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Organization Name: Massachusetts Department of Public Health
Primary Contact: Brittany Brown
Title: Director, Office of Oral Health
Phone Number: (617) 624-5943
Email: Brittany.L.Brown@state.ma.us

I. PROGRESS

Through dissemination and implementation of the *'Massachusetts Oral Health Practice Guidelines for Pregnancy and Early Childhood'* (the guidelines), the Massachusetts Perinatal Expansion Project (Mass PEP) continues to make progress towards our overall goal of reducing the prevalence of oral disease in pregnant women and infants. With the support of the Mass PEP Advisory Board, the Massachusetts Department of Public Health (DPH) Office of Oral Health (OOH), the Massachusetts League of Community Health Centers (the League) and our pilot community health center (CHC) staff, our dissemination, implementation, and sustainability efforts were acted upon during this reporting period.

The Mass PEP Advisory Board's main focus continues to be dissemination of the guidelines as well as identifying opportunities for Mass PEP team members to provide education on the guidelines to providers and the public alike. During this reporting period, the Mass PEP Advisory Board subgroup, which was developed in year 2 for planning our Perinatal Oral Health Summit, continued to convene to strategize about dissemination and opportunities for education on the guidelines. Four Advisory Board members participated in a perinatal oral health panel discussion at the Yankee Dental Congress, New England's largest meeting for dental professionals, in February 2019. Additionally, Advisory Board member, Dr. Lucy Chie, participated in an American Dental Association and American Academy of Pediatrics webinar on perinatal oral health to discuss South Cove Community Health Center's success participating in this project on May 31, 2019.

As dissemination activities continue, our Advisory Board is also actively engaged in the implementation phase of Mass PEP. During this reporting period, we began implementation at two additional CHCs, South Boston Community Health Center and Lowell Community Health Center, as the pilot CHCs no longer require extensive technical assistance from the Mass PEP team and efforts can be focused elsewhere. Advisory Board member Dr. Hugh Silk provided training on the guidelines and an overview of perinatal oral health integration recommendations before these new CHCs began implementation. Our Advisory Board has proven to be a wealth of knowledge as we have planned where and how to expand strategically throughout the project.

During the previous reporting period, we worked closely with one member of our Mass PEP Advisory Board, Dr. Hafsatou Diop, as well as DPH staff and a pre-dental student intern to develop and disseminate a provider survey for all providers in the dental and medical fields, including specialists and auxiliary staff. The survey assessed providers' attitudes toward and practices of providing oral health care for pregnant women. During this reporting period the survey results were analyzed. In total, 138 individuals completed the survey, with the majority of respondents identifying as dental hygienists (45%). The majority of respondents have read the guidelines (dentist = 75%, dental hygienists = 77%, prenatal providers = 84%), but

implementation of the recommendations in their practices was varied (dentist = 25%, dental hygienists = 55%, prenatal providers = 75%). There were also a significant percentage of respondents who were not aware of the guidelines, proving there is more work that needs to be completed in terms of dissemination and education.

During the summer/fall of 2018, the Mass PEP team worked with a Master of Public Health student intern who primarily focused on compiling a quality improvement toolkit. This quality improvement toolkit outlines the basics of quality improvement as well as examples of both successful and unsuccessful initiatives that occurred at pilot CHCs. While the toolkit is lengthy and covers a wide range of quality improvement tools, it is meant to be pared down based on each CHCs project and existing knowledge of quality improvement. This toolkit is being used to introduce new CHCs to quality improvement and how quality improvement can be used to test small scale interventions before site wide implementation.

Throughout the project, DPH has contracted with the League to work with CHCs piloting implementation of the guidelines. The three Mass PEP pilot CHCs and now the two additional CHCs have been implementing the guidelines and testing various projects to increase the number of pregnant women and young children 0-3 years old who are connected with dental care and in turn have a dental visit. In previous reporting periods, the Mass PEP team completed oral health knowledge surveys, 'Case for Change' trainings, workflow mapping sessions, and data collection technical assistance meetings with the pilot CHCs and during this reporting period completed these tasked with the two new CHCs. Collectively, these CHCs represent different health systems each piloting projects unique to their environment, but also common to systems across the state.

