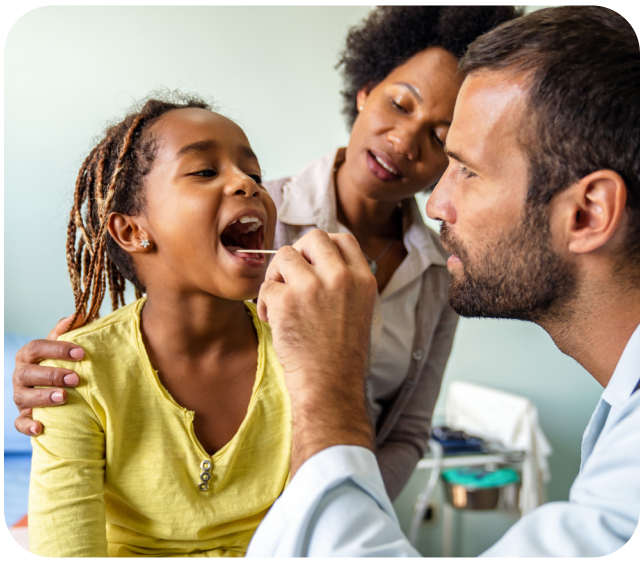
Midwest Network for Oral Health Integration (MNOHI)

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

Partners

MNOHI consisted of the Michigan Primary Care Association (lead) working in partnership with the Illinois Primary Health Care Association, the Iowa Primary Care Association, and the Ohio Association of Community Health Centers (OACHC). The National Network for Oral Health Access (NNOHA) provided technical assistance (TA) on outreach and educational activities. The Michigan Department of Health and Human Services, the Michigan Oral Health Coalition, and Oral Health Ohio partnered with MNOHI on policy activities. The Michigan Public Health Institute (MPHI) conducted an evaluation of the MNOHI project.



Approach

MNOHI state coordinators (one from each of the four primary care associations [PCAs]) worked with 34 participating CHCs (10 in Illinois, 9 in Iowa, 6 in Michigan, and 9 in Ohio) in three cohorts. Participating CHCs worked to develop, implement, evaluate, and improve models of care for integrating oral health care into primary care for children ages 6–11.

State coordinators supported CHCs in their respective states via

- Offering TA to identify project champions to create a team of primary care providers, oral health providers, information technology professionals, and quality-improvement (QI) professionals. The team participated in a CHC needs assessment and readiness assessment to determine where extra support was needed. The team developed and implemented new or revised policies to support the project and coordinated training sessions for primary care providers and staff, including community health workers (CHWs) and care coordinators.

- Offering 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. Offering TA to develop workflows to incorporate documentation into the EMR.
- Providing promotional and educational oral health materials for patients and parents and other caregivers. Offering TA on how to disseminate and report on an annual patient-satisfaction survey.
- Conducting monthly coaching calls to review progress, address challenges, and discuss opportunities for improvement.
- Conducting 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 improving dental-sealant-application rates and primary care provider engagement.

MNOHI, via each PCA, provided 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, provided CHCs with quarterly 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 coaching and LC calls.

Settings

MNOHI applied 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 worked 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 incorporated 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 primary care providers and parents and other caregivers
- Interprofessional collaborative practice

An important element of the MNOHI models of care was 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. All participating CHCs filled this position with existing staff or by hiring new staff. MNOHI, with assistance from 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 (see Community Health Worker and Care Coordination: Best Practices [2022] and Community Health Workers for Integrated Care Coordination [2022]). MNOHI built on lessons learned from the first cohort of CHCs to assist subsequent cohorts with refining the models of care. MNOHI compiled a set of best practices to inform efforts to integrate oral health care into primary care.

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

Optimize the EMR: The 34 participating CHCs incorporated documentation of preventive oral health care during well-child visits in their EMR. Participating CHCs developed templates for documenting the oral health evaluation, caries risk assessment, and structured referrals for follow-up care in the EMR, making it possible to monitor primary care providers' provision of anticipatory guidance on oral health. CHCs learned that it is important to make documenting the provision of preventive oral health care

From March 2020 through February 2024, over 750 primary care 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. During the same time period, participating CHCs provided over 195,000 preventive oral health services to children ages 6–11 (67,261 fluoride varnish applications, 32,557 risk assessments, 30,895 dental sealant applications, 19,755 referrals for care, 24,881 oral-health-education services [MNOHI Illinois only], and 20,043 oral health screenings [MNOHI Illinois only]). The percentage of children ages 6–11 who received preventive oral health services in participating CHCs increased from 5.6 percent (September 2020 through February 2021 reporting period) to 71.6 percent (September 2023 through February 2024 reporting period) in MNOHI cohorts 1–3.

in the EMR simple for primary care providers (e.g., by placing preventive oral health care near other preventive health care in the health record). This makes it easier to incorporate the provision and documentation of preventive oral health care without disrupting the flow of the well-child visit.

