

**MCH Title V National Performance Measure for Oral Health  
Summary (updated January 2023)**



The measures and the process states use for the application, needs assessment, and reporting for the Maternal and Child Health (MCH) block grant has changed. The system uses a three-tiered framework that includes the following categories further described in the Table: national outcome measures (NOMs); national performance measures (NPMs); and state-initiated evidence-based or evidence-informed strategy measures (ESMs). In addition, states are required to develop a set of state performance measures (SPMs).

<b>NOM for Oral Health</b>	<b>NPM for Oral Health</b>	<b>ESM</b>	<b>SPM</b>
NOM 14 - the percent of children ages 1-17 years who have decayed teeth or cavities in the past year*	NPM 13.1 - the percentage of women who had a dental visit during pregnancy*  NPM 13.2 - the percentage of children, ages 1-17, who had a preventive dental visit in the last year*	State developed, state specific and actionable, ESMs track and measure a state MCH program’s strategies and activities and their impact on the NPMs	SPMs address the priorities states have identified based on the findings of their 5-year needs assessments. State oral health programs can suggest an oral health SPM, especially if the state has not identified NPM 13 as a priority.

\* Data for NOMs and NPMs will come from national data sets and will be pre-populated, as available, for the states, territories, and the District of Columbia. The data source for NPM 13.1 is the Pregnancy Risk Assessment Monitoring System (PRAMS). The data source for NOM 14 and NPN 13.2 is the National Survey of Children’s Health (NSCH).

Because the selection of NPMs by states is based on the findings of the 5-year needs assessment, it is important to engage state oral health coalitions and stakeholders, and MCH coalitions and stakeholders early in the needs assessment process.

- Let stakeholders know if the state will be asking for input for the needs assessment in writing, during community focus groups, or at formal meetings
- Share state-based oral health surveillance indicators and data sources that provide benchmark information and that can be used to monitor and evaluate MCH program performance and the impact of oral disease on MCH populations
- Describe how integrating oral health priorities can lead to desirable outcomes for all MCH populations
- Demonstrate how NPM 13 aligns with national goals such as Healthy People 2030 goals and objectives; Oral Health Care During Pregnancy: A National Consensus Statement; the Association of Maternal and Child Health Program’s Life Course Indicators, the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set); the National Oral Health Surveillance System indicators; and the Chronic Disease Indicators

Identify ESMs that help support NPM 13. Some strategies that focus on oral health include:

- Data collection
- Promotion of community water fluoridation and school-based dental sealant programs
- Oral health education
- Development and dissemination of educational materials
- Promotion of oral screenings, education, fluoride varnish and referrals for dental care by obstetricians pediatricians and other health professional

In summary, there are numerous opportunities to promote and integrate oral health into a state’s MCH needs assessment, Title V application, and Title V reporting, so use the new framework to promote oral health in your state!

## MCH Title V National Performance Measure for Oral Health Details and Recommended Actions

### Introduction

Many state oral health programs are located within, receive funding from, or work closely with their state maternal and child health (MCH) programs. This document provides an overview of strategies SOHPs may want to consider in response to ensure that oral health is an integral part of MCH.

### Overview

The Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), provides MCH Services Block Grant funding to all U.S. states, territories, and the District of Columbia. To monitor how the funding impacts the health of MCH populations (women, infants, children and adolescents, including children and youth with special health care needs (CYSHCN), and their families), states are required to report on a number of performance measures. Since the early 1990's, MCHB has measured oral health through NPM 9: percent of third grade children who have received protective sealants on at least one permanent molar tooth. All states, territories, and the District of Columbia were required to report on all NPMs, including NPM 9. States were allowed to develop their SPMs, and many states developed measures related to oral health.

Since 2015, HRSA MCHB has utilized a three-tiered framework that includes the following categories: NOMs, NPMs, and ESMs. In addition, states may develop SPMs.

### National Outcome Measure for Oral Health

The NOM for oral health is NOM 14, the percent of children ages 1-17 years who have decayed teeth or cavities in the past year.