South Cove Community Health Center:
The first CHC has two sites, one with OB and a dental department and the other with pediatrics and a dental department. The site with OB and dental currently note that a referral is needed in the patient's electronic record and the OB receptionist schedules the patient with a dental appointment. This CHC has found it difficult to increase the percent of pregnant women visiting the dentist past 50% and is working to better understand the barriers to care that still exist for this population. DPH received Institutional Review Board approval to conduct a qualitative study of pregnant women in their second or third trimester at this community health center.
The study consisted of hour-long key informant interviews that were conducted with nine pregnant women between August and December 2018. The interviews were conducted by one of South Cove Community Health Center's labor coaches in Mandarin, as the patient population is predominantly Chinese. The interviews were then translated, transcribed and coded for themes. Several themes emerged and are detailed below.

> <u>Question 1: Many people have different views of what it means to have good oral health. What would you say good oral health means to you? Have you always held this view? Why or why not?</u>
> No issues - the lack of dental issues (sensitivity, bleeding, and pain) as an indication of good oral health
>
> - "Good oral health means no infection, no bleeding and no pain."
> - "When I am feeling good about myself, I don't think I need to see them."
>
> Extensive Practices - extensive oral health practices as an indication of good oral health: brushing teeth, flossing and visiting the dentist on a routine basis

- "Having no rotten teeth, brushing teeth regularly, checking with dentist regularly (basically 2-3 month) and flossing means good oral health for me."

Question 2: Can you describe, in general, your experience going to the dentist before you were pregnant? How often would you say that you saw a dentist before you became pregnant? Tell me a little about your dental provider(s) before you became pregnant, if you had one. What types of barriers, if any, did you face to visiting a dentist before you were pregnant? (anything that prevented you from visiting a dentist)

Dental habits before pregnancy - occasional visits to the dentist before pregnancy

- "Before pregnant, I went to see the dentist occasionally. The last time I saw was 2016."
- "Before I was pregnant, if I didn't have tooth pain or problems, I wouldn't see the dentist."
- "I saw dentist only when I needed."

Obstacles - the challenges they faced when seeking dental care: difficult to book appointments and when they did, they would only see the dentist on duty (as opposed to seeing a provider who is familiar with their medical history)

- "Whenever I went to the hospital, I saw whoever was on duty that day. That's in China. Before I was pregnant, I did not go to see dentist often because it was hard to book the appointment. And the timing never matched."

Cultural factors - that in China, they would only see the dentist if there was a problem

- "Traditionally, there is not much advertising or education in China about oral health. There's also no family teaching."
- "But before I came to USA, I was in China and I didn't care that much about my teeth. I saw dentist only when I needed."
- "If I were in China, because of the different culture, I may not have seen a dentist."
- "In China, I never saw a dentist as there was not that much education. People normally see dentist when they have a problem with their teeth. When I came to the USA, the doctor told me more about taking care of my teeth, so I would like to see dentist a bit more."

Question 3: Can you describe any changes to your dental habits since you became pregnant? Have you experienced any issues with your teeth or mouth since you became pregnant? Describe your personal feelings about whether or not you should see a dentist during pregnancy? If your views have changed over time, please describe why.

Advice – advice from doctor during pregnancy

- "During my pregnancy I went to see the dentist with the advice of South Cove doctor."

Education/culture shift - that the education about good oral health practices in U.S. allowed them to have a better understanding of the benefits of good oral health

- "In the US, the education is good and it made me have more of an understanding of the benefits of oral health."

Fear – fear of dental care during pregnancy

- "I am a bit afraid of having my teeth cleaned, particularly having to have X-rays."

- "Since I'm afraid of x-rays, that they are harmful to my baby, I resisted seeing the dentist."

No change – no change before and during pregnancy

- "After I became pregnant, not much changed with my oral health."

