Wisconsin MEDICAL DENTAL Integration

IMPLEMENTATION GUIDE TO INTEGRATE DENTAL HYGIENISTS INTO PRIMARY CARE TEAMS

Updated: Sept. 2023

Oral Health
Children's Health Alliance of Wisconsin

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*PLEASE NOTE THIS GUIDE IS CONSIDERED A WORKING DOCUMENT AND IS UPDATED AS NEW BEST PRACTICES AND FINDINGS ARE INDENTIFIED. IF YOU HAVE UPDATED INFORMATION TO ADD TO THE EXISTING GUIDANCE, PLEASE CONTACT JENNA LINDEN AT JLINDEN@CHILDRENSWI.ORG.

VISION

The Wisconsin Medical Dental Integration (WI-MDI) project aimed to create statewide system change within health care organizations to increase early access to preventive dental care and reduce the dental disease burden for young children and pregnant women through the integration of a dental hygienist into medical clinics (primary care teams).

PURPOSE OF GUIDE

The purpose of this implementation guide is to assist health systems and centers that are interested in addressing oral health inequities within their patient population, by implementing a MDI approach to their patient care process. This guide will help expand the audience's understanding of the WI-MDI model and the associated implementation process. It will describe the core drivers and steps needed to integrate a dental hygienist into primary care medical appointments, specifically well-child visits and obstetric visits. While the initial target populations for this model were children and pregnant women, it can be adapted for additional patient groups. This guide primarily describes the implementation process as it pertains to Wisconsin, however, it will also highlight key considerations for health systems or centers located outside of Wisconsin who are exploring variations of MDI efforts, recognizing dental hygiene scope of practice currently varies across states.

ACKNOWLEDGEMENTS

WI-MDI started in 2019 as a collaboration between the Children's Health Alliance of Wisconsin (the Alliance) and the Medical College of Wisconsin (MCW). From 2019-2022, the project was funded by Advancing a Healthier Wisconsin at MCW and Delta Dental of Wisconsin Foundation. Additionally, participating health systems and centers, as well as those who have served on our WI-MDI Advisory Council, have significantly contributed to the content and knowledge included in this guide.

PROJECT HISTORY

The MDI project executive team has collaboratively led the facilitation, coaching and implementation of the MDI model in Wisconsin. The executive team consisted of dental and medical professionals from the Alliance and MCW.

The WI-MDI Advisory Council is a group of vested representatives from health care organizations, professional medical and dental associations, as well as individual contributors who have supported and informed the progress of the MDI project from 2019-2022. They have served as a sounding board and expert panel to address and overcome challenges as well as monitor progress.

In June of 2017, Gov. Scott Walker signed Act 20 into law in Wisconsin, allowing dental hygienists to work in new settings without the authorization and supervision of a licensed dentist. Examples of these new settings include: child care locations, adult day care facilities, nursing homes and physician offices – thus making the WI-MDI model a possibility. During initial implementation, the WI-MDI project executive team utilized the Institute for Healthcare Improvement (IHI) Breakthrough Series model.[1] The Breakthrough Series uses the learning collaborative approach to accelerate learning and best practice implementation among various health care teams. This allowed collaborative learning across implementing teams statewide.

During the initial year of the WI-MDI project experts from the WI-MDI Advisory Committee and project staff developed a project charter, a change package, and a project measurement strategy. A change package, as described in the IHI Breakthrough Series model, is a vision for system change in the topic

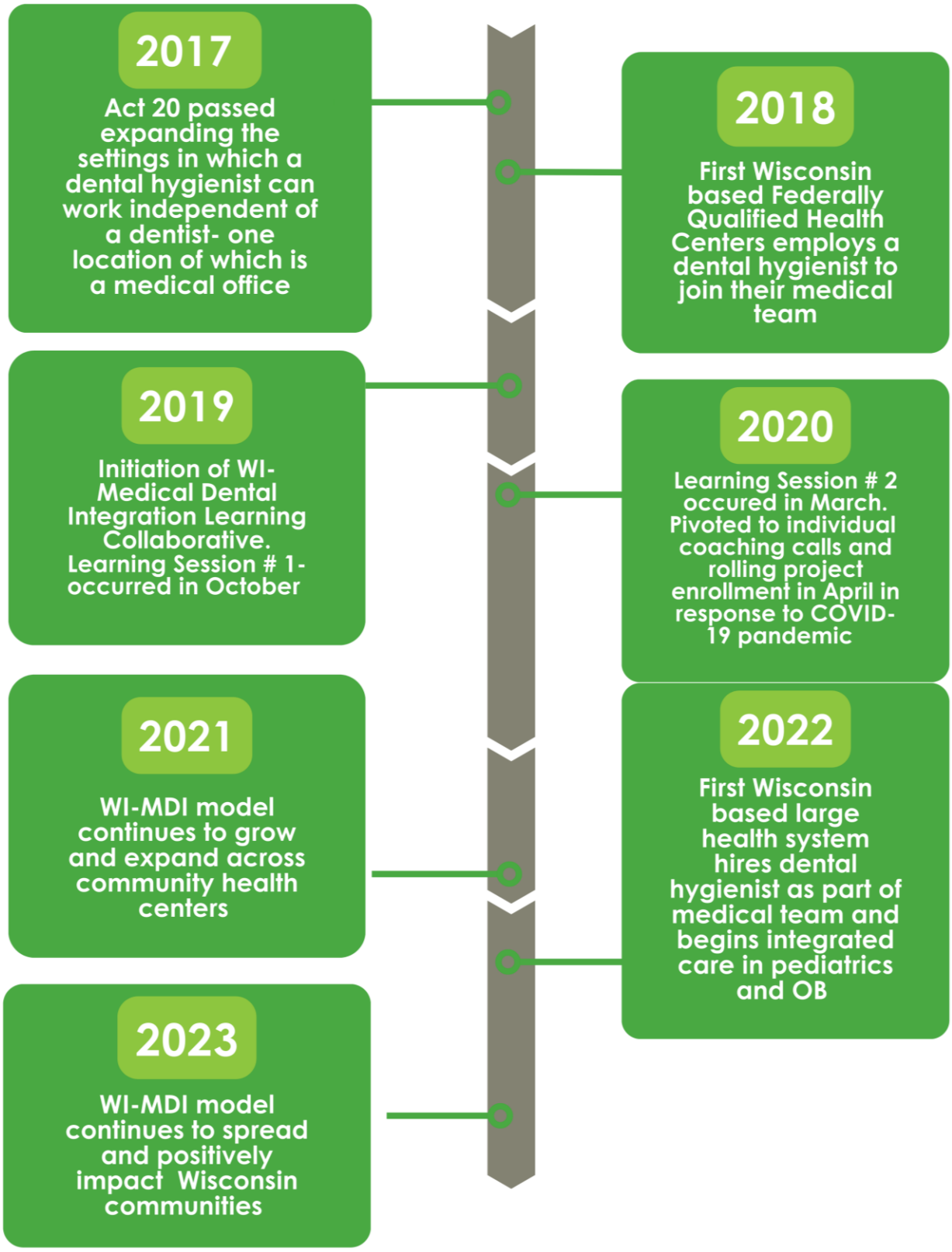
area and, when applied locally, will significantly improve the system's performance and progress. An initial learning session took place in October 2019 and a second one in March 2020.

In response to COVID-19, our MDI project executive team (with input from the MDI Advisory Council), adjusted the implementation method, pivoting from an in-person learning collaborative approach to virtual 1:1 learning and coaching following the March 2020 MDI learning session. In the pandemic environment we maintained the promotion of a continuous quality improvement approach in our coaching and technical support methods and allowed for rolling enrollment of health systems.

THE ALLIANCE SUPPORT

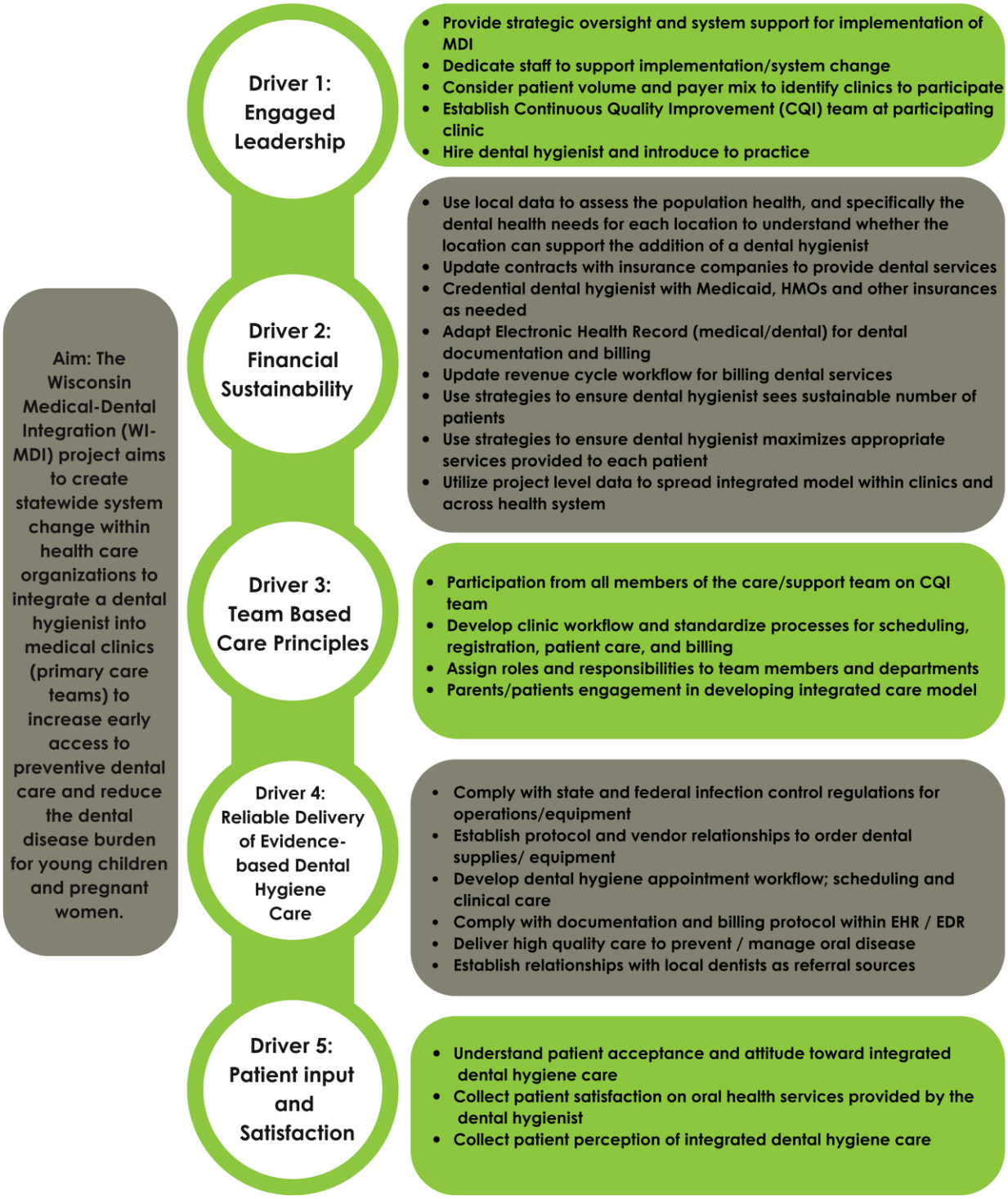
As funding has allowed, the WI-MDI project staff has provided coaching for health systems and centers through the planning and implementation stages of initiating and sustaining the model. Support has been provided in the following ways: planning and implementation support, assistance with proforma development, assist with the identification of an ideal clinic pilot location, project evaluation, assistance in establishing dental referral networks, connections to the dental hygiene workforce, project staff with 20+ years of nursing experience, project staff with 15+ years of public health dental hygiene experience, project staff with dedicated time to coach clinic teams for practice transformation, a $5,000 stipend, and Maintenance of Certification Part 4 (MOC IV) credits for participation in project.

