

Dental Disease in Pregnant Women: A Screening and Referral Process

by

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Abstract

Problem & Purpose: Adverse health outcomes increase with poor maternal oral health in pregnant women and their infants. Dental screenings and treatment during pregnancy are found safe and effective in improving women's health in pregnancy. Adult women on Medicaid are only eligible for dental benefits while pregnant, but in 2016, only 26.1% of pregnant women in Maryland on Medicaid utilized the dental benefit, resulting in the lowest utilization in four years. The purpose of this Doctor of Nursing Practice (DNP) project was to implement and evaluate a screening tool and dental referral process at a local federally funded community organization.

Methods: The dental screening used was the Maternal Oral Health Tool for pregnant women on Medicaid. The screening tool included two questions assessing if the woman 1) had seen a dentist in the last year or 2) has any current dental concerns and then when the screening indicated that a woman needed further dental treatment and evaluation, she was referred to the dental clinic. Once referrals were received, the dental clinic provided outreach to the women to educate and make appointments.

Results: Over 12 weeks, 23% of all pregnant women seen at the community organization were referred to the dental clinic and 25% of pregnant women referred scheduled appointments at the clinic. 87% of all women screened required further dental evaluation, indicating the need and importance of dental care for pregnant women on Medicaid in this area.

Conclusions: The overall recommendation is that staff continue to educate women about the importance of dental care, their benefits during pregnancy, and provide resources and information of dental clinics that accept Medicaid. To improve referral compliance, it's recommended that the screening be embedded in the electronic intake system.

Introduction

Background

During pregnancy, the health of a mother directly affects her baby. For example, when a pregnant mother has dental caries, also known as cavities, they are considered to have a chronic disease that can have systemic effects on the body, and nearly 60-75% of pregnant women suffer from gingivitis, the early stages of periodontal disease (CDC, 2019). Untreated caries in pregnant women can transmit pathogenic bacteria from mothers to their babies and place their children at risk for developing early childhood caries (ECC) (Hughes, 2010). Research demonstrates that poor maternal oral health increases the likelihood of preterm delivery, low birth weights (Turton & Africa, 2016), and is an independent risk factor for adverse pregnancy outcomes (Basha, Swamy, & Mohamed, 2015). In addition, studies have suggested that periodontal disease plays a role in the development of preeclampsia (Roth, 2010). Women of low socio-economic status are at a higher risk, and oftentimes only have insurance that covers dental care while pregnant, which makes it imperative that they seek dental attention during pregnancy to assure their own health and the health of their child.

Problem Significance and Need for Practice Change

In Maryland, adult women on Medicaid are only eligible for dental benefits while pregnant (Dental Plans, 2019). In 2016, only 26.1% of pregnant women in Maryland on Medicaid utilized the dental benefit resulting in the lowest utilization in four years (Annual Oral Health Legislative Report, 2017). A local federally funded organization that provides services to low-income pregnant women and children, sees about 300 pregnant women on Medicaid monthly; therefore, has the potential to reach large volumes of pregnant women in need of dental

care. During the visit, the women are provided with information about a local dental clinic that accepts Medicaid, but there is currently no structured referral process in place. The dental clinic in the area that accepts these women only saw a total of 40 women for the first quarter of Fiscal Year 2019 (FY19), and only 20 women during the second quarter of FY19. This is a very low utilization in this area given the volume of monthly visits at the federally funded organization which saw 855 women in the first quarter of FY19 (K. Perry, personal communication, January 25, 2019).

Guidelines support conducting an early caries-risk assessment of pregnant women to identify women at risk for having poor oral health (Council on Clinical Affairs, 2016) and recommend women schedule an appointment with a dentist early in their pregnancy for preventative and dental treatment (Roth, 2010). Oral Health Care During Pregnancy: A National Consensus Statement (2012) advises that dental providers partner with federally funded organizations in order to reach at risk women to provide early screening and intervention. One way to do this is by implementing a validated tool, for example the Maternal Oral Screening (MOS), to detect those in need of dental care (George et al., 2016). Once the at-risk pregnant women are identified an appropriate referral can be initiated to help ensure access to available dental services. The purpose of this Doctor of Nursing Practice (DNP) project was to implement and evaluate the MOS tool and dental referral process at a local federally funded community organization with referral to the dental clinic.

