Dental Public Health Activity Descriptive Summary

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Advancing Oral Health for New Mexico Perinatal Populations Through Community Training

The HRSA New Mexico *Perinatal & Infant Oral Health Quality Improvement* (NM-PIOHQI) project has adopted a community training model for advancing oral health education for the perinatal and infant workforce. This model employs a comprehensive and inclusive approach to oral health training of multiple provider types, agencies, and organizations that are engaged in the care and services provided to pregnant mothers and infants in a given community.

Site-specific training for individuals is labor-intensive, particularly when there is more than one potential site in a given community. This is particularly true, where most sites require significant travel. This challenge was also experienced when trainings are hosted across multiple service units in areas of the reservation where care and service networks are clustered. By changing strategies from site-specific training, to a multi-provider, multi-organization or program approach, we are able to increase our reach in a given community. Associated costs include development of oral health trainings adaptable to multiple provider types and roles, client education and self-management materials, travel and lodging for project team.

Outcomes include increased knowledge and skills in evidence-based content, educating clients and parents, and community-specific oral health and dental resource identification. Early lessons include learning that integration of oral health into existing programs must be implemented locally. Sites are very heterogeneous and require local adaptation for integration to occur. In addition, we learned that persistent systemic and policy factors contribute to misaligned reimbursement and performance measures that interfere with efforts to improve the oral health in prenatal and infant populations. These barriers continue to have persistent limiting impacts on large scale integration of oral health into primary care for this population.

Lessons Learned:

One of the most important lessons learned early on in our fragmented oral health and healthcare systems is that integration of oral health into existing programs is very much a local implementation. Sites are heterogeneous and require local adaptation for integration to occur. We started from a perspective of proposing integration of our entire program manual and quickly moved to a more consultative approach where program content is offered, but sites tend to choose parts most relevant to their scope and capacity. This has been consistent across clinical sites, community agencies, and home visitor programs. While content is to a large degree similar, implementations are local events and may vary significantly.

Large systemic challenges continue to significantly limit implementation. For example, in NM the issue of incorrect reimbursement by Medicaid payers for fluoride varnish has been an ongoing barrier to integrating fluoride varnish into well child visits for 0-3-year olds in primary care settings since 2014. It was first discovered during project activities in 2016, and remains unresolved today. An additional challenge from a policy perspective relates to current focus of our Medicaid managed care organizations on the oral health HEDIS performance indicator for only annual dental visit for adolescents, does not address pre-school needs, nor does it support state Title V oral health performance improvement aims. In short, the system barriers slowing large scale integration of oral health for prenatal and infant populations stem largely from a lack of policy alignment with what have been long-standing clinical standard of care recommendations. This is evidenced by reliance on

performance measures that do not support integration and reimbursement barriers. These are continuing to be addressed with NM Human Services Medical Assistance Division

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Contact Person(s) for Inquiries:

Jan Martin, DNP, RN, CCM, PAHM, Assistant Professor, University of New Mexico College of Nursing, University of New Mexico, Albuquerque, NM 87131, Phone: 505-720-2523, Email: jmartin@salud.unm.edu

Anthony Cahill, PhD, Director, University of New Mexico Center for Development and Disability, 2300 Menaul Blvd, Albuquerque, NM 87107, Phone: 505-272-2990, Email: acahill@salud.unm.edu