Question 4: If you currently have children, describe their daily oral health routine and how/why you developed this routine with them. If applicable, when did you start this routine with your child(ren)? Do you feel that your children need to see a dental provider?

Age of child (2 years) - that for their children, they would initiate a dental routine for them around the age of 2

- "I think 2 year old is the best time to start to take care their oral health."
- "When I have children, I will ask that he/she start brushing teeth. The best time would be 2 years old."
- "When they start feeling pain or bleeding , I will bring them to see the dentist. "
- "I will start this routine once when they start growing teeth."
- "Elder people are sometimes more traditional and may stop the parent from taking the baby see dentist."
- "When they grow up I will take them to see dentist, at about 3 years old."

Sugar/Sweet Snacks - feeding their children less sweets to help with their oral health

- "I will help them eat more nuts that are good for teeth. I plan to clean their mouth when they are 4-5 months old and will bring them to see dentist when they 2 years old. I will also feed them less sweets."
- "They have to brush frequently, not have sweets especially at nighttime."

The second South Cove Community Health Center site, with both pediatric medical and dental, is currently using a paper referral method, which they prefer. The child's parent is given a paper referral and is told to go to the dental department to schedule an appointment. If the parent does not schedule the appointment, the dental department will call the parent to schedule. Before the start of this project <1% of pediatric patients between the ages of 0 and 36 months old were seen in dental. As of March 1, 2019, this percentage has increased significantly to 45%.

Edward M. Kennedy Community Health Center:

The second pilot CHC has family medicine, pediatric medical and dental departments all within the same site. This CHC also engaged their perinatal community health workers to do the education and referral work with their pregnant population. Much like the South Cove Community Health Center, the medical receptionists are able to book appointments for pregnant patients directly into the dental schedule. During this reporting period between 40% and 50% of patients at this CHC had a dental visit during their pregnancy. This CHC too had difficulties increasing this percentage.

The pediatric site showed variable improvement by month and age group, with inconsistent improvement over baseline. The highest percentage of pediatric patients seen in the dental department in the past six months was among children aged 31-36 months of age and 25-30 months of age. After discussing the results of the project with the Edward M. Kennedy Community Health Center project team, they felt unable to make any further improvement due

to other priorities at the site. Their phase-out occurred in July 2018. The Mass PEP team is still available as a resource for this site, but Mass PEP funds will not be utilized.

Holyoke Health Center:
The third pilot CHC has a midwife practice, pediatric, and dental (both adult and pediatric) services on site. However, as noted in previous reports, the midwife practice is not owned or run by the CHC and due to commitment and data sharing issues are no longer participating in this project.

This CHC evaluated their data on infants on a monthly basis and recognized that their progress was hindered by a delay between when patients are referred from the medical to dental clinic and when they were able to schedule an appointment for the patient (typically this process took two to three months). This CHC's pediatric dental department also specializes in treating children with complex needs under general anesthesia; therefore the number of children being seen for routine care was low. This site saw increases over baseline in some age categories. There was an increase among young children aged 13-18 months of age and 25-30 months of age seen in dental by approximately 10% each over baseline, though total numbers are small. As the impact of Mass PEP activities at Holyoke Health Center has been low, the Mass PEP team discussed with the site phasing out project efforts. Their phase-out occurred in July 2018. The Mass PEP team is still available as a resource for this site, but Mass PEP funds will not be utilized.

Additional Community Health Centers
As pilot CHCs required less technical assistance from the Mass PEP team, we began considering additional CHCs to engage in year 3. A survey of all CHCs with perinatal services was conducted in May 2018 to gauge interest in project efforts and over ten CHCs expressed interest in this work. We developed a 'must haves' list of criteria CHCs must meet in order to select the sites best suited and most ready to participate in the project. This list includes medical and dental record data collection capabilities based on lessons learned from the pilot CHCs. We have found it is necessary to clearly define data expectations from the beginning in order to track outcomes as uniformly as possible across CHCs. A webinar for all interested CHCs was held in late summer 2018 to review project goals and requirements as well as respond to CHC questions about the project. After the webinar, two additional CHCs were selected for participation in the project: South Boston Community Health Center and Lowell Community Health Center. Both CHCs have dental, pediatrics, and OB/GYN services on site. These sites were initially engaged in the project in November 2018 and both recently began data collection using the same data template as the pilot sites. Initial results will be available in the coming months.

