



The Partnership for Integrating Oral Health Care into Primary Care Project 2019–2021: Final Report



Cite as

Battani K, Holt K. 2021. *The Partnership for Integrating Oral Health Care into Primary Care Project 2019-2021: Final Report*. Washington, DC: National Maternal and Child Oral Health Resource Center.

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This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an annual award totaling \$1,000,000 with no funding from nongovernmental sources. This information or content and conclusions are those of the author(s) and should not be construed as the official policy of HRSA, HHS, or the U.S. government, nor should any endorsements be inferred.

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Introduction



The Partnership for Integrating Oral Health Care into Primary Care (PIOHCPC) project was launched to improve access to oral health care by integrating the interprofessional oral health core clinical competencies into primary care. The competencies are described in the Health Resources and Services Administration's (HRSA's) report *Integration of Oral Health and Primary Care Practice*. The PIOHCPC project teams consisted of a state Title V Maternal and Child Health (MCH) health program addressing the Title V national performance measure (NPM) on oral health (NPM 13¹) and a local primary care setting. The project targeted pregnant women, children, and adolescents

at high risk for oral disease. It was implemented from January 2019 through June 2021 and included three sequential project periods.

The PIOHCPC project was funded by HRSA, Maternal and Child Health Bureau (MCHB), and supported by the National Maternal and Child Center for Oral Health Systems Integration and Improvement (COHSII). COHSII, a national consortium, is led by the National Maternal and Child Oral Health Resource Center (OHRC). With assistance from the National Network for Oral Health Access (NNOHA), COHSII provided technical assistance (TA) to the PIOHCPC project teams.

This document discusses the importance of integrating oral health care into primary care, provides information about the implementation of the PIOHCPC project, details project findings and strategies to integrate oral health care into primary care, and highlights TA activities provided to and feedback received from project teams.

¹ NPM 13 includes two measures: (1) NPM 13.1 (percentage of women who had a preventive dental visit during pregnancy) and (2) NPM 13.2 (percentage of children and adolescents ages 1–17 who had a preventive dental visit in the last year).

Background



In 2000, *Oral Health in America: A Report of the Surgeon General* was released. It emphasized that oral health is integral to overall health and should not be viewed as separate from overall health.¹ Since then, several reports have highlighted integrating oral health care into primary care as a promising strategy to expand access to oral health care and reduce health inequities; improve care coordination, health outcomes, and patient satisfaction; and reduce health care costs. In 2011, the Institute of Medicine published two reports, *Advancing Oral Health in America* and *Improving Access for Oral Health for the Vulnerable and Underserved*, which recommended that HRSA address the need for improved access to oral health care through the development of a core set of oral health competencies for non-oral-health professionals.^{2,3} In response to these reports, HRSA released *Integration of Oral Health and Primary Care Practice*, which provides interprofessional oral health core clinical competencies to facilitate change in the clinical practice of primary care health professionals (PCPs) working in safety net settings.⁴ Health professionals providing primary care for pregnant women, children, and

adolescents include family physicians, pediatricians, obstetricians, nurse midwives, nurse practitioners, and physician assistants.

Pregnancy is a unique period during a woman's life and is characterized by complex physiological changes, which may adversely affect oral health. Access to preventive oral health care is essential for pregnant women to have the best possible oral health and overall health. In many states, pregnant women with low incomes are eligible for Medicaid dental coverage that they don't have during other periods of their lives.⁵ Since non-oral-health professionals (e.g., obstetricians, family physicians, nurse midwives) are often first to assess pregnant women's health, they play a critical role in connecting women with the oral health care system and community-based programs.⁶ These professionals can integrate oral health care (e.g., risk assessment, screening, preventive intervention, anticipatory guidance and counseling, referral to an oral health professional) into primary care visits, thereby increasing access to oral health care during the perinatal period.⁷

Maternal oral health also has implications for infant oral health.⁸ Hormonal and immunologic changes make pregnant women susceptible to oral health problems that can affect infant oral health. Bacteria that cause dental caries primarily pass from mother to child via saliva-sharing activities, such as sharing spoons.⁸ Optimal maternal oral hygiene during the perinatal period may decrease the amount of caries-producing bacteria. Therefore, oral health interventions targeting women before, during, and after pregnancy can help prevent or reduce the risk of dental caries in their children.

Young children are seen by PCPs more often than by oral health professionals. It is recommended that children and adolescents have 12 preventive pediatric health care (well-child) visits in the first 36 months of life and an annual well-child visit between ages 3 and 21.⁹ During these visits, PCPs frequently confront morbidity associated with dental caries.¹⁰ Well-child visits offer an opportunity to integrate oral health care (e.g., risk assessment, screening, preventive intervention, anticipatory guidance and counseling, referral to an oral health professional) into pediatric health care. Such integration, in turn, can increase access to oral health care, thereby improving oral health.¹¹ With early referral to an oral health professional, there is an opportunity to maintain good oral health, prevent oral disease, and treat oral disease early. Establishing collaborative relationships between PCPs and oral health professionals at the community level is essential for increasing access to oral health care for all children and adolescents and for improving their oral health and overall health.¹⁰

Integrating oral health care into primary care is a key strategy for improving access to oral health care, especially for vulnerable and underserved groups that face barriers to accessing oral health care.



Implementation of the PIOHCPC Project

Project Team Selection

Selection of project teams was completed through a competitive application process. Eligibility criteria included:

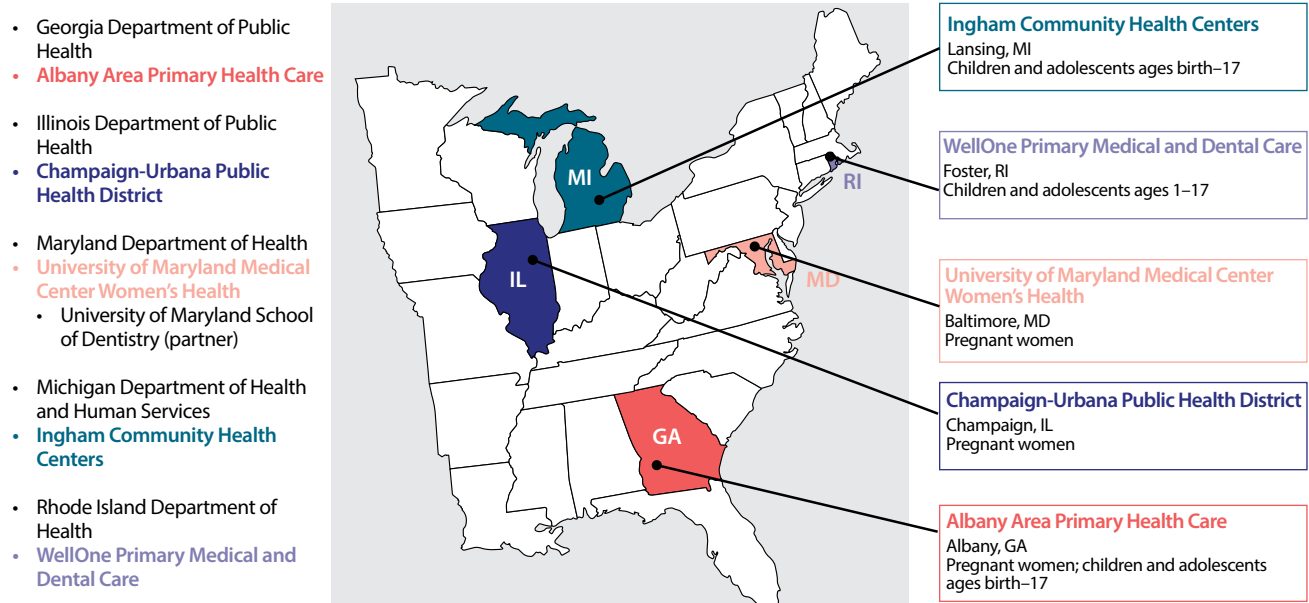
- State Title V MCH agency addressing NPM 13 and implementing strategies to improve access to oral health care in primary care settings.
- A project team to include at least one state staff member working on NPM 13 (e.g., dental director, designated staff) and at least two staff members from the selected primary care setting.
- One local primary care setting that is implementing strategies to integrate oral health care into primary care and is interested in integrating the interprofessional oral health core clinical competencies into practice.

Applicants were required to complete a project application that included a primary care setting readiness assessment and project budget. The

readiness assessment considered factors that foster the integration of oral health care into primary care, including leadership vision and support, oral health representation on the leadership or management team, staff buy-in and champions, current level of integration of oral health care into primary care, health information technology, and patient-enabling services. OHRC used a rubric to evaluate and score project applications.

