

# MEDICAL – DENTAL INTEGRATION TOOLKIT



**Florida Institute for  
Health Innovation**

RESULTS-ORIENTED. RESPONSIVE. DATA-DRIVEN.

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## 1. Medical Dental Integration

### *1.1 What is Medical Dental Integration?*

Medical-dental integration (MDI) is a concept that describes the integration of preventive and basic oral health services into primary care settings. Also known as Interprofessional Practice (IPP). Through this integration, primary care providers and dental professionals can address some of the main barriers faced in accessing, especially preventive, oral health services including transportation, costs, limited providers, time constraints, and long office wait times. The Institute's work has focused on integrating these services for pediatric practices, specifically for children aged 0-6, who are enrolled in Medicaid though children up to 17 with various types of insurance were also eligible to receive the same services. The goal of focusing on this age range and pediatric practices is for dental professionals, such as dental hygienists, to reach children at a much younger age with preventive oral health services and to establish a dental home sooner should the child need more extensive dental care. Utilizing a dental hygienist to lead these services relieves pediatricians and their office staff, who do not have trained oral health experts, of additional work. By offering an oral health specialist on-site, the health care system can reduce the burden of oral health disease by creating more points of contact for preventive services, oral health education for families and connecting children who need more extensive care to dental homes.

### *1.2 Why is oral health important for young children?*

Oral health is essential to a person's overall health, well-being, and dignity, yet dental caries affect [one-half of children](#) by the time they have reached the ages of 6 to 8 years. Good oral health affects children's (and adults') physical ability to speak, smile, smell, taste, touch, chew, and swallow. [Studies have found](#) that if individuals have difficulty accessing care, oral health issues can manifest as short-term maladies such as tooth pain, or in long-term conditions like heart disease or diabetes; evidence shows these impacts may affect the social, economic, and health development of children. What's more, in 2013, the United States spent [\\$26.9 billion](#) on child and adolescent oral health. This exceeds combined expenditures on asthma, upper respiratory tract infections, other infectious diseases, and anxiety.

Approximately 66.7 million Americans do not have [dental coverage](#) and many are less likely to use preventive dental services due to out-of-pocket costs. Oral pain inhibits a child's well-being and confidence, and evidence shows it can greatly affect their scholastic outcomes; oral pain is also a leading cause of chronic [school absenteeism](#) for young students. Among school-age children, tooth decay is the most common chronic disease and is five times more

prevalent than asthma. Children between 5 and 17 years miss nearly two million [school days](#) in a single year nationwide due to dental health-related problems. Dental caries, or cavities, have remained the most common chronic disease of children age 6-11 and 12-19 since the [Surgeon General's](#) first-ever report on Oral Health in America detailed the link between oral health and overall health in 2000.

### *1.3 Why is MDI a solution for Florida?*

In 2011, only 23% of children aged 0-20 whose families were eligible for Medicaid received dental services, nearly half as much as the nation's under-21 Medicaid population at the time. Additionally, only 14% of children aged 1-20 received preventative services in 2011, approximately one-third of the then-national average. Tangible progress has been made since then, with the percentage of Medicaid-eligible children seeking dental services increasing by 15% and those receiving preventative services [increasing by 23%](#) as of 2019. Efforts have also been made to increase Floridian's access to fluoridated water, a low-cost and widely recognized means of strengthening teeth and reducing the incidence of cavities. As of 2018, [77.4% of Florida's population](#) received fluoridated water from community water systems, continuing a modest upward trend for the state. Despite these positive strides, the current system of health care, including oral health, perpetuates poor outcomes.

[Florida is ranked](#) 43rd out of all 50 states in overall oral health wellness, 49th for the number of children with a dentist visit, and 48th for worst oral health condition. Florida's Medicaid-eligible population is particularly vulnerable to oral health disparities and has a history of low rates of access and utilization of dental care and preventive oral health services. Approximately [40.4% of 0-18 years old Florida's children](#) receive healthcare services through Medicaid. The percentage of Medicaid-eligible children ages 0-20 receiving dental services and preventative services has stagnated over the past four fiscal years. Florida remains 9% behind the [national average](#) for preventive dental services and 8% behind for any dental services. According to a [recent survey](#) of third grade students from 42 Florida elementary schools, 45.5% had experienced caries, 25.1% had untreated decay, 20.6% needed early care and 3.0% needed urgent care. Furthermore, only [29.7% of Florida dentists](#) currently participate in Medicaid or the Children's Health Insurance Program (CHIP), ranking Florida 44th in the nation. The Florida's [KidCare Evaluation](#) Final Report revealed that only 31.8% of 6-9-year-old children at elevated caries risk received dental sealants in CY 2019.

