



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

Overview and Project Profiles: Update 2021



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National Maternal and Child Oral Health Resource Center

Georgetown University
E-mail: OHRCinfo@georgetown.edu
Website: www.mchoralhealth.org

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

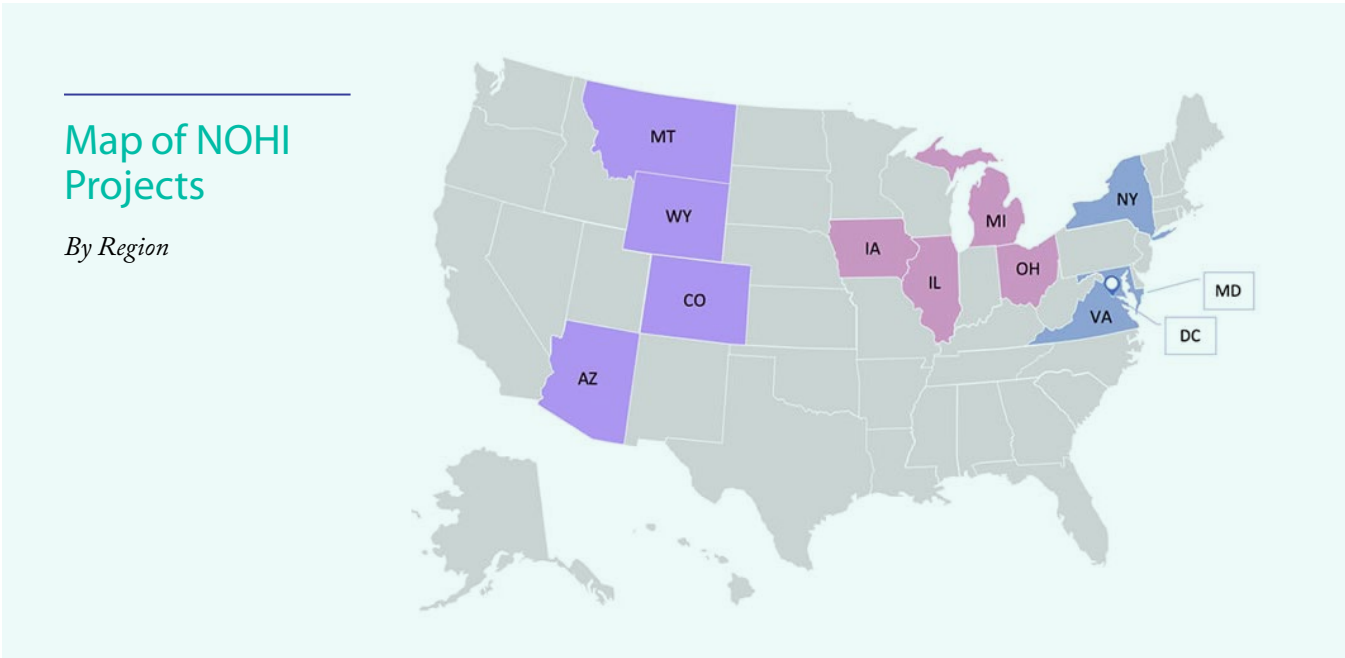
The NOHI projects will each develop, implement, and evaluate models of care using three collective strategies:

1. Enhance integration of oral health care within maternal and child health (MCH) safety net services. MCH safety net services are composed

of providers, payment programs (e.g., Medicaid, State Children’s Health Insurance Program), and facilities that provide clinical, nonclinical, and support services.

2. Increase knowledge and skills among health professionals, including oral health, non-oral-health clinical, and non-oral-health support service professionals, 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.

Each NOHI project team comprises the award recipient, partners, primary care associations, and select community health centers (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. Two projects are focusing on pregnant women, infants, and children up to age 40 months, and one project is focusing on children ages 6–11.





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. The cross-pollination of ideas

among LC participants enhances project activities and enables projects to achieve more collectively than they could as individual projects.

With support from COHSII, NOHI projects collaborated 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 level, with the purpose of informing NOHI projects' work. The scan includes questions focused on scope of practice of oral health and non-oral-health professionals, Medicaid reimbursement, and policies and regulations that impact the target population's oral health.

Midwest Network for Oral Health Integration (MNOHI)

MNOHI is focusing 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) 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 training and technical assistance (T/TA) on outreach and education activities. The project is also partnering with the state oral health program in Iowa to build on lessons learned from Iowa’s I-Smile program for children eligible for Medicaid and the state oral health program in Michigan to increase the number of school-based dental sealant programs operated by CHCs in Michigan.