Project teams were selected from five states—Georgia, Illinois, Maryland, Michigan, and Rhode Island—to participate in project period 1 from January through June 2019. All project teams continued in project period 2 from July 2019 through June 2020, and all except Rhode Island continued in project period 3 from July 2020 through June 2021. The Rhode Island project team was unable to continue participating in the project because the primary care setting had to shift its focus to activities related to the COVID-19 pandemic and away from supplemental projects like PIOHCPC.

Figure 1: Project Teams, Primary Care Setting Locations, and Populations of Focus



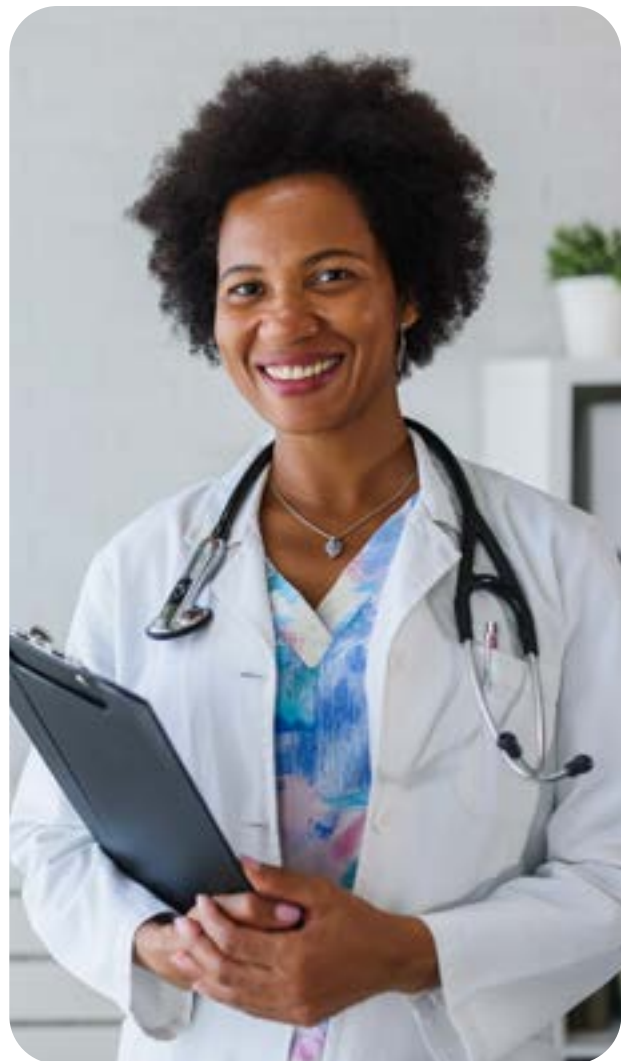
Project populations of focus included pregnant women, children, and adolescents. Project settings included community health centers (CHCs), a local public health department, and a university-based women's health center (see Figure 1: Project Teams, Primary Care Setting Locations, and Populations of Focus).

Oral Health Education for Primary Care Health Professionals

During project period 1, PCPs involved in the PIOHCPC project were required to complete at least two *Smiles for Life: A National Oral Health Curriculum (SFL)* courses based on their project population of focus and to submit certificates of completion by January 31, 2019. Fifty-eight courses were completed by 19 PCPs. Course 1: Oral to Systemic Health and Course 2: Child Oral Health were the most frequently completed courses, followed by Course 3: Adult Oral Health, Course 5: Oral Health for Women: Pregnancy and Across the Lifespan, and Course 6: Caries Risk Assessment, Fluoride Varnish, and Counseling.

A 3-month follow-up feedback form was sent to PCPs who completed *SFL* courses to gather information about the value of the content in influencing oral health practices. Thirteen PCPs completed the feedback form. A summary of results is below.

- All respondents strongly agreed or agreed that course content reinforced the importance of oral health to a patient's overall health and well-being, increased their awareness of and familiarity with oral health issues in their patients, and increased their confidence in integrating oral health care into primary care.
- Seventy-seven percent of respondents strongly agreed or agreed that course content helped reduce barriers to incorporating oral health care into primary care.
- Sixty-two percent of respondents strongly agreed or agreed that integrating oral health care into primary care, as reviewed and/or learned in the courses, improved their patients' oral health outcomes, while 38 percent were undecided/neutral.



- The majority of PCPs strongly agreed or agreed that course content helped them integrate each interprofessional oral health core clinical domain.

Additional feedback from PCPs about *SFL* courses included the following:

- “It was a great learning experience.”
- “Terrific material not covered at all during my medical training.”
- “Understanding [the] connection of oral health with systemic health; integrating the oral exam into the general wellness exam.”

Project Measures

Project measures were developed in collaboration with MCHB project officers and HRSA’s chief dental officer to align with the interprofessional oral health core clinical competencies. Project measures 1–5 remained the same for all project periods (see Table 1: Project Measures for Project Periods 1–3). Measure 6 was added as an optional measure for project periods 2 and 3 in an effort to determine if oral health referrals resulted in initial oral health visits (i.e., closing the loop). Only the Maryland project team reported data on measure 6 (during project period 3) and only for referrals that could be tracked to their primary oral health referral site. The Georgia, Illinois, Michigan, and Rhode Island projects did not report data on measure 6, either because it was not required or because they lacked adequate systems to track oral health referrals. In project period 2, project teams transitioned from submitting monthly data via an Excel worksheet to submitting data via a cloud-based Google spreadsheet that allowed all state- and local-level team members to access project data at any time to share with stakeholders. Data were displayed in both table and graph formats and used for tracking project progress and setting monthly goals.

Project Findings

The Georgia, Illinois, Maryland, and Michigan project team leads shared final project feedback in April 2021 about their top project accomplishments, challenges, lessons learned, efforts to overcome key challenges, adaptations made to continue to integrate oral health care into primary care in response to the COVID-19 pandemic, and top project activities that will be sustained or continued. The Rhode Island project team leads shared final project feedback at the end of project period 2 about their top project accomplishments, challenges, lessons learned, and top project activities that have been or will be sustained. Project data and key findings for each of the five project teams are presented below.

Because of the COVID-19 pandemic and changes in direct patient care and primary care setting foci (e.g., transition from in-person to virtual visits, redeployment of staff and changes in responsibilities, policy requiring masks during visits, COVID-19 testing and vaccination), project operations and delivery of oral health care fluctuated monthly within primary care settings and in some cases ceased altogether from March 2020 through April 2021.

Table 1: Project Measures for Project Periods 1–3

| | |
|--|--|
| Domain 1: Risk Assessment | Measure 1: Patients in population of focus (POF) with a documented oral health risk assessment by a PCP. |
| Domain 2: Oral Health Evaluation | Measure 2: Patients in POF with a documented oral health screening by a PCP. |
| Domain 3: Preventive Intervention | Measure 3: Patients in POF with a documented fluoride varnish application in the primary care setting. |
| Domain 4: Communication and Education | Measure 4: Patients in POF with documentation of receiving oral health education (e.g., feeding/eating practices, oral hygiene practices) by a PCP. |
| Domain 5: Interprofessional Collaborative Practice | Measure 5: Patients in POF with a documented referral by a PCP to an oral health professional. Measure 6: Patients in POF with a documented referral by a PCP to an oral health professional who had an initial oral health visit (e.g., preventive, diagnostic, restorative treatment) (optional measure). |



Project Findings—Georgia

Project Team

Albany Area Primary Health Care (AAPHC) (CHC)
Georgia Department of Public Health (GDPH)

Population of Focus

Pregnant women and children and adolescents from birth through age 17

Top Project Accomplishments

- Transitioned from the American Dental Association's (ADA's) caries risk assessment form to the American Academy of Pediatrics' (AAP's) oral health risk assessment for children and adolescents and integrated that assessment into the social history section of eClinicalWorks, the electronic health record (EHR) used by AAPHC.
- Transitioned from ADA's caries risk assessment form to project-identified oral health risk assessment questions for pregnant women and integrated the questions into the social history section of eClinicalWorks. Used questions developed by the Maryland project.

- Created a standing order for nurses to provide referrals during the triage process. If a patient answers "yes" to one of two oral health questions, a referral is made by the nurse. Questions include: "Do you currently have a dentist?" and "Have you seen a dentist in the last 6 months?"
- Integrating oral health care into primary care increased referrals and warm hand-offs to the oral health care team.
- Trained PCPs to use current dental terminology (CDT) codes for oral health risk assessment, screening, fluoride varnish, and education provided.