### National Performance Measures

The 15 NPMs cover five MCH population domains: 1) women/maternal health, 2) perinatal/infant health, child health, 4) adolescent health, and 5) children with special health care needs. A sixth domain addresses cross-cutting and system building needs.

NPM	Women/Maternal Health	Perinatal/Infant Health	Child Health	Adolescent Health	Children with Special Health Care Needs
Well-woman visit	✓				
Low-risk cesarean delivery	✓				
Risk-appropriate perinatal care		✓			
Breastfeeding		✓			
Safe sleep		✓			
Developmental screening			✓		
Injury hospitalization			✓	✓	
Physical activity			✓	✓	
Bully				✓	
Adolescent well visit				✓	

Medical home			✓	✓	✓
Transition				✓	✓
Preventive dental visit			✓	✓	
Smoking			✓	✓	
Adequate insurance			✓	✓	✓

The NPMs are intended to drive improved outcomes relative to one or more indicators of health status (i.e., NOMs) for the MCH population, so states will track the NOMs to monitor impact by the NPMs.

States will choose five (5) NPM from the list of 15 NPMs for their MCH programs to address during the 5-year needs assessment cycle. States will ensure that at least 1 NPM from each of the 5 MCH population domains is selected and that *the selected NPMs are based on the state priority needs identified in the state’s 5-year needs assessment*. There are no mandatory NPMs. The process of selecting NPMs at the state level is critical, as they should address state priorities and guide the development of the state-specific ESMs. The NPM for oral health is NPM 13. It has two parts: 13.1) the percentage of women who had a dental visit during pregnancy, and 13.2) the percentage of children, ages 1 through 17, who had a preventive dental visit in the last year. For 13.1, the numerator is the number of women who had a dental visit during pregnancy and the denominator is the number of live births. For 13.2, the numerator is the number of children and adolescents, ages 1 through 17, who had a preventive dental visit in the past year and the denominator is the number of children and adolescents, ages 1 through 17. Data for NOMs and NPMs will come from national data sets and will be pre-populated, as available, for the states, the territories, and the District of Columbia. The data source for NPM 13.1 is PRAMS and the data source for NOM 14 and NPM 13.2 is NSCH.

### **State-Initiated Evidence-Based or Evidence-Informed Strategy Measures**

State-initiated ESMs are the measures by which states will directly measure their impact on the NPMs. State-specific and actionable, ESMs seek to track a state MCH program’s strategies and activities and to measure evidenced-based or evidenced-informed practices that will impact population-based NPMs. ESMs are developed by states, and they provide accountability for improving quality and performance related to NPMs and to the MCH public health issues for which they are intended.

### **State Performance Measures**

States will also develop SPMs to address the priorities they have identified based on the findings of their 5-year needs assessments. To the extent that a priority need has not been fully addressed through the selected NPMs, state oral health programs can suggest an oral health SPM, especially if the state has not identified NPM 13 as a priority.

### **Making the Case for the NPM on Oral Health—Recommended Strategies**

State oral health programs may need to strategize to ensure that oral health is a priority when selecting NPMs. Because the selection of NPMs by states is based on the findings of the MCH 5-year needs assessment, it is important to engage state oral health coalitions and stakeholders, and MCH coalitions and stakeholders early on in the needs assessment process.

- Let stakeholders know how the state will be asking for input for the needs assessment. Will it be in writing, during community focus groups, or at formal meetings?

