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## Project Identifier Information

Grant Number: H47MC26549-03
Project Title: Perinatal & Infant Oral Health Quality Improvement / Intensive Community Outreach Project (PIOHQI/ICO)
Organization Name: State of Connecticut Department of Social Services
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**Period Covered -** First Half of Grant Year Two (9/30/2015 - 3/31/2016)

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## I. PROGRESS

a. Accomplishments

### *Continuance and Expansion*

Our Intensive Community Outreach (ICO) project continues to make progress by expanding to new cities and towns in Connecticut as well as continuing outreach in the Year One and Year Two communities. These communities account for about 60% of the HUSKY Health (Medicaid/CHIP) births in the state.

In Year Three of the Perinatal Infant Oral Health Quality Improvement Pilot Program (PIOHQI), there have been several additions and accomplishments to our project. As proposed in our original application, we are implementing ICO across seven additional cities and towns in Connecticut during Year Three. We have maintained existing relationships with and added new community partners across the state to address the oral health needs of pregnant women and infants. The Connecticut Dental Health Partnership (CTDHP) has been successful in establishing the Perinatal and Infant Oral Health Work Group (PIOH-WG), which includes oral health care providers, community based/service organizations, and state agencies. The progress made by the ICO project is directly aligned with the proposed project timeline. Despite some early delays, the project has been able to keep to the original timeline.

***Project Goals***

**Goal 1: Provide a coordinated approach across Connecticut that addresses the comprehensive oral health needs of pregnant women and infants most at risk.**

The ICO model has two components: first we do community outreach where we build relationships with community partners and second we do individual outreach to women who have been identified as being pregnant.

*Community Outreach*
Goal 1 responds to the work CTDHP does with regard to the ICO project. To meet this goal, the primary work that we do builds and maintains relationships with community partners across the state. This work involved Dental Health Care Specialists (DHCS), the Implementation Lead, the Clinical Lead and the Administrative Lead maintaining the relationships established with community partners including OB/GYN offices, pediatric PCP offices and community agencies who serve perinatal women and infants. To date, the Connecticut team has implemented the ICO project over 26 cities and towns in our state and project that we are on track to achieving this goal by the end of the grant period (See "Project Timeline" section).

Each year we add new target cities and towns to implement ICO. In Year One, we repeated our intervention in the pilot cites of Norwich, New London and Waterbury along with their larger adjacent towns. During that time, we added New Haven and two larger adjacent towns to the list. During the current grant year, the DHCS in New Haven and the Implementation Lead have connected with the MOMS Partnership as a potential community partner. The MOMS Partnership provides services for mothers and their children through community based resources. We hope to formally partner with the MOMS Partnership for the purpose of providing dental information and resources to their target population. A Memorandum of Understanding (MOU) with the MOMS Partnership is pending. Through this outreach, several signed MOUs have been obtained; however obtaining MOU's has proved to be more challenging than expected. In Year Two, we expanded to cities and suburbs of Hartford, Stamford, Norwalk and Windham/Willimantic where we established new relationships with medical providers and more community agencies. During this reporting period, the DHCS in the Hartford area was successful in establishing community partners. We were able to secure a signed agreement with the East Hartford Health Department, which houses a WIC program as well as other early childhood programs. We were equally successful in Willimantic and obtained a signed MOU with The ACCESS Agency - a community action agency with many human service programs. In Year Three, we have been successful in expanding to the following cities and neighboring towns: Bridgeport, Meriden, Middletown, and Danbury. The DHCS and the Implementation Lead's work involved the establishment of relationships with OB/GYN offices, pediatric PCP offices and community agencies who serve the target population. In each of the targeted areas, we do more intensive training with the staff of our community partners. The goal is to educate and motivate them to promote oral health among their clients.

Our work with the National Learning Network has encouraged our project staff to include community outreach to home visitor programs. The home visiting programs in our state are facilitated by the Connecticut Office of Early Childhood (CT-OEC). We hope to meet with them before the end of Year Three and enter into an agreement with the CT-OEC to begin coordination and possible data sharing as they may have better telephone numbers for contacting our mutual clients. Bad telephone numbers are a significant barrier to performing individual outreach with perinatal clients on HUSKY Health.

During the period of 9/30/2015- 5/31/2016, outreach staff completed 93 outreaches. As noted in the Outreach summary below, we have done outreach in visiting provider offices, collaborative meetings, presentations, and fairs/events.

- **Attachment 05 – Dental Health Care Specialist Outreach Activity Detail**

## DHCS_Outreach_Count

| Name | Entity Group | Entity Type | Entity Desc | Conference/Call | Drop Off | Fair/Event | Meeting/Colab | Presentation | Shipment | Visit | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ⊞ Jackie Romaniuk | | | | 2 | 9 | 0 | 1 | 0 | 8 | 12 | 32 |
| ⊞ Jessica Lyman | | | | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| ⊞ Karina Reininger | | | | 0 | 8 | 0 | 5 | 2 | 0 | 1 | 16 |
| ⊞ Luis Miguel Ayala | | | | 1 | 0 | 1 | 1 | 0 | 0 | 5 | 8 |
| ⊞ Nettie Sarro | | | | 0 | 2 | 2 | 1 | 0 | 3 | 6 | 14 |
| ⊞ Tyra Monteiro | | | | 2 | 13 | 0 | 5 | 0 | 0 | 2 | 22 |
| Total | | | | 5 | 33 | 3 | 13 | 2 | 11 | 26 | 93 |

## DHCS Outreach Materials by Entity Type

| | Total |
|---|---|
| ⊞ Community Action Agency | 1,830 |
| ⊞ FQHC w/Dental | 683 |
| ⊞ Healthy Start | 200 |
| ⊞ Nurturing Families | 299 |
| ⊞ OB/GYN | 2,383 |
| ⊞ Other (Specify in notes) | 37 |
| ⊞ Other Agency (specify in notes) | 12 |
| ⊞ Other State | 74 |
| ⊞ School Readiness/Daycare Center | 112 |
| ⊞ Social/Youth/Family Services | 568 |
| ⊞ WIC | 2,939 |
| Total | 9,137 |

During the above outreaches, DHCS and the Implementation Lead distributed materials including oral health kits, 'First-Tooth-First-Dental-Visit bibs', PRAMS recruitment cards, referral pads, posters, brochures and other oral health materials. During presentations they also distributed copies of the presentation. In total 9,137 pieces of material were distributed between

10/1/2015 and 5/31/2016. We have found that the most popular items are the oral health kits and our bibs. Providing a concrete give-away, that includes important oral health and referral information, is key keeping our community partners engaged with our mutual clients/patients. It is also an indirect measure of how many client/patients are reached, although of limited accuracy. We plan to create a new oral health kit for the caregivers of our infant clients. A copy of the to-be-included flyer is in:

- **Attachment 12 – Infant Oral Health Kit Information Flyer**

More detail is contained in Attachment 5.

