Issue BRIEF

Centers for Medicare & Medicaid Services
ORAL HEALTH Initiative

Moving from Goal to Impact: A Quality Improvement Approach to Advancing Children's Oral Health in Medicaid

In brief:
The Centers for Medicare & Medicaid Services (CMS) national Oral Health Initiative (OHI) has fostered state efforts to improve the oral health of child and adolescent Medicaid beneficiaries. This technical assistance brief describes a stepwise approach to state strategic planning to meet the dental service utilization improvement goals of the OHI.

Even though Medicaid coverage includes dental benefits for enrolled children, ensuring that children use that benefit has proved to be a challenge for states. To reduce barriers to oral health care for low-income children and to increase utilization, CMS launched a national Oral Health Initiative (OHI) in 2010. Through the OHI, CMS has asked states to increase the proportion of children who receive preventive dental services, as well as the proportion who receive dental sealants (see sidebar). CMS has also asked states to develop State Oral Health Action Plans (SOHAPs) to describe the steps they will take to achieve improvements. Under the auspices of the OHI, CMS is working with federal and state partners, dental and medical providers, managed care organizations, community advocates, and other oral health stakeholders to advance this work.

CMS Oral Health Initiative Goals

1. Increase the proportion of children ages 1 to 20 enrolled in Medicaid or CHIP for at least 90 continuous days who receive any preventive dental service by 10 percentage points between federal fiscal year (FFY) 2011 and FFY 2015.
2. Increase the proportion of children ages 6 to 9 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a dental sealant on a permanent molar tooth by 10 percentage points (target date to be determined).

CMS has offered technical assistance to help states (1) identify and address barriers to meeting the OHI goals, (2) develop strategic approaches to overcome these barriers, and (3) implement these strategies to improve service utilization and subsequent oral health among children served by Medicaid. One technical assistance vehicle is the OHI Learning Collaborative (OHILC), led by Mathematica Policy Research and the Center for Health Care Strategies (CHCS). The OHILC is providing technical assistance and facilitating peer-to-peer learning to support Medicaid agencies from five states in developing SOHAPs to meet CMS' goals.[1]

This technical assistance brief describes critical elements of the strategic planning process, drawing from the experiences of states in the OHILC. It highlights approaches that represent the interests of a diverse set of key stakeholders, are feasible to implement, are measurable, and are likely to achieve the desired impact on children's oral health.

THE IMPORTANCE OF STRATEGIC PLANNING

Effective strategic planning is essential to creating sustainable change in any environment, including oral health delivery systems. A comprehensive strategic plan provides both a roadmap for quality improvement, including a strategy for engaging stakeholders, and a foundation upon which to organize, execute, and assess interventions. Without a well-considered plan, state activities can be misdirected or less effective at achieving intended goals.

The SOHAP template developed for the OHILC (see Appendix A)[2] offers states a structured framework for conducting strategic planning, including the following steps:

1. Describe and assess the current Medicaid oral health delivery system
2. Identify key drivers of change
3. Determine which interventions will achieve your drivers
4. Identify resources needed to implement interventions
5. Anticipate barriers and identify potential solutions for each intervention

Taking these steps will give states an opportunity to consider important dimensions they may not otherwise have examined. The following sections describe this stepwise approach and the ways in which it can lay the foundation for successful implementation.

STEPS IN THE STRATEGIC PLANNING PROCESS

1. Describe and Assess the Current Medicaid Oral Health Delivery System

A good way to begin is to examine the state's current oral health delivery system. This includes describing and assessing current performance, strengths, opportunities, and challenges to improved delivery of oral health care.

Identifying factors that support or hinder improvement can help states in mapping out the delivery system's structure and workforce. In addition, examining available data can help states identify gaps in access, as well as areas where they may need better data. It is also helpful for states to establish clear roles for members of their quality improvement teams, and begin to identify and engage a wide variety of stakeholders and partners. A diverse team is a stronger team.

The strongest quality improvement teams include representatives from the state Medicaid agency, partner agencies such as the state department of health, Medicaid-contracted dental and health plans; providers or provider groups; community-based organizations, state oral health coalitions, and patient advocacy groups. It is also helpful to include oral health "champions" who can provide political influence or financial support, as well as perspectives and guidance, not found within the state Medicaid dental team.

