

Dental Public Health Activity Descriptive Report

Practice Number: 99001(a)
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SECTION I: PRACTICE OVERVIEW		
Name of the Dental Public Health Activity: Oral Health Disparities Collaborative		
Public Health Functions: Policy Development – Collaboration and Partnership for Planning and Integration Assurance – Population-based Interventions Assurance – Oral Health Communications Assurance – Building Linkages and Partnerships for Interventions Assurance – Building State and Community Capacity for Interventions Assurance – Access to Care and Health System Interventions		
Healthy People 2010 Objectives: 21-1 Reduce dental caries experience in children 21-2 Reduce untreated dental decay in children and adults 21-5a Reduce gingivitis among adults 21-5b Reduce periodontal disease among adults 21-10 Increase utilization of oral health system 21-12 Increase preventive dental services for low-income children and adolescents 21-14 Increase community health centers & local health departments with oral health component		
State: Colorado and Montana	Federal Region: Region VIII-West and Region VIII-Northwest	Key Words for Searches: Collaborative, disparities, early childhood oral health, perinatal oral health, community health centers
Abstract: The Oral Health Disparities Collaborative (OHDC) was launched in order to improve access to oral health services for low-income individuals in two target populations: children ages 0 to 5 and pregnant women. The traditional paradigm of surgical treatment of caries and periodontal disease has historically utilized the majority of resources, rather than a focus on preventive care. In addition, while physicians are in good position to identify dental problems and refer patients for appropriate services, few do, as dental care is often seen as a separate, stand-alone healthcare entity. With the recognition that caries and periodontal disease are in fact chronic diseases, improved outcomes should be achievable using a collaborative methodology focused specifically on oral health. The OHDC used the Chronic Care Model as the framework for delivery system redesign. Additionally, emphasis was placed on enhancing practice and office efficiencies to support improved access and outcomes in the targeted populations, as well as encouraging the integration of dental and medical services to make oral health a part of comprehensive primary care. Through the Collaborative, access for the two target populations not typically seen in dental clinics has been created, practices have successfully applied techniques to maximize operational efficiencies, the foundation for fiscal sustainability has been laid, and a critical paradigm shift from episodic, end-stage surgical care to a chronic disease prevention and management approach in dental practice has been achieved.		
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SECTION II: PRACTICE DESCRIPTION

History of the Practice:

Since 1999, the Health Resources Services Administration (HRSA) Health Disparities Collaboratives (HDC) have fostered the development of high quality, evidence-based systems of care in the nation's Federally Qualified Health Centers (FQHCs). Beginning with a focus on chronic diseases such as diabetes, followed by the integration of preventive services, the HDC have shown improvements in the health outcomes of underserved populations. Measures related to oral health have been incorporated into several collaboratives. However, with the recognition that caries and periodontal disease are in fact chronic diseases, improved outcomes should be achievable using the collaborative methodology focused specifically on oral health. The Oral Health Disparities Pilot began in August 2005 with the aim of developing comprehensive primary oral health care system change interventions to generate improvements in prenatal oral health and in the prevention and treatment of Early Childhood Caries (ECC), involving three health centers in Colorado and one in Montana.

At the heart of the program is the recognition that, although dental disease has traditionally been treated in the acute or surgical stage, the most common conditions, dental caries and periodontal disease, are fundamentally chronic conditions. The challenge is to shift the paradigm from end-stage surgical and emergency care toward outreach, prevention, and proactive management. Accordingly, the **Oral Health Disparities Collaborative (OHDC)** is based on the Chronic Care Model, which emphasizes, among other elements, interventions that support patient self-management, behavior change and delivery system redesign.

Justification of the Practice:

The majority of Americans over age five have at least one tooth with untreated caries (dental decay) and most adult mouths have some form of periodontal (gum) disease. Research shows that adults and children with major medical problems, such as diabetes, are at higher risk for periodontal disease. A pregnant woman's cavity-causing pathogens are passed along to her newborn, paving the way to another generation with poor dental health. Early Childhood Caries in children aged 0-5 is a risk factor for developing caries in later life. Risk assessment for ECC can begin with the pregnant mother and continue once the child is born. Ideally, the goal of assessment is to determine if the mother's oral health status, health care behaviors, or the environment are risk factors for her unborn child to develop ECC, and once the child is born to regularly assess caries risk in the infant and if needed, provide preventive interventions and identify incipient carious lesions for non-surgical treatment. ECC interventions with a focus on the mother to prevent transmission of caries-causing bacteria include education and improved self-management of risk factors, and suppression of caries-causing bacteria through chemotherapeutic means, as well as through surgical removal of existing carious lesions.