PROJECT TIMELINE

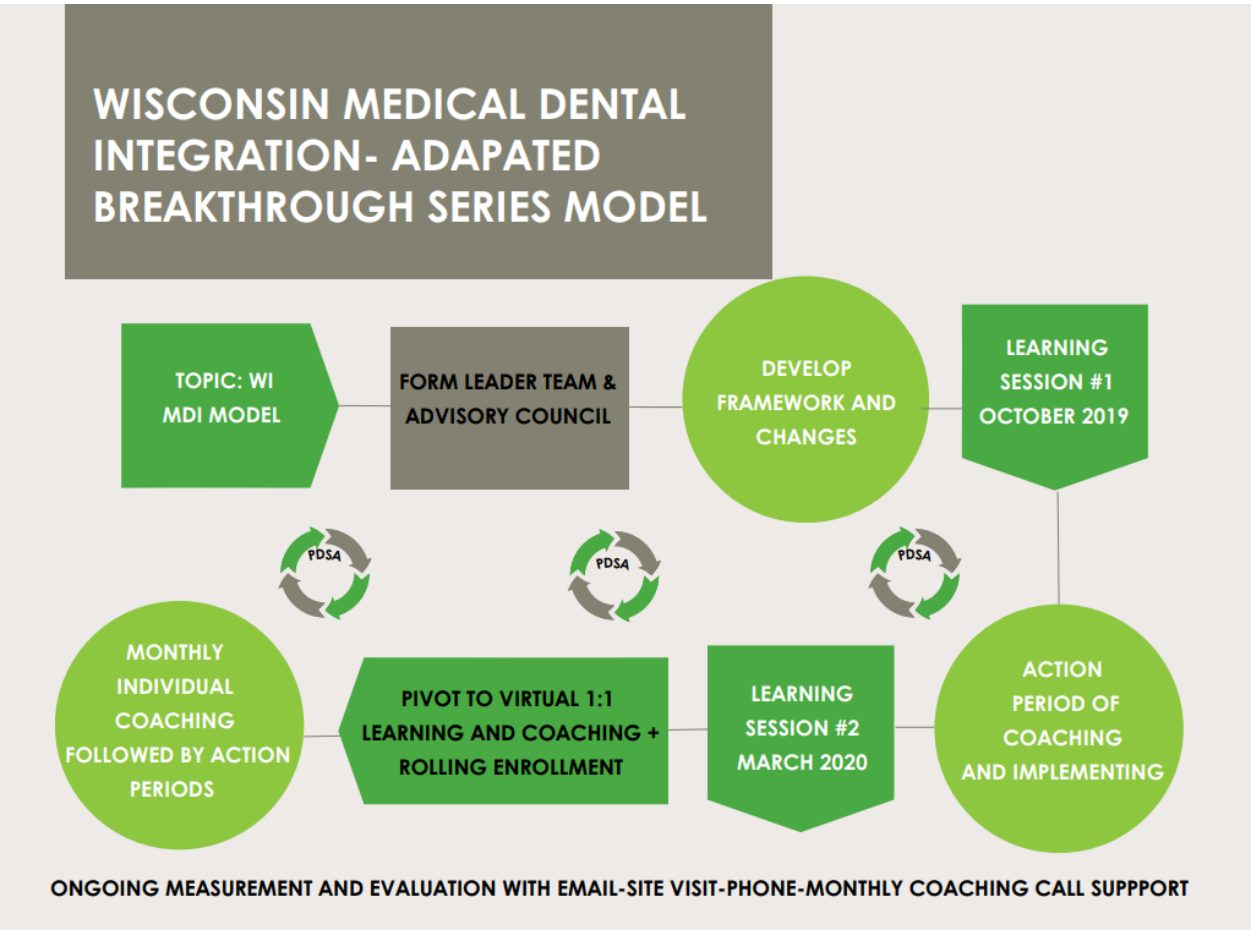


DRIVER DIAGRAM

Factors critical to success of the implementation of the WI-MDI model include the following primary drivers and associated change ideas:



ADAPTED LEARNING COLLABORATIVE MODEL



Once leadership conveys support to begin MDI, systems can anticipate the following estimated timeline (depending on the existing resources they have in place) to accomplish all necessary preparation steps for providing integrated dental services with an embedded dental hygienist.

LEADERSHIP AND ORGANIZATIONAL SUPPORT

- ☐ Gaining organizational and leadership support and considering the value proposition.
    - Determine the need and demand for integration of dental hygienists within the medical team at various clinic locations by reviewing patient volume, payer mix, access to dental home of patient population, dental disease level identified by providers/needs assessment and clinic geographic setting.
    - Determine alignment with the organization mission, purpose, and strategic plan.
    - Select a clinic to initiate MDI within.
    - Assess readiness using the Driver Diagram Readiness Assessment.
- ☐ Physicians and clinical staff are aware and support MDI.
    - Determine which medical provider is willing to champion MDI.
- ☐ Operations staff are aware of and support MDI.
- ☐ Engage IT for considerations around dental documentation in the medical settings within electronic medical or dental record.
- ☐ Engage insurance contracting to accommodate the addition of dental hygienist as a team member and the addition of dental services.
- ☐ Engage revenue cycle staff to plan for dental hygienists as new provider, verification of dental insurance, addition of dental services and coding, ensure the ability to bill using the dental claims form, and determine the associated billing process.
- ☐ Ensure all other support staff involved in future integrated workflows are aware of the project and their specific role in supporting implementation.

6+ MONTHS PRIOR TO GO LIVE

- ☐ Meet with contracting personnel to identify if insurance contracts need to be adapted to provide dental services.
- ☐ Meet with IT staff to discuss EMR adaptations needed to document oral health findings and services (D codes).
- ☐ Meet with revenue cycle staff (billing and coding staff) to discuss adaptations to these cycles to ensure successful billing of dental services (use of the ADA Claims Form, coding for risk level to support fluoride varnish applications, sealants, etc.).
- ☐ Meet with registration and scheduling staff to discuss adaptations to these processes to ensure the highest volume of patients for the dental hygienist and successful billing (ensure dental insurance information is recorded at registration).
- ☐ Establish foundational oral health knowledge base for involved medical staff through the completion of applicable modules within the *Smiles for Life Curriculum* and through peer learning between medical staff and integrated dental hygienist once hired.

- ☐ Register with the Department of Health Services (DHS) as a mobile dental program (if required).
- ☐ Review the organization chart and adapt it to include the dental hygienist. Identify the direct report supervisor and plan for performance review.

3+ MONTHS PRIOR TO GO LIVE

- ☐ Post job description and review applications.
- ☐ Interview candidates and extend offer.
- ☐ Confirm the start date for the dental hygienist (hygienist will be the lead person for many tasks listed below).
- ☐ New employee orientation and onboarding of dental hygienist following current new provider protocols at clinic.
- ☐ Establish contracts and credential dental hygienist to provide dental services with Medicaid and Delta Dental of Wisconsin (if applicable).
    - Medicaid (10 days for credentialing)
    - Delta Dental of Wisconsin (process in development as of January 2023)
    - Dental Health Maintenance Organizations (HMOs) for Southeast Wisconsin locations only (time frame varies, refer to the credentialing guide).
- ☐ Test the electronic medical record (EMR) oral health module/electronic dental record (EDR) (if applicable) to ensure templates are built and feasible to complete within the MDI workflow.
- ☐ Test dental billing cycle for functionality.
    - American Dental Association (ADA) dental claims form is linked to the EMR and contracts are in place.
- ☐ Introduce dental hygienist to provider teams (schedule a lunch and learn or team gathering).
    - Have RDH explain the services provided.
    - Determine the initial workflow. Use process mapping activity to incorporate the entire team (registration to patient visit).
    - Use quality improvement methods and team huddles to test workflow strategies and identify what works best for all providers.
- ☐ Implement a plan to comply with state and federal infection control regulations.
- ☐ Order supplies and equipment.
- ☐ Establish relationships with dentist as referral sources. Determine the referral process protocol (faxed, electronic, feedback from dental provider-closed loop process, etc.).
- ☐ Determine plan for gathering patient satisfaction with integrated dental hygiene services.