*Cocoa Infiltration*
Project staff and the DHCS have been meeting to discuss ways to measure 'infiltration' of targeted community partners (community agencies, pediatric PCP offices and OB/GYN offices) in order to measure effectiveness of each outreach. This committee developed a list of infiltration measures. We are currently in the testing phase, and DHCS will report to the team with results. We hope to analyze this information by 2017.

*Individual Outreach*
On a quarterly basis, we obtain lists of pregnant members identified from Community Health Network of Connecticut (CHNCT) the Administrative Service Organization (ASO) operating the medical care program of HUSKY Health (Medicaid/CHIP) program. We use our automated telephone system to call each of those identified as pregnant. The calls determine whether the client has a working telephone number. Clients not in a dental home are assigned as cases to the DHCS in their area. In the period 10/1/2015 to 5/31/2016 a total of 225 ICO direct outreach cases were closed. The detail is in:

- **Attachment 06 – Dental Health Care Specialist Cases Detail**

DHCS research the client's claims history and phone numbers. When they reach a client they educate them about the importance of oral health during pregnancy and offer to either refer them to dental offices or perform appointment assistance. Other services that may be offered include benefit information, translation assistance, transportation assistance and other support. A significant barrier to reaching these clients is bad phone numbers, about 50% of the numbers in the system. We have seen limited success in obtaining better phone numbers from community partners with whom we have MOU's.

**Goal 2: Promote an environment that supports perinatal and infant/toddler oral health and seeks to eliminate oral health barriers and disparities.**

In Goal 2, we continue to monitor activities around perinatal and infant health efforts in the state. We are doing so by our participation in several groups. We have been active in the Maternal and Child Health (MCH) Advisory Committee, coordinated by the Connecticut Department of Public Health (DPH). We also worked with other oral health stakeholders to get oral health included in

the State Health Improvement Plan (SHIP) and were successful in having oral health objectives for children under three in the MCH section of the plan.

*Perinatal & Infant Oral Health Work Group (PIOH-WG)*
As previously mentioned, we established the statewide Perinatal and Infant Oral Health Work Group (PIOH-WG) under the auspices of the Connecticut Coalition for Oral Health (CTCOH). Our Administration Team merged into the PIOH-WG and was first convened in late 2015 and meets quarterly. The workgroup consists of members from the original Administration Team and other stakeholders such as a Past President of the Connecticut Section of the American Academy of Pediatrics, the Co-Chair of the Women's Health Committee of the MAPOC (the legislative committee that oversees Medicaid/CHIP), a physician, dentists, hygienists, Director of the Connecticut Chapter of the March of Dimes and community agency leadership. We are eager to add other health professionals who are interested in the increased utilization of oral health services by pregnant women and children. We are actively recruiting an OB/GYN champion and a nurse/midwife. The work group is scheduled to have its next meeting in July 2016.

We are also working with the Connecticut Department of Children and Families (DCF), the protective services agency for the state. They have perinatal women and infants in their custody and in their support programs. We will be coordinating the Connecticut PIOHQI program with their programs for perinatal women and infants. This will likely include training, material distribution and referrals.

***Initial Quality Improvement Projects***

1. *WIC MOU*

We have worked to obtain a Memorandum of Understanding (MOU) with the Connecticut Department of Public Health (CT-DPH) in order for us to share client information with their WIC program. After considerable effort we were unable to obtain a direct MOU. We have shifted to adding an amendment to the existing CT DPH and Connecticut Department of Social Services (CT-DSS). We are presently writing the amendment for submission to CT-DSS who will approach CT-DPH.

2. *OB/GYN champion*

We have several strategies for obtaining an OB/GYN champion. As previously stated, we have developed the PIOH-WG, made up of stakeholders and professionals who see the importance of oral health during pregnancy. We have reached out to several birth professionals who may become potential 'champions' and serve on our work group. We have reached out to five individuals who may serve in this capacity. The first two are OB/GYN physicians who currently see our target population. After a face to face meeting with each of them, it was clear that they understand the importance of oral health and overall health. We have invited them both to be present at our next workgroup meeting. However they have not responded to subsequent contacts.

Additionally, project staff has begun to reach out to nurse midwives. We have identified a nurse midwife who is a member of the Connecticut General Assembly's Medical

Assistance Program Oversight Council (MAPOC)'s Women's Health Committee, of which we actively participate. He too has been invited to become a member of our workgroup and we are awaiting his reply. Further, we plan to contact the Connecticut chapter of the College of Nurse Midwives to gain more insight from the midwifery practice for our workgroup. The remainder of this grant year and for year four, the DHCS will begin outreach to midwifery practices who accept Medicaid. We have already identified the licensed nurse midwives and locations in our state.
Finally the Administrative Lead contacted the Dean of the University of Connecticut (UCONN) School of Dental Medicine with the hopes of facilitating a meeting with the medical school's OB/GYN department leadership. We have agreement that we can attend a departmental meeting of the UCONN School of Medicine's OB/GYN department. Our goal for the result of that meeting is to present at a medical Grand Rounds and obtain an OB/GYN champion.

*3. Infiltrate Reluctant OB/GYN offices*
Project staff continues to work on developing a strategy for reaching out to reluctant offices. Utilizing the skills from our participation in the Learning Network we created a PDSA cycle to work toward the goal of infiltrating these offices. Please see section b. Participation In Oral Health Learning Collaborative below for more details. The main objective is to individually identify reluctant OBGYN offices in each of the DHCH's regions. The goal is to understand why offices are reluctant and develop a strategy for infiltration.

**Goal 3: Improve the systems of oral health care in Connecticut and beyond through ongoing evaluation, including statewide data collection and analysis.**

The project has a robust data and evaluation system, maintained by our Evaluation Lead, Mary Alice Lee of Connecticut Voices for Children. Please see section III. Evaluation below for more details.

**Goal 4: Leverage available fiscal and other resources to maintain the ICO approach and evaluate its effectiveness**

For Goal 4, the main objective is to ensure that the Connecticut PIOHQI/ICO project approach, activities and positive impact are sustained over the long term. It is already well integrated into the HUSKY Health (Medicaid/CHIP) dental program, so this goal has been achieved. The Connecticut Department of Social Services and CTDHP have committed to continue the PIOHQI/ICO approach.

b. Participation In Oral Health Learning Collaborative

During the past grant year, the Connecticut PIOHQI team members have actively participated in the National Learning Network's scheduled in-person meetings as well as all webinar activities. Team members attended two in-person meetings of the Network (Arlington VA and Cincinnati

OH), where valuable sharing across state teams took place. The Administrative Lead presented at one of the in-person meetings. Our team members also distributed examples of our outreach materials to other state team colleagues. In addition to in-person participation, we provided all of our baseline data for its Dashboard and provided other information on our project via the PIOHQI List Serve. The Administrative Lead recently attended a portion of the Networks Technical Assistance meeting with the Rhode Island team.

