100 Million Mouths Campaign: Creating a Pilot Program to Advance Oral Health Equity

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ABSTRACT

PURPOSE More individuals access primary care compared with oral health services. Enhancing primary care training to include oral health content can therefore improve access to care for millions of individuals and improve health equity. We developed the 100 Million Mouths Campaign (100MMC), which aims to create 50 state oral health education champions (OHECs) who will work with primary care training programs to integrate oral health into their curricula.

METHODS In 2020-2021, we recruited and trained OHECs from 6 pilot states (Alabama, Delaware, Iowa, Hawaii, Missouri, and Tennessee) with representation from varied disciplines and specialties. The training program consisted of 4-hour workshops over 2 days followed by monthly meetings. We conducted internal and external evaluations to assess the program's implementation through postworkshop surveys, identifying process and outcome measures for engagement of primary care programs, and through focus groups and key informant interviews with the OHECs.

RESULTS The results of the postworkshop survey indicated that all 6 OHECs found the sessions helpful in planning next steps as a statewide OHEC. Each OHEC was also successful in engaging 3 primary care training programs within their state and incorporating oral health curricular content through various modalities, including lectures, clinical practice, and case presentations. During the year-end interviews, the OHECs reported that they would overwhelmingly recommend this program to future state OHECs.

CONCLUSIONS The 100MMC pilot program was implemented successfully, and the newly trained OHECs have the potential to improve access to oral health within their communities. Future program expansion needs to prioritize diversity within the OHEC community and focus on program sustainability.

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INTRODUCTION

Oral disease affects the vast majority of Americans. Dental caries is the most prevalent childhood chronic disease, and it leads to pain, hospitalizations, and missed school,[1] while periodontitis in adults worsens diabetes and heart disease through systemic inflammation.[2] Oral disease is a health equity issue; untreated decay in the adult population is more prevalent among Hispanic people (36%) and non-Hispanic Black people (42%) than among non-Hispanic White people (22%).[1] Prevention of oral disease and promotion of oral wellness require an interprofessional, multifaceted approach that uses creative methods from dental and nondental professionals. With tens of millions of Americans having no access to a dentist for various reasons and a national shortfall of approximately 10,000 dentists, dental prevention should be offered where people frequent care, such as in primary care settings.[3,4]

One of the reasons oral disease remains widespread is poor coordination of efforts between medical and dental organizations.[5] Furthermore, medical education is still lacking in consistent teaching of oral health concepts across primary care schools and programs. Recent research shows that more than one-half of schools/programs across multiple primary care disciplines teach only 1 to 3 hours of oral health content, and a majority of the disciplines report low perceived oral health competence among program graduates.[6] One of the main predictors of oral health inclusion in primary care training programs was an oral health champion's presence within the program. The majority of the disciplines with an oral health champion had a teaching relationship with a dental school and significantly more hours of oral health teaching.[7] Without systematic approaches such as discipline-specific

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mandates or accreditation requirements, the often unfunded, mission-driven passion of oral health champions is essential to the inclusion of oral health in the primary care curriculum.

Targeted investment in the identification and training of oral health champions in safety-net settings can have a ripple effect on primary care education.[8] A single champion has the potential to create many new champions who will care for many underserved patients in their lifetime. This community of newly minted primary care professionals will also join practices where they can influence colleagues and, collectively over time, millions of mouths. To realize this mission, the Center for Integration of Primary Care and Oral Health (CIPCOH) launched the 100 Million Mouths Campaign (100MMC).

CIPCOH, funded through a 5-year cooperative agreement with the Health Resources and Services Administration (HRSA), is a center having multiple disciplines and institutions (Harvard Medical School, Harvard School of Dental Medicine, the University of Massachusetts Chan Medical School's Department of Family Medicine and Community Health, and other academic partners).[9] The center's mission is to serve as a national resource to consolidate the evidence base for systems-level oral health integration into primary care training. The authors (all members of CIPCOH) created 100MMC to design, implement, and evaluate a community of practice for training state champions to engage health schools and programs in their respective states to implement or enhance oral health curricula.[10]

The goal of 100MMC is to train oral health education champions (OHECs) in every state to encourage primary care training programs (defined as family medicine, pediatric, internal medicine–pediatrics, and internal medicine residencies and geriatric fellowships, as well as nurse practitioner, physician assistant, midwifery, and medical schools) to teach oral health to their learners. Then, as these residents, fellows, and students across the country graduate, they will interact with their own patients to improve oral health, and collectively, will improve the oral health of millions of Americans.