Literature Review

The need for good oral health during pregnancy was the focus of the evidence of this literature review with three major themes. The first theme reviews why oral health care is

important during pregnancy, with the second theme revealing adverse pregnancy outcomes related to poor oral health and concludes with recommendations to conduct oral health screenings during pregnancy.

During pregnancy, women are at risk for multiple oral conditions including dental caries, pregnancy gingivitis, periodontitis (gum disease), pyogenic granulomas, and tooth erosion (Battani et al., 2018). Contributing factors include increased blood volume, gastric reflux, vomiting from morning sickness, and possible increased intake of sugary foods. About 60-75% of women experience gingivitis, a precursor to periodontitis, during pregnancy (CDC, 2019). Oral health can have systemic effects, so if a woman has poor oral hygiene while pregnant, this can affect her health and the health of her unborn child.

Several studies confirmed the correlation between oral health and adverse pregnancy outcomes. Basha, Swamy, and Mohamed (2015) reported that periodontitis is an independent risk factor for adverse pregnancy outcomes including low birth weight and preterm delivery. In their sample of 307 pregnant women, of those who had periodontitis (n=126), 15.87% had preterm birth and 34.25% had low birth weight babies. The women without periodontitis (n=181) was significantly different having 9.39% preterm birth and 18.78% low birth weight babies. A systemic review and meta-analysis by Corbella et al. (2016), also confirmed that periodontitis is associated with low birth weight, preterm delivery, and preterm low birth weight; this meta-analysis reviewed 22 studies with over 17,000 subjects. *S. mutans* and *S. sobrinus* are the main caries-causing bacteria and are directly transmitted from mother to child if the mother has high rates of dental caries; this predisposes the child to ECC and can have long-term consequences such as failure to thrive, loss of school days, and emergency room visits (Colak,

Dulgergil, Dalli, & Hamidi, 2013). The numerous adverse pregnancy outcomes that can occur from poor oral hygiene can be avoided if women seek oral health care during pregnancy.

Oral health screening helps determine a mother's current oral health status and at-risk women can be referred for further dental care to prevent poor pregnancy outcomes. Clinical Practice Guidelines set forth by the American Academy of Pediatric Dentistry recommend screening women who are high risk for dental caries and poor oral health in order to intervene with education and preventative therapies (Council on Clinical Affairs, 2016). Oral Health Care During Pregnancy: A National Consensus Statement (2012) recommended referral to a dentist early in pregnancy and encourages partnerships with community-based programs to reach at-risk women. Clinical Practice Guidelines set forth by the California Dental Association also recommended prevention, diagnosis, and treatment of oral conditions during pregnancy to reduce poor pregnancy outcomes and improve the oral health status of their future children (Roth, 2010).

The MOS tool had high sensitivity and can be used to recognize pregnant women needing a dental referral for poor oral health (George et al., 2016) and was used in this DNP project. Early detection of at-risk women through screening allowed for early intervention. A systemic review and meta-analysis by Kim, Lo, Pullin, Thronton-Johnson, and Karimbux (2012) of 12 studies concluded that scaling and root planing treatment for periodontitis reduced risk for preterm birth. Xiao conducted a systematic review and meta-analysis which included 4 studies and concluded that there was a significant reduction in *S. mutans* and ECC in the children of women who received prenatal oral care (2019). (See Table 1 for Evidence Review & Quality Table)

Implementation of the MOS and referral tool (see Appendix A) at the federally funded community organization allowed for early detection of poor oral health in this pregnant women population so they could avoid poor pregnancy outcomes for both themselves and their child. The MOS was built into the referral to make a comprehensive tool that was user-friendly and provided subjective and objective data for the dentist prior to the appointment. Though not all studies were specific to women on Medicaid, the consensus through all studies and guidelines was consistent with oral health screening to refer for proper dental treatment in order to improve oral hygiene and overall health of pregnant women.