SEE FIRST PATIENT

- ☐ Review the productivity and impact of dental hygienist monthly. Use data to inform changes to workflow processes.
- ☐ Review financial data monthly to ensure dental claims are successfully paid and integration is sustainable. Consider expanding services if desired (dental sealants, etc.).

IDENTIFYING THE NEED: WISCONSIN DENTAL HEALTH CRISIS

Oral health is essential to overall health and well-being

Caries, or tooth decay, is the most common chronic childhood health condition.

Although caries are largely preventable, if untreated, they can lead to pain, inflammation, and the spread of infection, difficulty eating, poor nutrition, delayed physical development, and poor self-image and socialization and even have negative affects on academic performance.

STATEWIDE STATISTICS WHICH DEMONSTRATE THE GAP IN DENTAL CARE

- 62 out of the 72 Wisconsin counties are considered dental professional shortage areas affecting over 2 million residents.[9]
- Approximately 30% of Wisconsin dentists accept Medicaid.[13]
- By age 5, 1 in 2 Wisconsin Head Start children have had tooth decay.[12]
- In 2020, only 33% of those ages 1 to 20 who were eligible to receive Medicaid funded dental preventive services, actually received them.[10]
- In 2021 in Wisconsin, nearly 20,000 emergency room visits for preventable dental conditions were reported.[6]
    - In contrast to 2020, where over 60% of those ages 0 to 6 enrolled in Medicaid attended well-child visits.[10]
- On average, there are 14 recommended well-child visits between the ages of 0 to 5.[11]
- Wisconsin Pregnancy Risk Assessment Monitoring System (PRAMS) oral health indicators show that approximately 50% of pregnant women have had their teeth cleaned during pregnancy.[4]
- Wisconsin ranks 43rd in the nation for access to dental care for children.[7]

AN INNOVATIVE PART OF SOLUTION: MDI

The Surgeon General's 2003 National Call to Action to Promote Oral Health emphasized the need for public and private partnerships to improve the oral health of all Americans and called for collaborative efforts to integrate general medical and oral health care.[5] Since then, there has been a national movement toward the integration of dental and medical services to:

The Alliance is leading the expansion of such a solution in partnership with forward thinking providers. A low-cost solution exists in Wisconsin to expand access to pediatric preventive dental services through the adoption of the 2017 Act 20, which permits dental hygienists to practice without the direct supervision of a dentist. Hygienists are also able to provide care in a nontraditional dental setting. The deployment of dental hygienists in the primary care setting will provide greater access to preventive services, such as:

- Oral health screening/oral evaluation
- Anticipatory guidance for patients and caregivers (Oral health education, nutritional counseling)
- Fluoride varnish
- Oral health risk assessment
- Referral coordination to dental homes
- Silver diamine fluoride

LEVERAGING THE WELL-CHILD VISIT

Physicians have a minimum of 10 contact points between 6 months to 5 years of a patient's life[11]. Additionally, statistics show that 3 out of 5 Wisconsin children on Medicaid, ages 0 to 5, visited their physician but did not receive any dental care or services[16]. MDI aims to break the engrained understanding of the medical and dental care are separate. This separation is often evident in education, licensure, regulation, practice, payment, information sharing and frequently viewed as two separate entities from a patient's perspective. MDI provides the opportunity to access patients at an early age and at a higher frequency, to provide dental prevention and intervention services. The WI-MDI project is not a replacement for a dental home. MDI utilizes case management efforts by the dental hygienists to help connect patients with dental care and dental homes.

COST-BENEFIT CONSIDERATIONS OF THE MDI MODEL

- Help respond to a significant health inequity and the leading chronic illness in children.
- Prevent more acute health conditions later in life through early prevention.
- Reduce dental emergency department (ED) dependency:
  - On average, the annual costs associated with these visits range from $1 billion to $2 billion dollars nationally.
  - Dental care provided in the ED seldom resolves the issue. As a result, 90% of dental-related ED visits result in prescription medication to manage pain and infection rather than appropriate dental procedures[15].
- The Oral Health in America: Advances and Challenges report, released by the Surgeon General in December 2021 states, "Dental and other health care professionals must work together to provide integrated oral, medical, and behavioral health care in schools, community health centers, nursing homes, and medical care settings, as well as dental clinics," as one of its three calls to action[5].
- Convenience for families. Decreasing the need to schedule and attend dental appointments for young children provides convenience and efficiency to time-starved families.

- Universal approach: while the goal of the project is to decrease health disparities that exist among underserved populations, all children can benefit from this intervention.
- Increase access to dental prevention and treatment during pregnancy.
- Innovative solution. Differentiates providers in the health care marketplace by expanding their reach to care for the whole person through an inter-professional collaborative team.
- Long-term cost avoidance in the ED and inpatient stays due to periodontal disease, abscesses, brain and heart infections.
- Support and resources from the Alliance to ensure successful deployment, as well as identifying best practices alongside other forward-thinking providers.

CONSIDERATIONS TO ESTABLISH LEVELS OF SUPPORT INITIATION OF MDI IMPLEMENTATION AND PROGRESS

- Determine the need and demand for the integration of dental hygienists within the medical team at various clinic locations by reviewing patient volume, payer mix, access to a dental home of patient population, dental disease level identified by providers/needs assessment, and clinic geographic setting.
- Determine alignment with the organization mission, purpose, and strategic plan.
- A commitment to pilot a primary care clinic site and to collect data for improvement.
- Identify a core team, including a designated champion. Critical engagement for involved departments includes the system leadership, primary care clinic, information technology, billing, contracting and financial decision making expertise.
- Identify an “oral health champion” to support the initiation and progress of the model at the senior leadership level, clinical leadership level and support team level, as needed.

CONSIDERATIONS UNIQUE TO FEDERALLY QUALIFIED HEALTH CENTERS

- Financial sustainability is positively affected by Prospective Payment System (PPS) reimbursement for medically necessary primary health services and qualified preventive health services given by a federally qualified health center (FQHC) practitioner, including services provided by the integrated dental hygienist in the medical setting.
- A patient seen in the medical clinic by both the medical provider and the dental hygienist is considered two separate encounters and can be billed as such.

DRIVER DOCUMENT READINESS ASSESSMENT

To identify the existing drivers health systems and centers have in place, and what drivers still need to be completed to move towards MDI, the WI-MDI Readiness Assessment can be utilized. The assessment process is as follows: 1) Each team will identify its starting point related to the driver document change concepts, 2) indicate if you have completed or not completed each Change Concept and then determine an overall score for each Driver using green, yellow or red (green indicates all of the change concepts are complete, yellow indicates some of the change concepts are complete and red indicates you haven't started on this yet/none complete), 3) if red and yellow areas are identified, teams can focus their next steps for addressing and strengthening these foundational pieces to best support progress towards implementing MDI.

Overall Score	Driver	Complete Yes/No	Change Concept
Green Yellow Red	**Engaged Leadership (Clinic/System)**		A. Provide strategic oversight and system support for implementation of MDI
			B. Dedicate staff to support implementation/system change
			C. Consider patient volume and payer mix to identify clinics to participate
			D. Establish Continuous Quality Improvement (CQI) team at participating clinic
			E. Hire dental hygienist and introduce to practice
Green Yellow Red	**Financial Sustainability**		A. Update contracts with insurance companies to provide dental services
			B. Credential dental hygienist with Medicaid, HMO's and other insurances as needed
			C. Adapt Electronic Health Record (medical/dental) for dental documentation and billing
			D. Update revenue cycle workflow for billing dental services
			E. Use strategies to ensure dental hygienist sees sustainable number of patients
			F. Use strategies to ensure dental hygienist maximizes appropriate services provided to each patient
			G. Utilize project level data to spread integrated model within clinics and across health system
Green Yellow Red	**Team based care principles**		A. Participation from all members of the care/support team on CQI team
			B. Develop clinic workflow and standardize processes for scheduling, registration, patient care, and billing
			C. Assign roles and responsibilities to team members and departments
			D. Parents/patients engagement in developing integrated care model
Green Yellow Red	**Reliable delivery of integrated evidence based dental hygiene care**		A. Comply with state and federal infection control regulations for operations/equipment
			B. Establish protocol and vendor relationships to order dental supplies/ equipment
			C. Develop dental hygiene appointment workflow; scheduling and clinical care
			D. Comply with documentation and billing protocol within EHR / EDR
			E. Deliver high quality care to prevent / manage oral disease
			F. Establish relationships with local dentists as referral sources
Green Yellow Red	**Patient Satisfaction**		A. Understand patient acceptance and attitude toward integrated dental hygiene care
			B. Collect patient satisfaction on oral health services provided by the dental hygienist
			C. Collect patient perception of integrated dental hygiene care

DOCUMENTATION OVERVIEW

Certain clinics may already have an EDR to capture dental documentation and findings. However, for health systems without an EDR, documentation tools can be created to support the need for oral evaluation and assessment within your existing EMR.

