Dental Public Health Project/Activity Descriptive Report Form

Please provide a detailed description of your **successful dental public health project/activity** by fully completing this form. Expand the submission form as needed but within any limitations noted.

NOTE: Please use Verdana 9 font.

CONTACT PERSON PREPARING THE SUBMISSION AND TO ANSWER QUESTIONS

Name: Dr. Francisco Ramos Gomez, DDS, MS, MPH

Title: SPICE PD Program Director and Professor of Pediatric Dentistry

Agency/Organization: UCLA School of Dentistry, Section of Pediatric Dentistry

Address: 10833 Le Conte Ave., Room 23-020, Los Angeles, CA 90095

Phone:310-825-9460

Email Address: frg@dentistry.ucla.edu

PROVIDE CONTACT INFORMATION FOR ONE ADDITIONAL PERSON WHO COULD ANSWER QUESTIONS REGARDING THIS PROGRAM

Name: Hamida Askaryar

Title: Program Manager

Agency/Organization: UCLA School of Dentistry, Section of Pediatric Dentistry

Address: 10833 Le Conte Ave., Room 23-020, Los Angeles, CA 90095

Phone:310-825-8064

Email Address: haskaryar@dentistry.ucla.edu

SECTION I: ACTIVITY OVERVIEW

Title of the dental public health activity:

Infant Oral Health Program (IOCP)

Public Health Functions*: Check one or more categories related to the activity.

"X"	**Assessment**
	1. Assess oral health status and implement an oral health surveillance system.
x	2. Analyze determinants of oral health and respond to health hazards in the community
x	3. Assess public perceptions about oral health issues and educate/empower them to achieve and maintain optimal oral health
	Policy Development
x	4. Mobilize community partners to leverage resources and advocate for/act on oral health issues
X	5. Develop and implement policies and systematic plans that support state and community oral health efforts
	Assurance
	6. Review, educate about and enforce laws and regulations that promote oral health and ensure safe oral health practices
x	7. Reduce barriers to care and assure utilization of personal and population-based oral health services
x	8. Assure an adequate and competent public and private oral health workforce
x	9. Evaluate effectiveness, accessibility and quality of personal and population-based oral health promotion activities and oral health services
x	10. Conduct and review research for new insights and innovative solutions to oral health problems

***ASTDD Guidelines for State and Territorial Oral Health Programs that includes 10 Essential Public Health Services to Promote Oral Health**

Healthy People 2020 Objectives: Check one or more key objectives related to the activity. If appropriate, add other national or state HP 2020 Objectives, such as tobacco use or injury.

"X"	**Healthy People 2020 Oral Health Objectives**	
x	OH-1	Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth
x	OH-2	Reduce the proportion of children and adolescents with untreated dental decay
	OH-3	Reduce the proportion of adults with untreated dental decay
	OH-4	Reduce the proportion of adults who have ever had a permanent tooth extracted because of dental caries or periodontal disease
	OH-5	Reduce the proportion of adults aged 45 to 74 years with moderate or severe periodontitis
	OH-6	Increase the proportion of oral and pharyngeal cancers detected at the earliest stage
x	OH-7	Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
x	OH-8	Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year
	OH-9	Increase the proportion of school-based health centers with an oral health component
x	OH-10	Increase the proportion of local health departments and Federally Qualified Health Centers (FQHCs) that have an oral health component
x	OH-11	Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers each year

	OH-12	Increase the proportion of children and adolescents who have received dental sealants on their molar teeth
	OH-13	Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water
	OH-14	Increase the proportion of adults who receive preventive interventions in dental offices
	OH-15	Increase the number of States and the District of Columbia that have a system for recording and referring infants and children with cleft lips and cleft palates to craniofacial anomaly rehabilitative teams
	OH-16	Increase the number of States and the District of Columbia that have an oral and craniofacial health surveillance system
X	OH-17	Increase health agencies that have a dental public health program directed by a dental professional with public health training

"X"	**Other national or state Healthy People 2020 Objectives: (list objective number and topic)**

Provide 3-5 Key Words (e.g. fluoride, sealants, access to care, coalitions, policy, Medicaid, etc.) These will assist those looking for information on this topic:
Early Childhood Caries (ECC) prevention, Access to care, Caries Management by Risk Assessment (CAMBRA), Dental Public Health, Oral Health Integration, Vulnerable/Underserved communities, Community-Based Intervention

Executive Summary: Complete after Section II: Detailed Activity Description. Please limit to 300 words in one or two paragraphs.