While physicians are in a good position to identify dental problems and refer patients for appropriate services, few do. Experts say this is partly because current medical education puts little emphasis on the connection between oral health and systemic disease and provides minimal oral health content. Dentists who do not receive this message during their training may also exhibit shortfalls in care. Some dental practitioners erroneously believe that children under age three do not need to have regular visits to the dentist or that pregnancy is a reason to avoid dental treatment due to possible risks. For disadvantaged patients, who are more likely than the general population to have concerns about cost or simply be uninformed, the result is that many low-income families seek dental care for young children or while pregnant only on an emergency basis or not at all.

Inputs, Activities, Outputs and Outcomes of the Practice:

The aim of the Oral Health Disparities Collaborative (OHDC) is to develop comprehensive primary oral health care system change interventions, based upon the Care model and evidence-based concepts that generated major improvements in process and outcome measures for (1) Early Childhood Caries prevention and treatment and (2) Prenatal oral health. Additionally, emphasis was

placed on practice redesign and office efficiencies that supported improvements in the targeted areas.

Pilot Locations in the Collaborative

Four pilot locations participating in the Collaborative:

1. High Plains Community Health Center in Lamar, Colorado
2. Salud Family Health Center in Ft. Lupton, Colorado
3. Sunrise Community Health Center in Greeley, Colorado
4. Community Health Partners in Livingston, Montana

Inputs

1. Leadership and Improvement Teams of the Collaborative

For each pilot location, the following were established:

- a. *Senior Leadership:* Senior leadership included the Executive Director, Dental Director, Medical Director, Chief Operating Officer, Chief Financial Officer, and Board of Directors. They had accountability for the outcome of the improvement initiative, and were responsible for working with the improvement team to target goals, support changes, remove obstacles, communicate changes and priorities to the staff and board, charter the team, and provide support and resources to assure success. Senior leadership directed the implementation of improvement changes throughout the organization, integrating them into their entire system of care.
 - b. *Improvement Team:* Team members were chosen based on their knowledge of, and involvement in, the overall goal and the processes necessary to realize that goal. The team composition was interdisciplinary and included members willing to try new ways of delivering care within and across the system. Six to eight individuals is a good size for the improvement team. Four of these individuals comprised the core team that was the primary driver of the Collaborative effort and implemented changes in the organization. Individuals selected for the core teams in the pilot locations included a senior leader, dentist, medical provider, case/care manager, dental hygienist or nurse, dental or medical assistant, and a staff member with information technology expertise. The core team filled four roles: senior leader, provider champion, clinical or technical expert, and day-to-day leader (one or more individuals on the team may occupy the same role and one individual may fill more than one role).
2. Methodology of the Collaborative: Applying the Chronic Care Model

The Oral Health Disparities Collaborative applied the Chronic Care Model with a focus on quality outcomes in perinatal oral health, especially treatment of periodontal disease in pregnant women, and risk assessment, prevention and treatment of Early Childhood Caries. The Care Model provides a framework consisting of six components that promotes an organizational approach to providing planned, proactive care for people within a primary care setting: Clinical Information Systems, Decision Support, Delivery System Design, Self-Management, Organization of Healthcare, and Community Resources. Focused efforts to address the principles that underlie each of the six elements of the model would yield improvements in the care and health outcomes of children 0-5 years of age and of pregnant women. Collaborative participants based their treatment decisions on explicit guidelines or standards of care, ideally supported by an evidence base of best practices.

Care Teams

The Oral Health Disparities Collaborative involved teams of individuals from the Health Center who provide and support patient care. Team members vary by Health Center but may consist of the front desk staff, a dentist, a dental hygienist, a dental assistant, a physician, and a quality improvement coordinator. Participating Health Centers formed teams to implement the oral health collaborative. The teams participated in quarterly learning sessions and periodic conference calls with OHDC faculty. Teams also met regularly to provide support in implementing the OHDC.

Care teams devised ways to embed these guidelines, standards, and best practices into the day-to-day practice of the dental care team in an accessible and easy-to-use manner. Ongoing education for providers and care team members about new protocols of care occurred regularly. Referral mechanisms to and from the medical clinic were established and monitored. Regular feedback about performance was integrated into standard clinic operations.

