SKIN CARE: SUNSHINE AND BUG BITES
Dear Colleagues,

February 14, 2019 was the somber one year anniversary of Parkland shooting. I wish I could say that we have come a long way since that time in better protecting our children from gun massacres. Unfortunately, that has not been the case.

Thoughts and prayers are just not enough anymore. We need to do more.

Gun massacres continue to threaten our children and other fellow citizens. One year and one month after the Parkland massacre, we woke up on March 15, 2019 to the horrific news of another massacre half way around the world in Christchurch, New Zealand.

Gun massacres are an epidemic in the United States, and must be dealt with as we deal with other epidemics. Our great nation has the wherewithal to respond to the gun massacre epidemic. We did it before by dealing with the culprit. We dealt with the AIDS epidemic by dealing with the culprit – HIV. We are dealing with the opioid epidemic by going after the culprit - opioids. Why are we afraid to deal with the culprit of the gun massacre epidemic - guns?

The Columbine shooting shocked the nation. The Excel Industries shooting traumatized us. Aurora and Las Vegas devastated everyone. Charleston, Pittsburgh and Christchurch shootings stunned the world. It appears that we are not safe at school, at work, at play, or at prayer. It is not enough to be just outraged. Think of this statistic: in 2017 guns were responsible for the death of more than double the number of children when compared to deaths of police and military personnel killed in the line of duty (2,462 vs 1,144).

As physicians, we need to take the lead as we have done in many other epidemics, past and present. The American Medical Association has called “gun violence a public health crisis”. The American Academy of Pediatrics’ “resolve for gun violence prevention is stronger than ever”. Your own Florida Chapter of the AAP, with your support, took on the State of Florida to fight laws that would not only thwart free speech but also prevent physicians from educating their patients about firearm safety. Although we won, we must to do more. Until we have stronger Federal laws, prevention of gun massacres has to be done State by State.

We need to demand that our state medical associations follow the AMA and AAP and take a stronger and more proactive stance on the gun massacre issue. We need to advocate both nationally and in our states.

Things can change quickly if there is a will to do so and if we have courageous leadership. If New Zealand can change its laws and ban all assault type firearms within six days of a mass shooting after 50 worshippers were massacred in a Masjid in Christchurch, we can certainly do it. Jacinda Arden, the Prime Minister of New Zealand, showed courage, compassion, and leadership after the gun massacre. All of us, especially our leaders, can learn from her. She has done more for gun violence prevention in six days than we in the United States have over a much longer time span.

Thank you, Madame Prime Minister for showing us how it should be done. Now is the time for us to take action.

Mobeen H. Rathore, MD, CPE, FAAP, FPIDS, FSHEA, FIDSA, FACPE
Editor, The Florida Pediatrician

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Contact the Editorial Committee at info@fcaap.org for more information!

Jacinda Arden
Prime Minister of New Zealand

Moeen H. Rathore, MD, CPE, FAAP, FPIDS, FSHEA, FIDSA, FACPE
Editor, The Florida Pediatrician
On Monday, April 1, 2019 Governor Ron DeSantis announced the appointment of FCAAP Treasurer Dr. Scott A. Rivkees as Florida Surgeon General and Secretary of the Florida Department of Health. Congratulations, Dr. Rivkees!
LETTER TO THE EDITOR

Addressing Knowledge Gaps in Sickle Cell Disease Through Networking and Project ECHO Telementoring

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4Salah Foundation Children’s Hospital at Broward Health, Ft. Lauderdale, Florida

In 2010, a publication estimated 70,000-100,000 people were living with sickle cell disease in the United States.1 Florida and New York are the two states with the highest number of patients with sickle cell disease, with the greatest number located in the metropolitan areas (Greater Miami, St Petersburg/Tampa, Orlando and Jacksonville). However, the exact population is unknown because no national registry exists. Since children with sickle cell disease are diagnosed through newborn screening and have a chronic illness with challenges across all age groups, the primary care physician should have an important role in monitoring and managing these patients. Nonetheless, some providers may not have the experience or time to keep up-to-date with the latest developments and may not feel prepared to handle patients with sickle cell disease.2

With that in mind, the Health Resources and Services Administration (HRSA) is sponsoring a 5-year program in all geographic regions in the United States with the purpose of increasing practitioners’ knowledge about sickle cell disease and consequently enhancing patient care. The University of Miami is the primary awardee in Florida within the Southeast Region. The University of Miami is working in collaboration with Johns Hopkins ALL Children’s Hospital, the University of Florida and the Salah Foundation Children’s Hospital at Broward Health, along with several community-based organizations, to begin reaching out to providers throughout Florida. The Institutions involved have dedicated sickle cell clinics and/or are patient advocate organizations.

