Networks for Oral Health Integration (NOHI) Within the MCH Safety Net

Overview and Project Profiles: Update 2022

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Overview

To improve access to and use of comprehensive, high-quality oral health care for pregnant women, infants, and children at high risk for oral disease, the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) funded the Networks for Oral Health Integration (NOHI) Within the Maternal and Child Health Safety Net. Three projects were awarded funding for a 5-year period (2019–2024).

- Midwest Network for Oral Health Integration (MNOHI): Illinois, Iowa, Michigan, and Ohio
- Rocky Mountain Network of Oral Health (RoMoNOH): Arizona, Colorado, Montana, and Wyoming
- Transforming Oral Health for Families (TOHF): District of Columbia, Maryland, New York, and Virginia

The NOHI projects were charged to develop, implement, and evaluate models of care using three collective strategies:

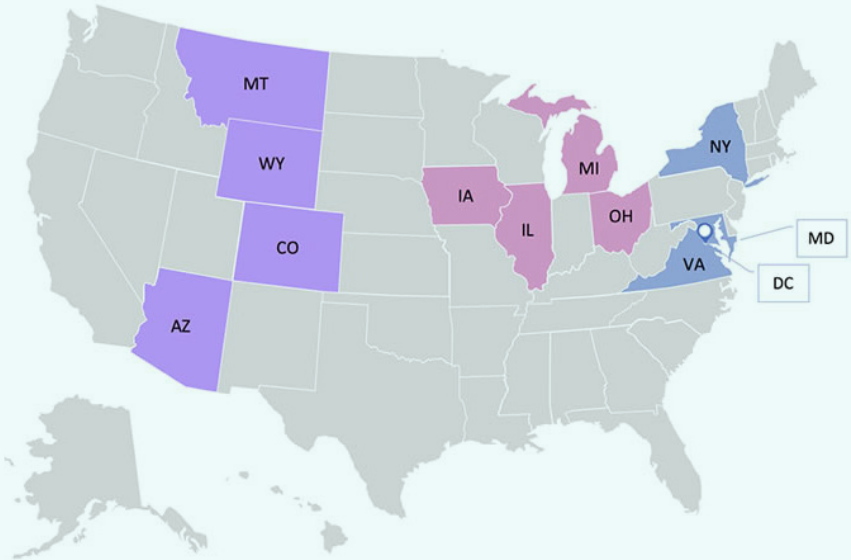
1. Enhance integration of oral health care within maternal and child health (MCH) safety net services.
2. Increase knowledge and skills among primary care health providers and support service providers for delivering optimal oral health care.
3. Increase awareness and knowledge of preventive oral health practices among parents and other caregivers to increase adoption of these practices, including use of oral health care.

NOHI projects were required to select one MCH safety net setting (e.g., community health centers [CHCs], migrant health centers, school-based health centers, local health department clinics). All three NOHI projects selected CHCs as their MCH safety net setting. In addition, NOHI projects were required to select a target population. Two projects selected pregnant women, infants, and children up to age 40 months, and one project selected children ages 6–11.

Each NOHI project team comprises the award recipient, partners, primary care associations, and select CHCs in four states (see map below). Partner organizations include the American Academy of Pediatrics, the National Network for Oral Health Access, state oral health coalitions, state oral health programs, a university medical program, and a university school of public health.

Map of NOHI Projects

By Region



NOHI projects participate in a learning collaborative (LC) supported by the Consortium for Oral Health Systems Integration and Improvement (COHSII), a cooperative agreement awarded to the National Maternal and Child Oral Health Resource Center in partnership with the Association of State and Territorial Dental Directors and the Dental Quality Alliance. FrameShift Group also supports the NOHI LC. The LC provides peer-to-peer learning opportunities for members to share information about successes, lessons learned, and challenges related to implementing models of care and building capacity around the three core function areas: (1) data, analysis, and evaluation; (2) outreach and education; and (3) policy and practice. LC members have shared project resources (e.g., practice readiness assessments, training tools, educational materials, workflows) and strategies for project implementation (e.g., motivating clinics to stay engaged in NOHI project activities, engaging patients, improving oral health providers' capacity to provide timely care for referred patients, sustaining the integration of oral health care into primary care). The cross-pollination of ideas and resources shared among LC participants enhances project activities and enables projects to achieve more collectively than they could as individual projects.