Activities

At pilot locations, the six components of the Chronic Care Model were translated into the activities below:

1. Clinical Information Systems (CIS):
 - Develop a database or a registry system to collect, manage, and report data on patients
 - Define a clear data tracking, entry, and maintenance process
 - Incorporate measures and guidelines into daily, standardized documentation methods
 - Run reports to find patients who were not in compliance with the measures
 - Use a dental balanced scorecard
 - Work toward real time data entry
 - Create a template for dental (EHR systems)
 - Use standardized language in daily processes and documentation
 - Develop a direct scheduling system (able to make dental appointments from the medical clinic) and train staff on the system

2. Decision Support:
 - Provide education and training for medical and dental staff about the oral health needs and appropriate assessment and management interventions for populations that have traditionally faced barriers in access to care, such as children 0-5 years of age and pregnant women
 - Develop a referral process from the medical department for patients 0-5 years of age and pregnant women
 - Educate and train dental staff in the treatment of very young children and pregnant women
 - Adopt standards of care for children 0-5 years of age and pregnant women
 - Give regular feedback to staff about performance/progress
 - Provide education and training for all staff about the importance and techniques of engaging patients in self-management activities to achieve and maintain an improved oral health status
 - Establish a dental presence in the medical setting – for example, providing infant oral care visits in the medical clinic
 - Utilize the six steps of infant oral care model as the standard care for all infants

3. Delivery System Design:
 - Define the roles of each dental and medical care team member
 - Fast track 0-5 year olds and pregnant women for exams and treatment
 - Employ a dental assistant-run chair for exams, sealants, and prophies (teeth “cleanings”)
 - Use redesign concepts to improve access and service capacity
 - Assess your business case as you improve your system of care
 - Utilize expanded duty dental assistants (EDDAs/EFDAAs) and dental hygiene assistants to expand capacity
 - Improve prevention by allowing time for the “infant oral care visit”
 - Process map current processes to identify gaps and areas for improvement
 - Dedicate a dental assistant for each dental hygienist to expand capacity
 - Provide fluoride varnish at each visit for patients age 5 and younger
 - Arrange for dental staff to perform dental exams in medical clinic
 - Establish a dental liaison to interface with medical staff and patients
 - Place confirmation calls to patients prior to appointments

4. Self-Management (SM) Support:
 - Provide education to increase patient understanding of the importance of oral health
 - Utilize effective SM techniques and tools (multiple languages; pictures)
 - Train care team members on how to help patients with self-management goals
 - Ensure consistency of oral health education provided by care team members
 - Utilize motivational interviewing techniques to facilitate collaborative goal setting

- Establish a system to follow up on progress toward goals – make a staff member accountable
5. Organization of Healthcare:
- Make an organizational commitment to see and treat young children and pregnant women (populations not typically seen)
 - Create a strong improvement team with provider champions from both medical and dental departments
 - Elect a “sponsor” from senior leadership to provide support and accountability for the improvement efforts
 - Include reports on oral health quality in Board of Director reports
 - Integrate dental aims into organizational PI/QI structures
6. Community:
- Increase access and outreach by partnering with community organizations that provide services to pregnant women, mothers and children (e.g., WIC and Head Start)
 - Raise community awareness on the importance of oral health for pregnant women and young children through education
 - Partner with community obstetric/prenatal providers (if the health center does not have obstetric services)
 - Direct outreach to pregnant women (if a clinic does not have perinatal/OB services)
 - Link with state or county health departments to gain support for outreach and educational efforts
 - Identify opportunities to inform other dental providers about enhancing oral health access and outcomes for pregnant women and children 0-5 years of age

Implementation Manual

An **Oral Health Disparities Collaborative Implementation Manual** was developed and provides a step-by-step guide to implement an OHDC. The manual is available at <http://www.nnoha.org/oralhealthcollab.html>.

Evaluation

To evaluate the success of the Oral Health Disparities Collaborative, each team tracked outcome measures (see below) using a database developed specifically for this collaborative. Team members entered patient data following each visit, and submitted reports monthly to the OHDC faculty. Data from all sites was aggregated, analyzed and reported to faculty and teams on a monthly basis. Each team reviewed their data in comparison to other sites at periodic team meetings. In addition, some teams added measures – such as changes in Medicaid users, to track additional data that was important in their communities.

