PERFORMANCE NARRATIVE

Summary of Progress
A. Accomplishments and Steps Taken to Overcome Barriers
   I. Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Strategic Plan

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Year 1-3 (Sep 30, 2013-Sep 29, 2016)</th>
<th>Barriers /Lessons learned</th>
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<tr>
<td>A statewide approach that responds to the needs of pregnant women and infants most at risk.</td>
<td>Healthy Baby Network (HBN) in Monroe County, is one of the 23 New York State Department of Health (NYSDOH) funded Maternal and Infant Community Health Collaboratives (MICHC). HBN was selected as the sub-contractor to pilot the PIOHQI initiative after a competitive bidding processes with the goal of expanding the initiative to the other 22 MICHC programs. The MICHC initiative prioritizes high-need women, infants and their families, with a focus on Medicaid-eligible individuals and populations residing in the highest need communities statewide, to improve maternal and infant health outcomes while reducing persistent racial, ethnic and economic disparities. Key priorities of the MICHC initiative include reducing preterm birth, low birth weight, and infant/maternal mortality.</td>
<td>HBN worked with subcontract partners including the New York State Oral Health Center of Excellence (OHCE) beginning in September, 2014 through 2016 to assist with implementation and evaluation of the project. The OHCE was established in 2014 to provide statewide assistance to communities, local health departments and health care institutions to improve population oral health as well as to enhance access to evidence-based oral health services. In 2016, HBN partnered with Eastman Institute for Oral Health (EIOH) to complete the MICHC Oral Health Manual and Toolkit (attachment 1) for community health workers (CHWs) and other</td>
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paraprofessionals, as well as prenatal care and dental providers. They also assisted in recruiting healthcare professionals, conducting trainings, and evaluation. This collaboration demonstrated the benefits of local partnerships. EIOH is a recognized leader in providing community-based oral health interventions in the Rochester NY area.

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| In 2016-2017, NYSDOH began expansion of the initiative statewide to the other 22 MICHCs to ensure that across the state the oral health needs of high risk pregnant women were being addressed. Throughout the project, periodic webinars were held with MICHC programs to present updates on HBN’s progress. In April, 2017, a webinar was held with all MICHC program coordinators and community health workers (CHWs) to report final progress of the HBN pilot and describe NYSDOH’s implementation plan to replicate the pilot model in all MICHC programs. Four regional “Train the Trainer” sessions were conducted beginning July 2017 – February 2018 for MICHC programs using the MICHC Oral Health Manual and Toolkit developed from the pilot project as a guide. The focus of the trainings were to provide guidance on how MICHCs can address oral health needs among the priority population; high-need pregnant/parenting women and their training MICHCs through a series of regional “Train the Trainer” sessions provided a platform for key MICHC staff to meet in-person, learn from each other and share ideas on the best ways to implement oral health strategies into their workflow. The NYSDOH Project Coordinator (PC) developed a pre-training survey to evaluate knowledge and practices before the training sessions. Overall results of the pre-training survey showed that 91% of MICHC programs conducted some type of oral health screening. A post-training survey was distributed and completed by attendees to assess the effectiveness of the trainings. Training recipients found the training highly useful in guiding their oral health integration efforts and valued the opportunity to meet in-person to
families. A copy of the training slides are provided in attachment 2.

Each MICHC program received a copy of the Oral Health Manual/Toolkit as a resource for training staff and community partners. The Toolkit was also shared with other state and federal stakeholders through the PIOHQI Learning Collaborative.

discuss best practices and barriers/challenges. The complete pre/post survey results are in attachment 3.

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<td>A statewide data system that drives quality improvement of the systems change.</td>
<td>HBN utilizes a health information technology (HIT) case management system to collect data on clients served in the MICHC program and provide referrals and follow up to ensure services were received. HBN is also participating in a NYSDOH Medicaid Redesign Team –HIT project to develop web-based HIT systems to capture medical and psychosocial needs and risk factors of high-risk pregnant women in order to facilitate timely needed referrals to health and social services. In 2015, HBN’s data system was modified to include two dental-specific questions to their screening tools: 1. Do you have any oral health problems? and 2. Have you been to the dentist in the past 6 months? In mid-2015, NYSDOH implemented a statewide policy for all MICHC programs to begin collecting standardized data on oral health status of clients served. Through a contracted agreement, the State University of New York - Center for Human Services Research (SUNY CSHR), was hired to construct a statewide data management information system (DMIS) for all MICHC programs, with built-in features to ensure that all clients reached through MICHC are screened for oral</td>
<td>The development and launch of the MICHC DMIS was delayed but launched on 4/1/2017. Due to funding cuts, the contract for data management was discontinued in June, 2017, and the project reverted back to using the pre-existing Excel Workbook known as the CHW Encounter Data Report. MICHCs are contractually required to submit quarterly data, which as of 2015 included standardized oral health information.</td>
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health problems using the same two dental questions from the pilot project. They also created universal forms to be used by all MICHC programs that fed the required data into the system, and embedded a process to utilize additional standardized screening tools to evaluate clients’ experiences with mental health issues, substance use and domestic violence.

Data captured in the system also includes the number of clients receiving oral health information and referrals for oral health needs.

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<td>Prior to the DMIS launch on April 1, 2017, SUNY CSHR convened a focus group comprised of select MICHC program coordinators to identify key elements to include in the database and address barriers/concerns with data collection. They also provided a series of training webinars and individual technical assistance to MICHC program staff as requested. An in-person information/training session was presented at BWIAH’s annual provider day held in Albany, NY in May, 2016.</td>
<td>With the discontinuation of the DMIS, NYSDOH data staff made modifications to the CHW Encounter Data Report to capture elements of the DMIS, and effectively monitor statewide progress on incorporating oral health strategies among MICHC programs. Improvements made include identification of new clients from recurring clients, and collecting data on the number of clients who completed referrals to needed services.</td>
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<td>A fiscal leveraging strategy that sustains this new delivery system.</td>
<td>Strategies developed through this project align with the existing MICHC scope of work and activities. During the project period, the PIOHQI project coordinator and NYSDOH in-kind staff provided continuous support, including data management, to the MICHCs via training</td>
<td>In 2016, administration of the PIOHQI project was transferred within NYSDOH’s Division of Family Health from the Bureau of Dental Health to the Bureau of Women, Infant and Adolescent Health, where the</td>
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and technical assistance as they began to integrate oral health into their programs. HBN staff continue to be resource for NYSDOH and MICHC programs on oral health integration and implementation. This effort will continue for the duration of the MICHC initiative. MICHC program is housed. This transition allowed for more direct oversight and rapid integration of oral health strategies into the MICHC program workflow. Over the last two state fiscal years, MICHC funding was significantly reduced. Contractors were encouraged to apply the cuts to administrative costs where possible to preserve community health worker (CHW) staff who are responsible for screening clients for oral health needs. Despite these efforts, CHW effort in the overall MICHC initiative has been reduced by 7% from 82 to 75 funded positions. It is anticipated that future funding will be available to sustain the MICHC initiative through 2025, however, future funding is not guaranteed.

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<td>During this period, the MICHC CHW Encounter Data Report was continually refined to streamline reporting and capture the number of new clients and completed referrals. Oral health questions are embedded within the data system as a standard requirement for all MICHCs, with quarterly qualitative and quantitative reports required. The full integration of oral health data collection and activities into the MICHC program allows NYSDOH to continue leveraging existing and future resources. Continuous training and technical assistance was required on data collection and reporting as well as oral health integration efforts. The PIOHQI project coordinator resigned in January 2018, which slowed progress in completing the final phase of oral health integration into MICHC programs. The principal investigator and other in-kind NYSDOH staff have provided support to the project.</td>
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### Strategies

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<th>Year 1-3 (Sep 30, 2013-Sep 29, 2016)</th>
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**Planned activities for integration of oral health-related services.**

- NYSDOH succeeded in carrying out all planned activities to integrate oral health into MICHC programs state-wide.

At the pilot site, HBN successfully:

- Incorporated two dental screening questions into their HIT case management system to better identify clients in need of oral health care referrals.
- Established an Oral Health Advisory Committee (OHAC) staffed with consumers, MICHC program participants, insurers, dentists, and representatives from health and human service agencies to provide input and direction on the project including development of the MICHC Oral Health Manual/Toolkit. As part of sustainability, training attendees are invited to attend bi-monthly OHAC meetings to ensure continued input from community stakeholders.
- With input from the OHAC, developed and published the MICHC Oral Health Manual and Toolkit (and other educational resources) under the direction of the sub-contractor, Eastman Institute for Oral Health (EIOH).
- Conducted focus groups with healthcare (medical/dental) and health and human services providers in the community to: identify topics of interest in oral health; determine the level of importance; and provide feedback on the draft of the Toolkit.

**Barriers /Lessons learned**

- HBN encountered difficulty engaging stakeholders as healthcare and human service providers are busy with competing priorities. Success was improved by extending invitations to community advisory committee meetings, and membership on their advisory committee.
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|   | • Conducted provider trainings to 126 participants, ranging from dental care providers, perinatal care providers, and CHWs via webinars and in-person meetings on use of the Toolkit and offered continuing education credits. Through use of pre/post tests administered by EIOH, oral health knowledge was assessed and showed an 65% increase in oral health knowledge among providers trained (attachments 4 and 5).
|   | • HBN staff continually provides oral health information and referral sources to consumers and partners via the OHAC, agency email and Constant Contact (email marketing software) distributions, and periodically posting information and updates on the agency social media and website, and continues to partner with the EIOH to attend community events to provide screenings, referrals, and information directly to consumers. Beginning in 1/2018, the OHAC has continued to meet bi-monthly.
|   | • Oral health supplies were purchased with grant funds and packaged as part of Oral Health Education Kits being used by MICHC, EIOH, OHAC, and collaborating dental, medical, and human service offices working with pregnant and parenting women to address healthy oral health behaviors.
|   | • With assistance from EIOH, created and continually update a database of dental practices accepting Medicaid, and disseminate to CHWs and health and human services (HHS) providers in the Rochester area. HBN continues to connect with dental practices and offer the oral health education kits, ask them to join the OHAC, and understand
more about the services they provide and how to better facilitate referrals to them.

- Oral health information is distributed by MICHC staff in the community, at HBN Community Action Network (CAN) meetings, HBN networking sessions, and other community meetings and events. MICHC Outreach Workers (OWs), CHWs, and Health Educators (HEs) are providing oral health information and referrals. HBN’s HE created an OH presentation for consumers to use when outreaching to existing and newly identified community partners.

- The HBN Oral Health webpage is completed and contains resources created during the project and links to EIOH and other relevant OH topics: [https://www.pnmc-hsr.org/oral-health/](https://www.pnmc-hsr.org/oral-health/).

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| At the state level, NYSDOH successfully: | • Changes in project oversight within NYSDOH caused delays in implementation including hiring qualified staff in October of 2016 to oversee the project (and early departure of project coordinator in January, 2018. In-kind staff were able to assist where possible to ensure the goals and objectives of the grant were met.  
• Leveraging the NYSDOH Title V program, the PIOHQI project coordinator often |

- Contracted with HBN for a fourth year (which included continuing the subcontract with EIOH) to allow them additional time to engage providers and community partners in finalizing the Toolkit, and refining their individual and systems-level strategies to improve maternal and infant access to oral health care and increase provider capacity.

- Evaluated resources and training materials developed by HBN, and utilized HBN training tools and lessons learned to develop a Train the Trainer module for MICHC programs.
<p>|• Continually updated MICHC programs via periodic webinars on progress and lessons learned at HBN, the pilot site, and disseminated resources they developed. | presented at Division of Family Health meetings to increase awareness among Department staff of the importance of pregnant and parenting women maintaining optimum oral health and healthy behaviors to improve birth outcomes. Also, in September, 2017, an in-person presentation titled “Integrating Oral Health into Maternal and Child Health Home Visiting, was presented at a Healthy Families NY meeting in Albany. The presentation was part of an interactive session on the importance of oral health among pregnant women, infants and children to demonstrate how home visiting programs can impact oral health of vulnerable populations. The presentation and workshop description are in attachments 6 and 7. |
|• Integrated two dental screening questions (used in the HBN pilot project) into the state-wide MICHC program protocol. |• Finalized statewide expansion plans and presented to MICHC programs via webinar in April, 2017. |
|• Finalized statewide expansion plans and presented to MICHC programs via webinar in April, 2017. |• Planned and conducted four regional training sessions (2017-2018) for MICHC program coordinators and agency directors. |
|• Planned and conducted four regional training sessions (2017-2018) for MICHC program coordinators and agency directors. |• Developed pre and post training surveys to assess oral health knowledge/readiness to implement oral health strategies, and the effectiveness of the trainings. The pre-training survey results were used to develop the MICHC training module. |
|• Developed pre and post training surveys to assess oral health knowledge/readiness to implement oral health strategies, and the effectiveness of the trainings. The pre-training survey results were used to develop the MICHC training module. |• Conducted monthly coaching calls with MICHC program coordinators to provide assistance with oral health integration activities. |
|• Conducted monthly coaching calls with MICHC program coordinators to provide assistance with oral health integration activities. |• Participated in the PIOHQI Learning Collaborative (monthly webinar learning events and check in calls with technical assistance provider, in-person meetings and submitted quarterly data to the project dashboard at <a href="http://cdhp.info/">http://cdhp.info/</a>). |
|• Participated in the PIOHQI Learning Collaborative (monthly webinar learning events and check in calls with technical assistance provider, in-person meetings and submitted quarterly data to the project dashboard at <a href="http://cdhp.info/">http://cdhp.info/</a>). |• Purchased oral health supplies (adult/child/infant toothbrushes, toothpaste and dental floss) and mailed to MICHC programs for use with providing oral health information to high-need pregnant/parenting women and infants. |</p>
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| Operational plan at the community level to accomplish the goals. | HBN implemented both individual and systems-level strategies to accomplish oral health goals. Activities included:  
- Established an Oral Health Advisory committee to provide feedback on oral health activities and the toolkit.  
- Developed a comprehensive database of community dental providers in the Rochester NY area who are willing to accept Medicaid/MICHC clients.  
- Conducted focus groups with healthcare providers in the community to provide feedback on resources being developed including the Toolkit.  
- Conducted provider trainings via in-person sessions and webinars on use of the Toolkit, offered continuing education credits, and conducted pre/post tests to assess oral health knowledge.  
- Conduct ongoing public health detailing to dental and human services providers on the importance of oral health screening and health care.  
- Continue the use of standardized oral health screening tools with CHW clients, providing education, referrals and follow up for needed services where appropriate. | HBN encountered several barriers such as subcontractor turnover, and delays in contract execution which slowed initial progress. The subcontractor relationship with EIOH proved to be most beneficial to the project’s success as they are equipped with experienced and knowledgeable staff and community resources to carry out the goals and objectives.  
HBN was able to leverage existing community partnerships and resources to identify additional local funding. |

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<td>Through on-going training and technical assistance, NYSDOH provided support to the additional 22 MICHC programs to integrate oral health strategies by adding two universal screening questions and data collection tools to the state-wide program protocol.</td>
<td>At the project mid-point, transfer of the PIOHQI grant oversight within NYSDOH caused delays, but was the most efficient choice to spread lessons learned from the pilot site to state-wide MICHC</td>
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To ensure sustainability, MICHCs were trained via webinars and in-person sessions to include oral health screening questions and activities to their scope of work as a standard of practice. Training was also provided on use and implementation of the data system.

Customized training tools were also developed for MICHC program coordinators to use in training internal CHW staff, providing education/training to MICHC partners (at coalition or community action network meetings and through outreach to local dental providers). These trainings included recommended strategies on community level interventions such as networking to strengthen referral networks and engaging local dental and social service providers. Four (4) regional trainings were conducted throughout NYS between July 2017 and February 2018.

All MICHC CHWs have been trained using these tools, and many programs have been successful in outreaching to providers through community network meetings and/or public health detailing.

In July/August, 2018, oral health supplies (adult, youth and infant toothbrushes and toothpaste) were purchased and distributed to all MICHC programs to use when providing oral health information to MICHC clients and their families.

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<td>Development of statewide policy, procedures, and standards of practice in support of the proposed strategies</td>
<td>A standard oral health screening tool was built into the new MICHC DMIS, using the same oral health screening questions implemented by HBN as part of the NYSDOH-PIOHQI initiative. Implementing policy changes at the state level required a team approach and dedicated staff at both NYSDOH and within MICHC agencies.</td>
<td>At the beginning of the process NYSDOH had a contract with SUNY CHSR to gather input from MICHC staff on important elements of an oral health screening tool to build into the new data system.</td>
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Taking the approach of the pilot project, at the conclusion of the NYSDOH Train the Trainer events, MICHC programs were tasked with, at minimum, training internal community health worker staff, and where possible strengthening community partnerships with oral health and social service providers to raise awareness of the oral health needs of pregnant women and families and building/strengthening referral networks.

Since 2015, efforts to integrate oral health into MICHC programs has resulted in increased oral health screening and education, and improved access to dental care for pregnant and parenting women and their children. See the MICHC program data summary in attachment 8.