LC members collaborated, with the support of COHSII, to identify a set of common metrics to respond to their program objectives and to develop an environmental scan tool to gain knowledge about factors that could impact the integration of oral health care into primary care at the state or jurisdiction level, with the purpose of informing NOHI projects' work. The environmental scan tool includes questions focused on scope of practice of medical and oral health providers, Medicaid payment, and policies and regulations that impact the target population's oral health.

Midwest Network for Oral Health Integration (MNOHI)

The MNOHI project is part of the Networks for Oral Health Integration (NOHI) Within the MCH Safety Net funded by the Maternal and Child Health Bureau to improve access to and use of comprehensive, high-quality oral health care for pregnant women, infants, and children at high risk for oral disease.

The MNOHI project focuses on improving access to and use of comprehensive, high-quality oral health care for children ages 6–11 who are receiving health care in selected community health centers (CHCs) throughout Illinois, Iowa, Michigan, and Ohio.

Partners

MNOHI consists of the Michigan Primary Care Association (PCA) (lead) working in partnership with the Illinois Primary Health Care Association, the Iowa PCA, and the Ohio Association of Community Health Centers. The National Network for Oral Health Access (NNOHA) provides technical assistance (TA) on outreach and educational activities. In addition, the Michigan Department of Health and Human Services, the Michigan Oral Health Coalition, and Oral Health Ohio partner with MNOHI on policy activities.

Approach

MNOHI state coordinators (one from each of the four PCAs) are working with 33 participating CHCs (9 in Illinois, 9 in Iowa, 6 in Michigan, and 9 in Ohio) in 2 cohorts. A third cohort begun in project year 3 includes 1 CHC in Illinois and 2 CHCs in Ohio. Participating CHCs are working to develop, implement, evaluate, and improve models of care for integrating oral health care into primary care for children ages 6–11.

State coordinators are supporting CHCs in their respective state via:

- TA to identify project champions to comprise a team of health providers, oral health providers, information technology professionals, and quality-improvement (QI) professionals. The team will participate in a CHC needs assessment and readiness assessment to determine where extra support may be needed and will develop and implement new or revised policies to support the project.

- Training sessions for health providers and staff, including community health workers (CHWs) and care coordinators.
- TA to develop structured data fields in the electronic medical record (EMR) to document oral health care provided to patients (e.g., templates for documenting results of oral health evaluations, results of caries risk assessments, and referrals for follow-up care), to strengthen data reporting. TA to develop workflows to incorporate documentation into the EMR.
- Oral health promotional and educational materials for patients and parents and other caregivers.
- Monthly coaching calls to review progress, address challenges, and discuss opportunities for enhancement.
- Quarterly learning collaborative (LC) calls with CHCs participating in the four MNOHI states to share successes, lessons learned, and challenges associated with implementing the models of care and to receive training from NNOHA on topics such as health provider engagement.

MNOHI via each PCA provides funding for a half-time CHW or care coordinator for patient and parent or other caregiver outreach and engagement and to follow up on referrals received by parents or other caregivers to schedule a dental appointment for their child. In addition, MNOHI via each PCA provides CHCs with semiannual incentive payments for reaching benchmark goals, such as designating project champions, hiring or designating time for a part-time CHW or care coordinator, and participating in LC calls.

Settings

MNOHI applies the following criteria for CHC recruitment and selection in Illinois, Iowa, Michigan, and Ohio:

- CHC leadership has a vision for integrating oral health care into primary care.
- CHC leadership agrees to participate fully in the 5-year project, or for cohorts that start later, to participate for the remaining project period.
- CHC serves children ages 6–11.
- CHC offers primary care and oral health care (co-located care preferred).
- CHC has experience with QI projects.
- CHC uses health information technology (HIT) for patient and clinical data.
- CHC leadership identifies champions (care integration, HIT, QI).
- CHC is in a geographically diverse location.

Models of Care

MNOHI state coordinators are working with participating CHCs in their respective states to develop, implement, evaluate, and improve models of care for integrating oral health care into primary care for children ages 6–11. The MNOHI models incorporate the five domains of the interprofessional oral health core clinical competencies:

- Risk assessment
- Evaluation
- Preventive interventions (e.g., fluoride varnish application, dental sealant application)
- Communication with and education of health providers and parents and other caregivers
- Interprofessional collaborative practice

An important element of the MNOHI models of care is the incorporation of a CHW or care coordinator into the primary care team to conduct outreach to parents and other caregivers and offer them education, help make appointments for patients referred for oral health care, and provide support to help ensure that patients keep their appointments. MNOHI, with assistance from its partner NNOHA, compiled a set of best practices and approaches for using CHWs and other care-coordination strategies to improve access to and use of oral health care. MNOHI is building on lessons learned from the first cohort of CHCs to assist subsequent cohorts with refining the models of care. MNOHI will compile a set of best practices to inform efforts to integrate oral health care into primary care.