We will continue our active level of participation with the National Learning Network through the duration of funding. Based on the new goals and AIMS, we anticipate ongoing participation with the National Learning Network through use of the Dashboard, in-person meetings, as well as conference calls.

As part of the Quality Improvement focus and as a result of the in person meetings, we developed three quality improvement projects (QIP) described above. They are:

1. Finding an OBGYN Champion
2. Increase Infiltration of reluctant OB/GYN provider offices
3. WIC Program Memorandum of Understanding (MOU)

For the second QIP the Implementation Lead recorded a Plan-Do-Study-Act (PDSA) process described below.

**PDSA: Reluctant OB/GYN Provider Offices**

For the purposes of this cycle, we have selected to study the reluctant OB/GYN offices. The objective: To address the gap in our implementation plan, we decided individually identify reluctant OBGYN offices in each of the DHCH's regions. The goal is to understand why offices are reluctant and develop a strategy for infiltration.

DHCS are to develop an approach to infiltrate the office.

**Plan**: To address the gap in our implementation plan, we decided to individually identify reluctant OBGYN offices in each of the DHCH's regions. We came up with four questions that each DHCS would consider as they developed a strategy for the reluctant offices. The goal is to understand why they are reluctant and develop a strategy for infiltration.
*Strategies for reluctant offices*

- How was the office selected?
- What was done with the office? History of the office?
- Strategy?
- Describe implementation? Was it successful or not? Why/How?

**Do**: DHCS physically visited and made phone calls to each of the pre-identified 'reluctant' OB/GYN provider offices. The questions (see above) were administered either over the phone or in person. In every test, the DHCS surveyed the front desk staff to capture the reasoning for reluctance.

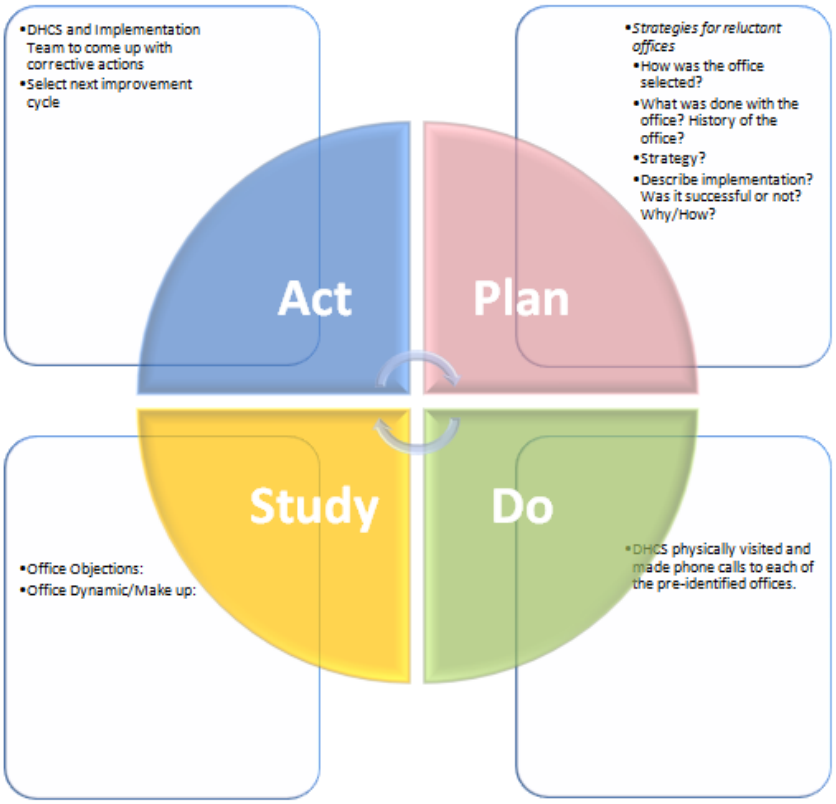
**Study**: As expected, there were office objections. Two main themes captured were:

- Not enough space in the office for our materials
- Lack of knowledge about CTDHP (HUSKY Dental)/Medicaid program

Office Dynamic/Make up:

- OBGYN (providers and practices (offices) VS. Midwifery (providers and practices (offices)

**Act**: Corrective actions:




1. Follow up phone call/in person visits to the office manager or 'person in charge'
2. For offices who do not want to receive the oral health kits and other materials, our thought is to limit the number of materials per office. For example, we normally deliver kits, bibs, pads, and posters. To make the office 'less reluctant', we will offer just pads or just a few posters. This will alleviate the stress of "having one more thing to do" and "not having enough space".
3. Reach out to midwifery practices, as opposed to OB/GYN office, and see how the two offices differ.
4. Separate the objections by theme and develop a plan for each theme
5. Identify other OBGYN offices that were not originally selected to continue outreach efforts.
6. Educate offices on HUSKY Dental. Perhaps, lunch and learn; presentation

c. <u>Contributions to the Preliminary Strategic Framework</u>

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

The Connecticut PIOHQI project gathers significant data on the needs of our target population: perinatal women and infants, the resources available and the readiness of the system to respond.

This includes birth certificate data, HUSKY Health (Medicaid/CHIP) medical and dental claims data, feedback from direct contact with clients, information from our community partners and information from other stakeholders. Six of our DHCS live and work in regions of the state and are active in the community with both community partners and clients. They participate in many community meetings. The Implementation Lead, the Clinical Lead and the Administrative Lead participate in a number of statewide stakeholder meetings. This information has given us a good position to look at the perinatal and infant oral health systems strategically.

Connecticut is fortunate that we had improved physical access for clients on HUSKY Health (Medicaid/CHIP) to the point that we greatly exceed all current standards for 'network adequacy', the term commonly used in Medicaid to measure physical access. Because of this we have been able to consider other factors that impact dental utilization for perinatal women and infants. We make the assumption that oral health is improved by dental utilization as is commonly believed and examination of that assumption is outside the scope of this grant.

We believe that physical access to dental care providers is necessary to improve dental utilization, but is not sufficient to optimize it. For example, as presented in prior reports, perinatal dental utilization increased significantly when physical access improved between 2005 and 2010. However the higher rate achieved rate was only about 50%, an amount of utilization consistent with general adult population utilization rates. Likewise we saw a similar increase in overall child dental utilization rates between 2006 and 2013, but with a maximum achievement of 62%, the highest in the country for Medicaid children. But what of the other half of perinatal women and the 40% or so of children who are not utilizing in an environment of excellent physical access?

