuana use**, with most only discussing marijuana with self-identified users.
- Not all hygienists have **adequate information or resources** to discuss marijuana use with their patients:
 - *“I haven't become comfortable discussing marijuana use and mainly because I don't have the resources/information to do so. I'd like to be comfortable for sure!”*



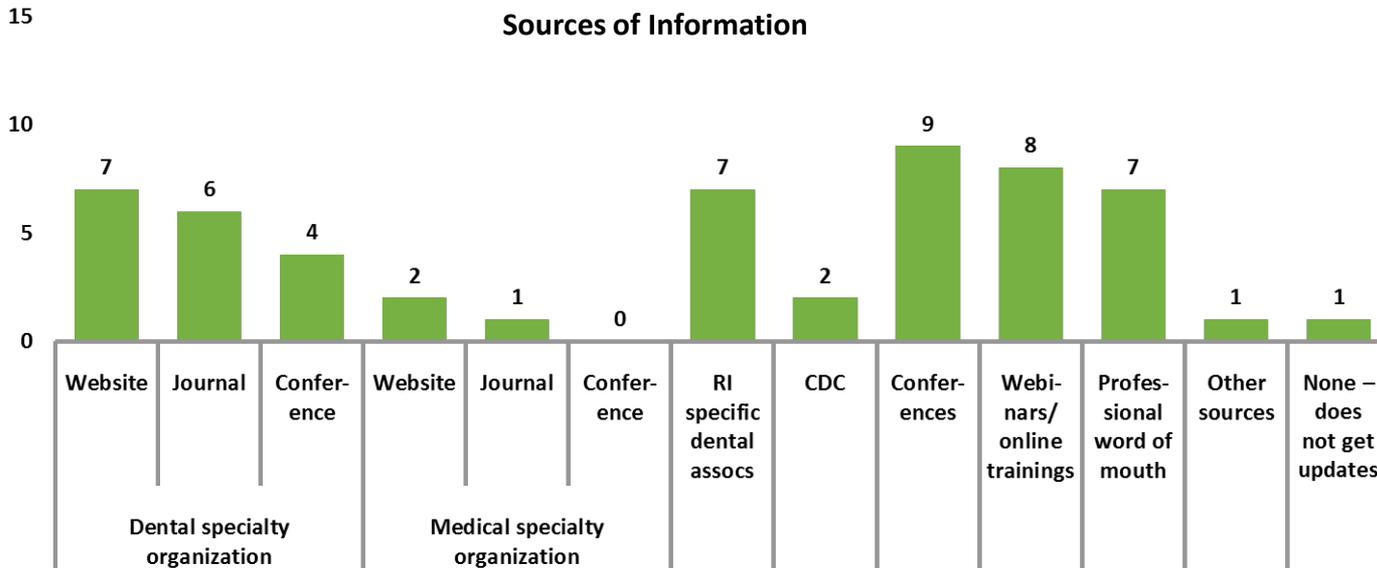
Experiences With and Attitudes Towards Tools and Resources

Most hygienists feel they have the tools they need to stay up-to-date on oral health recommendations.

- Hygienists are most likely to get information **from dental specialty organizations; Rhode Island-specific dental associations; conferences; webinars and online trainings; and word-of-mouth** from other dental professionals.
- A couple mentioned **posts on oral health Facebook pages**.
- The three who **do not feel they have the tools** actively seek out information about new recommendations, and would prefer to receive information through **email**.



Sources of Information



Specific websites mentioned:

- ADA
- ADHA
- Office of Disease Prevention and Health Promotion

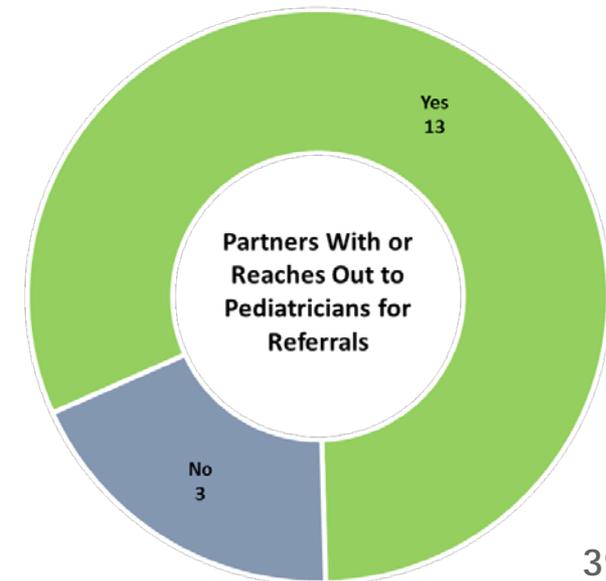
All of the hygienists indicated **interest in further education** about oral health recommendations and care for pregnant women and children under age two.

