



Dental Public Health Project Descriptive Report Form

Name of Project
MORE Care Ohio
Executive Summary
Oral health is an essential component of children’s overall health, yet many children in Ohio continue to face barriers to accessing preventive oral health care, particularly those enrolled in Medicaid and living in rural or underserved communities. Dental caries (cavities) remains one of the most common chronic conditions among children, and gaps in care are often driven by workforce shortages, geographic access challenges, and limited coordination between medical and dental providers, and prevailing payment models that shape how preventive services are reimbursed and delivered across care settings. To address these challenges, the Medical Oral Expanded Care (MORE Care®) Ohio pilot was implemented to test practical strategies for integrating oral health into pediatric primary care and strengthening communication across care settings.
Name of Program or Organization Submitting Project
CareQuest Institute for Oral Health

Detailed Project Description

Project Overview

Project Overview and Objectives

The Medical Oral Expanded Care (MORE Care®) Ohio pilot was a two year initiative designed to strengthen medical–dental integration for children by embedding preventive oral health services into pediatric primary care and improving coordination between medical and dental providers. Led by [CareQuest Institute for Oral Health](#) in partnership with [Oral Health Ohio](#), a statewide oral health coalition, the pilot tested a structured, evidence-based approach focused on feasible, practice-level change.

The project sought to align multiple components of care delivery, clinical workflows, interprofessional collaboration, referral processes, data use, and payment strategies, to support prevention-oriented, coordinated care for children. Rather than implementing a single intervention, MORE Care Ohio examined how these elements could work together within existing medical and dental practice settings.

Primary goals included:

- Integrating oral health risk assessment, fluoride varnish application, patient self-management discussions, and dental referrals into routine well-child visits
- Strengthening risk based preventive care in dental settings
- Establishing closed-loop referral processes between pediatric medical and dental providers¹
- Testing an oral health-focused alternative payment model designed to support prevention and coordination

Rationale and Context

Children in Ohio, particularly those enrolled in Medicaid and those living in rural or underserved communities, continue to experience high levels of untreated dental disease and delayed access to preventive care. These outcomes persist despite established clinical disease prevention guidelines and insurance coverage for preventive oral health services.

Multiple system-level factors contribute to these gaps, including dental workforce shortages, geographic and transportation barriers, limited interoperability between medical and dental electronic record systems, and care models that have historically prioritized treatment over prevention. Together, these challenges result in fragmented care and missed opportunities to address oral health during early childhood, when prevention is most effective.

Needs Assessment and Site Selection

Needs and priorities were identified through population level data analysis and extensive stakeholder engagement. Northwest and Southeast Ohio were selected as priority regions due to elevated oral disease prevalence, high Medicaid enrollment, and social and economic factors affecting access to care.

Between 2020 and 2021, Oral Health Ohio convened statewide listening sessions with pediatric medical and dental providers, public health agencies, payers, regulators, and advocates. These discussions highlighted that gaps in pediatric oral health care were rarely attributable to a single barrier. Instead, stakeholders emphasized the interaction of workflows, payment structures, referral infrastructure, and data limitations as central drivers of unmet need.

Implementation Approach

The MORE Care Ohio pilot was designed as a practical test of integration strategies within real-world practice settings. Participating sites included pediatric medical and dental practices serving children ages 0–18, with an emphasis on populations enrolled in Medicaid. Practices were located primarily in Dental [Health Professional Shortage Areas](#), where access challenges and oral disease burden are more pronounced.

¹ A closed-loop referral is a systemized referral process that includes tracking, confirmation of visit completion, and bidirectional communication between referring and receiving providers

Implementation supports included practice-level coaching, peer learning opportunities, shared tools and templates, and access to performance dashboards. These resources were intended to help practices adapt integration strategies to local capacity while maintaining fidelity to core prevention and referral components.

