A Best Practice Approach Report describes a public health strategy, assesses the strength of evidence on the effectiveness of the strategy, and uses practice examples to illustrate successful/innovative implementation.

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Best Practice Approach: Perinatal Oral Health

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Introduction

The perinatal period begins at conception and ends 2 months after delivery. However, many health care professionals believe the perinatal period should be extended to a year after the child is born for the associated benefits that would transpire. This period is a unique time in a woman's life, characterized by complex physiological changes that may affect oral health. A strong connection exists between the oral health of pregnant women and the health of their infants.[1]

Oral health treatment is safe throughout pregnancy. It is essential that women considering pregnancy and those who are pregnant receive appropriate and timely oral health care including preventive, emergency, diagnostic, restorative treatment, and education. Receiving such care reduces oral disease burden in pregnant women and decreases the transmissibility of bacteria that causes tooth decay in their infants. Many health care professionals believe this perinatal period should be extended to a year after the child is born for the associated benefits that would transpire.[2]

Inability to access oral health care before, during, and after pregnancy can contribute to negative outcomes for women and infants. For a variety of reasons, pregnant women frequently do not seek or receive oral health care, despite having obvious signs of oral disease such as red, swollen or bleeding gums; sensitive teeth; or bad breath. Hormonal changes during pregnancy can increase the risk of periodontal disease, which is linked to adverse birth outcomes including preeclampsia (high blood pressure during pregnancy), preterm birth, and

low-birthweight infants. All women need to be informed about oral health changes that may occur during pregnancy. This includes understanding the importance and safety of receiving oral health care while pregnant and what coverage for perinatal oral health care is available through Medicaid or private insurance.[3]

Various health professionals can play important roles in connecting medical, oral health, behavioral health, and supportive health care for pregnant women. Visualize a patient-centered perinatal care delivery system where a multidisciplinary group of health professionals can provide oral health services. Community health workers and dietitians could provide education about oral health and provide referrals. Primary medical and behavioral health professionals could assess oral health status and preventive behaviors and provide referrals. Oral health professionals could assess depression and reinforce self-management of medical or behavioral chronic health conditions for these women. These individual pieces of the puzzle contribute to the overall picture of patient-centered health care.

Since October 2022, all 50 states and the District of Columbia have offered some form of dental coverage for pregnant and postpartum women enrolled in Medicaid through at least 60 days after the pregnancy ends. Yet, the disparate nature of this coverage and the differing policies that govern it often hamper health professionals' ability to deliver comprehensive oral health care.[4,5,6]

Strategic Framework for Improving Perinatal Oral Health

Drawing from core activities described in the *Ten Essential Public Health Services* and the *Ten Essential Public Health Services to Promote Oral Health in the United States*, public health entities can formulate their own framework to build support for improving perinatal oral health. These actions include monitoring health status, providing education, promoting partnerships, developing policies and plans, promoting high-quality care, ensuring an adequate workforce, and conducting research.[7]

Monitoring Perinatal Oral Health Status

Collecting, analyzing, and reporting data in a timely manner are essential at the national, state, and local program levels for monitoring perinatal oral health status, disseminating findings, launching effective perinatal oral health programs, and evaluating such programs. Three data sources that provide perinatal oral health information are the Pregnancy Risk Assessment Monitoring System (PRAMS), the National Health and Nutrition Examination Survey (NHANES), and the Behavioral Risk Factor Surveillance System (BRFSS), and are housed within the Centers for Disease Control and Prevention. All three sources have limitations, making it difficult to assess access to oral health care for pregnant women and make comparisons across states.

PRAMS is a state-specific, population-based data monitoring system that collect information on maternal attitudes and experiences before, during, and shortly after pregnancy. About 81 percent of all U.S. births are currently included. Participation is voluntary, and data are self-reported. While 46 states, the District of Columbia, the Northern Mariana Islands, Puerto Rico, and New York City participate in PRAMS, some states do not collect all the data that the monitoring system addresses. The frequency of data collection and reporting is inconsistent among participating states and jurisdictions.[8] Three states, California, Idaho, and Ohio, do not participate in PRAMS, but administer their own similar questionnaire.