METHODS

Selection of the Pilot Program's States

Our recruitment of the first 6 OHECs was based on a review of state-by-state metrics used to develop an algorithm for rank-ordering the 50 states, including the following: the number of oral health integration programs identified by CIPCOH in years past; the number of students with caries experience and adults who have lost 6 or more teeth to decay or disease; the state's number of dental shortage areas; the type of Medicaid benefits for dental care; dentists per 100,000 individuals; oral health coalition in the state; oral health knowledge and attitude indices pertaining to each state; and oral health status and percentage of adults who have lost 6 or more teeth.

Using these metrics, we identified the states with the lowest scores (ie, those likely to benefit the most from training OHECs within their states). We based our final selection on these metrics plus geographic representation across the country. The states selected for the pilot program were Alabama, Delaware, Hawaii, Iowa, Missouri, and Tennessee.

Recruitment of the OHECs

To recruit OHECs, we created digital flyers and distributed them across primary care and dental listservs. A web page was developed to provide additional details for potential applicants. We received 17 applications across multiple disciplines from the 6 states. We created a 20-point grading criterion and selected 1 OHEC per state based on their responses to the application's questions, which evaluated their interest and experience in engaging primary care professionals on oral health. We used their curriculum vitae to assess stage in their career, connection to academic programs, prior oral health experience, and perceived promise for success.

The 6 OHECs selected were a pediatric nurse practitioner, a geriatric nurse practitioner, a dental hygienist, a family medicine physician, a pediatrician, and a medicine-pediatrics physician. All had some history of integrating oral health for vulnerable, underserved, and high-risk patients, including work serving school-based programs, long-term care facilities, and a Federally Qualified Health Center.

Development of a Standardized Training Program

Workshops

We developed 2 half-day workshops, each lasting 4 hours, that took place virtually in December 2020 using the Zoom platform (Zoom Video Communications, Inc). The training program included 7 modules, described below.

1. Tools to engage with other primary care professionals. The OHECs were provided with best practices to "make the case" for the importance of oral health teaching with deans and directors of health schools and primary care programs. This module included the prevalence of oral disease, the oral-systemic connection, the importance of local stories, and interprofessional education and practice; it also briefly described the curriculum and competencies that can be used for oral health integration in primary care training.

2. Working with state and national resources. The project team used this session to help orient the OHECs to a dynamic list of state and national resources including primary care training programs across the 6 states, state oral health coalitions, contact information for Departments of Public Health Oral Health Divisions and Medicaid state offices, and state dental societies. This session also included a talk from a Medicaid State Dental Director on how the various OHECs can work with different types of state oral health offices.

3. Resources on oral health integration within primary care curricula. This session described how existing curricular resources can be used by the OHECs to integrate oral health into a primary care curriculum. The OHECs were provided with a detailed description of Smiles for Life, American Academy of Pediatrics' curricula, and various sets of oral health

competencies in primary care, as well as entrustable professional activities for oral health developed by CIPCOH.[11,12] Additionally, presenters described different methods of integrating oral health into the curriculum, specifically the Curricular Mapping approach created by UMass Chan Medical School, which outlines integrating oral health into existing course material across the school's 4-year curriculum.

4. Case studies on integration. Oral health experts across nursing and physician assistant disciplines described their journeys in integrating oral health into their respective disciplines.

5. Evaluation methods. The OHECs were taught the foundations of program evaluation to prepare them for using an evaluation framework in their own statewide efforts working with primary care programs and developing other OHECs. They were provided with an overview of the Oral Health Curriculum Evaluation Tool (OHCET) and told how it is used to assess the integration of oral health in a program's curricula.[13] The OHCET is a validated instrument developed by CIPCOH researchers using input, process, and output measures to generate a summative score to assess curricula between programs within a discipline (eg, family medicine residency programs) and between disciplines (eg, midwifery programs vs obstetrical residencies).

6. Strategies to address challenges. The project team conducted exercises with the OHECs to address challenges to integration.