During the reporting period September 2021 through August 2022, over 500 primary care health providers, CHWs, and care coordinators received training on the importance of oral health to overall health and on preventive interventions to improve oral health for children ages 6–11. From September 2020 through August 2022, participating CHCs provided over 88,000 preventive oral health services to children ages 6–11 (18,520 risk assessments, 40,418 fluoride varnish applications, 17,967 dental sealant applications, and 11,884 referrals for care). The percentage of children ages 6–11 who received preventive oral health services increased from 53.5 percent during the March through August 2021 reporting period to 73.9 percent during the March through August 2022 reporting period.

Strategies to Help Sustain Models of Care in CHCs: Lessons Learned

The 33 participating CHCs have incorporated documentation of preventive oral health care during well-child visits in their electronic health record (EHR). Primary care health providers were providing anticipatory guidance on oral health, but their EHR did not have a place to document it; therefore anticipatory guidance was not reportable or trackable. Supporting CHCs to document oral health care in their EHR has been a main focus of the MNOHI project. One lesson learned is that it is important to make it as easy as possible for primary care providers to document the provision of preventive oral health care in the EHR (e.g., by placing preventive oral health care near other preventive health care in the health record). Thus, the provision and documentation of preventive oral health care is more easily incorporated into and doesn't disrupt the flow of the well-child visit.

MNOHI also required participating CHCs to develop a job description for the CHW or care coordinator position, as these positions tend to have a high turnover rate. If a CHW leaves the CHC, the duties will continue with the next CHW.

Core Function Activities

Data, Analysis, and Evaluation

MNOHI state coordinators are working with participating CHCs to develop structured data fields in the electronic medical record (EMR) to document oral

health care provided to patients. CHCs receive funding to assist with EMR enhancement. For data collection and reporting, Michigan and Ohio contracted with Azara DRVS (Data Reporting and Visualization System) to develop quality metrics on preventive and restorative oral health care and to track them, a first for Azara and a significant achievement for MNOHI. Since the launch of these measures in Azara DRVS, 64 CHCs in 13 states have implemented the measures. This is a significant step that will help CHCs across the country, regardless of whether they participate in NOHI, improve their efforts to integrate oral health care into primary care and provide high-quality oral health care to patients. Illinois and Iowa are also collecting metrics from participating CHCs and working with each center to refine their data-collection and -reporting processes.

Even with the use of Azara DRVS in Michigan and Ohio, data collection and reporting is a challenge, partly because there are 9 different EMR systems, 12 different electronic dental record (EDR) systems, and 16 different combinations of EMR and EDR systems used in the 33 participating CHCs. This has complicated the development of a consistent documentation process among all CHCs. Each CHC has a different workflow for documenting the required data. In addition, some CHCs have undergone EMR and EDR platform transitions, and some lack policies and protocols for referring patients for oral health care. These issues have engendered further challenges.

MNOHI created and continues to improve a CHW tracking form to capture care-coordination activities and gauge the impact of CHWs' efforts on closing referral loops. MNOHI is also building a data dashboard to enable visualization of progress across participating CHCs in all four states. MNOHI is using qualitative and quantitative data to track, assess, and report outcomes resulting from project activities. It is also tracking and assessing policy and systems changes to provide data for the oral health core clinical competencies.

Outreach and Education

MNOHI uses *Smiles for Life: A National Oral Health Curriculum* modules to train primary care providers and staff. To supplement the curriculum, NNOHA developed a module specific to MNOHI's target population. In response to feedback from participating CHCs, NNOHA is condensing the *Smiles for Life* curriculum modules and the NNOHA module to accommodate those whose schedules preclude their completing the training modules.

During quarterly LC calls with participating CHCs, MNOHI provides opportunities for peer learning, and NNOHA offers training, as needed. In addition, NNOHA is developing educational materials on oral health basics for CHWs and care coordinators to provide education to patients and parents and other caregivers. Feedback from parents and other caregivers indicates that they appreciate having their child's oral health addressed during well-child visits and that they value the referral process that enables them to obtain a dental clinic appointment before leaving the center.