### Yr4+NCTE (9/30/2016-9/29/2018)

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<td>During this period, NYSDOH was able to hire a new project coordinator to ensure dedicated staff could devote full time effort to integrating oral health within NYS MICHC programs state-wide. As of April 1, 2017, it is the standard of practice for MICHCs to screen/inform and refer all clients to needed services for oral health problems. The standardized policy and procedures require MICHCs to submit quarterly narrative reports and aggregate data to NYSDOH, including oral health data such as number of clients screened/referred for oral health services, and the number of clients who received oral health information. Narrative reports include progress on oral health integration activities, and challenges/barriers encountered.</td>
<td>The dedicated project coordinator left the project early in late January 2018. In his absence, the grant’s principal investigator delivered the final Train the Trainer event in February, 2018, and NYSDOH in-kind staff continued efforts to provide: project updates and opportunities for MICHC programs to share their progress, periodic technical assistance via webinars; data collection guidance; and dissemination of oral health supplies to compliment MICHC client information and outreach efforts.</td>
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With the loss of the SUNY CSHR contract in June 2017, NYSDOH in-kind staff continued training and integration efforts through various training opportunities and events where possible, which enhanced the capacity of MICHC program staff to incorporate oral health policies and practices into their programs.
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<td>Development of Initial and Ongoing Professional Development Training in Support of Implementation at the Local Level</td>
<td>HBN along with EIOH and OHAC partners:</td>
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<td>• Developed, updated and published/disseminated the MICHC Oral Health Manual and Toolkit.</td>
<td>With assistance from collaborative partners, HBN was able to continually gather feedback via focus groups with healthcare providers and MICHC staff to improve the content and accuracy of educational materials including the Toolkit.</td>
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<td>• Developed a provider training (used by NYSDOH as guide for the Train the Trainer module).</td>
<td>HBNs provider trainings resulted in attendees: building collaborative relationships and referral networks; a greater understanding among attendees about the challenges, supports needed and barriers to accessing dental care that high-risk pregnant and parenting women face; learning new skills and information to assist in educating, screening and referring pregnant and parenting women and families for care; and acquiring knowledge of local resources to assist their efforts.</td>
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<td>• Conducted focus groups with consumers, community partners and MICHC staff to garner feedback on the final draft of the Toolkit. Suggestions for improvement included adding more information on transmission of bacteria when sharing saliva and using more common language (less technical).</td>
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<td>• HBN partnered with EIOH to recruit healthcare (medical/dental) and human service professionals, and in 2016 conducted four in-person trainings and a webinar on the evidence-based perinatal oral health practices including safety of maintaining good oral health and receiving dental care during pregnancy, guidance on conducting an oral health assessment and advice for pregnant women, and effectively working in interprofessional collaborations. The webinar was recorded and archived on the HBN website. Healthcare providers who attended the trainings were also recruited to participate on the OHAC in an effort to build capacity of the oral health workforce to treat high-risk pregnant and parenting women.</td>
<td>As previously reported, HBN encountered several barriers such as subcontractor turnover, and delays in contract execution which slowed initial progress. Extending their contract for an additional year allowed adequate time to complete goals and objectives.</td>
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pregnant/parenting women and infants. In August, 2017, two additional in-person trainings were conducted.

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<td>Following the final development of the MICHC oral health toolkit in year 3, the NYSDOH PIOHQI program coordinator created a Train the Trainer curriculum and worked with MICHC program coordinators to plan and execute regional trainings. An introductory webinar on plans for oral health integration was presented to the MICHCs in April 2017, followed by four regional Train the Trainer events conducted in July-Sept 2017, and January-February 2018. NYSDOH provided ongoing technical assistance to all MICHCs as part of this initiative.</td>
<td>The NYSDOH PIOHQI project coordinator developed and deployed a capacity assessment survey of MICHC programs to identify current practices, resources and technical assistance needs. The feedback from the survey provided information on MICHCs oral health capacity, and results were used to inform the Train the Trainer module developed for the MICHC program.</td>
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Regional Health Information System, where OB/GYN providers can access the data collected and provide appropriate care and health information to reduce risky behaviors and improve birth outcomes.

HBN and EIOH, in collaboration with their OHAC developed a network of inter-professional oral health providers to assist high-risk pregnant and parenting women and infants in Monroe County. They successfully recruited medical, dental and social service providers to attend oral health trainings, provide feedback on the Oral Health Manual/Toolkit and other educational resources, participate in PDSA cycles to improve training and materials, and develop a provider data base of dentists accepting Medicaid. The provider list is continually updated and available on HBN’s website and in the HIT case management system to ensure referrals for needs identified.

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<td>As of April, 2016, the MICHC program model incorporates oral health strategies as the state-wide standard of practice – through use of standardized oral health screening questions and reporting forms that capture: women/infants in need of oral health services, information provided on healthy oral health practices/behaviors, women/infants referred for needed services and completed referrals. Trainings provided to MICHC staff, and resources available on both the HBN and NYSDOH websites, ensure access to up-to-date information for providers and for high-need women and infants.</td>
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Successes to date required dedicated continuous staff time and effort at both the pilot site and state level to achieve progress.

NYSDOH staff consistently shared success/lessons learned at the pilot site with the other MICHC programs via webinar updates and dissemination of tools and resources.

HBN, the pilot site, is continuing its efforts to expand access to care for high-need women and infants, and will
families on maintaining good oral health across the life course.

As of the end of the grant, oral health is fully integrated into the MICHC state-wide model which will ensure sustainability of oral health integration.

continue to be a resource for other MICHC programs in the future to guide their implementation efforts.

HBN is continuing to provide oral health education kits to pregnant/parenting women and their families as part of oral health education efforts. As an outgrowth of this work, HBN has been invited to participate in a community-based participatory research project, in collaboration with EIOH and the OHAC to explore the needs of pregnant and parenting women to access oral health consultations and treatment. HBN will utilize partnerships with their CAN, OHAC, Nurse Family Partnership and other perinatal health programs to recruit community members.

The EIOH will continue to accept all of HBN’s referrals for dental care, and is in the process of renovating 2nd floor office space in their dental clinic location to add dedicated dental chairs for pregnant/parenting women. They will also offer same-day and concurrent appointments for parents, children, and siblings, along with adding a play area for children. Other needed accommodations will be explored such as a lactation room for breastfeeding.
moms. HBN will also continue its partnership with the OHAC, and provide facilitation for focus groups and assist with their implementation.

The MICHC model will encompass oral health screening, information, referral and follow up as a standard of practice.

### II. Administration (Work) Plan

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<th>Year 1-4 &amp; NCTE (9/30/2013-9/29, 2018)</th>
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<td>1. Contract with the selected MICHC program:</td>
<td>HBN received the subcontract to pilot this initiative through a mini-bid process among all MICHC contracts state-wide. HBN subcontracted with EIOH to conduct the grant activities including recruitment of oral health champions (healthcare providers, community members etc.), development and facilitation of trainings and educational resources including the Toolkit, and evaluation. The contractor submitted quarterly reports outlining their progress towards grant goals. HBN completed all deliverables by the end of their subcontract on September 29, 2017.</td>
<td>NYSDOH’s original plan was to complete the pilot by year 3 with dissemination to the other MICHCs and full integration in year 4. Project delays at HBN and NYSDOH previously mentioned altered this timeline. This barrier was overcome by receiving a no-cost extension which allowed more time to expand to the other MICHCs, complete the trainings and fully integrate oral health into MICHC.</td>
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<td>- Develop scope of work</td>
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<td>- Develop contract</td>
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<td>- Obtain approvals from HRI and NYSDOH</td>
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<td>2. Conduct community perinatal/oral health needs assessment:</td>
<td>HBN finalized the MICHC Oral Health Manual and Toolkit. The process was guided by feedback from the OHAC members, and focus groups conducted with local healthcare, human service and partnerships and the subcontract with EIOH enabled HBN to continue its outreach to dental providers via surveys to assess the current level of dental</td>
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<tr>
<td>- Identify specific barriers to oral health utilization during pregnancy, gaps in patient</td>
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<td>knowledge, beliefs and perceptions of oral health through focus groups, community discussions, and individual communications from key informants</td>
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<tr>
<td>-Determine, collect, and disseminate applicable resources to pregnant women</td>
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<tr>
<td>-Develop materials, campaigns, and promotional items based on needs assessment and identified gaps</td>
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<tr>
<td>-Evaluate shared and developed resources</td>
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<tr>
<td>-Replicate successful resources and models in other communities</td>
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<table>
<thead>
<tr>
<th>MICH providers, led by the subcontractor EIOH.</th>
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<tr>
<td>Content and accuracy of the Toolkit was vetted by the OHAC and EIOH. EIOH conducted provider trainings using the Toolkit, and developed and administered pre and post training surveys to participants.</td>
</tr>
<tr>
<td>The Toolkit was disseminated to all MICH programs, and formed the basis for NYSDOH training materials used to educate MICHC staff on integrating oral health strategies into their programs.</td>
</tr>
<tr>
<td>Additional resources from the National Maternal and Child Oral Health Resource Center were used to educate pregnant women served in the MICHC program.</td>
</tr>
<tr>
<td>HBN purchased oral health supplies and magnets with oral health messaging, that were distributed to MICHC clients when providing oral health information.</td>
</tr>
<tr>
<td>HBN, EIOH and the OHAC recruited (via survey) dental providers and developed a list of dentists who accept Medicaid in the Rochester NY area. The list is continually updated and incorporated into HBN’s HIT case management system, and posted on HBN’s agency webpage as a resource for consumers.</td>
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<th>practices accepting Medicaid.</th>
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<tr>
<td>These partnerships have continued after the funding ended in 2017, and will ensure that resources continue to be available for high-risk pregnant and parenting women and infants.</td>
</tr>
<tr>
<td>NYSDOH staff will continue to monitor MICHC needs assessments for issues with access to dental care, and provide resources and/or technical assistance.</td>
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</table>
State-wide, all MICHC programs are required to conduct annual needs and resources assessments to identify the needs of their communities, develop strategies to address the needs identified and develop relationships with community partners to ensure available resources for health care and social supports.

| 3. Promote NY’s Oral Health Care During Pregnancy and Early Childhood Practice Guidelines https://www.health.ny.gov/publications/0824.pdf | The NY Oral Health Care During Pregnancy and Early Childhood Practice Guidelines was a resource for The MICHC Oral Health Manual and Toolkit, which includes information on these guidelines and recommendation for local perinatal and oral health providers on perinatal and infant oral health. NYSDOH distributed the final version of the Toolkit to MICHC programs at each in-person Train the Trainer event, via email, and is also available on HBNs website at: https://www.pnmc-hsr.org/oral-health/. NYSDOH is in the process of posting the tool kit on the NYSDOH website with other MICHC training resources. | MICHC programs report the guidelines and toolkit are extremely helpful in validating the facts about safety and importance of obtaining oral health care during pregnancy, and when sharing information with clients, providers and community partners. |
4. Engage providers:
- Meet, work, and collaborate with providers to:
- Determine existing barriers
- Create plan to minimize barriers
- Identify and refer individuals who may benefit from dental services
- Implement referral and follow-up system
- Promote web-based data systems to support coordination and referral for high need women
- Develop a list of dental providers willing to take referrals
- Train perinatal providers to offer counseling.

As previously stated, HBN was instrumental in forming an OHAC with members consisting of health educators, CHWs, healthcare providers (both medical and dental), health and human service providers, and MICHC staff in the design, review, and implementation of the project deliverables. The partnership with EIOH was integral to helping engage medical and dental providers in the community.

Key to OHAC’s success was frequent contact among members through quarterly meetings, and utilizing a team approach. Although HBN’s subcontract ended in 2017, they continue to collaborate with the OHAC to improve access to oral health services for high-need pregnant and parenting women and their families.

Oral health screenings are now a standard of practice in the statewide MICHC program. All MICHCs received training (via in-person Train the Trainer sessions) on integrating oral health strategies into their programs. In turn, all MICHC programs have trained their CHWs, and where possible will: work to identify oral health champions in their communities; share information with and/or train healthcare professionals through public health detailing; and/or educate partners at community network meetings.

HBN uses a HIT case management system to manage client case-loads, and provide referrals and follow-up to ensure services were received. A list of dentists who accept Medicaid is embedded in their system to ensure a warm hand off to dental services.

For MICHC programs statewide, there have been challenges in systematizing data collection. With the discontinuation of the DMIS, NYSDOH data staff made modifications to the Excel CHW Encounter Data Report to capture elements of the DMIS, and effectively monitor statewide progress on incorporating oral health strategies among MICHC programs. Improvements made include identification of new clients from recurring clients, and collecting data on the number of clients who completed referrals to needed services.
5. Engage health plans; work with health plans to:
- Develop and maintain a list of local dentists who accept the health plans’ coverage
- Directly connect their enrolled pregnant women to in-network oral health providers
- Assist with scheduling appointments for eligible women and infants
- Urge health plans to conduct a claims reviews to determine the women enrolled in their maternity program who have not received dental care during their pregnancy
- Follow-up with women who received a referral but did not seek care
- Assist with scheduling appointments for such women

| In 2015, HBN facilitated an initial survey of local dental providers, with a primary aim of determining the current level of dental practice in the community and compiling a list of dental providers in the community willing to accept referrals. The list is being maintained and is embedded within their HIT case management system, allowing for a direct referral to participating dentists. State-wide, all MICHC programs screen clients for oral health needs as a standard of practice, provide referrals for oral health services, and follow up to ensure services are received. All MICHC programs utilize CHWs to assist high-risk pregnant/parenting women and their families in accessing needed healthcare and social supports. This work includes following up with women who received a referral but did not seek care, and assisting with scheduling appointments. | In many areas of the state, access to dental care can be challenging due to a lack of dental providers overall, low provider participation in Medicaid, long waiting lists among participating providers, or issues with transportation. MICHCs are encouraged to work with their community partners to address these challenges and find solutions where possible. HBN’s partnership with EIOH allows for ready access to dental services. There is also a second dental clinic at Anthony Jordan Health Center in Rochester NY, that accepts Medicaid clients. |

B. Contributions to the Preliminary (National) Strategic Framework

1. Profile population needs, resources, and readiness to address the problems and gaps in service delivery

**Progress Made and Process Improvements:**

- HBN established an Oral Health Advisory Committee (OHAC), comprised of community stakeholders, including various health providers. OHAC identified resources in the community during the initial meetings in 2015. OHAC worked to identify barriers in coordinating dental care and developed a plan to address barriers.
- HBN and EIOH conducted provider trainings and assessed (via pre/post trainings) provider knowledge in the community regarding oral health among high-risk pregnant women and infants. They also developed and conducted a survey of the current level of dental practice and readiness to
accept high-risk pregnant women and infants, primarily Medicaid-eligible women and families. This survey resulted in a list of dental providers in Monroe County who either accept Medicaid or offer a reduced or sliding scale fee, which is embedded within their HIT case management system to ensure referrals and manage follow-up, and is also posted on HBN’s agency website.

- HBN developed resources including a provider training webinar, and the MICHC Oral Health Manual and Toolkit, which has been widely disseminated within the PIOHQI Learning Collaborative, and among MICHC and other home visiting programs statewide.
- NYSDOH utilized HBN’s tools, resources and lessons learned to develop a Train the Trainer module, and provided in-person trainings to MICHC program staff.

2. Mobilize and/or Build Capacity to Address Needs
   Progress Made and Process Improvements:
   - HBN was selected for the NYS PIOHQI pilot project as it demonstrated capacity and experience to address and/or promote oral health, to promote and address specific issues in perinatal and infant oral health, and to develop and implement the strategies in close collaboration with providers and other community partners.
   - The NYS PIOHQI project transitioned to the Bureau of Women, Infant, and Adolescent Health (BWIAH) to fully integrate oral health strategies into the MICHC program model and ensure sustainability.
   - HBN staff are systematically using the HIT case management system for their internal reporting system, and also the CHW Encounter Data Report to report quarterly data to NYSDOH. State-wide, all MICHC programs are universally screening women for oral health needs, providing information and referral/follow up to needed services.
   - More women are being screened as a result of MICHC staff, providers and community partners who received oral health education and resources.
   - At HBN, new partnerships were formed and connections to services strengthened. State-wide, all MICHC programs are working to strengthen partnerships and referral networks to improve oral health care access.

3. Develop/ Finalize a Comprehensive State Strategic Plan
   Progress made and process improvements:
   - HBN implemented specific strategies to integrate oral health into the infrastructure of MICHC. The NYSDOH awarded funds via a subcontract to HBN for four years to ensure they were successful in carrying out planned activities.
   - HBN conducted local provider trainings and developed resources and a MICHC Oral Health Manual and Toolkit. All tools, resources and lessons learned were shared with state-wide MICHC programs, and utilized to create a Train the Trainer module for MICHC programs to use for training their internal staff as well as community partners.
   - NYSDOH provided web-based and in-person trainings to all MICHC programs on use of a standardized data system and strategies for integration of oral health activities. Internal staff also provided technical assistance and guidance on implementation as needed – an activity that is continuing beyond grant funding.
4. Implement Evidence-Based Prevention Policies, Programs and Practices and Infrastructure Development Activities

Progress made and process improvements:
- To help build infrastructure, NYSDOH worked with HBN to incorporate two oral health screening questions into their HIT case management system by adding oral health as a category to the system for external referrals. The questions were tested and prepared for inclusion in the screening as part of the MICHC program intake process. A positive response to either of the questions generates a dental referral. HBN completed updating and testing the system in year 4, trained CHWs and outreach staff on its usage, and recruited OHAC members to buy into the system to join the referral network.
- NYSDOH now requires all MICHC programs to utilize the same two oral health screening questions on all clients, and refer clients to needed services. Data on oral health screenings, educational information provided, referrals made and followed up on is reported quarterly. Data will continue to be monitored and analyzed for trends including successful strategies and gaps in service, and guidance provided to improve outcomes for women and infants in New York State.

5. Monitor Process, Evaluate Effectiveness, Sustain Effective Program Activities, and Improve or Replace Those that Fail

Progress made and process improvements:
- At the state level, NYSDOH worked with the Public Health Information Group to include additional dental-specific questions to the Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Attachment 9 shows PRAMS data collected from 2012 – 2016. These results show a decreasing trend of Medicaid eligible women having teeth cleanings during pregnancy, however women were more likely to have had a cleaning before pregnancy. Percentages rose during the reporting period both for women who needed to see a dentist during pregnancy, and for those that saw a dentist during pregnancy. The NYS Team will continue to evaluate PRAMS data to determine trends in oral health access and utilization among pregnant women in NYS.
- The NYS Team has also worked with the Office of Quality and Patient Safety to obtain Medicaid dental claims/ utilization data. Attachment 10 shows data from 2013 compared to 2017. Compared to 2013 baseline data, the 2017 Medicaid claims data shows that services overall are down for women during pregnancy including diagnostic and preventative services, however the percentage of treatment services during pregnancy increased during this same period.