Reduce the burden of oral health training for primary care providers: Participating CHCs in Michigan informed MNOHI that the length of the four required *Smiles for Life: National Oral Health Curriculum (Smiles for Life)* modules and a NNOHA module made completing the modules burdensome for primary care providers. MNOHI worked with NNOHA to condense the *Smiles for Life* modules and the NNOHA module to reduce training time from 4.5 hours to under 2 hours. In addition, one participating CHC in Michigan incorporated the MNOHI training into its learning-management system and will have every staff member complete the training. This is a sustainable element of the project that can be continued after funding concluded.

Add oral health outreach duties to job descriptions: If participating CHCs added oral health outreach duties similar to those performed by a CHW or care coordinator to an existing staff member's job duties, MNOHI required that these duties also be added to the corresponding job description to help sustain efforts if there is staff turnover. If the staff member leaves the CHC, the duties will continue with their replacement.

Core Function Activities

Data, Analysis, and Evaluation

MNOHI state coordinators worked with participating CHCs to develop structured data fields in the EMR to document preventive oral health care provided to patients. CHCs received 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, 91 CHCs in 24 states have implemented the measures. This is a significant step that will help CHCs across the country, regardless of whether they participated in NOHI, improve their

efforts to integrate oral health care into primary care and to provide high-quality oral health care to patients. Illinois and Iowa also collected metrics from participating CHCs and worked 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 presented challenges, partly because there were 6 different EMR systems, 7 different electronic dental record (EDR) systems, and 13 different combinations of EMR and EDR systems used in the 34 participating CHCs. This complicated the development of a consistent documentation process among all participating CHCs. Each CHC had a different workflow for documenting the required data. In addition, some CHCs underwent EMR- and EDR-platform transitions, and some lacked policies and protocols for referring patients for oral health care. These issues engendered further challenges.

MNOHI created a CHW tracking form to capture care-coordination activities and gauge the impact of CHWs' efforts on closing referral loops. MNOHI built a data dashboard to enable visualization of progress across participating CHCs in all four states. MNOHI used qualitative and quantitative data to track, assess, and report outcomes resulting from project activities. It also tracked and assessed policy and

systems changes in participating CHCs to provide data for the oral health core clinical competencies. MPHI is conducting an evaluation of the MNOHI project.

Outreach and Education

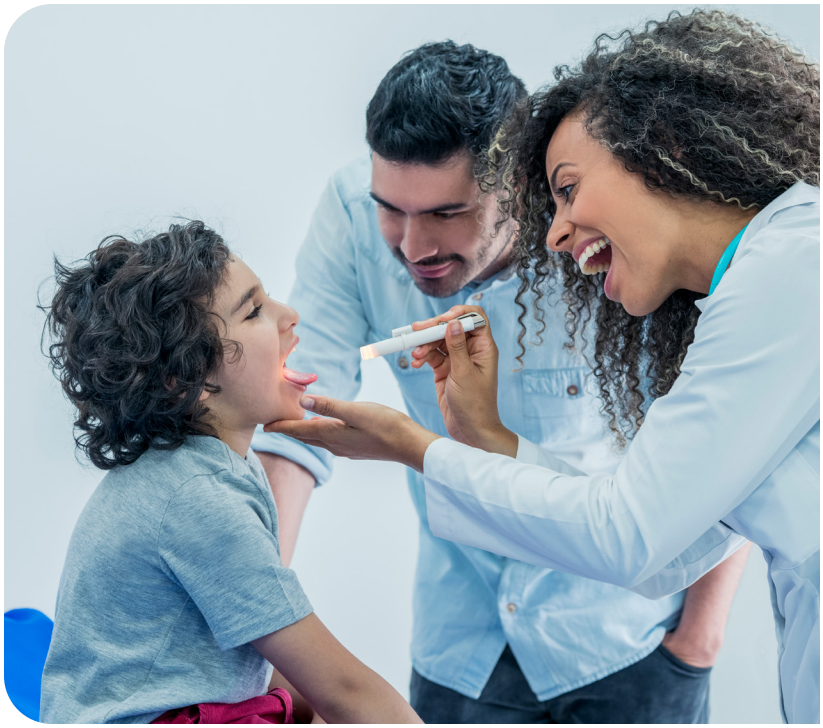
MNOHI used *Smiles for Life* modules to train primary care providers and staff. To supplement the modules, NNOHA developed a module specific to MNOHI's target population. In response to feedback from participating CHCs, NNOHA condensed the *Smiles for Life* modules and the NNOHA module to accommodate those whose schedules precluded their completing the training modules. In addition, MNOHI encouraged dental teams at some participating CHCs to provide oral health training to primary care teams and to consider having regularly scheduled interdepartmental meetings to inspire interprofessional collaboration and engagement in MNOHI activities. During quarterly LC calls with participating CHCs and CHWs, MNOHI provided opportunities for peer learning, and NNOHA offered training, as needed.