Theoretical Framework

The Health Promotion Model (HPM) was the theoretical framework used to guide this DNP project. This model was chosen based on its ease of utilization and personal preference for congruency in health beliefs. The HPM by Dr. Nola Pender strives for overall patient wellbeing through the promotion of healthy behaviors to avoid adverse outcomes. This is harmonious with the purpose of this DNP project: to provide early intervention to improve the oral health of pregnant women and their future children. There are four assumptions in the HPM: (1) individuals try to control their behavior, (2) individuals have a dynamic relationship with their environment which transforms both the environment and the individual, (3) health care professionals are an external influence for individuals, and (4) health behavior change is dependent on the individual's initiative for change (Health Promotion Model, 2016). The interactive relationship between the environment and the individual is affected by perceived barriers, perceived self-confidence, attitude, interpersonal support, situational influences, and prior beliefs. This was significant to the population in the DNP project because the women were

of low-socioeconomic status and considered vulnerable. These women's environments greatly influenced their capacity for improving their oral health. Accessibility to transportation, childcare, finances, and priority of dental care all were considered as likely constraints. The HPM was used in the project to improve the women's perceived self-confidence and attitudes towards oral hygiene to increase compliance through dental screening and education. Collaboration between the healthcare professionals at the community clinic and the women provided a positive external influence on the women's health behavior. Dental referrals were tracked and dental hygienists provided follow-up to reinforce education, reassurance, and positive-reinforcement. Support from health care providers, the provision of free dental care while pregnant, and oral hygiene education supported the positive external dynamics in the HPM to influence health behavior change in this vulnerable population.

Methods

Implementation of the Maternal Oral Screening Tool and referral process for dental disease in pregnant women at a community organization was a 12-week quality improvement project. The population was pregnant women on Medicaid who are seen at a local suburban community health organization that promotes wellness for women, infants, and children with women accessing services on three different occasions during their pregnancy. Inclusion criteria for the screening process included all pregnant women on Medicaid seen at the community organization. Children were excluded from the screening for the purposes of this project. Inclusion criteria for referral includes any pregnant women who scores a 1 or greater on the Maternal Oral Screening Tool. Scoring a zero is exclusion criteria because it indicates that the woman has already seen a dentist in the last year and is not having any dental problems. This

project was approved as non-human subject research by both the University of Maryland Baltimore and Maryland Department of Health Institutional Review Boards.

The intake process at the community organization was changed to include the dental screening and referral to dental clinic. A form was developed that served as both the screening tool and referral form for ease of use and the Maternal Oral Screening Tool, a validated instrument, was embedded in the form. (Permission was granted from Ajesh George to use the Maternal Oral Screening Tool, see Appendix B) Forms were pre-numbered for de-identification of patients and data collection. When the women presented to the clinic for their intake session, the dieticians took the form into the room with them and gave the women the accompanying disclosure form mandated by the Maryland Department of Health Institutional Review Board (See Appendix C). The woman had to consent to be screened, then if they scored at least a “1” during their screen, this indicated the need for dental referral. If a dental referral was warranted, the form was completed, scanned and securely emailed to the dental clinic, and then shredded to protect patient information.

Data Collection

Data collection was collected through participation of the secretary at the dental clinic. As the secretary received the emailed forms from the community organization, patients were de-identified. An Excel spreadsheet was provided with five columns: “Patient number,” “Date referral received,” “Patient scheduled appointment,” “Called by RDH,” and “Patient seen at dental clinic” (See Appendix D). The secretary would complete the column as appropriate. The dental clinic was visited weekly to audit the Excel spreadsheet to determine if the patient made an appointment, were followed-up by a dental hygienist, and were seen at the dental clinic.

Data Analysis

A Run Chart was utilized for data analysis of this quality improvement project. The data for the Run Chart was a display of the Outcome Measures: number of women referred to the dental clinic from total seen (Figure 1), number of dental appointments made (Figure 2), and number of women who screened positive of total screened (Figure 3). Data was collected at weekly increments for a total of 12 “observations,” and displayed as bi-weekly observations in the Run Chart. The Run Chart displayed trends in the data over the course of the project implementation and was used to communicate with the team how effective the project was in achieving the goals.