### Oral Health Learning Collaborative

<table>
<thead>
<tr>
<th>Work</th>
<th>Year 1-4 &amp; NCTE (9/30/2013-9/29, 2018)</th>
<th>Barriers /Lessons learned</th>
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<td>Interstate Collaboration - Members of the Implementation Team will participate and act as spokespersons for the State and the PIOHQI project. Select members will participate in all meetings, reporting back to both Teams who will have meetings to discuss progress.</td>
<td>NYSDOH participated in the monthly Learning Collaborative webinars and attended in-person grantee meetings with the PIOHQI Network of participating state grantees.</td>
<td>NYS shared resources with other state grantees, including the MICHC Oral Health Manual and Toolkit developed by HBN.</td>
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Intrastate Collaboration - Loosely based on the Learning Collaborative model. Learning sessions for all 23 MICHCs will participate in quarterly phone calls to learn, share, and discuss. In-person meetings will be conducted for training.

In August 2015, HBN delivered its first presentation via webinar to all MICHC projects on their oral health implementation efforts in the pilot project during the MICHC monthly call. Two more updates were presented in early 2016, and April 2017, with the latter presented jointly with the NYSDOH PIOHQI project coordinator to introduce plans for expansion and roll out HBN’s model to the 22 other MICHCs, including plans for conducting regional state-wide trainings.

Monthly webinars are held with MICHC program coordinators as an opportunity for training, sharing promising practices, and identifying challenges and barriers. NYSDOH recently instituted individual quarterly calls with MICHC program coordinators.

Recent feedback received from MICHCs highlight the benefit of group webinars where they can learn from each other and share ideas/strategies to improve services for the women and families they serve. The individual quarterly calls provide a more in-depth opportunity for sharing information and NYSDOH MICHC contract managers to provide program guidance and technical assistance.

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<tr>
<td><strong>I. The PIOHQI Approach (Alignment with ASTDD Best Practice Approach or BPA)</strong></td>
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1) **Impact/ Effectiveness**

NYS adopted a statewide approach that responds to the needs of pregnant women and infants most at risk through integration of state funded community-based MICHC programs (initially at the HBN pilot site). The MICHC program utilizes a community health worker model as a promising practice to find and engage high-risk women and infants in healthcare and other needed supportive services. This approach aligns with the ASTDD Best Practice Approach (pregnancy is an opportune time for oral health interventions and promotion).

By integrating oral health strategies into the statewide MICHC program, NYS has been successful at increasing awareness among pregnant women and providers of the importance of receiving dental care before and during pregnancy, and capacity of community health workers and health care providers to
provide information, education and guidance to high-risk pregnant and parenting women and their families. The MICHC implementation of universal dental screenings in 2015 has improved oral health services for all women of childbearing age who are enrolled in the MICHC program.

2) Efficiency
Through a competitive procurement, NYSDOH worked with HBN (an existing MICHC program in Monroe County) for efficiency as a pilot site to develop a best practice model for integrating oral health into a community-based prenatal care program. HBN served as a learning laboratory to engage and partner with oral health champions and experts in the community, develop and test oral health training materials and resources for consumers and providers, train providers to increase their capacity in serving high risk pregnant/parenting women and infants, and engage and recruit oral health providers who accept Medicaid or other low cost payment options (such as income-based sliding scale fees).

The partnership with HBN allowed for efficient sharing of strategies, lessons learned and materials developed during the pilot with the other 22 MICHC programs. PIOHQI funding allowed for a dedicated program coordinator to oversee the development and delivery of training materials and oral health integration efforts.

3) Fiscal Leveraging and Sustainability
Incorporating oral health into existing prenatal care programs and services will ensure continuity of the PIOHQI oral health efforts on a long-term basis. The MICHC initiative is a statewide program that focuses on changing individual/ family and community health and behavior through individual, organizational and systems-level changes. The NYS PIOHQI project goal of integrating oral health into existing state and local systems such as the statewide MICHC program is a successful strategy to ensure sustainability.

4) Collaboration/ Integration
Collaboration and partnerships are a central focus of the MICHC initiative. The MICHC model supports collaborative development, implementation and coordination of evidence-based and/or best practice strategies to achieve performance standards focused on improving outreach to find and engage high need women and their families in health insurance, health care and other supportive services; timely identification of needs and risk factors and coordinated follow-up to address risks identified; the integration and coordination of services within larger community systems; and the development of supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan.

HBN utilized the strength of the MICHC model to expand collaborations with oral health champions and experts in Monroe County and increase provider capacity through trainings and recruiting participation on their OHAC.

Through the NYSDOH Title V program, staff have utilized PIOHQI successes, tools and resources to increase awareness among Department staff in all maternal and child health programs of the importance of pregnant and parenting women maintaining optimum oral health and healthy behaviors to improve birth outcomes. The percentage of women who had a dental visit for teeth cleaning during pregnancy is a measure included as part of a Maternal and Child Health State Dashboard to monitor and track progress in NYS. Collaborations with other NYS programs such as the Public Health Information Group and Office of Quality and Patient Safety to access, analyze and monitor PRAMS and Medicaid dental
claims/utilization data are continuing. These data will be used to collaborate on strategies to improve access to dental care for high-need pregnant and parenting women and their families.

II. PIOHQI Data Collection and Analysis

1) Process indicators to assess the delivery of services
HBN uses a HIT case management system to manage client case-loads, and provide referrals and follow-up to ensure services were received. A list of dentists who accept Medicaid is embedded in their system to ensure a warm hand off to dental services.

For MICHC programs statewide, NYSDOH data staff made modifications to the Excel CHW Encounter Data Report to capture elements of the DMIS, and effectively monitor statewide progress on incorporating oral health strategies among MICHC programs. Since 2015, oral health screening questions were added as a standard of practice. Information collected include the number of clients screened for oral health problems, the number of clients receiving oral health information and referrals for oral health needs. Recent improvements made to the database include identification of new clients from recurring clients, and collecting data on the number of clients who completed referrals to needed services.

2) Outcome indicators to assess the accomplishment of program goals and objectives
HBN screens all short-term clients for oral health problems, and has a policy in place to assess and refer and monitor long-term clients for oral health issues.

HBN increased provider capacity by conducting two local trainings in Monroe County for healthcare professionals (126 total providers trained, 72 in 2016 and 54 in 2017).

NYSDOH MICHC programs overall have successfully incorporated oral health objectives into programming with increases of 46% for referrals to services, 305% for oral health education to clients, and 343% for oral health screening from baseline data in 2015 to 2018. Screening for women overall rose from 14% to 49% from 2015 to 2018, and from 39% to 57% specifically for pregnant and postpartum women during this period.

NYSDOH conducted four in-person regional Train the Trainer events; 17 of 23 MICHC programs attended the training. Results the post training survey show that 100% of participants will use the training to train CHWs and MICHC staff on oral health, 42% will offer the training to partners and community coalition members, and 58% will share information with local health providers during outreach.

The statewide data from PRAMS highlights the continued need for oral health services during pregnancy and demonstrates that the need is greater for women on Medicaid. Similarly, Medicaid claims data shows that preventative and diagnostic services are down for women, while treatment services have increased during pregnancy.

3) Impact indicators to assess the impact of the NYS PIOHQI pilot project on improvements in maternal and infant/child oral health and utilization of dental services
NYSDOH improved oral health services for pregnant/postpartum women among all 23 statewide MICHC programs including the pilot site, Healthy Baby Network:
In 2018, the percentage of pregnant/post-partum women served by MICHC that received an oral health screening was 57.0%; this is a marked improvement from the baseline of 16.6% in 2015.

- For all women served by MICHC, in 2018 – 48.8% received an oral health screening compared to 14.2% in 2015.
- In 2018, the percent of women who received oral health information was 46.8%; a significant increase from the baseline of 16.2% in 2015.
- In 2018, the number of women referred for oral health services increased to 11.5% from the baseline of 9.2% in 2015.

PRAMS data shows that a higher percentage of Medicaid eligible women are accessing care during pregnancy, from 20.2% in 2012 to 21.8% in 2016, and the percentage of women talking with a health care worker or dentist about care of teeth and gums during pregnancy increased from 43.8% to 46.2% during the same time period. Medicaid data showed an increase in treatment during pregnancy from 15% in 2013 to 16% in 2017.

### III. Quality Improvement (QI) Implementation

NYSDOH worked with the PIOHQI Network to develop two quality improvement (QI) exercises using the Plan Do Study Act (PDSA) and Before Action Review/After Action Review (BAR/AAR) models to assesses the effectiveness of oral health integration strategies through this project.

The pilot site, HBN, routinely conducted PDSAs throughout the project period to review and test consumer health messages and provider training materials including the MICHC Oral Health Toolkit. For example, one PDSA was conducted between October 2015 – February 2016 with MICHC CHWs, Outreach Workers and Health Educators to make improvements to the MICHC Oral Health Toolkit draft. Through a series of meetings, review sessions, and testing materials with MICHC clients (consumers), the following areas of improvement were identified:

- more saliva sharing messages were needed (re: transmission of bacteria from caregiver to infant)
- overall language should be less technical
- situational descriptions needed clarifying language

HBN also conducted a focus group in July, 2016 (see attachment 11) with a multi-disciplinary group of 13 members including general and pediatric dentists, dental hygienists, pediatricians, obstetricians, nurses, community educators and social workers to get feedback and evaluate the MICHC Oral Health Toolkit and discuss the importance of oral health care for pregnant women. As a result of the focus group, the Toolkit was updated to strengthen areas of patient education, dispelling misconceptions around the safety of receiving dental care during pregnancy, stressing the importance of consistent messaging when counseling/educating patients.

Although HBN’s contractual arrangement with EIOH has ended, their partnership continues and is expanding to improve oral health services for pregnant women. Through ongoing partnerships with EIOH and the OHAC, PDSAs and feedback opportunities will continue.

At the state level, NYSDOH tracks aggregate data reported quarterly by all 23 MICHCs to monitor the number of clients screened for oral health needs, receive appropriate oral health information, and are
referred for needed services. This data is reviewed quarterly, assessed for accuracy and presented back to the MICHC programs for quality improvement purposes. NYSDOH staff will continue to provide ongoing training, technical assistance, and support to the MICHC programs as they work to improve oral health access and services for pregnant and parenting women and families.

As a supplement to this ongoing activity, in January 2019, BWIAH will oversee a student project that will utilize quarterly MICHC program data to identify additional areas for improvement, design a continuous quality improvement project, and establish an implementation plan.
MICHC Oral Health Manual and Toolkit

For Maternal and Infant Community Health Collaborative (MICHC) Partners and Prenatal/Perinatal Health and Dental Care Providers in New York State
Acknowledgment

This Oral Health Manual and Toolkit was developed for the Integration of Oral Health Strategies into Monroe County Maternal and Infant Community Health Collaboratives (MICHC) that is supported by the Health Research Inc. (Contract # 4861-03) as part of New York State’s Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Initiative funded by the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (93.110 Catalogue of Federal Domestic Assistance).

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**BACKGROUND**

**Oral health** is an integral component of overall health and well-being\(^1\)\(^2\)\(^3\). The Surgeon General’s report on oral health in 2000 stated that oral health means much more than healthy teeth or merely being free of chronic orofacial pain and pathologic conditions\(^4\). The mouth is an entrance to the rest of the body, and oral health affects people’s eating, speech and their quality of life\(^4\). A growing body of research also shows a relationship between the bacterial infection and inflammation in the mouth and various diseases in the rest of the body\(^5\).

“*The mouth is an entrance to the rest of the body*”

During pregnancy, oral health problems such as swelling and bleeding from gums are common because of elevated hormone levels and soft tissue’s exaggerated response to bacterial plaque\(^6\). Women tend to eat more frequently during pregnancy and the acidity in the mouth increases accordingly. It is reported that one in four women in reproductive age have untreated tooth decay\(^3\).

Pregnant women with poor oral health might be at an elevated risk of experiencing adverse birth outcomes, including pre-term births, low birth weight infants, preeclampsia, miscarriage, fetal growth restrictions, and gestational diabetes\(^7\)-\(^11\). Additionally, children born to mothers with poor oral health reportedly have a greater chance of developing dental caries as a consequence of behavioral risk factors and the decay-causing bacteria being passed from the mother to the infant’s mouth through common saliva sharing practices such as sharing a spoon when tasting baby food or cleaning a dropped pacifier by mouth\(^12\)-\(^14\).

Despite the heightened needs of dental care, about 50% of women make a dental visit and get their teeth cleaned during pregnancy according to the 2012 New York State Pregnancy Risk Assessment Monitoring System (PRAMS) data\(^15\). Data from the Monroe County PRAMS (2009-2010) shows that there is a disparity in the utilization of dental services during pregnancy. While 56% of pregnant women had their teeth cleaned during pregnancy, only 35% of low-income pregnant women had their teeth cleaned during pregnancy in Monroe County\(^16\).
The Health Resources and Services (HRSA) Administration’s Maternal and Child Health Bureau convened an Expert Workgroup and published the Oral Health Care during Pregnancy Consensus document in 2012 in collaboration with the American College of Obstetricians and Gynecologists (ACOG) and the American Dental Association (ADA), and coordinated by the National Maternal and Child Oral Health Resource Center (NMCOHRC). The following year, HRSA established the Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Initiative and funded three states through pilot grant programs to demonstrate a successful community-based approach to increase utilization of high-quality preventive oral health care and restorative services for at-risk pregnant women and infants with a statewide reach.

New York State is one of three states that have received a PIOHQI pilot grant. In this four-year grant, NYS plans to integrate oral health services such as education, screening, and referrals into the statewide Maternal and Infant Community Health Collaboratives (MICH) project designed to improve health outcomes of high-risk mothers and infants using a case management model to address various barriers among socioeconomically disadvantaged pregnant women and infants. The New York State Department of Health selected the Healthy Baby Network of Monroe County and New York State Oral Health Center of Excellence to test and demonstrate best practice approaches and develop materials to be used in the statewide MICH programs in the future. Documentation of successful outcomes and lessons learned from New York State’s PIOHQI pilot grant project will inform a national strategic perinatal oral health framework that can be used to achieve statewide health care systems transformation.
OBJECTIVES

Objectives of the MICHC Oral Health Integration pilot program in Monroe County are:

1) To build a system of oral health support services within the MICHC program,

2) To train dental and perinatal health care providers as well as support service providers (Community Health Workers, Case Managers, Health Educators, and Outreach Workers) on evidence-based perinatal oral health practices, and

3) To establish an infrastructure for ongoing technical assistance to ensure MICHC providers’ engagement in perinatal oral health intervention for high-needs pregnant women and their children.

The goal of this program is to increase access to coordinated and evidence-based perinatal oral health services and enhance oral health self-management skills among high-needs pregnant women in the community and ultimately reduce disparity in maternal and child oral health in Monroe County.

HOW THIS MANUAL and TOOLKIT CAN BE USED

This manual and toolkit are largely divided into two parts: 1) Oral Health Recommendations and Provider and Consumer Tools to promote perinatal oral health and 2) Provider-type specific practice recommendations and tools.

This manual and toolkit is a living document and will be updated periodically.
Monroe County MICHC Oral Health Integration Project Logic Model drafted by OHCE

**INPUTS**
- Healthy Baby Network (MICHC, CHWs/ Baby Love, Health Education, Outreach)
- NYS Oral Health Center of Excellence
- Healthy Baby Network partners and providers (Centering Pregnancy, Head Start, WIC)
- Healthy Baby Network’s Constant Contact list-serve
- Peer Place Network (PPN)
- Monroe County PRAMS/University of Rochester
- Medicaid & Managed Care dental program
- Dental providers in FQHCs, Hospitals, Eastman Institute for Oral Health
- Grant funding and NYS DOH BDH project oversight

**ACTIVITIES**
- Develop MICHC OH manual & toolkit
- Integrate oral health in PPN: 1) work with local managed care organizations to develop dentist list for PPN referral, 2) include OH screening, referral, goal setting and follow-up systems in PPN
- Conduct provider surveys to 1) refine training content and 2) monitor provider behavior changes
- Train perinatal healthcare, support service, and dental providers on evidence-based perinatal oral healthcare
- Data collection and monitoring
- Develop SMG magnet and assemble oral hygiene kits for pregnant women
- Conduct focus groups at Centering Pregnancy (CP) sites to obtain consumer input on MICHC OH education materials and messages
- Organize periodic stakeholder meetings and ongoing communication for Healthy Baby Network & OCHE partners/ collaborators
- Provide ongoing technical assistance to MICHC & partner providers and share success stories

**OUTPUTS**
- CHWs and case managers are trained & motivated to use PPN to screen & facilitate OH services
- Outreach and Health Education providers share oral health messages with their clients
- Health Care professionals (MDs, RNs, and PAs) and dental teams provide evidence-based perinatal oral health services
- Healthy Baby Network and OHCE are the backbone of collective effort to improve maternal and child oral health and function as a hub for perinatal OH information and technical assistance for all perinatal healthcare, dental and support service providers in Monroe County
- PPN and Monroe County PRAMS capture MICHC OH integration project's process & outcomes data
- OH education and messages resonate with target audience

**OUTCOMES**
- Increased % of pregnant women receive routine and preventative dental care as well as needed emergency and acute dental care during the perinatal period
- Increased % of pregnant women receive OH education/advice during pregnancy, educated on ECC prevention
- Reduced disparities in OH care access and education during the perinatal period

**DISTAL**
- Increased preventative dental visits among infants and toddlers
- Reduced Early Childhood Caries (ECC) prevalence and reduced maternal and child oral health disparity
- OH education and referrals incorporated into perinatal care at each level of the healthcare system
A logic model, as used for the MICHC Oral Health Integration (Tool #1) is a planning tool to clarify and graphically display what your project intends to do and what it hopes to accomplish and impact. A logic model summarizes key program elements, explains rationale behind program activities, clarifies intended outcomes and provides a communication tool.