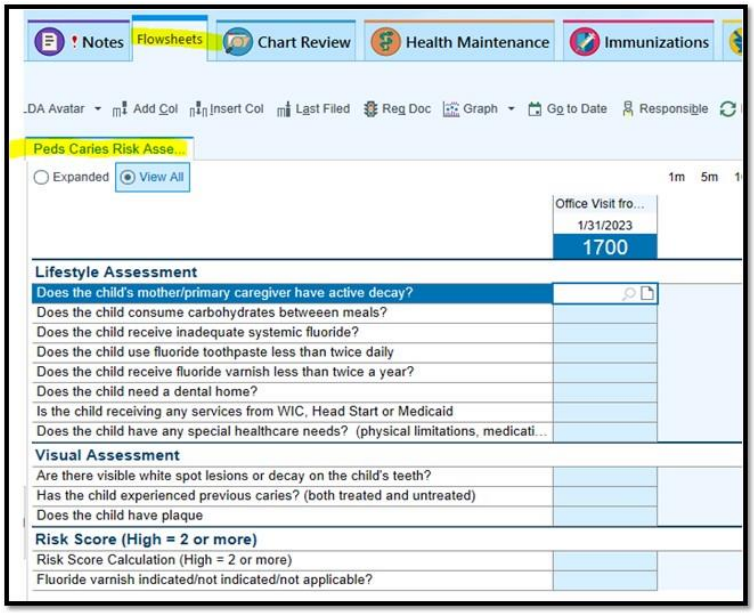
Three general areas for consideration:

1. **Documentation of:**
    a. **Oral evaluation and risk assessment.**
    b. **Fluoride varnish application.**
    c. **Oral health plan.**
        i. **After-visit summary.**
2. **Establishing fees/dental charges and billing.**
3. **Measuring progress and establishing reports.**

ORAL EVALUATION AND RISK ASSESSMENT: (D0191)

As a starting point, you can utilize an existing oral evaluation and risk assessment instrument as a guideline for your documentation template. This will include screening questions in addition to visual assessment findings. Some of the risk assessment questions can be incorporated into the existing medical health history questionnaire, making time spent with the dental hygienist most efficient. There are several available existing risk assessment tools including, but not limited to:

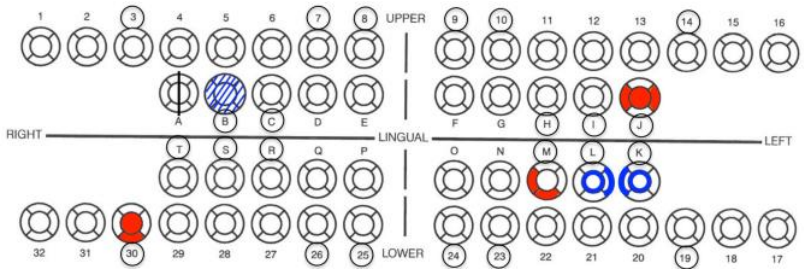
CAMBRA Caries Risk Assessment Ages 0 to 5
AAP Caries Risk Assessment



Based on the results of the risk assessment, auto-calculation could occur to determine caries risk level. **Applicable CDT codes include:** Oral assessment: D0191/ Risk assessment determination: D0601- Low caries risk, D0602- Medium caries risk, D0603- High caries risk. (Note: if you are an FQHC and therefore have ongoing Uniform Data System (UDS) reporting requirements, it may be appropriate to capture the patient risk assessment determination within a SmartForm to align with tracking in reference to UDS reporting.)

Next, based on your operational set up (medical clinic only vs. medical and dental clinics onsite), determine if you will document existing dentition, restorations and suspect caries, and if so, what

method you will use to document these findings in written format in notes or via a tooth diagram (see below). The extent of detail gathered in this section may vary based on the clinics needs and content requested as part of referral process to local dental providers.



In addition to the dental hygienist's dental documentation from integrated well-child visits and prenatal visits, physicians/medical clinicians also add a note to their own documentation indicating the dental hygienist provided care during the appointment.

The dental hygienist could, if the organization deems it appropriate, document observations of patient's behavior while providing dental services during the medical appointment. The Frankl Behavioral Rating Scale (below) or alternative behavior rating scale can be utilized. This assessment can be helpful to review for consecutive visits, as well as for use by referral dental offices.

Behavioral Guidance for the Dental Pediatric Patient-AAPD

Appendix 1.		FRANKL BEHAVIORAL RATING SCALE
1	_ _	Definitely negative. Refusal of treatment, forceful crying, fearfulness, or any other overt evidence of extreme negativism.
2	_	Negative. Reluctance to accept treatment, uncooperative, some evidence of negative attitude but not pronounced (sullen, withdrawn).
3	+	Positive. Acceptance of treatment; cautious behavior at times; willingness to comply with the dentist, at times with reservation, but patient follows the dentist's directions cooperatively.
4	++	Definitely positive. Good rapport with the dentist, interest in the dental procedures, laughter and enjoyment.

FLUORIDE VARNISH (D1206)

1. **Application of fluoride varnish**:
    - **a.** Risk based application – response options include yes/no/parent or patient declined.
    - **b.** Document "post-op" fluoride varnish instructions given.

AFTER VISIT SUMMARY

Integrate oral health into after-visit summary by adding the following topics:

- Anticipatory guidance/education.
- Self-management goals.
    - *Self-management goals_Infant caregiver/Cavity Free at Three-CO*
    - *Self-management goals_during pregnancy/Cavity Free at Three-CO*
- Post fluoride varnish application instructions.
- Oral health plan/recommendations.
- Referral and case-management details.

ADDITIONAL INFORMATION ON CHARGES

1. **Establishing dental fees/dental charges and billing:**

a. If setting fees for the utilized Current Dental Terminology (CDT) codes, consider reducing fee to the same rate as what is reimbursed by Wisconsin Medicaid (e.g., fluoride varnish is reimbursed at $18.05).

2. **Charging and Billing:**
   a. There are a limited number of CDT codes that can be utilized by an integrated dental hygienist as the rendering provider. Therefore, these codes will need to be added to the EMR and made available to the MDI dental hygienists.
   b. Dropping dental charges into a medical visit is a standard ambulatory charge capture workflow. This change can be made by a systems ambulatory analyst, allowing the hygienist to choose the charges off a charge capture preference list which would be filed when the encounter is closed.
   c. Consider how rendered services will be documented and how corresponding charges will be dropped (e.g., EMR drops charge for D0191 when risk level is calculated/documented D1206 for fluoride varnish is dropped when "yes" button is clicked/checked for "applied fluoride varnish").

- **Measuring progress and establishing reports:**
  A. Reference WI-MDI measurement strategy document for guidance on appropriate process and outcome measures to show impact of your integrated dental hygienist.(To view measurement suggestions: view section titled Measurement Strategy to Support Progress and Impact)

Suggested CDT codes to initially include/current 2022 Wisconsin Medicaid reimbursement rate/Wisconsin Medicaid dental pilot county reimbursement rates (*verify current reimbursement rates through WI Medicaid Interactive Fee Schedule). Note that highlighted codes are the most common codes that are associated with a medical dental integrated visit by a dental hygienist):

CDT Code/Description	Wis. Medicaid reimbursement rate (2022)	Wis. Medicaid pilot county reimbursement rates (2022)
D0191- Assessment of a patient	$15.16	$21.66
D1206- Topical application of fluoride varnish	$18.05	$28.00
D1354- Interim caries arresting medicament application- per tooth* (silver diamine fluoride)	$9.10/tooth	$13.00/tooth
D1351- Sealant- per tooth*	$24.02/tooth	$37.60/tooth
D1353- Sealant repair per tooth*	not reimbursed	not reimbursed
D0601- Low caries risk	not reimbursed	not reimbursed
D0602- Medium caries risk	not reimbursed	not reimbursed
D0603- High caries risk	not reimbursed	not reimbursed
D1330- Oral hygiene instructions	not reimbursed	not reimbursed
D1310- Nutritional counseling for the control and prevention of oral disease	not reimbursed	not reimbursed
D1120- Child Prophylaxis*	$30.55	$47.20
D1110- Adult Prophylaxis*	$37.69	$63.20
CPT99188	$12.89	$12.89

(*asterisk indicates procedures that will require the purchase of additional dental equipment)

To gain an estimate of what commercial dental insurance reimbursement rates are in your area visit the dental section and search by zip code at the following website: www.fairhealthconsumer.org.

DENTAL CLAIMS FORM CONSIDERATIONS

The CDT codes used by the dental hygienist will most often be billed to dental insurance. Although fluoride varnish can be billed on a CMS professional 1500 claims form, the oral health assessment code, as well as CDT codes requiring a tooth number, must be submitted via ADA claims form. We recommend that health systems utilize the dental claim for all codes submitted under the dental hygienist as the rendering provider. Health systems can request their local IT teams ensure the proper configuration is in place to accommodate creating a dental claims form for dental hygiene services. (Note: For a FQHC in Wisconsin, it is allowable to bill for one medical encounter and one separate dental encounter within the same day. A sample MDI claims form can be found below.)

MEASUREMENT STARATEGY TO SUPPORT PROGRESS AND IMPACT

An essential aspect of monitoring MDI progress, impact and opportunities for improvement, is data collection and understanding. In addition to tracking the time frame associated with preparation steps in the implementation process for MDI (prior to seeing the first patient), the measurement strategy collected through the WI-MDI project included the following process and outcome measures:

WI-MDI Program Measures (insert health center or health system name/clinic site location and year)
Program information (monthly)
All (unduplicated) children ≤ 72 months that have had a well-child visit
All children between the ages 6 to 18 years that have had a well-child visit
Unduplicated children ≤ 72 months that had a MDI program visit
Unduplicated children between ages 6 to 18 years that had MDI program visit
All MDI program visit encounters for patients ≤ 72 months
All MDI program visit encounters for patients ages 6 to 18 years
Services provided by procedure code (by integrated dental hygienist) (monthly)
D0191 Assessment of patient
D1330 Oral hygiene instruction
D1310 Nutritional counseling
D1206 Fluoride varnish
D1354 Silver diamine fluoride (interim caries arresting medicament)
D0601 Low caries risk
D0602 Moderate caries risk
D0603 High caries risk
CPT99188 fluoride varnish (medical billing code) applied by integrated dental hygienist
CPT99188 fluoride varnish (medical billing code) applied by other medical team member
Number of fluoride varnish applications by any provider (CPT or CDT code) in lifetime (ages 0 to 3 years)
Referral impact (monthly)
Total number of unique patients seen for a MDI program visit that were referred for any reason to dental clinic (untreated decay, to establish dental home, other)
Number of unique patients seen for a MDI program visit that were referred to dentist for untreated dental decay
Number of unique patients referred for follow up care that have had an initial dental visit
If known, number of referred patients that have had restorative treatment plan completed
If known, number of unique patients who established a dental home initiated through a referral from a MDI program visit
Insurance mix
Number of MDI program encounters with commercial coverage

Number of MDI program encounters with Medicaid coverage
Number of MDI program encounters -uninsured or self-pay
Population impact (reported biannually)
Number of children ≤ 72 months with a MDI program visit with untreated dental caries
Number of children from 6 to 18 years with a MDI program visit with untreated dental caries
Number of children ≤ 72 months with a MDI program visit with treated or untreated caries (caries experience)
Number of children from 6 to 18 years with a MDI program visit with treated or untreated caries (caries experience)
Number of children seen for an MDI program visit that have had no dental care in the past 12 months
Number of MDI program encounters with commercial coverage
Number of MDI program encounters with Medicaid coverage
Number of MDI program encounters -uninsured or self-pay
Clinical staff supporting MDI program
Full time equivalent (FTE) dental hygienist(s)
FTE Medical Assistant(s) (MA)
FTE Physician(s)
FTE Physician assistant(s)
FTE Nurse practitioner(s)
OTHER
Average number of days per week that a dental hygienist is integrated into medical clinic
Patient satisfaction (method of determined by each center/health systems internal process to gather and assess patient feedback)

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746
or go online at ADAcatalog.org

Private Medical Insurers explore utilizing medical code for fluoride varnish for patients with commercial medical insurance to be billed under the physician. Private insurers are required to cover all level A and B recommendations of the US Preventive Service Task Force (USPSTF).