The first objective of this research is to determine the baseline knowledge and experience of pediatricians throughout Florida about sickle cell disease. For this objective, we will contact physicians in our communities to collect online survey information. Also, interested practitioners could contact Dr. Alvarez at oalvarez2@med.miami.edu.

The second objective of the study is to promote the tele-ECHO Program as a way of networking and telementoring. Project ECHO (Extension for Community Healthcare Outcomes) is an evidence-based model that provides high-quality medical education for many different diseases through telementoring and co-management of patients with primary care clinicians. The ECHO model helps to bridge the gap between primary care clinicians and specialists by enhancing the knowledge, skills, confidence, and practice of primary care clinicians in their practices.3 Currently, there are 404 ECHO Programs, covering a multitude of different medical topics, including sickle cell disease.4 Two active sickle cell programs have reported their experience.5 During ECHO sessions, two patients are discussed in detail with feedback by the clinicians and experts participating in the session, and there is a short (15-20 minutes) didactic presentation. Participants may receive one-hour of continuing medical education upon request.

The current Sickle Cell Project ECHO Telementoring Programs are:

- Johns Hopkins
  - Physician: Sophie Lanzkron, MD, MHS
  - Coordinator: Bailey House
  - mrowland@c3dibd.org
  - Coordinator: Michael Rowland
  - mrowland@c3dibd.org

- Medical University of South Carolina (MUSC)
  - Physician: Julie Kanter, MD
  - Coordinator: Sarah Moderhack
  - Physician: Ify Osunkwo, MD
  - Coordinator: Tiffany Mackey
  - Physician: Kaitlin Jones
  - Coordinator: Aaron Koster

- STORM TeleECHO Cincinnati Children’s Hospital Medical Center
  - Co-Directors: Lisa Shook, MA, MCHES and Lori Crosby, PsyD
  - Program Specialist: Christina Bennett Farrell, MPH, GPM
  - stroetcho@chmc.org
  - Coordinator: Marsha Treadwell, PhD
  - Coordinator: Michael Rowland
  - mrowland@c3dibd.org

- Atrium Health
  - Physician: Ify Osunkwo, MD
  - Coordinator: Tiffany Mackey
  - Physician: Kaitlin Jones
  - Coordinator: Aaron Koster

- Western States Telementoring Collaborative For SCD
  - UCSF Benioff Children’s Hospital Oakland
  - Facilitator: Marsha Treadwell, PhD
  - Co-Director: Michael Rowland
  - mrowland@c3dibd.org

- Different Fridays 12:00 PM Monthly Call Pacific/Mountain Time

The third objective of the HRSA-sponsored research is to improve patient health outcomes. Health outcomes of interest are hydroxyurea utilization, pain management and a successful transition from pediatric to adult care, among others. Quality metrics, such as adherence to immunizations and transcranial Doppler screening for primary stroke prevention, are also tracked. Interested providers are welcome to contact us and/or take the online survey.

REFERENCES

Skin Care: Sunshine & Bug Bites

Laura Huang, MD1, Jordan D. Rosen, BS2, Lin-Lan Tang, MD3
1University of Miami Department of Dermatology and Cutaneous Surgery
2University of Miami Miller School of Medicine
3Pediatrician in Warren, New Jersey

Florida is the third most populated state in the United States and is visited by over 100 million tourists each year. As the “Sunshine State,” people are drawn to its subtropical and tropical climate. Locals and visitors alike yearn to go outside and enjoy the many activities that Florida has to offer. While relaxing on the sandy beaches or watching alligators in the Everglades from the safety of an airboat, people are exposed to the sun and wildlife. This article aims to address two common dermatologic conditions related to this environment.