After describing the overall delivery system, it is important to assess opportunities and resources in the state that are conducive to improving dental service utilization. These may include political or legislative support, positive changes in the reimbursement structure, scope of practice laws, new analytic tools, the involvement of stakeholders beyond the core quality improvement team, or reinforcing the efforts of community-based organizations or provider groups.

Similarly, describing key barriers to preventive service utilization can help states prioritize where to direct resources. Outlining all barriers, including those specific to certain regions or groups (such as age, racial, or ethnic groups) or to the delivery of a service such as dental sealants, can highlight areas that may need more support.

Key considerations in *step 1*:

- Engage a wide variety of external stakeholders—either on the quality improvement team or through outreach and engagement efforts—and establish clear roles for them to set the stage for productive collaboration
- Define planning process roles to ensure alignment and common understanding of engagement and project goals across the quality improvement team

2. Identify Key Drivers of Change

Key drivers of change are factors or components of a system that contribute to an aim (in this case, one of the two CMS OHI goals).[3] Primary drivers are system components that contribute directly to achieving the aim; secondary drivers are changes, actions, or interventions needed to achieve the primary drivers.

A "driver diagram" depicts the relationship among an aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers needed to achieve the primary drivers (see Exhibit 1). It can also include interventions that can influence the secondary drivers.[4]

Exhibit 1. Sample Driver Diagram Template for CMS Goal 2: Dental Sealant Utilization

AIM	Primary Drivers	Secondary Drivers	Interventions
Increase by 10 percentage points the proportion of children ages 6 to 9 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a dental sealant on a permanent molar tooth.	Medicaid reimbursement policies support payment for sealants placed on teeth by dental hygienists in school settings.	Federally Qualified Health Centers (FQHCs) can bill the full encounter rate for sealants placed by FQHC-employed dental hygienists in school settings.	Modify Medicaid FQHC billing manual to include dental hygienists as covered providers.
		Medicaid will reimburse for sealants placed on teeth by dental hygienists using portable equipment in schools.	Modify state agency sub-regulatory guidance to allow reimbursement of specified oral health programs for oral health services provided using portable equipment.
	Increased likelihood that parents of Medicaid-enrolled children will seek sealants on permanent molar teeth for children ages 6 to 9.	Increased awareness among parents of children enrolled in Medicaid or CHIP of the importance of dental sealants for their children.	Identify and adopt oral health education materials to share with families through local health departments, mailings, the Medicaid member guide, and Head Start.
			Request that Medicaid-contracted dental plans conduct telephonic outreach to families of children ages 6 to 9 without claims for dental sealants, to counsel them on the importance of the service and how to access it.

Creating a driver diagram can give a team "a shared view of the theory of change in a system. [It] represents the team members' current theories of 'cause and effect' in the system—what changes will likely cause the desired effects." It also helps to inform the subsequent identification of interventions.[5]

Effective aims in a driver diagram are data-driven; they are specific, measurable, and time-bound objectives that define what states are trying to accomplish, and include what will be improved, for whom, how much, and by when. If baseline data are not available, states can use surrogate data that reveal information about the system, data from a previous period, or early implementation data.

In developing driver diagrams, states in the OHILC identified a diverse set of primary and secondary drivers, along with related interventions, to meet the two CMS goals (that is, the "aims" of their driver diagrams). Although each state's driver diagram is unique, the drivers they each identified share common themes. These include:

- Improving engagement of primary care providers in children's oral health
- Increasing knowledge among beneficiary families about covered benefits, how to access services, and recommended oral health care clinical guidelines
- Expanding available services through alternative workforce models, expansion of the provider network, weekend/evening hours at dental offices, and so on
- Engaging schools, including expanding and strengthening school-based programs that offer dental services, particularly sealants
- Improving dental providers' awareness of and willingness to see child Medicaid beneficiaries, including very young children, particularly for services such as sealants.