- Hygienists' requests for information focused on **treating pregnant women**.
- Some want to know more about the **connection between a woman's oral health and the health of her baby**:
 - *"I would love to have a lecture specific to pregnant women and the ways that their changing bodies and oral cavity will affect their child."*
- A few expressed interest in information about the **latest oral health recommendations and guidelines** for treating these populations.
- Individuals mentioned specific interests, including **tips about talking to parents of young children; nutrition**; getting young children to **behave or cooperate** during their appointment; and information about **resources to provide pregnant women and parents of young children**.
- Others have a general desire to be kept **informed about treating pregnant women and children under age two**.

"My own knowledge is the foundation of my ability to be an effective clinician."

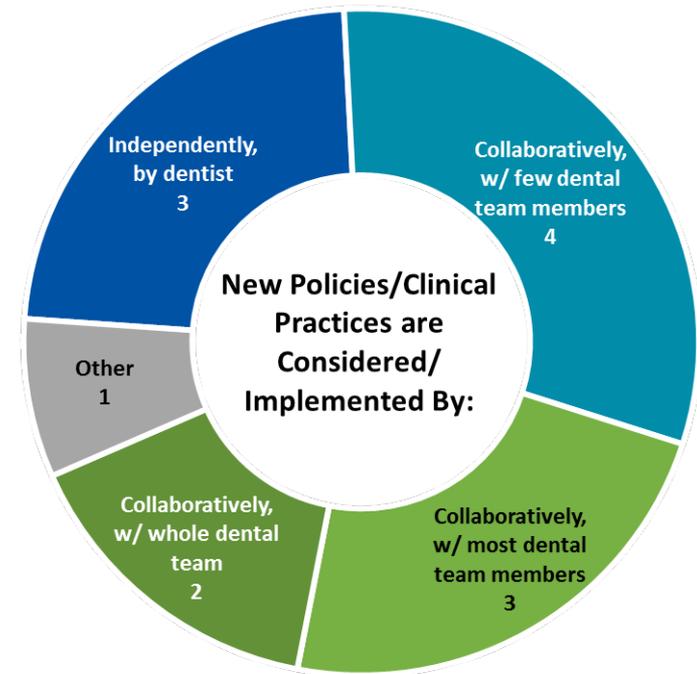
Most hygienists do not have partnerships for referrals for pregnant women and parents of young children.

- A few had **never thought of this as an option** for pregnant women.
 - *“To my knowledge I do not believe my office reaches out to OBGYNs. I am not sure if the thought has ever crossed my doctors mind.”*
- Some reach out to OBGYNs if they **require medical clearance**, or if there is an **issue with a pregnant patients**
- Most say their office partners with **pediatric practices**, but that largely related to **pediatric dental providers**, rather than pediatricians.
- This is most common when a child needs **extensive restorative care**.
 - *“My current office always refers the really young patients for restorative. I would say they refer children average of under 5, unless they are really cooperative.”*



New policies and practices are generally implemented collaboratively at hygienists' practices.