THE SUNSHINE STATE

Skin cancer is the most common malignancy worldwide and the incidence continues to rise [1]. There have been many risk factors linked to skin cancer, including genetics, cumulative sun exposure, history of sunburns, history of organ transplantation, and even the human papillomavirus [2, 3]. While the cause for skin cancer is multifactorial, ultraviolet (UV) radiation from the sun is a well-established factor that can be mitigated [1]. Awareness of the relationship between UV exposure and skin cancer has increased due in part to public health efforts established through the United States Surgeon General as well as the United States Preventive Services Task Force (USPSTF) [4]. The two main types of UV rays are UVA and UVB, both of which play a role in skin cancer. UVA rays have a longer wavelength and penetrate deeper into the skin compared to UVB rays. UV radiation directly and indirectly damages DNA by creating pyrimidine dimers, mutating p53 tumor suppressor genes, and inducing free radical damage [2]. The effects of UV radiation has led the International Agency for Research on Cancer of the World Health Organization to classify both sunlight and tanning beds as Group 1 carcinogens [4, 5]. The American Academy of Pediatrics (AAP) and USPSTF both support and recommend skin cancer prevention as well as counseling [4]. The importance of sun protection and sunscreen is also emphasized in media. However, studies have shown that knowledge alone is not enough to change long-term behavior. A study examining sun protection compliance in France found that individuals who use sunscreen had better knowledge of the risks associated with UV radiation compared to those who don’t use sunscreen. However, this same group of individuals—those with the greater knowledge—also endorsed more behaviors with sun exposure compared to the other group [1]. Hence, education from physicians and health professionals remains crucial and plays a key role in skin cancer prevention. A systematic evidence review found that in the pediatric population, interventions and counseling produces favorable behavioral outcomes [6]. Overall, pediatricians are counseling their patients more frequently about UV radiation exposure. A study of US American Academy of Pediatrics members in primary care compared their attitudes and practices in sun protection counseling in 2002 with those in 2015. The surveys demonstrate that the percentage of pediatricians that counsel greater than 75% of their patients increased from 23% in 2002 to 34% in 2015. This is especially important for children because overexposure to UV radiation at a young age increases the risk of skin cancer [4]. When counseling patients as well as their parents, the AAP and Centers for Disease Control and Prevention recommend using multiple methods of sun protection [4]. Table 1 displays the current recommendations adapted from the American Academy of Dermatology (AAD) [5].

<table>
<thead>
<tr>
<th>Sun Protection Factor (SPF)</th>
<th>Table 1: UV protection guidelines [5].</th>
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<tbody>
<tr>
<td>Minimize sun exposure (especially between 10 AM and 2 PM)</td>
<td></td>
</tr>
<tr>
<td>Utilize protective clothing to reduce sun exposure</td>
<td></td>
</tr>
<tr>
<td>- Long sleeved shirt</td>
<td></td>
</tr>
<tr>
<td>- Long legged pants</td>
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<tr>
<td>- Wide brimmed hat</td>
<td></td>
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<tr>
<td>- Sunglasses</td>
<td></td>
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<tr>
<td>- Clothing with UPF</td>
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<tr>
<td>Use a broad-spectrum sunscreen that is water-resistant and has an SPF 30+</td>
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</tr>
<tr>
<td>- Apply daily to all skin exposed to the sun, especially if you will be exposed to water, snow, or sand</td>
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</tr>
<tr>
<td>- Generally reapply sunscreen every two hours (especially if active outdoors)</td>
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<tr>
<td>Do not use tanning beds</td>
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</tbody>
</table>

For infants under 6 months of age, the AAD, U.S. Food & Drug Administration (FDA), and AAP primarily encourages avoidance of sun exposure [6, 7, 8]. If possible, the AAD and AAP suggest avoiding sunscreen entirely in infants under 6 months [6, 7]. However, if protective clothing and avoidance of sun exposure is not feasible, the FDA suggests applying a small amount of SPF 15+ sunscreen to the infant’s face and hands [8].

In terms of the sun protection factor (SPF) of the sunscreen, there has been some controversy. Currently, the AAD recommends SPF 30 or greater and the US Food and Drug Administration has proposed that sunscreens with SPF 50 or greater be labeled as having a high SPF 50+ instead of a specific number. However, a recent study funded by Johnson and Johnson demonstrated that sunscreen with SPF 100+ was significantly better in sunburn protection compared to sunscreen with SPF 50+ and hence, it may be important to not restrict the SPF labeling on sunscreens [9, 11].