REFERENCES:


17. National Network of Libraries of Medicine, Guide 5: Define how a program will work- The Logic Model; Available at https://nnlm.gov/outreach/community/logicmodel.html
Perinatal Oral Health Practice Recommendations

The prenatal/perinatal period provides opportunities for oral health intervention such as assessing, assisting, and addressing oral health needs. High-risk women who otherwise do not have any access to health care systems are likely to be enrolled in prenatal care programs during pregnancy. Extended Medicaid eligibility during the perinatal period also theoretically increases access to comprehensive dental services among women. Additionally, a pregnant woman may be more receptive to changing health behaviors that may negatively affect her unborn child.

In this chapter, we provide lists of oral health recommendations during the pregnancy and postpartum and early childhood along with useful tools that can be used by all levels of MICHC and dental providers.

DURING THE PREGNANCY

Every pregnant woman should be advised about the following four oral health practices:

- Get professional oral health care
- Practice good oral hygiene
- Eat healthy foods
- Practice other healthy behaviors (e.g., no smoking, etc.)

Providers should keep in mind that MICHC clients or high-needs pregnant women are likely to face various life-stresses and getting their teeth cleaned or a cavity treated may not be at the top of their priorities.
READINESS + WILLINGNESS + ABILITY = ORAL HEALTH ACTION

Oral health recommendations largely require behavior change at the individual level. It is important, therefore, that every provider who encounters a high-needs pregnant woman examines her level of readiness and barriers to practicing good oral health and making behavior changes for healthy family oral health through the Motivational Interviewing (MI) technique (Tool #2) and guide an appropriate oral health intervention and action plan over time.²³

Some pregnant women may previously have had an unpleasant dental experience or may have heard from friends or family members that dental treatment is not recommended during pregnancy.

Pregnant women’s literacy level, cultural background and beliefs/self-efficacy also influence their ability and willingness to comprehend and act on oral health recommendations¹.
DURING THE POSTPARTUM PERIOD AND EARLY CHILDHOOD

The postpartum period is critical for the maintenance of good maternal and family oral health behavior and providing informational and enabling support services for mothers to carry out infant oral health care recommendations.4 5

Continue motivating and guiding the client for behavior change and oral health self-management goals during this critical period for prevention of Early Childhood Caries (tooth decay).

Every parenting woman should be advised about the following oral health practices:

- Maintain good maternal and family oral health—it helps prevent transmission of decay causing germs6.
- Breastfeed your baby – Breast milk is the best food for baby6.
- Avoid putting the child to bed with a bottle6.
- Repeated use of a sippy or no-spill cup with sugar-containing drinks (e.g., juice, formula, soda) increases the risk of caries.
- Wipe the infant’s gums and teeth with a washcloth after feeding6.
- Use a smear or rice grain size of fluoride toothpaste when wiping or brushing the child’s teeth6.
- Make the child’s first dental visit or ask the pediatrician to screen the child’s mouth before the child’s first birthday6.

Research shows that human milk and breast-feeding of infants provide good general health, nutritional, developmental, psychological, social, economic, and environmental advantages while significantly decreasing risk for a large number of acute and chronic diseases 7. The American Academy of Pediatric Dentistry encourages breast-feeding of infants to ensure the best possible health and developmental and psychosocial outcomes, with care to wiping or brushing as the first primary tooth begins to erupt and other dietary carbohydrates are introduced8.
ABOUT EARLY CHILDHOOD CARIES

Early childhood caries (ECC) is a form of tooth decay that affects the baby teeth of infants, toddlers and preschool children.6

- ECC is preventable. However, it occurs as a result of repetitive imbalance between risk and protective factors in the mouth while it is preventable.
- ECC can form in the child’s mouth as early as <1 year of age and progress rapidly resulting in pain and distress.
- Human breast milk is uniquely superior in providing the best possible nutrition to infants and has not been epidemiologically associated with caries.9 10. Dental caries has been associated with prolonged breast feeding.
- Because young children often cannot tolerate dental treatment in dental chair, ECC is usually treated under general anesthesia in the hospital, costing an average of $150011 and can be as high as $550012 per child.
- Children with ECC tend to experience more cavities in adult teeth than those who had no ECC during early childhood.
- Children who lose baby teeth early because of decay may also be at risk for crooked teeth as baby teeth are important to save spaces for adult teeth6.

### Protective factors
- Fluoride in drinking water and toothpaste
- Healthy eating and drinking habits
- Daily brushing and flossing
- Regular preventive dental visit

### Risk factors
- Inappropriate bottle/sippy cup use
- High-sugar in diet and liquids
- Lack of oral hygiene practices
- Primary care giver with untreated tooth decay
PERINATAL ORAL HEALTH MOTIVATIONAL INTERVIEWING (TOOL #2)

Motivational Interviewing (MI) is a collaborative conversation to strengthen a person’s own motivation for and commitment to change. Successful collaborative conversation may be outlined as follows:

Step 1: Open-ended questions to encourage self-exploration

Examples:
- “What do you think about the condition of your teeth and gums?”
- “What do you do to keep your teeth and gums healthy?”
- “What does healthy teeth/loosing teeth mean to you?”
- “How do you feel about going to a dentist?”

Step 2: Reflective listening and affirmation

Examples:
- “It sounds like you are really trying ..”
- “What I hear you saying is that you are concerned about…. but …." “Did I get that right?”

Step 3: Find out what the client already knows about oral health and prevention of dental diseases

Examples:
- “What do you know about preventing tooth decay/gum disease?”
- “What do you know about how fluoride/diet affects the health of your teeth?”
- “What do you know about tooth decay in young children?”
Step 4: Ask permission for advice/feedback

Examples:

- “Would it be alright if I share some information with you about how to improve your own and your baby’s oral health?”

- “I would like to give you some information about the benefit of having your teeth cleaned during pregnancy. Would you be interested in hearing that?”

- “There are things we typically discuss with pregnant women to promote healthy teeth in their families: healthy eating, limiting/avoiding sugar-sweetened beverages, good self-care and the importance of regular professional care. I am wondering if you would be interested in exploring one of these topics or perhaps something else?”

Please see Tool #3 for ideas of oral health messages and advice

Step 5: Assessment of Readiness

Use the Perinatal Oral Health Self-Management Goal Menu (Tool #4) to explore which new behavior is most likely to be implemented.

Examples:

- “On the scale from 1 to 10, where 1 is definitely not ready and 10 is definitely ready, what number best reflects how ready you are at the present time to …..”
Step 6: Planning for Change* --Negotiate an oral health agenda based on a menu of options

Examples:

- “Is there anything you would like to try for your oral health in the next week or two?”
- What do you think you want to try for your family’s oral health as a starter?”

* Acknowledge that the client is the expert on her own life and encourage her to use the information in the way that suits her best.

When developing a plan for change toward oral health self-management goals, plan to

- Build patient commitment and confidence in the plan
- Treat the plan as an experiment

Step 7: Self-Summarization and Clarification

Example:

- “Can you repeat your plan so I am sure you have understood?”
Resistance means the patient is not ready to make a change.

Signs of resistance might include:

- Interrupting
- Ignoring
- Arguing
- Denying

When a client shows resistance to oral health behavior change, instead of being confrontational or directional, you may use a technique called “Therapeutic Paradox,” and emphasize that the client has a choice and control over the goals, and plan to follow-up at a later time.

Examples of Therapeutic Paradox talk:

- “Maybe what I am asking is just too difficult for you.”
- “Maybe now is not the right time for you to make changes for your baby’s oral health.”
- “So it sounds like you have a lot going on with trying other things and these priorities are competing with your oral health goals at this time. Maybe you are not ready to make changes for your oral health at this time.”
KEY ORAL HEALTH MESSAGES DURING THE PERINATAL PERIOD (TOOL #3)

Providers may share the following oral health messages and recommendations with pregnant women and parenting women when making oral health advices as part of MI or providing oral health education to a group of pregnant women or parenting women.

DURING THE PREGNANCY

- Dental visit during pregnancy is safe and recommended by medical and dental experts4,14,15.
- Baby teeth start forming at 8 weeks of pregnancy, and mother’s healthy diet and healthy teeth and gums are important for baby’s oral and overall health outcomes16.
- Early Childhood Tooth Decay is preventable6.

DURING THE POSTPARTUM AND EARLY CHILDHOOD

- Baby teeth are important – they help a child eat, talk, smile, and hold space for adult teeth16.
- Untreated tooth decay can lead to pain and a serious infection6.
- Decay causing germs can be passed from mother to infants and toddlers during early childhood through common saliva-sharing activities (i.e. sharing utensils, pre-tasting/chewing foods, or cleaning baby’s pacifier in mom’s mouth before giving it to the baby)6.
- Dentists and pediatricians recommend all children receive dental examination before the first birthday6.
- Fluoride is a natural mineral that helps prevent tooth decay6.
PERINATAL ORAL HEALTH SELF-MANAGEMENT GOAL MAGNET (TOOL #4)

Oral Health Goals During Pregnancy and Early Childhood

- Regular Dental Visit during Pregnancy
- Floss Daily & Brush with Fluoride Toothpaste
- Balanced & Healthy Diet
- Drink & Cook with Tap Water with Fluoride
- Breastfeed Baby
- Let Baby Sleep Without a Bottle
- Avoid Sweet Liquid in Bottle & Clean Baby’s Gums and Teeth After Feeding
- 1st Dental Visit Before Age 1

Objetivos De Salud Oral
Durante El Embarazo Y La Primera Infancia

- Visita dental regular durante el embarazo
- Utilice hilo dental diariamente y cepillo con pasta dental con fluoruro
- Dieta equilibrada y saludable
- Beber y cocinar con agua del grifo con fluoruro
- Amamantar al bebé con
- Dejar queel bebé duerma sin una botella
- Evite líquidos dulces en la botella y limpiar la encias de bebé y los dientes después la lactancia materna
- Primera visita al dentista antes de la edad 1
After Your Baby Is Born

After your baby is born, it is important for you to keep track of your baby’s oral health. You can do this by brushing your baby’s teeth twice a day.

**Care for Your Baby’s Gums and Teeth**

- Brush twice a day: Brush your baby’s teeth for 4 months or longer.
- Choose a toothbrush that is gentle on your baby’s gums.
- Clean your baby’s gums after every feeding, even if your baby has no teeth.
- Use a clean, damp washcloth or toothbrush with soft bristles to clean your baby’s gums and teeth.

**Resources**

- Finding a Dentist
  - [Website](http://www.nationalmaternalandchildoralhealthresourcecenter.org)
- Finding Low-Cost Dental Care
  - [Website](http://www.mchoralhealth.org/PDFs/pregnancybrochure.pdf)

While You Are Pregnant

Changes to your body when you are pregnant can make your gums sore, puffy, and red. If you do not take steps to keep your gums healthy, this condition is called gingivitis (gin-giv-i-tis). If gingivitis is not treated, it may lead to periodontal (per-i-oh-don-tal) disease. This disease can cause tooth loss.

After your baby is born, take care of your baby’s gums and teeth too.

**Give your baby a healthy start!** Here are tips to keep your baby’s teeth and gums healthy.

**Two Healthy Smiles**

**Tips to Keep You and Your Baby Healthy**

- **Brush and floss:** Brush your teeth at least twice a day and floss at least once a day before bedtime.
- **Eat Healthy Foods:** Eat fruits, vegetables, whole grains, protein, like beans, nuts, seeds, and dairy products like milk, cheese, and yogurt. Avoid sugary foods and drinks.
- **Get Dental Care:** Visit a dentist regularly for check-ups and cleanings. If you have dental problems, talk to your dentist about the best treatment options.

LIST OF NIDCR PEDIATRIC ORAL HEALTH BROCHURES FREE TO ORDER
(TOOL #6)

A Healthy Mouth for Your Baby
This easy-to-read brochure is for parents of infants or toddlers. It explains why baby teeth are important, gives tips on how to prevent early childhood tooth decay, and promotes the age 1 dental visit.

A Healthy Mouth for Your Baby (for American Indians and Alaska Natives)
This easy-to-read brochure is for parents of infants or toddlers. It explains why baby teeth are important, gives tips on how to prevent early childhood tooth decay, and promotes the age 1 dental visit.

Open Wide and Trek Inside
For use with students in grades 1 and 2, this curriculum supplement focuses on oral health and the science of the oral environment. Includes educational videos and games (in English and Spanish).

The Tooth Decay Process: How to Reverse It and Avoid a Cavity
Information for parents of school-age children on how the tooth decay process starts and how it can be stopped (Available only on the web and in English and Spanish)
COMMON PERINATAL ORAL HEALTH QUESTIONS AND ANSWERS (TOOL #7)

Q. What are the healthy snacks for teeth and gums?

A. Fresh fruits, vegetables, cheese, and plain yogurt are low in sugars and nutritious compared to candy, cookies, cake, and chips that are high in sugar/fat and/or stick to teeth for a long time.

Drinking milk and fluoridated tap water are healthy choices for your teeth while juice, fruit-flavored drinks, and pop (soda) are not. Eating a variety of foods including meats, fish, eggs, beans and nuts are also important for health of gums.

Q. Are there any oral health tips for a pregnant woman who experiences nausea with tooth brushing?

A. Try using a small amount of fluoridated, alcohol-free mouthwash after meals and before going to bed.

Also rinsing after vomiting with a cup of water with a teaspoon of baking soda added helps neutralize acids in the mouth.

Q. When is the best time during pregnancy to have a dental visit?

A. Throughout the pregnancy. If the pregnant woman has not had a dental exam or tooth cleaning for more than 6 months, it is time for her to see a dentist. While some pregnant women may be uncomfortable about sitting or reclining on the dental chair during the late third trimester, there is no time during pregnancy that a dental visit is contraindicated and no dental procedures that should be avoided during pregnancy.

Q. Are there any types of pain medicine or antibiotics that pregnant women can use for toothache and/or infection?

A. In general, acetaminophen and penicillin are the analgesic and antibiotic of choice for pregnant women. However, the patient’s dental provider should consult with her OBGYN or primary health care provider before making a recommendation.

Moreover, it is highly recommended to refer such a pregnant woman with dental conditions to a dentist ASAP so that the cause of the toothache and infection is properly addressed. For more information regarding pharmaceutical considerations for pregnant women, please see Tool #15 on page 51.
Q. At what age does the first tooth appear in the baby's mouth?

A. At around 6 months, most children get their first tooth. It is usually one of the lower front teeth.

There are a few babies, however, who are born with a baby tooth at birth or get a tooth soon after the birth. Such babies should have a dental visit (to a pediatric dentist, if possible) ASAP to establish a dental home earlier than the general recommendation (by the first birthday) and have professional guidance on feeding and care for natal or neonatal teeth from the dentist.

---

Q. At what age should a child start using toothpaste that contains fluoride?

A. The American Dental Association recommends using a smear or rice grain size amount of fluoride toothpaste when the first tooth erupts until 3 years of age. So mothers can put very small amount of fluoride toothpaste on a washcloth or a soft bristled tooth brush and wipe/brush to protect her baby’s teeth from tooth decay¹⁹.

A smear or rice grain size amount of fluoride toothpaste is safe even if infants/toddlers swallow most of it ¹⁹.

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Q. How should a mother who plans to, or is already feeding her baby with powdered formula and is concerned about the risk for fluorosis, be advised?

A. The mother should be advised that the chance of her baby getting fluorosis that is esthetically noticeable from the use of infant formula reconstituted with fluoridated community water is unlikely.

Exclusive feeding of infant formula mixed with optimally fluoridated water could theoretically increase the risk for mild fluorosis on permanent incisors. However, the critical time for such risk is usually after most infants start mixed feeding (start eating baby food in addition to formula), and the outcome is mild fluorosis at the most, and this is usually not noticeable to a lay person’s eyes.
For that reason, the expert panel of American Dental Association said it is okay to recommend the use of optimally fluoridated water to mix infant formula\textsuperscript{20}. If a mother is still concerned about the chance of mild fluorosis, she should be advised to breastfeed the baby, use ready-to-feed formula, or use non-fluoridated bottled water to reconstitute powdered infant formula.

**Q. What are the mechanisms in the potential relationship between gum disease and birth outcomes?**

Inflammation caused by gram negative bacterial infection in the advanced stage of gum disease can enter the blood stream and reach the placenta, and then activate the inflammatory mediators resulting in clinical outcomes (i.e. infection, hemorrhage, placental ischemia, stress) that could ultimately cause various adverse birth outcomes.

**Q. How does the transmission of decay-causing bacteria from mother to her child occur?**

While oral flora is fairly stable in the adult's mouth, infants and toddlers usually acquire decay-causing bacteria (i.e. Mutans Streptococci) from primary care givers through common saliva sharing activities as follows by the time baby teeth appear in the mouth:

- Sharing utensils
- Putting a pacifier into caregiver’s mouth before putting in baby’s mouth
- Pre-chewing food for baby

Transmission of decay-causing bacteria can be largely prevented if an infant’s caregiver has no untreated decay, and therefore low-level of decay-causing bacteria in the mouth.
MYTHS AND FACTS ABOUT ORAL HEALTH RELATED, CULTURALLY INFLUENCED, BELIEFS (TOOL #8)

People say, “When we know better, we do better”. However, many oral health beliefs and behaviors are inherited over generations in the community and deeply rooted in family’s cultural background. Providers who identify misconceptions related to oral health that compromise their patient’s optimum oral health should guide them to resolve the misconception using MI (See Tool#2) and provide enablers and social support. Here are some examples of such myths and facts.

**MYTH #1 “Bottled water is safer than tap water”**

**FACT:** Bottled water and tap water are both regulated by the government (bottled water by Food and Drug Administration [FDA]; tap water by Environmental Protection Agency [EPA] and State Health Department), ensuring its quality and safety in the US. While people may think bottled water is of higher quality or purer than tap water because they are buying it or how it is advertised in the market, Natural Resources Defense Council (NRDC) says it is not the case. They found that potentially harmful chemical contaminants are sometimes found in some brands of bottled water. Researchers in North Carolina also found that bottled water can contain more trihalomethanes, a complex mixture of disinfectant by-product, than disinfected tap water. Distrust toward municipal water quality in subgroups of US population, e.g., Latino immigrants, may be rooted in their previous experience and cultural beliefs.