From our analysis of this data we established a working hypothesis that there is a significant 'demand side' component to increasing dental utilization. We do not believe that it is purely a lack of knowledge and eschew use of the term 'dental literacy' as being too weak to describe it. In 2014 we conducted two focus groups of adults whose claims record showed had no utilization in the past year. One group was made up of perinatal women and the second group was of all other adults. Both groups were ethnically diverse. All of the participants verbalized that oral health and regular dental care were important and about half claimed they had been to the dentist in the past year, which we knew was not true. Clearly there are factors other than physical access and oral health knowledge involved in their lack of utilization. Additionally, and anecdotally, we often hear from clients that they "went to the dentist last year" when their claims record shows otherwise. We also know from various studies that cost and dental anxiety are barriers. A recent survey by the American Dental Association's Health Policy Institute, Oral Health and Well-Being in the United States, 2016 (http://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being?source=PromoSpots&Medium=ADAHPIRotator&content=HPIWell-Being) shows that 95% of the adults surveyed agree with the statement "Regular visits to the dentist will keep me healthy" and 77% say they plan to visit the dentist in the next year while only 37% said they actually visited the dentist within the last year. An amazing gap exists between intent and action.

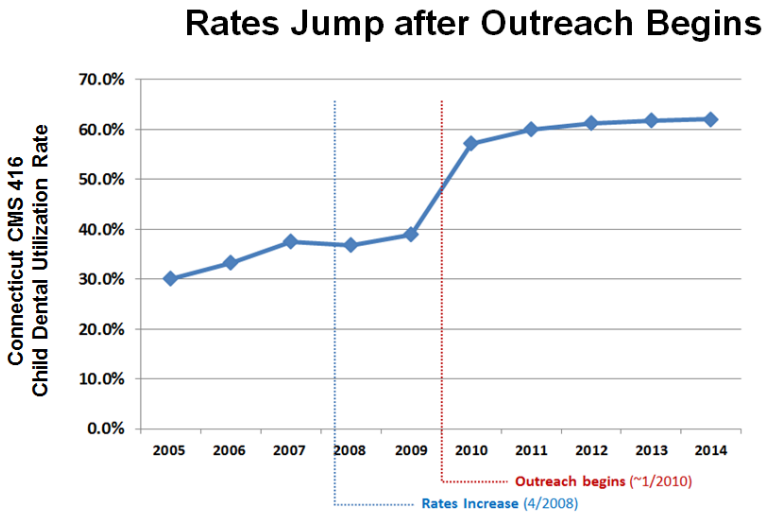
That survey also showed that 59% cited cost and 22% cited fear of the dentist as reasons for not visiting the dentist in the past year.

Our hypothesis for this grant, and for that matter our program, is that if we can influence factors on the demand side, then dental utilization will increase.

*2. Mobilize or build capacity to address needs*
Our approach, as previously reported, has been to increase client demand through community and individual outreach. The community outreach component primarily uses a 'trusted person' model. That assumes we can increase demand if we can convince people in the community with whom our clients interact (and trust) that oral health is important. In addition that they should encourage our mutual clients/patient that they should believe that too and get into regular care in a dental home.

We have used this model since we started in 2008. We have made thousands of outreaches to hundreds of community partners across the state. We have distributed hundreds of thousands of pieces of materials to those community partners who we believe have distributed them to our mutual clients/patients. One learning from this work is that relationships matter, that it is important to maintain contact with our community partners on a regular basis to maintain that relationship and their commitment to promoting oral health to our mutual clients/patients.

There is some indirect evidence that this approach works. One comment often made about our large utilization increase is that it is based in dental payment rates. In March of 2008 Connecticut's child HUSKY Health (Medicaid/CHIP) dental rates were increase significantly. However, child dental utilization rates only increased modestly. It wasn't until 2010, after we started our community outreach work that the child dental utilization rates jumped.



Likewise an analysis of child dental rates nationally by state also implies that rates alone do not account for our high child dental utilization rates. Looking at child payment rates against child utilization rates across all states shows that while Connecticut had the third highest payment rate in 2013, its child utilization rate was significantly higher than the other states with high payment rates. Connecticut was ten points higher that the number two state and almost twenty points higher than the average of the other nine states.

| Top Ten States by ADA Pediatric Medicaid Dental Rate * | 2013 | |
|---|---|---|
| | ADA Pediatric Dental Rate † | CMS 416 Utilization Rate ‡ |
| Delaware | 102.83 | 44% |
| Alaska | 93.51 | 40% |
| Connecticut | 85.27 | 62% |
| District of Columbia | 82.31 | 47% |
| New Jersey | 81.89 | 45% |
| Massachusetts | 74.28 | 52% |
| North Dakota | 63.76 | 27% |
| West Virginia | 61.00 | 44% |
| Wyoming | 59.89 | 39% |
| Texas | 58.88 | 50% |

| | |
|---|---|
| Average Top 10 excluding Connecticut | 43% |
| Average Top 5 excluding Connecticut | 44% |

* Are Medicaid and Private Dental Insurance Payment Rates for Pediatric Dental Care Services Keeping up with Inflation?, American Dental Association Health Policy Institute Research Brief, Kamyar Nasseh, Ph.D.; Marko Vujicic, Ph.D., December 2014, http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1214_2.ashx, accessed 6/12/2015
† Values represent a weighted average of reimbursement rates and charges for a basket of common dental care procedures.
‡ 2013 Centers for Medicare and Medicaid Early and Periodic Screening, Diagnostic, and Treatment CMS 416 Report, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt2013state.zip, accessed 6/12/2015

These reviews are consistent with a 2008 study by the National Academy for State Health Policy (NASHP) that concluded "(t)he research concludes that reimbursement rate increases were a necessary, but not sufficient, part of making Medicaid dental reforms succeed". (From 'Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?'; Alison Borchgrevink, Andrew Snyder, Shelly Gehshan, National Academy for State Health Policy, published by the California HealthCare Foundation, 2008, accessed 6/12/2015 http://www.chcf.org/publications/2008/03/increasing-access-to-dental-care-in-medicaid-does-raising-provider-rates-work http://nashp.org/sites/default/files/CHCF_dental_rates.pdf)

This is important to our PIOHQI project because we are using the same model and, in fact, testing whether it will work with perinatal women and infants. The grant has allowed us to focus and intensify our effort to do so by allowing us to increase outreach to community partners that interact with perinatal women, OB/GYNs and pediatric PCPs. We are optimistic we will be successful.

*3. Develop/finalize a comprehensive state strategic plan*

We have been successful in establishing the PIOH-WG under the Connecticut Coalition for Oral Health (CTCOH). Our intent is to align the work of the various stakeholders through the PIOH-WG. These include the Maternal and Child Health Coalition (MCH Coalition) created from the Title V MCH Advisory Committee and the Coalition to Improve Birth Outcomes. Other groups on the PIOH-WG include the Women's Health Committee of the Medical Assistance Program Oversight Council, Connecticut Section of the American academy of Pediatrics, the Connecticut Department of Health Office of Oral Health, Connecticut March of Dimes, the Connecticut Oral Health Initiative, the Connecticut State Dental Association and others. We are actively recruiting OB/GYN and nurse/midwife champions for the PIOH-WG.

