Dental Public Health Project Descriptive Report Form

Name of Project
Improving Oral Health for Young Children in Connecticut Through Policy, Practice, Education, and Evaluation

Executive Summary

This project addresses worsening oral health outcomes among young children (ages 6 months to 5 years) in Connecticut (CT), particularly those from low-income families. Despite existing coverage and programs, rates of tooth decay remain high, with significant disparities linked to socioeconomic status. Data from state surveillance systems, Medicaid claims, and federally qualified health centers (FQHCs) highlight declining use of preventive services and persistent barriers, including limited access to care, workforce shortages, low oral health literacy, and structural inequities.

Overall, HUSKY Health dental utilization dropped from 51% to 37% between pre-pandemic and peak-pandemic periods (2018–2021), a decline accelerated by the COVID-19 pandemic, which disrupted routine care and exacerbated existing disparities in access to preventive services. Despite Connecticut ranking 3rd nationally for preventive dental services among Medicaid members under age 20, utilization has not returned to pre-pandemic levels. As of 2023, only 61% of continuously eligible children utilized dental services statewide.

The project's primary goal is to improve early childhood oral health by increasing access to and use of preventive services, especially for underserved populations. It combines state-level policy and systems change with local clinical interventions. At the state level, efforts focus on identifying gaps, strengthening data systems, and enhancing provider training. Locally, the project integrates preventive oral health services, such as screenings, fluoride varnish, and caregiver education, into well-child visits at selected health centers.

Key lessons emphasize the importance of aligning reimbursement policies with clinical workflows, addressing social determinants of health (SDOH), and actively engaging both providers and caregivers to improve oral health literacy. Strong partnerships across agencies and organizations have been critical, though coordination remains complex.

Supported by a $1.7 million federal grant, the project uses robust data collection and evaluation to track implementation and outcomes. Sustainability efforts focus on embedding services into existing clinical systems, securing reimbursement pathways, and advancing supportive policies. Ultimately, the project aims to create a scalable, data-driven model to reduce disparities and improve oral health outcomes for young children statewide.

Name of Program or Organization Submitting Project
Moses/Weitzman Health System

Detailed Project Description

Project Overview

This project addresses significant unmet oral health care needs among young children ages 6 months to 5 years in CT, particularly those from low-income households. Despite existing public health programs and insurance coverage, poor oral health outcomes persist and, in some cases, are worsening. In 2022, approximately one in four CT kindergarteners had experienced tooth decay, and 9% had rampant decay, defined as five or more teeth affected by untreated caries, representing a 29% increase in rampant decay among kindergarteners since 2017, when the rate was approximately 7%.[1] Statewide, 16% of kindergarten and third grade children have untreated decay, while 15% require dental treatment. Disparities are pronounced among specific groups, such as children eligible for the National School Lunch Program experience up to twice the rates of dental decay compared to higher-income peers. Hispanic and Asian children are among the populations identified as disproportionately affected by both decay experience and untreated decay.[2]

The problem was identified through multiple data sources, including statewide surveillance systems such as the Behavioral Risk Factor Surveillance System (BRFSS), HUSKY (Medicaid) claims data, and reports from FQHCs. HUSKY Health data illustrate this decline concretely. In the pre-pandemic period (July 2018–June 2019), 51% of continuously enrolled HUSKY members used dental services, with children comprising 72% of dental utilizers. By the height of the COVID-19 pandemic (March 2020–March 2021), overall dental utilization had dropped to 37%, and children's share of dental users fell to 52%. This is a pattern that has not fully recovered.[3] Among Medicaid-enrolled children ages 6 months to 5 years served by project FQHCs, preventive dental visits declined by 42% between 2018–2019 and 2020–2023. Additionally, FQHC-reported sealant application rates have dropped substantially over the same period.