Results

Report of Changes

The processes changed during this quality improvement project included the communication between the community organization and the dental clinic and also communication between pregnant patients and the dental clinic. There was previously no communication between the community organization and the clinic, therefore the dental staff were completely unaware of the pregnant women in Harford County who qualified for and were in need of dental care. The screening tool and referral form served as a means to bridge this gap in communication. In addition, there was no outreach from the dental clinic to its patients, but with the increased awareness of women in need of care through receiving the emailed form, dental hygienists at the clinic made follow-up phone calls to the patients to encourage appointments and provide education. The change of implementing a dental screening tool during routine pregnant women visits and increasing communication between the community organization and dental clinic resulted in increased awareness of needs and the ability for staff to work together to disseminate a sustained change.

Description of results

During the twelve-week implementation of the screening and referral tool, the community organization saw a total of eighty-six pregnant women. Of those 86 women, a total of 23 were screened and 20 of them were referred to the dental clinic. A total of five dental appointments were made. So, 23% of all women seen at the community organization had referrals sent to the dental clinic, 25% of women referred scheduled dental appointments, and 87% of total women screened were positive for needing a dental referral.

Unintended consequences were that not all women were being screened. After talking to community organization staff, one of the reasons included women who were due to deliver within the next week or so, and this was too soon for the dental clinic to see them. Another major barrier was the Disclosure Statement which was mandatory per the Maryland Department of Health Institutional Review Board. In general, this population had a lower health literacy level, so when they received the Disclosure Statement saying this screening was a part of a project, many declined to be screened which may have been due to not understanding this was not experimental, but in an effort to increase their access to healthcare. The cost of making and copying all referral forms was paid for by this author and while inexpensive, this is another unintended consequence. An observed association is that the last five weeks of the project fell between the Thanksgiving and Christmas holiday, and by observing the Run Charts one can see that numbers decreased during this time.

Institutional Review Board was needed for this project through both the University of Maryland and Maryland Department of Health. Approval was another barrier because it was at least a month process due to difficulty with communication and limited hours of operation, therefore pushing back the start date for implementation.

All staff at both organizations were facilitators, but especially those at the dental clinic, which was an unexpected benefit. The secretary single handedly de-identified patient information and tracked data on the spreadsheet daily. Dental staff called all of the women who were referred to educate them on their dental benefits and importance of dental care while pregnant in an effort to increase the number of pregnant women accessing care and seen at the dental clinic.

Discussion

The total number of women screened at the community organization is lower than the anticipated goal, but this may be in part due to low health literacy. The mandatory Disclosure Statement explained to the women that they have dental benefits only while pregnant, the following screening was a part of a project, and their participation would not affect their federal benefits. While this was important, the use of the word “project” may be associated with research or experiment and be a deterrent. The word “screening” may have a negative connotation because it’s associated with finding a problem and may evoke an unwanted fear. Much of this relates to low health literacy levels, especially among individuals of low socioeconomic status (Mahadevan, 2013).

Low health literacy can also result in poor follow-through for referrals and appointments (Mahadevan, 2013). Only 25% of all referrals scheduled an appointment at the dental clinic at the end of the twelve-week period. While this is still a success because some women were able to be scheduled, the low rate of appointment scheduling may also be in part due to logistical barriers for the women. Many of these women work, sometimes multiple jobs, so may have difficulty in making time for a dental appointment in addition to their appointments at the community organization and prenatal visits; it is estimated that about 24% of women of low socioeconomic status do not receive the care they need due to lack of time (Kaiser Family Foundation, 2018). Lack of transportation and finding childcare are

also barriers to receiving care. Literature suggests that these barriers are more frequent in women of low socioeconomic status and those in fair or poor health (Kaiser Family Foundation, 2018).

One of the most significant outcomes of this quality improvement project was that 87% of women screened required a referral, indicating the need for dental care during pregnancy. This statistic means that all of those women either have a current dental problem or have not seen a dentist in the last twelve months. As supported by numerous guidelines and literature, it is important for the mother to receive oral health care during pregnancy to avoid adverse outcomes for both her and her child, and this outcome shows the continued need for dental care intervention. Because dental care in Maryland is only covered on Medicaid during pregnancy, this project supports the necessity for dental care screening and interventions in this population.