Legislation meant to tackle these challenges remain comparatively limited. Florida has limited scope-of-practice laws that adversely impact the number of mid-level dental professionals who can provide care in health access settings. State level limitations on

progressive dental policy impact the most vulnerable populations. As one focus group participant in our Oral Health Consumer Engagement research study responded, “Even if you have Medicaid not all doctors accept it. I have [a provider] and it hasn’t been stable. It has taken a long time to find a dentist.”

As research suggests, a combination of individual efforts (like consumer engagement education), institutional efforts (like supporting Medicaid-eligible families to access preventative dental services), and public health efforts (like community water fluoridation) are all necessary to prevent dental caries in children as well as avert the long-term costs of neglectful health care. While measuring the short and long-term impacts of (1) individual efforts; (2) institutional efforts; and (3) public health efforts is difficult, it is of great necessity to move forward with designing cost-effective policies that reach our most vulnerable children and their access to preventative dental health care.

## **2. Locations for MDI Practices**

### *2.1 MDI Works in Many Settings*

Medical Dental Integration works in many settings and for a variety of reasons. Having dental care available to vulnerable populations or populations with limited access will improve the overall health of children and adults through increased access to preventive services, education, and screenings. The following are some areas where integration will thrive.

*2.1.1 Federally Qualified Health Centers (FQHC):* Community Health Centers care for low-income, uninsured, and underserved populations and have led the way in developing and adopting innovative models of integration to meet patients’ complex needs. Community Health Centers are a safety net provider that serve populations at the greatest risk for poor oral health outcomes. A model at the Wayne Memorial Community Health Center in PA integrates primary care and oral health services to provide coordinated care. Success stories from the clinic highlight improved care. In one example, the primary care physician asked the dental staff to assess a diabetic patient who was complaining of a toothache and had been unable to eat for several days. The oral health exam revealed serious tooth decay. The staff worked together to schedule a same day appointment with the dentist on staff. The Oral Health Workforce Research Center at the Center of Health Workforce Studies at the University at Albany’s School of Public Health provides several excellent examples of [integrated health services](#) delivery models at various FQHCs from across the nation.

2.1.2 *Not-for-Profit Clinics:* Not-for-profit clinics that are designed to reach underserved populations are especially well suited for Medical Dental Integration. [Free and Charitable Clinics](#) are safety-net health care organizations that utilize a volunteer/staff model to provide a range of medical, dental, pharmacy, vision and/or behavioral health services to economically disadvantaged individuals. Such clinics are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization. Using existing, innovative outreach practices and community connections, not-for-profit clinics can ensure comprehensive medical and oral health care. Many of these clinics are funded by philanthropies, religious organizations, and local grant makers. They fund efforts in workforce development, access, pilot projects and research to improve health in communities and target populations.

2.1.3 *Medical Clinics:* Medical clinics in the US may be privately operated by employers, governments, hospitals, or outside organizations, or be publicly funded and managed. Medical clinics focus primarily on the care of outpatients and typically cover preventive and primary healthcare needs of local communities, leaving major surgical and pre- and post-operative care to larger facilities such as hospitals. Having accessible dental care in medical clinics will make it easier and more likely for patients to have integrated care. Through collaboration with dental hygienists and dentists, treating physicians can help guide and control diseases that may manifest as oral conditions, and subsequently oral conditions that may enhance systemic complications. For example, sharing the electronic health records between medical and dental providers has enabled [Kaiser Permanente](#) to work towards closing the gaps in dental and medical care. Having patients' medical/dental information in front of the physicians/dentists during the appointment allows the providers to encourage patients to schedule preventive care or follow-up with their medical/dental team. Efforts to integrate primary and oral health care can be observed in various public settings where Medical Dental Integration models target more than one risk factor to reduce health disparities and improve cost-effectiveness via [coordinated primary prevention](#) of oral and systemic diseases.