Policy and Practice

MNOHI state coordinators and partners have been conducting environmental scans to gather information about factors that could impact the integration of oral health care into primary care at the state level. The scans include questions about scope of practice of primary care health providers and oral health providers, Medicaid billing and payment, and policies and regulations that impact the oral health of children ages 6–11. The Michigan Department of Health and Human Services, the Michigan Oral Health Coalition, and Oral Health Ohio conduct the environmental scans for their states.

State coordinators and partners use information from the environmental scans to raise awareness about needed system changes (e.g., reimbursement for CHW and care-coordination activities, increasing the upper age limit for which health providers can be reimbursed for applying fluoride varnish to children's teeth). Illinois and Michigan recently passed legislation to reimburse CHW services. As a result, using CHWs to conduct outreach to parents and other caregivers and offer them education, help make appointments for patients referred for oral health care, and provide support to help ensure that patients keep their appointments is a viable strategy going forward. Information from the environmental scans has informed the development of the *2025 Michigan Oral Health Plan* and the *Ohio's State Oral Health Plan 2022–2023* (under development).

Impact of COVID-19

The COVID-19 pandemic has significantly impacted health behaviors and health care use for children ages 6–11 who are receiving care in CHCs in the MNOHI states. CHCs continue to experience staff shortages. As COVID-19 infection rates fluctuate in the MNOHI states, CHCs shift staff responsibilities to focus on testing and vaccination, making it challenging to engage project champions and delaying MNOHI timelines. Troubleshooting is often necessary to make adjustments in response to these disruptions. In Iowa, CHCs' dental clinics struggled to hire sufficient staff, and as a result, the wait time for dental appointments made through referrals from the medical clinic increased, resulting in more appointment no-shows. In response, the state coordinator discussed options for providing referrals from medical clinics to dental clinics (e.g., designated appointment times for referrals from medical clinics to dental clinics) during monthly coaching calls. CHCs in Illinois experienced health care provider burnout and staff shortages related to COVID-19. In response, CHCs adjusted their workflows and gave CHWs more responsibility for oral health education and follow-up to help the care team.

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Rocky Mountain Network of Oral Health (RoMoNOH)

The RoMoNOH project is part of the Networks for Oral Health Integration (NOHI) Within the MCH Safety Net funded by the Maternal and Child Health Bureau to improve access to and use of comprehensive, high-quality oral health care for pregnant women, infants, and children at high risk for oral disease.

RoMoNOH is focusing on primary prevention of dental caries in pregnant women and infants and children from birth to age 40 months who are receiving health care in participating community health centers (CHCs) throughout Arizona, Colorado, Montana, and Wyoming.

Partners

RoMoNOH consists of the Denver Health Office of Research (lead) working in partnership with the University of Colorado Department of Family Medicine, the American Academy of Pediatrics (AAP), the Colorado Department of Public Health and Environment (CDPHE), the National Network for Oral Health Access (NNOHA), and primary care associations (PCAs) in Arizona, Colorado, Montana, and Wyoming.

Approach

RoMoNOH developed and is implementing a change package to support the integration of oral health clinical competencies into primary care in 24 CHCs: 8 in Arizona, 9 in Colorado, 3 in Montana, and 4 in Wyoming.

RoMoNOH is supporting CHCs via:

- Technical assistance (TA) on optimizing their electronic medical record (EMR) and electronic dental record (EDR) for documenting the oral health core clinical competencies and creating an oral-disease registry for population management.
- Five eLearning modules to train primary care health providers on delivery of preventive oral health care.
- Training sessions for primary care health providers and staff to improve self-management goal setting among parents and other caregivers of patients in the target population using AAP's Brush Book Bed program. Implementation materials include a children's book about oral health in English and in Spanish, a child-sized toothbrush, fluoride toothpaste, handouts for parents to support health messages, and caregiver oral health goal-setting tools in English and in Spanish.
- Site-specific toolkit developed to sustain the integration of oral health care into primary care for the target population when the project ends.
- Monthly 1:1 meetings with a PCA coach to develop, implement, and validate RoMoNOH's models of

care using the change package to guide activities. The coach reviews the CHC's progress toward meeting project objectives and uses its monthly metrics to identify gaps and opportunities for improvement.
- Quarterly learning collaborative calls with participating CHCs in each state to share successes, lessons learned, and challenges associated with implementing the models of care.
- Annual in-person TA visits with the RoMoNOH leadership team and PCA coach.
- Incentive payments for reaching annual benchmark goals for delivering preventive oral health care and submitting monthly metrics.
- Funding for dental hygiene equipment and/or oral health providers' salaries for 12 CHCs that are embedding oral health providers into their primary care clinic.