The Mass PEP team is still working with South Cove Community Health Center, who has chosen to continue into year 3 of the project with a focus on sustainability, but most of our effort will be turned to implementation at a new cohort of CHCs using lessons learned from the pilot sites. The pilot CHCs will also act as coaches and provide technical assistance to CHCs starting the project. Lessons learned and accomplishments made at all these CHCs will all be compiled and contribute to the statewide plan for how oral health care can be integrated into a primary health care delivery system. This statewide plan will first be disseminated and used within the state's network of 49 community health centers, which are best equipped to initiate this work.

While the largest component of this project involves integration at the CHC level, we are also working with six Early Intervention (EI) sites in two communities to integrate oral health referrals into their workflow. One hundred and four staff at six EI sites in Holyoke and Worcester received oral health training between April and July 2017. Additionally, one site in Holyoke received a second training in February 2018 and another in April 2019 due to extensive staff turnover. At the initial EI intake visit, EI staff members are instructed to ask questions about the child's oral health history using an oral health screening form. If the child has not had a dental visit in the past six months a list of community dental providers is given to the family and they are encouraged to make an appointment for their child. At the six-month review visit with the family, EI staff members follow up to see if the child actually had a dental visit as instructed. Data collection for this process began in September 2017. Since August 2018, 930 total screening/referral tracking forms have been collected. 81% of the children screened had teeth and, of those, 60% were in need of dental appointment and 85% were encouraged to make an appointment with a dental provider. The percentage of children who were seen by a dental provider by their 6-month EI follow up appointment increased from 41% in August 2018 to 53% in December 2018. With this data, we plan to make the case to develop an oral health training module specific to early childhood providers that can be used during employee onboarding. This training is in development and is planned to be completed by the end of summer 2019.

The Center for Oral Health Systems Integration and Improvement (COHSII) team and oral health learning collaborative have proven to be a valuable resource as Mass PEP continues and expands. Brittany Brown, Director of the Office of Oral Health and Principal Investigator of Mass PEP, was able to join the October 2018 COHSII/PIOHQI in-person meeting in Alexandria, Virginia and the May 2019 COHSII/PIOHQI in-person meeting in Arlington, Virginia. Overall, this in-person meeting was one of the most effective learning sessions as all states are now engaged in the implementation phase of their projects with enough experience to share their successes, challenges and lessons learned. The COHSII team is very familiar with each state's projects so they are able to target resources and connect states based on project needs, goals and partners. The oral health learning collaborative has been very helpful and we foresee the relationships we have built with PIOHQI states continuing after the project has come to a close.

Additionally, our work with the quality improvement aspects of the PIOHQI project and within the oral health learning collaborative has led to three Mass PEP team members; Brittany Brown, Kate Festa and Heather Benabbou, to become certified as green belts in Lean/Six Sigma in May 2018.

During this reporting period, we made process improvements which contributed to the Strategic Framework. Progress on each of the five preliminary steps that make up the national implementation framework are outlined below:

i. <u>Profile population needs, resources, and readiness to address the problems and gaps in service delivery.</u>
   The three pilot CHCs and two additional CHCs were chosen to participate in this project based on individual community need and their level of integration with the communities that they serve. The pilot sites were chosen deliberately for their embedded nature within their communities which helps to best identify the needs of the population. During this reporting period, the Mass PEP team has met with the medical, dental and

OB/GYN teams at the pilot sites to discuss ways to improve their processes within their practices to best address the community needs.

ii. Mobilize and/or build capacity to address needs.
The Mass PEP Advisory Board is comprised of individuals familiar with community needs across the state. The Advisory Board is a multidisciplinary team which helps to identify areas of the state where there are gaps in service delivery. The members are uniquely positioned in a variety of different types of programs across the state to provide/mobilize resources to those areas. The members work with the pilot CHCs to provide resources for addressing the barriers that their population may be facing.