2.1.4 *Hospitals:* Hospitals are typically classified as general, specialty, or government depending on the source of income received and they are usually funded by the public sector, health insurance companies, or charities. As they are larger facilities that have the capability of providing patient treatment with specialized medical and nursing staff and equipment, they are usually distinguished by their ability to admit and care for inpatients. Many patients are not given guidance or resources to

maintain oral health when admitted, and nursing staff does not have time and a full scope of oral health knowledge to provide prophylactic care. Reducing the number of bacteria in the oral cavity may delay or eliminate further complications. Examples of this type of integration within a hospital setting can be seen with a variety of conditions. For example, an [intervention](#) at a tertiary-care medical center in Boston, Massachusetts, integrated a dental hygienist into the care teams of hospitalized patients with type 2 diabetes mellitus. As a results, patient and provider positive perceptions of the oral health care were identified as a contribution to overall care.

2.1.5 *Worksites, Nursing Homes, and Medicare Advantage Clinics:* Many individuals cannot take time off work to receive oral health care. Mobile dental practices such as [Onsite Dental](#) provide unique, innovative alternatives to accessing quality dentistry by collaborating with corporate offices to provide in-network dental services and teams on-site, eliminating barriers to access. Alternatives such as this can be considered in settings such as Adult Living Facilities or skilled nursing homes, as the elderly inhabiting these locations often have decreased mobility, as well as motor and cognitive skills that inhibit proper oral maintenance. Another setting this may considered is in Medicare Advantage Clinics; Medicare Advantage is a type of health insurance plan that provides Medicare benefits through a private-sector insurer. Within this framework, it would be in the provider's best interest to cover the cost of the dental services for their patients, as it's important that patients maintain their overall health and well-being. Collaborations with on-site, in-network dental clinics may provide major benefits.

### **3. Integrating Medical and Oral Health Services**

#### **3.1 Operations**

There are several steps that must occur prior to beginning a medical-dental integration project. It is critical that a practice assessment is conducted at the practice site to ensure project viability. During this assessment, the goals, values, and objectives of the medical-dental integration project must be explained and thoroughly communicated to the practice site and a discussion should take place that focuses on the current capacity and readiness of the practice to undergo such an integration. The assessment will include practice observation and process mapping to determine how the practice operates on a typical day-to-day schedule and where the hygienist and oral health services can best be integrated into the daily practice operations. Basic practice demographics and statistics, referral processes,

staffing structure, electronic medical record system capacity, and staff engagement and flexibility should be discussed during this time as well.

Medical-dental integration policies, procedures, and protocols should be developed in collaboration with the practice site to guarantee they are specific to and in compliance with the partner practice site. Ample time should be allocated for staff training prior to project launch to ensure that all team members are aware of and comfortable with the incorporated services, policies, and operational flow, in respect to their role.

### *3.2 Billing*

Billing and processing payment for oral health services requires basic knowledge of dental and medical scopes of practice and what services are billable. The following have been identified as key considerations for finance projections for integrating preventive oral health services into a primary care setting and should be considered in the early stages of integration.

- All medical practices bill either Fee for Service (FFS) or by encounter. FQHCs bill by encounter. In Florida, providers can bill for separate medical and dental encounters on the same day.
- Which dental procedures (CDT codes) can be provided in the clinic and how to get paid for them (this may vary by insurer).
- Insurer criteria for payment (e.g., documentation of high risk for caries for approval of >2 fluoride varnish applications/year).
- Which procedures need prior authorization (e.g., scaling and root planting).
- Consulting with insurers about policies and submission practices.
- Scheduling on-going service training for office staff and providers regarding best practices for billing.

### *3.3 Reimbursement*

Reimbursement for most MDI clinics comes from Medicaid or private insurance. Recent Medicaid reimbursement practices can be found in the Statewide Medicaid Dental Health Program guidelines.

- **Medicaid:** In 2016, the Florida Legislature directed the Agency for Health Care Administration to enroll most Medicaid recipients into dental plans.



→ **Private Insurers:** Each private insurer has its own process and rates for reimbursement. Contact each insurer individually to request this information. Additionally, some insurers will not pay for procedures performed by an independent dental hygienist, so be sure to confirm that dental hygienists can bill independently and receive reimbursement for services within the scope of dental hygiene practice.