Key Findings and Lessons Learned

- 1. Preventive oral health activities can be integrated into well-child visits with minimal disruption.** Pediatric practices were able to incorporate oral health screening, fluoride varnish application, and brief self-management conversations into existing visit workflows. These changes did not require major restructuring and demonstrated that primary care visits offer a viable platform for expanding access to preventive oral health services.
- 2. Closed-loop referrals improve coordination even without full HIT system interoperability.** Structured referral processes improved communication and accountability between medical and dental providers, including confirmation that patients were seen by dental partners. While lack of shared electronic records remained a limitation, standardized workflows and clear points of contact supported meaningful coordination.
- 3. Ongoing technical assistance supports sustained practice change.** Practices benefited from continued coaching to address documentation, coding, and reporting requirements. Performance dashboards and peer learning helped teams identify opportunities for refinement and supported gradual improvement over time.
- 4. Policy and reimbursement constraints influence implementation scope.** During the program phase, reimbursement policies restricting fluoride varnish coverage in medical settings to children ages 0–6 limited incentives to extend preventive services to older children, even when clinical need existed. This highlighted the importance of aligning payment policies with evidence-based prevention goals. Program findings related to these constraints were shared with system stakeholders as part of a broader implementation learning, without pursuing changes to reimbursement policy during the project period.
- 5. Workforce and capacity challenges affect the pace of system change, not feasibility.** Dental workforce shortages and staffing constraints slowed some aspects of implementation but did not prevent integration. Practices adapted by prioritizing high-risk populations and focusing on achievable workflow changes.

Practical Considerations for Replication

The MORE Care Ohio experience offers several practical considerations for communities interested in applying similar integration strategies:

- **Utilize existing resources.** Training tools, such as the [Smiles for Life](#) oral health curriculum, can build baseline oral health knowledge and staff confidence.
- **Prioritize relationships.** Identifying medical and dental partners and establishing a referral process, even if initially manual, lays the foundation for coordination.

- **Focus on feasible workflow changes.** Small, well-defined practice adjustments can yield meaningful improvements in preventive care delivery.
- **Track progress using simple tools.** Basic referral logs or spreadsheets can support learning and quality improvement where advanced systems are unavailable.
- **Support peer learning.** Learning networks create opportunities for shared problem solving and reinforce consistency across sites.

Resources, Data, Impact, and Outcomes

CareQuest Institute for Oral Health and Oral Health Ohio jointly led the design and implementation of the project. Together, they provided staffing support for workforce training, practice coaching, data analytics, evaluation, and technical assistance. This shared support structure helped ensure that participating practices received consistent guidance while retaining flexibility to adapt changes based on local workflows and capacity.

The project used a train-the-trainer approach to prepare an Ohio-based implementation coach, who worked directly with participating pediatric medical and dental practices. This approach supported hands-on problem solving and relationship building at the local level, while allowing implementation support to be tailored to each practice's needs and readiness for change. Within participating organizations, medical and dental practices identified internal champions and relied on both clinical and administrative staff to carry out integration activities, engage staff, and manage data reporting.

Financial incentives were an essential component of the project's infrastructure. Participating practices continued to receive standard fee-for-service reimbursement and were also eligible for incentive payments through an alternative payment model (APM) designed to reinforce preventive service delivery, referral completion, and data quality. The model tied incentive payments to clearly defined quality improvement measures, including timely reporting, delivery of evidence-based preventive services, and documentation of closed-loop referrals from medical and dental settings. This fee-for-service plus incentive structure encouraged targeted improvements without exposing practices to downside financial risk. Medical and dental participants worked toward specific performance measure goals and earned a flat fee or total cost percentage (for prevention and surgical rate measures) for each completed service. Funding for incentive payments was provided by CareQuest Institute, with Oral Health Ohio serving as the fiscal agent responsible for payment distribution. CareSource, a nonprofit managed care organization, served as a system-level partner by contributing to stakeholder listening sessions, supporting recognition of the initiative as a Health Care Quality Improvement Activity with the Ohio Department of Medicaid, and funding to the APM operation within MORE Care.

Data was collected throughout the project to track metrics related to implementation and service delivery. Participating practices submitted encounter-level data from their medical or dental electronic health records, including counts of oral health risk assessments, fluoride varnish applications, self-management goal discussions, preventive dental procedures, surgical dental procedures, and referrals between medical and dental providers. Medical practices tracked the share of well-child visits that included oral health services, while dental practices monitored completion of caries risk assessments and the balance between preventive and surgical care. Over the two year period, nearly 20,000 children received care through participating practices. Closed-loop referral tracking captured both referral activity and confirmation that follow-up communication occurred between providers. Data quality, completeness, and timeliness were also built into reporting expectations through the payment model.