Key considerations in *step 2*:

- When developing driver diagrams, consider which stakeholders to engage for input and feedback, to ensure that the diagram represents a complete and diverse set of perspectives
- Use data strategically to help determine aims
- Explore the CMS Quality Improvement Workshop Series, a set of three webinars offering additional guidance on creating driver diagrams[6]

3. Determine Which Interventions Will Achieve Your Drivers

The next step is to identify evidence-based or promising interventions that are likely to influence the selected drivers of change. Sources for such interventions include (1) a catalogue of oral health efforts shared by the state of Missouri;[7] (2) CMS reports, such as Keep Kids Smiling[8] and Improving Oral Health Care Delivery in Medicaid and CHIP–A Toolkit for States;[9] and (3) the American Dental Association's Center for Evidence-Based Dentistry.[10]

After compiling an initial list of potential interventions, it is important to assess each intervention to determine:

- Whether it is feasible to implement in the state
- Whether it is likely to have the desired impact on the driver
- What resources are needed to implement it
- Which interventions can be implemented in the near term
- Which interventions may require additional work prior to implementation[11]

For each intervention, it is helpful for states to identify specific partners they will need to engage for implementation, and to assess the steps needed to engage them.

Key considerations in *step 3*:

- Consider how to address stakeholders' potentially conflicting priorities
- Prioritize interventions that can be implemented in the short term with available resources

- Consider any legislative or administrative policy changes needed for implementation, and whether they are feasible
- Investigate the data capacity needed for implementation

CASE STUDY

Florida's OHILC Intervention-Selection Process

The Florida OHILC team used a structured method to select its interventions, which allowed it to involve all stakeholders and team members in narrowing down the interventions to include in its SOHAP. First, stakeholder groups identified and revised the primary and secondary drivers. Then, the team discussed each driver and compiled ideas for interventions. After assembling interventions for each driver, the team split into three groups to assess the intervention ideas, rating them high, medium, or low according to the following factors:

- **Leverage.** The strength of impact, that is, whether the intervention addresses the driver's most important root cause
- **Feasibility.** Whether the intervention can be implemented
- **Specificity.** How specific the intervention is to that particular driver
- **Values.** Whether the intervention is consistent with the values of the community and the stakeholders involved

Using these factors, the groups were able to narrow the list of proposed interventions to a manageable number. They then identified the resources needed to implement each intervention, as well as the interventions that the team could implement in the short term.

4. Identify Resources to Implement Interventions

For each identified intervention, it is important for states to consider the resources they will need for implementation and how to ensure those resources are available. Types of resources include:

- *Staff time*. How many hours per month will be needed to perform the work, and over what time period? Which organization will provide the staff and/or cover staff salaries?
- *Staff expertise*. What skill sets—such as data analysis, brochure design, or patient counseling— are needed for implementation? Who can provide those skills?
- *Political/organizational/community-based will or internal and/or external champions*. This less-tangible resource may be necessary to implement an intervention successfully and have the desired impact on drivers.
- *Non-staff budget lines*. What elements of the intervention have direct monetary costs? Examples include brochure printing, postage for appointment-reminder postcards, room rental fees, and transportation costs.
- *Data*. Data are an often-overlooked yet critical resource for implementing and assessing an intervention. States need data to establish starting points (such as how many schools host dental sealant programs) and to demonstrate improvements (such as an increase in the number of schools doing so).

It can be helpful to create a table showing resource needs and potential sources for them. Exhibit 2 is an example of such a table, drawn from the SOHAPs of states in the OHILC. In some cases, the resources or sources may not be clear at this stage of planning. Documenting those unknowns can prompt states to explore those issues before diving into implementation and, if they cannot obtain the resources, to reconsider the feasibility of an intervention.