Output/Outcome Measures of the Collaborative

The Oral Health Disparities Collaborative has set up the following output/outcomes measures that the four pilot locations tracked and reported:

A. Perinatal Measures:

1. Core/Required Measures
 - a. Pregnant women with comprehensive dental exam completed while pregnant
 - b. Pregnant women with completed *Phase I Dental Treatment* plan within 6 months of exam
 - c. Pregnant women with *Self Management Goals* developed in either the medical and/or dental setting while pregnant
2. Optional Measures
 - a. Pregnant women referred by medical to dental for comprehensive oral health exam
 - b. Pregnant women who received patient education for oral health and anticipatory guidance in the medical setting while pregnant (*Primary Care Physician Dental Counseling in the Medical Setting*)
 - c. Pregnant women who completed recommended periodontal treatment while pregnant

B. Early Childhood Measures:

1. Core/Required Measures
 - a. Children with dental exam by age 12 months

- b. Children age 12 to 60 months with exam
 - c. Children age 12 to 60 months with completed *Phase 1 Treatment* plan within 12 months of exam
 - d. Children ages 12 to 60 months whose caregivers developed *Self Management Goals* in either the medical or dental setting
2. Optional Measures
- a. Children age 12 to 48 months who received patient education for oral health and anticipatory guidance in the medical setting (*Primary Care Physician Dental Counseling in the Medical Setting*)
 - b. Children age 12 to 60 months with 1 or more fluoride varnish applications documented
 - c. Children age 6 to 60 months with an initial dental exam and a recall dental exam
 - d. Children age 6 to 60 months with fluoride assessment documented in either the medical or dental setting
 - e. Children age 6 to 60 months assessed as having inadequate fluoride who have been prescribed fluoride in either the medical or dental setting
 - f. Children age 6 to 60 months referred by medical to dental for comprehensive oral health exam

Each team reported success in all of the above measures. The following are three graphic illustrations of tracking measures:

Figure 1.

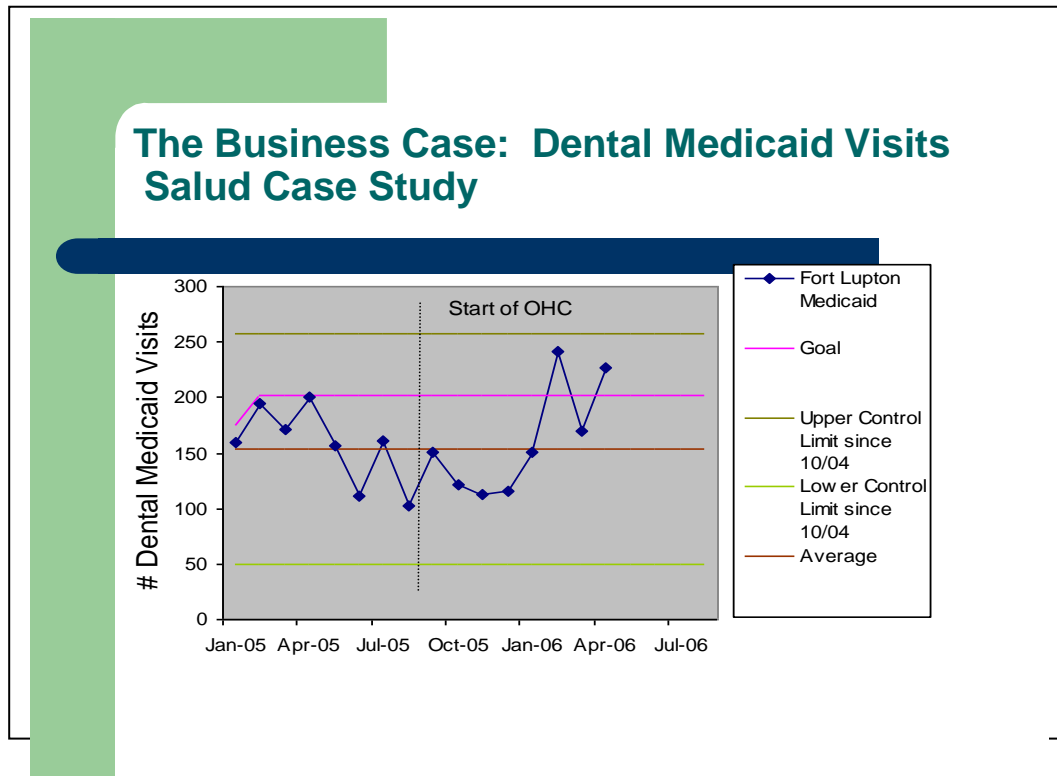


Figure 2.