Provide a brief description of the dental public health activity. Include information on: (1) what is being done; (2) who is doing it and why; (3) associated costs; (4) outcomes achieved (5) lessons learned, both positive and negative.

Model for a Community-Based Infant Oral Care Program (IOCP)

Objectives:
Early Childhood Caries (ECC) is a chronic infectious multifactorial disease in children 6 years of age or younger and it affects 600 million children worldwide [1,2]**.** Yet ECC is entirely preventable. When left untreated, ECC can lead to pain and infection as well as to difficulty in eating, speaking, and learning. These difficulties can have detrimental and long ranging effects on cognitive development, school readiness, self-esteem and lead to a diminished quality of life.
In 2010, UCLA launched an Infant Oral Care Program (IOCP) at the Venice Family Clinic (VFC) Simms/Mann Health and Wellness Center. The IOCP provides care coordination that is culturally competent, sensitive to language and oral health literacy challenges and increases access to care and improves oral health outcomes through a disease prevention management model with appropriate and cost-effective dental services targeted at underserved, low-income, minority children ages 0- 5 and their caregivers in a non-traditional setting. This innovative and unparalleled Interprofessional (IPE) prevention model represents the future of oral health, early intervention and dental disease management, and sets a new standard of comprehensive, integrated, widely accessible and evidence-based dental care. The specific aim of the program is to simultaneously increase entry points of access and increase the number of trained dental ***and pediatric primary care providers*** (MDs, nurse practitioners, nurses…) to integrate perinatal and pediatric health care with oral health services to improve overall health outcomes. To strengthen the infrastructure of the medical & dental delivery system, we have partnered with WIC, HS/EHS, and a Federally Qualified Health Center (FQHC) to provide basic dental services in a non-clinical setting. FQHC dental clinics in close proximity would provide secondary (acute) dental care, and university or similar programs, supply specialized tertiary care treatment.

Methods:
The program aims to increase access to care and improve oral health outcomes through an individualized disease prevention and management model (CAMBRA) targeted at underserved, low-income, minority children ages 0-5 and their caregivers in a non-traditional setting[3]. It established

partnerships with Women, Infants and Children (WIC) and Early Head Start/Head Start programs to increase entry points to dental care through coordinated referrals and with assistance from Early Head Start (EHS) coordinators.
IOCP not only trains dental students/residents but it includes training for pediatric medical residents and pediatric nurse practitioner students and works in collaboration with trained Community Oral Health Workers (COHWs).

Results:
IOCP has provided comprehensive care for a total of 1206 unique patients across 3599 visits from July 2010-Janaury 2019 (*the IOCP clinic only operates one day a week*!). From caries reduction perspective -19% of patients have presented themselves with early evidence of caries (white spot lesions) and 20% of patients have presented themselves with evidence of dental caries. IOCP program has been able to maintain a majority of these cases without further caries progression. We have been able to reduce the burden of disease for these patients from 78% incidence to 23% in 8 years through medical/dental collaboration.

Conclusion:
This innovative and unparalleled IPE model represents the future of oral health, early intervention and individualized dental disease management, and sets a new standard of comprehensive, integrated, widely accessible and evidence-based dental care emphasizing prevention. Promoting the AGE-ONE visit, early detection and intervention as part of the primary care model within a medical/dental integration setting is an essential pathway for helping to reduce ECC rates.
UCLA IOCP: http://www.uclaiocp.org/

References
1. Pitts N, Diaz-Guallory C, et al. Early childhood caries: IAPD Bangkok Declaration. Int J Paediatr Dent. 2019;29:384-386.
2. FDI Policy Statement. Perinatal and infant oral health. 2014, New Delhi: India.
3. Ramos-Gomez F, Ng MW. Into the future: keeping healthy teeth caries free: pediatric CAMBRA protocols. J Calif Dent Assoc. 2011 Oct;39(10):723-33. PubMed PMID: 22132584; PubMed Central PMCID: PMC3457698.