Top Project Challenges and Lessons Learned

- PCPs were not completing ADA's caries risk assessment form routinely in eClinicalWorks for pregnant women, children, and adolescents. Feedback from PCPs was that the form was too long and technical (i.e., better understood by oral health professionals than PCPs). To address this challenge, AAPHC transitioned from ADA's oral health risk assessment to AAP's oral health risk assessment for children and adolescents, and the project identified oral health risk assessment questions for pregnant women.



- PCPs frequently forgot to routinely document CDT codes for oral health care in eClinicalWorks because they were not used to enter dental codes. To address this challenge, PCPs were reminded to document CDT codes for oral health care during monthly project meetings and morning huddles. A reminder sheet listing CDT codes was developed and placed next to data-entry computers.
- There was no additional reimbursement for oral health care provided by PCPs outside prospective payment system Medicaid rates for well-child and prenatal visits. Enhanced reimbursement for oral health care may have served as an incentive to provide oral health care and enter CDT codes.
- Medical insurance clerks were removing CDT codes from medical claims because they were dental codes and not medical codes. To address this challenge, medical insurance clerks were instructed to deselect CDT codes on medical claims to retain data.
- All projects, activities, and initiatives in early stages were deprioritized because of the COVID-19 pandemic. The PIOHCPC project required a significant amount of buy-in and coordination among PCPs, and the COVID-19 pandemic resulted in a big step back for relationship-building.

- It was difficult to document and track oral health referrals, warm hand-offs, and follow-up to ensure that referrals resulted in dental visits (i.e., closing the loop), as these are not automated and depend on several human contacts.

Adaptations Made by the Project to Continue to Integrate Oral Health Care into Primary Care in Response to the COVID-19 Pandemic

- PCPs were hesitant to provide oral health screenings and fluoride varnish applications, so they began taking patients to the dental operator within the primary care facility to receive oral health care from the dental hygienist embedded in the CHC.
- The state oral health program continued to provide oral health resource bags for pregnant and postpartum women through established partnerships (i.e., care management organizations; Healthy Mothers Healthy Babies regional coordinators; home visitors; public health nurses; private practice nurses; Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics; Department of Family and Children Services local offices; Georgia Obstetrical and Gynecological Society).



Top Project Activities That Will Be Sustained or Continued

- Sustain all oral health care integration into primary care activities.
- Continue to work with PCPs on documenting CDT codes in eClinicalWorks.
- Continue to educate PCPs using *SFL*.
- Continue to enhance CenteringPregnancy group prenatal care program.

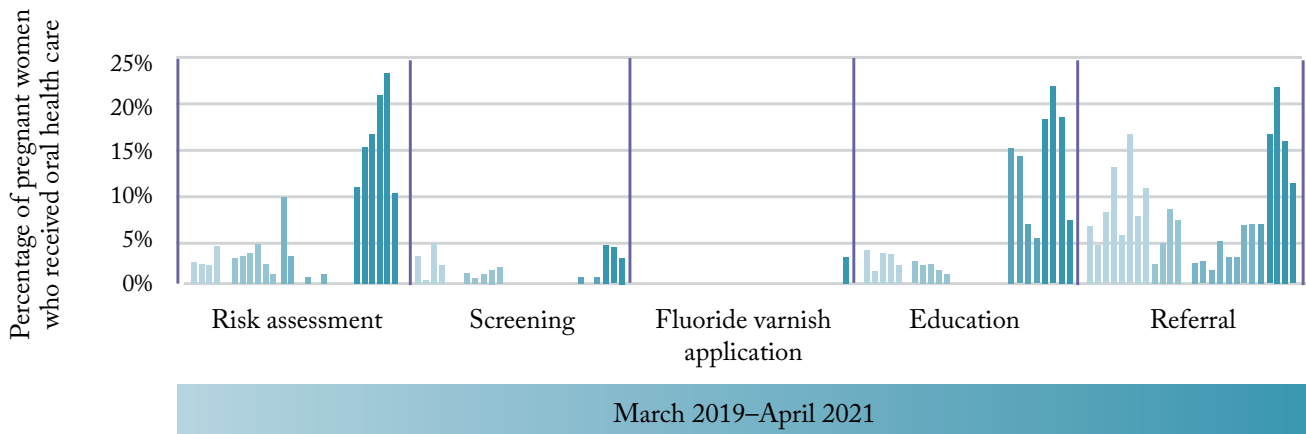
Other Noteworthy Project Activities

- The state dental director at GDPH invited AAPHC to share their model with the Georgia Oral Health Coalition and its stakeholders. This led to a relationship with the Grady Hospital general practice residency program, which allowed for a new residency rotation at AAPHC.
- In July 2020, the administration and management of the CenteringPregnancy program transitioned from the county’s local health department to AAPHC. The program

connected with the Maryland team to learn about their long-standing CenteringPregnancy group prenatal program.

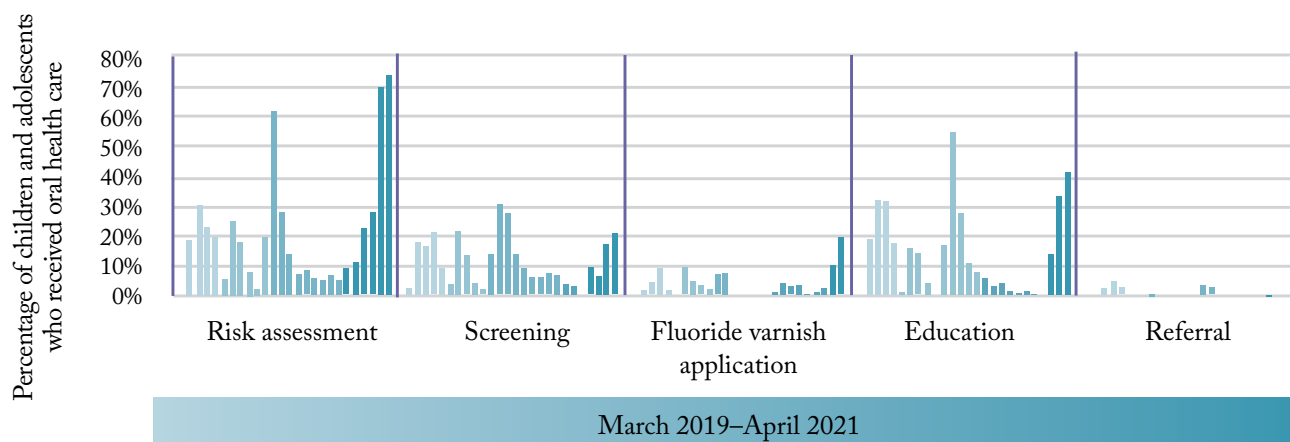
- In partnership with the Maryland PIOHCPC project, prepared and presented the Five Replicable Strategies to Effectively Integrate Oral Health Care into Prenatal Care roundtable at the National Oral Health Conference (2021).
- With support from the American Rescue Plan Act, AAPHC is planning to build a clinic in Terrell County, Georgia, that will include primary care, oral health, podiatry, optometry, and behavioral health services. Oral health training, workflows, and data processes and lessons learned from the PIOHCPC project will inform oral health integration into primary care activities at the new site.
- Georgia selected NPM 13.1 (percentage of women who had a preventive dental visit during pregnancy) and NPM 13.2 (percentage of children and adolescents, ages 1–17, who had a preventive dental visit in the past year) to address in fiscal year 2021.

Table 2: Georgia Project Data, Pregnant Women (March 2019–April 2021)



Note: Range was 67–139 pregnant women seen per month (project period 3).

Table 3: Georgia Project Data, Children and Adolescents (March 2019–April 2021)



Note: Range was 81–492 children and adolescents seen per month (project period 3).

Key Findings from Project Data

(See Table 2: Georgia Project Data, Pregnant Women, and Table 3: Georgia Project Data, Children and Adolescents)

- Oral health risk assessments, education, and referrals were provided most frequently for pregnant women (with some improvement during the second half of project year 3) and oral health screenings and fluoride varnish applications were provided infrequently or not at all for pregnant women. Oral health referrals were provided less often for children and adolescents compared with referrals for pregnant women. Because of data challenges noted above, project data may not accurately reflect actual oral health care provided.
- When the primary care setting project team lead was asked on the final project feedback questionnaire, “On a scale of 1 to 10, to what extent has your project integrated [risk assessment; screening; fluoride varnish application; education; referral] into primary care practice for pregnant women?” responses included: risk assessment–6, screening–7, fluoride varnish application–[skipped], education–8, and referral–9.
- When the primary care setting project team lead was asked on the final project feedback questionnaire, “On a scale of 1 to 10, to what

extent has your project integrated [risk assessment; screening; fluoride varnish application; education; referral] into primary care practice for children and adolescents?” responses included: risk assessment–7, screening–7, fluoride varnish application–7, education–8, and referral–7.