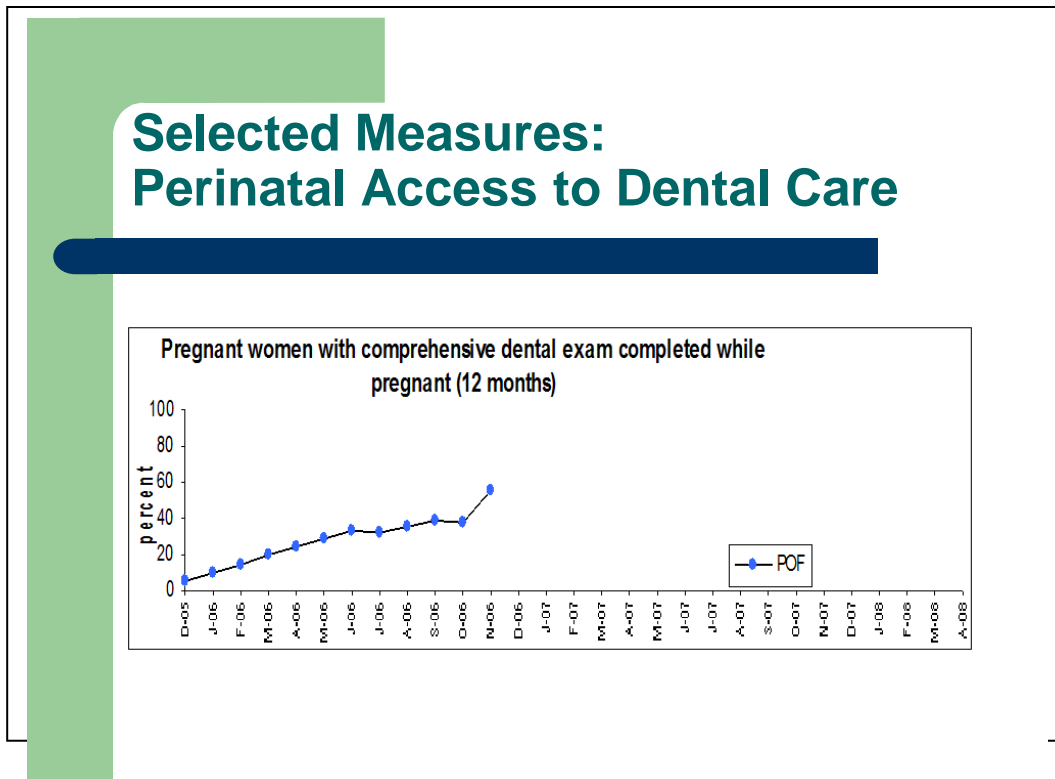
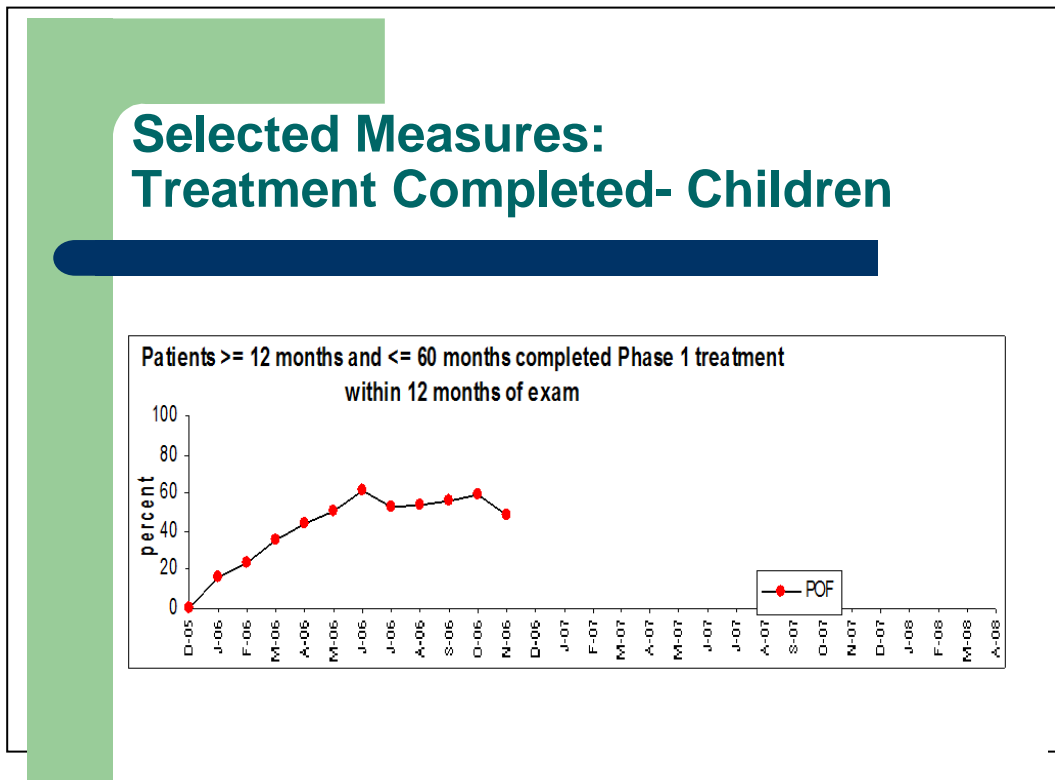