7. OHECs' scope of work. Finally, we outlined the programmatic expectations of the OHECs. The primary outcome for the OHECs was to engage with at least 3 primary care training programs in year 1 and begin the process of integrating oral health into the programs' curricula. The OHECs were provided with a template for monitoring their own work and updating process and outcome measures as they engaged with various schools and programs.

Ongoing Engagement With the OHECs

We held monthly sessions from January to June 2021 wherein OHECs were asked to provide updates, discuss challenges, and share promising practices. Time was built into each session for a minididactic such as curriculum mapping, grant funding for sustainability, and methods for measuring success. Finally, we held bimonthly 1-to-1 mentoring meetings with each OHEC paired with a member of the CIPCOH team.

We created a shared Google folder (Google LLC) accessible to all OHECs that contained all training materials, recruitment flyers, CIPCOH publications, and evaluation templates. The shared folder also housed recordings of our 2 half-day workshops and the monthly check-in meetings to assist them in developing their own training materials and share, if needed, with faculty recruits from schools and residencies. Each OHEC was provided with a $4,000 stipend for their work over the 6-month timeframe and $1,000 for supplies and related costs. The OHECs were expected to spend 50 hours on the program in addition to the 2 half-day workshops.

Evaluation of the Pilot Program

We evaluated the 100MMC internally and externally. The internal evaluation examined the training program and its many components, and the external evaluation examined the efforts of the OHECs and their overall perception of the program.

For internal evaluation, we assessed our 2-day training workshops using a postworkshop survey. We asked the respondents if the presentations had been helpful in planning their next steps as OHECs, their perceptions of the roll-out of the training workshops, and their confidence level in framing their own toolkit for recruits within their states.
External evaluation included working with the state-specific OHECs to track both process and outcome metrics related to engaging primary care programs within their states. We developed a template for them to track the following metrics: different academic programs engaged by the OHEC; individuals and organizations engaged outside of creating curricular change; different resources used in their recruitment efforts; methods used to recruit programs; training modalities developed and used to achieve curricular change; and ways in which oral health curricula were incorporated, which included both progress made toward curricular change and tangible curricular changes achieved.

Lastly, the 100MMC team collaborated with an external CIPCOH evaluator to conduct a focus group with the 6 OHECs followed by 30-minute in-depth key informant interviews obtaining each OHEC's perceptions of the program as well as their own progress. We designed and implemented an Appreciative Inquiry SOAR (Strengths, Opportunities, Aspirations, and Results) Analysis[14] interview protocol, using a cognitive systems approach[15] 3-P (presage, process, product) model of interprofessional learning and teaching[16] for group and key informant interviews.

RESULTS

Internal Evaluation

On the basis of the postworkshop survey, all 6 OHEC trainees found the presentations in the 2 half-day workshops to be helpful in planning the next steps (Table 1). Additionally, when asked about the rollout of the training, the majority of respondents felt it was the right amount of time, the workshop format was easy to follow, the content was delivered in an engaging manner, there was sufficient opportunity to address their needs, and appropriate resources were provided to help formulate the next steps. When asked to rate their confidence, from very low to very high, in their ability for identifying and training other programs within their states, the majority of the OHECs were confident in finding resources within their state for identifying and recruiting future OHECs and knew where to find resources to train the new OHECs.

External Evaluation

The OHECs used various resources to help recruit primary care training programs (Table 2). Many state and national organizations, such as oral health coalitions and discipline-specific