Project Findings—Illinois

Project Team

Champaign–Urbana Public Health District (C-UPHD) (local health department)
Illinois Department of Public Health (IDPH)

Project Population of Focus

Pregnant women

Top Project Accomplishments

- The state dental director at IDPH developed the white paper *Next Steps in Oral Health: Case for Fluoride Varnish Reimbursement for Children and Pregnant Women*. The paper was presented to Illinois’s managed care organizations (MCOs) and Bureau of Managed Care to encourage policy change to expand fluoride varnish coverage for children ages 3–6 and pregnant women to be provided by both medical and oral health professionals.
- Developed an oral health risk assessment form and integrated it into every WIC visit with

pregnant and postpartum women (see Appendix 1: Oral Health Assessment and Integration).

- In May 2021, C-UPHD provided approval for all five dental hygienists working at its pediatric dental clinic to complete training (i.e., 42 hours in advanced areas specific to public health dentistry) to become certified as public health dental hygienists. This first step is necessary to establish a dental hygienist–embedded model for C-UPHD, Division of Maternal and Child Health WIC clinic.
- Based on discussions during project check-in calls, IDPH will be conducting a Basic Screening Survey of pregnant women in fall 2021. Input on the survey questions and process was gathered from IDPH Title V staff and C-UPHD. Survey findings should provide an understanding of barriers to receiving oral health care and may be combined with data from other state sources to help inform policy change and programmatic efforts. IDPH plans to share survey results and data with Medicaid MCOs to better target women of childbearing age, pregnant women, and health professionals.



Adaptations Made by the Project to Continue to Integrate Oral Health Care into Primary Care in Response to the COVID-19 Pandemic

- Transitioned to providing oral health risk assessments, education, and referrals during virtual WIC visits.

Top Project Activities That Will Be Sustained or Continued

- Continue to promote *SFL* and other oral health training opportunities at C-UPHD, especially for new staff.
- IDPH and C-UPHD will continue their partnership to spread the program to other public health settings in Illinois.
- All five dental hygienists at C-UPHD will complete training to become certified as public health dental hygienists. This is the first step in establishing a dental hygienist–embedded model for C-UPHD’s WIC clinic.
- Illinois selected NPM 13.1 (percentage of women who had a preventive dental visit during pregnancy) and NPM 13.2 (percentage of children and adolescents, ages 1–17, who had a preventive dental visit in the past year) to address in fiscal year 2021. These measures will be included in the Illinois Oral Health Plan (2021–2025) and monitored on an annual basis.

Top Project Challenges and Lessons Learned

- Because of the COVID-19 pandemic, all programs, including WIC, within C-UPHD’s Division of Maternal and Child Health transitioned to curbside and virtual, and oral health care was temporarily discontinued from March through August 2020. Staff were reassigned to providing coverage for COVID-19-related activities for periods of time, making it difficult to sustain the integration of oral health care during WIC visits. It is anticipated that in-person WIC visits will start again in August 2021.
- Finding dentists who participate in Medicaid and are willing to see pregnant women is an ongoing challenge. The COVID-19 pandemic further reduced the capacity of dental offices and clinics to see pregnant women with low incomes. To address this challenge, C-UPHD worked collaboratively with a local dental association to provide COVID-19 vaccinations to oral health professionals, which helped build relationships and improve trust. C-UPHD will leverage these relationships in an effort to expand its oral health referral network for pregnant and postpartum women.
- Staffing changes and shortages are ongoing challenges at C-UPHD.
- Accessing oral health care during pregnancy is a challenge for many pregnant women.



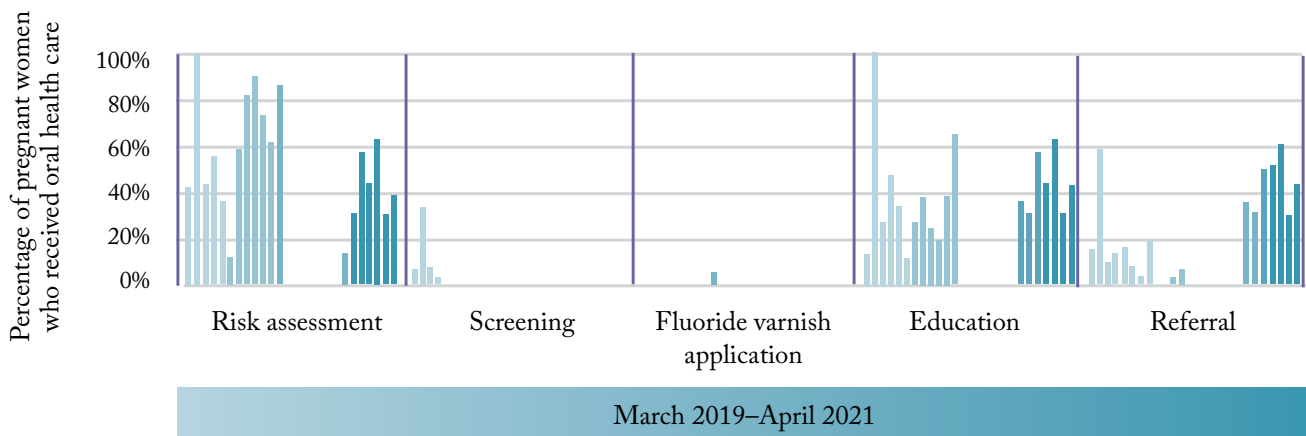
Other Noteworthy Project Activities

- The C-UPHD Division of Maternal and Child Health received \$15,000 in supplemental funding from IDPH’s Title V program for project activities for project period 2.
- In April 2021, Illinois Medicaid extended health benefits, including oral health benefits, from 60 days to 12 months postpartum, following the Centers for Medicare & Medicaid Services approval of Illinois’s 1115 waiver. Note: In July 2018, Illinois Medicaid expanded dental benefits to

include prophylaxis, periodontal maintenance, and scaling and root planing procedures for all adults. This policy change allows access to these oral health services during the preconception period.

- Two of Illinois’s six MCOs are disseminating newsletters to oral health professionals and pregnant women about the importance of oral health care during pregnancy.
- Illinois Medicaid enhanced payments for oral health care for local health department dental programs.

Table 4: Illinois Project Data, Pregnant Women (March 2019–April 2021)



Note: Range was 0–73 pregnant women seen per month (project period 3).

Key Findings from Project Data

(See Table 4: Illinois Project Data, Pregnant Women)

- No oral health care was provided from March through September 2020 because of WIC clinic restrictions related to the COVID-19 pandemic, and only oral health risk assessment, education, and referrals were provided from October 2020 through April 2021 because the WIC clinic was providing oral health care virtually versus in person.
- Oral health risk assessments, education, and referrals were provided virtually (primarily by

phone) to pregnant women from October 2020 through April 2021.

- When the primary care setting project team lead was asked on the final project feedback questionnaire, “On a scale of 1 to 10, to what extent has your project integrated [risk assessment; screening; fluoride varnish application; education; referral] into primary care practice for pregnant women?” responses included: risk assessment–10, screening–5, fluoride varnish application–6, education–10, and referral–8.



Project Findings—Maryland

Project Team

University of Maryland Medical Center Women’s Health (UMWHC) (university-based clinic)
 Maryland Department of Health, Office of Oral Health
 University of Maryland School of Dentistry (UMSOD)

Project Population of Focus

Pregnant women

Top Project Accomplishments

- All nine nurse midwives completed *SFL* courses.
- Added six questions to the oral health risk assessment that previously included only one question about whether the last dental visit was over 1 year ago. Risk assessment questions are asked during initial nurse intake visits with pregnant women. Oral health education is provided and referral is made, if needed.
- Developed and started using dot phrases (i.e., smart phrases) in Epic, UMWHC’s EHR, to document oral health care provided to pregnant women.

Risk Assessment Questions (Y/N)

1. Have you had your teeth cleaned in the past 12 months?
2. Do you currently have a dentist? If yes, list dentist:
3. Do you have any dental problems or concerns?
Does anything hurt? Explain:
4. Do you have sugary foods or drinks between meals (including juice, soda, energy drinks)?
5. Do you brush your teeth with fluoride toothpaste?
6. Do you drink water from the tap/faucet?