**MYTH #2 “Prenatal fluoride helps prevent cavities in children”**

**FACT:** While fluoride can cross the placenta, there is no scientific evidence suggesting that maternal intake of fluoride will make her baby’s teeth stronger and protected from dental caries. However, pregnant women are recommended to use fluoridated dentifrices (i.e. toothpaste and mouth rinse) and drink fluoridated water to prevent and control dental caries on their own teeth, which ultimately helps prevent early childhood caries in their children.
MYTH #3 “Pre-chewing food helps baby’s health”

FACT: There are some hypothetical health benefits of pre-chewing or premastication discussed in the literature including psychological benefit (i.e. enhancing mother-child bonding), nutritional benefit for weaning infants (i.e. supplement iron, zinc, and vitamin B12 when baby still has few teeth to chew grains and meats), immunological benefits (i.e. promoting immune tolerance help to moderate allergic reaction), in addition to socioeconomic benefit (i.e. easier and more practical than purchasing or cooking baby foods). However, the mechanisms of such health benefits of premastication are poorly understood or supported by scientific evidence and controversial. In fact, there is a growing body of evidence suggesting the increased risk for transmission of diseases and pathogens such as HIV, EBV (Epstein–Barr Virus; aka Infectious Mononucleosis/Human Herpes Virus 4/Kissing Disease: spreads most commonly through bodily fluids, primarily saliva), and dental caries through regular saliva exchanges from caregivers to infants.23

MYTH #4 “Pregnancy leaches calcium from your teeth”

FACT: The fetus does not take calcium from its mother’s teeth. Tooth enamel is the hardest substance in the body. Adult tooth development starts early and completes maturation by age 16. By age 16, the teeth are no longer developing and the strong enamel layer no longer requires nutrients from the bloodstream. The calcium the baby needs is provided by the mother’s diet not from the teeth. If the mother’s intake of calcium is inadequate during pregnancy, her bones – not her teeth – will provide the calcium her growing baby needs.

MYTH #5 “One tooth is lost with every pregnancy”.

FACT: A pregnant woman with poor oral health and with no access to care, or with nutritional habits that promote poor dental health can easily lose a tooth. Tooth loss occurs due to untreated dental disease (most commonly gum disease or dental caries) and not because of pregnancy. A pregnant woman can follow some simple guidelines for preventing tooth decay and gum disease- Brushing with toothpaste and mouth rinse containing fluoride; chewing sugarless gum containing xylitol after eating to reduce bacteria and clean teeth. For those pregnant women who suffer from “morning sickness”- Rinsing with a teaspoon of baking soda dissolved in a cup of water will help neutralize the acids remaining in the mouth after vomiting. A pregnant woman’s teeth will remain healthy with proper hygiene at home and professional help from the dentist.
GUIDELINES AND RECOMMENDATIONS FOR ORAL HEALTH CARE FOR PREGNANT AND LACTATING WOMEN

FROM:

The American Dental Association (2016)
Available at http://www.mouthhealthy.org/en/pregnancy/

The American Academy of Pediatric Dentistry (2011)
Available at http://www.aapd.org/media/policies_guidelines/g_perinataloralhealthcare.pdf

The American Congress of Obstetricians and Gynecologists (2013)
Available at http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Oral-Health-Care-During-Pregnancy-and-Through-the-Lifespan

REFERENCES:

Available at https://www.health.ny.gov/publications/0824.pdf
21. Environmental Working Group; Bottled Water Quality Investigation; Available at http://www.ewg.org/research/bottled-water-quality-investigation
Oral Health Guide and Tools for MICHC Support Service Providers (i.e. Community Health Workers, Case Managers, and Home Visitors)

The primary role of Community Health Workers (CHW), Case Workers, and Home Visitors in the MICHC Oral Health Integration project is to provide their clients with 1) oral health screening (ASSESS), 2) perinatal oral health messages (ADVISE), and 3) oral health referrals as needed (ARRANGE).

ASSISTING WOMEN AND YOUNG CHILDREN’S DENTAL VISIT

Historically dentists had been hesitant to see patients during pregnancy and early childhood and have recommended pregnant patients return to the dental clinic after the delivery or the child return to the clinic when he/she can sit on a dental chair by himself/herself. Outdated and insufficient knowledge and experience among dentists may be a part of this problem. Furthermore, a shortage of dentists who accept Medicaid beneficiaries only adds more barriers for MICHC clients to access dental care during the perinatal period1-4. A high rate of no shows is one of the concerns often reported by dentists in private practices as a reason for not participating in the Medicaid program5. Effective strategies are needed to be implemented to reduce the no show rate6 7.

As noted in the previous chapter, pregnant women may have competing priorities, fear about going to a dentist, or concerns about safety of dental procedures during pregnancy. In addition, MICHC clients may not be aware of professional recommendations regarding a child’s first dental visit and how to prevent tooth decay.

MICHC clients’ oral health should be addressed collaboratively among perinatal health care providers, support service providers, dental care providers, and the women and their families. Fragmented systems and services make high-needs families more likely to fall through the cracks and leave their oral health needs unmet. Support service providers are, therefore, important players in coordinating information, assistance, and services for MICHC clients’ oral health and follow up with them to ensure oral health interventions are provided during the perinatal period.
Keeping the above perinatal oral health barriers in mind, MICHC support service providers are expected to provide pregnant women and mothers and infants with the following interventions:

- Assess oral health needs by asking the pregnant or parenting woman:
  1) If she has had bleeding gums, cavities, pain, and/or other problems in her mouth
  2) If she had dental visit in the past 6-12 months
  3) If her baby had or is planning to have a dental visit within the 6 months after tooth eruption or before the first birthday

- Conduct MI to assess her oral health knowledge level, readiness, and barriers to effectively advise her on perinatal oral health and facilitate critical behavior change (See Tool #2 and 3 for more information).

- Provide assistance for the pregnant or parenting woman and a dentist to arrange:
  1) A dental appointment (see Tool#9: Decision and Action Tree for Dental Referral), and
  2) A prenatal dental care referral form completed by the pregnant woman’s medical provider (see Tool #10: Rx Dental Care Referral Form)

What is a Dental Home? Why is it important during the perinatal period?

A Dental Home is an approach to provide continuous, comprehensive, compassionate, and patient- and family-centered dental care. We recommend that all high-needs women establish a Dental Home during the pregnancy because pregnancy is the time when women have heightened dental needs (clinical care and education). Having a Dental Home for the mother assures her baby’s healthy start in his/her mouth and timely referral for his/her first dental visit.

Support Service Providers are critical players in a Perinatal Dental Home especially for high-needs families. Providing information and assistance for transportation services to a dentist, dental insurance, phone calls to dentists, referral letters, and effective motivation might be the important ingredients of the Dental Home for some high-needs women overcoming barriers.
PRENATAL ORAL HEALTH REFERRAL—DECISIONS and ACTION TREE (TOOL #9)

Screening Question #1:
"Do you have bleeding gums, cavities, pain, and/or any other problem in your mouth?"

Yes

Screening Question #2:
"Have you had a dental visit in the past 6-11 months?"

No

Advise
Use SM Goal Magnets (Tool #4) to identify achievable perinatal oral health goals
Disseminate oral health messages

Assess and Advise
Use MI to assess readiness and barriers for dental visit
Advise the importance of regular and preventive dental care
Use SM Goal Magnets (Tool #4) to identify achievable perinatal oral health goals

Assist and Arrange
Refer the pregnant woman to her existing Dental Home for her oral conditions
Arrange Oral Health Referral Form filled by medical providers

Assist and Arrange
Help establish a Dental Home by identifying MICHIC dental provider
Arrange Oral Health Referral Form filled by medical providers

Follow-up with the pregnant woman and referred dentist to ensure dental care is in progress

Follow-up with the pregnant woman and referred dentist to ensure dental care is in progress
PERINATAL ORAL HEALTH CONSULTATION FORM

Referred To: ___________________________ Date: __________________

Patient Name: Last ___________________________ First: ___________________________

DOB: ___________ Estimated Delivery Date: _______ Week of Gestation Today: _______

Known Allergies: ________________________________________________________________________

Precautions: None Specify (If any): _______________________________________________________

_________________________________________________________________________________________

This patient may have routine dental evaluation and care, including but not limited to: (Check all that apply)

<table>
<thead>
<tr>
<th>Oral health examination</th>
<th>Dental X rays with abdominal and neck lead shield</th>
<th>Dental treatment with local anesthetics (Extractions/Root canals/Fillings as appropriate/Deep cleaning)</th>
</tr>
</thead>
</table>

Patient may have: (Check all that apply)

- Acetaminophen with codeine for pain control
- Alternative pain control medication: (Specify)
- Penicillin
- Amoxicillin
- Clindamycin
- Cephalosporins
- Erythromycin (Not estolate form)

Prenatal Care Provider: ___________________________ Phone: __________________
Signature: ___________________________ Date: __________________

DO NOT HESITATE TO CALL FOR QUESTIONS

DENTIST’S REPORT (for the Prenatal Care Provider)

Diagnosis: ____________________________________________________________________________

Treatment Plan: _______________________________________________________________________

Name: ___________________________ Date: _______ Phone: __________________
Signature of Dentist: __________________________________________________________________

Source: New York State Department of Oral Health Care during Pregnancy and Early Childhood.
August 2006
ORAL HEALTH RECOMMENDATIONS CHART

Pregnancy by itself is not a reason to defer routine dental care and necessary treatment for oral health problems

- Dental treatment is safe and effective throughout pregnancy
- In the 1st trimester, dental x-rays are safe to diagnose dental problems for urgent and immediate treatment.
- The best time for dental treatment is in the 2nd trimester. However, routine dental care is recommended at any time during pregnancy.
- Both mother and child are at risk if dental treatment is delayed
- Elective treatment can be deferred but emergency treatment is important anytime during pregnancy
- Throughout pregnancy and after: Brush twice for two minutes; Use Fluoride Toothpaste; Floss between teeth
- For Moms: Have fruit, not fruit juice; Drink water or low fat milk; Limit food containing sugars
- Advise Moms to:
  - Wipe infant teeth/gums after feeding with soft bristle brush or soft cloth
  - Supervise children’s brushing with an amount of toothpaste that is rice grain size for less than 3 year olds and pea size for more than 3 year olds
  - Avoid putting your child to bed with a bottle
  - After breastfeeding at night, wipe infant’s teeth and gums with soft bristle brush or soft cloth
  - Avoid sharing spoon for tasting food; Avoid cleaning dropped pacifier by mouth
- Visit dentist by age 1

ORAL HEALTH SCREENING AND REFERRAL USING PEERPLACE NETWORK (TOOL #11)

REFERENCES:


Oral Health Guide and Tools for Perinatal Health Care Providers

The primary role of perinatal health care providers such as physicians, nurses, and midwives is two-fold: 1) to encourage pregnant women and mothers of infants to adhere to the evidence-based oral health recommendations (**ADVISE**) and 2) answer questions that dentists or pregnant women may ask about safety and medical implications of dental care (**ASSURE**). In the perinatal care programs that do not have support service providers such as case workers or care coordinators available, perinatal health care providers should assess oral health needs and arrange oral health referrals for pregnant women and infants.

**THE ROLE OF PRENATAL HEALTH CARE PROVIDERS**

During pregnancy, many pregnant women and dental providers have concerns about the effect of dental visits and dental treatments on pregnancy\(^1-4\). It is critical for prenatal health care providers to understand the evidence-based oral health recommendations\(^5,6\) and be able and available to effectively and timely address such concerns. Prenatal health care providers are also in the perfect position to educate high-needs pregnant women about the importance of oral health to overall health and a healthy pregnancy.

**ORAL HEALTH REFERRAL FORM- A Tool to Communicate with the Dentist**

While pregnancy is not a pathological condition but physiological condition in women, many dentists feel that dental visits should be postponed until after the delivery based on outdated knowledge and myths regarding the effect of dental procedures on pregnancy\(^1\). Please use the Prenatal Oral Health Referral Form (Tool #10) to communicate the pregnant woman’s medical history, presence of any co-morbid conditions (i.e. gestational diabetes) and/or precautions, and oral health needs and concerns with a dentist. Please also provide your contact information to ensure timely communication and completion of needed dental care during the pregnancy.
ONLINE TRAINING RESOURCES

**Smiles for Life: Course 5 – Oral Health and the Pregnant Patient**

This course addresses the importance of oral health before, during, and after pregnancy. Information is provided on the prevalence of oral disease during pregnancy and its consequences for both mothers and children, as well as a review of dental treatment guidelines for pregnant women. Continuing education credit is available.

**University of Washington, School of Dentistry Continuing Dental Education Online Course- OC 1504: Managing and Treating Pregnant Patients**

The course teaches dentists and other dental professionals to manage and treat pregnant patients. It is designed to educate dental professionals on the important health implications of oral disease in a pregnant woman and her baby. The course highlights the evidence-based guidelines for delivering care to pregnant women, including the use of medications and x-rays, positioning the patient, educational messaging, and also addresses dentists' liability concerns. The course includes a presentation on the lack of liability from a Northwest Dentists Insurance Company representative.

**COMMITTEE OPINION: The American College of Obstetricians and Gynecologists**

**Oral Health Care during Pregnancy and Through the Lifespan. No. 569. August 2013**

Available at:
THE ROLE OF PEDIATRIC HEALTH CARE PROVIDERS

During infancy and early childhood, children have multiple well child visits and are much more likely to encounter pediatric health care providers than dental providers. Given the shortages of pediatric dental specialists, it is important for pediatricians, pediatric nurses and physician assistants to conduct oral health screenings and risk assessments, parental counseling, and appropriate oral health interventions (i.e. fluoride varnish application for high risk children and referrals to dental providers for more comprehensive services).

In general, the child’s first dental visit is recommended to occur before the first birthday so that a comprehensive oral examination and anticipatory guidance are provided to high-risk mothers and children before early childhood caries (ECC) appears in the child’s mouth. However, per pediatric health care providers’ comfort level, availability of pediatric dental providers for referral, and clients’ preference and oral health needs, infants and toddlers could remain in pediatric health care systems as long as oral health needs are addressed.

ONLINE TRAINING RESOURCE

Smiles for Life: Course 6 – Caries Risk Assessment, Fluoride Varnish and Counseling

Available at http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbreceipt=0

This course focuses on caries prevention. It offers a brief review of Early Childhood Caries (ECC) and addresses how the use of fluoride is part of a comprehensive approach to a child’s oral health. Specifically, clinicians will learn the benefits, appropriate safety precautions, and dosing for fluoride, as well as how to apply fluoride varnish and provide adequate follow-up care. Continuing education credit is available.
### US PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS

**Prevention of Dental Caries in Children from Birth Through Age 5 Years (May 2014)**


<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children from 0-5 years</td>
<td>Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride</td>
<td>B</td>
</tr>
<tr>
<td>Children from 0-5 years</td>
<td>Primary care clinicians apply fluoride varnish to the primary teeth of <strong>all infants and children starting</strong> at the age of primary tooth eruption</td>
<td>B</td>
</tr>
<tr>
<td>Children from 0-5 years</td>
<td>The current evidence is insufficient on routine screening examinations for dental caries performed by primary care clinicians</td>
<td>I</td>
</tr>
</tbody>
</table>
Oral health education can be incorporated into centering pregnancy programs. The importance of oral health is addressed in the 2nd session (16-20 weeks) and is included in the centering curriculum (Tool #12).

Healthy Gums and Teeth

It may be useful to have a dentist or a hygienist at this session.

Agree-Disagree: Oral Health

Objective

This is a time to review good brushing and flossing techniques. Use a timer to demonstrate how long we are encouraged to brush. Some groups may want to brush their teeth together using good technique.

Supplies

Oral Health Question Cards,
Agree-Disagree Discs

Activity

Use the question cards and the discs to stimulate discussion. People take turns reading a card and the group responds to it by agreeing or disagreeing. Encourage conversation with each question. The accuracy of the responses will help you decide how long to stay in discussion or move on to the next question.

Healthy Gums and Teeth

It is important to have healthy gums and teeth, especially during your pregnancy. Hormone changes in pregnancy can make gum disease worse. Women with gum disease are more likely to have babies born too early. Women with poor oral health are more likely to have children with tooth decay.

Signs of gum disease

- Gums are red, swollen, or bleeding
- Teeth are very sensitive
- Commonly have bad breath for no obvious reason

Improve your oral health

- Get a dental exam twice a year
- Brush your teeth twice a day with fluoride toothpaste
- Floss your teeth every day
- Use a mouth rinse
- Eat a balanced diet
- Don’t use any kind of tobacco
REFERENCES:


Practice Recommendations and Tools for Dental Care Providers

THE ROLE OF DENTAL CARE PROVIDERS

When MICHC clients have a dental visit, they may be informed about the importance of dental care during the perinatal period either by support service providers or prenatal health care providers. Dental teams, i.e. dentists, dental hygienists, dental assistants, and administrative office staff, have the following two roles:

1) Develop, discuss and provide a comprehensive care plan that includes prevention, treatment, and maintenance of oral health during the perinatal period and beyond and address pregnant women’s oral health needs (urgent as well as regular dental care needs).

2) Educate pregnant women about the prevention of ECC and provide them with appropriate self-management skills and anticipatory guidance for good family oral health.

During pregnancy, women may be concerned about the effect of dental treatments on their fetus, i.e. dental x-rays and local anesthesia.

Some pregnant dental patients may have co-morbidities such as diabetes, hypertension, or a cardiac condition that may affect management of oral problems in the dental office.

Pregnant women in MICHC program most likely have other priorities and keeping their dental appointment might not be their top priority.