The theoretical framework, the Health Promotion Model, supported the outcomes of this project through its four assumptions. As discussed, these women try to control their own behavior and are choosing to attend their appointments at the community organization or dental clinic. However, they have a lot of external factors influencing them including multiple jobs and lack of time so their dynamic relationship with their environment can make follow-through with dental appointments difficult. The women's interactions with health care professionals, community organization and dental clinic staff, provided positive external influences through education and encouragement to seek dental care which aided compliance. Ultimately, women's initiative for change is dependent on the woman, and varied in this population.

One of the strengths of this project is overall communication was increased between the community organization and dental clinic to facilitate patient care. There is a small geographic distance between the community organization and dental clinic which increased the likelihood

the women could get to their appointment. The small distance was beneficial in this project, but is unique to this community, and a limitation should this project be implemented in another location. The flexibility of staff was also a strength of this project, but once again unique to these organizations, which may inhibit the generalizability of the project.

Conclusions

The screening and referral process for dental disease in pregnant women on Medicaid quality improvement project demonstrated the need for continued assessment of dental care in this population. This project has the potential to be implemented in similar settings; however, the availability of dental providers within the area who also accept Medicaid insurance must be considered. The project would likely have increased sustainability if the MOS tool could be implemented as a routine screen provided for the women at the community organization and if it could be embedded in the electronic intake system to eliminate the need for both the paper forms and the disclosure statement. Eliminating the disclosure statement and paper, may encourage staff to be more vigilant about screening, and increase the number of women referred for dental care. Outcomes reveal that dental care is needed in this population, so it is recommended that staff continue to educate women about the importance of dental care, their benefits during pregnancy, and provide resources and information of dental clinics that accept Medicaid. Due to the numerous factors inhibiting access to medical care for individuals of low socioeconomic status, interprofessional collaboration is necessary to reach these populations in need. Together, they can educate pregnant women, provide access to care, and improve their overall health outcomes.

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Table 1. Evidence Review & Quality Table

Author(s), year	Study objective/ intervention or exposures compared	Design	Sample (n)	Outcomes studied (how measured)	Results	Level and Quality Rating
Battani et al., 2018	To provide recommendations to prenatal health providers and dentists on the oral health care of women during pregnancy.	Clinical Practice Guidelines	N=4 federal organizations which provided data to support guideline	Oral health status of women during pregnancy and how this affects the developing child.	It is recommended that pregnant women see a dentist early in their pregnancy, and partnerships should be established with community programs to provide referrals for care. Women's oral health should be assessed, and women should be advised on good oral health behaviors. Oral health care is safe during all trimesters of pregnancy.	7/B
Council on Clinical Affairs, 2016	To provide guidelines for perinatal and infant oral health care.	Clinical Practice Guidelines	N=61 guidelines and studies included in the making of these guidelines	1) How a mother's oral health determines the oral health of her child 2) Long term effects of ECC on children	1) It is recommended to conduct a caries risk-assessment on pregnant women to encourage them to have dental care while pregnant. Counsel women on diet and good oral hygiene. 2) Parents should be encouraged to find a dental home for their child by one year of age. Counsel parents on proper oral hygiene for their children.	2/A
George et al., 2016	To assess the sensitivity and specificity of the Maternal Oral Screening (MOS) tool by comparing it to the Oral Health	Patients were recruited from a larger randomized	N=211 pregnant women, with a	The MOS tool revealed that 86% of women were at risk for	Analysis of the MOS tool compared to the OHIP-14 and a dental screen revealed the MOS tool	3/B