PCA coaches are essential to the RoMoNOH approach, and they are supported via

- Training sessions to improve oral health knowledge and coaching skills.
- Monthly 1:1 meetings to review their state's participating CHCs' progress toward meeting project objectives, opportunities for improvement, and strategies for addressing challenges to implementing models of care.
- Monthly coaching calls and semiannual in-person meeting with all PCA coaches to provide TA and enhance peer learning and support.
- Basecamp©, a communications platform, to share project information and resources.

Settings

PCA coaches are coaching and retaining 24 CHCs in Arizona, Colorado, Montana, and Wyoming. RoMoNOH applied the following criteria for CHC recruitment and selection:

- Provides perinatal and/or infant and child care (those with a large population of infants and young children are prioritized).
- Is located in health professional shortage areas.
- Has insufficient on-site and/or community-based oral health care for pregnant women, infants, and young children.

Models of Care

RoMoNOH supports CHCs in the establishment of several models of care depending on the oral health needs and capacity of the CHC and the state's policies and regulations on the provision of preventive oral health care (e.g., scope of practice, Medicaid reimbursement). All models feature a variety of services that address the five interprofessional oral health core clinical competencies for integrating oral health care into primary care (i.e., risk assessment, evaluation, preventive interventions, communication and education, interprofessional collaborative practice) and referrals to oral health providers. The models include coordinated care with a referral from health care providers to off-site oral health providers, co-located care with a referral to on-site oral health providers, and integrated care with an oral health provider embedded in the primary care team. Some CHCs are implementing a combination of these models based on the oral health needs of their population.

During the reporting periods from September 2020 through August 2022, over 700 primary care health providers received training on oral health preventive care and the key components of oral health integration. Fourteen of the 24 CHCs have embedded oral health providers into their medical teams on site. During the same reporting periods, RoMoNOH's participating CHCs provided over 52,000 preventive

oral health services to young children (24,956 risk assessments, 13,365 fluoride varnish applications, and 14,046 referrals for care). The percentage of young children who received preventive oral health services increased from 53.3 percent during the March through August 2021 reporting period to 72.6 percent during the March through August 2022 reporting period. All but two participating CHCs have successfully earned all incentive benchmark payments.

Strategies to Help Sustain Models of Care in CHCs: Lessons Learned

CHCs showing the most success in implementing their models of care have strong leadership support and primary care health providers, have defined health care team member roles and workflows, ensure that health care teams have dedicated time to work on their model, reliably submit and use monthly metrics to drive their continuous-quality-improvement activities, and provide care to a population with substantial oral health needs. These drivers are supporting practices' success at attaining the project objectives and earning their benchmark payments. PCA coaches provide support and hold CHCs accountable for making ongoing changes and improvements to their models of care.

While the COVID-19 pandemic has substantially impacted the implementation of the RoMoNOH activities, CHC teams remain largely resilient and dedicated to RoMoNOH activities. RoMoNOH speculates that it is the characteristics of CHCs that are showing the most success that buoyed the project through the worst of the pandemic.

Core Function Activities

Data, Analysis, and Evaluation

RoMoNOH leadership from the Denver Health Office of Research and the University of Colorado Department of Family Medicine are using the Shared Practices Learning Improvement Tool (SPLIT) to collect and analyze aggregated data for evaluation across the four RoMoNOH states to ensure that sites are using common metrics definitions, data-collection processes, methodologies, and analyses. RoMoNOH works with each CHC to refine their processes for

documenting provision of preventive oral health care. All CHCs are entering monthly aggregated data into SPLIT, and RoMoNOH creates monthly feedback reports that coaches use in their continuous-quality-improvement activities with CHCs. SPLIT is also used for coaching field notes.

Aspects of the adaptation and use of electronic health records (EHRs) have posed challenges, including a lack of interoperability between EMRs and EDRs and the transition of some CHCs to a new EHR platform. In addition, some information technology (IT) staff have limited experience with supporting medical-dental integration, and some are unavailable or unwilling to be a part of the larger implementation team. To overcome these challenges, RoMoNOH invested in Azara©, a centralized data-reporting and analytics system, to extract data from EHRs, leveraged IT expertise from successful CHCs to help other CHCs, worked to engage IT staff with the implementation team to resolve problems immediately, and developed additional strategies to count preventive oral health services provided outside the EHR, such as documentation of parent and caregiver goal setting using a goal-setting tool.