- Share state-based oral health surveillance indicators and data sources that can be used to provide benchmark information and monitor and evaluate MCH program performance and the impact on oral disease on MCH populations. Describe oral health disparities that need to be addressed. Examples of indicators and data sources, in addition to indicators from NSCH and PRAMS, are:
  - Dental decay experience and dental treatment need among children enrolled in Head Start (data source: statewide oral health screening survey: Basic Screening Survey);
  - Dental decay experience and dental treatment need among children attending kindergarten (data source: statewide oral health screening survey: Basic Screening Survey);
  - Dental decay experience and dental treatment need among 3<sup>rd</sup> grade children (data source: statewide oral health screening survey: Basic Screening Survey);
  - Sealant prevalence and need among 3<sup>rd</sup> grade children (data source: statewide oral health screening survey: Basic Screening Survey);
  - Sealant prevalence and need among children served by school-based sealant programs (data source: state data, as available);
  - Annual dental visit among adolescents in grades 9-12 (data source: Youth Risk Behavior Survey);
  - Preventive and any dental services for children enrolled in Medicaid or the Children's Health Insurance Program (CHIP) Medicaid Expansion (data source: CMS-416);
  - Sealant use among children 6-9 years enrolled in Medicaid or CHIP Medicaid Expansion (data source: CMS-416);
  - Sealant use among children 10-14 years enrolled in Medicaid or CHIP Medicaid Expansion (data source: CMS-416).
- Describe how integrating oral health priorities can lead to desirable outcomes for all MCH populations, such as:
  - Increased understanding of the interaction between oral diseases and other systemic conditions;
  - Improved identification of oral diseases, injuries, and craniofacial disorders leading to timely referral for care and coordination of services;
  - Improved oral health behaviors such as proper tooth brushing with fluoride toothpaste, appropriate feeding and eating practices, healthier food choices, using mouth guards and helmets during sports and recreational activities, and cessation of tobacco use;
  - Increased access to preventive oral health services, especially for families with low incomes or those with inadequate or no insurance; and
  - Opportunities for improved birth outcomes, less-frequent ear infections and prevention of obesity.
- Demonstrate how NPM 13 aligns with Healthy People 2030 goals and objectives. Healthy People 2030 identifies Leading Health Indicators (LHI) to communicate high-priority health issues and actions that can be taken to address them. LHI OH8 is to increase use of the oral health care system." See <https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care/increase-use-oral-health-care-system-oh-08>. By having MCH populations as an index population for NPM 13, states can promote preventive dental programs and multi-sector partnerships to improve the oral health of populations that may influence health across the lifespan.
- Describe how NPM 13.1 aligns with the recent national consensus statement developed by the HRSA MCHB hosted an expert work group <http://www.mchoralhealth.org/PDFs/Oralhealthpregnancyconsensusmeetingsummary.pdf> HRSA convened an expert work group meeting in collaboration with the American College of Obstetricians and Gynecologists and the American Dental Association and published the consensus statement on oral health care during pregnancy in 2012. The statement provides guidance for both prenatal care health professionals and oral health professionals, emphasizing an Interprofessional approach to increase access and to coordinate oral health care during pregnancy. NPM 13.1 is an important indicator that reflects positive changes in the health care delivery system and improvement to the overall standard of care for pregnant women.