Figure 3.



Achievements and Outcomes

1. In the pilot locations, the project has effectively modified the dental care delivery system. At the Sunrise Community Health Center in Greeley, Colorado, the project's team leader said that participating in the pilot has "forced a complete rethinking of how we do dentistry...We weren't aggressive with in-office fluoride treatments...and we definitely didn't make any connection between the mom's oral health and her child's well-being...All that has changed now." The Salud Family Health Centers in Fort Lupton, Colorado, reported: "The Collaborative brought about a lot of change. There is increased awareness of the importance of oral health, greater integration of care, our patients are more informed and have better access, and we are practicing preventive oral health care." Community Health Partners in Montana reported reductions in wait time for appointments and "no-shows", while experiencing increases in number of patients seen, dental billings and Medicaid visits compared to prior to collaborative participation.
2. Pilot locations were able to gain a high level of patient compliance, such as 58% of pregnant women completing their dental exam during the period of their pregnancy (this was 0% at the start of the OHDC). Resistance from patients is less than might be expected. Once mothers-to-be learn that their oral health is related to their baby's health, not just their own teeth, they are usually very interested in pursuing treatment for themselves.
3. The pilot locations established efficient and cost-effective processes for delivering oral health services. Relatively small efficiencies can result in large time-saving dividends. Participating teams are always on the lookout for new time-savers. In Greeley, the health center's physicians have online access to the dental clinic schedule so they can make an appointment for the patient without even contacting the dentist. Greeley's system also takes full advantage of Colorado's more liberal dental practice act regarding which health professionals are allowed to perform dental work. For example, when a patient needs a filling, the dentist removes decay, the assistant places the filling, and then the dentist checks the work.
4. Project-wide, between December 2005 and June 2006, the percentage of pregnant women receiving dental care has nearly tripled, and the percentage of very young children has increased eightfold. Some pilot sites have been more successful than others, with the percentage of dental exams completed in their individual target populations ranging from 18 percent to 85 percent.
5. The project created professional guidelines for the oral care of pediatric patients, which were fully integrated into the provider practice and patient management of the pilot locations. All participating pilot sites fully implemented the guidelines, and demonstrated improvement in providing dental services to pregnant women and very young children. Authored by members of the American Academy of Pediatrics and the American Academy of Pediatric Dentistry, the guidelines provide another step forward in overcoming the compartmentalization of oral health care services. In addition, an Implementation Manual including the OHDC detailed measures and Steps to Success ("change package") was created.
6. The four health center organizations that participated in the pilot were able to build strong relationships with their medical counterparts and experienced varying degrees of success in moving toward a truly integrated model of primary care. Improved communication among departments, greater respect and understanding of their counterparts' contributions, and increased staff satisfaction are just some of the positive results achieved. Chief Dental Officer at the Sunrise Community Health Center in Greeley, CO stated, "The oral health collaborative pilot made dentistry relevant to the delivery of health care within a community health center. The dental department is at the table and no longer a sideshow."
7. Status of the locations after the pilot: Due to funding constraints, long-term follow-up has not been conducted with the pilot sites. Anecdotally, we know that 3 of the 4 pilot sites have fully integrated preventive oral health services for pregnant women and very young children into their regular practice.