- Fluoride varnish by medical providers for children ages 6 months to 5 years (to the 6th birthday) is a Level B recommendation.
- Use CPT 99188 (billing commercial insurers).
- Note: if the provider is out of network the claim could be denied. Contact commercial insurance providers to verify coverage and billing/reimbursement requirements and limitations

DOCUMENTATION SAMPLES

The note templates were developed with the support of health systems and centers that enrolled and implemented the MDI model in Wisconsin from 2019 through 2022.

SAMPLE PEDIATRIC DENTAL RISK ASSESSMENT DOCUMENTATION

Age/sex accompanied by: _____ presents for pediatric integrated dental visit/dental hygiene assessment (D0191):

Chief Dental Complaint:

Risk Factors: (select all that apply from the drop down menu) *indicates automatic high risk

*Mother or Primary caregiver had active decay in the past 12 months:
Mother or primary care giver does not have a dentist
Continual bottle/sippy cup use with fluid other than water
Frequent snacking (>3 times/day)
Special health care needs
Medicaid, WIC, Head Start eligible
Other:

Protective Factors: (select all that apply from the drop down menu)

Existing dental home
Drinks fluoridated water or takes fluoride supplements
Fluoride varnish in last 6 months
Teeth brushed twice daily
Flosses daily

Clinical Findings:

*White spots or incipient lesions (yes/no)
*Restorations present (yes/no)
*Teeth missing due to caries (yes/no)
*Suspected decay (yes/no)
Suspected caries on (list teeth):
Visible plaque accumulation (none, localized, generalized)
Calculus (none, localized, generalized)
Gingivitis (yes/no)
Teeth present (indicate existing teeth on tooth chart)
Healthy teeth (yes/no)
Other soft tissue findings:
Other hard tissue findings:

Overall assessment of dental caries risk: (D0601) Low, (D0602) Moderate, (D0603) High

(D1330) Oral hygiene instruction (yes/no): Reviewed home care including brushing and flossing and use of oral hygiene aids as needed.

(D1310) Nutritional counseling (yes/no):

Addressed patients current dietary habits/risk factors contributing to the caries process:
Recommended the following dietary adjustments to support oral health:

(D1206) Fluoride varnish applied (yes/no)

Post-operative instructions given

Self-management goals set (select from drop down menu all that apply):

Regular dental visits
Dental treatment for parents
Brush twice daily
Use fluoride toothpaste
Wean off bottle
Less juice/no juice
Only water in sippy cup
Drink tap water
Healthy snacks
Less snacking/junk food/candy
No soda
Xylitol

Dental referral (yes/no)

Urgency of dental referral: (select from the following immediate/urgent dental care, early dental care, routine dental care)

SAMPLE PRENATAL DENTAL RISK ASSESSMENT DOCUMENTATION

Age/sex/_months pregnant presents for Prenatal Integrated Dental Visit:

Chief Dental Complaint:

Does the patient have tooth or gum pain? (yes/no)
Current homecare: # of times brushing per day (0/1/2/3)
Flossing daily (yes/no)
Has the patient seen a dentist in the last 12 months? (yes/no)

(D0191) Clinical assessment:

Plaque: (localized/generalized)
Calculus visible: (yes/no)
Bleeding: (located/generalized)
Gingiva: (WNL/erythema and edema present)
Suspected decay: (yes/no) list teeth

Caries risk factors: (select from drop down menu)

Frequent vomiting associated with pregnancy
Other dietary risk factors
Decalcification present
Caries experience (restorations and/or active decay)
Other: fill in blank

Overall assessment of dental caries risk: (D0601) Low, (D0602) Moderate, (D0603) High

Other findings:

(D1330) Oral hygiene instruction (yes/no): Reviewed home care including brushing and flossing and use of oral hygiene aids as needed.

(D1310) Nutritional counseling (yes/no):

Addressed patients current dietary habits/risk factors contributing to the caries process:
Recommended the following dietary adjustments to support oral health:

(D1206) Fluoride varnish applied (yes/no)

Post-operative instructions given

Note: include tooth chart as in pediatric documentation

Self-management goals set (select from drop down menu all that apply):

Regular dental visits
Obtain dental treatment

Brush twice daily with fluoride toothpaste
Only water between meals
Drink tap water
Healthy snacks
Decrease frequency of snacking
No soda
Xylitol

Dental referral (yes/no)

Urgency of dental referral: (select from the following immediate/urgent dental care, early dental care, routine dental care)

SUPERVISING A DENTAL HYGIENISTS AS PART OF THE MEDICAL TEAM

Medical staff can utilize the following resources to broaden their understanding of the practice of dental hygiene, oral health promotion and oral disease prevention. This foundational knowledge will assist in supporting the supervision aspects of having a dental hygienist as part of their medical team.

REVIEW DENTAL HYGIENIST SCOPE OF PRACTICE IN WISCONSIN AND PRACTICE SETTINGS IN ACT 20

Dentistry and Dental Hygienists Wisconsin Administrative Code (View Dental Examining Board Chapter DE 3- the Practice of Dental Hygiene and Wisconsin Statute 447)

APPLY FOR MOBILE DENTISTRY LICENSE (IF REQUIRED)

Mobile Dentistry Program Registration

PHYSICIAN CONTINUING EDUCATION AND GUIDANCE TO AID IN SUPERVISION OF DENTAL HYGIENIST

1. To gain a baseline understanding of oral health and disease, we recommend all medical staff complete at least the applicable modules offered through the free online *Smiles for Life Curriculum*. It is considered the nation's most comprehensive and widely used oral health curriculum, specifically created for primary care clinicians. The curriculum consists of eight 60-minute modules covering core areas of oral health, such as, relationship between oral and systemic health, child oral health, adult oral health, acute dental problems, pregnancy and women's oral health, caries risk assessment, fluoride varnish and counseling, the oral exam and geriatric oral health.
2. National Maternal and Child Oral Health Resource Center also offers an online oral health curriculum for health professionals, Open Wide: Oral Health Training for Health Professionals.
3. Utilize American Dental Hygiene Association (ADHA) Standards for Clinical Dental Hygiene Practice Guide to gain an understanding of the dental hygiene process of care.

PERFORMANCE REVIEW SUGGESTIONS

1. Determine who the dental hygienist will report to at the medical clinic site (physician and/or clinic manager, etc.).
2. Create a competency/orientation check list including: safety and security, infection control, clinical/chair-side, administrative, documentation and case management.
3. Peer review/360 review completed by dental hygienist (if more than one RDH is on staff), nurse, and medical assistant. Information gathering, clinical treatment provided and patient/caregiver interaction.
4. An annual performance review conducted by the supervising pediatrician or clinic manager.
5. Patient surveys/feedback.

MAINTENANCE OF LICENSURE FOR DENTAL HYGIENIST IN WISCONSIN

1. A dental hygienist must graduate from a dental hygiene school accredited by the ADA Commission on Dental Accreditation. The licensure renewal date in Wisconsin is Sept. 30 of the odd year for a cost of $74.
2. Wisconsin continuing education requirements (Dental Hygienist CE DSPS-WI).
    a. 12 hours of continuing education related to the clinical practice of dental hygiene or the practice of medicine.
    b. CPR and AED requirement (licenses cannot obtain more than two credit hours to satisfy the CPR and AED requirement).
    c. Infection control requirement (no less than two of the credit hours required must be satisfied by such training).

DENTAL HYGIENE STANDARD OF CARE

1. As licensed professionals, dental hygienists are individually accountable to the standards set by the discipline. Additionally, they are accountable to the applicable federal, state and local statutes and regulations that define and guide professional practice. The ADHA Standards for the Clinical Practice of Dental Hygiene document can be used to help guide an individual dental hygienist's practice in conjunction with a dental hygienist's professional clinical judgment.

LIABILITY INSURANCE

1. It is recommended that the dental hygienist carry their own liability insurance. There are several companies that offer liability insurance for a dental hygienist (e.g., HPSO and Proliability). The ADHA also offers a discount on dental hygienist liability insurance as one of their member benefits.

HIRING A DENTAL HYGIENIST FOR THE MEDICAL TEAM

UNDERSTANDING A DENTAL HYGIENIST'S SCOPE OF PRACTICE

Knowledge of the current scope of practice for dental hygienists in the state of Wisconsin, will help you as you plan to integrate this new team member into your practice. The details of the practice of dental hygiene in the state of Wisconsin, are outlined on the following website:

Dentistry and Dental Hygienists Wisconsin Administrative Code

Also note the passage of **Wisconsin Act 20** in 2017, which expanded the locations at which dental hygienists can work without the supervision of a dentist; these locations now include a physician's office. Details of Wisconsin Act 20 can be found at the following link: 2017 Wis. Admin Code Act 20.