SECTION II: DETAILED ACTIVITY DESCRIPTION

Provide detailed narrative about the dental public health activity using the headings provided and answering the questions. Include specifics to help readers understand what you are doing and how it's being done. References and links to information may be included.

Complete using **Verdana 9 font.

Rationale and History of the Activity:

1. What were the key issues that led to the initiation of this activity?

Early Childhood Caries (ECC) is a chronic infectious multifactorial disease in children 6 years of age or younger and it affects 600 million children worldwide [1 2]. Yet ECC is entirely preventable. When left untreated, ECC can lead to pain and infection as well as to difficulty in eating, speaking, and learning. These difficulties can have detrimental and long ranging effects on cognitive development, school readiness, self-esteem and lead to a diminished quality of life.[2-3]

A systematic review of 72 studies worldwide showed the prevalence of ECC in children 4 years of age ranged from 12% to 98%.[3] In the United States, 23% of children between 2-5 years of age have ECC, and 80% percent of dental disease (including ECC) is concentrated in just 20–25% of the country's children who are primarily from low socioeconomic and/or minority backgrounds.[4-6] Oral health inequalities are universal.7 Children in lower-income groups and countries have been shown to have the highest dental caries rates, and children from disadvantaged backgrounds are disproportionately more likely to be admitted to the hospital to have teeth extracted.[8]

References
1. Pitts N, Diaz-Guallory C, et al. Early childhood caries: IAPD Bangkok Declaration. Int J Paediatr Dent. 2019;29:384-386.
2. FDI Policy Statement. Perinatal and infant oral health. 2014, New Delhi: India.
3. Tinanoff N, Baez RJ, Diaz-Guillory C, et al. Early childhood caries epidemiology, aetiology, risk assessment, societal burden, management, education, and policy: Global perspective. Int J Paediatr Dent. 2019;29:238-248. Doi: 10.1111/ipd.12484.
4. Fleming E, Afful J. Prevalence of total and untreated dental caries among youth: United States, 2015-2016. NCHS Data Brief no 307. 2018. Hyattsville, MD: National center for health Statistics.
5. Cooper D, Kim JS, Duderstadt K, et al. Interprofessional oral health education improves knowledge, confidence, and practice for pediatric healthcare providers. Front Public Health 2017;5(209). doi: 10.3389/fpubh.2017.00209.
6. Dye BA, Thornton-Evans G, Li X, Iafolla TJ. Dental Caries and Sealant Prevalence in Children and Adolescents in the United States, 2011–2012. 2015. Hyattsville, MD: National Center for Health Statistics 2015.
7. Costa SM, Martins CC, Bonfim Mde L, et al. Int J Environ Res Public Health. 2012;9:3540-3574.
8. Jackson SL, Vann Jr WF, Kotch JB, Pahel BT, Lee JY. Impact of poor oral health on children's school attendance and performance. Am J Public Health. 2011;101:1900-1906.

2. What rationale/evidence (may be anecdotal) did you use to support the implementation of this activity?

Child well-being is an interprofessional issue-area and it has consequences among multiple dimensions. The American Academy of Pediatric Dentistry (AAPD), affirms that child oral care is an absolute "medical-necessary" in child health [1]. For instance, low income parents often lack the means such as transportation and the ability take time off from work to take their children to the dentist. So, we have integrated the dental visit within a FQHHC primary car setting to alleviate some of the barriers that low-income parents and underserved populations may face when seeking quality oral health care for their children. Additionally, it is crucial that all child health providers work together to provide the best patient-centered service. The goal of IOCP is to unite child well-being in all aspects, specifically with primary care, which will give parents a more specific understanding of what is happening with their children's systemic health and oral health.