NHANES is a nationally representative survey designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in combining interviews and both medical and oral examinations. NHANES does not include an analysis of oral health data specific to pregnant women. Even if NHANES pregnancy-specific data were reported at the national level, only information from a moment in time would be provided.[9]

BRFSS collects data through phone interviews with adults ages 18 and older about their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS collects data in all 50 states, the District of Columbia, and three jurisdictions (Guam, Puerto Rico, and the U.S. Virgin Islands).[10]

An oral health surveillance system should, in a timely manner, disseminate health data to policymakers and the public in a way that enables them to take actions to prevent or manage disease. Health authorities are encouraged to implement an oral health surveillance system and create a communication plan for the system that considers six topics: primary audience, communication message, communication channels, message marketing, cultural sensitivity, and evaluation. In addition, health authorities are encouraged to translate numeric information into plain language while also interpreting and presenting the meaning of the results. Transforming surveillance system data into a story that frames the issue and presents visually engaging data will help health authorities create a data dissemination message or product that policymakers and the public can understand and use.[11]

Examples of Actions

- Identify stakeholders in the public and private sectors who can contribute knowledge and expertise related to data collection in a collaborative data collection endeavor.
- Collaboratively develop guidelines to indicate what data should be collected at the state level to contribute to national databases.
- Establish baseline data and evaluate progress of perinatal oral health goals and objectives at the state, local, and program level.
- Correlate perinatal oral health data collection and assessment efforts with those conducted by other public health entities.
- Use data from community-based programs to identify oral health needs and disparities, effective and innovative oral health services, and workforce models to address barriers to accessing oral health care.

Educating and Engaging Women of Reproductive Age

Lack of knowledge and understanding about perinatal oral health crosses demographic boundaries and is not limited to a single socioeconomic group. Pregnant women's oral health knowledge and beliefs vary according to their education levels. Women from families with low incomes, who are enrolled in Medicaid, or who belong to certain groups are half as likely to obtain oral health care when they are pregnant compared to women from families with higher incomes, who are privately insured, or who are non-Hispanic white.[12]

All women need to receive education about oral health changes during pregnancy, how their oral health is connected to that of their child, and oral health programs and oral health care coverage available in their state. They can benefit from learning about healthy eating habits, good oral hygiene habits, and other lifestyle behaviors to keep themselves and their infants healthy.

Targeted interventions such as education and counseling during prenatal visits can increase knowledge about the importance and safety of oral health care during pregnancy. Using educational health materials written in plainly and in multiple languages with clear visuals can improve understanding and engagement to develop and maintain good oral health care at home and obtain regular dental visits, thus improving pregnant women's oral health and the subsequent oral health of their child.[13,14]

Examples of Actions

- Promote awareness of resources (e.g., *Oral Health Care During Pregnancy: A National Consensus Statement*, *Smiles for Life: A National Oral Health Curriculum*) for health professionals and community health providers to increase awareness of the importance of oral health and engagement in oral health care.
- Encourage health professionals and community representatives to promote effective and clear communication to pregnant women, emphasizing the importance and safety of receiving oral health care during pregnancy.
- Encourage health professionals and community representatives to assist pregnant women in finding dental practices and clinics that welcome and serve them.
- Develop accurate, clearly written, and culturally appropriate materials about the importance of oral health for pregnant women and their infants, in languages that pregnant women and their families can understand.
- Disseminate perinatal oral health success stories such as the periodic updates shared by the National Maternal and Child Oral Health Resource Center, to health professionals, program administrators, educators, policymakers, and the public.

Promote Partnerships

The perinatal period offers women opportunities to access oral health care that they may not have during other periods of their lives. To make perinatal oral health a priority, health professionals must first understand the importance of oral health across the lifespan before sharing information with pregnant women.

To enhance a patient-centered environment for these women, interdisciplinary partnerships should be promoted among health professionals, community-based organizations and national interest groups. Incorporating oral health care into primary care delivered by non-oral health professionals to pregnant women is a promising strategy; however implementing it can be challenging. Embracing care management to coordinate these diverse but related services can enhance the patient-centered experience.[15] Although such integration improves coordination of care for pregnant women, health care systems (particularly individual electronic medical records and electronic dental records) are not well connected, making it difficult for a diverse range of health professionals to work together to improve the oral health of their patients.

While many primary care providers (PCPs) agree that preventive oral health care is important, many have not received training on addressing oral health with pregnant women. It is promising that most PCPs acknowledge their role in oral health promotion and agree they should be able to identify oral health issues in patients. Completing continuing education courses and enhancing personal awareness about the importance and safety of oral health care are strongly associated with the likelihood of PCPs providing perinatal oral health counseling.[16]

Educating the next generation of health professionals about oral health is important. Educational interventions aimed at promoting interdisciplinary approaches should focus on long-term

outcomes and clinical skill development. Oral health promotion by medical professionals is associated with improving pregnant women's use of oral health care.[17]

Examples of Actions

- Integrate oral health education into community-based programs, such as Early Head Start, home visiting, prenatal, childbirth preparation classes, and tobacco-cessation programs, as well as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- Increase established referral arrangements among perinatal health clinics and dental practices and clinics.
- Offer interdisciplinary continuing education sessions to promote greater awareness of the importance and safety of oral health care and to foster increased collaboration and referrals.
- Encourage perinatal care settings to include oral health care or to facilitate referrals.
- Ensure that state and local agencies encourage partners to replicate successful programs and initiatives that focus on improving oral health care for pregnant women.
- Share successful quality improvement efforts implemented at the program level, such as at community health centers, with other programs.
- Coordinate interaction between medical professionals and oral health professionals to enhance effective and informed access to oral health care through bi-directional referral mechanisms.