Key considerations in *step 4*:

- Explore how to obtain necessary resources and look beyond the state's core planning team to consider tangible and intangible contributions from nontraditional stakeholders
- Identify any budget line items that are highly susceptible to reduction or elimination, so that back-up funding sources can be considered before funding is cut

Exhibit 2. Assessment of Resources Needed to Implement Interventions

Intervention	Resources Needed	Provider(s) of Resources
Develop and implement a streamlined provider credentialing process in the Medicaid managed care delivery system.	Information from providers on the challenges they have faced with the current credentialing process.	Health and dental plan network representatives (to survey or interview providers).
		Providers practicing in health access settings (such as health departments, FQHCs, school-based clinics, and so on).
	Research on other centralized credentialing approaches.	State Medicaid staff (to complete research).
		Council for Affordable Quality Healthcare.
	Best practices in this area from other states.	State Medicaid agency staff (to conduct online research and contact Medicaid dental program directors in other states).
	Process mapping of the new credentialing process.	Medicaid Process Improvement Office.
	Facilitator for new workgroup that will develop the new process.	State department of health.
	Meeting room for workgroup convenings.	Health or dental plan office space.
	Vehicles and channels to communicate the new process to network providers.	Health and dental plan marketing departments.

5. Anticipate Barriers and Identify Potential Solutions for Each Intervention

A final step for states in completing a SOHAP or other strategic plan is anticipating barriers to achieving each intervention's aim and identifying how to address those barriers. Barriers may be systemic or isolated, and they may arise within the state Medicaid agency or within a partnering organization (such as a contracted dental plan). They may be deeply rooted, or superficial and easy to change. They may be financial, political, social, or otherwise. Barriers may hinder an intervention's successful implementation (such as low pediatrician turnout at oral health training sessions due to lack of interest or scheduling conflicts), or its impact on a driver (such as whether an oral health training session for pediatricians leads to an increase in the number of dental referrals they provide).

When identifying barriers and potential solutions, it is important for states to engage a diverse set of stakeholders to provide broader knowledge of possible barriers—and potential solutions—than the

state agency possesses. Depending on the focus of the state's plan and its interventions, stakeholders may include contracted health or dental plans, medical and dental providers, beneficiary representatives, state or local oral health coalitions, schools, community-based organizations, and other organizations that can affect or be affected by the planned interventions.

After creating a list of potential barriers related to each intervention, the next step is to consider solutions to overcoming them (see Exhibit 3 for examples drawn from the OHILC). This process can suggest the relative feasibility of specific interventions, as well as highlight the advance work that the state must undertake for successful implementation.

Key consideration in *step 5*:

- Identify and address barriers and available solutions that may shift or evolve over time. An initial strategic plan will reflect an early "snapshot" of barriers and solutions, so it is important to revisit them as they evolve.

Exhibit 3. Assessment of Barriers to Interventions

Intervention	Anticipated Barriers	Potential Solutions to Overcoming Barriers
Streamline the provider credentialing process for the managed care delivery system.	Health plans may still require unique provider information even after the core credentialing requirements are streamlined.	Process-map the credentialing process.
		Form a workgroup with plans to gain consensus on the most critical credentialing elements and to narrow the scope of unique information requested by plans.
Talk to managed care dental plan representatives at next Quality Improvement Council meeting to explore opportunity for reimbursing dental providers for applying fluoride varnish with greater frequency.	Potential differences of opinion on the value of adding this additional reimbursement.	Hold collaborative discussion to achieve an evidence-based decision.
Enroll all dental and dental hygiene schools located in dental managed care counties as Medicaid providers, and provide technical assistance for billing procedures and outreach activities.	Lack of interest or support by schools to participate in Medicaid and/or the managed care program	Educate school administrators about the value of providing dental services to Medicaid beneficiaries.
	Lack of timely training and ongoing support among the dental and dental hygience schools for billing and outreach.	Engage dental plan network representatives to provide needed training and support to the schools.

CONCLUSION

Embarking on a statewide or regional quality improvement effort requires a commitment of time, expertise, and other resources from a diverse set of stakeholders interested in a given goal. To achieve targeted aims—whether increasing preventive dental service utilization among children enrolled in Medicaid, or another health aim—requires a thoughtful, stepwise approach to strategic planning to move from goal to impact. Increasing the likelihood of achieving the intended quality improvement will also reward engaged stakeholders for their commitment and lay the foundation for future partnership and support.