iii. Develop a strategic approach for implementation that utilizes a health care delivery system with statewide reach.
The three pilot CHCs represent different perinatal and infant care delivery systems that are common across Massachusetts. During this reporting period, the clinics within the CHCs continued their work to find and develop referral models that will be adaptable to future practices. To facilitate the development of sustainable and replicable practice systems, the CHCs complete and document PDSA cycles regularly. In addition, the CHCs are located within underserved communities and will ensure that the approach is both applicable and meaningful to those with the most need across the state. In the coming months, the Mass PEP team will use the lessons learned as two new CHCs join the project, furthering our goal to reach systems across the state.

iv. Implement evidence-based prevention policies, programs and practices, and infrastructure development activities.
Throughout the reporting period, when the CHCs encountered any areas where they were in need of input, the Mass PEP team consulted the other participating PIOHQI states to ensure that evidence-based solutions and best practices were implemented.

v. Monitor the approach, evaluate effectiveness, sustain effective programs/activities, and improve or replace those that fail.
During the reporting period, the Mass PEP team began to work with each CHC to discuss sustainability of the processes that they have implemented. To facilitate this discussion, the Mass PEP team developed feedback reports for each CHC highlighting the data collected to date and potential next steps. These reports along with next steps for sustainability will be discussed with each of the CHCs at in-person meetings in the coming months. The results of these meetings and lessons learned will be used as the Mass PEP team approaches new CHCs to expand the project efforts.

For our upcoming six month No Cost Extension period we will continue working with the three participating CHCs to continue implementing and testing practice changes and monitoring progress and data with the goal of increasing the number of pregnant women and infants receiving oral health care. The CHCs will continue to submit quantitative and qualitative data on a monthly basis and participate in check in meetings and phone calls as appropriate. The completion of data collection and analysis is essential to determine if the changes implemented throughout this project have been effective and the number of individuals within our target population receiving oral health care has been impacted.

II. SIGNIFICANT CHANGES

No significant changes were made during this reporting period. As stated in previous reports, we have contracted with the League for Shannon Wells to act as our Mass PEP Network Liaison. This change did not have any negative effect on the project's goals or objectives, but instead added great value as Shannon Wells has years of experience working with CHCs.

III. EVALUATION

Data collection from the CHCs participating in this project began in March 2017. Our plan for data collection on this outcome was informed by workflow mapping exercises and conversations with the data collection teams at each of the CHCs participating in the project. Based on these conversations, taking into account each of the different site-specific projects and data collection capabilities, we have defined the following data collection points related to oral health care access. These measures are collected monthly:

Pregnant women:

- Total number of women who were defined as pregnant at the CHC during a specified six-month date range (collected monthly throughout the project)
- Total number of pregnant women who were seen by dental services during a specified six-month date range (collected monthly throughout the project)

Infants and Young Children:

- Total number of children who are currently registered patients in pediatrics within defined age ranges (collected monthly throughout the project). The age ranges collected are:
    - 6-12 months of age
    - 13-18 months of age
    - 19-24 months of age
    - 25-30 months of age
    - 31-36 months of age
- Total number of children who are currently registered patients in the dental clinic within defined age ranges (collected monthly throughout the project). The age ranges collected are:
    - 6-12 months of age
    - 13-18 months of age
    - 19-24 months of age
    - 25-30 months of age
    - 31-36 months of age

The health centers that were unable to measure these outcomes were offered an alternate option for data collection:

- Total # of pediatric medical patients seen in the past six months in the below age ranges (collected monthly throughout the project):
    - 6-12 months of age
    - 6-18 months of age
    - 6-24 months of age
    - 6-30 months of age
    - 6-36 months of age

- Total # of pediatric dental patients seen in the past six months in the below age ranges (collected monthly throughout the project):
    - 6-12 months of age
    - 6-18 months of age
    - 6-24 months of age
    - 6-30 months of age
    - 6-36 months of age

a. Increase opportunities for access to oral health care.