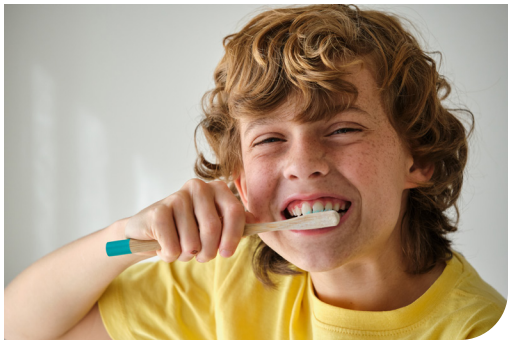
Feedback from parents and other caregivers indicated that they appreciated having their child's oral health addressed during well-child visits and that they valued the referral process that enabled them to obtain a dental clinic appointment before leaving the center.

Patient satisfaction evaluations in 2022 revealed that, on average, 98.5 percent of parent and other caregiver respondents strongly agreed or agreed that CHC staff treated them and their child with respect and gave them an opportunity to ask questions and share thoughts about their child's oral health. Respondents also found it helpful to have their child's oral health checked during the medical visit; thought the oral health instructions were easy to understand and follow; and, if a dental appointment was recommended, planned to schedule it within 30 days.

Policy and Practice

MNOHI state coordinators and partners conducted 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 included questions about scope of practice of primary care 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 conducted the environmental scans for their states. See the environmental scan tool and Midwest Network for Oral Health Integration (MNOHI): Environmental Scan 2023 Chartbook for environmental scan results.





State coordinators and partners used 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 primary care providers and oral health providers can be reimbursed for applying fluoride varnish to children's teeth). Illinois and Michigan recently passed legislation to require Medicaid reimbursement for CHW services. As a result, CHCs in the two states will be motivated to hire and retain CHWs, and the strategy of using CHWs to conduct outreach, education, and care-coordination activities will be more feasible and sustainable. Information from the environmental scans informed the development of Ohio's 2023–2027 State Oral Health Plan and Michigan's 2025 State Oral Health Plan.

Impact of COVID-19 and Workforce Shortages

The COVID-19 pandemic significantly impacted health behaviors and health care use for children ages 6–11 who were receiving care in CHCs in the MNOHI states. As COVID-19 infection rates fluctuated, CHCs shifted staff responsibilities to focus on testing and vaccination, making it challenging to engage project champions and delaying MNOHI project timelines. Troubleshooting was often necessary to make adjustments in response to these disruptions.

Participating CHCs continued to experience workforce shortages and staff turnover. In Michigan, participating CHC dental clinics continued to struggle to recruit dentists, dental hygienists, and dental assistants. In response, CHCs prioritized primary care referrals by saving designated appointment times in the dental clinic schedule for children referred by primary care to limit their wait time for a dental appointment. Facing similar challenges in Iowa, CHCs considered this option, and the Iowa state coordinator encouraged the primary care team to collaborate with the dental team to determine the best way to address pediatric primary care referrals. In response to primary care provider and oral health provider burnout and staff shortages in Illinois, CHCs adjusted their workflows and gave CHWs more responsibility for oral health education and follow-up to help the primary care team. OACHC provided TA to its CHCs, which, like CHCs in other MNOHI states, also faced workforce shortages and explored options to address the problem.

Resources

- Midwest Network for Oral Health Integration: Project video and presentation
- Azara DRVS (Data Reporting and Visualization System) Dental Measures (2021)
- Community Health Worker and Care Coordination: Best Practices (2022)
- Community Health Workers for Integrated Care Coordination (2022)
- Midwest Network for Oral Health Integration (MNOHI): Environmental Scan 2023 Chartbook (2023)
- Oral Health Risk Assessment, Children Ages 6–11 (2020)
- Participating Community Health Center Needs Assessment (2020)
- Patient Satisfaction Survey (2022)
- Prospective Community Health Center Readiness Assessment (2020)
- Training Modules
  - Condensed Smiles for Life modules 2 and 6 (2022)
  - Instructions for Accessing the Modules (revised edition) (2022)
  - Oral Health in the Well Child Visit (2020)

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