Practice acts, and therefore the scope of practice for a dental hygienist, varies by state. The following resources can be used to better understand the scope of practice for dental hygienists working in other states.

- Dental Hygiene Scope of Practice by State ADHA
- Dental Hygiene in Medical and Health Clinics ADHA
- State Specific Information on Silver Diamine Fluoride Application ADHA

WISCONSIN MEDICAID ACT 20 INTERPRETATION

1. **Can dental hygienists practice in a physician clinic where they would not be under the direct supervision of a dentist?**
    a. Yes. Act 20 of 2017 authorized this expanded practice setting and was codified in Wis. Stat. 447.06(2)(9) under "facilities that are primarily operated to provide outpatient medical services."

2. **Can physician offices bill Wisconsin Medicaid for dental hygienist services, if the hygienist is individually enrolled?**

a. Yes. Providers should refer to the online handbook and max fee schedule for coverage policies and limitations for each allowable service. In addition, some dental hygienist services must be billed on a dental claim form. The physician office will need to use that form in order for the claim to be processed correctly.

CONSIDERATIONS FOR INTEGRATING A DENTAL HYGIENIST INTO A RURAL HEALTH CENTER

1. **Can dental hygienists practice at a rural health clinic (RHC) where they would not be under the direct supervision of a dentist?**
    a. Yes. Act 20 of 2017 authorized this expanded practice setting and was codified in Wis. Stat. 447.06(2)(9) under "facilities that are primarily operated to provide outpatient medical services."
2. **Can dental services, performed by a hygienist, be included in the cost-settlement process for RHCs?**
    a. No. Dental services are not considered RHC services.
        i. Wisconsin DHS admin code: DHS 107.29
    b. Wisconsin Medicaid follows Medicare billing guidelines for RHC services.
    c. Medicare defines RHC visits as medically necessary, face-to-face medical, or mental health, visit, or a qualified preventive health visit, with an RHC practitioner during which time one or more RHC services are rendered. An RHC practitioner is a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker.
        i. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

3. **Can RHCs bill Wisconsin Medicaid for dental hygienist services, if the hygienist is individually enrolled, outside of the cost-settlement process?**
    a. Yes. Providers should refer to the online handbook and max fee schedule for coverage policies and limitations for each allowable service. In addition, some dental hygienist services must be billed on a dental claim form. The RHC will need to use that form in order for the claim to be processed correctly.

DENTAL HYGIENSITS SKILL SET CONSIDERATIONS

When considering who you will hire as your dental hygienist, it is important to understand the differences between working in a traditional dental office vs. working in a MDI setting. Being part of a MDI team involves unique responsibilities that are often not part of a traditional dental hygiene job. Factors you should consider as you prepare a job description and conducting interviews include:

1. **Patient population characteristics:** (modified from CO-MDI Toolkit[2]) Age, language, culture, health literacy levels and patient barriers to care (transportation, higher degree of oral health needs, lower socioeconomic status, etc.).
2. **MDI dynamics:** (modified from CO-MDI Toolkit)
    a. Collaboration with medical staff to coordinate patients receiving dental hygiene services (e.g., warm hand-offs).
    b. Flexibility/mobility: Provide care in multiple locations (e.g., dental exam room, medical exam room, etc.).
    c. Self-support: Dental hygienists may sterilize their own instruments, coordinate equipment maintenance as needed, turn over room between patients and complete their own charting/progress notes.
    d. Network: Build and maintain relationships with local dentists in order to coordinate follow up/restorative care.
    e. Marketing/education: Aid in educating and recruiting patients to receive dental hygiene services.
    f. Billing: Base knowledge of dental CDT codes and frequencies.

g. Health literacy: Educate patients at an appropriate health literacy level. Aid with the education of colleagues as needed on oral health topics.
h. Administrative tasks: Aid with scheduling, insurance verification, use of medical/dental electronics records, supply and consumable ordering and maintaining compliance with Occupational Safety and Health Administration (OSHA) and other regulations and updating Safety Data Sheets.
i. Budgeting: Work within the budgeting restraints as applicable.
j. Care coordination: Assist in addressing barriers to care by facilitating referrals for dental follow up care and establishing dental homes for patients seen for MDI visits.

3. **Personal characteristics:**
    a. Pioneer: Willingness to work in a new environment.
    b. Creative, able to think outside the box, takes initiative, innovative thinker and problem solver.
    c. A continual learner who communicates across professional disciplines and utilizes quality improvement work.
    d. Cultural competency: Exemplifies cultural sensitivity and responsiveness in patient/provider interactions.

WI-MDI DENTAL HYGIENIST POSITION SAMPLE JOB DESCRIPTION

We are seeking a self-motivated and innovative **medical dental integrated dental hygienist** for approximately 32 hours per week/four days per week, to join our medical care team to provide oral health services during patient well-visits. We believe oral health and general health should not be addressed as separate entities. Therefore, this collaborative approach of integrating a dental hygienist into a medical team helps bridge access to care barriers, is prevention focused and brings dental care directly to patients while they're already at a pediatrician appointment. <Add clinic-specific patient population information here-age range/children/pregnant women etc.>
We are looking for a flexible self-starter who understands the value of early prevention and intervention in dental care, desires to make a difference in our community and is passionate about educating patients and their families. The ideal candidate should be cognizant of the public health, social and economic factors that impact overall health and the oral health of their patients. Additionally, the candidate must be able to creatively and proactively work across health care disciplines and in flexible settings as a pioneer to this new collaborative approach of providing dental hygiene care within medical visits.

EXPECTED DUTIES AND KNOWLEDGE

- Provide high-quality dental hygiene clinical services within Wisconsin's allowable scope of dental hygiene practice with portable dental equipment.
- Accurately and appropriately assess caries risk to implement prevention focused care, and when necessary, coordinate follow-up restorative care with community dentists while acting as an advocate for patients.
- Collaborate with medical staff to coordinate patients receiving dental hygiene services during well-visits.
- Possess flexibility and mobility to provide care in multiple, non-traditional locations (e.g., medical exam room, knee to knee exams). Ability to work in a fast-paced environment.
- Capable of providing self-support. Willingness to complete sterilization procedures, coordinate equipment maintenance as needed, turn over rooms between patients and complete proper charting/progress notes.
- Network – build and maintain relationships with local dentists in order to coordinate follow up/restorative care and to establish a dental home.
- Educate patients and families at appropriate health literacy levels to obtain/maintain oral health and recruit patients to receive dental hygiene services via marketing efforts.
- Billing – base knowledge of dental CDT codes and frequencies.

- Administrative tasks – aid in scheduling, insurance verification, use of medical/dental electronic records, supply and consumable ordering, maintain compliance with OSHA and other regulations and maintain updated SDS sheets.
- Work within the budgeting restraints, as applicable.

REQUIREMENTS/ LICENSURE/ CERTIFICATIONS

Required Credentials:

- Graduation from an accredited school of Dental Hygiene.
- Basic Life Support (BLS) provider credentialed from the American Heart Association (AHA).
- Dental hygienist licensed by The Wisconsin Dentistry Examining Board obtained prior to hire date.
- Professional malpractice insurance obtainable.

Required Qualifications:

- Have at least two years or 3,200 hours of active practice experience as a licensed dental hygienist.
- Experience in public health, mobile dentistry, serving underserved populations or similar settings.
- Experience working in pediatric dentistry.

Preferred Qualifications:

- Bilingual
- Excellent interpersonal and written communication skills.
- Leadership experience.
- Experience in quality improvement work and/or health care collaborative.

BENEFITS/CAREER DEVELOPMENT

- **<Add clinic/position specifics/answer- answer why join our team>**

INTERVIEWING TIPS

Examples of interview questions for MDI dental hygienists (CO-MDI Toolkit[2]):

1. Share an example of when you had to be flexible with your work routine and how you handled it.
2. Describe a time you had to do something you hadn't done before at work and how you handled this challenge.
3. What previous experience do you have with striving to change the behavior of patients and their families? Were you successful? What would you change about your previous approach to make it more effective?
4. What experience do you have working with families from diverse backgrounds and experiences? What have you learned from these experiences?
5. Describe your previous experience working with children in the dental field. What level of dental disease have you seen in working with children?
6. What previous experience do you have with placing dental sealants? Have you used Silver diamine fluoride?
7. What dental anticipatory guidance would you provide to a parent or guardian of a 1-year-old who presents with decalcification on his/her upper front teeth?
8. What challenges do you anticipate in working with medical providers and how would you approach overcoming these challenges?
9. What interests you about public health? Why are you interested in this non-traditional dental hygiene position?
10. What motivates you?

(For other example interview questions view the following link: Sample RDH Interview Questions.)

TIPS FOR INCORPORATING A DENTAL HYGIENIST INTO THE MEDICAL CARE TEAM

Consider a launch meeting or lunch-and-learn to increase staff buy-in and participation by walking them through the following MDI roll out:

- Review the clinic's vision for integration and describe the reasons and motivation behind pursuing these efforts.
- Describe the expectations for the dental hygienists, the value of the services they will provide to patients/families and the prevention expertise they bring to the medical team.
- Provide oral health education to medical staff to create a foundation of dental knowledge and understanding. Consider utilizing the dental hygienist to help teach this content, or at no cost national oral health curriculums created for health professionals (e.g., Smiles for Life).
- Discuss methods for bidirectional support between the dental hygienists and medical team. It is important to make your dental hygienist an equal member of your medical team. Be certain to include the dental hygienist in staff meetings, celebrations, and events. Add the dental hygienist's photo to locations where other clinicians' photos are displayed in your waiting room and on your website.

DENTAL INFECTION CONTROL, EQUIPMENT AND SUPPLIES

COMPLYING WITH STATE AND FEDERAL REGULATIONS

When adding dental services to your medical practice, it is vital to comply with state and federal regulations for patient and provider safety and for infection control protocols. This is not intended as legal advice and consulting with an attorney prior to engaging in any regulated activity, including the practice of dental hygiene, is guided by the discretion of individual health systems.