Approach

MNOHI state coordinators (one from each of the four associations) serve as liaisons among participating CHCs in their state to create an integrated medical/dental home, a coordinated care model, for children ages 6–11. State coordinators:

- Recruit CHCs and help them identify MNOHI champions—a team of medical, oral health, information technology, and quality-improvement (QI) professionals.
- Provide T/TA to MNOHI champions to develop, implement, and continuously evaluate and improve a model for oral health care for the target population.
- Provide training to CHC health professionals and staff, including community health workers (CHWs)/care coordinators, and promotional and



educational materials for patients and parents and other caregivers.

An important element of MNOHI’s approach is the integration of a half-time CHW/care coordinator into the primary care team in each CHC to focus on oral health education with patients and parents and other caregivers and on referral for oral health care.

The four associations receive payments for achieving project-implementation benchmarks. Participating CHCs receive payments for attaining QI benchmarks and initial funding for the CHW/care coordinator.



Settings

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

- Leadership has a vision for integrating oral health care into primary care
- CHC serves the target population
- CHC offers primary care and oral health care (co-location preferred)
- CHC has experience with QI projects
- CHC uses health information technology (HIT) for patient and clinical data
- Leadership identifies champions (care integration, QI, HIT)
- Leadership agrees to participate fully in the 5-year project
- CHC is in a geographically diverse location

Models of Care

MNOHI state coordinators are working with the first cohort of 22 CHCs to develop, implement, continuously evaluate, and improve models of care for an integrated medical/dental home for children ages 6–11. The

MNOHI models incorporate the five domains of the interprofessional oral health core clinical competencies: (1) risk assessment, (2) evaluation, (3) preventive interventions (e.g., fluoride varnish application, dental sealant application), (4) communication with and education of health professionals and parents and other caregivers, and (5) interprofessional collaborative practice. A key component of the MNOHI models is the incorporation of a CHW/care coordinator into the primary care team to conduct outreach among parents and other caregivers, offer patient education, make referrals for oral health care, and provide follow-up support to ensure that patients keep their appointments and comply with instructions from physicians, dentists, and other health professionals. MNOHI is building on lessons they are learning with the first cohort of 22 CHCs to recruit up to 13 additional CHCs (cohort 2) to refine the models of care. MNOHI will disseminate best practices to inform efforts to integrate oral health care into primary care.

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 to document oral health care provided to patients. CHCs receive funding to assist with electronic medical record enhancement. For data collection and reporting, Michigan and Ohio contracted with Azara DRVS (Data Reporting and Visualization System) to develop and track quality metrics on preventive and restorative oral health care, a first for Azara and a significant achievement for MNOHI. Illinois and Iowa are also collecting metrics from all participating CHCs and working with each to refine their data-collection and -reporting processes. MNOHI is building a data dashboard for 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. The evaluation plan will also track and assess process outcomes related to implementation practices as well as policy and systems change needed to sustain the oral health core clinical competencies.

Outreach and Education

MNOHI uses *Smiles for Life: A National Oral Health Curriculum* to train primary care clinical professionals and support staff. To supplement the Smiles for Life curriculum, MNOHI's partner, NNOHA, developed a module for non-dental clinical professionals that is specific to MNOHI's target population. State coordinators provide T/TA during monthly coaching calls, and all CHCs participate in the MNOHI learning collaborative that convenes quarterly. NNOHA also offers T/TA to the CHCs, as needed. NNOHA is developing educational materials on oral health basics for CHWs/care coordinators to provide outreach and education to patients and parents and other caregivers.

Policy and Practice

MNOHI state coordinators have been conducting an annual environmental scan since 2020 to identify factors at the state level that influence the target population's oral health status and at participating CHCs (e.g., health professional scope of practice, Medicaid fee-for-service reimbursement for primary care and oral health professionals, payment innovations). The Ohio oral health coalition and the Michigan oral health coalition and Michigan oral health program conduct the environmental scans for their states. Coordinators use information



from the environmental scans to gain knowledge about state-level barriers and opportunities for integrating primary care and oral health care and to raise awareness about needed system changes (e.g., reimbursement for CHW/care coordination activities, increasing the patient age for reimbursement of fluoride varnish application). Information from the Ohio environmental scan in 2020 informed the development of [Ohio's State Oral Health Plan 2021–2022](#).

Impact of COVID-19

The COVID-19 pandemic has significantly impacted health care behaviors and health care use for all Networks for Oral Health Integration projects, including MNOHI. As COVID-19 infection rates vary in the MNOHI region, CHCs shift staffing and focus to accommodate testing and vaccination activities, making it more challenging to consistently engage MNOHI champions and recruit new CHCs for cohort 2.

Project Contacts

Project director: Amber Desgranges, M.P.H., C.E.D.

