Dental Public Health Project Descriptive Report Form

Please provide a description of your organization's successful dental public health project by completing this form. Add extra lines to the form as needed but stay within **word limits**.

Please return the completed form to Lori Cofano: lcofano@astdd.org

Name of Project
Maternal and Child Health: Improving Oral Health Integration
Executive Summary (250-word limit))
In efforts to reduce the disease burden for young children and prenatal populations, Children's Health Alliance of Wisconsin (the Alliance) and the Medical College of Wisconsin launched the Wisconsin Medical Dental Integration (WI MDI) project in 2019 to create a statewide system change to increase early access to preventive dental care through integrating a dental hygienist into primary care teams. To date, 14 clinics have integrated 18 hygienists across 11 health systems reaching over 17,000 children and pregnant women, using the Advancing a Healthier Wisconsin Endowment (AHW). Opportunity exists via the Health Resources and Services Administration's (HRSA) Maternal Child and Health – Improving Oral Health Integration (MCH-IOHI) project funding, presenting the pathway to address oral health needs and invest in prevention in primary care through enhancement of dental knowledge and skillsets of medical providers. The integrated preventative oral health care (POHC) approach necessitates support at the state level, including policy implementation, addressing education requirements and surveillance. This two-tier, state, and local, improvement approach addresses: • ***Policy & Practice:*** State policy and infrastructure informs implementation of four new state level improvement strategies. At the local level, sites address oral health inequities by integrating a POHC model. For the current grant project using HRSA funding efforts will initially focus on pediatric patients ages infant to 21 years, in order to clinics to get the flow, followed by an expansion to reach pregnant women and other maternal and child health (MCH) populations. The model embeds dental hygienists in primary care teams to provide assessments, fluoride applications, guidance, silver diamine fluoride (if applicable) and care coordination during medical appointments. • ***Outreach & Education:*** A state gap analysis will be conducted, and a corresponding health literacy plan will be executed. A local gap analysis will be conducted and

associated oral health trainings will be developed and implemented for medical, dental and non-clinical staff.

- ***Data, Analysis & Evaluation:*** State surveillance data is being assessed and enhanced to improve access, better define and monitor MCH population disparities and identify factors influencing MCH oral health outcomes.

Name of Program or Organization Submitting Project

Children's Health Alliance of Wisconsin (the Alliance)

Essential Public Health Services to Promote Health and Oral Health in the United States

Place an "X" in the box next to the Core Public Health Function(s) that apply to the project.

x	Assessment
x	Policy development
x	Assurance

http://www.astdd.org/state-guidelines/

Project submissions will be categorized by the Core Public Health Functions on the ASTDD website.

Healthy People 2030 Objectives

List Healthy People 2030 objectives related to the project.

- OH-01 Reduce the proportion of children and adolescents with lifetime tooth decay.
- OH-02 Reduce the proportion of children and adolescents with active and untreated tooth decay.
- OH-09 Increase the proportion of low-income youth who have a preventative dental visit.
- OH-10 Increase the proportion of children and adolescents who have dental sealants on one or more molars.
- AHS-05 Reduce the proportion of people who can't get the dental care they need, when they need it.
- OH-D01 Increase the number of states that have an oral health surveillance system.

This information will be used as a data resource for ASTDD purposes.

Keywords for sorting the project by topic.

Provide **three to five** keywords (e.g., access to care, children, coalitions, dental sealants, fluoride, policy, Medicaid, older adults, pregnant women, etc.) that describe the project. Keywords are used to categorize submissions.

Medical Dental Integration,
Maternal Child Health
Access to care

Detailed Project Description

Project Overview
(750-word limit)

1. What problem does the project address? How was the problem identified?

Early access to most POHC can improve MCH oral health outcomes; however, populations with low socioeconomic status, and those from racial/ethnic minority groups, often encounter obstacles. Only one-third of dentists in Wisconsin accept Medicaid[1] and social and structural barriers exist in obtaining oral health care. Unequal access to preventative and restorative dental care leads to worse oral health outcomes. Children that live in poverty and children of color are impacted with one-third of Head Start students experiencing caries by 3 years old and half by age 5.[2] Kindergarteners and third-graders of color have a higher prevalence of caries and early or urgent dental needs compared with white students.