Multiple systemic barriers contribute to these outcomes. SDOH, including economic instability, limited transportation, and structural inequities, play a foundational role. Oral health literacy among caregivers and providers remains insufficient, leading to missed appointments and delayed care. These challenges are compounded by longstanding policy and reimbursement constraints. Connecticut's children's dental reimbursement rate under HUSKY Health has not been updated since 2008, creating persistent disincentives for private dental provider participation in Medicaid.[4] While the state increased adult dental reimbursement rates by 25% in 2022, the adult rate remains 34% below the children's rate. Separately, the unwinding of pandemic-era continuous Medicaid enrollment, which had extended coverage for approximately 42% of Connecticut's MAGI-eligible population, introduced eligibility disruptions that further

[1] Connecticut Department of Public Health [CT DPH] & Connecticut Oral Health Initiative [COHI], 2022, Table 1.6A
[2] CT DPH & COHI, 2022
[3] CTDHP, 2022
[4] CTDHP, 2023

reduced continuity of care access for young children. Workforce shortages further limit access: Connecticut currently has 43 designated dental Health Professional Shortage Areas (HPSAs) serving a population of approximately 649,000 residents, with only 30% of dental care need being met and an estimated 114 additional dentists needed statewide.[5] Together, these factors contribute to underutilization of preventive services and worsening oral health outcomes among young children..

1. Target populations

The primary target population for this project is children ages 6 months to 5 years in CT, with a particular focus on those at highest risk for poor oral health outcomes. This includes children from low-income households, especially children enrolled in HUSKY Health (CT's Medicaid program).

A secondary target population includes caregivers of young children, whose oral health knowledge, beliefs, and behaviors strongly influence children's access to and utilization of preventive services. Additionally, the project targets healthcare providers and systems that serve these populations, including FQHCs, safety-net providers, primary care clinicians, dental providers, and care teams involved in well-child visits.

2. Project goals

The overarching goal of this project is to improve oral health outcomes for young children in CT by increasing access to and utilization of preventive oral health services, particularly among underserved populations. To achieve this goal, the project integrates policy, systems, and practice-level interventions across state and local levels.

At the state level, the project aims to identify and implement policy and practice improvements that expand access to preventive oral health services. This includes conducting environmental scans, capacity assessments, and gap analyses to better understand barriers and opportunities within the current system. The project will also strengthen oral health literacy among FQHCs and safety-net providers through targeted education and training initiatives. Additionally, it will enhance data-driven decision-making by conducting surveillance and evaluation of oral health outcomes and service utilization, with a focus on SDOH factors.

At the local level, the project will demonstrate and test the integration of preventive oral health services into well-child visits at four FQHC sites operated by Community Health Center, Inc. (CHCI). These services include activities such as oral health screenings, fluoride varnish application, and caregiver education, particularly for children who have not received dental care in the past six months. The project will refine and implement educational materials to improve oral health literacy among caregivers and providers at demonstration sites.

The project seeks to build a robust data infrastructure to support ongoing monitoring, evaluation, and sustainability of integrated preventive oral health services. Through collaboration with key stakeholders, including the CT Department of Public Health, CT Oral Health Initiative, CT Dental Health Partnership, the project aims to create a coordinated, scalable model for improving early childhood oral health across the state.

[5] HRSA, 2026

3. **What lessons learned would be useful for others seeking to implement a similar project, including what did not work?**

- Integrating oral health services into primary care requires alignment of policy, reimbursement, and workflow. While co-located medical and dental services and shared electronic health records facilitate coordination, reimbursement limitations, such as restrictions on billing for fluoride varnish application during medical visits in FQHCs, can significantly hinder implementation. Addressing these structural barriers is essential for sustainability.

- Improving oral health outcomes requires addressing upstream SDOH, not just clinical care delivery. While traditional approaches often focus on individual behaviors, this project highlights the importance of understanding and addressing broader socioeconomic and environmental factors that influence access to care. Identifying and measuring the most relevant SDOH factors remains challenging and requires dedicated data infrastructure and analytic capacity.