APPENDIX A

State Oral Health Action Plan (SOHAP)
Template for Medicaid and CHIP Programs

State Name:_____

Program Type Addressed in Template: ☐ Medicaid Only ☐ Combined Medicaid and CHIP

State Medical Dental Program Lead:

Name:_____ E-mail:_____ Phone:_____

This State Oral Health Action Plan (SOHAP) template is for use by states participating in the CMS Oral Health Initiative (OHI) Learning Collaborative. It includes a simplified framework for planning and evaluating state-specific strategies to improve utilization of preventive dental services by children enrolled in Medicaid or CHIP, consistent with the following CMS national children's oral health improvement goals:

- Increase the proportion of children ages 1-20 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a preventive dental service by 10 percentage points between FFY2011 and FFY2015; and
- Increase the proportion of children ages 6-9 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a dental sealant on a permanent molar tooth by 10 percentage points over five-year period (baseline year TBD).

Technical assistance provided through the OHI Learning Collaborative will support each state to use this template and a subsequent Plan-Do-Study-Act (PDSA) template. The SOHAP template guides each state through the following activities:

1. Describing and assessing the state's Medicaid dental delivery system, including: (a) its structure, (b) current workforce participation, (c) dental reimbursement rates, (d) opportunities and resources conducive to improved dental service utilization, and (e) key barriers to preventive service utilization;
2. Identifying key drivers of change and interventions needed to meet the CMS goals, using a driver diagram;
3. Determining the resources needed for intervention implementation, and from where those resources will come;
4. Anticipating barriers to each intervention, and identifying potential solutions and the technical assistance needed to overcome them; and
5. Creating plans to assess the success of each intervention and subsequent achievements of drivers, including the data needed to do so.

APPENDIX A

Centers for Medicare & Medicaid Services ORAL HEALTH Initiative

State Oral Health Action Plan (SOHAP) Template

Please complete this template in its entirety as a Word document, attaching separate documentation (e.g., historical utilization reports, previous strategic plans, etc.) that would add value to the completed SOHAP. Feel free to add rows to each table as needed.

1. Overview and Assessment of State Medicaid Dental Delivery System

A. Structure of Dental Delivery System

	YEAR IMPLEMENTED	NUMBER OF CHILDREN CURRENTLY ENROLLED IN MEDICAID/CHIP[1]	NAMES OF PLANS CONTRACTED WITH PROGRAM
Fee for Service			
Administered by the state agency, including **carved out** of medical managed care			
Administered by a contractor, including **carved out** of medical managed care			
Administered by a contractor, but **carved in** to medical managed care			
Other fee-for-service (please describe): _____			
Dental Managed Care			
Carved in to medical managed care			
Carved out of medical managed care			
Other dental managed care (please describe): _____			

[1] Include date, and distinction between Medicaid and CHIP enrollees, where applicable.

B. Dental Workforce

i. Participating Dental Providers ("Participating" = submitted at least one claim; "Active" = submitted at least $10,000 in claims):

PROVIDER TYPE	YEAR OF DATA	NUMBER LICENSED IN STATE	PRIMARY DENTAL DELIVERY SYSTEM TYPE: _____		SECONDARY DENTAL DELIVERY SYSTEM TYPE: _____	
			# PARTICIPATING	ACTIVE	# PARTICIPATING	ACTIVE
Dentists						
Dental Hygienists						
Other Mid-Level Dental Provider						
Dental Specialists (enumerated by type)						

ii. Participating Non-Dental (Medical) Professionals Providing Dental Services ("Participating" = submitted at least one claim; "Active" = submitted at least $10,000 in claims):

PROVIDER TYPE	YEAR OF DATA	NUMBER LICENSED IN STATE	NUMBER PARTICIPATING	NUMBER ACTIVE	REIMBURSEMENT FOR DENTAL SERVICES (PAYMENT RATE OR NO)	NUMBER OF PROVIDERS DELIVERING DENTAL SERVICES
MDs/DOs						
Nurse Practitioners						
Physician Assistants						
Other Non-Dental, Mid-Level Providers						

C. Dental Service Reimbursement Rates

CODE	SERVICE	CURRENT REIMBURSMENT RATE	PLANS TO ADJUST
D0120	Periodic Oral Exam		
D0140	Limited Oral Evaluation, problem-focused		
D0150	Comprehensive Oral Exam		
D0210	Complete X-rays with Bitewings		
D0272	Bitewing X-rays – two films		
D0330	Panoramic X-ray film		
D1120	Prophylaxis (cleaning)		
D1208	Topical Application of Fluoride		
D1206	Topical Fluoride Varnish		
D1351	Dental Sealant		

