**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 |