*4. Implement evidence-based prevention policies, programs and practices and infrastructure development activities*
So far we (as part of the CTCOH) have been able to include perinatal and/or infant oral health measures in the State Oral Health Plan, the State Health Improvement Plan and preliminarily in the State Innovation Model. However these efforts have not been well coordinated. We intend to use the PIOH-WG to do that and to include the results and insights of our PIOHQI project in that work. While we have brought together nearly all of the stakeholders we must build the capacity of the PIOH-WG and strengthen the involvement of its members.

*5. Monitor process, evaluate effectiveness, sustain effective programs/activities, and improve or replace those that fail*
The evaluation component of this project is robust and more fully described in the evaluation section below. In terms of the strategic framework we think our use of hard data (birth certificate, Medicaid/CHIP medical and dental claims) is optimal.

d. Project Timeline

During the current grant year, our project timeline of activities aligns with the original grant submission. There are additions to account for the work with the National Network. Our project's Implementation Team continues to meet regularly, on a monthly basis, and reviews progress.

*ICO Implementation*

The expansion of the ICO project to the major areas of the state has continued as scheduled. As mentioned, when complete, the project will cover cities and adjacent areas where 80% of HUSKY Health (Medicaid/CHIP) births occur. Following is a summary of the timetable for initial implementation in each area. After implementation the project has and will continue in each area through the term of the grant.

| | Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|---|
| **Eastern CT** | Norwich, New London, Groton | Windham, Killingly | | |
| **Western CT** | Waterbury, Naugatuck | | Danbury | Torrington |
| **New Haven County** | New Haven, East Haven, West Haven, Ansonia | | | |
| **Hartford County** | | Hartford, East Hartford, West Hartford, Bloomfield | | Manchester, Vernon |
| **Southern CT** | | Stamford, Greenwich, Norwalk | Bridgeport, Stratford, Milford | |
| **Central CT** | | | Meriden, Wallingford, Middletown | New Britain, Bristol |

Through the implementation period, towns neighboring the larger, primary ones listed have and will received ICO as well. For Year 4, the project will continue to implement the ICO initiative in the towns listed/highlighted above. Year 4 will begin in September 2016.

There was some delay in producing outcome data during the period caused by budget difficulties within the State of Connecticut and bureaucratic issues. Our evaluation contractor, Connecticut Voices for Children, was delayed in receiving permission to access HUSKY Health (Medicaid/CHIP) claims data. We rely on their contracts with the Connecticut Department of Social Services (DSS) for HUSKY Health (Medicaid/CHIP) claims data and their contract with the Connecticut Department of Public Health for birth certificate data. The matter was recently resolved and we hope to have outcome data, specifically dental utilization by HUSKY Health (Medicaid/CHIP) perinatal women and children aged zero to two. We may soon have additional baseline data for 2011 and 2013. We may possibly have outcome data for 2014, the first full year of this grant.

We are examining ways to circumvent these delays in the future.

## II. SIGNIFICANT CHANGES

During this reporting period, there were only minor changes.

Key Personnel

In our last report, we mentioned the health status of our Project Director, Dr. Donna Balaski. Dr. Balaski was out on a six-month extended medical leave. She has been recuperating and has

recently returned to her role as Project Director. The Implementation Team continues to meet on a monthly basis. There are no additional changes to key personnel.

Contract/subcontract(s), Methodology, or Financial Resources
There are no anticipated changes to contract/subcontract, methodology, or financial resources/budget areas in the upcoming year. The project's use of funds will be described in full in the 'Plans for the Upcoming Budget Year' section of this report.

Other Significant Changes
There have been no other significant changes.

## III. EVALUATION

### a. The PIOHQI Approach

#### *i. **Progress toward collecting data that leads to an evidence-based approach that responds to the comprehensive oral health needs of the pregnant women and infants most at risk***

The Connecticut PIOHQI project is made up of an initiative that we call Intensive Community Outreach (ICO). The ICO project, as described in our original application, goes beyond traditional outreach - phone calls and mailings - to include more involved outreach to community partners, or as we say, 'trusted persons'. The expectation is that the targeted population, perinatal women and the caregivers of infants enrolled in the HUSKY Health (Medicaid/CHIP) program are more likely to be convinced of the importance of oral health by those in the community with whom they regularly interact, that is, community agency staff, physicians and others. Our hypothesis is that the result will be increased dental utilization. We call these folks 'community partners'. This model is a promising approach, based on two pilot studies conducted prior to this grant.

During the period of the grant we have continually collected data on these activities, specifically we record 'outreaches' and any materials distributed as part of those outreaches. An 'outreach' to a community partner includes visits, meetings, drop-offs, certain phone calls and other contacts. We are working to be able to link these 'outreaches' to pediatric primary care physicians (PCPs) and OB/GYNs with the dental utilization rates of our mutual clients. We have nearly completed a process to use HUSKY Health (Medicaid/CHIP) medical claims and enrollment data to attribute clients to their physicians. Once we have completed that we will be able to look at the dental utilization of the attributed clients and obtain an average utilization rate for each physician office. Further we are trying to measure the quality of the interaction with the community partners, a measure we call 'infiltration'. We know anecdotally that there is a big difference between an outreach visit where we only speak to the front desk person to one where we are able to present to all or most of the clinical staff. With that we will be able to see the effectiveness of the outreach relationship by looking at the client dental utilization by the level of infiltration of physician offices.

As described previously, CTDHP is also providing individual outreach to at-risk pregnant women in Connecticut who are not in regular preventive oral health care. Lists of identified pregnant members are obtained from the medical Administrative Service Organization in HUSKY Health (Connecticut Medicaid/CHIP). Traditional outreach (telephone calling and mailings) is conducted, and collaboration with community agencies, such as WIC and other agencies supporting at risk pregnant women and young children, around dental home messaging and referral for dental services. In some cases we enter into a memorandum of understanding (MOU) where we exchange information with the community partner. In particular, we ask them for better client phone numbers if we are unable to reach the client. The progress has been slow in obtaining these MOUs, but we will continue to work on doing that.

These measures will give us a better picture and help us respond to the comprehensive oral health needs of pregnant women and infants in the HUSKY Health (Medicaid/CHIP) program.

***ii. progress towards collecting data that leads to an evidence-based fiscal leveraging that affords program sustainability***

As mentioned in our project goals (Goal 4), CTDHP and Connecticut Department of Social Services strives to have meaningful outreach activities that will ensure our PIOHQI project is sustained, and serve as a strategy for statewide implementation. Despite some budget issues in our state, we are committed to continuing our ICO efforts beyond the life of the grant as part of the regular CTDHP program.