Additionally, disparities in accessing preventive care result in significantly fewer Asian and non-Hispanic Black third-graders with sealants. Despite the importance of good oral health during pregnancy for both mother and baby, pregnant women of color and pregnant women with public insurance experience disparities and are less likely to receive a dental cleaning during pregnancy.[3] It is difficult to define oral health disparity data for Children and Youth with Special Health Care Needs in Wisconsin, resulting in an incomplete understanding of current oral health differences for this population.

The initial aim of the MDI project was to create statewide system change within health care organizations and clinics to increase early access to preventive dental care and reduce the dental disease burden for young children (ages infant to 5 years) and pregnant women through the integration of a dental hygienist into medical clinics' primary care teams. As we received more funding through HRSA, we were able to expand this population size to ages infant to 21 and pregnant patients.

Through initial MDI work, we learned that a multi-pronged approach is needed for integrated POHC to allow for unique health system and community needs to appropriately address MCH oral health disparities. MCH-IOHI key personnel and the Alliance will utilize five action oriented strategies to ensure a health equity approach throughout project implementation: 1) Ground the work in data and context and target solutions; 2) Focus on systems change, in addition to programs and services; 3) Shift power in the Alliance; 4) Listen to and act with community and 5) Build equity leadership and accountability.

2. Who is the target population?

With the HRSA grant funding, we were able to expand patient populations from 0-5 and pregnant patients to pediatric patients ages infant to 21 years and pregnant populations. Expanding access to integrated POHC is a crucial approach to improving access and disease prevention for MCH populations at higher risk for disparities. Policy changes, outreach, education, practice model change, provider skill development and ongoing data collection and surveillance, are necessary to reach the intended project outcome of long-term sustainability to reduce the burden of dental disease in MCH populations in Wisconsin.

3. Provide relevant background information.

State and local level changes are needed to better define and address MCH oral health disparities. Integrating POHC in primary care services is one method to overcome social and structural barriers to improve access for MCH populations at increased risk for poor oral health. Following advocacy that led to legislative changes in 2017 (expanding the settings where dental hygienists could practice without supervision in Wisconsin), the Alliance and the Medical College launched the WI MDI project in 2019.

The Alliance and the Medical College have partnered to improve oral health for children through multiple successful funding opportunities from AHW and the CareQuest Institute for Oral Health. They have collaboratively led the facilitation, coaching and implementation of the WI MDI model over the last five years. The team has provided coaching for health systems and Federally Qualified Health Centers through the planning and implementation stages of initiating and sustaining the WI MDI model. Support has been provided in the following ways: planning and implementation support, assistance with documentation modifications, billing and revenue cycle adaptations, financial sustainability, project evaluation, assistance in establishing dental referral networks and connections to the dental hygiene workforce. The team also provided dedicated time coaching clinics for practice transformation. Most recent work has focused on elevating the patient and caregiver voice in the integrated POHC system and exploring MDI billing barriers to support model growth and sustainability.

To date,14 Wisconsin clinics have integrated 18 dental hygienists across 11 health systems, reaching over 17,000 children and pregnant women with integrated POHC. Of the clinics who have integrated a dental hygienist as a member of their medical teams, care began with pediatric patients, and as systems improved their processes and workflows, four health systems expanded to prenatal patients. Through efforts funded by CareQuest (which ended in October 2024), the program focused on elevating patient/caregiver voice and exploring insurance reimbursement barriers in MDI. This foundation will allow for structural changes during the MCH-IOHI project to create sustainable input from those with lived experience and address billing barriers associated with integrated POHC to promote sustainability which has been funded by HRSA from July 2024 through June 2028.

4. Describe the project goals.

1. Develop and implement at least four specific improvement strategies aimed to increase access and integrated POHC for MCH populations in communities underserved by oral health care, utilizing measurable approaches that demonstrate a linkage between state level improvement and improved access outcomes. The strategies are identified below and are still in the process of implementation.
    a. Construct a State oral health literacy plan.
    b. Identify oral health surveillance enhancements.
    c. Act 20 education
    d. SDF Medicaid reimbursement for medical providers
2. By June 30, 2028, 85% of targeted organizations/professionals will demonstrate an increase in oral health literacy/awareness through the establishment and implementation of a state health literacy plan to address and meet the oral health needs of Wisconsin communities more equitably.
    a. Medical, dental, and non-clinical professionals will participate in an oral health gap analysis that will inform the health literacy plan and oral health infrastructure.
3. **I**mplement a minimum of three improvements to state level oral health surveillance to enhance the monitoring of disparities in oral health status and burden of oral disease among MCH populations and to assess the impact of practice improvement approaches and inform potential adjustments.