- The dental team works in collaboration with health care and support service providers in the prenatal health care systems to optimize MICHC clients’ oral health care,
- The dental team and pregnant patient make an informed decision after clearly discussing the benefits and risks of dental treatment and alternatives of treatments, and
- The dental team uses standard and evidence-based dental practices (i.e. use lead apron to protect patient and fetus when obtaining x-rays, high-speed vacuum and rubber dam isolation when placing restorative materials and performing endodontic procedures).
ONLINE GUIDELINE RESOURCES

- Oral Health Care During Pregnancy: A National Consensus Statement
  Available at [http://www.mchoralhealth.org/PDFs/Oralhealthpregnancyconsensusmeetings summary.pdf](http://www.mchoralhealth.org/PDFs/Oralhealthpregnancyconsensusmeetings summary.pdf)

CARIES RISK ASSESSMENT

Caries Risk Assessment (CRA) is a cornerstone of the disease prevention and management approach. CRA involves two parts: 1) an interview with the patient or a caregiver of child patient and 2) clinical examination to guide clinicians to identify the level of protective and risk factors as well as disease indicators.

<table>
<thead>
<tr>
<th>Protective Factors</th>
<th>Risk Factors</th>
<th>Disease Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoridated water</td>
<td>Frequent sugar intake</td>
<td>Early demineralized enamel surfaces (white spot)</td>
</tr>
<tr>
<td>Use of fluoridated toothpaste/mouth rinse</td>
<td>Inadequate exposure to fluoride</td>
<td>Cavitated lesions</td>
</tr>
<tr>
<td>Daily brushing and flossing</td>
<td>Medications/medical conditions that cause dry mouth</td>
<td>Remineralized lesions</td>
</tr>
<tr>
<td>Saliva and Sealants</td>
<td>High-level of decay-causing bacteria</td>
<td>Plaque</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of salivary flow</td>
</tr>
</tbody>
</table>

Although there is very little evidence to support the universal adoption of a CRA tool, CRA is an essential first step to aid the provider in determining a preventive and restorative treatment plan and the patient’s recall periodicity (three months, six months, or one year).

ADA CODES FOR CARIES RISK ASSESSMENT

<table>
<thead>
<tr>
<th>ADA Codes</th>
<th>Description</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0601</td>
<td>Low risk for caries</td>
<td>Per use of caries risk assessment</td>
</tr>
<tr>
<td>D0602</td>
<td>Moderate risk for caries</td>
<td>Instrument and documentation</td>
</tr>
<tr>
<td>D0603</td>
<td>High risk for caries</td>
<td>Per use of caries risk assessment</td>
</tr>
</tbody>
</table>

MICHC ORAL HEALTH MANUAL AND TOOLKIT – AUGUST 2017
LIST OF CRA FORMS

- ADA Caries Risk Assessment Form for Child >6 years and Adult
  Available at http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx

- ADA Caries Risk Assessment Forms for Children 0-6 years
  Available at http://www.ada.org/~/media/ADA/Member%20Center/Files/topics_caries_under6.ashx

- CAMBRA CRA Resources
  Available at http://www.cda.org/Portals/0/journal/journal_102007.pdf

Please refer Chapter 2 Guide and Tools for more information on Motivational Interviewing Techniques, Early Childhood Caries, Oral Health Messages and Qs and As.
COMMUNICATING RISK AND BENEFIT OF DENTAL TREATMENT WITH PREGNANT DENTAL PATIENT (TOOL #13)

To successfully manage a pregnant woman’s dental needs, a dentist and dental team should be able to effectively communicate risks and benefits of dental care and prepare instructional resources that assist her informed decision making. Good dentist-patient relationship, clear communication between a dentist, pregnant dental patient, and her obstetrician, and documentation of communication and procedures are integral components of risk management in any dental practice. Here are some of common scenarios and example conversations in a dental office explaining dental procedures to a pregnant patient:

SCENARIO #1: Dental x-rays/radiographs and timing of dental treatment

Stacy, a 23-year-old woman who is in the 11th week of pregnancy, comes to your clinic, referred by MICHIC Community Health Worker, for initial exam with a chief complaint of a “cavity” in the mouth. She reports no spontaneous pain, and her dental referral form indicates no significant medical history or at-risk pregnancy. After conducting the patient interview, you clinically examine the patient’s mouth and complete clinical charting. The patient receives oral hygiene instructions and education, scaling, prophylaxis, and fluoride varnish application with a dental hygienist. You are going to talk to Stacy about your plan of taking some x-rays in order to complete your treatment planning and recommend her to return for restorative treatment.

Examples of communication
Stacy, I found some cavities in your mouth with my visual exam and would like to take 4 bitewing x-rays to better diagnose the extent of decay. Taking several diagnostic dental x-rays presents virtually no risk to your fetus because we use fast x-ray film to reduce radiation exposure and you will wear a protective lead apron—that is the standard of care we practice for any patient. Please be reassured that the radiation exposure from x-rays taken in a dental office is minimal and does not pose any risk to you or your baby when appropriate precautions are taken.

The first trimester is the time when fetal structural and organ development occurs and this is the time when any exposed risk would have the most impact on your baby. However, national experts of obstetricians and dentists say dental treatment is safe throughout the pregnancy. As you are currently in your late first trimester and you are not presently experiencing a toothache, how about taking diagnostic dental x-rays when you return for treatment in your second trimester? We can schedule these appointments for you today."
SCENARIO #2: Use of Local Anesthesia and restorative dental treatment

Stacy returned to your clinic when she is in the 18th week of pregnancy for restorative treatment on tooth #14 (occlusal caries). You update her medical history and there is no contraindication for dental treatment. You are going to inform her about today’s dental procedure that involves the use of local anesthesia, rubber dam, and direct restoration.

Examples of communication

Stacy, I am going to fix a cavity on your upper left molar today. In order to prevent pain and discomfort while I remove decay on your tooth, I am going to numb the gum and tooth locally. Lidocaine that contains epinephrine is most widely used for the purpose in dentistry because of its effectiveness and safety. I feel comfortable using the local anesthesia on you because there is no proven ill effect reported during pregnancy and your obstetrician reported to me that your pregnancy is going well and approved the use of local anesthesia (have the copy of perinatal dental referral form in the dental chart) (Tool #10).

The second trimester is the best time to receive regular dental treatment like this, and if the cavity is left untreated, it could possibly cause a toothache and infection while you are in labor or after your baby is born.

There are a few options of dental material that I can use to fix your tooth. Amalgam filling is a silver-color, mercury containing dental material that has been used in dentistry for many years. There are no studies in humans that have shown an ill effect on pregnancy from placing this dental material or that the mother’s existing amalgam fillings cause any adverse effect to the fetus. We will also use a high-speed vacuum to minimize your exposure to the vapor of Amalgam. Composite resin is a tooth-color dental material. It relies on bonding technology so I will have to ensure that the tooth will stay dry while I place it.

In either case, whether you choose amalgam or composite resin, I would like to place a rubber dam in your mouth so that the tooth and the filling will remain dry and clean. It also prevents you from swallowing bad tasting decay and dental materials etc. If you have any problem keeping it in your mouth, you can always let me know.
SCENARIO #3: Dental extraction and endodontic dental treatment

Anne, 27-year-old woman who is in the 28th week of pregnancy, visits your clinic with a chief complaint of toothache on tooth #19. As she is not your regular dental patient, you make a phone call to her prenatal care provider to confirm her medical history and any perceived contraindication for dental treatment while your dental hygienist is taking a periapical x-ray of the affected tooth. The radiographic image shows a periapical abscess on tooth #19, and you clinically observe large MO surfaces of the crown missing due to caries. Her obstetrician gives you clearance for dental treatment. Anne seems to be a bit nervous on the dental chair, and you are going to discuss treatment options with her.

Example of communication

Your tooth has large decay and infection causing an abscess and pain. There are a few treatment options that I will explain to you and would like you to think about carefully. One is to remove the tooth. This procedure is covered by your dental insurance and also it can be done today. The procedure is to numb your tooth and gums locally and remove the affected tooth. This is a procedure that I do every day.

If you are feeling too nervous to take your tooth out, I can discuss with you and your obstetrician about the option of using low dose of laughing gas or referring you to an oral surgeon who does sedation to manage your anxiety better during the extraction.

The other treatment option is to have root canal treatment to save the tooth. Your dental insurance unfortunately will not cover this treatment and I do not perform root canal on molars. So, if you would like this option, I will refer you to the nearby dental school or to a specialist (endodontist). As root canal treatment usually requires more than a few dental visits to be completed, it is possible that the treatment won’t be completed before you deliver your child and you may continue to experience some discomfort in your mouth. After the completion of root canal treatment, you will need to have a crown because so much tooth structure is gone because of cavity. Your dental insurance will not cover crowns, but our clinic can provide you with sliding fee schedule and payment plan if necessary. It is very important to maintain good oral hygiene if you would like a good prognosis of these treatments. Our dental hygienist can teach you how to keep your teeth healthy at home. Otherwise, you will end up having this tooth with a costly root canal and crown removed a few years later.

My professional recommendation for you is to have the tooth removed today because infection from the tooth could spread out to your body while you are waiting for consultation and root canal treatment. Prolonged use of antibiotics and pain medicine is not good for your health and health of your fetus. What do you think about these options and how can I help you?
MEMOS ON DENTAL RADIOGRAPHS

- No increase in congenital anomalies or intrauterine growth retardation has been reported for x-ray radiation exposure during pregnancy totaling less than 5-10 cGy.
- A full-mouth series of dental x-rays results in only 8-10^{-4} cGy.
- A bitewing and panoramic radiographic result in about 1/3 of radiation exposure associated with full-mouth series with E-speed film and rectangular collimated beam.

ADA’s Professional Guideline for Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure (2012) is available at
http://www.ada.org/~/media/ADA/Member%20Center/Files/Dental_Radiographic_Examinations_2012.ashx

MEMOS ON LOCAL ANESTHESIA

- 2% Lidocaine with 1:100,000 epinephrine (the most widely used local anesthetic in dentistry) is Category B drug for use during pregnancy
- Prilocaine is also Pregnancy Category B drug.
- Mepivacaine, Septocaine, and Bupivacaine are in Pregnancy Category C.
- In a healthy pregnant patient, local anesthesia with 1:100,000 epinephrine concentration used in dentistry is safe if administered using proper aspiration technique, preventing intravascular injection and its use is limited to the normal dose^{3,4}. 
MEMOS ON GENERAL ANESTHESIA AND SEDATION DRUGS

- The U.S. Food and Drug Administration (FDA) is warning that repeated or lengthy use of general anesthetic and sedation drugs during surgeries or procedures in children younger than 3 years or in pregnant women during their third trimester may affect the development of children’s brains.
- Consistent with animal studies, recent human studies suggest that a single, relatively short exposure to general anesthetic and sedation drugs in infants or toddlers is unlikely to have negative effects on behavior or learning. However, further research is needed to fully characterize how early life anesthetic exposure affects children’s brain development.
- **Health care professionals** should balance the benefits of appropriate anesthesia in young children and pregnant women against the potential risks, especially for procedures that may last longer than 3 hours or if multiple procedures are required in children under 3 years. Discuss with parents, caregivers, and pregnant women the benefits, risks, and appropriate timing of surgery or procedures requiring anesthetic and sedation drugs.
- **Parents and caregivers** should discuss with their child’s health care professional the potential adverse effects of anesthesia on brain development, as well as the appropriate timing of procedures that can be delayed without jeopardizing their child’s health.
- **Pregnant women** should have similar conversations with their health care professionals. Also talk with them about any questions or concerns.

POSITIONING PREGNANT PATIENT ON DENTAL CHAIR (TOOL #14)

- Keep the woman’s head at a higher level than her feet
- Place women in a semi-reclining position as tolerated
- Allow frequent position changes
- Place a small pillow or rolled towel under the right hip, or have the women turn slightly to the left as needed to avoid dizziness or nausea resulting from hypotension
**Pharmacological Considerations for Pregnant Women**

The pharmacological agents listed below are to be used only for indicated medical conditions and with appropriate supervision.

<table>
<thead>
<tr>
<th>Pharmaceutical Agent</th>
<th>Indications, Contraindications, and Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Analgesics</strong></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>May be used during pregnancy.</td>
</tr>
<tr>
<td>Acetaminophen with Codeine, Hydrocodone, or Oxycodeine</td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td></td>
</tr>
<tr>
<td>Meperidine</td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td>May be used in short duration during pregnancy; 48 to 72 hours. Avoid in 1st and 3rd trimesters.</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td></td>
</tr>
<tr>
<td>Naproxen</td>
<td></td>
</tr>
<tr>
<td><strong>Antibiotics</strong></td>
<td></td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>May be used during pregnancy.</td>
</tr>
<tr>
<td>Cephalosporins</td>
<td></td>
</tr>
<tr>
<td>Clindamycin</td>
<td></td>
</tr>
<tr>
<td>Metronidazole</td>
<td></td>
</tr>
<tr>
<td>Penicillin</td>
<td></td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>Avoid during pregnancy.</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td></td>
</tr>
<tr>
<td>Levofloxacin</td>
<td></td>
</tr>
<tr>
<td>Moxifloxacin</td>
<td></td>
</tr>
<tr>
<td>Tetracycline</td>
<td>Never use during pregnancy.</td>
</tr>
<tr>
<td><strong>Anesthetics</strong></td>
<td></td>
</tr>
<tr>
<td>Local anesthetics with epinephrine (e.g., Bupivacaine, Lidoacaine, Mepivacaine)</td>
<td>May be used during pregnancy.</td>
</tr>
<tr>
<td>Nitrous oxide (30%)</td>
<td>May be used during pregnancy when topical or local anesthetics are inadequate. Pregnant women require lower levels of nitrous oxide to achieve sedation; consult with prenatal care health professional.</td>
</tr>
<tr>
<td><strong>Antimicrobials</strong></td>
<td></td>
</tr>
<tr>
<td>Cetylpyridinium chloride mouth rinse</td>
<td>May be used during pregnancy.</td>
</tr>
<tr>
<td>Chlorhexidine mouth rinse</td>
<td></td>
</tr>
<tr>
<td>Xylitol</td>
<td></td>
</tr>
</tbody>
</table>

Recently, the United States Food and Drug Administration set forth new guidelines for pregnancy and lactation labelling of medications\textsuperscript{14,15,16}. This new labelling rule went into effect on June 30, 2015 but its implementation will take place over a 3-5 year period. This new labelling requires changes to the content and format of prescription drug labelling to help the practitioners make decisions based on updated evidence and has put the decision-making onus back on the individual practitioner\textsuperscript{16}. The practitioner must continue to weigh the benefit of using the medication against all possible risks to patients before administering or prescribing it (For example, see table below)\textsuperscript{17}.

<table>
<thead>
<tr>
<th>Medications in pregnancy</th>
<th>Previous Classification</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local anesthetics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lidocaine</td>
<td>B</td>
<td>No known risks</td>
</tr>
<tr>
<td>Mepivacaine</td>
<td>C</td>
<td>No known risks</td>
</tr>
<tr>
<td>Bupivacaine</td>
<td>C</td>
<td>No known risks</td>
</tr>
<tr>
<td>Benzocaine</td>
<td>C</td>
<td>No known risks</td>
</tr>
<tr>
<td>Epinephrine</td>
<td>C</td>
<td>Reports of fetal malformations with intravenous doses; no documented risk when used in association with a local anesthetic</td>
</tr>
<tr>
<td><strong>Antibiotics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>B</td>
<td>None</td>
</tr>
<tr>
<td>Penicillin</td>
<td>B</td>
<td>None</td>
</tr>
<tr>
<td>Amoxicillin and clavulanate potassium (Augmentin)</td>
<td>B</td>
<td>None</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>B</td>
<td>None</td>
</tr>
<tr>
<td>Azithromycin</td>
<td>B</td>
<td>None</td>
</tr>
<tr>
<td>Metronidazole (Flagyl)</td>
<td>B</td>
<td>Fetal carcinogen in mammals; no proven risk in humans; contraindicated for use in first trimester as per manufacturer</td>
</tr>
<tr>
<td><strong>Analgesics</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Ibuprofen                | D                      | ● Associated with ductus arteriosus constriction when used during first trimester  
● Associated with pulmonary hypertension when used in the third trimester  
Frequent use may be associated with fetal abnormality  
● First trimester use: low risk of neural tube defects  
● Third trimester use: risk of fetal dependence and newborn respiratory depression |
| Acetaminophen            | B                      |          |
| Opioids (oxycodone, hydrocodone, codeine) | C |          |
| **Steroids**             |                        |          |
| Dexamethasone            | Not applicable         | Low risk of oral clefts during first trimester  
First trimester risk of oral clefts; continued use may restrict fetal growth  
Low risk of oral clefts during first trimester |
| Triamcinolone            | C                      |          |
| Prednisone               | Not applicable         |          |
PHARMACOLOGICAL CONSIDERATIONS FOR LACTATING DENTAL PATIENTS

Knowledge about medication use during lactation or breastfeeding is extremely important. It is imperative to be up-to-date with information on medication use and its effect on the nursing infant during breastfeeding. Factors that reduce the ability of mothers to metabolize or excrete the drug may increase infant exposure to the drug\(^\text{18}\). Infants who breastfeed more often and consume a higher volume of milk are more vulnerable to maternal drugs than those who breastfeed less often and ingest a lower volume of milk\(^\text{18}\). Infant exposure to the drug can be reduced if the drug is used by the mother immediately before or after breastfeeding. Consultation with the obstetrician or pediatrician is very useful. Drugs that are known to be toxic to infants such as antineoplastic drugs, radioactive drugs or drugs of abuse are contraindicated during the breastfeeding period\(^\text{19,20}\). It is beneficial to evaluate the risks versus the benefits of medications prior to administration to a nursing mother. (See table below for compatibility with breastfeeding of some commonly used medications in lactating dental patients)\(^\text{17,19,20}\).