D. Opportunities and Resources Conducive to Improved Preventive Dental Service Utilization

Describe opportunities or resources in your state (e.g., political/legislative support, changes in reimbursement, scope of practice laws, stakeholder support, etc.) that could support increased preventive dental service access and utilization among children enrolled in Medicaid or CHIP:

E. Key Barriers to Preventive Dental Service Utilization

Describe the key barriers to preventive dental service utilization among children in your program, including those specific to certain geographic areas or demographic groups (e.g., by age or race/ethnicity), and/or to the specific service of dental sealant application:

2. State-Specific Aims, Drivers of Change, and Interventions

Please complete the following two templates:

Driver Diagram Template 1

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	INTERVENTIONS
Increase by 10 percentage points the proportion of children ages 1-20 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a preventive dental service by FFY2015.			

Driver Diagram Template 2

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	INTERVENTIONS
Increase by 10 percentage points the proportion of children ages 6-9 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a dental sealant on a permanent molar tooth.			

3. Resources Needed to Implement Interventions

For each intervention noted above, describe the resources (e.g., staff time, funding, subject-matter expertise) that will be needed to implement it, and from where you anticipate these resources will come (e.g., program budgets, contracted plans, philanthropy, etc.).

Intervention	Resources Needed	From Where Resources Will Come

4. Anticipated Barriers to Interventions

For each intervention, describe any specific, anticipated barriers to implementation and/or effectiveness, potential solutions to overcoming these barriers, and the technical assistance you will need to do so:

Intervention	Anticipated Barriers	Potential Solutions to Overcoming Barriers	Technical Assistance Needed (if any)

5. Plan to Assess Interventions

For each intervention, describe your process for assessing successful implementation:

Intervention	Intervention Assessment	Specifications and Sources of Assessment Data

6. Plan to Assess Achievement of Drivers

Describe your process for assessing achievement of each secondary and primary driver, including the data you will use, and the sources for those data:

Secondary Driver	Goal/Baseline (if applicable)	Data Specifications	Data Sources
Primary Driver	**Goal/Baseline (if applicable)**	**Data Specifications**	**Data Sources**

ENDNOTES

[1] Participating states are Florida, Kansas, Michigan, Utah, and Washington, D.C. The states' completed SOHAPs, as well as those of other states that have submitted SOHAPs to CMS, are available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html.

[2] The template developed for the OHILC is a variation on the initial template issued by CMS in 2011; the latter can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html under "State Oral Health Action Plans."

[3] Centers for Medicare & Medicaid Services (2013). "Defining and Using Aims and Drivers for Improvement: A How-to Guide." Available at: http://innovation.cms.gov/files/x/hciatwoaims-drvrs.pdf.

[4] Ibid.

[5] Ibid.

[6] Centers for Medicare & Medicaid Services. "CHIPRA Initial Core Set of Children's Health Care Quality Measures: Quality Improvement Workshop Series." Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html.

[7] Missouri Department of Health and Senior Services: Community Health Improvement Resources. "Oral Health Evidence-Based Interventions." Available at: http://health.mo.gov/data/InterventionMICA/OralHealth/index_5.html.

[8] Centers for Medicare & Medicaid Services (2013). "Keep Kids Smiling: Promoting Oral Health through the Medicaid Benefit for Children and Adolescents." Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Keep-Kids-Smiling.pdf.

[9] Centers for Medicare & Medicaid Services (2014). "Improving Oral Health Care Delivery in Medicaid and CHIP: A Toolkit for States." Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Oral-Health-Quality-Improvement-Toolkit-for-States.pdf.

[10] American Dental Association Center for Evidence-Based Dentistry. "Community Oral Health and Health Policy." Available at: http://ebd.ada.org/en/evidence/evidence-by-topic/community-oral-health-and-health-policy.

[11] C. Botsko (2015). "CMS Oral Health Initiative Intervention Selection and Planning Tool." Developed for the CMS Oral Health Initiative Learning Collaborative by the Altarum Institute. Available at: www.altarum.org/OHITool.

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