Transforming Oral Health for Families (TOHF)

The TOHF project was part of the Networks for Oral Health Integration (NOHI) Within the Maternal and Child Health Safety Net, funded by the Maternal and Child Health Bureau. NOHI's goal was 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 focused on increasing access to preventive oral health care in the primary care setting for infants and children from birth to age 40 months and pregnant women. The project was implemented in selected community health centers (CHCs) in Virginia, New York, Maryland, and the District of Columbia.

Partners

TOHF was led by HealthEfficient, located in New York, working in partnership with the Maryland Dental Action Coalition, the Regional Primary Care Coalition (District of Columbia), the Schuyler Center for Analysis and Advocacy (New York), and Virginia Health Catalyst. 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 to assist with health-literacy assessments.

Approach

TOHF activated a network of CHCs in the three states and the District of Columbia to develop, implement, continuously evaluate, and refine a family-centered, team-based primary care model for the delivery of preventive oral health care to the target population. TOHF used the *Breakthrough Series* collaborative model developed by the Institute for Healthcare Improvement as a method for training and improvement. TOHF initiated four 18-month learning collaborative (LC) cycles with a total of 20 participating CHCs across four cohorts during the project period.

TOHF supported CHCs via:

- Online learning sessions and virtual group coaching sessions for primary care providers and staff of participating CHCs.
  - Sessions were designed to align with the CHC's learning needs and competencies related to evidence-based oral health care, communication and education, interprofessional collaborative practice, health information technology (HIT) integration, optimization of quality-improvement (QI) data,

sustaining of integration activities, and scaling of activities from the pilot project to standard CHC operation.

- Opportunities for peer learning among participants during team storyboard presentations to share best practices, successes, and strategies for overcoming obstacles to implementing preventive oral health care.
- A curated compilation of oral health training modules for primary care providers to assist with the development and implementation of a sustainable training program that aligns with individual CHC operations.
  - Topics included early childhood caries, oral health risk assessment, oral health anticipatory guidance, and fluoride varnish application.
- One-on-one guidance to optimize the use of HIT and to facilitate changes within the electronic health record (EHR) to support the integration of oral health care into primary care and data collection and reporting.
- Development of data dashboards and associated analytics to facilitate data-driven decision-making.
- A best practice workflow guide including an oral health risk assessment, a clinical-decision-support algorithm, and EHR template examples.
- An implementation toolkit to support team development, goal setting, and workflow analysis to help increase the number of primary care providers delivering preventive oral health care in a structured and sustainable manner.
- One-on-one practice facilitation to address challenges to and opportunities for enhancements specific to each site.
- Oral health kits and educational materials for primary care providers to share with parents and other caregivers during discussions about oral hygiene practices and self-management goals.
- Stipends for CHCs upon start and completion of LC participation that were tied to project deliverables, including data collection, testing and implementing change models, sharing best practices, and participating in learning sessions.
- Development of a list of individualized strategies and activities for sustaining oral health care integration and continued monitoring of data after the 18-month LC cycle.

Settings

TOHF 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).
- Have experience using QI approaches to implement, evaluate, and refine models of care.

Models of Care

TOHF worked with participating CHCs to build, implement, continuously evaluate, and improve their family-centered, team-based primary care models for delivery of preventive oral health care. Each CHC project team followed a similar approach for integrating oral health care into primary care in five focus areas: provider knowledge, oral health risk assessment, education and anticipatory guidance, fluoride varnish application, and referrals. Specific adjustments were made based on individual CHC needs. The lessons learned from the first two LC cohorts and participating CHC experiences were incorporated into planning and resource development for subsequent cohorts.

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

- Build a strong working relationship early on with the CHC to evaluate the EHR and HIT system, assist with the development of data templates and billing alignment, and train primary care 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 providers as part of onboarding and annual training, leveraging the CHC's internal learning-management system when possible.
- Emphasize leadership buy-in and multidisciplinary participation during implementation to help make the provision of oral health care in primary care a part of the organization's culture.
- Incorporate oral health quality measures into existing QI programs and data-analytics systems to help make integrated oral health care a part of the QI culture.
- Acquire input on clinic workflow from all team members.
- Use EHR alerts and reminders for primary care providers about conducting the caries risk assessment during the well-child visit to help make the procedure part of standard practice.
- Incorporate health-literacy concepts when developing or selecting educational materials.

From March 2020 through February 2024, over 300 primary care providers received training on preventive oral health care and the key components of integrating oral health care into primary care. During the same period, participating CHCs provided over 62,000 preventive oral health services to infants and children from birth to age 40 months (33,898 risk assessments, 25,339 fluoride varnish applications, and 3,286 referrals for care). All participating CHC sites made the provision of preventive oral health care in primary care a standard operation of care.

- Use motivational interviewing and goal setting to engage parents and other caregivers.
- Provide education and hands-on training for primary care 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 between primary care providers and oral health providers whenever possible.