Table 1. OHECs' Ratings of the 100 Million Mouths Campaign 2 Half-Day Workshops

Workshop Component/Attribute	Score, Mean (Range)
Helpfulness of training session presentations[a]	
Introduction to CIPCOH	4.50 (4-5)
Ice breaker	3.83 (3-5)
Making the case that oral health matters	5.00 (5-5)
Working with state resources	4.50 (4-5)
Resources for oral health teaching	4.83 (4-5)
Using EPAs and core competencies to guide teaching efforts	4.50 (3-5)
How to assess an oral health curriculum	4.50 (3-5)
Recap/highlights from session 1	4.50 (4-5)
Identifying schools and programs in your state	4.50 (4-5)
Case studies in changing oral health curriculum	4.17 (3-5)
Role playing—making the case, changing the curriculum	4.17 (3-5)
Implementing evaluation	4.33 (3-5)
Reporting efforts to date/recommendations using template	4.17 (3-5)
Agreement level regarding workshop content and conduct[b]	
The two 4-hour workshops were the right amount of learning time.	4.00 (2-5)
The workshops could have been shorter in time without a loss of attention to the individual sessions' goals.	3.50 (2-5)
Some of the materials could have been presented asynchronously without a loss to group learning.	3.33 (2-5)
The workshops could have been longer with more detailed attention to each segment.	1.50 (1-2)
The workshop format (eg, a combination of didactics/interactive discussions, via Zoom) was easy to follow.	4.50 (4-5)
The workshop content was presented in an engaging manner.	4.33 (3-5)
During the training sessions, there was sufficient opportunity for addressing my needs as an OHEC for my state.	4.67 (4-5)
Preworkshop websites/documents that were sent before the first training were valuable resources for me.	4.50 (4-5)
Resources related to the workshop content (eg, database of state-specific information, slide decks of presentations, contact information for targeting new recruits) were useful to me/helped me to formulate my next steps.	4.83 (4-5)
Confidence level to begin framing own toolkit[c]	
Knowing where to find resources within my state for identifying and recruiting future OHECs	4.17 (3-5)
Knowing where to find resources for training future OHECs	4.17 (3-5)
Knowing where to find EPAs and other competencies/standards for training OHECs who will be working with trainees from different disciplines and specialties	4.00 (3-5)
Identifying some case studies and/or role-playing activities to help future OHECs with potential "pushback" from program directors for incorporating oral health into primary care training programs	3.67 (3-4)
Knowing how to develop some internal evaluation assessments to monitor my own progress in rolling out an OHEC program in my state	3.33 (3-4)
Knowing how to develop some external evaluation assessments to monitor the progress of learners	3.33 (3-4)
Understanding the OHCET to assess health professions schools/programs curriculum and future needs	4.33 (4-5)

CIPCOH = Center for Integration of Primary Care and Oral Health; EPAs = entrustable professional activities; OHCET = Oral Health Curriculum Evaluation Tool; OHEC = oral health education champion.

[a] Extent to which the workshop presentations helped in planning next steps as a statewide oral health champion (1 = not at all helpful to 5 = very helpful).
[b] Level of agreement regarding workshop attributes (1 = strongly disagree to 5 = strongly agree).
[c] Confidence level to begin framing their own toolkit for identifying and training the next level of OHECs in their state (1 = very low to 5 = very high).

primary care associations, assisted in connecting the OHECs with primary care training programs. The OHECs used previous relationships with colleagues in their organization, their discipline/specialty, and dental faculty, and engaged peer OHECs to develop connections with new training programs. OHECs used a wide variety of modalities to recruit primary care training programs in their states, including informational e-mails and flyers created with templates provided by the 100MMC research team. They also used the OHCET tool to help programs quantify the baseline inclusion of oral health in their training programs. The summative scores (compared with best-practice programs) and recommendations on integrating oral health generated by the OHCET tool incentivized the program directors to build more oral health into their curriculum. Additionally, 1 OHEC also used television media to publicize the 100MMC to help recruit programs within their state.

On the basis of the data they reported, all 6 OHECs engaged with multiple primary care training programs across