Michigan Primary Care Association

E-mail: adesgranges@mpca.net

Project manager: Lindsay Sailor, B.S.

Michigan Primary Care Association

E-mail: lsailor@mpca.net

Rocky Mountain Network of Oral Health (RoMoNOH)

RoMoNOH is focusing on primary prevention of dental caries in pregnant women, infants, and children up to age 40 months who are receiving health care in selected 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 National Network for Oral Health Access (NNOHA), and primary care associations (PCAs) in Arizona, Colorado, Montana, and Wyoming. An additional network partner is Colorado's Cavity Free at Three program at the Colorado Department of Public Health and Environment (CDPHE).



Approach

RoMoNOH staff and partners developed and are implementing an oral-health-integration change package and toolkit to support the integration of oral health clinical competencies into primary care provided in CHCs.

- RoMoNOH provides CHCs with technical assistance (TA) on adapting their electronic health records to ensure collection of quality-improvement (QI) metrics and on creating oral disease registries for population management.
- RoMoNOH's change package and toolkit include integration approaches that support coordinated, co-located, and fully integrated medical-dental models that accommodate the health professionals' scope of practice and Medicaid reimbursement policies and regulations in each state.

- RoMoNOH developed a five-module eLearning course to train non-oral-health professionals on delivery of preventive oral health care.
- RoMoNOH provides funding for dental hygiene equipment and/or oral health professional salaries for up to 12 CHCs that are embedding an oral health professional into their primary care clinic.
- RoMoNOH is also testing a value-based payment approach to provide CHCs with incentives to reach QI benchmarks.

Settings

RoMoNOH staff support the PCAs in recruiting, contracting, and coaching up to 26 CHCs in Arizona, Colorado, Montana, and Wyoming. CHCs' characteristics include:

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

Models of Care

RoMoNOH staff support 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 domains 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 professionals. The models include coordinated care with a referral from medical professionals to off-site oral health professionals, co-located care with a referral to on-site

oral health professionals, and integrated care with a referral to an oral health professional embedded in the primary care team. Some CHCs are implementing a combination of these models based on the oral health needs of their population.

Core Function Activities

Data, Analysis, and Evaluation

RoMoNOH staff 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) for metrics collection and to conduct data analyses for evaluation across the four states to ensure that sites are using common metrics definitions, data-collection processes, methodologies, and analyses. RoMoNOH staff are collecting metrics from all participating CHCs and working with them to refine their processes for documenting provision of preventive oral health care. Using SPLIT, RoMoNOH staff provide monthly data feedback reports and comparative dashboards for each CHC to motivate them to reach metrics benchmarks. SPLIT is also used for PCA coaching field notes. 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 that compares the costs of implementing the models and providing integrated oral health care to the benefits of providing care at the community (CHC) and state levels.

Outreach and Education

RoMoNOH staff, in partnership with NNOHA and CDPHE, developed a five-module e-Learning course to train non-oral-health professionals 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, and Module 5: Perinatal Oral Health. RoMoNOH staff and partners developed short coaching tools to train non-clinical staff on integrating oral health care into primary care. In addition, RoMoNOH staff and partners provide TA and subject matter expertise related to oral health education, practice, and patient engagement to CHCs and PCA coaches as needed.

Policy and Practice

RoMoNOH staff, in partnership with AAP, has been conducting an annual environmental scan since 2020 to gather information about health professional scope of practice, Medicaid fee-for-service reimbursement for oral health care, policies and regulations related to non-oral-health professionals and managed care approaches, and other areas. RoMoNOH staff use the information to gain knowledge about state-level barriers and opportunities for integrating oral health care into primary care and to raise awareness about system changes.

Primary Care Associations

PCA coaches recruited and support participating CHCs for the development, implementation, and validation of RoMoNOH's models of integration, using the RoMoNOH change package to guide

activities. In addition, PCA coaches in each state established and maintain a state-level learning network composed of participating CHCs in the state to share successes, lessons learned, and challenges with implementing the models of care. RoMoNOH project leads provide on-site TA to support PCA coaches and participating CHCs.

Impact of COVID-19

The COVID-19 pandemic has significantly impacted health behaviors and health care use for all Networks for Oral Health Integration projects, including RoMoNOH. CHCs have had to dedicate time and effort to managing new and additional challenges during the pandemic, which has taken them away from RoMoNOH activities and other projects. Two CHCs asked to pause their participation in RoMoNOH because of the stress the pandemic has placed on their staff. In some CHCs, data and information technology staff's time was shifted from developing processes for collecting and reporting metrics for RoMoNOH to emergent COVID-19 needs, which resulted in RoMoNOH project delays. On the positive side, the pandemic forced RoMoNOH staff, partners, and participating CHCs to use an online environment for meetings and coaching sessions, and, in the process, RoMoNOH staff learned that it's possible to make necessary adjustments to accomplish project goals and objectives, such as building virtual learning networks to support activities. Additionally, during the pandemic, patients are still coming to CHCs for medical visits and immunizations; these medical visits are leveraged for same-day integrated oral health visits.