As a federally designated Health Center Controlled Network responsible for helping CHCs and other health professionals in its network, HealthEfficient has successfully incorporated an integrated oral health component into its menu of services to help CHCs improve clinical and operational performance while integrating oral health care into care delivered.

Core Function Activities

Data, Analysis, and Evaluation

The HealthEfficient HIT team provided each CHC with an evaluation of its HIT system, 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. For data collection and reporting, the HealthEfficient HIT team created templates for collecting de-identified clinical and administrative project data from CHCs. The team worked with each CHC to incorporate processes for data collection and validation. With input from participants in the first two LC 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 included:

1. Percentage of primary care 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
5. Percentage of target-population patients receiving a dental referral during a well-child visit

The use of separate EMR and EDR systems posed challenges for certain elements of integration, most notably closed-loop referral processes. In addition, the complex nature of diverse analytics platforms that CHCs used to pull data from the EHR required site-specific strategies for HIT optimization. By providing 1:1 guidance to each CHC, the HealthEfficient HIT team helped address these challenges.

Outreach and Education

TOHF produced a curriculum for educating primary care providers and staff, which was delivered to CHC teams via learning sessions, coaching sessions, and training programs that individual CHCs developed. Trainings targeted 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 QI, utilizing informatics). Trainings also incorporated the interprofessional oral health core clinical competencies (i.e., risk assessment, evaluation, preventive interventions, communication and education, interprofessional collaborative practice). TOHF 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 identified best practices, educational materials, and other tools to deliver patient education and anticipatory guidance at an appropriate health-literacy level. TOHF 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. The University of Maryland School of Public Health completed an oral-health-literacy review with a sample of CHCs to identify opportunities to enhance educational and promotional materials and improve communication with the target population. A summary document with key recommendations and resources was developed for all participating CHCs. In addition, TOHF worked with its state and jurisdiction coordinators to develop community partnership maps that outline potential opportunities for collaboration between participating CHCs and community maternal and child health organizations to support oral health activities.

Policy and Practice

Coordinators from each of the three states and the District of Columbia conducted environmental scans 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 the jurisdiction level. The scans included questions focused on state-based scope of practice of primary care providers and oral health providers, Medicaid billing and payment, and policies and regulations. Coordinators used 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 and to share information about scope of practice, Medicaid billing and payment, and policies and regulations in other NOHI states. Specific policies and regulations that could potentially impact the integration of oral health care into primary care included payor reimbursement for related procedures; Medicaid coverage for adults, particularly for pregnant women; growth and expansion of telehealth for oral health care delivery; and expansion of scope of practice for nondentists.

At a community level, information gleaned from the environmental scans related to scope of practice helped CHCs optimize clinical workflows. Information about billing regulations 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 also developed and used 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 significantly impacted health care behaviors and health care use for all NOHI projects, including TOHF. CHCs experienced challenges with staffing shortages, maintaining and adjusting patient care, and managing testing and vaccination activities. Despite the end of the COVID-19 public health emergency, CHCs continue to experience challenges due to staffing shortages and turnover of staff involved in patient care, administration, data processing and analytics, and QI. In

response, TOHF worked with each CHC to modify project timelines, adapt project plans, set realistic goals for QI, and support HIT development for data collection and analytics. In addition, group coaching sessions provided opportunities for CHC teams to share strategies for managing these obstacles.

Resources

- Transforming Oral Health for Families: Project video and presentation
- Knowledge Assessments and Scoring Rubrics for Medical and Oral Health Care Providers, Staff, and Patients (2020)
  - Survey of Dental Caries Prevention and Scoring Rubric: Dental Assistants (2020)
  - Survey of Dental Caries Prevention and Scoring Rubric: Dental Hygienists (2020)
  - Survey of Dental Caries Prevention and Scoring Rubric: Dentists (2020)
  - Survey of Dental Caries Prevention and Scoring Rubric: Medical Assistants (2020)
  - Survey of Dental Caries Prevention and Scoring Rubric: Non-Clinical Staff (2020)
  - Survey of Dental Caries Prevention and Scoring Rubric: Nurses (2020)
  - Survey of Dental Caries Prevention and Scoring Rubric: Obstetric Providers (2020)
  - Survey of Dental Caries Prevention and Scoring Rubric: Patients (2020)
  - Survey of Dental Caries Prevention and Scoring Rubric: Physicians (2020)
- Participating Community Health Center Assessments
  - Health Information Technology Assessment (2020)
  - Oral Health Integration Readiness Profile for Participating Community Health Centers (2020)
  - Oral Health Literacy Environmental Scan (2020)
  - Oral Health Services Assessment (2020)
  - Participating Health Center Needs Assessment (2020)
  - Policy Assessment Matrix for Community Health Centers (2021)
  - Practice Referral Process Assessment (2020)
- Selection of Oral Health Training Modules for Medical Providers (2020)
- TOHF eCW Workflow & Configuration Guide (2022)
- Transforming Oral Health for Families (TOHF): Environmental Scan 2023 Chartbook (2023)

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