Furthermore, to help create a new cadre of primary care providers trained and willing to provide for the oral health of underserved children, UCLA created the Strategic Partnership for Interprofessional Collaborative Education in Pediatric Dentistry (SPICE PD) project in 2015. The UCLA SPICE PD project aims to educate, train and mentor pediatric dental residents, pediatric medical residents, nurse practitioner students and AEGD/GPR residents in infant and toddler oral health through an interdisciplinary, interprofessional and multifaceted collaborative approach.
Many factors influence collaborative education, there is a world of opportunity for better holistic approach in collaboration. Multidimensional integrative learning and teaching is an essential step to prepare our health workforce of tomorrow. By facilitating oral health education in medical residency programs, nursing programs, public health programs, the overall health of children will dynamically improve. http://www.uclachatpd.org

References

1. American Academy of Pediatric Dentistry. Definition of medically-necessary care. Pediatr Dent 2015

For some of the published papers on the IOCP & SPICE PD project please visit:

- ✓ Ramos-Gomez F, Askaryar H, Garell C, Ogren J. Pioneering and Interprofessional Pediatric Dentistry Programs Aimed at Reducing Oral Health Disparities. Front Public Health. 2017;5:207. doi: 10.3389/fpubh.2017.00207. eCollection 2017. PubMed PMID: 28856133; PubMed Central PMCID: PMC5557784

- ✓ Ramos-Gomez FJ. Changing the education paradigm in pediatric dentistry. J Calif Dent Assoc. 2014 Oct;42(10):711-5. PubMed PMID: 25345116. https://www.ncbi.nlm.nih.gov/pubmed/25345116/

- ✓ Ramos-Gomez FJ, Silva DR, Law CS, Pizzitola RL, John B, Crall JJ. Creating a new generation of pediatric dentists: a paradigm shift in training. J Dent Educ. 2014 Dec;78(12):1593-603. PubMed PMID: 25480274. https://www.ncbi.nlm.nih.gov/pubmed/25480274

- ✓ Ramos-Gomez FJ. A model for community-based pediatric oral heath: implementation of an infant oral care program. Int J Dent. 2014;2014:156821. doi: 10.1155/2014/156821. Epub 2014 Jan 23. PubMed PMID: 24587803; PubMed Central PMCID: PMC3920860.

- ✓ Ramos-Gomez F, Crystal YO, Ng MW, Tinanoff N, Featherstone JD. Caries risk assessment, prevention, and management in pediatric dental care. Gen Dent. 2010 Nov-Dec;58(6):505-17; quiz 518-9. PubMed PMID: 21062720.

3. What month and year did the activity begin and what milestones have occurred along the way? (May include a timeline.)

IOCP has been in operation since 2010 and has provided comprehensive care for a total of 1206 unique patients across 3599 visits from July 2010-January 2019. 19% of patients have presented themselves with early evidence of caries (white spot lesions) and 20% of patients have presented themselves with evidence of dental caries. IOCP program has been able to maintain a majority of these cases without further caries progression. We have been able to reduce the burden of disease for these patients from 78% incidence to 23% in 8 years through medical/ dental collaboration.

For the SPICE PD project survey data (n=60) demonstrates that nearly all participants agreed/strongly agreed that they know more about the abilities/contributions of other health professionals working together for improved patient health and all agreed/strongly agreed that an interprofessional approach enhances patient care.

The sections below follow a logic model format. For more information on logic models go to: W.K. Kellogg Foundation: Logic Model Development Guide

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	OUTCOMES

1. What resources were needed to carry out the activity? (e.g., staffing, volunteers, funding, partnerships, collaborations with various organizations, etc.)