- Oral health literacy is a critical but often overlooked factor. Both caregivers and providers may lack awareness of the importance of early oral health care and available services. Educational interventions must be tailored, culturally responsive, and integrated into routine care workflows to be effective. Early findings suggest that passive dissemination of information alone is insufficient; active engagement strategies are needed to change behaviors.

- Workforce capacity and access barriers must be addressed in tandem with service expansion. Even when demand for services increases, shortages of dental providers and difficulty scheduling appointments can limit impact. Efforts to expand the role of primary care providers in delivering preventive services can mitigate these challenges but require training, support, and clear role definitions.

- Strong multi-sector partnerships are essential. Collaboration among state agencies, healthcare providers, community organizations, and payers enables a more comprehensive and coordinated approach. However, aligning priorities and maintaining consistent engagement across stakeholders can be complex and resource intensive.

Resources, Data, Impact, and Outcomes

1. **What resources were necessary to support the project, such as staffing, volunteers, funding and collaboration with other agencies or organizations?**

   The project leveraged a combination of staffing, partnerships, data systems, and organizational infrastructure to ensure effective implementation. Key staffing resources included leadership and coordination from the Weitzman Institute (project director and manager) and clinical leadership from CHCI, including the chief dental officer.

   A strong multi-agency alliance supported the work, including partners such as the CT Department of Public Health, CT Dental Health Partnership, CT Oral Health Initiative, Inc., and the Community Health Center Association of CT. These partnerships enabled policy alignment, technical expertise, and stakeholder engagement.

Additional resources included:

- Consortium expertise and technical assistance
- Existing documents (e.g., provider manuals, surveillance reports)
- Data sources such as CT BRFSS, HUSKY Health claims, and electronic health records (EHRs)
- Internal infrastructure like Moses/Weitzman Health System-CHCI's EHR system and Planned Care Dashboard
- Training systems for workforce development

Together, these resources supported clinical integration, policy work, training, and evaluation.

2. What process measure data (counting) were collected, such as number of sealants placed or people served?

The project has collected, or will collect, extensive process (output) measures to track implementation and reach at the state and/or local levels. These included:

- Policy and systems change
  - Number of enhanced state policies or scope-of-practice changes improving access to care
- Training and oral health literacy
  - Number of organizations and health professionals participating in trainings
  - Participant demographics
  - Training completion and engagement metrics
- Service delivery and integration
  - Number and percentage of children who:
    - Received preventive oral health services during well-child visits
    - Received dental referrals
    - Had dental visits
    - Selected care goals
- Data infrastructure
  - Number and percentage of sites modifying workflows
  - Number of sites tracking referrals and integrating data systems
- Surveillance and evaluation
  - Number of surveillance system enhancements
  - Number of analyses conducted on access

These measures focus on tracking how widely the intervention was implemented and how systems and providers engage with it.

3. What outcome measure data (results) were collected, such as improvement in health?

Outcome measures assessed the effectiveness of the intervention in improving health and system performance. Outcome measure data were collected on the following:

- Health outcomes:
  - Increased use of preventive oral health services

        - Reestablished dental care for 66 children who had not been since 2023 or 2024.
        - 167 children established a dental home at a MWHS clinic
    - Increased proportion of children connected to a dental home
        - 167 children established a dental home at a MWHS clinic
- Behavioral and service utilization outcomes:
    - Sustained use of preventive services after initial visits
        - 111 caregivers scheduled a 6 month follow-up appointment for their children, 14 have had more than 1 follow-up appointment (i.e., have gone every 6 months since establishment at a regular cadence.)
- Knowledge and capacity outcomes:
    - Improved oral health literacy among providers, caregivers, and staff
        - After oral health literacy education using the Smiles for Life curriculum, healthcare staff members say an 156% improvement in their knowledge of effective early childhood caries prevention strategies and an 133% improvement in the knowledge of a first dental visit timing.