MOSQUITO BITES

Mosquitoes are nuisances that we are far too familiar with in Florida. Not only can they produce very pruritic wheals that can lead to secondary infection when excoriated, but they are also vectors for many mosquito borne illnesses. These illnesses include dengue, malaria, chikungunya, West Nile virus, and even Zika. With human travel, climate change, and mosquito population migration, these insects as well as the diseases they can transmit are now appearing beyond their traditional borders [12]. A recent example that highlights this pattern is the Zika outbreak in 2016. The epidemic in Latin America and the Caribbean was especially worrisome with the potential severe neurologic sequelae seen in the offspring of infected pregnant women [13]. By the end of 2016, there were over 4,500 travel-associated cases of Zika seen in the United States. The relationship with human travel was further supported by seeing a greater number of cases in states with more influx of international travel. Additionally, the first non-travel-associated case of Zika virus infection in the United States was identified in Miami, Florida. A pregnant woman with the infection presented with fever, myalgias, joint pain, and a widespread erythematous, pruritic rash [14].
The most effective means to prevent transmission of mosquito borne illnesses is to control the mosquito population and to minimize human contact with mosquitos. This encompasses a wide array of tactics, including space spraying, which is recommended to only be used in emergencies, and biological control, which is the use of other organisms to reduce mosquito populations [12].

There are also many simple behavior modifications and prevention strategies that can be executed at the level of individuals. The Florida Department of Health has a “Drain and Cover” campaign with a public service announcement as well as public posters to highlight these approaches [15]. Table 2 lists environmental changes that have been recommended. In terms of counseling, patients and parents often inquire about repellants that are recommended. The following ingredients have been found to provide several hours of protection: DEET, IR3535, oil of lemon eucalyptus, and picaridin. Additionally, people should be counseled to avoid being outdoors at dusk and dawn and to cover their skin with long-sleeved shirts and pants [12].

<table>
<thead>
<tr>
<th>Environmental changes to reduce mosquito borne illnesses [12 15]</th>
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</thead>
<tbody>
<tr>
<td>Updating and maintaining appropriate community and household water supplies to limit potential habitats for larvae</td>
</tr>
<tr>
<td>Frequent draining and cleaning of vessels that may collect water, including planters, old tires and bird baths</td>
</tr>
<tr>
<td>Minimizing contact with mosquitos through the use of barrier devices such as wire screens for windows or doors and mosquito nets</td>
</tr>
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</table>

There is no doubt that Florida is a beautiful state that offers many outdoor adventures. We encourage everyone to enjoy their activities while practicing these preventative measures.

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11. Williams JD, Maitra P, Arillasoy E, et al. SPF 100+ sunscreen is more protective against sunburn than SPF 50+ in actual-use: Results of a randomized, double-blind, split-face, natural sunlight exposure, clinical trial. Journal of the American Academy of Dermatology 2017
12. McFee RB, Bush L, Vazquez-Pertejo MT. Mosquito vectors. Disease-a-Month 2018
To recognize and understand what resources are available to patients in our communities is paramount in addressing the problem. It is well known that homeless youth have health consequences related to injury, drug use, prescribed medication use, I discovered that the patient had difficulty obtaining inhalers due to minimal finances and periods of homelessness. For example, in the Pinellas County 2016 Point-In-Time Homeless Report, the one-day count (a snapshot of homelessness in one day) found 127 unaccompanied youths, defined as 24 years old or younger, with 34 individuals under age 18 (7). Adolescents often struggle to overcome additional informal access barriers such as issues surrounding confidentiality, need for parental consent, distrust of professionals, and lack of awareness of services. Every day as providers, we encounter individuals and families struggling with homelessness.

As pediatricians, we are on the front lines and should encourage one another to screen for the basic needs of our patient’s daily living as these are pertinent to overall health. Determining housing status requires asking questions in a sensitive and non-threatening manner. First steps include identifying community resources, utilizing simple screening tools such as the Hunger Vital Sign (5) and encouraging staff and providers to have an open dialogue with families. Asking families “Do you have any concerns about your housing?” can be an easy screening question to help determine housing status, environmental exposures, or parental concerns.