***iii. progress towards collecting data that leads to an evidence-based continuous quality improvement plan that effectively validates the project's capacity to demonstrate long-term, sustainable impact of systems change***

The Evaluation and CQI leads meet regularly and bring forth ideas for analysis at Implementation Team meetings, where we meet monthly to review the project. We also discuss the project at regular weekly staff meetings in-between the monthly meetings. Please see section III. Evaluation for more details.

**b. PIOHQI Data Collection and Analysis**

Dental Health Care Specialists (DHCS) have worked with dental care providers, obstetrician-gynecologists, pediatricians and community-based health and social service organizations to share information about the importance of oral health care during pregnancy. They have also distributed material for clients to help them understand how to protect their own oral health and that of their babies.

***Process Measures***

As mentioned earlier in this report, process measures are represented in the following attachments, for the current grant year to 5/31/2016:

- **Attachment 05 – Dental Health Care Specialist Outreach Activity Detail**
- **Attachment 06 – Dental Health Care Specialist Cases Detail**

***Outcome and Impact Measures***

As described in our project's evaluation plan, we are linking HUSKY Health (Medicaid/CHIP) claims data, along with birth certificate data to measure achievement of the project goals. We continue to receive birth certificate data from the Connecticut Department of Public Health (DPH). Our Evaluation Lead then links this to the dental claims and enrollment data in HUSKY Health (Medicaid/CHIP) to produce perinatal dental utilization rates. There was some delay in getting 2012 and 2013 birth certificate data during the current grant year, but we have obtained it and hope to have the analysis done by the end of the current grant year. We may receive the 2014 data in addition. This will allow us to build on the 2005 and 2010 baseline data we presented in earlier reports.

We have been working with Connecticut's largest Federally Qualified Health Center to identify barriers to pregnant women getting into care. In Phase One (grant Year Two) they had identified a statistically significant association between anxiety and depression and decreased dental uptake among a group of their clients. In Phase Two (grant Year Three) of their work they utilized warm hand-off and care coordination, but were unable to improve outcomes. In Phase Three (grant Year Four), they will utilize behavioral health staff support to address the previously identified anxiety and depression issues. More detail is contained in their Phase Two report and request for Phase Three in:

- **Attachment 07 - Warm Hand-off and Care Coordination Pilot**

In addition our Evaluation Lead recently completed an analysis report on CTDHP's provider survey which seeks to understand how participating HUSKY Health (Medicaid/CHIP) dental offices serve HUSKY program enrollees. The purpose of the analysis is to determine the impact of the PIOHQI project on access to care for pregnant women and infants in. About 40% of the babies born in Connecticut are to mothers enrolled in the HUSKY Health (Medicaid/CHIP) program. The following table shows the connection to the number of births to mothers with HUSKY Health (Medicaid/CHIP) coverage (by location) over the first three years of our PIOHQI project implementation.

**Table 1. Perinatal and Infant Oral Health Quality Improvement Project: Implementation Schedule**

| Connecticut Towns | Births to mothers with HUSKY coverage [a] | Percent of all births to town residents | PIOHQIP Year 1 | PIOHQIP Year 2 | PIOHQIP Year 3 |
|---|---|---|---|---|---|
| New Haven | 1,204 | 62.8% | ✓ | ✓ | ✓ |
| Waterbury | 1,053 | 67.5% | ✓ | ✓ | ✓ |
| Norwich | 345 | 64.4% | ✓ | ✓ | ✓ |
| New London | 265 | 70.3% | ✓ | ✓ | ✓ |
| Hartford | 1,568 | 80.0% | | ✓ | ✓ |
| Stamford | 472 | 27.5% | | ✓ | ✓ |
| Norwalk | 361 | 30.7% | | ✓ | ✓ |
| Windham | 199 | 64.6% | | ✓ | ✓ |
| Bridgeport | 1,571 | 70.0% | | | ✓ |
| Meriden | 454 | 58.1% | | | ✓ |
| Middletown | 192 | 36.8% | | | ✓ |
| Danbury | 489 | 47.8% | | | ✓ |

[a] Lee MA, Feder K, Learned A. Births to mothers with HUSKY Program Coverage (Medicaid and CHIP): 2011. New Haven CT: Connecticut Voices for Children, 2015. Available at: www.ctvoices.org. These linked data are the latest available for describing the reach of PIOHQIP.

**Table 4. Access to Dental Care for Pregnant Women, 2012 and 2015**

| | Provider Practices | |
|---|---|---|
| | 2012 | 2015 |
| Total respondents | 692 | 698 |
| Respondents who report that they care for pregnant women | 588 | 585 |
| | 85.0% | 83.8% |
| Practice features: | | |
| Accepts new patients (any type) | 91.3% | 90.9% |
| Speaks languages other than English in the office or clinic | 38.6% | 37.8% |
| Requirements and restrictions: | | |
| Sees pregnant women 21 and under | 95.9% | 95.9% |
| Sees pregnant women 21 and over | 52.7% | 52.5% |
| Requires referral letter from OB/GYN or midwife | 57.8% | 57.9% |
| Provides preventive services only | 1.2% | 1.2% |
| Provides both preventive services and restorative services | 96.4% | 94.7% |
| Provides urgent care for pregnant women | 95.1% | 95.2% |
| Provides emergency care for pregnant women | 95.4% | 95.6% |
| Treats in first trimester as needed | 88.6% | 89.2% |
| Treats in second trimester as needed | 96.3% | 96.4% |
| Treats in third trimester as needed | 93.9% | 94.2% |
| Uses local anesthesia as needed | 91.2% | 91.3% |
| Takes x-rays if medically necessary with lead apron | 85.7% | 86.3% |
| Any other restrictions [a] | 19.4% | 20.2% |

[a] Other restrictions to caring from pregnant women that were reported include: Will treat only with doctor permission, will see only existing patients, will see on case-by-case basis, will not do x-rays or restricts the use of x-rays, will provide Novocain only for anesthesia.

Source: Provider survey data compiled by the Connecticut Dental Health Partnership for administration of services provided to HUSKY Program enrollees. Data analysis by Connecticut Voices for Children, acting as lead evaluator of Perinatal and Infant Oral Health Quality Improvement Project.

