TOOLKIT

DELTA DENTAL®

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Is Your Practice Ready for Medical-Dental Integration?

Assessing your practice's readiness to integrate a dental hygienist is an essential first step toward setting you on path for success. Taking various factors into consideration may highlight the need to wait, pull in outside resources, or further investigate key questions before you start.

Practice Characteristics Will Influence Your Medical-Dental Integration Model

- Leadership: A practice's leadership and support will help lead your project to success. Complex, adaptive leadership requires both the "top-down", bureaucratic approach as well as the "bottom-up" flexible, adaptable, supportive, and enabling approach (1).

- Need: The CO MDI model best fits practices that serve patient populations with high oral health needs. Patient populations with the highest oral health needs may include those that struggle to access dental care or have medical conditions that impact their oral health: low-income populations, young children, pregnant women, those living in rural communities, students receiving medical care at school-based clinics, diabetics, the homeless, refugees, and seniors.

- Space: Integrating a hygienist who provides full scope dental hygiene services will require appropriate space to provide adequate care. Your practice needs a room in the medical space to implement this model. If dedicated space is not an option, a plan to use a variety of spaces using mobile equipment will work. Using multiple spaces will require additional time to schedule those spaces for use.

- Daily Leadership: The person leading the day-to-day implementation of the project will lead it to success if they value oral health integration and take daily actionable steps to champion it. This person will provide constant direction, lead problem solving activities, and break down barriers when needed.

- Provider and Staff Engagement: Providers and staff that understand the value of offering oral health services in a medical practice, are willing to take on new activities associated with implementation, and have the time to do so will help the project be successful.

- A Team with Time: Each practice department will be influenced by the addition of dental services. Create an implementation team that meets monthly. One representative from each department

should be included on this team. The day-to-day medical-dental integration leader will lead the smaller team including the hygienist and possibly others. The teams need time to devote to this work to provide capacity for problem solving and making progress.

- Experience with Integration and Quality Improvement: A practice that has had previous experience with other integration models, e.g. behavioral health integration, and with quality improvement, can apply their experiences to integrating dental into medical.

- Practice Location/Access to a Dentist: Hygienists must have a relationship with a dentist to refer patients for exams and restorative care. If your practice doesn't already have a relationship with a dentist, initiate one before beginning this work.

- On-site Dental: Having an existing dental department is convenient for multiple reasons including having an existing electronic dental record, systems in place to sterilize equipment, relationships with equipment vendors, and easier access to restorative dental care. Additionally, a staff dentist can provide clinical supervision and support to your hygienist. If your practice doesn't have a dental department and you work with external dental practices, you can still do CO MDI. There may a steeper learning curve as you learn about dental and build relationships with external practices.

- Capacity for Change: Your practice needs the capacity to add medical-dental integration to its workload. Consider the number of other grants, coaching requirements, and changes that are pending. Pending changes could include a new electronic medical record, a new built environment, or new leadership.

- Practice Resources: A smaller practice may have fewer resources to dedicate to practice transformation such as a quality improvement department or staff who has the capacity to work on new projects.

- Practice Size: The size of the population served and risk of that population for oral diseases will influence how busy the hygienist will be. In a small practice, one hygienist per two to four medical providers may be sufficient. In a bigger practice, there may be a need for more hygienists. The best hygienist-to-medical provider ratio will be influenced by the number of patients served, the proportion of child to adult patients, the payer (insurer) mix of the population, and access to community dental services.

- Payer Mix: Your payer mix will influence your financial sustainability. Dental payers in Colorado are Medicaid, CHP+, and private insurers. Self-pay and sliding fee scales could also be part of your mix. Medicaid has dental coverage for children. In Colorado, Medicaid has adult dental coverage up to a $1,000 annual limit. CHP+ is for children. Medicare doesn't include a dental benefit, however Medicare Advantage (Medicare Part C) plans often offer supplemental dental benefits that are managed by private insurers. Private insurers typically cover children and adults and the benefit varies by insurer.

- Payment Mechanisms: Fee-for-service practices are paid by procedure and Federally Qualified Health Centers (FQHCs) receive an "encounter rate" per visit. Learn more about payment mechanisms for FQHCs here: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html.

1. deGruy FV, 3rd. Integrated Care: Tools, Maps, and Leadership. Journal of the American Board of Family Medicine : JABFM. 2015; 28 Suppl 1:S107-10.