	Impact Profile (OHIP-14) and an assessment by trained dentists.	controlled trial and screened for poor oral health.	mean age of 29, and 92% were in their second trimester	poor oral health. The OHIP-14 showed 44% at risk for poor oral health and the dental assessment showed 56% at risk for poor oral health.	has high sensitivity (93%) and specificity of 20.5%. The MOS tool is able to identify up to 94% of women needing a dental referral for poor oral health.	
Oral Health Care During Pregnancy Expert Workgroup, 2012	To improve the standard of care to increase dental care utilization and provide recommendations to health care providers of how to do so.	National Consensus Statement	N=26 federal resources used in the making of the consensus statement	The effect of oral health during pregnancy on the woman and her child.	Pregnant women should be referred to a dentist early in their pregnancy for treatment. Partnerships should be made in the community to refer and treat high-risk women. Oral health care is safe during pregnancy, and women should be advised on good oral hygiene.	7/B
Roth, 2010	To provide recommendations to health care providers about oral health care of pregnant women.	Clinical Practice Guidelines	N=249 data sources from organizations and a variety of studies to support the guideline	The effects of a pregnant woman's oral health status on her developing child.	Provide education and dental referrals to pregnant women for them to seek oral health care while pregnant for preventative and dental treatment. Dental care is safe during pregnancy and good oral health while pregnant reduces ECC and poor pregnancy outcomes.	2/B
Xiao et al., 2019	To determine if prenatal oral health intervention results in	Systematic Review	5 studies: 3 randomized	ECC incidence was measured among children	The incidence of ECC is reduced along with <i>S. mutans</i> (bacteria	1/A

	lower rates of early childhood caries (ECC).		d control trials, 1 prospective cohort study, and 1 nested case-control study	ages 1-4 and compared with maternal intervention (dental education, fluoride supplement, prenatal health care)	associated with dental caries) carriage in the children of women who had prenatal oral health care.	
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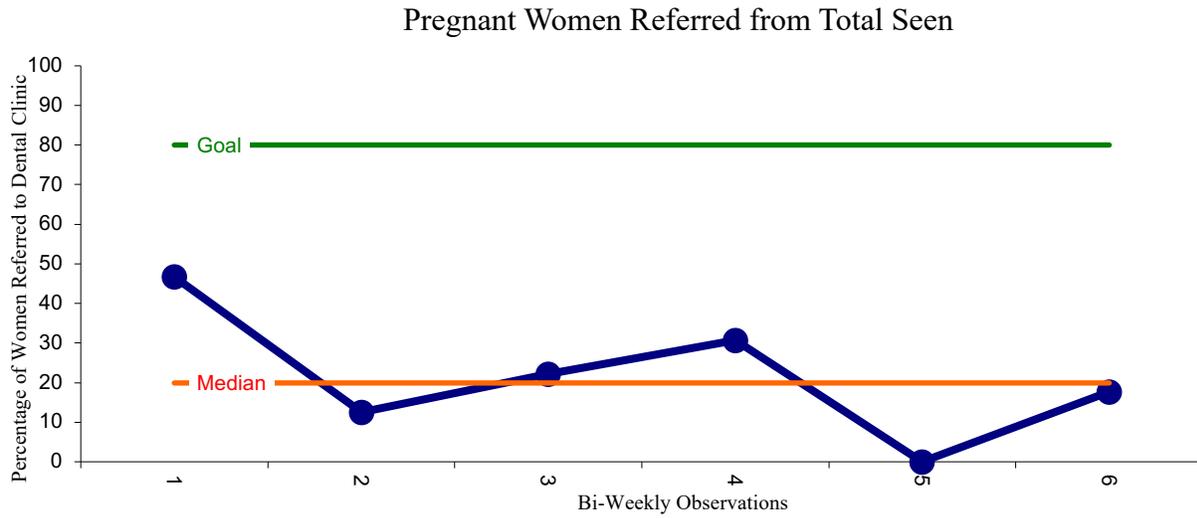


Figure 1: Run Chart depicting the percentage of women referred to the dental clinic from total number of women seen at community organization over twelve-week implementation period.