The results of the study also show that about 70 percent of dental practices will see children age 1 or younger, which was similar to a 2012 survey (69.7%). Among those locations that will see

pregnant women, practice features, requirements and restrictions, and common office or clinic practices affect access to care (Table 4). When comparing response rates from the 2015 survey to the earlier one, it is clear that practices have not changed much since PIOHQIP began. Many offices require referral letters from the prenatal care provider. Of note is the lower percentage of practices that will see adult pregnant women, compared with women under the age of twenty-one. Still the ration of perinatal clients to available dentists greatly exceeds access standards. A copy of the full report can be found in the report Perinatal and Infant Oral Health Quality Improvement Project: Monitoring the HUSKY Program's Capacity for Caring for Pregnant Women and Infants, Mary Alice Lee, Connecticut Voices for Children, May 2016. This is:

- **ATTACHMENT 08 - PIOHQIP Provider Survey Report May 2016**

We have also obtained the first Connecticut PRAMS data from the survey conducted in 2014-2015. Our Evaluation lead completed an analysis that is covered in the report Using PRAMS Data for the Evaluation of Connecticut's Perinatal and Infant Oral Health Quality Improvement Project, Mary Alice Lee, Connecticut Voices for Children, February 2016. She points out the limitations of using that data to evaluate this project. This is:

- **Attachment 09 – Using PRAMS Data for CT PIOHQIP Evaluation.pdf**

Finally we started regularly measuring the application of fluoride varnish by pediatric PCP offices on HUSKY Health (Medicaid/CHIP) children under the age of three. Our Evaluation Lead conducted an initial review which is the report: Oral Health Care for Young Children in the HUSKY Program - Services Delivered by Primary Care Providers, 2008–2013, Mary Alice Lee, Connecticut Voices for Children, August 2015. This is:

- **Attachment 10 - PIOHQIP OH Services for Young Children by PCPs 2008-2013**

The report is in conjunction with a new cooperative effort with the Connecticut From the First Tooth program, a sister program to the Maine PIOHQI grantee, operated by the Connecticut Section of the American Academy of Pediatrics. We have seen impressive growth in the application of fluoride varnish both in the attached report and in more current data.

Finally our Evaluation Lead also prepared an analysis on utilizing data from the National Survey of Children's Health to evaluate this project. It is the report: Using Data from National Survey of Children's Health for Evaluation of Connecticut's Perinatal and Infant Oral Health Quality Improvement Project, Mary Alice Lee, Connecticut Voices for Children, March 2016.

- **Attachment 11 - Using NSCH for Evaluation of CT-PIOHQIP March 2016**

As with the PRAMS analysis, she points out the limitations of this data set.

In summary, the project has established benchmarks, measured some progress using the ICO approach, has linked data from several sources and is well positioned to deliver meaningful measures and hopefully results soon and by the end of the fourth grant year in September 2017.

## IV. PLANS FOR UPCOMING BUDGET YEAR

The use of funds for year four of the PIOHQI Project will be focused on continued expansion of the ICO initiative throughout Connecticut. As stated in our work plan, we will continue implementation of the ICO imitative in the towns/areas mentioned and begin implementation in the areas identified for Year four of the project.

| **Implementation Plan: Year Four** | |
|---|---|
| **Target City/Town** | **Nearby Town** |
| New Britain | Bristol |
| Manchester | Vernon |
| Torrington | -- |

Funds will be used to support continued outreach in the communities identified. In addition to outreach, the funds will be used to continue to provide outreach materials to those communities listed above as well as those where implementation began in the prior grant years. We continue to show that the oral health kits that are distributed as well as other health educational materials help strengthen our message that oral health is important.

During Year Four, funds will go towards the salary, fringe benefits and travel of the Implementation Lead (FTE) and the Clinical Lead (Outreach Coordinator). Travel will include mileage reimbursement for the aforementioned roles. The budget has set aside $50,000 in each year for Evaluation. Supplies, including printed outreach materials and the items in the oral health kits, are also accounted for the upcoming grant year.

In the upcoming grant year(s), we have funds to support participation in National Network (State-National Learning Network). During the upcoming year, we will allot funds for the project staff to attend the 2017 National Oral Health Conference (NOHC).

### Change from Original Approved Budget

There is a minor change in the proposed budget for Year Four, compared to the original budget submitted in our original grant application. The changes are primarily due to incorrect assumptions about the amount of both in-state and out-of-state travel. We also underestimated the popularity and impact of the oral health kits for perinatal women we distribute. This chart shows the changes:

| Category | Original Budget | Proposed | Change | Reason |
|---|---|---|---|---|
| **Travel** | **$ 21,015** | **$ 13,730** | **- $ 7,285** | **Over-estimation on local and out-of-state travel** |
| **Supplies** | **6,019** | **13,304** | **+ 7,285** | **Under-estimation of need for kits** |

**Budget Narrative – Year Four**

The total budget for year four is $175,000.

**a. Personnel**

| **Personnel** | | | |
|---|---|---|---|
| Implementation Lead | FT (2,080 hours/year) | $64,613 | |
| Clinical Lead | 12% (250 hours/year) x $73,544 | 9,046 | |
| **Total** | | | **73,659** |

One full-time and one part-time allocation are maintained.

The full-time Implementation Lead (one FTE), assuming satisfactory performance, will receive a 2.5% raise, which is consistent with CTDHP policy. The CTDHP Outreach Coordinator, as Clinical Lead, assuming satisfactory performance, will receive a 2.5% raise, and will continue to spend 12% (.12 FTE, 250 hours/year) of their time on the project.

Contribution to the progress and success of the project: The Implementation Lead will oversee and perform the outreach that is essential to the project's success. Both the Implementation Lead and the Clinical Lead will support participation in the National Network, a required expenditure.

**b. Fringe Benefits**

| **Fringe Benefits** | | | |
|---|---|---|---|
| Fringe Benefits | 33% x $73,659 | $23,714 | |
| **Fringe Total** | | | **$24,307** |

Fringe Benefits include FICA, Worker's Compensation, Health Insurance, Dental Insurance and Unemployment Insurance. The benefits are consistent with those of all CTDHP staff.

Contribution to the progress and success of the project: These expenditures are required to allow the Implementation Lead to oversee and perform the outreach that is essential to the project's success. In addition it supports both the Implementation Lead and the Clinical Lead as they support participation in the National Network, a required expenditure.

**c. Travel**

**Travel**

| | | |
|---|---|---|
| **In-State Travel** | | |
| Dental Health Care Specialists | 6 DHCS x 55¢/mile x 100 miles/month x 12 month | $3,960 |
| Implementation Lead | 55¢/mile x 75 miles/month x 12 months | 495 |
| Administration Lead | 55¢/mile x 50 miles/month x 12 months | 330 |
| Clinical Lead | 55¢/mile x 75 miles/month x 12 months | 495 |
| **Subtotal** | | **5,280** |
| | | |
| **National Network Travel** | One trip to DC area by three staff | |
| Rail/Plane Transportation | $400 RT HTF to WAS x 3 staff | 900 |
| Hotel | $250/night x 2 nights x 3 staff | 1,500 |
| Food | $75 est. per diem x 3 days x 3 staff | 675 |
| Misc. | Local transportation, other | 500 |
| **Subtotal** | | **3,575** |
| | | |
| **NOHC Travel** | | |
| Plane | $500 RT x 3 staff | 1,500 |
| Hotel | $250/night x 3 nights x 1 trip x 3 staff | 2,250 |
| Food | $75 est. per diem x 3 days x 3 staff | 675 |
| Misc. | Local transportation, other | 550 |
| **Subtotal** | | **4,875** |
| | | |
| **Total** | | **$13,730** |

Includes mileage reimbursement for the Dental Health Care Specialists (DHCS), who cover specific regions of the state, and who will perform the visits to community agencies, Primary Care Physicians and OB/GYN offices in the targeted towns. The visits are the key outreach activity of the project. The amount is estimated based on our experience with community outreach. The full-time Implementation Lead will drive in fulfillment of his/her work with assisting the DHCSs, the PIOH-WG, the Connecticut Coalition for Oral Health and other statewide and community stakeholders. Mileage for Clinical Lead is in fulfillment of his/her work with the PIOH-WG, the Connecticut Coalition for Oral Health and other statewide and community stakeholders. Travel funds will also be used for the National Oral Health Conference and National Network meetings.