Messaging and Communication Leading to Developing Policies and Plans

Promoting the importance of oral health for pregnant women and their infants has been a crucial strategy for improving perinatal health. Despite the realization among health professionals that effective communication plays a role in disease prevention, public oral health campaigns often lack an interdisciplinary, coordinated approach, leading to health professionals sharing different messages to women of reproductive age.

Oral health professionals can collaborate with behavioral health professionals to develop more effective communication techniques that facilitate positive behavioral change through strong messages that prioritize oral health during the perinatal period. All messaging should be tailored to their various audiences, be that patient, health professionals, and/or policymakers.

Public policy shapes oral health care, who administers it, and where it can be provided. State dental boards regulate who can provide what care and in which settings, with various levels of supervision. States should expand the capacity and capability of oral health team members, who can provide oral health preventive care and education in settings visited by pregnant women. By allowing all oral health team members to work "at the top" of their professional training and experience, dental practices can be more efficient, effective, and profitable, while maintaining quality of care and patient safety, and increasing access for underserved populations.[18]

The number of pregnant women who have adequate dental coverage or any dental coverage at all is unknown. Many women with low incomes continue to face barriers to accessing and receiving high-quality, affordable oral health care during pregnancy and the postpartum period. States are not required to provide a comprehensive Medicaid dental benefit for adults. Adult dental Medicaid services are available in all 50 states; however, some states provide only emergency services. There is considerable variation among states in eligibility policies and scope of dental coverage for women with low incomes during the perinatal period. Policies

ensuring consistent, comprehensive care are foundational when making the case to policymakers to provide adequate funding to support improved oral health for pregnant women and their infants.

Pregnant adolescents up to age 21 enrolled in Medicaid can receive comprehensive and preventive dental coverage through Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Preventive oral health care is defined as including, at a minimum, relief from pain and infections, restoration of teeth, and oral health maintenance. A strategy is needed for financing oral health care for all women during the perinatal period who cannot otherwise afford care. Although pregnant women enrolled in Medicaid are entitled to "pregnancy-related services," oral health care is not explicitly included as a pregnancy-related service.[19]

Examples of Actions

- Encourage health professionals to use more effective communication strategies, including motivational interviewing, as a means of furthering interdisciplinary collaboration to improve patient health.[20]
- Educate policymakers about the positive benefits and outcomes of policies that support consistent access to perinatal oral health care.
- Encourage stakeholders, such as academic institutions, faith-based groups, managed care organizations, mother-to-mother networks, and not-for-profit philanthropies to establish and promote perinatal oral health goals. Include these goals in strategic and operating plans such as Title V 5-year needs assessments and state action plans, state health plans, state oral health plans, and organizational and clinic strategic plans.
- Enhance benefits for all women eligible for Medicaid during the perinatal period through one-year postpartum such as including dental benefits in "pregnancy-related" services.

Promote the Delivery of High-Quality Care through a Competent and Adequate Oral Health Workforce

Promoting high-quality oral health care during the perinatal period is critical to ensure that every woman and her child can achieve the best possible oral health. Surveys of dentists indicate that the majority believe perinatal oral health is important and are willing to provide oral health education and counseling during pregnancy; however, their beliefs about and practices related to providing care for pregnant women vary significantly.[21]

Despite documented benefits of receiving oral health care during pregnancy, oral health professionals historically have been hesitant to provide care, often postponing it until after delivery. The American Dental Education Association's patient-care competencies for general dentists do not include a competency for care of pregnant women.[22] In follow up to the release of *Oral Health Care During Pregnancy: A National Consensus Statement*, the American Dental Association (ADA) fostered efforts to make the profession aware of the importance and safety of providing oral health care throughout pregnancy. In response to these efforts, the 2014 ADA House of Delegates approved these resolutions as ADA policy:

- Resolved, that the ADA urges all pregnant women and women of child-bearing age to have a regular dental examination.
- Resolved, that the ADA acknowledges that preventive, diagnostic, and restorative dental treatment is safe throughout pregnancy and is effective in improving and maintaining the oral health of the mother and her child.[23]

Although these policies are a step in the right direction, a shortage of dentists willing to treat pregnant women and a lack of dentists enrolled as Medicaid providers persists. Inadequate education and training, as well as a fear of addressing the extensive oral health care needs of vulnerable populations including people enrolled in Medicaid, contribute to dentists' and dental hygienists' unwillingness to serve pregnant women.