### 3.4 MDI Model Budget Template

The Colorado Medical Dental Integration Toolkit offers a [budget template](#) that can be used for an integrated practice that exists in a medical office or dental office. It is also a guide for medical practices considering the integration of oral health services. It lists current codes for each setting. The template also provides guidance on reimbursement rates for CDT codes, eligibility criteria, and permitted frequencies. These details can change regularly, so it is best to confirm all details frequently.

### 3.5 Standard Framework for Levels of Integrated Medical – Dental Health Care

The following [adapted framework](#) details six levels of medical-dental integration on a continuum from coordinated, to co-located, to integrated care and allows for comprehensive measurement of integrated dental care in pediatric facilities. This framework will allow us to measure our progress against nationally recognized benchmarks which will allow for evaluation between other sites implementing similar initiatives.

Table 1: Standard Framework for Levels of Integrated Medical-Dental Health Care

Integration Levels	Integration Categories	Description - PCP: Primary Care Provider OHP: Oral Health Professional (hygienist)
Coordinated Care	Level 1 - Minimal Collaboration	<ul style="list-style-type: none"> <li>→ PCP and OHP work at separate facilities with separate systems.</li> <li>→ Providers rarely communicate.</li> <li>→ Any communication is typically related to a provider's need for specific information about a mutual patient.</li> </ul>
	Level 2 - Basic Collaboration at a Distance	<ul style="list-style-type: none"> <li>→ PCP and OHP work at separate facilities with separate systems.</li> <li>→ Providers view each other as resources and communicate periodically about shared patients.</li> </ul>

Co-Located Care	Level 3 - Basic Collaboration On-site	<ul style="list-style-type: none"> <li>→ PCP and OHP are co-located in the same facility but may or may not share the same practice space.</li> <li>→ Providers still use separate systems.</li> <li>→ Communication is more regular, with an occasional meeting to discuss shared patients.</li> <li>→ Movement of patients between practices is most often through a referral process. That process is more likely to be successful because the practices are in the same location.</li> <li>→ Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined.</li> <li>→ Most decisions about patient care are made by individual providers.</li> </ul>
	Level 4 - Close collaboration with Some System Integration	<ul style="list-style-type: none"> <li>→ PCP and OHP begin to collaborate more because they are co-located in the same practice space.</li> <li>→ Integration is beginning to take shape through some shared systems.</li> <li>→ A typical model may involve a PCP setting embedding a dental hygienist or dentist. In an embedded practice, the PCP front desk schedules all appointments, and the OHP has access and enters notes in the medical record.</li> <li>→ Complex patients often drive the need for consultation, which is done through personal communication</li> </ul>
Integrated Care	Level 5 - Close Collaboration Approaching an Integrated Practice	<ul style="list-style-type: none"> <li>→ There are high levels of collaboration and integration between PCP and OHP.</li> <li>→ Providers begin to function as a true team with frequent communication. The team actively seeks system solutions.</li> <li>→ Some issues, like the availability of an integrated medical and dental record, may not be easily resolved.</li> <li>→ Providers understand the different roles team members need to play and have started to change their practice and the structure of care to achieve goals</li> </ul>
	Level 6 - Full Collaboration in a Transformed/Merged Practice	<ul style="list-style-type: none"> <li>→ There are very high levels of collaboration and integration between PCP and OHP.</li> <li>→ Providers begin to function as a true team with regular personal communication. The team actively seeks</li> </ul>

		<p>system solutions.</p> <ul style="list-style-type: none"> <li>→ An integrated medical-dental health record exists for ready exchange of health information.</li> <li>→ Providers understand the different roles team members need to play, and they have started to change their practice and the structure of care to achieve goals.</li> </ul>
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#### **4. A step-by-step plan to implement and sustain a Medical-Dental Integration Pilot Site**

The average child, by law, will visit their pediatrician a minimum of twelve (12) times by the time he/she reaches 4 years old. In addition, a school physical is required in Florida, and most states, before a child can enter school each year. By increasing the number of preventive oral health services opportunities that the child has to receive, screening and education, families are provided with the opportunity to address childhood caries before the age of 6 in a setting that is familiar, convenient, and comfortable. Dental hygienists can operate within their scope of practice under Florida law to provide oral health screenings, fluoride varnish, anticipatory guidance, and other preventive services that do not involve diagnosis or treatment requiring supervision of a dentist as dictated by the Florida Board of Dentistry. It is important to identify scope of practice for both medical and dental professionals that are considered for an MDI pilot.