<table>
<thead>
<tr>
<th>Medications compatible with breastfeeding</th>
<th>Safety Recommendation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local anesthetics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lidocaine</td>
<td>According to FDA, compatible with breastfeeding</td>
<td>No studies found addressing presence of Lidocaine in breast milk following a dental procedure</td>
</tr>
<tr>
<td>Epinephrine</td>
<td>Caution is advised because of possible effects on milk production Safety unknown Safety unknown</td>
<td>Limited studies found</td>
</tr>
<tr>
<td>Mepivacaine Bupivacaine</td>
<td>No study found</td>
<td>No study found</td>
</tr>
<tr>
<td><strong>Antibiotics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amoxicillin Penicillin</td>
<td>Usually compatible Usually compatible</td>
<td>Penicillins incorporate into breast milk in small doses</td>
</tr>
<tr>
<td>Clindamycin Azithromycin Cephalosporin</td>
<td>Usually compatible Usually compatible Usually compatible</td>
<td>Cephalosporin incorporates into breast milk in small doses</td>
</tr>
<tr>
<td>Erythromycin Metronidazole (Flagyl)</td>
<td>Usually compatible Caution is advised</td>
<td>Has shown to cause carcinogenesis in rodents but has not been shown to cause similar outcomes in humans</td>
</tr>
<tr>
<td><strong>Analgesics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td>Potential toxicity</td>
<td>Give with caution; should be given at low doses (&lt;150 mg/d); consider alternate choice if possible</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>Usually compatible</td>
<td>No risk to infant at normal doses</td>
</tr>
<tr>
<td>Celecoxib</td>
<td>Usually compatible</td>
<td>Black box warning that it is contraindicated because of potential adverse effects</td>
</tr>
<tr>
<td>Diclofenac</td>
<td>Usually compatible</td>
<td></td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>Usually compatible</td>
<td></td>
</tr>
<tr>
<td>Indomethacin</td>
<td>Usually compatible</td>
<td></td>
</tr>
<tr>
<td>Ketorolac</td>
<td>Usually compatible</td>
<td></td>
</tr>
<tr>
<td>Naproxen</td>
<td>Usually compatible</td>
<td></td>
</tr>
</tbody>
</table>
### Opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Caution</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>Caution is advised</td>
<td>When given at low levels, is present in breast milk in small amounts; Some infants possess the ability to rapidly metabolize the drug causing high levels in the blood.</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Caution is advised</td>
<td>Hydrocodone has been shown to reach as high as 9% of the maternal dose. Tolerated well by infants and is preferable over codeine and hydrocodone use. Moderate amounts found in human milk.</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>Caution is advised</td>
<td>Relatively high amounts found in human milk.</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Caution is advised</td>
<td></td>
</tr>
<tr>
<td>Meperidine</td>
<td>Not recommended</td>
<td></td>
</tr>
</tbody>
</table>

### REFERENCES:

7. ADA Caries Risk Assessment Form for Child >6 years and Adult. Available at http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx
8. ADA Caries Risk Assessment Forms for Children 0-6 years
Available at http://www.ada.org/~/media/ADA/Member%20Center/Files/topics_caries_under6.ashx

9. CAMBRA CRA Resources
Available at http://www.cda.org/Portals/0/journal/journal_102007.pdf


12. U. S. Food and Drugs Administration Drug Safety Communication: FDA review results in new warnings about using general anesthetics and sedation drugs in young children and pregnant women; Available online at https://www.fda.gov/Drugs/DrugSafety/ucm532356.htm


14. U. S. Food and Drug Administration; Pregnancy and Lactation Labeling (Drugs) Final Rule; Available at http://www.fda.gov/drugs/developmentapprovalprocess/developmentresources labeling/ucm093307.htm; Accessed on 7/10/16


Oral Health Guide and Tools for MICHCH Partner Programs (i.e. Head Start, WIC Programs)

The goal of this Tool Kit and Manual has been to introduce the topic of the importance of oral health screenings, care, and maintenance for Pregnant and Parenting women and to support women in obtaining the care and treatment they need to maintain good oral health for themselves and their children. MICHCH partner programs play a key role in assisting pregnant and parenting women and their children to understand about the importance of learning, practicing, and maintaining good oral health habits. By providing screenings and asking women:

(1) Have you had a regular or preventative dental visit within the last 6 months, and
(2) Do you have any problems in your mouth (bleeding gums, toothache, loose tooth, etc.), and then educating women and connecting them to needed services or supports.

MICHCH partners working with women are best positioned to assist them in exploring their barriers and crafting interventions and supports to navigate them.

TIPS FOR BUILDING ORAL HEALTH PROGRAMS

The MICHCH program uses a variety of resources to provide oral health education to partners and consumers. We recommend that programs have a variety of educational information on hand for overview education, then assess their needs and utilize information that addresses barriers women presented.

SOME EXAMPLES ARE BELOW:

- **Oral Health and Health in Women: A Two-Way Relationship** - flyer that provides information and strategies about the importance of oral health across the lifespan and during pregnancy for health and human service providers (not recommended for consumers).
- **Two Healthy Smiles** – brochure in English and Spanish addressing oral health during and after pregnancy and for infants. (Recommended for use with consumers) **The National Center on Health has Healthy Habits for Happy** – 2-sided flyer that has English and Spanish versions of infant oral health information addressing teething pain and tips to help babies. (Recommended for use with consumers).
The Cavity Free Kids: An Early Start, Oral Health Education for Pregnant Women, Infants, and Toddlers, the companion curriculum to Cavity Free Kids: Oral Health Education for Preschoolers and Their Families. Developed by Delta Dental in conjunction with the Washington Dental Service Foundation, has parent resources in English and Spanish, can be delivered during home visits or in group settings, and has supporting materials (DVDs, handouts, etc.) that can be purchased. Recommended for use with consumers.

The Partners for a Healthy Baby Curriculum (for a cost – contact S. Bullock MICHC Program Director) includes oral health information for infants including, “Signs of Incoming Teeth”, “Teething and What To Do”, and “Bottle Use, Decay, and How to Prevent Tooth Decay”.

***TO ASSIST PREGNANT OR PARENTING WOMEN WITH REFERRALS FOR ORAL HEALTH OR OTHER SUPPORTS CALL THE HEALTHY BABY OUTREACH TEAM AT (585) 546 – 4930 OR ACCESS THE HEALTHY BABY RESOURCE DIRECTORY ONLINE AT (http://www.pnmc-hsr.org/resources/directory/)
MICHC Oral Health Webinar

A webinar on training prenatal, perinatal and dental providers and support staff about oral health care during pregnancy was scheduled in September 2016 and thereafter the recording has been available at the Healthy Baby Network website as well as the Eastman Institute for Oral Health website.
# MICHC Oral Health Contacts and Networking Tips

## MICHC ORAL HEALTH PARTNER CONTACTS

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Email</th>
<th>Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy Baby Network of Monroe County</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Director</td>
<td>Lauren Deutsch</td>
<td><a href="mailto:lauren@healthy-baby.net">lauren@healthy-baby.net</a></td>
<td>585-546-4930</td>
</tr>
<tr>
<td>MICHC Director</td>
<td>Sherita Bullock</td>
<td><a href="mailto:sherita@healthy-baby.net">sherita@healthy-baby.net</a></td>
<td>x214</td>
</tr>
<tr>
<td>Healthy Start Director</td>
<td>Valerie Garrison</td>
<td><a href="mailto:valerie@healthy-baby.net">valerie@healthy-baby.net</a></td>
<td>x213</td>
</tr>
<tr>
<td><strong>Anthony Jordan Health Center</strong></td>
<td></td>
<td></td>
<td>585-423-5836</td>
</tr>
<tr>
<td>Dentist</td>
<td>Mary Miller</td>
<td><a href="mailto:mmiller@JordanHealth.org">mmiller@JordanHealth.org</a></td>
<td></td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>Tera Bell</td>
<td><a href="mailto:tbell@JordanHealth.org">tbell@JordanHealth.org</a></td>
<td></td>
</tr>
<tr>
<td><strong>Eastman Institute for Oral Health</strong></td>
<td></td>
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</tr>
<tr>
<td>Dentist</td>
<td>Sangeeta Gajendra</td>
<td><a href="mailto:sangeeta_gajendra@urmc.rochester.edu">sangeeta_gajendra@urmc.rochester.edu</a></td>
<td>585-275-5007</td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>Chia Taw Huang</td>
<td><a href="mailto:chiataw_huang@urmc.rochester.edu">chiataw_huang@urmc.rochester.edu</a></td>
<td></td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>Robby George</td>
<td><a href="mailto:robby_george@urmc.rochester.edu">robby_george@urmc.rochester.edu</a></td>
<td></td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>Mary Pistilli</td>
<td><a href="mailto:mary_pistilli@urmc.rochester.edu">mary_pistilli@urmc.rochester.edu</a></td>
<td></td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>Lenora Colaruotolo</td>
<td><a href="mailto:lenora_colaruotolo@urmc.rochester.edu">lenora_colaruotolo@urmc.rochester.edu</a></td>
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<tr>
<td><strong>Urgent Care</strong></td>
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<tr>
<td>Dentist</td>
<td>Yanfang Ren</td>
<td><a href="mailto:yanfang_ren@urmc.rochester.edu">yanfang_ren@urmc.rochester.edu</a></td>
<td>585-273-2465</td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>Linda Rasubala</td>
<td><a href="mailto:linda_rasubala@urmc.rochester.edu">linda_rasubala@urmc.rochester.edu</a></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric Dentistry</strong></td>
<td></td>
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</tr>
<tr>
<td>Dentist</td>
<td>Erin Shope</td>
<td><a href="mailto:erin_shope@urmc.rochester.edu">erin_shope@urmc.rochester.edu</a></td>
<td>585-275-5031</td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>Cynthia Wong</td>
<td><a href="mailto:cynthia_wong@urmc.rochester.edu">cynthia_wong@urmc.rochester.edu</a></td>
<td></td>
</tr>
<tr>
<td><strong>General Dentistry</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dentist</td>
<td>Hans Malmstrom</td>
<td><a href="mailto:hans_malmstrom@urmc.rochester.edu">hans_malmstrom@urmc.rochester.edu</a></td>
<td>585-276-5718</td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>Jin Xiao</td>
<td><a href="mailto:jin_xiao@urmc.rochester.edu">jin_xiao@urmc.rochester.edu</a></td>
<td></td>
</tr>
<tr>
<td><strong>University of Rochester Strong</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dentist</td>
<td>Sharon Elad</td>
<td><a href="mailto:selad@urmc.rochester.edu">selad@urmc.rochester.edu</a></td>
<td>585-275-5531</td>
</tr>
<tr>
<td><strong>New York State Department of Health, Bureau of Women, Infant, and Adolescent Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal &amp; Infant Oral Health</td>
<td>Cindi Dubner, RDH, BS</td>
<td><a href="mailto:cindi.dubner@health.ny.gov">cindi.dubner@health.ny.gov</a></td>
<td>518-474-0535</td>
</tr>
</tbody>
</table>
With Special Thanks to:

Sangeeta Gajendra, DDS, MPH, MS
Associate Professor/Clinical Chief
Department of Community Dentistry and Oral Disease Prevention
Eastman Institute for Oral Health, University of Rochester
Rochester, NY 14620

Robby George, BDS, MDS
Assistant Professor
Department of Community Dentistry and Oral Disease Prevention
Eastman Institute for Oral Health, University of Rochester
Rochester, NY 14620

Neelam Jadeja, BDS, MPH
Former Dental Public Health Resident
Department of Community Dentistry and Oral Disease Prevention
Eastman Institute for Oral Health, University of Rochester
Rochester, NY 14620

Isma Khalid, BDS, MPH
Dental Public Health Resident
Department of Community Dentistry and Oral Disease Prevention
Eastman Institute for Oral Health, University of Rochester
Rochester, NY 14620
MICHC Regional Training

ORAL HEALTH “TRAIN THE TRAINER” MODULE

Perinatal and Infant Oral Health Quality Improvement (PIOHQI)

February 12, 2020

Outline

• Introduction/Background
• Using the Oral Health Toolkit (slides 8-44)
• Developing your training events
• Feedback on MICHC Oral Health Survey
Introduction

• Oral health commonly unaddressed during pregnancy
  – 45% of women had dental visit during pregnancy (NYS PRAMS 2012)
  – 37% Medicaid prenatal records included an oral health assessment (NYS 2012)

• National focus on oral health to improve health outcomes

• PIOHQI—Federal initiative to improve oral health in pregnant women & children

• PIOHQI aligns with current MICHCs’ work

NYS-PIOHQI Goal and Objectives

PIOHQI Goal:
-improve oral health of pregnant women and infants in NYS.

Objectives:
• Increase % of pregnant women with dental visits
• Increase % of pregnant women with oral health assessment
• Increase % of women engaged in healthy behaviors
  (e.g. infant oral hygiene, appropriate feeding habits).
**NYS-PIOHQI: PILOT PROJECT - WORKPLAN OVERVIEW**

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVES</th>
<th>STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the oral health of pregnant women &amp; infants in NYS</td>
<td>Increase % of women who visit a dentist during pregnancy</td>
<td>Ensure adequate oral health workforce to promote dental visits</td>
</tr>
<tr>
<td></td>
<td>Increase the % of pregnant women with oral health assessment (screenings/referrals)</td>
<td>Ensure infrastructure to assist high-risk pregnant women</td>
</tr>
<tr>
<td></td>
<td>Increase % of pregnant women engaging in healthy behavior</td>
<td>Enhance capacity in perinatal care system for referrals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish Center for Excellence (C.O.E)</td>
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<tr>
<td></td>
<td></td>
<td>Adopt evidence-based practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ensure culturally appropriate health education material</td>
</tr>
</tbody>
</table>

**Pilot Project Accomplishments**

- Developed Oral Health Toolkit & educational materials
- Provided training to Healthcare providers
  - 4 in-person sessions held in 2016-17.
  - Total of 72 participants trained with more trainings planned for 2018.
  - Improved oral health knowledge: increase from average of 55.7% to 91%.
- Standardized oral health screening
  - Increase in screenings from baseline of 44.5% to 58.8% (Pregnant/PP clients)
### Implementation Plan

- Incorporate oral health screenings and referrals into MICHC as a standard of practice.

- Piloted at HBN with goal to expand statewide using lessons & training tools developed from pilot to guide implementation.

- Statewide expansion: Replicate pilot project, conduct trainings and provide TA to MICHCs:
  - MICHCs train internal CHW staff at own agency
  - Provide education/training to MICHC partners
    - At coalition or community action network meetings
    - Oral Health outreach to local dental providers (public health detailing)

### Oral Health Toolkit Training

**FOR MICHC SERVICE PROVIDERS (CHWS & PARAPROFESSIONALS)**

**Perinatal and Infant Oral Health Quality Improvement (PIOHQI)**
Objectives

At the end of this training MICHC staff will be able to:

• Describe the goal of the NYSDOH PIOHQI project
• List or identify oral health recommendations
• Describe how motivational interviewing can be used to address oral health with clients
• Utilize the oral health toolkit as a resource to work with clients & community partners

Why talk about Oral Health?

• Oral health is integral to general health and quality of life
• Regular checkups and interventions can prevent severe oral diseases
• Oral health in pregnancy:
  – Poor oral health has been linked to poor birth outcomes such as: Premature birth and low birth weight
  – Poor oral health can be a sign of a more severe or chronic health problems which can affect pregnancy and the health of the baby
Introduction

- Oral health commonly unaddressed during pregnancy
  - 45% of women had dental visit during pregnancy (NYS PRAMS 2012)
  - 37% Medicaid prenatal records included an oral health assessment (NYS 2012)
- National focus on oral health to Improve health outcomes
- PIOHQI-Federal initiative to improve oral health in pregnant women & children
- PIOHQI aligns with current MICHCs’ work

NYS-PIOHQI Goals and Objectives

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Improve oral health of pregnant women and infants in NYS.

Objectives:
- Increase % of pregnant women with dental visits
- Increase % of pregnant women with oral health assessment
- Increase % of women engaged in healthy behaviors
  (e.g. infant oral hygiene, appropriate feeding habits).
Background

- Goal: Incorporate Oral Health screenings and referrals into MICHC as a standard of practice.

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Pilot Project Accomplishments

- Developed Oral Health Toolkit & educational materials

- Provided training to Healthcare providers
  - 4 in-person sessions held in 2017.
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- Standardized oral health screening
  - Increase in screenings from baseline of 44.5% to 58.8% (Pregnant/PP clients)
MICHC Oral Health Toolkit

Purpose of Toolkit:
- Introduce importance of oral healthcare in pregnant/parenting women and infants.
- Train MICHC providers on screening for oral health problems/referrals.
- Provide oral health recommendations to perinatal healthcare providers (RNs, Pediatricians, Dentists etc.).

Using the Oral Health Toolkit

Highlights
- Perinatal oral health recommendations
- Motivational Interviewing (M.I) tool
- Key messages during perinatal period
- Oral health guide for MICHC providers—AAA (Assess, Advise, Arrange)
- Oral Health screening workflow (2 Dental questions)
- Talking points: Working with perinatal healthcare providers
Perinatal oral health recommendations

During Pregnancy:

- Get professional oral healthcare
- Practice good oral hygiene
- Eat healthy foods
- Practice healthy behaviors (e.g. not smoking)

*DReferences 14, 15, 16 can be found on toolkit page 28*
Perinatal oral health recommendations

During postpartum & early childhood periods:

- Maintain good oral health for mother and family
- Breastfeed the baby when possible
- Avoid putting child to bed with bottle that contains sugary drinks
- Wipe baby’s gum/teeth with washcloth after feeding
- Use grain size of fluoride toothpaste to clean baby’s gum/teeth
- Make child’s first dental visit before first birthday

KEY ORAL HEALTH MESSAGES DURING THE PERINATAL PERIOD (TOOL #3)

DURING THE POSTPARTUM AND EARLY CHILDHOOD

- Baby teeth are important – they help a child eat, talk, smile, and hold space for adult teeth.
- Untreated tooth decay can lead to pain and a serious infection.
- Decay causing germs can be passed from mother to infants and toddlers during early childhood through common saliva-sharing activities (i.e. sharing utensils, pre-tasting/chewing foods, or cleaning baby’s pacifier in mom’s mouth before giving it to the baby).
- Dentists and pediatricians recommend all children receive dental examination before the first birthday.
- Fluoride is a natural mineral that helps prevent tooth decay.