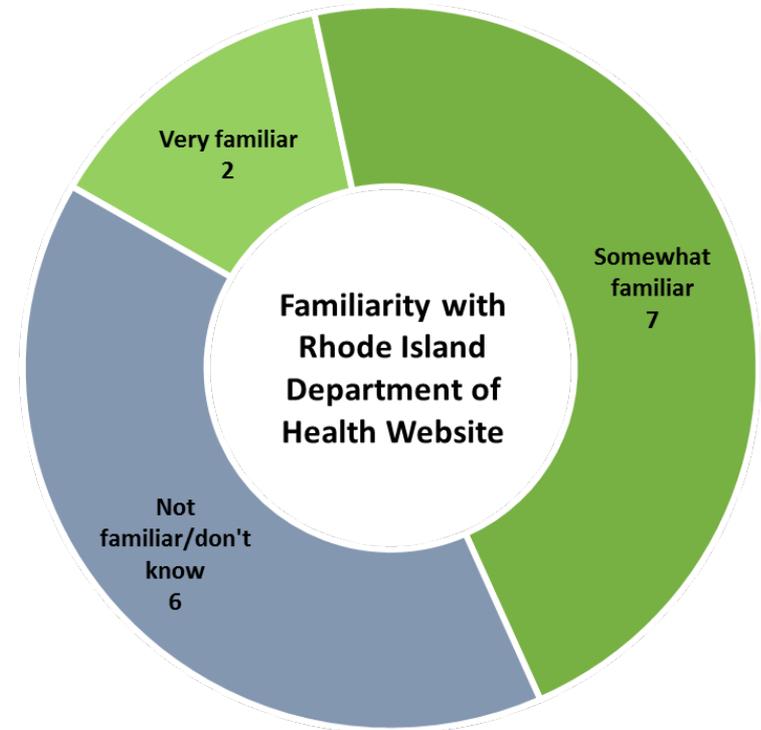
- Some reported these decisions start from the **top down**, with **feedback welcomed** along the way:
 - *“New policies and clinical practices are passed down by the director and manager. There is plenty of room for input by staff, then changes are made and an email is then sent so all are on the same page.”*
- Others describe a more **open** approach:
 - *“We don't have a set schedule for office meetings, but will meet as needed. Frequently, the staff member with the idea will approach the doctor first and then we will have a discussion. For hygiene-related policies or clinical practices, I would have the most input as the senior hygienist on our team.”*
- A few said decisions about new policies and practices are **decided by a small number of people**, usually the dentist or dental director, with **little room for feedback**.
 - *“My office is a bit old school and does not accept change readily. Being a recent grad I find that I am constantly trying to advocate change and implement new practices in my office. We have had a few lunch and learns about clinical practices but do not usually actually implement them into our office.”*



Experiences With and Attitudes Towards RIDOH and TeethFirst!

Hygienists are familiar with the Rhode Island Department of Health oral health website in general, but many are not aware of its specific content and resources.

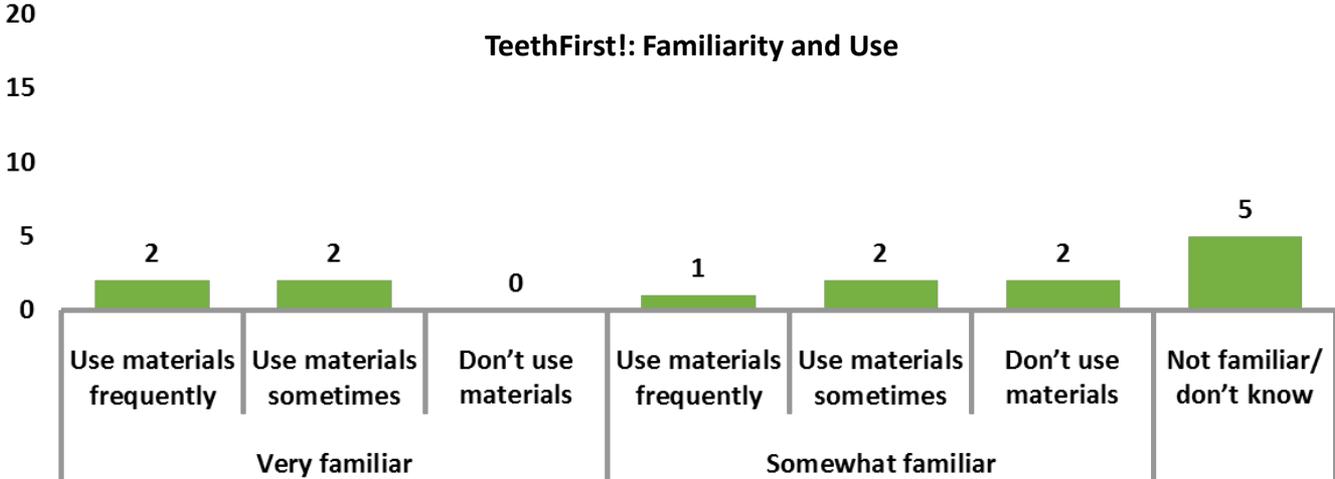
- Though many have visited the website, few are *very familiar* with it, and **couldn't suggest improvement** or perceptions of its content.
- A couple noted that they would like to see more **continuing education courses**.