Personnel for IOCP:
Full time IOCP coordinator (could be a Community Oral health worker): The scheduler is responsible for scheduling appointments, ensuring accurate information on paperwork including patient electronic chart records, the verification and pre-authorization of insurance benefits, and other administrative support. This person is budgeted at **$42,000/year**.
The clinic only operates every Wednesday year-round: 2 Wednesdays a month 4 hours and 2 Wednesdays a month for 8 hours. The program currently utilizes already available staff for scheduling and billing. However, these positions are critical to operations and should be considered in the development of IOCP budgets. Note that this position could be combined into one position (Community Oral health worker) with proper training and some of its cost defrayed by reimbursable services.
Start Up Costs:
Currently, the Simms/Mann Health and Wellness Center provides the space and other supplies as part of the collaborative agreement with the IOCP. Included below are figures related to how much it would cost to start a new pod at a different site.
Supplies: The total start-up cost is **$4300**. This includes: $900 for chairs, $3,000 for portable lamps, $400 for mirrors, gowns, … (if ***not*** already supplied by the medical clinic!!).
Per Patient Costs: The cost per patient is approximately **$18.15**. This figure takes into account: fluoride varnish, gloves, gauze, toothbrushes & toothpastes, and prescription fluoride gels.

INPUTS	**PROGRAM ACTIVITIES**	OUTPUTS	OUTCOMES

2. Please provide a detailed description the key aspects of the activity, including the following aspects: administration, operations, and services.

The IOCP program occurs every Wednesday at two of Venice Family Clinic locations year-round. Both locations are primary care and dental care co-located clinics that provide comprehensive services to low income and underserved populations.
SPICE PD is the HRSA supported pediatric dental residency training program and its efforts are focused on interprofessional education (IPE) and evidence-based skills training and through these facets, pediatric dental residents, pediatric medical residents, nurse practitioner students, dental students (third and fourth year students) and AEGD/GPR residents are conditioned and trained to remain involved and active in issues of diversity, advocacy, community involvement, issues of equity

and policy development, which are foreign topics in today's pediatric oral health curriculum and for dentists in training. This approach is developed to prepare our residents with the innovative knowledge and versatile skills needed to better serve communities, advocate for children's' oral health while focusing on patient-centered care. Residents are taught to be involved in their communities, learn about cultural competencies and their effect on children's oral health, and also learn how to effectively engage with the caregiver(s) to propel health behavioral changes.

INPUTS	PROGRAM ACTIVITIES	**OUTPUTS**	OUTCOMES

3. What outputs or direct products resulted from program activities? (e.g., number of clients served, number of services units delivered, products developed, accomplishments, etc.)

IOCP has been in operation since 2010 and has provided comprehensive care for a total of 1206 unique patients across 3599 visits from July 2010-January 2019. For more on the IOCP program, please visit: https://www.uclaiocp.org/

SPICE PD is the HRSA supported pediatric dental residency training program and by June 2020 will have provided didactic and hands-on clinical training to about 107 pediatric medical residents, 73 pediatric nurse practitioners students, 60 AEGDs, and 30 GPR residents. Additionally, the SPICE PD sponsors pediatric dental residents to receive their MPH degree simultaneously while in their pediatric dental residency program. By June 2020, the CHAT/SPICE PD program will have sponsored 19 DDS/MPH graduates. For more on the SPICE PD project impact and evaluation, please visit: https://www.uclachatpd.org/
(password: ucladent) For the SPICE PD evaluation report, please visit:
https://www.uclachatpd.org/spice-pd-evaluation-framework.html

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	**OUTCOMES**

4. What outcomes did the program achieve? (e.g., health statuses, knowledge, behavior, care delivery system, impact on target population, etc.) Please include the following aspects:
   a) How outcomes are measured:

We track the patient outcomes via the electronic dental records (EDR). We pull monthly reports for dental codes and analyze the following data points:

- Number of children seen for a preventative oral health visit to include caries risk assessment, oral exam, fluoride varnish application, anticipatory guidance and self-management goals.
    - Caries risk code at initial visit (baseline) and subsequent visits for the child, defined as EDR CDT codes:
        - Low risk: D0601
        - Medium risk: D0602
        - High risk: D0603
- Number of children with clinical findings for white spot lesions (active vs. inactive) or dental caries
- Number of kids who were referred out for restorative treatment.
- Data analysis involves statistical trend analysis

b) How often they are/were measured: we prepare monthly reports
c) Data sources used: EDR
d) Whether intended to be short-term (attainable within 1-3 years), intermediate (achievable within 4-6 years), or long-term (impact achieved in 7-10 years): all our data tracking is intended for long term trend analysis and for quality improvement measures.