*References 16, 6 can be found on toolkit page 28
Early Childhood Caries

Key Points
• Childhood caries is preventable
• Caries can form in child’s mouth before 1 year
• Breast milk is the best nutrition for baby
• Children with caries tend to have adult caries
• Losing baby teeth early puts child at risk of crooked adult teeth

What effective techniques can be used to share oral health recommendations and messages?
Motivational Interviewing

- **O**pen-ended questions that frame the agenda
- **A**ffirmations
- **R**eflective listening
- **S**ummarize

**PERINATAL ORAL HEALTH MOTIVATIONAL INTERVIEWING (TOOL #2)**

Motivational Interviewing (MI) is a collaborative conversation to strengthen a person’s own motivation for and commitment to change. Successful collaborative conversation may be outlined as follows:

**Step 1: Open-ended questions to encourage self-exploration**

Examples:
- “What do you think about the condition of your teeth and gums?”
- “What do you do to keep your teeth and gums healthy?”
- “What does healthy teeth/loosing teeth mean to you?”
- “How do you feel about going to a dentist?”

**Step 2: Reflective listening and affirmation**

Examples:
- “It sounds like you are really trying ...”
- “What I hear you saying is that you are concerned about ... but ....”
- “Did I get that right?”

**Step 3: Find out what the client already knows about oral health and prevention of dental diseases**

Examples:
- “What do you know about preventing tooth decay/gum disease?”
- “What do you know about how fluoride/diet affects the health of your teeth?”
- “What do you know about tooth decay in young children?”
**Step 4: Ask permission for advice/feedback**

Examples:
- “Would it be alright if I share some information with you about how to improve your own and your baby’s oral health?”
- “I would like to give you some information about the benefit of having your teeth cleaned during pregnancy. Would you be interested in hearing that?”
- “There are things we typically discuss with pregnant women to promote healthy teeth in their families: healthy eating, limiting/avoiding sugar-sweetened beverages, good self-care and the importance of regular professional care. I am wondering if you would be interested in exploring one of these topics or perhaps something else?”

---

**Step 5: Assessment of Readiness**

![Image of person asking, “ARE YOU READY?”](Image)

---

**Step 6: Planning for Change**

---

*Negotiate an oral health agenda based on a menu of options*

Examples:
- “Is there anything you would like to try for your oral health in the next week or two?”
- “What do you think you want to try for your family’s oral health as a starter?”

---

When developing a plan for change toward oral health self-management goals, plan to:
- Build patient commitment and confidence in the plan
- Treat the plan as an experiment

---

**Step 7: Self-Summarization and Clarification**

Example:
- “Can you repeat your plan so I am sure you have understood?”
**Oral Health Guide and Tools for MICHC**

**What is the role of MICHC staff in addressing oral health?**

- **Assess**
- **Advise**
- **Arrange**

The primary role of Community Health Workers (CHW), Case Workers, and Home Visitors in the MICHC Oral Health Integration project is to provide their clients with 1) oral health screening (**ASSESS**), 2) perinatal oral health messages (**ADVISE**), and 3) oral health referrals as needed (**ARRANGE**).

---

**Intervention for pregnant women/mothers & infants**

- **Assess oral health needs, ask screening questions**
  - Does she have bleeding gums, pain, cavities, problems in the mouth etc.
  - Has she had dental visit in past 6-12 months
  - Or has baby had dental visit before 1st birthday or within 6months of first tooth

- **Use motivational interviewing to assess oral health knowledge, readiness, barriers**

- **Provide assistance and dental referral for client as appropriate**
Activity: True or False?

Dental treatment is only safe in first month of pregnancy (true/false)

Dental x-rays should never be done during pregnancy (true/false)

Throughout pregnancy and after: brush twice for 2 minutes, use fluoride toothpaste, floss between teeth (true/false)

Emergency dental treatment should be delayed till after pregnancy (true/false)

There is no need to wipe baby gums until the teeth grow(true/false)

For pregnant women, fruit juice is better than fruits (true/false)

Delaying dental treatment in pregnant woman cannot affect the baby (true/false)

Schedule child’s dental visit by age 3. (true/false)
**ORAL HEALTH RECOMMENDATIONS CHART**

Pregnancy by itself is not a reason to defer routine dental care and necessary treatment for oral health problems.

- Dental treatment is safe and effective throughout pregnancy.
- In the 1st trimester, dental x-rays are safe to diagnose dental problems for urgent and immediate treatment.
- The best time for dental treatment is in the 2nd trimester. However, routine dental care is recommended at any time during pregnancy.
- Both mother and child are at risk if dental treatment is delayed.
- Elective treatment can be deferred but emergency treatment is important anytime during pregnancy.
- Throughout pregnancy and after: Brush twice for two minutes; Use Fluoride Toothpaste; Floss between teeth.
- For Moms: Have fruit, not fruit juice; Drink water or low fat milk; Limit food containing sugars.
- Advise Moms to:
  - Wipe infant teeth/gums after feeding with soft bristle brush or soft cloth.
  - Supervise children’s brushing with an amount of toothpaste that is rice grain size for less than 3 year olds and pea size for more than 3 year olds.
  - Avoid putting your child to bed with a bottle.
  - After breastfeeding at night, wipe infant’s teeth and gums with soft bristle brush or soft cloth.
  - Avoid sharing spoon for tasting food; Avoid cleaning dropped pacifier by mouth.
- Visit dentist by age 1.


---

**Agency Policies & Resources**

- List oral health resources that you use to educate clients as a CHW.

- List oral health policies at your agencies that you are familiar with.
Resources/Brochures

- Tool #2: Perinatal Oral Health Motivational Interviewing ......................................... 14
- Tool #3: Key Oral Health Messages During the Perinatal Period ................................. 18
- Tool #4: Perinatal Oral Health Self-Management Goal Magnet ................................. 19
- Tool #5: Sample Oral Health Brochure ...................................................................... 20
- Tool #6: List of Pediatric Oral Health Brochures Free To Order ................................. 21
- Tool #7: Common Perinatal Oral Health Questions and Answers ............................ 22
- Tool #8: Myths and Facts about Oral Health Related Beliefs ..................................... 25
- References .................................................................................................................. 27

Additional Resources

- The Toolkit is useful to share with MICHC partners:
  - Prenatal/Perinatal healthcare providers
  - Dentist/Dental care providers

- Oral Health outreach to local dental providers (public health detailing)
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<td>ACOG Committee Opinion: Prenatal/Perinatal Oral Health</td>
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<td>US Preventive Services Task Force Recommendations</td>
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<thead>
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<td>Practice Recommendations and Tools for Dental Care Providers</td>
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<td>List of CRA Forms</td>
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<tr>
<td>References</td>
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</tbody>
</table>
Questions and Answers

Q. When is the best time during pregnancy to have a dental visit?

A. Throughout the pregnancy, if the pregnant woman has not had a dental exam or tooth cleaning for more than 6 months, it is time for her to see a dentist. While some pregnant women may be uncomfortable about sitting or reclining on dental chair during the late third trimester, there is no time during pregnancy that a dental visit is contraindicated and no dental procedures that should be avoided during pregnancy.²⁵
Questions and Answers

Q. At what age should children start using fluoride containing toothpaste?

Q. At what age should a child start using toothpaste that contains fluoride? (when first tooth erupts)

A. The American Dental Association recommends using a smear or rice grain size amount of fluoride toothpaste when the first tooth erupts until 3 years of age. So mothers can put very small amount of fluoride toothpaste on a washcloth or a soft bristled toothbrush and wipe/brush to protect her baby’s teeth from tooth decay. A smear or rice grain size amount of fluoride toothpaste is safe even if infants/toddlers swallow most of it.
Questions and Answers

Q. “Pregnancy leeches calcium from the teeth” (True/False)

• “Pregnancy leeches calcium from the teeth” False

**MYTH** “Pregnancy leeches calcium from your teeth”

**FACT:** The fetus does not take calcium from its mother’s teeth. Tooth enamel is the hardest substance in the body. Adult tooth development starts early and completes maturation by age 16. By age 16, the teeth are no longer developing and the strong enamel layer no longer requires nutrients from the bloodstream. The calcium the baby needs is provided by the mother’s diet and from the teeth. If the mother’s intake of calcium is inadequate during pregnancy, her bones—not her teeth—will provide the calcium her growing baby needs.
Questions and Answers

Q. “One tooth is lost for every pregnancy” (True/False)

False

**MYTH** “One tooth is lost with every pregnancy”.

**FACT**: A pregnant woman with poor oral health and with no access to care, or with nutritional habits that promote poor dental health can easily lose a tooth. Tooth loss occurs due to untreated dental disease (most commonly gum disease or dental caries) and not because of pregnancy. A pregnant woman can follow some simple guidelines for preventing tooth decay and gum disease—Brushing with toothpaste and mouth rinse containing fluoride; chewing sugarless gum containing xylitol after eating to reduce bacteria and clean teeth. For those pregnant women who suffer from “morning sickness”—Rinsing with a teaspoon of baking soda in a cup of water will help neutralize the acids remaining in the mouth after vomiting. A pregnant woman’s teeth will remain healthy with proper hygiene at home and professional help from the dentist.
Questions?

End of Toolkit training

Contact:
Cindi Dubner
NYSDOH
cindi.dubner@health.ny.gov

Activities-Next steps

• Developing your training event
  – Action Steps:
    • Who do you plan to train? (your audience)
    • What does your program need to do to organize trainings? (list out steps)
    • How will you achieve the listed steps?
    • DOH can provide TA
    • Include oral health activities in your MICHC quarterly reports
NYSDOH MICHIC Pre-training Survey

Survey Goal: To assess MICHICs’ capacity and readiness to integrate oral health. Objectives: Identify barriers to oral health integration and identify TA needs.

Results of survey showed:
- 21 of 23 MICHICs report screening clients for oral health problems:
  - 14 programs screen client at intake.
  - Only 9 have a written oral health policy.
- 22 of 23 MICHICs participate in a community coalition:
  - Only 9 community coalitions include an oral health professional.
- 17 of 23 MICHICs have a partnership with a local dental provider.

Survey Participants

<table>
<thead>
<tr>
<th>Community Based Organization</th>
<th>Hospital/Federally Qualified Health Center</th>
<th>Local Health Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>
Role of Survey Participant

- Director/Special Project Manager: 4
- CHW Supervisor: 2
- MICHC Program Coordinator: 17

Formal Policy by Organizational Type

- Community Based Organization: 6 Yes, 7 No (46%)
- Hospital/Federally Qualified Health Center: 1 Yes, 3 No (25%)
- Local Health Department: 2 Yes, 4 No (33.3%)

Does your MICHC Program currently have a formal policy for oral health screenings/referrals? 9 -YES, 14 - NO
Oral Health Screening Policy

- **9 of 9** Referrals to Dental Providers
- **2 of 9** Oral Health Education
- **2 of 9** Assess problems in the mouth

Oral Health Decision Tree

- **9 Programs** have a decision tree
- **12 Programs** do not have a decision tree
- **2 Programs** did not respond
21 Programs screen for oral health
- Is oral health screening currently included in your program’s routine client encounter?

14 Programs screen at intake
4 Programs screen at specific intervals
2 Programs screen at every encounter
1 Program screens during and after pregnancy

Community Coalition or Advisory Group

Does your program oversee or participate in any community health coalition or advisory group?

22 Yes
Is oral health represented?
9 Yes Great!
13 No

23 MICHC Programs

1 No Room for growth.

Is there a community member to recommend to champion oral health issues?

8 Yes Methods to recruit oral health to the community health coalition?
5 No How can we identify an oral health partner?
Does your program have an existing partnership (formal or informal) with any of the dental providers in your community?

17 Programs are working with dental providers

6 Programs need to establish a partnership

Community Dental Providers

Does your program have a directory/contact list of dental providers in your community that accept oral health referrals from MICHC?

20 Programs currently have a list of local providers

3 Programs do not have a list

Are there dental providers in these communities?
Community Dental Providers

5 Programs have an electronic directory that can be accessed by the general public

15 Programs do not have an electronic directory

The comfort level/willingness of your program staff to address oral health with clients

26.1%
• Rated 3 (Average Level)

43.5%
• Rated 4 (High Level)

30.4%
• Rated 5 (Highest Level)

(Statements are rated on a 1-5 scale, 5 being the highest)
The level of readiness of your program to integrate routine oral health screening questions

- 13.0% • Rated 3 (Average Level)
- 56.5% • Rated 4 (High Level)
- 30.5% • Rated 5 (Highest Level)

(Statements are rated on a 1-5 scale, 5 being the highest)

How well does your program screen clients for/address oral health in clients

- 4.4% • Rated 2 (A little bit)
- 39.1% • Rated 3 (Average Level)
- 47.8% • Rated 4 (High Level)
- 8.7% • Rated 5 (Highest Level)

(Statements are rated on a 1-5 scale, 5 being the highest)
The level of interest from your clients about seeking oral health services or inquiring about oral health information

43.5% • Rated 2 (A little bit)

39.1% • Rated 3 (Average Level)

17.4% • Rated 4 (High Level)

(Statements are rated on a 1-5 scale, 5 being the highest)

What are some challenges/barriers your program has encountered with oral health screenings/referrals

20 Competing priorities – clients have other issues to address first

11 Limited number of providers in our community who accept Medicaid/MICHIC clients

5 Little or no funding specifically for oral health activities/screening
What are some challenges/barriers your program has encountered with oral health screenings/referrals

- Limited amount of educational materials at a low literacy level to explain the importance of oral health in relation to preterm birth
- Undocumented clients
- Previous bad experience at the dentist

Oral Health Resources

- 86.9% of programs are using pamphlets or brochures
- 47.8% of programs are using oral health kits (toothbrushes, tooth paste, etc.)
Oral Health Training

39.1% of programs would like in person training

56.5% of programs would like webinars

4.3% of programs would like a combination of in-person and webinar trainings

Questions?

Thank you.

Contact:

Cindi Dubner
NYSDOH
cindi.dubner@health.ny.gov
MICHC Oral Health Surveys: Pre and Post Training Results

INTEGRATION OF ORAL HEALTH INTO MICHC PROGRAMS

February 12, 2020

Survey Participants

13 Community Based Organization

4 Hospital/Federally Qualified Health Center

6 Local Health Department
February 12, 2020

Role of Survey Participant

- Director/Special Project Manager: 4
- CHW Supervisor: 2
- MICHC Program Coordinator: 17

Oral Health Screenings

Does your MICHC Program currently have a formal protocol or written policy regarding oral health screenings/referrals?

- 9 Programs with a policy or protocol
- 14 Programs without a policy or protocol
Formal Policy by Organizational Type

- **Community Based Organization**: 6 Yes, 7 No (46%)
- **Hospital/Federally Qualified Health Center**: 1 Yes, 3 No (25%)
- **Local Health Department**: 2 Yes, 4 No (33.3%)

Oral Health Screening Policy

- **9 of 9**: Referrals to Dental Providers
- **2 of 9**: Oral Health Education
- **2 of 9**: Assess problems in the mouth
Oral Health Decision Tree

9 Programs have a decision tree
12 Programs do not have a decision tree
2 Programs did not respond

Oral Health Screenings

Is oral health screening currently included (in any format) in your program’s routine client encounter?

21 Programs screen for oral health
21 Programs screen for oral health

14 Programs screen at intake

4 Programs screen at specific intervals

2 Programs screen at every encounter

1 Program screens during and after pregnancy

February 12, 2020

Community Health Coalition or Advisory Group

Does your program oversee or participate in any community health coalition or advisory group?

22 Yes

Is oral health represented?

9 Yes

Great!

13 No

Is there a community member to recommend to champion oral health issues?

8 Yes

Methods to recruit oral health to the community health coalition?

5 No

How can we identify an oral health partner?

1 No

Room for community growth.
Does your program have an existing partnership (formal or informal) with any of the dental providers in your community?

<table>
<thead>
<tr>
<th>Programs working with dental providers</th>
<th>Programs need to establish a partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 Programs</td>
<td>6 Programs</td>
</tr>
</tbody>
</table>

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- 17.4% Rated 4 (High Level)

(Statements are rated on a 1-5 scale, 5 being the highest)

What are some challenges/barriers your program has encountered with oral health screenings/referrals

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- 56.5% of programs would like webinars
- 4.3% of programs would like a combination of in-person and webinar trainings

Post Training Survey

- 23 MICHC Programs
- 17 MICHC Programs attended PIOHQI Train the Trainer Training
- 13 Participants Completed Post Training Survey
February 12, 2020

Post Training Survey Results

Agreed the Training was Clear and Met Expectations

100%

Found the Content Useful for Training CHWs

100%

Post Training Survey Results

<table>
<thead>
<tr>
<th></th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation was useful in improving your oral health knowledge</td>
<td>23%</td>
<td>46%</td>
<td>31%</td>
</tr>
<tr>
<td>Information received from this training applies to my daily work</td>
<td>15%</td>
<td>62%</td>
<td>23%</td>
</tr>
<tr>
<td>Material was presented in an understandable manner</td>
<td>15%</td>
<td>54%</td>
<td>31%</td>
</tr>
<tr>
<td>Instructor encouraged questions and participation</td>
<td>15%</td>
<td>23%</td>
<td>62%</td>
</tr>
<tr>
<td>Length of the presentation was appropriate</td>
<td>8%</td>
<td>69%</td>
<td>23%</td>
</tr>
</tbody>
</table>
Post Training Survey Results

- Programs wanted additional resources not covered in the training
- More coordination between programs to share ideas and resources
- Specific instructions for approaching dental providers in the community

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Post Training Survey Results

Over the next 6-12 months...

- I/my organization will train OHWs and MICHIC staff on oral health: 100%
- I/my organization will use the information during outreach to local healthcare providers (public health detailing): 58%
- I/my organization will provide this oral health training to MICHIC partners (e.g. community action network or coalition members): 42%