Budget Estimates and Formulas of the Practice:

HRSA funding for the Collaborative pilot totaled \$400,000. Funding supported expenses including:

- Project Manager from the Institute for Health Care Improvement
- Contracting Collaborative Co-Directors,
- Contracting expert faculty
- Contracting data manager and statistical analysis
- Travel for faculty and Care Team members to attend quarterly learning sessions

Lessons Learned and/or Plans for Improvement:

Through the work of the OHDC pilot, it became clear that successful application of the Chronic Care model to oral health in the pilot health centers required transformation of every aspect of the health center organization. The work became an opportunity to integrate oral health within the medical, administrative and financial systems of the individual health centers. Traditional paradigms of how and when dental care is delivered were replaced with new organizational designs that increased access and quality of care. Teams experienced increased success as medical-dental integration increased, and were also able to make a business case for collaborative participation.

Available Information Resources:

Oral Health Disparities Collaborative Implementation Manual – Developed by the faculty of the Oral Health Disparities Collaborative. Available online at <http://www.nnoha.org/oralhealthcollab.html>.

The following documents are referenced throughout the **Oral Health Disparities Collaborative Implementation Manual**. Access documents online at <http://www.nnoha.org/oralhealthcollab.html>.

1. **Pedi Caries Risk Assessment** – Sticker used for children ages 0-5 during initial exam and prevention visit.
Author: High Plains Community Health Center
2. **CAMBRA Risk Assessment** – Caries Management by Risk Assessment – Caries risk assessment tool for children 0-5 years of age.
Authors: John D.B. Featherstone, MSc, PhD, Department of Preventive and Restorative Dental Sciences at UCSF and others.
3. **Anticipatory Guidance** – Can be used by health professionals to educate pregnant women and caregivers of children about the importance of oral health and appropriate preventive interventions.
Author: Bright Futures: A National Health Promotion Initiative
4. **Oral Health and Pregnancy: A Review**
Authors: Sangeeta Gajendra, BDS, MPH and Jayanth V. Kumar, DDS, MPH
5. **Clinical Considerations for an Infant Oral Care Program**
Author: Francisco J. Ramos-Gomez, DDS, MS, MPH, Associate Professor of Pediatric Dentistry, University of California, San Francisco, San Francisco, California
6. **ECC AG-6 step visit** – Six steps for the child dental exam including Anticipatory Guidance
Author: First Smiles: California First 5 Oral Health
7. **Fluoride Varnish Study 2006**
Authors: J.A. Weintraub, F. Ramos-Gomez, B. Jue, S. Shain, C.I. Hoover, J.D.B. Featherstone, and S.A. Gansky
8. **OHDP Patient Satisfaction Survey** – Satisfaction survey for dental patients
Author: Developed by the Oral Health Disparities Pilot.
9. **CHP Dental Balanced Scorecard** – A dashboard of measures to assess program improvement and vitality. Author: Community Health Partners
10. **Perinatal Oral Health** – A PowerPoint presentation about oral health in pregnant women.
Authors: Jay R. Anderson, DMD, MHSA and Mary E. Foley, RDH, MPH
11. **Example of Flow Child** - An example of a process map of the flow of a young child visit.
Authors: Kevin Little, Ph.D. and Martin Leiberman, DDS
12. **Redesign Tools Exercises** –Power Point describing how to measure demand and capacity, work analysis, process mapping, and waste analysis.
Author: Christine St. Andre, CSI, LLC.
13. **Cycle Time Tool** - a tool used to measure the time of a patient visit (from when the patient enters the clinic to departure from clinic).
Author: © 2001, Trustees of Dartmouth College, Godfrey, Nelson, Batalden, Institute for Healthcare Improvement
14. **Cycle Time Tool Spanish** – unknown translator

15. **Oral Health DSD Indicators** – A set of 6 Delivery System Design (also called redesign) measures to assess practice efficiency and patient care effectiveness.
Author: Christine St. Andre, Colleen Lampron
16. **Improving Access and Efficiency Dental** – A presentation describing the principles behind improving access and practice efficiency in the dental setting.
Author: Christine St. Andre, CSI LLC
17. **Prenatal Brochure HP** – Oral health educational brochure for pregnant women.
Author: High Plains Community Health Center
18. **HP Perinatal SMGS** – Example of a Self Management Goal Sheet for use with pregnant women. Author: High Plains Community Health Center
19. **HP ECC SMGS** – Self Management Goal Sheet for use with young children and caregivers.
Author: High Plains Community Health Center
20. **CHP SM Sheet Child** – Example of a Self Management Goal Sheet for use with young children. Author: Community Health Partners
21. **CHP SM Sheet Caregiver** – Example of a Self Management Goal Sheet for use with caregivers of young children. Author: Community Health Partners
22. **Self Management Bibliography** – Obtained from the Institute for Healthcare Improvement website (www.ihl.org)
23. **Dental SM Tool** – Example of a Self Management tool for use in the dental setting.
Author: Grace Hill Community Health Center
24. **NYSDOH Perinatal Guidelines** - Practice guidelines developed by the New York State Department of Health. Author: New York State Department of Health, 2006