RoMoNOH is using the Practical, Robust Implementation and Sustainability Model, a multilevel, mixed-method evaluation tool, to frame its evaluation. The evaluation of RoMoNOH's approach will include a cost-benefit analysis by a health economist to compare the costs of implementing different models of care to the benefits of providing such care for children at the CHC and state levels.

Outreach and Education

RoMoNOH, with assistance from its outreach and education partners, CDPHE and NNOHA, developed a five-module eLearning course to train primary care health providers on delivery of preventive oral health care. The modules incorporate the five oral health core clinical competencies and include

- Module 1: Introduction | Interprofessional Collaborative Practice
- Module 2: Caries Risk Assessment | Oral Evaluation | Preventive Interventions
- Module 3: Communication and Education | Patient Engagement

- Module 4: Interprofessional Collaborative Practice | Dental Referral
- Module 5: Perinatal Oral Health

The eLearning modules are also used by PCA coaches and CHC primary care health providers in coaching events and to onboard new CHC staff and residents, reinforce the delivery of the oral health core clinical competencies, and support sustainability. RoMoNOH developed coaching tools to train nonclinical staff on integrating oral health care into primary care. RoMoNOH also developed an enhanced parent and caregiver engagement activity using AAP's Brush Book Bed program to motivate primary care health providers to discuss oral health and oral hygiene practices with parents and other caregivers and encourage them to set and accomplish oral health goals for their children. In addition, RoMoNOH provides TA and subject matter expertise related to oral health education, practice, and patient engagement to CHCs and PCA coaches as needed. RoMoNOH will evaluate the impact of goal setting on parent and other caregiver behaviors.

Policy and Practice

RoMoNOH, with assistance from its policy and practice partner, AAP, conducted two environmental scans to gather information about the scope of practice for primary care health providers and oral

health providers, Medicaid payment for preventive oral health care, and policies and regulations that impact the target population's oral health. RoMoNOH uses the information to gain knowledge about state-level barriers and opportunities for integrating oral health care into primary care. RoMoNOH also uses the information to raise awareness among key stakeholders in each state about policies that provide opportunities for or create barriers to promotion of oral health and delivery of preventive oral health care to the target population. For example, RoMoNOH educated key stakeholders in Wyoming about a barrier to patients receiving care in federally qualified health centers (FQHCs). FQHCs were not reimbursed by Medicaid for a medical visit and a dental visit if both occurred on the same day. The stakeholders requested that Medicaid remove the barrier, and Medicaid reimbursement rules in Wyoming were changed to allow FQHCs to be reimbursed for a medical visit and a dental visit that occurred on the same day. A third and final environmental scan will be conducted in summer 2023.

Impact of COVID-19

The COVID-19 pandemic has significantly impacted health behaviors and health care use for all NOHI projects. CHCs have had to dedicate time and effort to managing new challenges during the pandemic, which has taken them away from RoMoNOH activities. Two participating CHCs asked to pause their participation in RoMoNOH for a few months because the pandemic had overstressed their staff, but they rejoined RoMoNOH with added energy and enthusiasm and have been exceptionally successful at meeting project objectives. In some CHCs, data and IT staff's time shifted from developing processes for collecting and reporting data for RoMoNOH to emergent COVID-19 pandemic needs, which resulted in RoMoNOH project delays. In response, RoMoNOH adjusted timelines for assigned tasks, moved meetings and coaching sessions to an online platform when necessary, and provided additional support when needed. Patients continue to come to CHCs for well-child visits and immunizations, and these visits are leveraged for same-day integrated oral health care visits.

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Transforming Oral Health for Families (TOHF)

The TOHF project is part of the Networks for Oral Health Integration (NOHI) Within the MCH Safety Net funded by the Maternal and Child Health Bureau to improve access to and use of comprehensive, high-quality oral health care for pregnant women, infants, and children at high risk for oral disease.

The TOHF project focuses on increasing access to preventive oral health care in the primary care setting for pregnant women, infants, and children up to age 40 months. The project is being implemented in selected community health centers (CHCs) in Virginia, New York, Maryland, and the District of Columbia.

Partners

TOHF is led by HealthEfficient working in partnership with Virginia Health Catalyst, the Schuyler Center for Analysis and Advocacy (New York), the Maryland Dental Action Coalition, and the Regional Primary Care Coalition (District of Columbia). During September 2019 through August 2022, TOHF also partnered with the Mid-Atlantic Association of Community Health Centers to assist with recruiting CHCs and with the University of Maryland School of Public Health (UMD SPH) to support outreach and educational activities.