These measures will be evaluated by the end of the project:

- System-level outcomes:
    - Improved ability to identify children needing services through EHR systems
    - Enhanced data systems supporting monitoring and evaluation
    - Improved equitable access to care based on SDOH-informed analysis
- Long-term impact:
    - Lower oral health service costs
    - Reduced disparities in oral health outcomes among low-income children

These outcomes reflect both clinical improvements and broader system transformation.

4. How frequently was data collected?

Data were collected at multiple intervals depending on the measure:

- Annual data collection:
    - State-level surveillance and evaluation measures (e.g., BRFSS, claims data)
- Biannual (twice per year):
    - Training participation and literacy outcomes
    - Service delivery metrics (e.g., preventive services, referrals, dental visits)
    - Site-level training outcomes
    - Workflow and data infrastructure changes
- Periodic (years 1, 3, and 4):
    - Environmental scans
    - Policy and systems assessments
- Continuous/ongoing:
    - EHR-based data collection for clinical services and referrals
    - Real-time monitoring through dashboards

This mixed cadence allowed for both real-time program monitoring and longer-term evaluation.

5. How were the results shared?

Findings were shared through multiple channels to reach stakeholders, policymakers, and the broader public health community:

- Reports to HRSA and the project consortium for monitoring and accountability
- Regular updates and knowledge-sharing within the Alliance and partner organizations
- Presentations at national conferences, including the National Association of Community Health Centers Community Health Institute and EXPO
- Peer-reviewed publications in journals such as the Journal of Primary Care and Community Health and Journal of Community Health
- Policy briefs developed for legislators and their staff to inform decision-making

This multi-pronged dissemination strategy ensured that findings informed practice, policy, and future research while supporting broader adoption of successful interventions.

Budget and Sustainability

1. What was the budget for the project?

$1,700,000 over four years.

2. How was the project funded, such as governmental or philanthropic funding?

The project was funded by a HRSA grant.

3. What was the sustainability plan for the project?

We are currently in year 2 of a 4-year grant. We will be working on the sustainability plan in years 3 and 4. The plan focuses on making the program sustainable by formally evaluating it after 3 years and then using those findings to create a long-term action plan in year 4.[6] Sustainability is assessed across key areas such as funding, partnerships, organizational capacity, communication, and ongoing adaptation.

A major highlighted strength is organizational capacity: the program will be integrated directly into existing systems, especially the EHRs. By embedding workflows like risk assessments, referrals, alerts into routine clinical processes, and training staff through established systems, the program can continue smoothly even after initial funding ends and can scale across all sites.

Financial sustainability is addressed by working with leadership to secure reimbursement for services and by collaborating with external partners to advocate for supportive policies, particularly around Medicaid dental coverage. The project demonstrates meaningful potential for return on investment (ROI), which strengthens the case for long-term financial sustainability. The core interventions, which include fluoride varnish and caries risk assessment delivered during well-child visits, have well-established cost-saving profiles in

[6] **Editor's note**: Though every program approaches sustainability in different ways, it would seem prudent to begin creating a long-term action plan well before the last year. Action steps related to fiscal reality often take time to develop trust and competence, eventually resulting in a preliminary plan that will need to be tested over time and a variety of variables,

comparable Medicaid populations. Fluoride varnish application by primary care providers saves an estimated $75.32 per child when accounting for averted restoration costs, with total population savings of nearly $2 million per year in comparable state Medicaid programs.[7]

A multi-state analysis of Medicaid-enrolled children found that preventive dental services generated per-member per-year savings ranging from $88 to $156 compared to children who did not receive preventive care, with aggregate state-level savings in the millions annually even at modest penetration levels.[8] Beyond direct dental cost savings, Medicaid enrollees with five continuous years of preventive dental care experienced 43% lower dental costs than those with no preventive care, driven primarily by reductions in oral surgeries and restorative procedures.[9]

For this project specifically, ROI can be realized through three pathways: reduced downstream Medicaid expenditures on restorative and emergency dental care; averted emergency department visits for preventable dental conditions; and reimbursable services embedded within existing well-child visit infrastructure, which generates revenue for participating FQHCs while reducing net cost per patient encounter. As reimbursement pathways for primary care-delivered oral health services are secured, a key goal of the sustainability plan, the program has the potential to become self-sustaining and financially beneficial to participating health centers over time. Overall, the plan combines evaluation, system integration, staff training, and policy advocacy to ensure the program can continue and expand beyond its initial funding period.