The following resources can be useful in implementing, and maintaining, proper infection control protocols:

- *CDC Infection Control Check List*
- *Infection control checklist- portable equipment programs (OSAP)*
- *OSAP Site Assessment Worksheet (portable equipment and mobile vans)*
- *Follow The Centers for Disease Control and Prevention *COVID-19 Infection Prevention and Control Guidelines for the Healthcare Setting*

SUPPLIES

The following list of supplies outlines what will be needed to initially implement the integrated WI-MDI model at your medical clinic. These supplies will allow the hygienist to provide prevention services directly in the exam room as part of the well-child visit workflow. Initial prevention services include, but are not limited to: patient assessment, screenings, fluoride varnish, silver diamine fluoride if indicated and caregiver/patient anticipatory guidance and care coordination.

National dental vendor contact information and fluoride varnish product list-DentaQuest

(*Note picture below courtesy of Sixteenth Street Community Health Center: sample portable caddy for room to room transfer of supplies.)

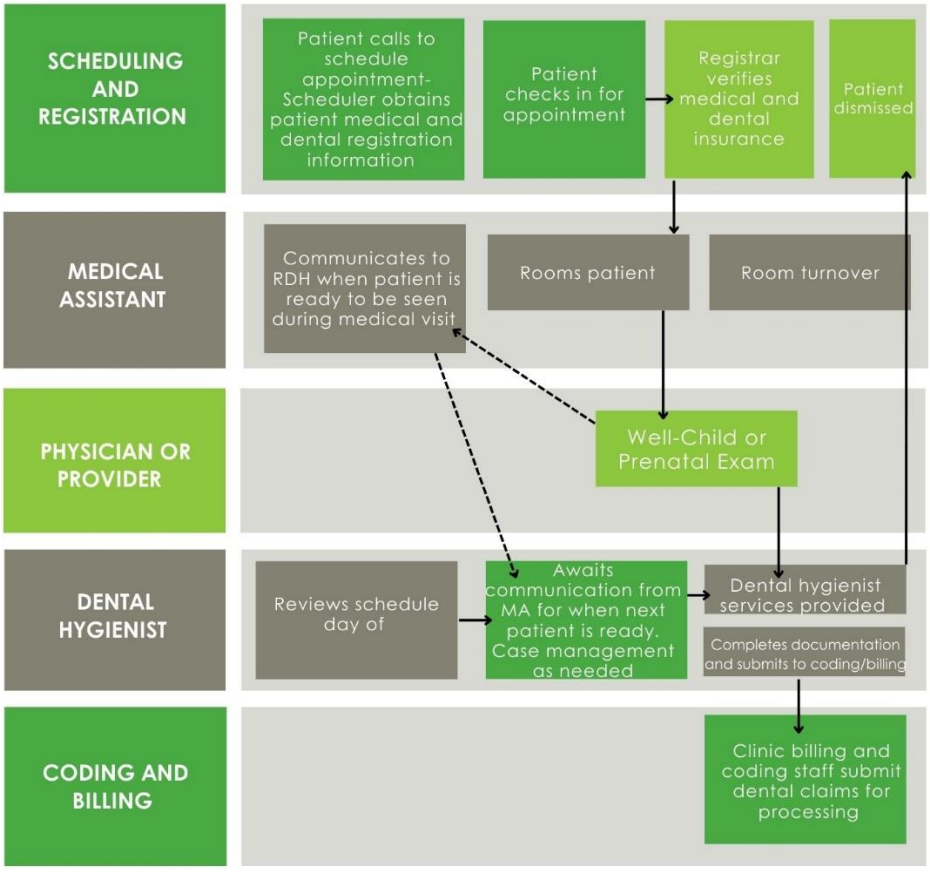
Supplies Checklist

- [ ] Fluoride varnish and applicators
- [ ] Sterilization wipes/supplies
- [ ] Silver diamine fluoride, applicators, tray and consent forms
- [ ] Disposable mouth mirrors
- [ ] Supply caddy (pictured to the right)
- [ ] Gauze
- [ ] Homecare supplies (toothbrushes,floss, paste etc.)
- [ ] Headlight/loupes (optional)
- [ ] Educational materials as needed
- [ ] Personal protective equipment

INTEGRATED DENTAL HYGIENIST CLINICAL WORKFLOW

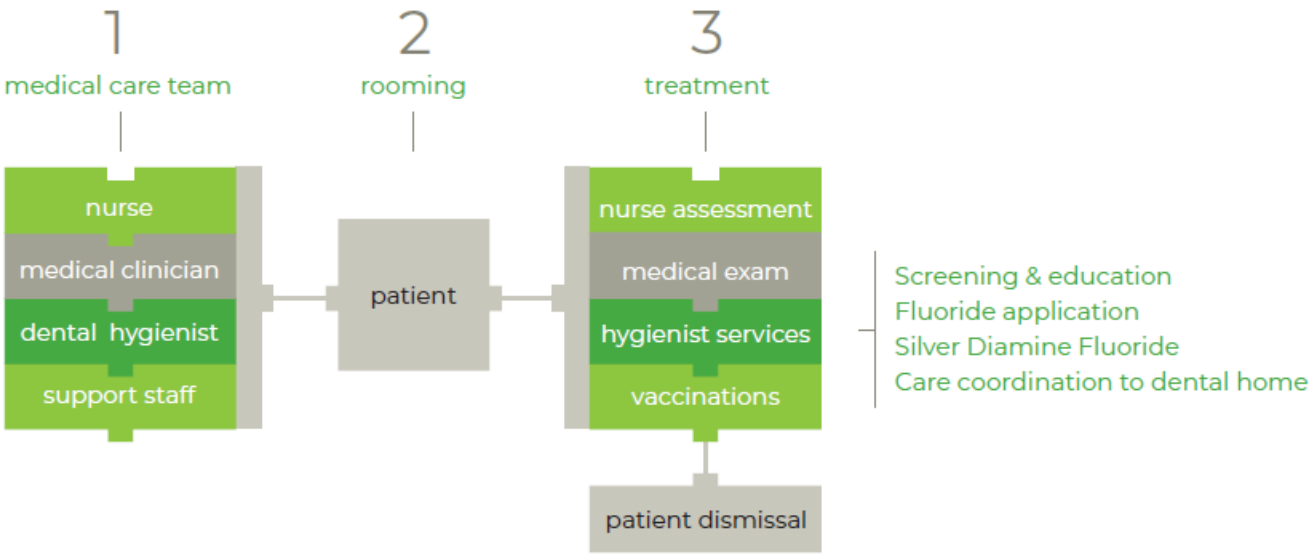
WORKFLOW ACROSS DEPARTMENTS

Incorporating a dental hygienist into the medical team will require systems change across all areas of the care process including, but not limited to: scheduling, registration, clinical workflow and revenue cycle. The following swim lane diagram exemplifies modifications made across departments in order to incorporate the role of a dental hygienst into the medical team. Sample cross department process map:



WI-MDI MODEL

Integrating a dental hygienist into the medical care team is a system change that is possible due to the passage of Wisconsin Act 20 as of June 2017. The WI-MDI model encourages that the dental hygienist be a full-time member of the medical team and employed by the given health system. Care by a dental hygienist will be incorporated into the well-child or prenatal care visit work flow, typically at the end of the appointment before immunizations, for a time frame of 5-10 minutes. During this time, the dental hygienist will provide a screening, education/anticipatory guidance, fluoride, silver diamine fluoride if indicated, and referral to a dental home for follow-up care as needed. For clinics with high patient volumes, the workflow has benefited from the addition of a dental assistant to support tasks such as scheduling, documentation, case management, etc.



PROCESS FUNDAMENTALS

1. Establish a baseline understanding of oral health and disease for medical staff (see *Resources to Support Patient and Family Oral Health Education section for available trainings and continuing education*).
2. Determine, with input from all involved team members, approaches to integrate dental hygienists into existing workflow and test changes prior to full implementation.
3. Scheduling:
    a. Begin by "scrubbing" physicians' schedules two days prior and creating appointments for patients who will most likely receive dental services within the dental hygienist's schedule.
    b. Note: Additional patients can be added to the dental hygienist's schedule same day as needed.
4. Establish a means of communication to notify the dental hygienist when there is an ideal open slot during the well-visit for providing dental services. Possible options include an instant messaging feature, exam room flags, exam room lights, etc. The timing of dental hygienist's portion of appointment can vary based on many variables, such as the need for immunizations, if the physician is on schedule, if there are multiple siblings in one exam room, etc.

Often the MAs are considered "traffic controllers" in this process to indicate where the hygienist is needed next, and are key to maintaining an efficient flow throughout the day. Although increased cycle time is a common concern among medical clinicians when considering MDI, those clinics implementing the model have found there is little change to the cycle time with the addition of the dental hygienist to the appointment workflow.