Half of the hygienists use TeethFirst! materials in their practice.



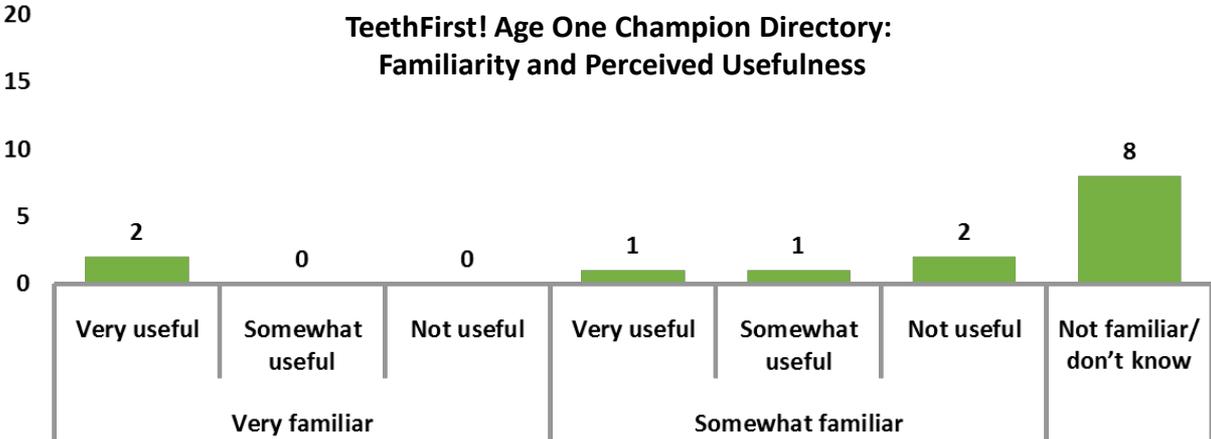
- Those who use the materials mention **flip books, brochures, and tooth brushes**, and are **highly satisfied** with them.
 - *“Yes I love to whip out my chair side flip chart with expecting Mother's and parents who are bringing their children in. I love the visual and explanations that are really able to get through to the patients. I met with Katy Chu a couple months back where she gave me plenty of flip charts, brochures, and tooth brushes which I have all put to good use.”*
- Those who are unfamiliar were **enthusiastic about using the materials**:
 - *“Yes! I would love to have more information regarding Teeth First. It could be very helpful in promoting young early good dental habits.”*



More than half of hygienists are not familiar with the TeethFirst! Age One Champion Directory.



- Two hygienists work for an Age One Champion practice, and consider this to be **very useful**.
 - *“My office is an age one champion. Having this as a tool for medical providers to know where to send children is a very important tool.”*
- The two who said this is *not useful* are **unlikely to see young children**, and that the **dentist** at their practice would **prefer not to be included**.
- Several were **interested** in joining, but the decision is **not up to them**:
 - *“I am not familiar with this tool but would like to hear more. I would have to ask my practice before I sign them up for this because our office standard is 3 as of right now. Given more information I'm sure they can be persuaded if it will make a difference.”*



When asked to make a recommendation to the Rhode Island Department of Health to improve the oral health of pregnant woman, infants, and children, most hygienists mentioned the importance of education.