Table 2. Process and Outcome Metrics Assessing the OHECs' Impact

Metric	Alabama	Delaware	Hawaii	Iowa	Missouri	Tennessee
Academic programs engaged by OHECs						
Medical schools			X	X	X	X
Family medicine residency		X	X	X		X
Internal medicine residency				X		
Pediatrics residency				X	X	
Medicine-pediatrics residency		X				
Physician assistant programs				X	X	X
Family nurse practitioner programs	X	X		X		
Pediatric nurse practitioner programs	X					
Adult-gerontology primary care training program	X					
Doctor of nursing practitioner program	X					
Resources used by OHECs to engage programs						
Oral health coalitions			X		X	
State center for nursing			X			
National discipline-specific primary care associations					X	
Departments of Public Health and other state offices	X	X	X	X	X	
Dental faculty	X	X	X	X		
Colleagues in the university	X				X	
Peer OHECs and/or 100MMC team				X	X	
Other previous relationships		X		X		
Lists developed by CIPCOH			X	X		X
Modalities used by OHECs to recruit programs						
Informational e-mails/telephone calls	X	X	X	X	X	X
Introductory meeting	X	X	X	X		
Introductory presentations		X		X		X
Informational flyers	X	X				
Tools prepared by CIPCOH (curriculum mapping tools and OHCET tool)	X	X	X	X	X	X
Media publicity			X			
Training modalities developed by OHECs and primary care programs						
Implementation of an oral health elective				X		
Fluoride varnish implementation in clinics, trainings, and/or workshops	X		X	X	X	X
Dental sealant programs			X		X	
Student projects and/or mentorship of students			X	X		
Cases incorporated into courses		X			X	X
Presentations and lectures delivered by OHECs, program faculty, dentists, etc	X	X	X	X	X	X
Oral health challenges			X			
Oral health day				X		
Asynchronous material such as informational and training videos	X		X			

100MMC = 100 Million Mouths Campaign; CIPCOH = Center for Integration of Primary Care and Oral Health; OHCET = Oral Health Curriculum Evaluation Tool; OHEC = oral health education champion.

disciplines such as medical schools; residencies including family medicine, internal medicine, pediatrics, and medicine-pediatrics; and nurse practitioner programs (Table 2). Engagement with primary care programs resulted in the development of various training modalities to include oral health in the programs' curricula including fluoride varnish and dental sealant training; incorporation of didactic material into courses in the form of lectures and cases; and use of informational and training videos. OHECs used innovative methods such as an "oral health challenge" and an "oral health day" to help the training programs highlight the importance of oral health.

Focus Groups and Key Informant Interviews

From the SOAR Analysis and 3-P model, we identified distinct themes within the pretraining (presage), intratraining (process), and posttraining (product) periods.

In the pretraining (presage) period, OHECs expressed general appreciation for the opportunity to be selected as their state representative; unanimous appreciation of the recruitment flyers and the application process; general appreciation for the data-driven identification of their states as recruitment targets; appreciation for the process of notification of selection and induction into the program; and general appreciation that their expectations and aspirations would be considered and met. Additionally, program participation and retention were exceptional.

In the intratraining (process) period, OHECs were generally very appreciative of the program's faculty expertise and learning experiences; appreciative of the opportunity to meet individually with 100MMC staff for ongoing 1-on-1 mentoring and feedback; appreciative of the monthly formative evaluation and requests for input/preferences for future sessions; appreciative of the opportunity to share progress and experiences with the other state OHECs as a community of practice; and very appreciative of the opportunities to track and report on progress. Additionally, the OHECs felt that the initial 2 half-day training workshops and the shared resources and tools in the Google folder were very valuable.

In the posttraining (product) period, OHECs were generally appreciative of opportunities to provide written summative evaluation feedback and participate in group and individual interviews; generally committed to continuing their work as state OHECs; and hopeful that CIPCOH's affiliation and potential mentoring opportunities would continue. Additionally, the OHECs reported that they would overwhelmingly recommend this program to future state OHECs and would recommend that collaborative teams (ie, OHEC communities of practice) for each state be considered in the future to strengthen interprofessional integration and statewide reach.

DISCUSSION

Our evaluations conducted to date suggest success in this initial 100MMC pilot program and support continuing the campaign to ultimately train OHECs across the 50 states. Currently, CIPCOH is partnering with the CareQuest Institute for Oral Health[17] to engage new OHECs in the next 8 states based on our original metrics and ranking of state need.

Although the research team focused on discipline-specific diversity of the OHECs, it is imperative that the future expansion focus on racial and ethnic diversity within the OHEC community; therefore, as we roll out the program nationally, it will use a health and racial equity lens in all its activities including a multilevel community engagement model to involve the community perspective in enhancing health professional training. Going forward, CIPCOH will work to evaluate the sustainability of expanding an oral health curriculum in primary care training programs and also continue working on the sustainability of the larger program.

Read or post commentaries in response to this article.

Key words: oral health; primary care; education, medical; curriculum; interdisciplinary communication; workforce development; organizational innovation; organizational change; access to care; vulnerable populations

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