In 2022, the ADA's Health Policy Institute estimated that only one in three dentists in the United States accept Medicaid. Dentists often note low reimbursement rates, slow payment, administrative burdens, and high no-show rates for appointments as the primary reasons for not accepting pregnant women enrolled in Medicaid. Although dentists are more likely to accept Medicaid for patient care when reimbursement rates are at least 85 percent of the dentist's fees, 56 percent of dentists indicated they would still accept Medicaid for patient care if reimbursement rates were only 55 percent of their fees if they were told the patient would never miss appointments and that claims would be approved on initial submission.[24,25,26]

A competent and adequate oral health workforce, which encompasses both oral health professionals and non-oral health professionals, is essential to facilitate positive changes in women's oral health and behavior during the perinatal period. Interdisciplinary collaborative efforts by academic institutions, professional health organizations, and state and national agencies are necessary to educate health professionals about how and when to provide perinatal oral health care. These efforts can be formalized by integrating oral health competencies into the overall competencies required of all health professionals.[27,28,29.30]

Examples of Actions

- Ensure that perinatal oral health care is comprehensive, continuously accessible, coordinated, culturally effective, compassionate, and patient-centered.
- Encourage oral health professionals to promote effective, clear communication in plain language and in the patient's own language to emphasize the safety and importance of oral health care during pregnancy.
- Promote interdisciplinary oral health risk assessments and risk-based oral health interventions to improve the quality of oral health care.
- Adopt and endorse interdisciplinary perinatal oral health guidelines and recommendations, while promoting them to health professionals and professional organizations that provide perinatal health, social, and educational services.
- Implement strategies to develop and enhance case management, care coordination, and referral services across disciplines to improve the oral health of pregnant women and their children.
- Educate all oral health students, residents, and practitioners that it is safe to address the oral health needs of pregnant women across all nine months of pregnancy. Reducing the oral disease burden in pregnant women is a fundamental step towards improving the oral health of both mothers and their children.
- Develop or revise perinatal clinical competencies and integrate them into dental school and dental hygiene program education and board certification as well as continuing education courses.
- Include information about oral health in the training of community health representatives and those organizations that serve pregnant women and infants.
- Expand the oral health workforce pipeline to reflect the demographics of pregnant women.
- Recruit new oral health allies and champions to expand the reach of preventive messaging and availability of therapeutic interventions.

Support, Conduct, and Promote Research

Data from research informs how to educate health professionals to promote oral health, deliver effective oral health care, and coordinate referrals and consultations during the perinatal period. Conducting and disseminating research focused on perinatal oral health is important to help ensure that evidence-based and evidence-informed science is available to health professionals providing care to women during this period. Dissemination of these data provides information about progress being made and work that remains to be done.[31,32]

Examples of Actions

- Support, conduct, and promote research to improve the effectiveness of perinatal oral health care for pregnant women and treatment protocols for addressing dental caries and periodontal disease in pregnant women.
- Support, conduct, and promote research to determine effective mechanisms to increase oral health knowledge, enhance awareness of the importance and safety of oral health, and change behaviors among women during the perinatal period and the medical professionals and oral health professionals who serve them.
- Promote effective storytelling as an efficient way to share best practice results.

Federal Initiatives

Building State Capacity for Integration

In October 2024, the Consortium for Oral Health (COH), funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, selected five state oral health programs to participate in the Building State Capacity for Integration (BSCI) Learning Collaborative (LC). The BSCI LC is a 16-month project focused on improving systems-level capacity for integrating oral health care and prenatal care. The five states are Idaho, Michigan, Pennsylvania, Rhode Island, and West Virginia. The LC will run from January 2025 through April 2026. A second LC is planned to run from October 2026 through January 2028.

Project teams are using the Capacity Inventory for Integrating Oral Health Care into Primary Care for Pregnant Women: Tool to assess systems-level capacity factors, prioritize needs, and create action plans to enhance integrating oral health care and prenatal care in their states.

Maternal and Child Health—Improving Oral Health Integration

In July 2024, MCHB, HRSA funded the Maternal and Child Health—Improving Oral Health Integration (MCH-IOHI) projects for 4 years (2024–2028). Projects were funded in Colorado, Connecticut, Montana, New York, Puerto Rico, South Carolina, Texas, and Wisconsin. The projects aim to advance the integration of preventive oral health care (POHC) into primary care to make POHC more accessible to infants, children, adolescents, and pregnant women, including those with special health care needs, who are at risk for poor oral health.