4. Implement and validate the evidence-based model of integrated POHC which addresses barriers to care in communities underserved by oral health care within the target population of children (infant to 21 years) and pregnant patients in three initial primary care settings in the first year of the grant, with expansion to three to four additional primary care sites each year for grant years 2, 3 and 4 and/or departments per year reaching additional MCH populations by June 30, 2028.
5. Create a more equitable oral health care knowledge infrastructure by increasing oral health knowledge and skills among nondental primary care providers and improving the oral health awareness of target populations and their caregivers to equip individuals to influence their oral health and health decisions.
6. Establish a clinical data collection approach and institute an impact analysis of integrated POHC across all primary care settings, including demographic data when possible.
7. Complete dissemination strategy to diverse audiences using multiple approaches (e.g., publications, oral health presentations and one-on-one meetings) to support improving oral health integration services accessible to MCH populations statewide and nationally (particularly in areas that experience inequities in access to oral health care).

Resources, Data, Impact, and Outcomes
(750-word limit)

1. What resources were/are necessary to support the project (e.g., staffing, volunteers, funding, partnerships, collaborations with other agencies or organizations)?

The MCH-IOHI key personnel, in collaboration with the Alliance, the Medical College leaders, content experts, clinicians and key decision makers, will serve as the primary community partners and lead the implementation of the MCH-IOHI project. Combined, the MCH-IOHI key personnel have 20+ years of nursing experience, 30+ years in grant management, 10 years in pediatric medical care and 30+ years of public health dental hygiene experience. Project efforts will be informed and enhanced through participation in the MCH-IOHI Consortium learning collaborative and in partnership with participating primary care teams.

The MCH-IOHI project will initially assist three primary care sites that will address oral health inequities within their patient population by implementing an evidence-based MDI approach to their patient care process. Committed health system partners who will integrate POHC into their primary care process to validate the model and receive a contracted participation stipend include for year 1:

- Family Health La Clinica (Steven's Point, Wis.) (served 18,108 total patients in 2022)
- Northeast Wisconsin (N.E.W.) Community Clinic (Green Bay, Wis.) (served 4,768 total patients in 2022)
- Western Wisconsin Health (Baldwin, Wis.) (served 209,415 patients across their system in 2023)

MDI aims to leverage primary care appointments to provide early dental prevention and intervention services. The model reframes the thinking that medical and dental care are separate. This separation is often evident in education, licensure, regulation, practice, payment, and information sharing, while being frequently viewed as two separate entities from a patient's perspective. MDI provides the opportunity to access patients at an early age and at a higher frequency to provide dental prevention and intervention services. The WI MDI project utilizes case management efforts by dental hygienists to help connect patients with dental care and dental homes.

2. **(a) What process measure data are being collected (e.g., sealants placed, people hired, etc.)?**

    - Primary care providers: Number of primary care providers who completed training organized by the MCH-IOHI project.
    - Primary care support service providers: Number of primary care support service providers who completed training organized by the MCH-IOHI project.
    - Oral health risk assessment: Children and pregnant women who received an oral health risk assessment during a primary care visit.
    - Oral health evaluation (screening): Children and pregnant women who received an oral health evaluation (i.e., clinical oral health screening) during a primary care visit.
    - Fluoride varnish: Children and pregnant women who received a fluoride varnish application during a primary care visit.
    - Self-management goal: Children and pregnant women with an oral health self-management goal established during a primary care visit.
    - Urgent referral: Children and pregnant women who received a dental referral for urgent treatment during a primary care visit.
    - Closed urgent referral: Children and pregnant women who received a dental referral for urgent treatment during a primary care visit who had a subsequent dental visit.
        - Dental referral sites are up to the implementing clinics to identity.
        - The work of this current grant, in which we are in year one, will work to collect data and track whether dental referrals and visits are completed.