- Added oral health to the pregnancy guide for pregnant women and the educational roadmap checklist for PCPs. The roadmap standardizes the content of oral health education and the timing for providing education and follow-up during prenatal visits. This now occurs during the prenatal visit between 15 and 21 weeks of pregnancy. PCPs use the alpha-fetoprotein screening test, offered during this gestational period, as a reminder to address oral health.
- UMSOD developed a weekly dental clinic for pregnant women referred from UMWHC to expedite appointment scheduling and streamline delivery of care.



- UMWHC and UMSOD established a closed-loop system for oral health referrals. UMSOD adds notes to the referral form, including clinical findings and whether the patient reported for their dental visit (see Appendix 2: Dental Referral Form for Pregnant Women). The referral forms are scanned and sent back to UMWHC via secure e-mail. Forms are uploaded into patient charts in Epic so prenatal care health professionals can follow up with patients at subsequent prenatal visits. Also, every 2 to 3 weeks, UMSOD sends a detailed spreadsheet with all information to UMWHC.
- Enhanced UMSOD dental and dental hygiene students' clinical education experiences and knowledge and understanding of oral health during pregnancy, Medicaid oral health coverage, and social determinants of health.

Top Project Challenges and Lessons Learned

- There was a reduction in oral health referrals due to the COVID-19 pandemic, since UMSOD and local dentists temporarily discontinued all elective and preventive oral health care and were providing only emergency care until August 2020.
- UMSOD dental visit cancellations and pregnant women failing to show up for appointments is an ongoing challenge.
- Ensuring that prenatal care health professionals remember to educate pregnant women about oral health is an ongoing challenge. To address this challenge, UMWHC standardized the content of oral health education and the timing for providing education during prenatal visits.
- Buy-in from PCPs to apply fluoride varnish on pregnant women's teeth is an ongoing challenge (even independent of the COVID-19 pandemic).
- There is no connection between UMWHC's EHR, named Epic, and UMSOD's electronic dental record (EDR), named Axium. To address this challenge, UMWHC and UMSOD created a workaround to send oral health referrals back and forth via a secure e-mail server.



Adaptations Made by the Project to Continue to Integrate Oral Health Care into Primary Care in Response to the COVID-19 Pandemic

- Implemented a policy under which pregnant women, PCPs, and staff had to wear masks 100 percent of the time. Oral health screenings were conducted only if the pregnant woman reported pain and only if the PCP wore an N95 mask. N95 masks were prioritized for inpatient sites, so at the beginning of the pandemic, the availability of N95 masks was limited in ambulatory settings. UMWHC adapted to this policy change by focusing project efforts on services that were most feasible during the COVID-19 pandemic (i.e., oral health risk assessments, education, referrals).
- Shifted certain individual prenatal care as well as CenteringPregnancy group prenatal care and educational baby shower visits to Zoom.

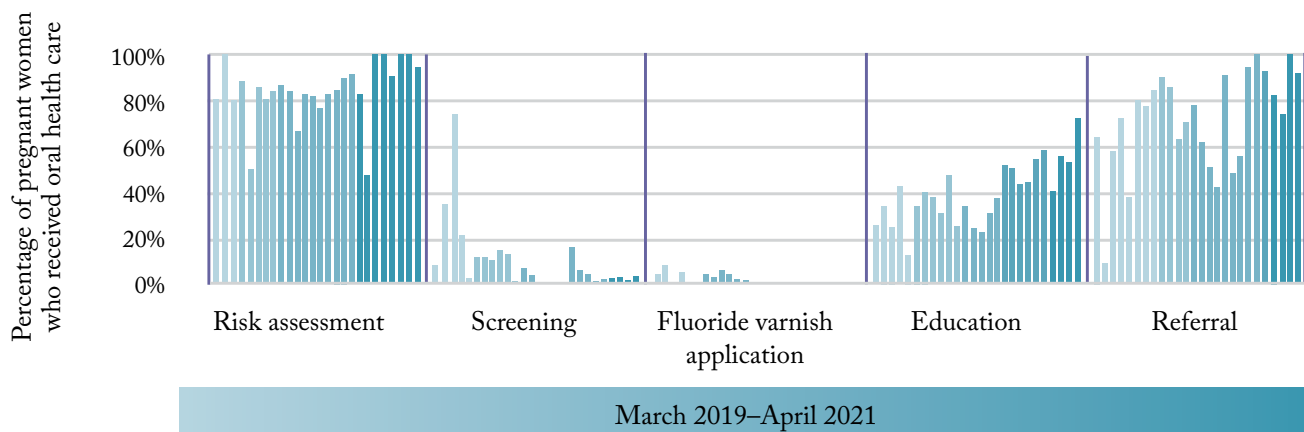
Top Project Activities That Will Be Sustained or Continued

- UMSOD will receive continued funding (\$30,000) beyond the PIOHCPC project in fiscal year 2022 from the Maryland Department of Health, Office of Oral Health, to provide case-management services for pregnant women referred from UMWHC.
 - UMWHC will enhance its partnership with UMSOD's Ryan White Program to refer pregnant patients with HIV/AIDS to UMSOD.
 - UMWHC will expand oral health integration activities to include medical residents.
 - UMWHC and UMSOD will continue to revise the oral health feedback section (i.e., Section B) of the referral form to include only information that UMWHC needs to follow up with pregnant women.
 - UMWHC and UMSOD will continue to discuss the sustainability of case-management services in the absence of state grant funding.
- The Maryland Department of Health selected NPM 13.1 (percentage of women who had a preventive dental visit during pregnancy) to address in fiscal year 2021.
 - Maryland will expand Medicaid postpartum coverage for all health services, including oral health services, from 60 days to 1 year, starting in 2022. This expansion builds upon recent policy changes to add oral health services to Medicaid's 60-day postpartum coverage for all health services. Currently, Medicaid oral health care coverage for pregnant women ends at the conclusion of pregnancy.

Other Noteworthy Project Activities

- UMSOD received \$25,000 (project period 2) and \$30,000 (project period 3) in funding from the Maryland Department of Health, Office of Oral Health, to provide case-management services for pregnant women referred from UMWHC.
- In partnership with the Georgia project team, UMSOD prepared and presented the *Five Replicable Strategies to Effectively Integrate Oral Health Care into Prenatal Care* roundtable at the National Oral Health Conference (2021).
- The Maryland Dental Action Coalition, UMSOD, and UMWHC developed and submitted a \$10,000 partnership development grant proposal to the Johns Hopkins Institute for Clinical & Translational Research, Community Collaboration Core pilot grant program. Funding would support an interprofessional and consumer prenatal/postpartum advisory board to (1) identify strategies to increase access to and utilization of oral health care for pregnant and postpartum women and their infants, (2) develop research questions based on knowledge gaps in identified strategies, and (3) develop a plan for research with community partnerships. The proposal was developed in response to recent expansion of Medicaid coverage for oral health care from 60 days to 1 year postpartum and to a 2019 law that allows dental hygienists to work in medical settings in Maryland.

Table 5: Maryland Project Data, Pregnant Women (March 2019–April 2021)



Note: Range was 86–124 pregnant women seen per month (project period 3).

Key Findings from Project Data

(See Table 5: Maryland Project Data, Pregnant Women)

- Few oral health screenings and no fluoride varnish applications were provided from March 2020 through April 2021 because of a COVID-19 clinic policy that all pregnant women must wear a mask during prenatal visits.
- Oral health risk assessments, education, and referrals were routinely provided for pregnant women.
- Of the 212 pregnant women referred from UMWHC to UMSOD from July 2020 through April 2021, 69 (33 percent) had at least an initial oral health visit at UMSOD. UMSOD provided all pregnant women who received a referral with case-management services.
- When the primary care setting project team lead was asked on the final project feedback questionnaire, “*On a scale of 1 to 10, to what extent has your project integrated [risk assessment; screening; fluoride varnish application; education; referral] into primary care practice for pregnant women?*” responses included: risk assessment–10, screening–3, fluoride varnish application–1, education–7, and referral–10.





Project Findings—Michigan

Project Team

Ingham Community Health Centers, Cedar Pediatrics (CHC)
 Michigan Department of Health and Human Services
 Michigan Primary Care Association (key partner)

Population of Focus

Children and adolescents from birth through age 17

Top Project Accomplishments

- Established a requirement that all incoming and current pediatric medical residents complete *SFL* courses.
- Established a requirement that all pediatric medical residents complete yearly in-person training with the dental hygienist embedded in the pediatric clinic.
- All children and adolescents seen for well-child visits received an oral health referral that is documented in NextGen.
- A laminated copy of the AAP oral health risk assessment was placed in every patient room as a resource for PCPs and support staff.