Funding supports an MCH-IOHI alliance to include key state stakeholders such as policy, practice, and public health leaders; health professionals; health care payers; and public health surveillance experts. The alliance is implementing a two-tier, state-level and local-level improvement approach that addresses three core functions: (1) policy and practice; (2) education and outreach; and (3) data, analysis, and evaluation. The state-level approach aims

to inform state policy and practice decisions that promote integrated POHC; increase oral health literacy across the state using an organizational health-literacy approach; and enhance the state's oral-health-surveillance activities. These activities, in turn, support the local-level approach, which aims to establish, implement, and validate evidence-based models of integrated POHC in communities underserved by oral health care.

Guidelines and Recommendations from Authoritative Sources

Materials with National Focus

Oral Health During Pregnancy Expert Workgroup
Oral Health Care During Pregnancy: A National Consensus Statement (2012)

> This consensus statement resulted from an expert workgroup meeting convened by the Health Resources and Services Administration in collaboration with the American College of Obstetricians and Gynecologists and the American Dental Association. It contains guidance on oral health care for pregnant women, pharmacological considerations, and guidance for healthcare professionals to share with pregnant women. A series of periodic updates provide an overview of selected national and state activities related to this work.

American Academy of Pediatric Dentistry, Council on Clinical Affairs
Guideline on Perinatal and Infant Oral Health Care (2021) [2025, in progress]

> This paper provides information and recommendations related to perinatal and infant oral health care, including caries risk assessment, anticipatory guidance, preventive strategies, and therapeutic interventions. Background information is presented on the role of health professionals in perinatal and infant oral health care, tooth eruption, pregnancy and the prenatal period, diet for newborns and infants, and tooth decay risk in newborns and infants.

American College of Obstetricians and Gynecologists, Women's Health Care Physicians, Committee on Health Care for Underserved Women
Oral Health Care During Pregnancy and Through the Lifespan (2013; reaffirmed 2022)

> This committee opinion offers information and recommendations for obstetricians, gynecologists, and other health professionals about the importance of counseling pregnant women about maintaining good oral health habits throughout their lives as well as the safety and importance of oral health care during pregnancy. Topics include general health, common oral health conditions during pregnancy, periodontal disease and pregnancy outcomes, oral health assessment and counseling during pregnancy, and access to oral health care.

Association of State and Territorial Dental Directors, Dental Public Health Policy Committee
***Perinatal Oral Health Policy* Statement** [2025, in progress]

> This policy statement provides information about oral health during the perinatal period. It explains what the perinatal period is and discusses barriers to accessing oral health care during this period, women's knowledge about and understanding of perinatal oral health,

and health professionals' attitudes to providing oral health care to pregnant women. A strategic framework for improving perinatal oral health is presented.

Barzel R, Holt K, Kolo S
Opioids and Pregnant Women: Information for Oral Health Professionals *(*2022)

This paper provides an overview of dental pain management for women of reproductive age. Discussed are pharmacological considerations for pregnant women, neonatal opioid withdrawal syndrome, guidelines for providing opioids, managing acute dental pain, and guidelines for discharging women with opioid prescriptions. Information about prescription drug monitoring programs is included.

Casamassimo P, Holt K, eds.
***Bright Futures: Oral Health—Pocket Guide* (3rd ed.)** (2016)

This pocket guide, which offers an overview of preventive oral health supervision for five periods: pregnancy and postpartum, infancy, early childhood, middle childhood, and adolescence, is designed to help health professionals implement specific oral health guidelines during these periods.

Materials with State Focus

CDA Foundation
Oral Health During Pregnancy and Early Childhood: Evidence-Based Guidelines for Health Professionals (2010)

These guidelines provide information about the importance of oral health; maternal physiological considerations related to oral health; pregnancy, oral conditions, and oral health care; oral health and early childhood; access to care; and systems improvement and public policy changes. Sample forms, websites for parents, and a policy brief are available.

Diop H, Hwang S, Leader D, Silk H, Chie L, Lu E, Stone SL, Flaherty K
Massachusetts Oral Health Practice Guidelines for Pregnancy and Early Childhood (2024)

These guidelines provide information about oral diseases, the status of oral health among pregnant women and children in Massachusetts, national state efforts to improve oral health among pregnant women and children, and health professionals' role in improving their oral health. Guidelines for health professionals and oral health professionals who serve pregnant women and children are included.

Massachusetts Health Quality Partners
2024 Perinatal Care Guidelines (2024)

These guidelines address the first prenatal visit (6–12 weeks) and each subsequent prenatal visit (13–42 weeks). Topics include initial and interval history; psychosocial assessment; physical examinations; immunizations; laboratory evaluation and additional testing; oral health; genetic counseling, screening, and testing; general counseling, education, and discussion; and the postpartum visit.

Maryland Department of Health, Office of Oral Health
Oral Health Care During Pregnancy: Practice Guidance for Maryland's Prenatal and Dental Providers (2022)

This report provides information for prenatal health professionals and oral health professionals about oral health during pregnancy and discusses myths and facts related to this topic. Oral conditions that may occur during pregnancy are discussed. A table presenting pharmacological considerations for pregnant women is included, along with tip sheets about good oral health during infancy in English and in Spanish that are available in stand-alone format.