- Connect NPM 13.2 to the Association of Maternal and Child Health Programs (AMCHP) life course Indicator set (<http://www.amchp.org/programsandtopics/data-assessment/Pages/LifeCourseIndicators.aspx>). AMCHP has developed standardized metrics comprised of 59 indicators guided by the life course framework, a model to understand and address disparities in health and disease patterns. The LC-41 is on oral health preventive visit for children. Oral health preventive visit for children is an important indicator that not only reflects access to dental care and standard of care for children, but also disparities. Oral health disparities exist throughout the country, where children from lower income families and racial/ethnic minority groups continue to be disproportionately affected by oral disease than their counterparts. Only one third of eligible children enrolled in Medicaid/ CHIP were reported to have received any preventive dental services based on the 2010 Early Periodic Screening Diagnosis and Treatment (EPSDT) Participation Report. Use of dental services and maintaining optimal oral health in childhood are critical to both oral health and general health throughout the life course.
- Align NPM 13.2 with the Centers for Medicare & Medicaid Services (CMS) child core set, which includes two oral health care measures among children enrolled in Medicaid or CHIP (preventive oral health services, dental sealants among children aged 6-9 at elevated risk): <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>. CMS continues to focus on children's access to oral health care to measure the quality improvement efforts in Medicaid and CHIP. State performance related to children's access to dental care is evaluated through two measures in the Child Core Set on 1) Preventive Dental Services, and 2) Dental Treatment Services. In light of the children's dental benefit becoming mandatory through the CHIP Reauthorization Act, it is critical for states to implement community-based oral health programs that reduce barriers to dental care access and promote children's use of dental care.
- Demonstrate the alignment of NPM 13.2 with the National Oral Health Surveillance System (NOHSS) indicators and the Council of State and Territorial Epidemiologists (CSTE) chronic disease indicators. ASTDD's Perinatal Oral Health Committee, in collaboration with the ASTDD Best Practice Committee, has reviewed the best scientific evidence, public health strategies and practice examples and developed a Best Practice Approach Report on perinatal oral health issues. This report provides a 6-step strategic framework for improving perinatal oral health at state and local levels and includes examples of actions to establish state/community-based perinatal oral health surveillance and build infrastructure and partnerships.

### **State Initiated Evidence-Based or Evidence-Informed Strategy Measures (ESM) and Oral Health**

Once a state selects its NPMs, it will need to identify ESMs that help support the performance measures. It is important that SOHPs demonstrate how their work supports the state's MCH program. Here are some strategies that SOHPs can implement that focus on oral health.

- Collaborate with MCH leadership to collect data through PRAMS;
- Provide oral health education at local WIC clinics and other appropriate venues;
- Develop educational materials, public service announcements and social marketing geared to target populations and health professionals that promote preventive oral health services;
  - Develop oral health education materials targeting pregnant women;
  - Develop oral health education materials for parents and other caregivers on the importance of good oral health and the need for preventive oral health services (e.g., fluoride varnish, dental sealants).
  - Develop oral health education materials promoting fluoride varnish and the application of dental sealants geared toward oral health and other health professionals working in school-based health centers, FQHCs, or other community clinics;
- Promote the practice of perinatal medical providers providing oral screenings, education, and referrals for pregnant women for dental care;
- Promote the practice of early childhood medical providers providing oral screenings, fluoride varnish applications, anticipatory guidance, and dental referrals by age one;
  - Establish in-service training or online courses for pediatricians and other health professionals;

- Promote the provision of preventive oral health services by health professionals in federally qualified health centers (FQHCs), and school-based health centers;
- Promote the provision of oral health education and dental sealants to children enrolled in the Free and Reduced Lunch Program;
- Establish outreach programs promoting oral health to adolescent parents;
  - Identify outreach services for adolescent parents through school-based health centers;
    - Provide oral health education to adolescents;
    - Establish an oral health network for adolescents for education and overall services;
- Promote community water fluoridation;
- Increase oral health literacy as a mechanism for reducing health disparities by aligning with local and regional literacy partners/coalitions/efforts;
- Promote oral health integration into other MCH priority domains, such as:
  - Injury prevention- use of seat belts, car seats, and mouth guards during contact sports; ○ Perinatal health / infant mortality reduction- relationship between poor oral health and negative birth outcomes;
  - Breastfeeding- relationship between breastfeeding and reduced caries risk;
  - Smoking- relationship between smoking and oral cancer;
  - Adequate insurance coverage;
- Promote oral health integration into state Maternal, Infant, and Early Childhood Home Visiting Programs (MIECHV) by providing oral health training, education, and resources to home visitors;
- Collaborate with the state Early Childhood Comprehensive Systems program (ECCS) to implement collaborative oral health initiatives (e.g., oral health training for medical providers, fluoride varnish program for CYSHCN);
- Promote oral health integration into all MCH programs targeted towards CYSHCN.

In summary, there are numerous opportunities to promote and integrate oral health into a state's MCH needs assessment, Title V application, and Title V reporting, so use the new framework to promote oral health in your state.