- Incorporated a tracking template in NextGen, the EHR used by Cedar Pediatrics, to document oral health risk assessments, screenings, education, and referrals. Fluoride varnish applications are tracked by code.

Top Project Challenges and Lessons Learned

- The COVID-19 pandemic resulted in temporary discontinuation of oral health screenings and fluoride varnish applications for children and adolescents.
- Because of the COVID-19 pandemic, the dental hygienist embedded in Cedar Pediatrics stopped seeing patients until October 2020, when all enhanced infection-prevention and -control equipment and supplies were obtained.
- Getting health professionals to complete the tracking template in the EHR was a challenge. To address this challenge, the embedded dental hygienist reviews *SFL* training and clinical workflow processes with pediatric medical residents annually and as needed.
- Staff turnover at the health center was high. The information technology staff member who developed the workflow and reporting template resigned during project period 3.



- Communication and scheduling within a very busy and complex organization was challenging. To address this challenge, Cedar Pediatrics added the embedded dental hygienist to daily huddles with PCPs.

Adaptations Made by the Project to Continue to Integrate Oral Health Care into Primary Care in Response to the COVID-19 Pandemic

- The dental hygienist embedded in Cedar Pediatrics stopped going into primary care rooms to provide oral health care. Instead, she escorted children and adolescents to her dental room that had enhanced infection-prevention and -control equipment and supplies.

Top Project Activities That Will Be Sustained or Continued

- Continue requiring all incoming and current pediatric medical residents to complete *SFL* courses and a yearly in-person training with the dental hygienist embedded in Cedar Pediatrics.
- Continue using AAP oral health risk assessment.

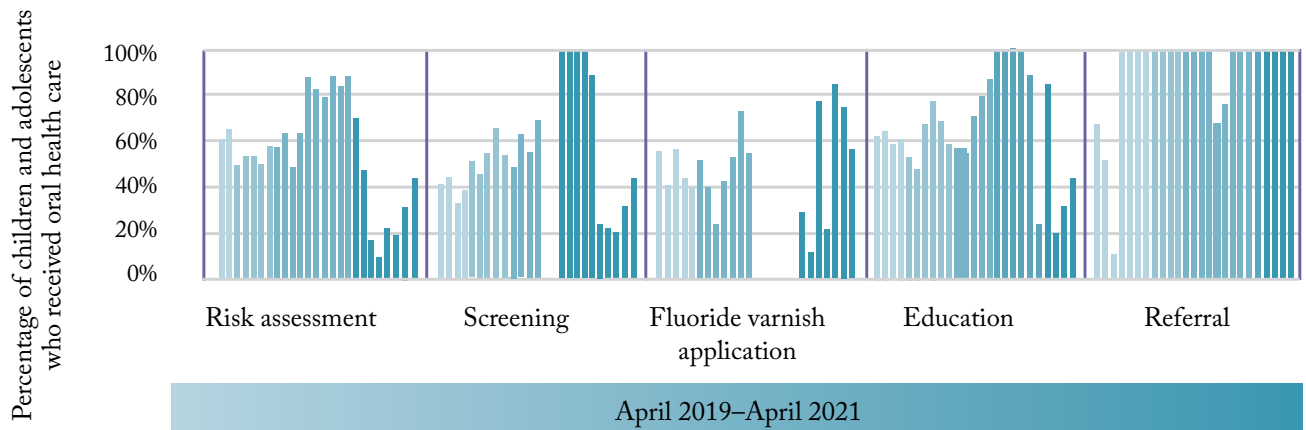
- Continue working in partnership with the Michigan Primary Care Association on oral health referral tracking using Azara, a centralized data analytics and reporting platform for population health management of CHCs in Michigan.
- Continue working to integrate AAP's oral health risk assessment into NextGen to document oral health findings and services provided.
- Michigan selected NPM 13.1 (percentage of women who had a preventive dental visit during pregnancy) and NPM 13.2 (percentage of children and adolescents, ages 1–17, who had a preventive dental visit in the past year) to address in fiscal year 2021.

Other Noteworthy Project Activities

- As part of the MCHB-funded Networks for Oral Health Integration Within the Maternal and Child Safety Net project, a community health worker was hired in April 2021 to provide follow-up on referrals and case management services for children and adolescents. This will help ensure that oral health referrals result in oral health visits (i.e., close the loop).



Table 6: Michigan Project Data, Children and Adolescents (April 2019–April 2021)



Note: Range was 86–124 pregnant women seen per month (project period 3).

Key Findings from Project Data

(See Table 6: Michigan Project Data, Children and Adolescents)

- Oral health care provided by PCPs fluctuated monthly from March 2020 through April 2021 because of disruptions due to the COVID-19 pandemic.
- Oral health referrals were the type of oral health care provided most often for children and adolescents.

- When the primary care setting project team lead was asked on the final project feedback questionnaire, “On a scale of 1 to 10, to what extent has your project integrated [risk assessment; screening; fluoride varnish application; education; referral] into primary care practice for children and adolescents?” responses included: risk assessment–7, screening–7, fluoride varnish application–9, education–9, and referral–9.





Project Findings—Rhode Island

(Note: Participated in project periods 1 and 2 only)

Project Team

WellOne Primary Medical and Dental Care (CHC)
Rhode Island Department of Health

Population of Focus

- Children and adolescents ages 1–5 (project period 1)
- Children and adolescents ages 1–17 (project period 2)

Top Project Accomplishments

- Developed a clinical workflow that includes attaching AAP’s oral health risk assessment tool to patients’ charts to ensure that PCPs complete the tool.
- Provided oral health training to new PCPs as they were onboarded.

- Developed an effective system using a manual spreadsheet to track oral health referrals.

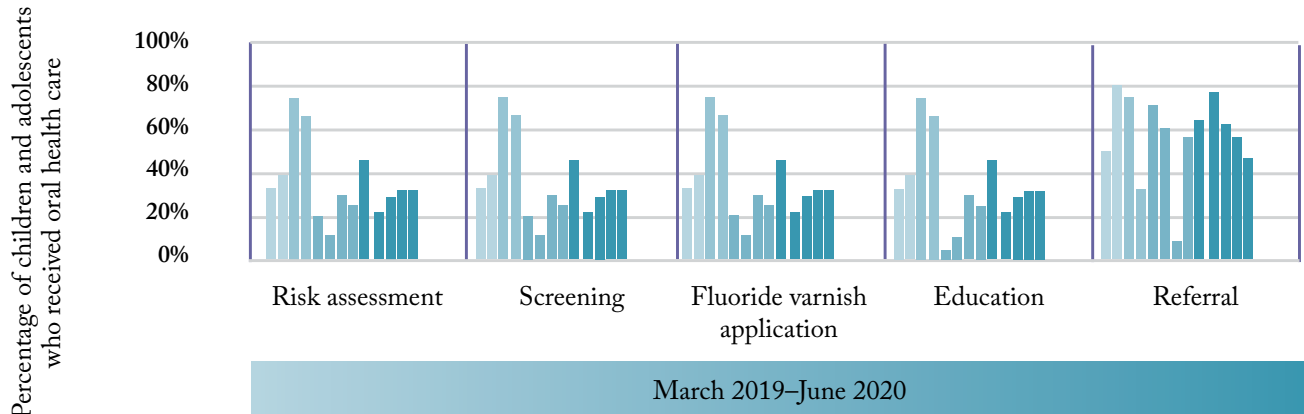
Top Project Challenges and Lessons Learned

- Trying to find a practical way to close interdepartmental referrals.
- COVID-19 affected project operations from March through June 2020, as all preventive medical and dental visits stopped.

Top Project Activity That Has Been or Will Be Sustained

- Planning to sustain the clinical workflow at WellOne’s participating primary care setting and expand oral health integration work to WellOne’s other three primary care settings.
- Rhode Island did not select an NPM 13 measure to address in fiscal year 2021.

Table 7: Rhode Island Project Data, Children and Adolescents (March 2019–June 2020)



Note: Range was 12–41 children and adolescents seen per month (project period 2).

Key Findings from Project Data

(See Table 7: Rhode Island Project Data, Children and Adolescents)

- Oral health risk assessment, screenings, fluoride varnish, education, and referrals were provided fairly consistently, with referrals provided most often.
- At least 20 percent of children and adolescents received risk assessment,

screenings, fluoride varnish, education, and referrals in all domains almost all months in the reporting period, with 50 percent or more of children and adolescents receiving referrals for all but one month between July 2019 and March 2020.