South Carolina Oral Health Coalition
Oral Health Care for Pregnant Women (2017)

These updated guidelines present information about clinical practice for the oral health care of pregnant women in South Carolina (SC). They include data on infant mortality and preterm birth, use of oral health care and counseling, and key findings from the SC Pregnancy Risk Assessment Monitoring Systems.

Virginia Department of Health, Dental Health Program
Oral Health During Pregnancy: Practice Guidance for Virginia's Prenatal and Dental Providers (2019)

These guidelines provide information for prenatal health professionals and oral health professionals in Virginia. The guidelines include an infographic about oral health care during pregnancy, a discussion about myths vs. facts related to oral health during pregnancy, and information about oral conditions that may occur during pregnancy and oral-health-related pharmacological considerations for pregnant women.

Research Evidence

Policy

Kumar J, Crall JJ, Holt K. 2023. **Oral health of women and children: Progress, challenges, and priorities.** *Maternal and Child Health Journal* 27(11):1930–1942.

This article describes achievements during the last 20 years in improving women's oral health and, in turn, pregnancy outcomes and children's oral health, assesses current challenges, and discusses future priorities.

Education and Training of Health Professionals

Brame JL, Quinonez RB, Ciszek BP, Weintraub JA. 2023. **Implementing a prenatal oral health program for dental students: Lessons learned.** *Health Promotion Practice* 15248399231207070.

This article presents findings from the Prenatal Oral Health Program, which was developed by the University of North Carolina School of Dentistry's Department of Pediatric Dentistry and School of Medicine's Department of Obstetrics and Gynecology. The program's

purpose is to educate dental students on prenatal oral health and promote access to oral health care for pregnant women.

Linden JE, Gundacker CLU, Deinhammer L, Crespin M. 2023. **Medical dental integration in Wisconsin: Integrating dental hygienists into pediatric well child visits and prenatal care.** *Journal of Dental Hygiene* 97(3):13–20.

This article describes how the Wisconsin Medical Dental Integration model, which expanded early access to preventive oral health care by integrating dental hygienists (DHs) into pediatric primary care and prenatal care teams to address oral health inequities with the goal of reducing oral disease. The model led to DHs being incorporated into medical care teams in Wisconsin, and the article describes how legislation expanding scope of practice made this possible.

Panda A, Silk H, Hayes C, Savageau JA. 2024.**An assessment of oral health training in obstetrical care in Massachusetts.** *Maternal and Child Health Journal* 28(7):1168–1177.

This study assesses the perspectives of obstetrical clinicians about oral health education and promotion.

Vamos CA, Cayama MR, Mahony H, Griner SB, Quinonez RB, Boggess K, Beckstead J, Daley EM. 2023. **Oral health during pregnancy: An analysis of interprofessional guideline awareness and practice behaviors among prenatal and oral health providers.** *BMC Pregnancy and Childbirth* 23(1):721.

This article discusses awareness of and familiarity with oral health guidelines and oral-health-related beliefs and practice behaviors among prenatal care professionals and oral health professionals.

Oral Hygiene

Geurs NC, Jeffcoat MK, Tanna N, Geisinger ML, Parry S, Biggio JR, Doyle MJ, Grender JM, Gerlach RW, Reddy MS. 2023. **A randomized controlled clinical trial of prenatal oral hygiene education in pregnancy-associated gingivitis.** *Journal of Midwifery and Women's Health* 68(4):507–516.

This article provides information on whether an oral health intervention including oral hygiene education delivered by nurse-led staff and an over-the-counter oral home care regimen improved gingival inflammation in pregnant women with moderate-to-severe gingivitis compared with a standard-oral-hygiene control group.

Parry S, Jeffcoat M, Reddy MS, Doyle MJ, Grender JM, Gerlach RW, Tanna N, Geisinger ML, Geurs NC, Biggio J. 2023. **Evaluation of an advanced oral hygiene regimen on maternity outcomes in a randomized multicenter (OHMOM) clinical trial.** *American Journal of Obstetrics & Gynecology Maternal-Fetal Medicine* 5(8):100995.

This article presents information from a clinical trial of obstetrical patients with moderate-to-severe gingivitis who were randomized to an advanced oral hygiene program vs. usual oral hygiene care; the primary obstetrical outcome compared between the treatment groups was gestational age at delivery.

Testa A, Jackson DB, Crawford A, Mungia R, Ganson KT, Nagata JM. 2024. **Adverse childhood experiences and dental cleaning during pregnancy: Findings from the North and South Dakota PRAMS, 2017–2021.** *Journal of Public Health Dentistry* 84(2):198–205.