Type and Number of Testing (Learning Laboratory) and Other Intervention Sites

Site Type	Number of Testing (Learning Laboratory) Sites	Number of Other Intervention Sites
Federally qualified health center; please list OB/GYN, pediatric, and dental clinics separately	3 Community Health Centers and 8 testing sites are included in this pilot project: 2 OB/GYN or family medicine clinics 3 Dental clinics 3 Pediatric clinics	N/A
WIC	N/A	N/A
Home visiting	N/A	N/A
Community clinic	N/A	N/A
Other, please specify (e.g., school-based clinic)	N/A	N/A

b. Increase opportunities for training on oral health care, including training on oral health clinical competencies.

Type and Number of Providers Receiving Training at Testing (Learning Laboratory) and Other Intervention Sites

Type of Provider	Number of Completed Pre-Tests	Number of Completed Trainings	Number of Completed Post-Tests
Primary care providers (e.g., family physician, pediatrician, nurse practitioner)	We did not complete any pre-tests as part of our trainings	3	We did not complete any post-tests as part of our trainings
Prenatal care providers (e.g., OB/GYN provider, midwife)		2	
Oral health providers (e.g., dentist, dental hygienist)		10	

Other (e.g., community health worker)			

c. Increase opportunities for outreach and oral health education.

Number of Pregnant Women Receiving Education at Testing (Learning Laboratories) and Other Intervention Sites

Activity	Number of Completed Pre-Tests	Number of Completed Trainings	Number of Completed Post-Tests
Focus group	0	0	0
Training, in-person	0	0	0
Training, online	0	0	0
Webinar	0	0	0
Other, please specify	0	0	0

d. Increase opportunities for utilization of oral health care.

Number of Pregnant Women, Infants, and Children Receiving Oral Health Care

Infants (Birth to 12 Months)							
Period of Service	Number of Clients Enrolled in Site	Number Receiving Oral Health Education	Number Receiving Anticipatory Guidance	Number of Referrals to Providers for Dental/ Oral Health Care	Number Receiving Preventive Dental/ Oral Health Care	Number Receiving Restorative Treatment	Number with Treatment Completed
Baseline	411	These are not components of our project			11		
June ‘17	415				14		
July ‘17	443				25		
August ‘17	441				29		
September ‘17	440				25		
October ‘17	440				23		
November ‘17	431				20		
December ‘17	426				15		
January ‘18	413				10		
February ‘18	430				6		
March ‘18	404				9		
April ‘18	432				5		
May ‘18	415				6		

June ‘18	183		1
July ‘18	165		3
August ‘18	162		11
September ‘18	158		10
October ‘18	160		5
November ‘18	584		25
December ‘18	556		19
January ‘19	561		24
February ‘19	558		20
March ‘19	503		8

Infants (Age 12-36 Months)							
Period of Service	Number of Clients Enrolled in Site	Number Receiving Oral Health Education	Number Receiving Anticipatory Guidance	Number of Referrals to Providers for Dental/Oral Health Care	Number Receiving Preventive Dental/Oral Health Care	Number Receiving Restorative Treatment	Number with Treatment Completed
Baseline	1396	These are not components of our project			118		
June ‘17	1360				163		
July ‘17	1365				198		
August ‘17	1394				231		
September ‘17	1397				277		
October ‘17	1388				310		
November ‘17	1398				345		
December ‘17	1398				369		
January ‘18	1394				413		
February ‘18	1393				442		
March ‘18	1428				464		
April ‘18	1400				465		
May ‘18	1418				359		
June ‘18	802				394		
July ‘18	824				403		
August ‘18	849				439		
September ‘18	851				440		
October ‘18	864				428		
November ‘18	1597				506		
December ‘18	1583				512		
January ‘19	1588				492		
February ‘19	1563				498		
March ‘19	1258				129		