Since its inception in 2010, the IOCP has completed over 3500 patient visits. This success is attributed to the case management and triage based on individual overall risk level, dental care need, and the collaboration with the community health center staff. Over the past two years, its once weekly clinic has increased the number of patients as well as the recall appointments kept. In addition to wrap-around services provided to children and families, the IOCP serves as a community learning environment which gives students, residents general dentists, nurse practitioners and doctors experience providing preventive oral health care in locations where mothers and their children also receive their Well-Baby visits as well as dietary education and counseling. Active participants in this program gain clinical, knowledge and experience in individual caries management by risk assessment

(CAMBRA), motivational interviewing, behavior management, disease management, fluoride varnish applications and the unique dental care needs of young patients. In addition, they also acquire a more in-depth understanding of cultural competencies in the community clinic setting as they learn first-hand how to navigate through cultural and language barriers, and patients/caregivers' socioeconomic limitations. Upon completion of the IOCP rotation, dental and health providers are not only better equipped with a greater awareness of the value of good oral health in maintaining children's overall health, but are also adequately trained, both clinically and culturally, to effectively early diagnose, prevent and treat very young and underserved young children.

Budgetary Information:
NOTE: Charts and tables may be used to provide clarity.

1. What is the annual budget for this activity?

The annual budget is about $104,000 which includes startup costs of $4,300 in the first year of operation. *See table*

2. What are the costs associated with the activity? (Including staffing, materials, equipment, etc.)

Please refer to this table

IOCP sample budget for initial year of operation							
Name	**Role on Project**	**Type Appt. (months)**	**% Effort on Project**	**Inst. Base Salary**	**Salary requested**	**Fringe Benefits /Taxes**	**Totals**
Attending Dentist or Medical Doctor*	Attending Doctor	12 months	2%	$189,600	$3,792	$1,441	$ 5,233
IOCP Coordinator (or community dental home coordinator or community oral health worker)*	Project Coord.	12 months	100% (*or 50%)	$42,000	$42,000	$15,960	$ 57,960
						Subtotal	$ 63,193
Equipment(itemize) *Startup costs*							$ 4,300
Supplies (itemize by category)							
Project supplies (includes oral hygiene supplies, toys, etc.) $200/month							$ 2,400
Printing costs of oral health educational materials							$ 200
						Subtotal	$ 2,600
Travel							$ -
Patient Care	Inpatient						$ -
	Outpatient						$ -

Other expenses (itemize by category)							
*Technology Infrastructure Fee- TIF (billed at $41.22 per FTE per month)							$ 592
General Liability Assessment -GLP (billed as $ 0.81 per $100 of salary costs)							$ 512
						Subtotal	$ 1,104
UCLA Indirect Costs (Itemize, at 56%*)							$ 37,462
TOTAL COSTS							$ 104,359
Monthly Revenue from insurance billing (Avg. per $126 per patient visit, 35 patients per month: $4410 (*12 for a year)							$ 52,920

**Salary rates, benefit rates, and indirect rates are institution specific!*

3. How is the activity funded?

Initial funding came come from the University and from support from the FQHC. Continued revenue support is achieved through patient insurance billing. Almost all patients at the IOCP clinic have Medi-cal insurance and some patients are pay at a reduced sliding scale fee.

4. What is the plan for sustainability?

Fiscal sustainability is achieved through patient insurance billing within the medical/dental collaboration FQHC model. Additionally, there are now insurance pilot projects out there that explore feasibility of a value-based (patient outcome-based) reimbursement system that emphasizes early oral health prevention and intervention strategies for children and reduces incentives for unnecessary restorative procedures and over treatment. In the traditional reimbursement system, providers are **not** incentivized to keep healthy teeth healthy because prevention is often not (adequately) reimbursed. Yet through the Medi-Cal dental program's Dental Transformation Initiative (DTI) participating medical/dental providers in Los Angeles receive an additional monetary incentive ($126) to perform preventative bundle services for children to include a Caries Risk Assessment, nutritional counseling, and self-management goals to patients. For more on this please visit: https://www.dhcs.ca.gov/provgovpart/Documents/DTI/Domain%202/D2-Caries-Risk-Assessment-and-Disease-Management-Pilot-Fact-Sheet.pdf
For many years, the UCLA SPICE PD and IOCP prevention IPE models have been on the forefront of supporting and advocating for a value-based (patient outcome-based) reimbursement system.