The Institute adapted a successful MDI model developed by Delta Dental of Colorado Foundation for the MDI pilot. The Institute’s pilot was divided into two phases: the planning phase and the implementation phase in 4 pilot sites.

##### ***4.1 Planning for Medical Dental Integration***

During the planning phase of the pilot, FIHI followed a series of steps that allowed for the proper integration of protocols necessary for the pilot launch. Initial steps included holding introductory planning meetings with the practice sites to understand their operational processes and procedures. Discussions were held to learn more about the practice’s motivation for embarking on a medical-dental integration pilot, as well as staff engagement, willingness, and capacity to handle the integration of new services. Ample time was dedicated to learning about the practice’s EHR system, its capacity to collect additional dental data or services, and its ability to pull data reports necessary for later analysis.

Additionally, during the planning phase, practice observation and process mapping was conducted at the pilot site to determine exact operational workflows and best practices for integrating the dental hygienist and preventive oral health services into the practice operation. These components allowed for furthered understanding of how the patient-interaction process evolves throughout a patient's appointment, including a detailed timeline of who the patient meets with, when, and for how long, etc. This helped to determine at exactly what time during the appointment the dental interaction would take place and how long it could last, in addition to when care coordination would happen between the pediatric office and the dental office (when necessary).

Practices and partner organizations undergoing a medical-dental integration pilot may consider hiring a practice operations or practice transformation consultant to assist in certain components of the planning and implementation phases. Assigning clearly defined deliverables for the consultant to manage can be beneficial for organizations that may be lacking in specific expertise. For example, FIHI hired a practice transformation consultant to assist with the MDI pilot who was responsible for managing staff training and financial planning and projections for the pilot. During the planning phase, it is recommended and encouraged to project very low utilization for the first three years of the pilot, and to anticipate quarterly staff re-training to ensure the entire team is kept up to date on their roles and procedures, while consistently addressing any barriers that may be impeding the integration of services.

*4.1.1 Dental Hygienist Scope of Practice in Florida 2020:* Florida dental hygienists may provide services in health access settings without the physical presence, prior examination, or authorization of a dentist, though the dental hygienist must maintain liability insurance. Currently, dental hygienists do not have prescriptive authority.

## ***4.2 Implementing Medical Dental Integration***

The Institute's first MDI pilot site was launched in November 2018 in partnership with a private pediatric medical practice. A dental equipment/material vendor was identified, and a list of dental providers in the area who had the capacity to facilitate dental referrals was provided to the practice. In collaboration with a Registered Dental Hygienist who worked for the dental equipment vendor, the practice transformation consultant conducted lunch trainings with all qualified healthcare professionals on staff at the medical practice to teach them how to properly set-up and apply fluoride varnish applications. All pediatricians, medical assistants, and registered nurses were required to attend and participate in the capacity-building training, even if they were not specifically responsible for applying the

fluoride varnish. Furthermore, a strategy was put in place to ensure the oral health data could be collected and reported in a seamless way throughout the pilot, which required coordination with both the practice's clinical coordinator and a contact from their Electronic Health Record service provider. The practice transformation consultant worked closely with the pediatric practice billing department to ensure their billing software had the correct reimbursement codes uploaded into their system's database for easy utilization. The pilot sites patient policies were reviewed and a policy and consent form explaining the fluoride varnish application and procedure was provided to the front desk coordinators of the practice, to be provided to patients and families at check-in.

To receive full reimbursement for the service of fluoride varnish application through Florida Medicaid, a qualified healthcare professional (i.e., a physician, physician assistant, advanced registered nurse practitioner) must be the one to administer the service; in the state of Florida, a dental hygienist administering the fluoride varnish application would not receive full reimbursement for the service. As such, FIHI adapted their MDI model to accommodate for the qualified healthcare professionals being the ones responsible for providing the fluoride varnish to ensure full reimbursement through Florida Medicaid. The consultant worked alongside the practice's clinical coordinator to ensure that this step was seamlessly integrated into their operational flow.