5. Dental hygienist workflow:


DENTAL HYGIENE CARE WORKFLOW WITHIN PRIMARY CARE APPOINTMENT
TIMEFRAME: 10 MINUTES
PRE DENTAL HYGIENE CARE
• Medical appointment is scheduled and family is made aware of the opportunity for dental hygiene care during routine appointment
• Hygienist reviews schedule for eligible patients day prior and day of
• Patient checks in and medical and dental insurance are verified
• Patient roomed, medical provider exam occurs, dental hygienist care introduced by medical assistant or provider
1
INITIATE DENTAL HYGIENE CARE
• Greet patient/family
• Introduce self and role
• Medical provider may share relevant information and conduct warm hand off
ASSESSMENT
• Verbal assessment of risk and protective factors
• Clinical dental hygiene assessment
2
3
DOCUMENT FINDINGS
• Document findings during appointment and post appointment if needed
• Determine need for follow up care
PATIENT AND FAMILY ANTICAPATORY GUIDANCE
• Based on determined risk provide patient specific education
• Establish self-management goal
• Answer any related questions
4
5
PROVIDE PREVENTIVE/INTERVENTION CARE
• Based off of determined risk, apply fluoride varnish
• Apply silver diamine fluoride, if indicated
CONCLUDE ORAL CARE PORTION OF APPOINTMENT
• If appropriate-handoff back to medical team member (e. g. if immunizations need to be administered)
• Or dismissal of patient
6
7
POST APPOINTMENT
• Provide post appointment care coordination
• If dental assistant is part of the team, they also support care coordination efforts
• Submit charges to coding/billing

OTHER TOOLS TO SUPPORT WORKFLOW AND IMPLEMENTATION OF VARYING DEGREES OF ORAL HEALTH INTEGRATION

1. Motivational Interviewing: *Motivational Interviewing for the Dental Hygienist-Dimensions of Dental Hygiene*
2. Inter-professional collaboration and consultation opportunities from systems implementing similar models and approaches.
3. American Academy of Pediatrics (AAP) Prevention Primer was created to help health professionals address oral health in practice, understand the roles of oral health allies and learn how to collaborate and advocate to achieve optimal oral health for their community to prevent disease before it starts.
4. Integration of oral health and primary care practice – U.S. Department of Health and Human Services health resources and services administration guide and framework for interprofessional practice mode to integrate oral health and primary care: https://www.hrsa.gov/sites/default/files/hrsa/oral-health/integration-oral-health.pdf

RESOURCES TO SUPPORT PATIENT AND FAMILY ORAL HEALTH EDUCATION

A. Health systems and centers that have enrolled in the WI-MDI project learning collaborative (2019-2022) received the following educational materials. These items helped support anticipatory guidance and dental education conversations with patients, families and caregivers:
   a. American Academy of Pediatrics: A Pediatric Guide to Children's Oral Health- Flip Chart and Reference Guide (can request additional copies for multiple rooms)
   b. Books: "Brush, Brush, Brush" and "If the Dentist were an Animal"
   c. Bright Futures Oral Health Pocket Guide
   d. Educational dental typodont
   e. Infant, child and adult toothbrushes
   f. Self-management goal magnets- English/Spanish
   g. Tap Into Healthy Teeth Community Water Fluoridation Toolkit
   h. Tooth puppet/toothbrush

B. AAP Oral Health Kit: contains oral health materials for both patient outreach and education to assist with integrating oral health into your practice (printable and in multiple languages).

The AAP Oral Health Toolkit includes: waiting room posters, infographics, brochures, dental referral forms, conversation guide, oral health screening and integration workflow.

C. The National Maternal and Child Oral Health Resource Center provides high-quality oral health technical assistance, training and resources.

MAINTAINING AN ENVIRONMENT OF IMPROVEMENT

In alignment with the IHI Breakthrough Series Model,[1] maintaining a team approach and mindset of continuous quality improvement is instrumental to the success of integrating a dental hygienist into the medical team. One quality improvement method that can be utilized to test changes is a four step problem solving approach called the Plan-Do-Study-Act (PDSA) cycle. Testing changes on a smaller scale using PDSA cycles help to determine the effectiveness of a change prior to scale implementation. This approach allows for input from all involved team members, increases acceptance of eventual changes and keeps the team connected and informed. To learn more about how to incorporate quality improvement methods into your project progress please visit: Open School Course from the Dental Quality Alliance .

ESTABLISHING A DENTAL REFRRAL NETWORK

MDI TEAMS BUILDING RELATIONSHIPS WITH DENTISTS AS REFERRAL SOURCES

Health systems without sufficient internal dental clinics will need to develop referral relationships with external dental practices. Ideally these referrals will be completed in a timely fashion, be bidirectional, and include an accurate transfer of findings. Steps and tools that can assist with this relationship building include, but are not limited to:

- Initially meeting face-to-face to introduce the project and explain why a successful referral relationship is vital. Explain the patient dental need that exists within your medical practice and the limited options of referral sources. This first meeting will help establish a working relationship, goals and strategies to collectively achieve them.
- Consider having a physician accompany the dental hygienist for the initial meeting with potential referral sources.
- Consider bringing breakfast or lunch to assist with the ease and success of initial introductions.
- Share referral tools that will assist with making the referral process effective and efficient.
    - Encrypted emails and confidential faxes
    - Example encrypted referral form for restorative care- CO-MDI
    - Example referral form for restorative care- From the First Tooth CO
    - Prenatal medical-dental referral form-AAP
- Plan to meet with referral sources on a regular basis to ensure open communication, creating room for improvement.
- When possible, establish a referral base with both general dentists and dental specialists, to best address the needs of your patient population (pediatric dentists, oral surgeons, etc.).

QUESTIONS AND INFORMATION TO DISCUSS DURING INITIAL REFFERAL ESTABLISHMENT MEETING

- Number of anticipated referrals to a dental office or community health center.
- Determine the capacity limitations of dental referral partners for new patients.
- Disease level range seen in the patient population.
- Comfort level/capacity of dental office to treat specific age groups:
    - Dental home for 1-year-old children
    - Early childhood caries
    - Pediatrics up to 18 years old

        - Pregnant women
- Determine the insurances accepted by the dental office.
- Establish the main contacts from each side of the referral:
    - Discuss the desire to establish a closed referral loop/bidirectional referral system.
    - Consider creating a "treatment report" form to be sent back to the medical office after treatment is complete to close the referral loop.
- Establish information exchange methodologies to ensure the referral process is Health Insurance Portability and Accountability Act (HIPAA) compliant:
    - Determine what type of referral form will be used.
    - Determine what information the referral form will contain.
        - Consider if a limited medical history will be included with the referral.
            - Patient problem list including medical concerns and major medical history.
            - Patient allergies.
            - Patient medication list.
            - Medical specialists the patient sees and contact information (e.g., ENT, Cardiology, Neurology).
- Discuss scheduling workflow options:
    - The dental clinic receives patient contact information and calls patient to schedule.
    - The dental hygienist/dental assistant from the medical team calls to schedule the appointment with dental office while the patient/parent are still present at the medical appointment.
    - The patient/caregiver is given phone number to call the dental office to schedule an appointment (risk of higher no-show rate or non-compliance/underutilization of dental services with this method).
- Discuss the average timeline for scheduling a new patient/preventative visit.
- Discuss the best process for emergency scheduling and treatment:
    - Consider a teledentistry consult to triage if possible.

HEALTH SYSTEMS WITH INTERNAL DENTAL CLINIC

Some organizations may already have a dentist/dental care team as part of their health systems. Having both medical and dental practitioners in the same health system will increase the success of internal referrals through increased coordination and potentially integrated electronic health records. This valuable resource can add to the success of medical dental integration by:

- Involving the dental team in the planning of a coordinated referral system.
- The dentist can provide direct or indirect supervision as necessary if the dental hygienist expands services.
- The dentist could serve as the billing provider for the dental hygienist.
- Utilizing the dental team for follow up care and as a dental home.

SAMPLE REFERRAL FORMS

- Example Referral Form for Restorative Care- From the First Tooth Maine
- Example Encrypted Referral Form for Restorative Care- Colorado Medical Dental Integration (CO-MDI)

FACTORS TO CONSIDER FOR MDI WITHIN YOUR OWN STATE

1. IDENTIFY DISPARITIES AND ACCESS ISSUES IN YOUR COMMUNITY/STATE

- **Conduct a needs assessment:**
  - Consider the target population, services needed vs. able to be provided, care coordination and educational strengths vs. needs.
  - Assess who is experiencing gaps in dental care or carrying the greatest burden of dental disease.
  - Identify which dental service options exist and where additional resources are needed (brick and mortar clinics, but also mobile and community sites (e.g., hospitals, home visitors, primary care, nursing homes, and schools).
- **Potential data sources:**
  - Form CMS 416 Early and Periodic Screening, Diagnostic, and Treatment
  - ED visits, Medicaid, fluoridated water systems, etc.
  - Environmental Public Health Tracking: Oral Health Module
  - Local DHS: Oral Health Program
  - Local school-based oral health programs
  - Mandatory school oral health screenings, etc.
  - National Oral Health Data Portal
  - PRAMS
  - Workforce, burden of oral disease, Head Start, youth, adult, and older adult oral health screenings

2. UNDERSTAND YOUR STATE'S CURRENT SCOPE OF PRACTICE FOR DENTAL HYGIENISTS

- Dental Hygiene Scope of Practice
- Dental Hygiene in Medical Settings and Health Clinics
- State Specific Information on Silver Diamine Fluoride

3. EXPLORE EXISTING RESOURCES LOCALLY, REGIONALLY, AND NATIONALLY.

- Identify individuals and groups already engaged in this work:
  - DHS oral health program
  - Local (state) chapter of the American Dental Hygienists' Association
  - Medical schools and residency programs
  - Partners, mentors, and advisors
  - State and local oral health coalitions
  - State dental director

4. DEVELOP AND IMPLEMENT YOUR PLAN WITH PARTNERS

- What type of intervention or systems change could address your identified community needs?
- Where do gaps and opportunities for integration exist? Possible locations or access points?
- What is possible in your state as a dental hygienist?
- Is further advocacy needed first?
- Is further education needed first for dental or medical?
- Identify hygienists with an adaptable dental hygienist skill set.
- Evaluation planning incorporated from the beginning.
- Consider funding opportunities.

Future opportunity:

Want to begin integration in your health system for your community?

To meet the dental needs of our communities - dental and other health care professionals must continue to work together to provide integrated care in a variety of settings to aid in reducing and eliminating social, economic, and other systemic inequities that affect oral health and access to care.

Consider:

As a medical team adding basic oral health assessments, fluoride and care coordination to your patient care

Incorporating minimally invasive approaches to dental and medical visits

As a medical team adding chronic disease screenings to your patient care

The option of adding dental hygienists to medical teams in your community to create additional dental access points

CONTACT US

Wisconsin Medical Dental Integration:

https://www.chawisconsin.org/initiatives/oral-health/wisconsin-medical-dental-integration/

To learn more about how you can join medical dental integration efforts contact:

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Oral Health
Children's Health Alliance of Wisconsin

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