Communication is key when approaching patients and families and it is important to take into consideration patient access to phone, web, and mail services. Consider connecting patients to local resources to assist with transportation vouchers and offering flexible office visit scheduling policies and late policies. When discussing treatment options consider prescribing affordable treatments (6), ease of compliance to therapy, and resources for discounts or coupons at local pharmacies. It is also pertinent to refer families to programs such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance for Nutrition (SNAP), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). These are just a handful of resources to keep in mind during patient encounters.

I have been fortunate to connect with my community by being curious, identifying hospital advocacy champions, and reaching out to local organizations. Through this partnership, we hope to establish safety and shelter services for adolescents and youth identifying as lesbian, gay, bisexual, and transgender (LGBT) in our county. We are also discussing how our resident ambulatory clinic may be a resource to these individuals by connecting them with community partners. Thanks to having an experienced inter-professional team ranging from social workers to law enforcement personnel, we are taking steps in the creation of a safe environment for youth to take shelter and transition into sustainable transitional programs. Seeking out a similar partnership in your own community, could be a meaningful way to bridge the gaps in healthcare we encounter in daily practice.

I encourage my fellow trainees to reach out to hospital and community individuals who share your passions, get involved in local government, and openly discuss ideas for advocacy for your patients with your colleagues. I encourage you all to continue to be advocates in your community as leaders in child health and to raise awareness for this issue throughout our state.

RESOURCES
BACKGROUND

Early childhood caries is the most common chronic disease in children. Twenty-four percent of US children 2 to 4 years of age, 53% of children 6 to 8 years of age, and 56% of 15-year-old adolescents have had experiences with tooth decay. Untreated dental caries, filled teeth, and removal of diseased teeth are the most frequent of these experiences. The Centers for Disease Control data reveals that caries is four times more common than asthma, making it a prominent issue in pediatrics. Tooth decay can impair young children’s overall health, speech development, growth, school performance, and mental health.

Childhood tooth decay is preventable and largely reversible in its early stages through self-care, use of professional services, and exposure to community interventions such as water fluoridation. The rising concern about the impact of dental disease on overall health and poor utilization rates of dental care services over the past decade led to recommendations from various organizations. The American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry. In fact, both professional organizations have recommended that children establish a dental home by 12 months of age. However, data has shown a lack of oral health training in pediatrics’ programs by creating a comprehensive oral health risk assessment tool for general pediatrics.

Previous studies have shown an association between the age of a child’s first preventative oral health visit and subsequent dental related costs to both the caregiver and for the health care system. Billing data from children aged zero to seven years was collected from 20 corporate treatment centers serving children from lower socioeconomic backgrounds and found that patients whose first dental visit was before 4 years of age had on average 3.58 fewer dental procedures and incurred less dental related costs. Medicaid data from 6 states in children aged 1 to 20 years who received surgical care in the operating room (OR) or ambulatory surgery center (ASC) in 2010 and 2011 for potentially preventable diagnoses, as defined with diagnostic codes was extrapolated to the United States. This data suggested that approximately $450 million in additional expenditures occurred in 2011 because of OR or ASC surgical care for potentially preventable pediatric dental conditions.

OBJECTIVES

The global aim of this project was to improve overall oral health counseling in the pediatric office setting by utilizing a standardized oral health survey and education program. Improvement was tracked by analyzing the following measures: (1) documented oral health counseling and examinations for patients seen for well child examinations, (2) rate of dental referrals, and (3) the application of fluoride varnish by pediatricians as a means of encouraging preventative dental services.

METHODS

A standard Plan-Do-Study-Act (PDSA) quality improvement model was utilized. As part of this initiative, caregivers were asked to complete an oral health survey designed to assess risk factors for the development of childhood caries and the current level of knowledge primary caregivers have in general oral health for children. Participation was voluntary. The study was conducted at an ambulatory practice located in a not-for-profit academic pediatric hospital. Surveys were offered to caregivers of children who presented for scheduled well child examinations. The survey was a modified version of the AAP Oral Health Assessment Tool for pediatricians and was comprised of thirteen questions regarding age at initial dental examination, risk factors for caries (i.e. bottle to bed practices, breastfeeding past 12 months of age, snacks), toothbrushing habits, emergency dental treatments, fluoridated water supply, and parental caries. Both pediatricians and pediatric dentists reviewed the survey to determine its feasibility as a screening and counseling tool. Surveys were available in English and Spanish to prevent translation barriers. Survey participants included parents of Medicaid-eligible and privately insured children at least 12 months of age.