(b) What outcome measure data are being collected (e.g., improvement in health)?

- Reduce the dental disease burden using Head Start surveillance data or Medicaid utilization data—but the HRSA funded project is not specifically designed to research individual patient outcomes.

(c) How frequently are data collected?

- Data was collected monthly from the participating clinics.
- We learned from the AHW grant funded project, that data collection is key to sustainability. We have contracted with a health information specialist to work through data collection with the implementing clinics and how best to disseminate that throughout the length of this project.

3. **How are the results shared?**

    - For the MCH-IOHI project, we are collaborating with data specialists to identify a data dashboard that would display our data in an engaging and interactive way.
        - Clinics will share their data monthly to the Alliance, in which MCW biotechnicians will aggregate the data and the Alliance shares with HRSA every 6 months.
    - Dissemination of the data collection template and associated workflow recommendations occurred through communication between the primary care integration coordinator, implementing primary care sites and through guidance added to the WI MDI Implementation Guide for public access. The template will guide health systems in workflow adaptations to support documentation and data collection across varying electronic medical records systems. Community members with lived experience will help inform the best methods and locations for data dissemination at the local level.
    - The Alliance has a robust history of presenting at national conferences, such as the National Oral Health Conference, and was recently awarded the American Academy of Pediatrics (AAP) best section on oral health abstract.

Budget and Sustainability
(500-word limit)

Note: Charts and tables may be used.

1. **What is/was the budget for the project?**

   $1,700,000
   The Wisconsin Medical Dental Integration project is funded by the Health Resources and Services Administration (HRSA) of the U.S Department of Health and Human Services (HHS)
   Each implementing clinics receives two $5000 stipends in their grant year sign on, staff salary, benefits and travel are allocated to the remaining funds.
   Staff include 2 full-time FTE positions, and 5 other staff members with varying percentages of FTE allocated.

2. **How is the project funded (e.g., federal, national, state, local, private funding)?**

   Federal funding for the HRSA funding that is currently funding MDI in Wisconsin, back in 2019 the grant that was used to fund this project was AHW, which is state funding that is primarily funded by a private gift from Blue Cross & Blue Shield United of Wisconsin

3. **What is the sustainability plan for the project?**

   The Alliance and the Medical College have extensive experience convening similar partnerships, and a strong history of creating engagement and driving systems change. The success thus far of the WI MDI project is only possible because of the collaboration of numerous entities, including Wisconsin Department of Health Services (DHS), Wisconsin Dental Hygienists Association, the Wisconsin Primary Health Care Association, the Wisconsin Academy of Family Physicians, the Wisconsin Dental Association, the Wisconsin Oral Health Coalition and the Wisconsin Chapter of the American Academy of Pediatrics.

   In support of the MCH-IOHI project, the DHS Oral Health Program will participate in discussions related to allocation and management of project resources and facilitate collaboration with the Division of Medicaid Services and MCH Section for the purposes of enhancing the oral health surveillance system. They will also participate in the identification and maximization of resources and community ownership to sustain project services beyond the project period of federal funding. State medical and dental professional associations will serve as a connection point to Wisconsin medical and dental clinicians to support project implementation, adaptation, growth, and dissemination.

   Sustainability is a top concern to keep MDI work thriving in the state of Wisconsin. One option that the Alliance and the Medical College have identified via an environmental can, is Medicaid reimbursement for in specific clinic settings, as well as the potential to move into private insurance and have MDI hygienists be able to bill. Once clinics are implemented, Medicaid reimbursement is how they will sustain the work.

Lessons Learned
(750-word limit)

(a) What lessons were learned that would be useful for others seeking to implement a similar project?

Useful lessons learned come from a previous AHW grant that outlined the work being done for this current project, HRSA MCH-IOHI.

With the conclusion of our AHW funding report, we applied the foundational and significant learning we have accumulated over the past three years to inform a spread and sustainability plan for the continuation and expansion of integration in Wisconsin. As part of this plan, we continued supporting WI MDI implementation of the most recently added systems Hospital Sisters Health System–Prevea, Access Community Health Center, Bridge Community Health Clinic and Children's Wisconsin – Forest Home through ongoing technical assistance and coaching calls.