- Because of the COVID-19 pandemic, project operations stopped from April through June 2020.





Technical Assistance to Project Teams

OHRC, with assistance from NNOHA, supported PIOHCPC project implementation by providing TA to project teams using a learning collaborative (LC) approach. Aspects of the Emergent Learning (EL) Framework and The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement (Breakthrough Series) were used. The EL Framework helps identify innovative ideas or models for addressing program and system issues, and the Breakthrough Series provides a framework to implement and test ideas or models, refine approaches to change, and share what was learned with colleagues working toward common aims. This approach allows LC members to learn from one another and from subject matter experts to make “breakthrough” improvements in systems-level change. Using combined elements for an LC instead of strictly imposing a single framework provides flexibility, especially since organizations involved in oral health care delivery may lack capacity and resources (time, personnel, subject matter expertise). The approach fosters shared learning in a variety of modes at different levels (i.e., local, state).

PIOHCPC learning sessions were conducted using videoconferencing and were project driven, with discussions focused on topics that project teams were addressing in their work. Interactive webinars and workgroups provided project teams with opportunities to talk with one another and share project activities, accomplishments, barriers, and lessons learned. Exchange of ideas among project teams helped drive progress and enabled them to achieve more than any one project could on its own. Individualized TA to project teams was provided via check-in calls held every other month and by sharing information and resources via a project e-mail discussion list, webpage, and private portal.

LC activities were also informed by *A User's Guide for Implementation of Interprofessional Oral Health Core Clinical Competencies: Results of a Pilot Project*, which describes implementation of clinical competencies using a sustainable-systems approach to integrate oral health care into primary care through interprofessional collaborative practice.¹² Additional seminal implementation guides, including *Integration of Oral Health and Primary Care Technical Assistance Toolkit* and *Organized, Evidence-Based Care Supplement: Oral Health Integration*, guided the approach.^{13,14}

Webinar topics in project period 1 focused on systems for implementing a project to integrate oral health care into primary care as described in *A User's Guide for Implementation of the Interprofessional Oral Health Core Clinical Competencies: Results of a Pilot Project*. Webinar topics in project period 2 addressed the provision of oral health care by PCPs and support staff, including how oral health care was documented and tracked using health information technology. Webinar and workgroup topics in project period 3 focused on COVID-19 pandemic project adaptations, workforce issues, and sustainability. For two of the topics in project period 3, separate pediatric and prenatal interactive workgroups were held for projects focusing on the same population (i.e., pregnant women; children and adolescents). Webinar and workgroup topics for project periods 1–3 are listed below.

Topics in Project Period 1 (January through June 2019)

- Oral health training for PCPs.
- Health information technology.
- Clinical care systems.

Topics in Project Period 2 (July 2019 through June 2020)

- Sharing of project period 1 findings and strategies to address challenges related to changing PCP and staff behavior and concerns about time.
- Project sharing and discussion related to clinical workflows, and documenting and tracking oral health care in EHRs.
- Oral health and referral management.
- Motivational interviewing and self-management goal setting.

Topics in Project Period 3 (July 2020 through June 2021)

- COVID-19 pandemic landscapes in states, changes that have been implemented or need to be implemented to integrate oral health care into primary care, and new opportunities for integrating oral health care into primary care.
- Primary care settings' use of telehealth to integrate oral health care into well-child and prenatal visits (pediatric workgroup and prenatal workgroup).
- Strategies to engage or re-engage pediatric and prenatal care health professionals in providing oral health care and to ensure that referrals for oral health care result in dental appointments (pediatric workgroup and prenatal workgroup).
- AAP's Protect Tiny Teeth Toolkit and early learnings from their implementation project, oral health resources for health professionals and consumers being used in primary care settings, and how resources are integrated into clinical workflows.
- Sustaining the integration of oral health care into primary care.



Project Team Feedback

OHRC solicited final feedback from the projects about their satisfaction with participating in the project, provision of TA activities, collaboration with other project teams, and assessment of the level of integration of oral health care into primary care. Project teams also provided feedback on top project accomplishments, challenges, lessons learned, efforts to overcome key challenges, adaptations made to project activities in response to the COVID-19 pandemic, and top project activities that will be sustained or continued. All project teams responded to the questionnaire in April 2021.

Feedback about project satisfaction and the value of the state/local partnership is detailed below and indicates that 100 percent of respondents were very satisfied with participating in the PIOHCPC project. Eighty percent felt the partnership between the state oral health program and local primary care

setting was very important to their project efforts, and 20 percent felt it was important. Examples that highlight the value of the partnership from state oral health program team leads in Georgia and Michigan are included below.

Project Satisfaction

Question: Indicate your level of satisfaction with participating in the PIOHCPC project.

Responses included: Very satisfied–100 percent.

State/Local Partnership

Question: How important has the partnership between the state oral health program and local primary care setting been to your project efforts?

Responses included: Very important–80 percent and Important–20 percent.

The Value of the State/Local Partnership from the State Perspective

Georgia

- Sharing of resources.
- Bi-directional learning.
- Platform and voice to share models with other partners throughout the state.
- Relationship building.
- Future growth and partnership opportunities.

Michigan

- Supports NPM 13 work and Title V data reporting focused on integration of oral health care into primary care.
- PIOHCPC aligns with other state and national MCH health initiatives such as the Michigan Maternal and Infant Oral Health project and Networks for Oral Health Integration project.
- Bi-directional learning and precedent setting.

Technical Assistance Activities

Feedback about satisfaction with TA activities is detailed below and indicates a high level of satisfaction with the various TA activities that were part of the PIOHCPC project. Two comments were shared related to TA activities that could have been enhanced or provided. The first comment was to consider including asynchronous activities, as it can be difficult for busy PCPs and support staff to participate in all meetings. OHRC will consider ways to foster participation among project team leads, PCPs, clinic support staff, and others who are involved in the project (e.g., data analysts, leadership). For example, if project team leads are unavailable, they could identify a representative to participate in their place. OHRC will also remain flexible and available for individualized TA for project teams, as needed.

The second comment mentioned topics that could be enhanced or provided (e.g., effective referral

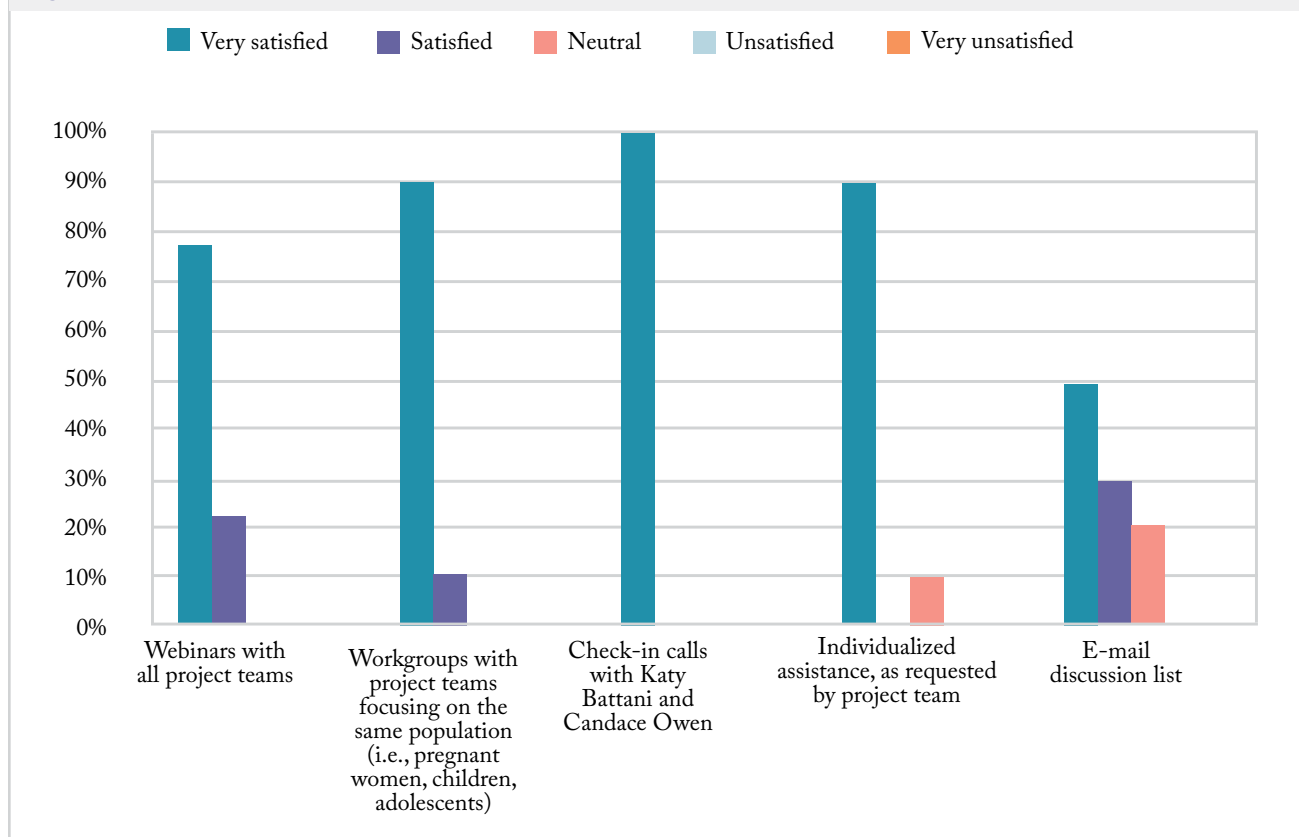
systems, checklists, patient-care-coordination approaches). Oral health and referral management was a webinar topic during project period 2, but more examples of effective oral health referral systems could be shared with and discussed among project teams, along with examples of checklists for PCPs and care-coordination approaches.