This article extends existing research demonstrating that adverse childhood experiences (ACEs) (i.e., experiences of abuse, neglect, and household dysfunction) are related to low use of preventive oral health care in childhood and adolescence. The researchers investigated the relationship between ACEs and dental cleaning and oral health care use during pregnancy among a sample of women who delivered live births in North Dakota and South Dakota.

Coverage for and Access and Use of Oral Health Care

Battani K, Norrix E, Sailor L, Farrell C. 2023. **Improving access to oral health care: Integrating dental hygienists into federally qualified health center obstetrics and gynecology clinics in Michigan.** *Journal of Dental Hygiene* 97(3):7–12.

This case study describes a program that integrates dental hygienists into obstetrics and gynecology clinics in federally qualified health centers located in underserved areas of Michigan with the goal of improving the oral health of pregnant women.

Byrappagari D, Cohn L, Sailor L, Clark S. 2024. **Association between dental visits during pregnancy and setting for prenatal care.** *Journal of Public Health Dentistry* 84(1):21–27.

This article provides a comparison of receipt of dental visits during pregnancy for women who received prenatal care at a federally qualified health center (FQHC) vs. a non-FQHC setting.

Foxman B, Davis E, Neiswanger K, McNeil D, Shaffer J, Marazita ML. 2023. **Maternal factors and risk of early childhood caries: A prospective cohort study.** *Community Dentistry and Oral Epidemiology* 51(5):953–965.

This article provides an evaluation of associations between time-varying factors (mother's oral health, oral hygiene, smoking habits, diet, food insecurity and stress) socioeconomic factors (mother's employment, marital status, household income, insurance status, household size) and medical history on children's risk of developing a carious lesion in the first three years of life.

Herndon JB, Ojha D, Amundson C. 2024. **Measuring quality of dental care during pregnancy.** *Journal of the American Dental Association* 155(2):167–176.

This article describes the development and validation of two Dental Quality Alliance measures of access to oral health care during pregnancy using claims and enrollment data and reports performance on these measures for a sample of Medicaid and Children's Health Insurance Program participants.

Laxer KR, Hammersmith KJ, Amini H, Casamassimo PS. 2022. **Knowledge and perceptions of dental care during pregnancy: A cross-sectional survey of adolescents and young adults.** *Journal of Dentistry for Children* 89(3):155–161.

This article provides an evaluation of knowledge, perceptions and current practices related to care-seeking behaviors and oral health in pregnant and non-pregnant adolescent and young adults and assesses barriers to accessing oral health care during pregnancy.

Lee H, Deshpande R, Benn EKT. 2024. **Race, ethnicity, and other barriers to access dental care during pregnancy.** *Journal of Racial and Ethnic Health Disparities* Online ahead of print.

This article discusses whether race and ethnicity modifies associations between barriers to accessing oral health care and use of oral health care during pregnancy.

Liang L, Aris IM. 2024. **Association between age at first birth and long-term dental caries experience among women in the United States.** *Journal of Women's Health (Larchmont)* 33(10):1409–1416.

This article discusses whether maternal age at first birth is associated with tooth decay over time.

Reynolds JC, Comnick C, Heeren T, Xie XJ, Damiano PC. 2024. **Medicaid dental benefits for pregnant people and dental care use among very young children.** *Maternal and Child Health Journal* 28(9):1604–1611.

This article discusses the association between Medicaid dental benefits for pregnant women and oral health care use among very young children enrolled in Medicaid.

Spencer M, Idzik SK. 2023. **Dental screening and referral during prenatal care.** *MCN: The American Journal of Maternal/Child Nursing* 48(6):320–325.

This article provides information about a quality-improvement project to implement use of an oral-health-screening tool during prenatal care visits to identify pregnant women with oral health care needs and to provide subsequent referrals to a dentist.

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This article provides information from a scoping review investigating the impact of pregnant women's oral-health-related knowledge, attitudes, practices, and oral health literacy levels on their oral health.

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Mental Health and Oral Health

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> This article discusses the independent and combined effects of depression and stress on oral self-care behaviors of women during the perinatal period in Appalachia, given the high burden of oral disease in the region.

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> This article provides an assessment of the relationship between cumulative disabilities and specific forms of disability (seeing, hearing, walking, remembering, self-care, and communicating) for six indicators of oral health experiences during pregnancy.

Testa A, Gimeno Ruiz de Porras D. 2023. **The association of employment status and unwanted job loss with maternal oral health experiences: Findings from the Pregnancy Risk Assessment Monitoring System.** *BMC Oral Health* 23(1):168.

> This article discusses the impact of pregnant women's employment status and job loss on oral health experiences during pregnancy.