Approach

TOHF is activating a network of CHCs in the three states and the District of Columbia to develop, implement, and continuously evaluate and improve a family-centered team-based primary care model for the delivery of preventive oral health care to the target population. Using the *Breakthrough Series Collaborative* model developed by the Institute for Healthcare Improvement as a method for training and improvement, TOHF has initiated four 18-month learning collaborative (LC) cycles, for a total of up to 30 CHCs during the project period.

TOHF is supporting CHCs via:

- Online learning sessions for primary care health providers and staff serving the target population to improve core competencies in evidence-based oral health practices, communication and education, interprofessional collaborative practice, health information technology (HIT) integration, and optimization of quality-improvement (QI) data.
- A curated training curriculum on oral health for primary care health providers and staff to assist with the development and implementation of a

sustainable training program that aligns with individual CHC operations.
- An implementation toolkit to support team development, goal setting, and workflow analysis, with the intention of increasing the number of primary care health providers delivering preventive oral health care in a structured and sustainable manner.
- A best practice workflow guide including an oral health risk assessment, a clinical-decision-support algorithm, billing guidance, and electronic health record (EHR) template examples.
- On-site EHR assessment for data collection and HIT-optimization support.
- Dashboard metrics to facilitate data-driven decision-making among CHC teams using a tracking tool and data-visualization platform.
- One-on-one practice facilitation to address challenges to and opportunities for enhancement specific to each site.
- Opportunities for peer learning among participating CHCs during team storyboard presentations at learning sessions and at group coaching sessions to share best practices, successes, and strategies for overcoming obstacles to implementing preventive oral health care.
- Oral health kits and educational materials for primary care health providers to share with parents and other caregivers during discussions about oral hygiene practices and self-management goals and to promote healthy oral hygiene practices at home.
- Stipends for CHCs upon start and completion of LC participation that are tied to project deliverables, including data collection, testing and implementing change models, sharing best practices, and participating in learning sessions.

Settings

TOHF has applied the following criteria for CHC recruitment and selection in Virginia, New York, Maryland, and the District of Columbia:

- Provide primary care to infants and children from birth to age 40 months.
- Have at least 30 percent of the target population enrolled in Medicaid.
- Serve as a patient-centered medical home with care coordinators and navigators assisting families with complex health care needs.

- Use electronic medical records (EMRs) and electronic dental records (EDRs) (ideally an interoperable EHR).
- Have experience using QI approaches to implement, evaluate, and refine models of care.

Models of Care

TOHF is working with participating CHCs to build, implement, and continuously evaluate and improve their family-centered, team-based primary care models for delivery of preventive oral health care. Each CHC project team follows a similar approach for integrating oral health care into primary care in five focus areas (provider knowledge, caries risk assessment, education and anticipatory guidance, fluoride varnish application, and referrals), with specific adjustments based on individual CHC needs. TOHF has identified intervention components that contribute to the successful implementation of the models with the first two cohorts of CHCs and plans to continue implementing, evaluating, and refining the models with two additional cohorts. By the end of the 5-year project period, TOHF will have identified, refined, and disseminated strategies to support promising models of care in CHCs.

During the reporting periods September 2020 through August 2021 and September 2021 through August 2022, over 150 primary care health providers received training on oral health preventive care and the key components of oral health integration. During these reporting periods, TOHF's participating CHCs provided over 35,000 preventive oral health services to infants and children up to age 40 months (20,553 risk assessments, 13,328 fluoride varnish applications, and 1,494 referrals for care). The percentage of infants and children up to age 40 months who received preventive oral health services in the first two cohorts of CHCs increased from 49.1 percent during the March through August 2021 reporting period to 60.7 percent during the March through August 2022 reporting period.

Strategies to Help Sustain Models of Care in CHCs: Lessons Learned

- Work early on with a CHC (before analyzing its workflow) to evaluate the EHR and HIT system, assist with the development of data templates and billing alignment, and train primary care health providers on how to use the system to make it easier to adopt and sustain an integrated workflow. EHR optimization is essential to supporting sustainable integration of oral health care into primary care.
- Include oral health training for primary care health providers as part of onboarding and annual training, leveraging the CHC's internal learning-management system (LMS) when possible. LMS is a software application or web-based technology used to administer, track, and deliver training.
- Acquire input on clinic workflow from all team members.
- Use EHR alerts and reminders for primary care health providers about conducting the caries risk assessment during the well-child visit to help make the procedure part of standard practice.
- Incorporate health-literate concepts when developing or selecting educational materials and using motivational interviewing and goal setting to engage parents and other caregivers.
- Provide education and hands-on training for primary care health providers and staff on fluoride

varnish application to increase their confidence and competence.
- Develop a process to track and monitor referrals within the EHR, closing the loop whenever possible.