As the second tier to the project, pediatric residents and attending-level physicians were asked to provide preventative dental counseling. The pediatric primary care providers were instructed on the AAP Oral Health Risk Assessment tool and Management protocols through electronic and paper communication. This teaching included a formal lecture on oral health principles in children, hands-on clinic instruction on applying the fluoride treatment, and email blasts with dental health guidelines. Providers had paper copies of the oral health risk assessment tool available during patient encounters to guide dental counseling. Providers also had access to fluoride treatments with detailed application instructions.

Retrospective review of 150 patients’ charts was completed. Selection criteria for review included the following: patient age equal to or greater than 12 months of age, well child examination as the primary visit reason, and if the health care provider evaluating the patient had the caregiver of the patient complete the dental health assessment survey. Qualitative data reflective of survey findings and descriptive data from both the caregiver and from the medical provider were included in analysis.

Survey for Smiles: The Role of Structured Oral Health Counseling in the Pediatrician’s Office

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2University of Florida Shands Children's Hospital, Gainesville, Florida (new affiliation)
RESULTS

The records of 150 patients meeting inclusion criteria were reviewed. Following structured dental counseling in a primary care pediatrics setting, the rate of documented oral health counseling and examinations (Measure #1) increased from 48% to 94%. The rate of dental referrals made by pediatricians (Measure #2) increased from 22% to 89%. Health care providers were also more likely to offer and/or apply fluoride varnish (Measure #3) to patients once the structured dental counseling program was in place. Documentation prior to intervention revealed that only one patient among those reviewed had been offered a fluoride varnish during the annual physical examination.

Most caregivers were not aware that the health of their children’s primary teeth affected their permanent teeth. Over 65% of caregivers did not know that the American Academy of Pediatrics and the American Academy of Pediatric Dentistry recommend that all children have a general dental evaluation by 12 months of age. Oppositional or uncooperative behavior of the child during the tooth brushing process, requiring special needs, and a misperception that the primary teeth did not need to be brushed more than once daily were the most common reasons reported for poor dental hygiene. Caregivers further expressed fears of their children requiring general anesthesia or sedation for oral procedures as reasons for not seeking recommended procedures.

DISCUSSION

The study results suggest that there is a role for pediatricians in educating caregivers about the disease process of dental caries, preventative measures, and interventions available to maintain and restore oral health in children. This study found that having a structured dental health counseling program within the general pediatrics setting encouraged good oral health behaviors. The structured program resulted in improved oral health counseling after which many caregivers expressed an understanding about the importance of good dental care hygiene and increased the referral rate to pediatric dentists. Healthcare providers also demonstrated increased knowledge of the recommendations made by the American Academy of Pediatrics and of their roles in encouraging oral health in their documentation of patient encounters.

The study population was composed predominantly of Medicaid patients, lending a unique feature to the study. In the State of Florida, Medicaid fiscal care data reflects that a largely disproportionate population does not utilize dental services when compared to the nation’s average. In Florida, twenty-one percent versus 38 percent of children nationwide utilize any dental service with an even smaller percentage – fourteen percent – with preventative dental services utilization. As a result of the structured oral health counseling, the study identified a general lack of knowledge regarding the recommended timing for structured oral health counseling, the study identified a general lack of knowledge regarding the recommended timing for tooth decay remains a substantial problem in children. Because children are exposed to pediatricians at an early age, pediatricians have an integral role in promoting the establishment of a dental home by all children by 12 months of age and in providing preventative oral health counseling. This study has identified that a structured oral health counseling program within a primary care setting can promote oral health and the referral process to dentists. The structured oral health program increased pediatricians’ proficiency in providing risk assessment, early detection, and referral services. Results of the study suggest that dental screenings can easily be incorporated into a busy practice and that pediatricians can provide oral health promotion to eliminate or delay dental disease and the need for high-cost treatments.

REFERENCES

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