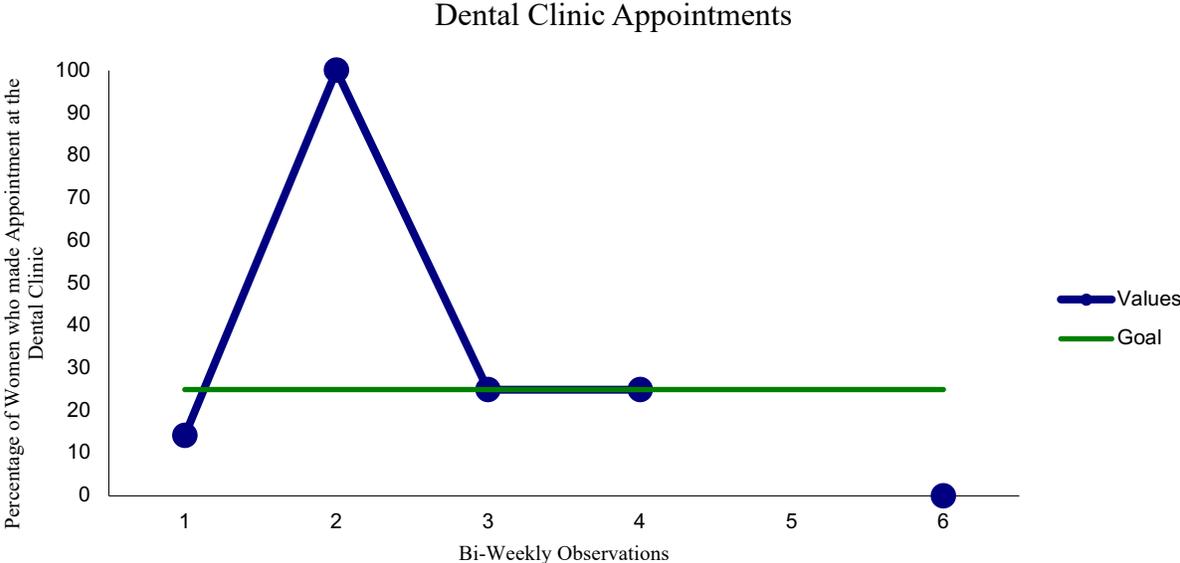


Figure 2: Run Chart depicting the percentage of women who scheduled dental clinic appointments from total number of women referred.

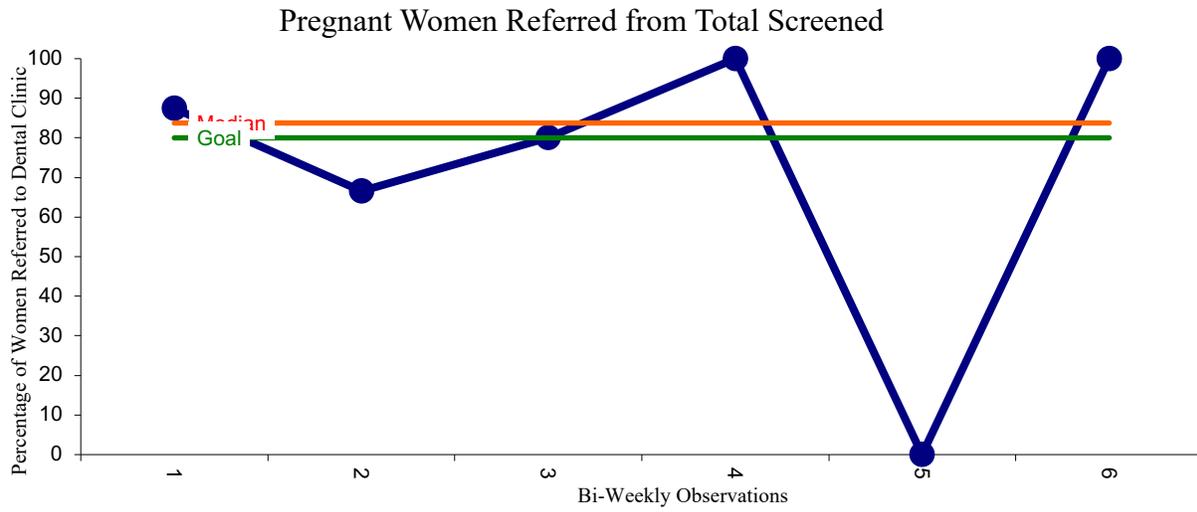
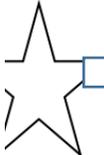


Figure 3: Run Chart depicting the percentage of women who were referred to dental clinic from total number of women screened.