SECTION III: PRACTICE EVALUATION INFORMATION

Impact/Effectiveness

How has the practice demonstrated impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence, outcomes of the practice and/or evaluation results)?

- Increased access to dental care for populations of focus – pregnant women and children 0-5;
- Improved oral health status of pregnant women; and
- Implemented best practices in Early Childhood Caries prevention.

Efficiency

How has the practice demonstrated cost and resource efficiency where expenses are appropriate to benefits? How has the practice demonstrated realistic and reasonable staffing and time requirements? Provide unit cost analysis or cost-benefit analysis if appropriate.

- The initiative was implemented within the existing health care delivery systems in the pilot Health Centers.
- The Collaborative initiative became part of day-to-day work at each pilot location.
- The initiative resulted in modification of the health center delivery system.
- Changes in the organization and the care system leveraged services delivered in the medical and dental settings of the community health centers.
- Concurrent practice redesign activities resulted in increased visits and more effective visits.

Demonstrated Sustainability

How has the practice showed sustainable benefits and/or how has the practice been sustainable within populations/communities and between states/territories? What mechanisms have been built into the practice to assure sustainability?

The work of the four pilot centers has suggested a possible business case. Through increasing the percent of Medicaid patients seen and increasing productivity by lowering no-show rates and more efficient use of staff, two of the four pilot centers documented gains in revenue. These results should be applicable across health center locations.

Collaboration/Integration

How has the practice built effective partnerships/collaborations among various organizations and integrated oral health with other health projects and issues? What are the traditional, non-traditional, public and private partnerships/collaborations established by the practice for integration, effectiveness, efficiency and sustainability?

- Integration of medical and dental services in primary care was demonstrated in the health center setting at both the formal and informal level. This included establishing referral systems, integrated appointments, common educational materials, and joint meetings.
- Integration and collaboration resulted in increasing the knowledge of both medical and dental staff on comprehensive primary oral health care system interventions, Early Childhood Caries prevention, prenatal oral health.
- Other collaborators of the participating health centers included WIC, Head Start & Early Head Start, county health departments, and community perinatal practitioners.

Objectives/Rationale

How has the practice addressed HP 2010 objectives, met the National Call to Action to Promote Oral Health, and/or built basic infrastructure and capacity for state/territorial/community oral health programs?

The Oral Health Disparities Collaborative advanced efforts to achieve several Healthy People 2010 objectives related to reducing caries experience and untreated tooth decay among children ages 0-5, reducing gingivitis and periodontal disease in pregnant women, and increasing utilization of the oral health system, particularly for low income children.

The OHDC responded to all 5 Action Steps listed in the Surgeon General's Call to Action. The activities changed the perceptions of oral health in health center medical and administrative staff as well as in perinatal populations and caregivers of children 0-5. Barriers to oral health care access were overcome for the targeted populations and health promotion was enhanced. Transfer of the latest science based practices in ECC prevention and perinatal oral health were accomplished at the clinical level. Training of health center medical staff resulted in a workforce with improved ability to understand oral health needs and in increased collaboration with medical partners.

Finally, the project builds infrastructure and capacity for local oral health programs by integrating medical and dental services in primary care provided by community health centers. Every state can benefit from having these activities implemented in Health Centers.

Extent of Use Among States

Describe the extent of the practice or aspects of the practice used in other states?

The OHDC was piloted in health centers located in Colorado and Montana. Due to changes in the HRSA funding structure for all Collaboratives, which occurred immediately following the OHDC pilot phase, HRSA funding was not available for expansion to other states. Some states have obtained funding to implement parts of the OHDC model. Through NNOHA's website the OHDC Implementation Manual has been downloaded over 500 times and NNOHA has provided technical assistance to several Health Centers and Primary Care Associations related to the implementation of the model. NNOHA continues to seek funding opportunities at the national and state level.