- Pregnant women and parents of young children need to **understand the importance of oral health** for themselves and their children.
- Several mentioned the role of **providers** in educating patients—specifically dentists, OBGYNs, and pediatricians.
 - *“Education is the most important! This should **start in the doctors office** once a woman is told she is expecting and given info by her OBGYN such as basic guidelines during pregnancy. When I became pregnant I was never told about oral health by my OB and I was never told to be seen by a dentist, thankfully my career is based on this so I was educated unlike most newly expectant mothers. There should be more basis on prevention starting at the OB and pediatricians offices! Maybe referrals to dentists office can be given to help expedite this process.”*
- A few mentioned the need for **improved access to care**, noting that dental care can be prohibitively **expensive**, especially when providers do not accept state insurance.
 - *“Being in a FQHC access to dental care I feel is the number one barrier. More facilities should accept state coverage so pregnant women and children have more options. Private practices should be mandated to take a certain percentage of these families across Rhode Island so that these vulnerable populations can be served and the FQHCs are not over populated but will and can take the majority of these families.”*

Summary and Recommendations

Awareness of Oral Health Recommendations for Pregnant Women and Children

- Most are **aware of and agree with** ACOG's recommendations about dental care for **pregnant women**.
- Some had **concerns** about taking x-rays except in emergencies, and with administering anesthesia. A few would rather administer "risky" care after the baby is born.
- Most are **aware** of the recommendation that children should see a dentist within 6 months of eruption of their first tooth or by one year of age, and **most agree** with it.
- Hygienists see the function of this visit as an opportunity to **educate parents** on the importance of oral health; **early exposure to the dental environment**; and to **identify and address oral health problems** in young children.

Comfort and Confidence Treating Pregnant Women and Children

- Hygienists **are comfortable** providing oral health **preventative care** to pregnant women.
- Hygienists are **less comfortable** providing **scaling and root planing** with local anesthesia.
- Comfort varies by trimester, with hygienists **least comfortable** providing scaling and root planing during the first trimester. Some are concerned about **patient comfort** during the third trimester.
- The majority of hygienists **are comfortable** treating children **under age two**, but noted the potential for behavioral issues.
- Many do not regularly see children for their age one visit, and a few noted that their **office generally does not see patients under the age of three**.

Perceived Barriers to Care

- **Cost** and **patient education and understanding** are the most significant barriers for pregnant women and parents of young children.
- They also expressed concern that pregnant women and parents of young children **lack understanding** of the importance of oral health.
- Cultural barriers did not surface as a major issue, though many hygienists have experienced **language barriers**.

Tools and Resources

- Education is **clearly important** to hygienists, with the majority having the needed tools to stay up-to-date on the latest oral health recommendations.
- **All** were **interested in further education** about recommendations and care for pregnant women and children under age two.
- Most **do not have partnerships** with OBGYNs or pediatricians. Many have relationships with and reach out to pediatric dental practices.
- Half of the hygienists use TeethFirst! materials, and consider them to be **useful**, and those who are unfamiliar with these materials expressed interest in learning more and potentially using them.
- There is **room to increase awareness and use of the TeethFirst! Age One Champion Directory**.
 - Some were interested in learning more about this resource, but a few noted that the decision to join the Age One Champion Directory would be out of their control.

Blue Sky: Recommendations from Hygienists to the RIDOH

- **Improved patient and provider education.**
- Hygienists advocated for **improved connections between medical and dental care**, specifically among OBGYNs and pediatricians.
- Several shared the belief that there is a general **lack of understanding** about the importance of oral health among OBGYNs and pediatricians.
- Others noted that **too much responsibility is left in the hands of the patient** when it comes to oral health care for pregnant women and young children.

Increase Awareness of Existing Tools Among Hygienists

- The hygienists who were not familiar with **TeethFirst!** materials were **enthusiastic about learning more** about them, and potentially using them.
- RI KIDS COUNT should **target hygienists** when promoting these materials.
- If RI KIDS COUNT **increases awareness of TeethFirst! materials among hygienists**, some may bring the idea of using these materials back to their practice.

Continue and/or Expand Educational Campaigns For Providers

- Parental education around oral health is clearly an issue, but some hygienists in this research suggested that the responsibility should start at the provider level—especially **OBGYNs** and **pediatricians**.
- Hygienists feel that OBGYNs and pediatricians **do not adequately emphasize the importance** of oral health during pregnancy and early childhood.
- Some also noted that these providers should make sure to inform pregnant patients about the **safety of dental care** throughout their pregnancy.
- All of the hygienists were interested in **further professional education** about oral health among pregnant women and young children.
- RI KIDS COUNT should make sure hygienists are **aware of existing resources** for continuing education topics, and to the extent possible, offer more opportunities to hygienists, specifically.