**Appendix A
Dental Referral Form for Pregnant Women**

+			
Patient referred to:		Dental Clinic	Phone number: (443) 922-7670
		1040	
Referral Date: ___ / ___ / ___ <small>mm dd xxxx</small>			
Patient Information (patient to complete)			
Name: _____ <small>(First) (Last)</small>			
DOB: ___ / ___ / ___ <small>mm dd xxxx</small>		Estimated Delivery Date: ___ / ___ / ___ <small>mm dd xxxx</small>	
Phone number: (____) _____ - _____ (best number to reach you)			
Name of OB/GYN: _____ Preferred Language: _____			
Maternal Oral Screening Tool (WIC to complete)			
1. Do you have bleeding gums, swelling, sensitive teeth, loose teeth, holes in your teeth, broken teeth, toothache, or any other problems in your mouth? <i>(Please check one)</i>			
No ___ (0)			
Yes ___ (1)			
2. Have you seen a dentist in the last 12 months? <i>(Please check one)</i>			
No ___ (1)			
Yes ___ (0)			
Note: A dental check-up is recommended for pregnant women with a score ≥ 1.			
Patient Release of Information (patient to complete)			
I, _____ (print name), hereby authorize the _____			
_____ Program to share the above information with the _____ alth			
Department Dental Clinic.			
Signature: _____		Date: _____	
Oral health care is covered by Medicaid for pregnant women in Maryland.			



Appendix B

• Re: Permission to use the Maternal Oral Screening Tool

Yahoo/Inbox ★



• **Ajesh George** <A.George@westernsydney.edu.au>
To: Carolyn Greely, ajesh.george@sswahs.nsw.gov



May 31 at 1:02 AM ★

Hi Carolyn

Thanks you for your email. I would be happy for you to use our MOS tool as part of your project. I only ask that you please acknowledge the tool in any output from your project.

I would love to hear of any outcomes from your project down the track- good luck!!

Kind regards
Ajesh

A/Prof Ajesh George

Director

Centre for Oral Health Outcomes & Research Translation (COHORT)

School of Nursing & Midwifery, Western Sydney University

South Western Sydney Local Health District/Ingham Institute Applied Medical Research

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Appendix C Disclosure Statement

In Maryland, if you are pregnant and have Medicaid, you can see a dentist for free during your pregnancy. Many women in Maryland are unaware of this benefit. Dental care while pregnant is safe for both mom and her baby, and can help you have a healthier pregnancy. Having a healthy mouth can decrease pregnancy problems and lower the chance of your child having cavities. The tool attached is a part of a student project at the University of Maryland Baltimore to help increase the number of women seen by a dentist for free while they are pregnant. The goal is to help at least 80 women see a dentist using this form. The Dental Clinic in ***** is a local office that accepts Medicaid insurance. Pregnant women seen at *** will be asked for permission to complete the following form, and if you are having dental problems, will be referred to the Dental Clinic for further care.

You are invited to be a part of this project by filling out the attached form. If you agree to be a part of this project, the next page has a two-question screening tool to see if you have any dental problems right now. If you are having any problems, or haven't seen a dentist in the last year, with your permission your *** dietician will securely email this tool to the Dental Clinic in ***** along with your contact information and some general information about your pregnancy. (After emailing the form, the original copy will be shredded) If you don't schedule an appointment, a dental hygienist may call you to help you make an appointment if you wish. Your contact information will not be shared with anyone other than the staff at the Dental Clinic to help you schedule an appointment. None of your information will be collected by the student conducting this project. If you do not want to participate in this project, you do not need to complete the attached tool, and no information will be collected from you. You do not need to complete this form in order to continue your *** benefits, and participating in this project will not affect your *** benefits. You can change your mind at any time about your participation and can contact the Dental Clinic for care at any time unrelated to this project. If you have questions regarding your rights as a participant, contact Ms. G** H***** at (410) ***-**** or *****@maryland.gov If you have any questions about this project, please email the student, Cara Greely, at cmccomas@umaryland.edu Please keep this paper for your records, thank you!