A job description for a Registered Dental Hygienist was posted to multiple job boards via national job search organizations such as Indeed and LinkedIn and through existing relationships with dental schools and associations in the area. Several interviews were held to identify the appropriate candidate. The Institute was responsible for screening the first round of candidates, and those that passed were required to attend an in-person interview with both the Institute and the medical practice to ensure best fit. It is important to note that the dental hygienist should embody several characteristics that will contribute to a successful pilot. Key characteristics include: being ready to adapt to and manage changing work environments and expectations; being flexible, in regard to their usual scope of work and patient schedule; familiarity with electronic health record systems; outstanding communication skills; competence in working in a medical setting other than a dental office; developing working relationships with other healthcare practitioners; ability to work independently and take initiative with troubleshooting problems as they arise; and interest and engagement in community public health and sincere interest in the outcome of integrating oral health care services into a medical setting.

In total, three in-person interviews were held prior to hiring a qualified dental hygienist. The dental hygienist's role is primarily to facilitate oral health education and anticipatory

guidance, oral health assessments, and dental referrals to previously identified dental practices that were within a certain radius of the medical practice and had the capacity to take on new, Medicaid-eligible patients. As the pilot progressed, the hygienist was responsible for quarterly data pulls to monitor the progress and quality of the pilot. The EHR being used by the practice site had the capacity to run data reports on two variables: dental referrals made and CPT Code 99188, which is the billing code used to report the application of topical fluoride varnish by a physician or other qualified health professional. Due to limited capabilities in the EHR's data reporting, the dental hygienist was responsible for doing a manual audit of patient charts to determine how many patients received an oral health screening in the past year, how many patients received anticipatory guidance and education in the past year, how many patients reported having an established dental home in the past year, how many patients reported attending a dental visit in the last year, and how many patients presented with no dental caries experience and untreated dental decay. Physicians were asked to discuss these questions while they were reviewing the patient's history and to document this data within the oral health data set of the patient's record.

4.2.1 *How to screen patients:* This model relies on all members of the primary care team to screen patients and identify those at risk of dental caries. Figure 1, as adapted from the Colorado model, breaks down how the primary care team will [assess patients](#). First, clerical and nursing staff will ask if patient has a dental provider, and if so, when was the last they saw this provider (Braun and Cusick, 2016).

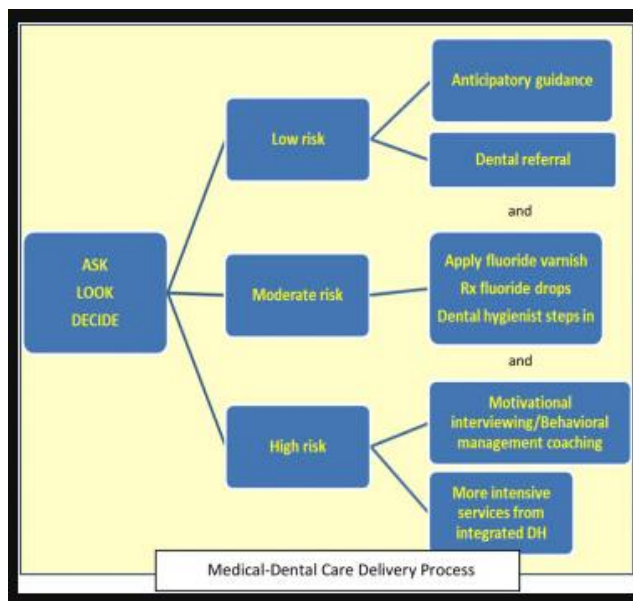


Figure 1: Flow chart of the Medical-Dental Care delivery process.

**4.2.2 Review and follow-up on denied dental claims:** Many times, rejected claims can still be paid. Usually there is a minor error that needs to be corrected and then the claim can be re-submitted. Make sure your billers understand that you expect them to follow-up on all denied claims, and that communication with the hygienist might be necessary to work out the issue. This will lead to more claims being successfully paid. If you have questions, you may contact the Professional Relations representative at the dental insurance company for additional guidance.

Make sure to routinely audit claims. Because there are multiple people (credentialing, hygienist, coders, billers, etc.), steps, and requirements to receive payment for services, there are also multiple opportunities for error. This can be assessed and assigned by the practice transformation consultant, if necessary. As you establish and implement new billing codes, procedures, and roles, develop an internal method to verify if what your hygienist says s/he is doing is being paid by the insurance provider. It is not uncommon to find discrepancies. Those discrepancies leave income on the table.

### **4.3 Sustaining Medical Dental Integration**

Embarking on a medical dental integration project takes a lot of engagement, time, and resources. Be sure to support your partner clinics in reaching their identified goals as best you can. It can be helpful to discuss and describe both organizations' common vision for their MDI role to ensure all partners are on the same page. Coach your practice in building integrated care models and share success stories.