Contribution to the progress and success of the project: Travel by the Dental Health Care Specialists, the Implementation Lead and the Clinical Lead is required to perform the outreach which is a core activity and essential to the project's success. In addition, travel is budgeted for participation in the National Network, a required activity.

**e. Supplies**

| | | | |
|---|---|---|---|
| **Supplies** | | | |
| Oral Health Kits | 13,304 kits x $1.00/kit, including assembly and printing | $13,304 | |
| **Total** | | | **$13,304** |

This item covers the cost for Oral Health Kits. The kits will be purchased from an oral health products company and will be packaged and boxed by a local non-profit serving people with disabilities. These estimates are consistent with our past costs, but we will use our system of comparable quotes to get the best price. The kits will be distributed by DHCS to clients in the targeted agencies and offices. Additional kits and materials are provided in-kind form the current CTDHP budget. The kits are key to establishing the initial relationship with the target offices and agencies. The cost of the kits includes assembly.

Contribution to the progress and success of the project: The oral health kits will provide clients with a toothbrush, tooth paste, floss and additional information on how to rush and floss. The kits also help to reinforce the relationship with the targeted PCP offices, OB/GYN offices and WIC offices. This item provides the tools and motivation necessary to the success of the project.

**f. Contractual**

| | | | |
|---|---|---|---|
| **Contractual** | | | |
| Data and Evaluation Contract | Connecticut Voices for Children | $50,000 | |
| **Total** | | | **$50,000** |

Consists of the proposed contract with Connecticut Voices for Children for $50,000 to provide the Data and Evaluation Lead and to coordinate and perform all related data collection/analysis and evaluation activities as described in the Evaluation Plan. A letter of agreement has been signed by both CT Voices and CTDHP. CTDHP has worked extensively with CT Voices in the past.

Contribution to the progress and success of the project: This is a required expenditure and is essential to measuring the success of the project.

| | | |
|---|---|---|
| **Grand Total** | **Budget Year Four** | **$175,000** |

**Addendum to Plans for Budget Year 4 (2016-2017)**

***Perinatal and Infant Oral Health Quality Improvement (PIOHQI) National Learning Network***

During Year Three of the PIOHQI Project, we have actively participated in the activities of the National Learning Network. We participated in the two in-person meetings of the Network as well as all of the regular monthly webinar meetings. As part of the National Learning Network

we developed three Quality Improvement Projects (QIPs), utilizing all of the QI knowledge gained at the in-person meetings. They are described above. We will continue our active level of participation with the National Learning Network in year four of the project.

We have already incorporated quality improvement methodology into our plan and operations. And do not expect any significant changes to our work plan or timetable. We have made substantial progress in entering data into the PIOHQI Dashboard and will refine its use in the balance of Year Three and in Year Four.

We have participated actively in the discussion on national metrics and AIM statements, both in the National Network and our Implementation Team. Given the timing and the design of our PIOHQI project, our team has chosen to concentrate efforts on both pregnant women and infants, as they are identified as long term outcomes.

| **National Long Term Outcomes** | |
|---|---|
| **Pregnant Women:** | By September 2019, increase by 15% over the state baseline the percent of women who have received oral health care, defined as prophylaxis, during pregnancy, as measured by the PRAMS (or equivalent) survey data. |
| **Infants:** | By September 2019, increase by 15% over the state baseline the percent of infants who have received preventive oral health care (including check-ups, dental cleanings, x-rays, fluoride varnish, sealants, and/or anticipatory guidance), as measured by the NSCH data on dental visits for 12-24 month olds. |

Under these National Outcomes and the three National Strategies we have chosen these local AIM statements. They are consistent with the work and timetable already in place.

| **Connecticut PIOHQI AIM Statements** | |
|---|---|
| **Strategy #1 –** Increase oral health messages delivered to pregnant women and infants**.** | **Aim 1.a. & 1.b.** - By August 2017, CT PIOHQI will continue to work with multiple community partners impacting Connecticut HUSKY Health (Medicaid/CHIP) pregnant women and infants aged zero to two years, including Community Action Agencies Head Start, Healthy Start, Nurturing Families, WIC, dental providers, medical providers and others. We will maintain our level of outreached and materials distributed to those organizations. |
| **Measurement -** CTDHP reports showing the number of outreaches to community partners and the amount of materials distributed to them.<br><br>**Notes -** As our outreach since the beginning of the grant has integrated both target populations, | |

<table>
<tr><td colspan="2">we will continue to focus on perinatal women and infants aged 0 to 2 year. Our 'trusted person' model is for these organizations to multiply our impact by spreading the messages that oral health is important, our mutual clients should get regular care in a dental home and that the CTDHP is available to assist them.</td></tr>
<tr><td>Strategy #2 – Improve state- or systems-level policies and practices.</td><td>Aim 2.a. – By August 2017, CT PIOH will develop, adopt, or improve operationalization of at least one pregnant woman-centered policy and/or practice at the state or health plan level that helps to improve access to or quality of oral health care for those populations.</td></tr>
<tr><td colspan="2">Measurement – Report from the Perinatal and Infant Oral Health Work Group (PIOH-WG).<br><br>Notes – The PIOH-WG will identify the policy/practice to impact and develop the plan to do so. The PIOH-WG is described above.</td></tr>
<tr><td>Strategy #3 – Improve access to and utilization of preventive oral health care</td><td>Aim 3.d. – By August 2017, increase by 15% over baseline in Connecticut the rate of HUSKY Health (Medicaid/CHIP) pregnant women who receive preventive, treatment and any oral health services.</td></tr>
<tr><td colspan="2">Measurement – HUSKY Health (Medicaid/CHIP) claims and enrollment data are already being used to measure this AIM. Baseline data has been set for 2005. There is also baseline data for 2010, a period for which some of the techniques utilized in the grant had been already initiated. Note – Please see section III. Evaluation above for more detail.</td></tr>
</table>