Feedback about collaboration with other project teams indicates that 40 percent of respondents collaborated with another project team in some way. This finding is important, as the LC is designed to bring project team members together to build relationships and share ideas, successes, challenges, lessons learned, and resources that can help drive progress.

Question: Indicate your level of satisfaction for each of the following TA activities provided by OHRC.

Responses: See Figure 2 for respondents' level of satisfaction with TA activities.

Figure 2: Level of Satisfaction with Technical Assistance



Question: *Indicate TA activities that could have been enhanced or provided.*

Responses included:

- “It would be nice for the providers to have more asynchronous activities since it can be hard to accommodate meetings with clinical demands.”
- “Examples of effective referral systems, checklists, and patient care coordination approaches.”

Collaboration with Other Project Teams

Question: *Outside of scheduled project activities (e.g., webinars, workgroup), have you collaborated with individuals from other project teams?*

Responses included: Yes—40 percent, No—50 percent, and Can’t remember—10 percent.

Question: *If yes, please describe how you’ve collaborated with individuals from other project teams.*

Responses included:

- Worked with one of the teams to learn how they perform oral health risk assessments on their prenatal patients and my organization has adopted the same risk assessments. This has been very helpful to our team.

- The project allowed me to be introduced to the Rhode Island team. At our breakfast at the National Oral Health Conference in 2019, I sat across from the Rhode Island program manager and learned about a flip book they created for their home visitors on oral health for families they serve. We got approval to rebrand their materials with our logo and create the same flip books and distribute to home visitors throughout the state. It was part of a larger home visiting partnership to incorporate oral health into their education and resources.
- Learned about oral health risk assessment and screening tools developed by other states.
- Worked with the Georgia team on CenteringPregnancy group prenatal care and shared ideas about its oral health components.
- In 2021, the Georgia and Maryland project teams presented *Key Strategies to Effectively Integrate Oral Health Care into Prenatal Care* roundtable at the National Oral Health Conference.

Conclusion



This report highlights PIOHCPC projects' important contributions toward the goal of integrating oral health care into primary care, including top project accomplishments, challenges, lessons learned, and activities that will be sustained or will continue to be developed. It also includes feedback from project teams about their satisfaction with and suggestions to enhance TA activities. Ongoing feedback from project teams has helped structure and improve the LC over time. Input from team members has driven the selection of time-sensitive discussion topics and planning for engaging webinars and workgroups that include interactive activities and use time efficiently to meet project team members' needs.

The goal of the project was to increase access to oral health care by integrating the interprofessional oral health core clinical competencies into primary care settings for pregnant women, children, and adolescents at high risk for oral diseases. Major challenges at the systems level include an insufficient number of dentists enrolled as Medicaid providers and lack of or insufficient Medicaid reimbursement for oral health care provided by PCPs. Other system-level challenges specific to the primary care setting include documenting and tracking oral health care by

PCPs in EHRs, staff turnover, lack of connection between EHRs and EDRs, and obtaining buy-in from PCPs and staff to provide oral health care during primary care visits.

Despite barriers, the projects had notable achievements related to oral health training of PCPs; clinical workflow development; interprofessional collaboration; documenting and tracking of oral health risk assessments, screenings, fluoride varnish applications, education, and referrals; and Medicaid oral health coverage and reimbursement. Primary care setting team members were also able to establish strong partnerships with their state oral health program and/or Title V MCH health program to support and expand upon the success of their work in other settings across the states, an important accomplishment. Findings from this project contribute to the field's understanding of integrating oral health into primary care practice. More work is needed at federal, state, and local levels to ensure that oral health is an integral component of primary care visits to ultimately improve oral health and reduce oral health disparities and inequities for pregnant women, children, and adolescents.

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Appendix 1: Oral Health Assessment and Integration

Client Initials: _____ DOB: _____ Service Date: _____

| Population of Interest | |
|------------------------|-------|
| Pregnant Woman | _____ |
| Postpartum Woman | _____ |

| Contributing Conditions | | | |
|---|------------------------------|-----------------------------|-------------------------------------|
| Dental home Last dental visit: _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| Dental pain (If yes, immediate referral) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Fluoride exposure (through drinking tap water, toothpaste, professional applications, supplements) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unknown <input type="checkbox"/> |
| Sugary foods or drinks between meals (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Flosses daily | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Current smoker | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

| Anticipatory Guidance | | |
|------------------------------|------------------------------|-----------------------------|
| Oral health education | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Nutritional counseling | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Tobacco cessation counseling | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Oral hygiene kit provided | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Services Provided | | |
| Fluoride Varnish | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Other: _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

| Referral (Check all the apply) | |
|--|--|
| <input type="checkbox"/> Immediate within 24-48 hours - to dentist for pain, abscess, swelling or fever | <input type="checkbox"/> Made appointment today |
| <input type="checkbox"/> Within 2 weeks / will follow up with dentist for routine treatment for caries, periodontal disease, broken asymptomatic teeth, dry mouth, suspicious lesion | <input type="checkbox"/> Patient has a dental home |
| Insurance Type: | |
| Staff Signature: | |

Appendix 2: Dental Referral Form for Pregnant Women

SECTION A: PRENATAL PROVIDER TO COMPLETE (SEND TO DENTAL PROVIDER)

| | |
|---|--|
| Patient Referred to: _____ Referral Date: _____ <i>(Dentist Name Practice)</i> | |
| Patient Information: | |
| Name: _____ <i>(Last)</i> _____ <i>(First)</i> | |
| DOB: ____ / ____ / ____ <i>mm dd yyyy</i> | Estimated Delivery Date: ____ / ____ / ____ <i>mm dd yyyy</i> |
| Gestational Age Today: ____ / ____ / ____ <i>mm dd yyyy</i> | |
| Known Allergies and Precautions: <i>(Specify, if any)</i> | |
| The following are considered safe during pregnancy: | |
| Dental Procedures: Oral Examination Dental Prophylaxis Scaling and Root Planing Extraction Dental X-ray with Lead Shielding Local Anesthetic with Epinephrine Root Canal Restorations Fillings | Medications: Amoxicillin Cephalosporins Clindamycin Metronidazole Penicillin Acetaminophen Acetaminophen with Codeine, Hydrocodone, or Oxycodone |
| Patient may NOT have: | |
| NSAIDS and tetracycline, doxycycline or fluoroquinolone classes | |
| REFERRING PRENATAL PROVIDER | |
| Name: University of Maryland Women's Health Center _____ | Signature: _____ |
| Date: _____ | Phone #: _____ |
| Email: _____ | Fax #: () - |

SECTION B: DENTAL PROVIDER TO COMPLETE (RETURN TO PRENATAL PROVIDER)

| | |
|--------------------------------------|------------------|
| Diagnosis: | |
| | |
| Treatment Plan: | |
| | |
| DENTAL PROVIDER | |
| Name: _____ <i>(Please Print)</i> | Signature: _____ |
| Date: _____ | Phone #: () - |

Oral health care is covered by Medicaid for pregnant women in Maryland. To find a dentist who accepts Medicaid, visit: OralHealth4BetterHealth.com

Provided By:



MARYLAND
Department of Health

Published: February 2018