**Aligning Oral Health Prevention to Evidence-Based Intervention Strategies Contained in the**

**Four Domains of Chronic Disease Prevention - Some Examples**

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| **Domain 1: Epidemiology and Surveillance**   * Conduct surveillance of behavioral risk factors (BRFSS, ATS, YTS) and social determinants of health, and monitor environmental change policies related to oral health and chronic disease risk factors. * Collect cancer surveillance data to assess burden and trends and to identify high-risk populations (oral and pharyngeal cancer). * Collect, use and disseminate data on oral diseases and use of preventive oral health services. * Monitor social and environmental factors that influence health, as well as policies that affect chronic diseases, such as those related to smoking, access to healthy foods, and community water fluoridation.   **Value Added:** Cross reference BRFSS data on obesity, tobacco use, diabetes, hypertension with oral health data. HPV vaccinations protect against oral and pharyngeal cancer. | **Domain 2: Environmental Approaches**   * Expand access to and availability of healthy foods and beverages through a variety of strategies to promote healthful nutrition and reduced consumption of sugar sweetened beverages and foods to reduce dental caries and obesity in children (and adults). * Expand access to community water fluoridation. * Support policies to reduce access and use of tobacco products to make smoking, chewing and vaping less attractive to youth and adults. * Support for policies to reduce access to sweetened foods and beverages through school lunch programs, increased taxes, etc.   **Value Added:** Water fluoridation protects children and adults from smooth surface caries  **DP16-1609 Grantees:** AK, NY |
| **Domain 3: Health Care System Interventions**   * Expand access to and use of clinical and preventive oral health services for children and adults. * Remove barriers to access to help ensure delivery of care to hardest-to-reach populations. * Define high-impact preventive services and priorities (e.g., dental sealants or children). * Establish patient/family-centered medical and dental homes. * Implement integrated health care information systems with automated prompts for physicians/dentists and patient reminder letters for screening and follow-up clinical counseling or referral. * Deliver tobacco use cessation services and make referrals for counseling and treatment. * Screen for high blood pressure, diabetes and prediabetes in dental offices.   **Value Added:** Annual dental exam can facilitate referral by dentist to a primary care provider and vice versa (primary care provider to dentist) for the treatment and management of chronic conditions (diabetes, hypertension, medication management.  **DP16-1609 Grantees:** CO, GA, MN | **Domain 4: Community Programs Linked to Clinical Services**   * Deliver school-based and school-linked dental prevention and referral programs. * Outreach to high-risk populations to increase use of clinical and other preventive services. * Implement systems to increase provider referrals of people with prediabetes or multiple diabetes risk factors to sites offering a CDC-recognized lifestyle change program. * Use health care providers (physicians, dentists, nurses, dental hygienists, pharmacists, etc.), community health workers, and/or patient navigators to support prevent and control risk factors for oral and chronic diseases (high blood pressure, high cholesterol, and high blood glucose levels).   **Value Added:** 1) Evidence-based diabetes management programs should include oral care and recommended dental visit. 2) Dental care providers can screen high-risk patients for prediabetes and evaluate the oral health of patients with diabetes, referring them to their primary care provider for follow up as needed.  **DP16-1609 Grantees**: MD |