MDI in Wisconsin is currently funded by the Health Resources and Services Administration (HRSA) of the U.S Department of Health and Human Services (HHS). Funding is awarded from July 1, 2024-June 30, 2028, with an award totaling $1,475,000 with no funding from non-governmental sources.

As implementation has progressed over the last three to four years, we have learned that a need exists to offer an expanded and flexible approach to the integration of oral health services within the medical setting. This adaptable approach with varying levels and degrees of integration better accommodated differences in clinic structure and provider panels while more equitably providing access to differing patient populations to meet their dental needs. The care variation within this approach ranges from foundational oral health screening and application of fluoride varnish by the medical team, to the integration of a dental hygienist within the medical team. We will remain flexible in our guidance and coaching methods with varying health systems as we consider how each operates and functions uniquely. We applied and received HRSA MCH-IOHI additional funding to support the coaching and implementation of this range of oral health integration approaches.

Other components of spread and sustainability include:

- The completion of the first draft of the WI MDI Implementation Guide which helps our team spread the model both in Wisconsin and nationally.
    - This guide will be updated annually as we address lessons learned from previous year clinics.
- Seeking additional avenues to publish the findings that have occurred because of WI MDI efforts from 2019-22.

The following activities will continue:

- Coaching teams that have recently implemented.
- Convene/engage the WI MDI Advisory Council.
- Convene integrated dental hygienists peer learning calls bimonthly.
- Finalization of the automated report template in OCHIN-EPIC.
- Data collection and evaluation to capture population health impact data.

We are exploring gaps in knowledge within integration practices that would benefit from additional research and understanding. One of these areas is understanding the patient voice and perspective within the MDI care approach. Recently, we have been invited to submit a full proposal to CareQuest for funding, which focuses on elevating the patient voice within MDI models.

(b) Any unanticipated outcomes?

Recruitment for a dental hygienist has become a challenge. The MDI model allows a dental hygienist to practice without the supervision of a dentist. With that, we have found newly graduated dental hygienists struggle in this type of environment, and finding a more experienced dental hygienist has had more success in sustainability and retention.

The expected timeframe of when clinics were able to implement was an unanticipated outcome. With the current HRSA project that we are using for MDI, year one had three implementing clinics, that we started having conversations within the fall, with timeframe that they would be able to start seeing patients in that spring. We had learned that with political pulls from their own institutions, lack of being able to hire and a general busyness, that the timeframe had to be pushed, in order from them to implement with the chance of the most success.

(c) Is there anything you have done differently?

Identifying clinics to participate in our MDI model and be a part of this project in year 1 and year 2 was based more on who was able to sign on in the timeframe and who had capacity. When planning for identifying clinics for years 3 and 4, conversations and plans around having our state epidemiologist plot a map of children on Medicaid that were attending well child visits but did not have a dental home would allow us to better address and identify higher need areas. This is still in the process phase, and we are still adjusting how we identify clinics and areas of need.

Patient voice is a top priority of the Alliance. We used past projects, such as CareQuest Institute for Oral Health Elevating Community Voice in Medical Dental Integration Systems Change Mid-grant report from Children's Health Alliance of Wisconsin. This grant allowed partners to engage with patients and understand their experiences with medical dental integration. This past project has allowed us to take a deeper understanding of patient voice, and it drives the current work we are doing trying to implement more patient voice in our current work.

Resources

List resources developed by this project that may be useful to others (e.g., guidelines, infographics, policies, educational materials). Include links if available.
Children's Health Alliance Medical Dental Integration
Wisconsin Medical Dental Integration Implementation Guide
WI MDI Infographic Series

References

1. Wisconsin Department of Health Services. (2023). Oral Health Program. https://www.dhs.wisconsin.gov/oral-health/index.htm
2. *Healthy Smiles Survey:* Wisconsin's Kindergarten and Third-Grade Children. (2024). Unpublished report. Wisconsin Oral Health Program, Wisconsin Department of Health Services.
3. Oral Health Program: PRAMS data. (2023, October 3). Wisconsin Department of Health Services. https://www.dhs.wisconsin.gov/oral-health/data-prams.htm

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