Resources

- MCH-IOHI Environmental Scan Chartbook (2025)
- CT's Oral Health Environmental Scan: Summary Report
- Oo, M., Srinivasan, S., & Wang, G. (2026). Enabling factors and oral health care use among children aged 0 through 5 years: Insight from the 2022-2023 National Survey of Children's Health. *Journal of the American Dental Association (2026)*, *157*(3), 257–265. https://doi.org/10.1016/j.adaj.2025.10.002

References:

Connecticut Dental Health Partnership. (2022, September). *Press release: HUSKY Health dental utilization data.* https://ctdhp.org/press-release-september-2022/

Connecticut Dental Health Partnership. (2023). *HUSKY Health dental plan benefit member survey results.* https://ctdhp.org/wp-content/uploads/2023/06/CTDHP-2023-Member-Survey-Summary-Report_Final-2023.pdf

Connecticut Department of Public Health, Office of Oral Health, & Connecticut Oral Health Initiative, Inc. (2022, December). *Every Smile Counts: The oral health of Connecticut's children.* https://portal.ct.gov/-/media/DPH/Oral-Health/Every-Smile-Counts-Report-2022.pdf

[7] Scherrer & Naavaal, 2019
[8] Lee et al., 2018
[9] Okunev et al., 2022

Health Resources and Services Administration. (2026, April). *Designated health professional shortage areas statistics: Second quarter, fiscal year 2026.* U.S. Department of Health and Human Services. https://data.hrsa.gov/default/generatehpsaquarterlyreport

Lee, I., Monahan, S., Serban, N., Griffin, P. M., & Tomar, S. L. (2018). Estimating the Cost Savings of Preventive Dental Services Delivered to Medicaid-Enrolled Children in Six Southeastern States. *Health services research*, *53*(5), 3592–3616. https://doi.org/10.1111/1475-6773.12811

Okunev, I., Tranby, E. P., Jacob, M., Diep, V. K., Kelly, A., Heaton, L. J., & Frantsve-Hawley, J. (2022). The impact of underutilization of preventive dental care by adult Medicaid participants. *Journal of public health dentistry*, *82*(1), 88–98. https://doi.org/10.1111/jphd.12494

Scherrer, C., Naavaal, S., Lin, M., & Griffin, S.O. (2022). COVID-19 pandemic impact on US childhood caries and potential mitigation. *Journal of Dental Research, 101*(10), 1147–1154. https://doi.org/10.1177/00220345221090183

Unite Us & Connecticut Dental Health Partnership. (2025). *Improving dental access in Connecticut: Social care tech & Medicaid success.* https://uniteus.com/report/dental-access-connecticut/

Contact for Inquiries	
Name:	Katrina Yamazaki
Title:	Assistant Director of Research Operations – Principal Investigator
Agency/Organization:	Moses\Weitzman Health System
Address:	19 Grand St., Middletown, CT 06457
Phone:	475-301-4516
Email:	ymazak@mwhs1.com
Second Contact for Inquiries	
Name:	Lynsey G. Huppe
Title:	Program Manager
Agency/Organization:	Moses\Weitzman Health System
Address:	19 Grand St., Middletown, CT 06457
Phone:	860-347-6971 ext. 3462
Email:	lynsey@mwhs1.com

To Be Completed By ASTDD	
Descriptive report number:	99011
Associated BPAR:	Integrating Oral Health Care into Primary Care
Submitted by:	Moses/Weitzman Health System
Submission file name:	DES99011MWHS-improving-oh-children-policy-education-evaluation
Submission date:	April 2026
Last reviewed:	May 2026
Last updated:	May 2026