Core Function Activities

Data, Analysis, and Evaluation

For data collection and reporting, the Health-Efficient HIT team created templates for collecting de-identified clinical and administrative project data from CHCs. The team works with CHCs to incorporate processes for data collection and validation at each individual site. With input from participants in the first two cohorts, the team identified five key health center metrics to display on a dashboard for assessing progress and supporting implementation of oral-health-integration practices. The metrics are: (1) percentage of primary care health providers completing oral health training, (2) percentage of target population patients receiving a risk assessment during a well-child visit, (3) percentage of target population patients receiving oral health education and anticipatory guidance and establishing a self-management goal during a well-child visit, (4) percentage of target population patients receiving a fluoride varnish application during a well-child visit, and (5) percentage of target population patients receiving a dental referral during a well-child visit. Data collected through these methods throughout project implementation will also be used for project evaluation.

The use of separate EMR and EDR systems has posed challenges for certain elements of integration, such as closed-loop referral processes. Additionally, some CHCs have undergone EHR platform transitions, which impacted the timeline for HIT optimization. These issues are compounded by the complex nature of diverse analytics platforms that CHCs use to pull data from the EHR. To respond to challenges, TOHF provides each CHC with an evaluation of current HIT systems, site-specific recommendations for EHR optimization, assistance with development of templates and billing alignment, and identification of useful HIT-infrastructure investments to support the integration of oral health care into primary care.

Outreach and Education

TOHF has developed a curriculum for educating primary care health providers and staff, which is delivered to CHC teams via learning sessions, coaching sessions, and training programs developed by individual CHCs. Trainings target skill enhancement to achieve the five competencies recommended by the Institute of Medicine (i.e., providing patient-centered care, employing evidence-based practice, working in interdisciplinary teams, applying quality improvement, utilizing informatics) and to incorporate the interprofessional oral health core clinical competencies (i.e., risk assessment, evaluation, preventive interventions, communication and education, interprofessional collaborative practice). TOHF has administered knowledge assessments pre- and post-training to gauge overall understanding and to use information from the assessments to improve training for subsequent cohorts.

To enhance patient knowledge and awareness, TOHF has identified best practices, educational materials, and other tools to deliver patient education and anticipatory guidance to support oral health literacy. TOHF has also assembled oral hygiene kits containing toothbrushes, fluoride toothpaste, dental floss, and oral

hygiene instructions for distribution to patients and parents and other caregivers at participating CHCs as part of anticipatory guidance and educational activities to encourage the use of healthy oral hygiene practices at home. UMD SPH completed an oral health literacy review for each CHC in the first two cohorts to enhance primary care health providers' understanding and prioritization of health literacy. The reviews inform CHCs about opportunities to enhance educational and promotional materials and improve communication, and will influence the creation of new materials geared toward the target population.

Policy and Practice

Coordinators from each of the three states and the District of Columbia have been conducting an environmental scan to gain knowledge about factors that could impact the integration of oral health care into primary care for the target population at the state or jurisdiction level. The scans include questions focused on scope of practice of primary care health providers and oral health providers, Medicaid billing and payment, and policies and regulations. Coordinators are using information from the scans to raise awareness among stakeholders, legislators, government officials, and community partners about facilitators of and barriers to improving access to oral health care for the target population in each state or jurisdiction. Specific policies and regulations that could potentially impact the integration of oral health care into primary care include payor reimbursement for related procedures; adult Medicaid coverage, particularly for pregnant women; and the growth and expansion of telehealth for oral health care delivery. In addition, information gleaned from the environmental scans related to scope of practice will help CHCs optimize clinical workflow, and information about billing regulations has led to the development of a best practice guide on clinical workflow, EHR template generation, and billing practices for preventive oral health care delivered in the primary care setting. TOHF has also developed and uses a policy matrix tool to support individual CHC sites in identifying potential areas for optimization of practice and barriers to implementation.

Impact of COVID-19

The COVID-19 pandemic has significantly impacted health care behaviors and health care use for all NOHI projects, including TOHF. CHCs continue to experience challenges due to staffing shortages, maintaining and adjusting patient care, and managing testing and vaccination activities. In response, TOHF modified project timelines, adapted project plans, and helped participating CHCs set realistic goals for QI. Learning sessions, coaching sessions, and other project meetings have been moved to an online platform.

Project Contacts

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