- Use clinic-level metrics in coaching and with decision makers.
- Educate partners on financial metrics used to achieve sustainability.
- Discuss short term, intermediate, and long-term strategic plan and budget.

**4.3.1 Stay up to date on changes:** One of the hardest things about coding and billing, particularly for Medicaid, is keeping up to date on changes to the codes, criteria, documentation requirements, and frequencies allowed. Your hygienist and billers should check the Medicaid ORM on a regular basis. S/he should also check with other insurers occasionally to remain informed of changes.

#### *4.4 Challenges for Medical Dental Integration*

Merging dental services into a medical practice presents a number of challenges and, as such, some previous attempts by medical practices have failed to sustain the additional services. The following list highlights some of the most frequent concerns for MDI integration models:

- Limitation in Florida's scope of work for unsupervised dental hygienists.
- Determining and understanding medical vs. dental diagnosis and reimbursement codes.
- Establishing a best practice methodology to reach the patient and to ensure the office is properly reimbursed.
- Understanding practitioner and patient motivation.
- Effectively introducing MDI services to patients and ensuring there is an adequate frequency of oral health screenings and evaluations in accordance with the aforementioned recommendations.
- Identifying an appropriate, engaged dental hygienist.
- Staff resistance.
- Staff turnover.
- Competing priorities and engagement within practice leadership.
- Bureaucratic systems impeding operations change.
- Delayed implementation process.
- Coordinating around a high-demand practice schedule.
- Liability concerns surrounding the dental hygienist's role within certain practices and organizations EHR capability in documenting and pulling oral health data sets.
- Patient/family engagement.

#### *4.5 Reflections*

It is important to note that when collaborating with external organizations on such a pilot, their timelines, objectives, and goals must be considered and align well with your own. Overall intentions must be communicated clearly and consistently to avoid any delay in the planning or implementation process. Furthermore, it can be extremely beneficial to share and present on your model and experience as much as possible. This presents an opportunity to discuss lessons learned with other organizations or practices that may have embarked on a similar medical-dental integration pilot and allows for best practices to be shared within and between partner networks.



## 5. Evaluating and Communicating Your Success

### 5.1 Evaluating Medical and Dental Integration

Evaluation of a Medical Dental Integration program can help assess progress, health outcomes, and financial viability. Evaluation activities can also help administrators make real-time adjustments in program delivery and processes. Sharing evaluation results helps tell the MDI story, justify program continuation, modification or expansion, and guide the allocation of resources.

Three types of evaluation can be used to evaluate your integration efforts. Quantitative evaluation collects and analyzes raw data. Examples of quantitative measures can be seen with utilization rates, such as the number of patients seen, with referral metrics, such as the number of referrals made for restorative care, or with reimbursement/billing data, such as the number of CPT 99188 codes submitted. Qualitative evaluation seeks to better understand the subjective realities of people involved (patients, providers, staff, families, etc.). Methods of collecting qualitative data can include patient questionnaire's which could help in elucidating the patient experience and/or the patient's reasons for opting out of a certain service. Using quantitative and qualitative methods systematically results in a mixed-methods evaluation. This approach allows for ongoing assessment of both program metrics and perceptions of individuals involved.

MDI Evaluation often includes data about:

- Utilization rates.
- Finances.
- Processes.
- Policies.
- Practice statistics vs. state statistics.
- Comparative analysis for oral health statistics for patient population by year.
- Perceptions (of patients, providers, staff, partners, public).
- Oral Health Outcomes.
- Dissemination of information.

### 5.2 Communicating your Success

Sharing results of planning, implementing and evaluating MDI is an important step in [ongoing quality improvement](#). Providers and clinic administrators can use data and success stories to:

- Write op-eds for local, state, and national newspapers and journals about the impact you are making at your practice.
- Volunteer to speak on care coordination panels, or at conferences, summits, and symposiums regarding the topic of innovative practice models, oral health, and/or care coordination.
- Contribute stories to local Story banking efforts surrounding community oral health.
- Demonstrate financial incentives alongside patient outcomes.

As evaluation results and resources become available, FIHI is glad to serve as a resource for other interested practices, organizations, and sites attempting to launch their own medical-dental integration pilot.