Outcome measurement focused primarily on changes in care delivery and coordination. Medical practices showed steady increases in the use of oral health services during well-child visits. Across participating medical practices, the share of well-child visits that included oral health services increased from under 1% at baseline to an average of approximately 8% during implementation, with Medicaid-covered well-child visits reaching approximately 10% as workflows became more established. Dental practices increased the proportion of services that were preventive, with preventive visits rising from approximately 30% to 34% of all dental visits, while reliance on surgical procedures declined from 16% to 12%, reflecting a shift toward minimally invasive risk-based care. More consistent use of caries risk assessments supported better targeting of prevention, and increased documentation of patient self-management goals reflected stronger patient engagement. Closed-loop referrals improved communication and coordination between medical and dental providers.

Data was collected on an ongoing basis throughout the project. Practices submitted baseline data covering the year before implementation, followed by monthly data submissions from November 2022 through October 2024. This regular reporting schedule allowed practices and program staff to track progress, identify challenges, and adjust workflows over time using performance dashboards.

Results were shared in multiple ways to support learning and transparency. Participating practices received individualized dashboards and discussed results during peer learning calls, coaching sessions, and sustainability planning meetings. Aggregated findings were shared with system level stakeholders, including Medicaid partners and managed care organizations. Program outcomes and implementation lessons were also shared through public reports, national presentations, professional publications, and peer reviewed manuscripts to inform future efforts to integrate oral health into primary care.

Budget and Sustainability

Although MORE Care Ohio was implemented with a defined cohort of medical and dental practices, the initiative was intentionally designed to extend learning beyond participating sites and inform broader system improvement. Funded through philanthropic support from CareQuest, the program invested in practice transformation rather than one-time service delivery, including an incentive fund with each participating clinic eligible to earn up to \$25,000 tied to defined quality improvement and reporting milestones. Expectations for spread and sustainability were established early, positioning dissemination as an integral part of implementation rather than a post project activity. Participating practices were encouraged to view integration work as iterative and transferable, resulting in examples such as one practice training medical residents and another adding oral health measures to provider dashboards.

One mechanism that supported broader impact was alignment with [Maintenance of Certification \(MOC\) Part IV](#) requirements for pediatric providers.² MORE Care Ohio was structured as a formal quality improvement initiative with defined measures, regular data reporting, and documentation of change over time. This created a pathway for participating pediatricians to meet MOC Part IV requirements through real-world practice transformation, reinforcing

² Maintenance of Certification (MOC) Part IV refers to the American Board of Pediatrics performance assessment requirement, which allows physicians to earn certification credit by participating in structured quality improvement initiatives that include defined measures, data collection, and demonstrated improvement over time.

sustained participation and engagement. The approach also demonstrated how quality improvement and workforce development can be paired with professional certification requirements, an insight that may be useful for other integration initiatives.

Stakeholder engagement further supported impact beyond the immediate learning community. The program was built on statewide listening sessions convened by Oral Health Ohio between 2020 and 2021, which included pediatric medical and dental providers, public health agencies, payers, regulators, and other system partners.³ Insights from these sessions informed program design and ensured alignment with identified needs related to care coordination, prevention-focused service delivery, and payment structures. Continued communication with stakeholders during implementation, including sharing aggregated findings, reinforced shared ownership, and sustained interest beyond participating practices.

As practices demonstrated progress integrating oral health services and implementing closed-loop referral processes, they were encouraged to share their experiences with peers within and outside Ohio. Tools, workflows, and lessons were disseminated through peer learning calls, conference presentations, blogs, and professional publications, supporting informal spread. In one instance, integration work conducted through MORE Care Ohio was recognized as an approved quality improvement activity and shared within pediatric residency training environments, exposing future providers to medical–dental integration early in their careers.

At the systems level, program leaders shared findings with Medicaid stakeholders, managed care organizations, and policymakers, including analyses of patient reach and geographic distribution. Situating practice level improvements within a population health context supported discussions about sustaining and scaling integration through policy, payment, and data infrastructure alignment.

Together, these experiences demonstrate that amplifying impact requires intentional planning across training, data use, stakeholder engagement, professional incentives, and policy alignment. MORE Care Ohio demonstrates that a well-organized approach to quality improvement, combined with intentional sharing of lessons learned, can extend the impact of a pilot beyond its original learning community.

Additional details on outcomes, implementation lessons, and system-level impact are available in the MORE Care Ohio Impact Report, [Partners in Progress: Pursuing Medical-Dental Integration in Ohio](#).

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³ Other system partners refers to organizations and stakeholders that influence or support care delivery and system-level improvement (e.g., coalitions, training institutions, and community organizations).

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