Testa A, Jackson DB, Simon L, Ganson KT, Nagata JM. 2023. **Stressful life events, oral health, and barriers to dental care during pregnancy.** *Journal of Public Health Dentistry* 83(3):275–283.

> This article provides information on how stressful life events during the prenatal period are associated with oral health and patterns of oral health care use.

Violence and Oral Health

Testa A, Lee J, Jackson DB, Mungia R, Ganson KT, Nagata JM. 2023. **Physical intimate partner violence and prenatal oral health experiences in the United States.** *BMC Oral Health* 23(1):749.

> This article discusses the relationship between intimate partner violence during pregnancy and women's oral health experiences.

Testa A, Lee J, Neumann A, Jackson DB. 2023. **Physical intimate partner violence and oral health problems during pregnancy.** *Journal of the American Dental Association* 154(4):293–300.e1.

> This article assesses the association between physical intimate partner violence during pregnancy and reports of prenatal oral health problems among a sample of mothers.

State Practice Examples

The following practice examples illustrate various elements or dimensions of the best practice approach to perinatal oral health. These reported success stories should be viewed in the context of the state's and program's environment, infrastructure and resources. End-users are encouraged to review the practice descriptions (click on the links of the practice names) and adapt ideas for a better fit to their states and programs.

Summary Listing of Practice Examples

Table 1 provides a listing of programs and activities submitted by states. Each practice name is linked to a detailed description.

Table 1. State Practice Examples Illustrating Strategies and Interventions for Perinatal Oral Health

#	Practice Name	State	Practice
1	Alaska Childhood Understanding Behaviors Survey (CUBS)	AK	02004
2	Infant Oral Care Program (IOCP)	CA	06006
3	Children's Dental Services WIC and Early Childhood Collaborative Project	MN	26011
4	Perinatal Oral Health Program	NC	36017
5	Maternal and Child Health: Improving Oral Health Integration	WI	56008

Highlights of Practice Examples

AK Alaska Childhood Understanding Behaviors Survey (CUBS) (Practice #02004)

The Alaska CUBS is a follow-up survey to the Pregnancy Risk Assessment Monitoring System (PRAMS) that was developed by the Alaska Division of Public Health, Section of Women's, Children's and Family Health, in 2006. Each version of the CUBS survey has included multiple questions related to the child's dental health including whether a health care provider has ever said the child had tooth decay or cavities, whether the child has ever been to see a dentist, at what age the child first saw a dentist, what types of dental care the child had received, and reasons for the child's first dental visit. By using the methodology of re-interviewing mothers who completed a PRAMS survey, CUBS is also able to evaluate factors present at birth or early life that affect risk for later adverse childhood outcomes. By linking back to PRAMS, data analyses can also examine associations between maternal dental health during pregnancy and health outcomes for the child at age three.

CA Infant Oral Care Program (IOCP) (Practice #06006)

The specific aim of the IOCP is to simultaneously increase entry points of access and increase the number of trained dental team members (DDS, RDHs, RDAs) and primary care providers (MDs, nurses) to integrate perinatal and pediatric health care with oral health services to improve overall health outcomes. IOCP trains dental students/residents, family and pediatric

medical residents and family and pediatric nurse practitioner students in partnership community organizations and community oral health workers (COHWs). After the COVID-19 pandemic, the IOCP transitioned to a telehealth format, enabling residents and COHWs to reach families virtually in their homes. This adaptation maintained continuity of care during a critical time and expanded capacity to reach populations with flexible, accessible, and prevention-focused oral health services.

MN Children's Dental Services WIC and Early Childhood Collaborative Project (Practice #26011)

Children's Dental Services (CDS) expanded services and dental education across Minnesota through partnerships with agencies that host Women, Infants, and Children (WIC) programs, Early Head Start programs, Early Childhood Dental Network, Early Childhood Family Education Programs, Minnesota Department of Health, and other primary medical providers targeting care to pregnant women and infants. CDS and partners developed a system for identifying pregnant women in need of oral health services and referred them to appropriate and accessible services. This project has been conducted through three phases: logistical planning, implementation, and evaluation.

NC Perinatal Oral Health Program (Practice #36017)

The Perinatal Oral Health Program (POH), part of North Carolina's Division of Public Health-Oral Health Section, aims to improve the overall standard of care for pregnant women by educating healthcare providers on the importance and safety of dental care during pregnancy and collaborative practice to improve maternal-child oral health outcomes. The one-hour educational program targets medical, dental, and pregnancy support service providers. The Oral Health Section is comprised of twenty regional public health dental hygienists who recruit and deliver perinatal oral health trainings each fiscal year.

WI Maternal and Child Health: Improving Oral Health Integration (Practice #56008)

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. The integrated preventative oral health care (POHC) approach necessitates support at the state level including policy implementation, addressing education requirements and surveillance.

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