Lessons Learned and/or Plans for Addressing Challenges:

1. What important **lessons** were learned that would be useful for others looking to implement a similar activity? Was there anything you would do differently?

Benefits for working with a co-located primary care community site, is that the medical and dental electronic records are merged, so therefore all providers have easy access to the patient's social and

medical, and dental history. Communication between different providers for the same patient is improved (for example to help close car gaps) and referrals can be easily tracked. This helps support and improve interprofessional communication and practice and improves patient outcomes.
It is important to maintain one consistently employed IOCP coordinator who can make dental appointments for the patients, confirm patients for their appointments, maintain follow up schedules, and oversee the correct electronic dental records input.

Being co-located makes it easy for patients to receive comprehensive wrap-around services during one visit to the clinic and it improves follow up and reduces no show rates. Patients appreciate the warm hand-offs between medical and dental providers.

Dental students and residents really enjoy working in a community clinic interprofessional setting and being able to observe and learn from medical providers, as well as from dental providers.
Here are some testimonials form IOCP participants:

Dorin Coffler Volunteer Testimony:
"Volunteering with Dr. Ramos-Gomez's Infant Oral Care Program (IOCP) has been such an amazing learning experience. I have learned about the CAMBRA survey, and its effective approach to prevention and treatment of caries. Watching the Pediatric residents administer these surveys, and having the opportunity to do so myself, has taught me how to communicate with and teach the IOCP patients about best oral health practices. As an undergraduate pre-dental volunteer, this experience has helped me understand the barriers to access of oral health care and the importance of implementing preventative treatments early on."

Tanya Kavuossi IOCP Selective Testimony:
"I had an extremely positive experience during my time participating in IOCP. This opportunity allowed me to create strong bonds with both the parents and children in order to positively impact how they approach their oral health and nutrition/diet habits at home. I learned the importance of anticipatory guidance and to choose 2 simple achievable goals that the parents could rate their level of compliance on a scale of 1-10. By not overwhelming the parents with a huge list of new goals they would be more likely to follow through and make a positive impact on their child's oral health. This experience allowed me to use the tools that I have gained during my dental school career to change these patient's behaviors. I was taught how to take on a behavioral interventionist approach in order to make a positive impact on these patients' lives and how they can continue improving their oral health in the future."

2. What **challenges** did the activity encounter and how were those addressed?

Working within a co-located primary care community clinic, there are issues with availability and sharing of patient rooms, scheduling of patients, and avoiding overlaps in appointments. Additionally, due to the patient population being mostly Hispanic mono-lingual Spanish speakers, occasionally there is a shortage of available translators or bi-lingual providers. And the fact that the services are provided by rotating dental residents, parents/caregivers may perceive a lack of continuity with the same provider. And not all children can be seen once referred by the same provider due to rotating schedules. Finally, the UCLA IOCP training program has many residents/ students eager to learn about prenatal and infant/toddler oral health care but we are running out of physical space and available rotation sites to provide them with this valuable and essential IPE training opportunity.

Available Information Resources:

Share any models, tools, and/or guidelines developed by the program specifically for this activity that may be useful to others seeking additional information. Hyperlink resources if possible.
For more information on the IOCP program please visit: https://www.uclaiocp.org/

For more information on the SPIC PD program, please visit: https://www.uclachatpd.org/

TO BE COMPLETED BY ASTDD	
Descriptive Report Number:	06006
Associated BPAR:	Perinatal Oral Health
Submitted by:	UCLA School of Dentistry, Section of Pediatric Dentistry
Submission filename:	DES06006CAuclainfantoralcareprogram-2019
Submission date:	June 2012
Last reviewed:	September 2019
Last updated:	September 2019