Project Contacts

Project director: Patricia Braun, M.D., M.P.H.
Denver Health and Hospital Authority
E-mail: patricia.braun@dhha.org

Project manager: Cherith Flowerday, B.S.
Denver Health and Hospital Authority
E-mail: cherith.flowerday@dhha.org

Transforming Oral Health for Families (TOHF)

The TOHF project is focused 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). The network is also partnered with the Mid-Atlantic Association of Community Health Centers to assist in recruitment of CHCs, and with the University of Maryland School of Public Health to support outreach and education 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 the model of family-centered team-based primary care 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, TOHF is leading three 18-month learning collaborative (LC) cycles with approximately 10 CHCs in each cycle, for a total of 30 CHCs during the project period.

TOHF is supporting CHCs via:

- Online learning sessions and a curated training curriculum for primary care professionals 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.
- QI tools to assist with planning and implementing oral-health-integration activities, such as a best practice workflow guide, a clinical decision support algorithm, billing guidance, and HIT support and electronic health record (EHR) template examples.
- One-on-one practice facilitation and group technical assistance (TA).
- Peer learning and sharing.
- TA for data collection and reporting, HIT optimization, and other needs as projects progress.
- Stipends upon start and completion of LC participation.

Settings

TOHF applies 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 EHRs and electronic dental records (ideally an interoperable EHR)
- Have experience with the Plan-Do-Study-Act cycle and QI

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, and referrals), with specific adjustments based on individual CHC needs. TOHF is identifying intervention components that contribute to the successful implementation of the models with the first cohorts (cohort 1 and 1A) and plans to continue implementing, evaluating, and refining the models with two additional cohorts of 10 CHCs each in 2021 (cohort 2) and 2023 (cohort 3). By the end of the 5-year project period, the TOHF team will identify, refine, and disseminate strategies to support promising models of care in CHCs.

Core Function Activities

Data, Analysis, and Evaluation

For data collection and reporting, the HealthEfficient HIT team created templates for collecting de-identified clinical and administrative project data. The team works with individual CHCs



to create a data-compliant platform to extract and share the relevant data. Dashboards developed by the HIT team for each CHC allow for visualization of data throughout the 18-month collaborative cycle and sustainability phase as a tool for assessing progress and supporting implementation of oral-health-integration practices. Data collected through these methods throughout project implementation will also be used for project evaluation.

Outreach and Education

TOHF developed a curriculum for educating primary care professionals and staff, which is delivered to individual CHCs via online learning sessions, coaching sessions, and an online training package. Trainings include the interprofessional oral health core clinical competencies (i.e., risk assessment, evaluation, preventive interventions, communication and education, interprofessional collaborative practice). TOHF worked with the American Academy of Family Physicians and the National Network for Oral Health Access to establish a process whereby primary care and oral health professionals can earn continuing medical education and continuing dental education units for participation in education sessions and to incentivize their participation in the trainings. In addition, TOHF is working to identify best practices, educational materials, and other tools to deliver patient education and anticipatory guidance to support oral health literacy. TOHF assembled oral hygiene kits containing toothbrushes, 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 education activities to encourage healthy oral hygiene practices at home.

Policy and Practice

Coordinators from each of the three states and the District of Columbia have been conducting an annual environmental scan since 2020 to identify factors at the state and district levels and at participating CHCs (e.g., health professional scope of practice, Medicaid fee-for-service reimbursement for primary care and oral health professionals, payment innovations) that influence the target population's oral health. Coordinators are using information from the environmental scans

to gain knowledge about state-level barriers and opportunities for integrating oral health care into primary care and to raise awareness about system changes. 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 helps 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.

Impact of COVID-19

The COVID-19 pandemic has significantly impacted health care behaviors and health care use for all Networks for Oral Health Integration projects, including TOHF. CHCs continue to experience challenges due to staffing shortages, maintaining and adjusting patient care, and managing testing and vaccination activities. With CHCs overwhelmed by these demands on their time and resources, consistently engaging participating CHCs and recruiting new ones is challenging. 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 were moved to an online platform.

Project Contacts

Project director: Rachel King, D.D.S., M.P.H.,
M.B.A., M.S.
HealthEfficient
E-mail: rking@healthefficient.org

Program manager: Victoria Potter
HealthEfficient
E-mail: vpotter@healthefficient.org