Pregnant Women							
Period of Service	Number of Clients Enrolled in Site	Number Receiving Oral Health Education	Number Receiving Anticipatory Guidance	Number of Referrals to Providers for Dental/Oral Health Care	Number Receiving Preventive Dental/Oral Health Care	Number Receiving Restorative Treatment	Number with Treatment Completed
Baseline	594	These are not components of our project			284		
June '17	614				312		
July '17	612				309		
August '17	599				302		
September '17	597				312		
October '17	578				297		
November '17	576				295		
December '17	556				273		
January '18	545				254		
February '18	560				230		
March '18	538				226		
April '18	540				213		
May '18	537				196		
June '18	507				180		
July '18	326				134		
August '18	330				204		
September '18	336				206		
October '18	335				206		
November '18	957				239		
December '18	975				226		
January '19	957				202		
February '19	1030				181		
March '19	918				167		

e. Telling Your Story

Name of testing site: South Cove Community Health Center
Location: South Cove OB/GYN department
Target population: Pregnant patients at South Cove
Medical/dental (oral health) care – description of services provided: South Cove OB/GYN has experienced some difficulty in increasing the percentage of women who have seen a dentist during their pregnancy above 50%. In the fall of 2018, the South Cove staff began a qualitative research project in order to better understand the barriers to care. The project involved interviewing 9 patients during their pregnancy to determine their knowledge, attitudes and beliefs around dental care. Several themes emerged from these qualitative interviews and are detailed on pages 2 through 4.

Results: The interviews were conducted in the fall of 2018 and showed several themes which are highlighted in the attached document.
Next step: We would like to do similar interviews with other sites participating in this project to better understand challenges and next steps related to both pregnant women and infants.

IV. IMPACT

During this reporting period, efforts have taken place to disseminate the information gathered thus far from the CHCs at national conferences for greatest impact. The Mass PEP team presented a poster at the American Public Health Association annual conference in San Diego in November 2018. The abstract entitled *Implementation of The Perinatal and Infant Oral Health Quality Improvement Project (PIOHQI) in Massachusetts: Initial barriers and successes in 3 pilot community health centers* highlights initial results of Mass PEP. The goal of this presentation was to share what we have learned thus far with the hope that other states and organizations interested in implementing a similar project will learn from our successes and challenges. The Mass PEP team will continue to seek opportunities for dissemination, including the 2020 National Oral Health Conference.

A statewide Perinatal Oral Health Summit was held on May 30, 2018. The goal of the Summit was to give providers the tools and resources needed to build sustainable oral health systems within their practice settings. The Summit included keynote speakers and multidisciplinary discussions around perinatal oral health. The conference also provided an opportunity for the Mass PEP pilot sites to share their lessons learned and provide suggestions for providers looking to begin this type of work. The Summit hosted 85 attendees from across medical and dental disciplines including dentists, dental hygienists, dental assistants, community health workers, and physicians. On the post-survey evaluation, 90% of participants indicated that they plan to make or suggest changes to their practice based on the information presented at the Summit. In addition, 73% of participants indicated that they are now comfortable in providing treatment/referrals for dental care during pregnancy and approximately 90% of participants indicated that they are now comfortable in providing treatment/referrals to infants and children.

As part of another federally funded project we are collaborating on, the Oral Health Equity Project, we will be hosting a statewide oral health equity summit in spring 2020. As part of this conference we plan to have a learning session dedicated to addressing equitable access to oral health care for pregnant women and young children. This session will showcase efforts and successes experienced by the five CHCs that participated in the Mass PEP project.

V. PLANS FOR NO COST EXTENSION

As stated in our No Cost Extension request, we plan to utilize year three savings to continue funding our Epidemiologist position. Our Epidemiologist will continue to be responsible for monitoring CHC data and progress as our participating CHCs continue to implement and test practice changes with the goal of increasing the number of pregnant women and infants receiving oral health care. The CHCs will continue to submit quantitative and qualitative data on a monthly basis and participate in check in meetings and phone calls as appropriate. The completion of data collection and analysis is essential to determine if the changes implemented

throughout this project have been effective and the number of individuals within our target population receiving oral health care has been impacted.