Washington Rural Health Clinic
Dental Services Toolkit

A Guide to Implementing Dental Services in Washington's Rural Health Clinics

Washington State Department of Health

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Thank you to Jefferson Healthcare and Klickitat Valley Health for their contributions to this guide and for sharing their journeys, lessons learned, and practical advice which will undoubtedly benefit other Rural Health Clinics in improving oral health access for rural populations.

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INTRODUCTION

This guide is intended to help Washington's Rural Health Clinics (RHCs) implement dental services in addition to their primary care services. This guide will cover how to:

- Assess the oral health needs of your community and how your RHC can address them
- Find funding and the equipment required
- Determine a dental encounter rate
- Recruit staff
- Collaborate with primary care and emergency services
- Select health records software
- Manage cost and patient processes

Encounter Rate Model

In 2018, the Centers for Medicare and Medicaid Services approved Washington's Rural Health Clinics to receive an encounter rate for Washington Apple Health-covered dental services. This change allows RHCs to be reimbursed based on cost instead of the fee-for-service Medicaid rate.

WHAT IS A DENTAL ENCOUNTER?

A dental encounter is a face-to-face encounter between a dentist, dental hygienist, or orthodontist and a client for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.

WHAT IS A DENTAL ENCOUNTER RATE?

Determined by the Washington State Health Care Authority (HCA), a dental encounter rate is a flat rate that RHCs receive for each face-to-face dental encounter, based on the anticipated average cost for direct and supporting services (including allocated costs).

See the Establishing an Encounter Rate section for more information.

HRSA Grant

The Washington State Department of Health (DOH) was awarded a four-year, 1.6-million-dollar Oral Health Workforce Activities grant from Health Resources and Services Administration (HRSA) to promote and evaluate the new and innovative encounter rate payment model for dental services. The primary goal of this funding is to improve access to high-quality, integrated oral healthcare for vulnerable rural populations by increasing the number of RHCs providing dental services to Medicaid clients in rural dental health professional shortage areas (HPSAs). During the 2018–2022 grant cycle, DOH sub-awarded grant funds to JH and KVH to support the startup and early implementation costs of their dental clinics.

RHCs with Dental Services

Throughout this implementation guide examples from Jefferson Healthcare (JH) and Klickitat Valley Health (KVH) are used to highlight the process of developing and integrating dental service lines of care within a RHC and provide concrete examples and lessons learned.

Jefferson HealthCare

JH is the first Rural Health Clinic in Washington to offer dental services and served as the initial pilot model for the HRSA grant project. JH opened a 6-chair dental clinic within their Rural Health Clinic and began seeing patients in June of 2019. There were challenges with electronic health record system integration and billing, but less than two years into their project, JH succeeded in their goal to add integrated dental services. The JH model and their lessons learned serve as a foundational resource for other RHCs who wish to integrate dental care.

JEFFERSON HEALTHCARE HISTORY

Established in 1890 by the Sisters of Providence and originally known as St. John's Hospital, Jefferson Healthcare has been owned and operated by Jefferson County Public Hospital District No. 2 since 1975. It is the only hospital and clinic provider serving the entirety of Jefferson County, and it is also the largest employer in the County. Several expansions occurring over the past decade have provided district residents with new emergency and specialty service programs. JH's vision is to "be the community's first choice for quality health care by providing exceptional patient care to every person we serve".

Klickitat Valley Health

KVH opened their 3-operatory dental clinic in October 2019. They were able to see their first dental patient about one year after planning was underway for their project. They repurposed and renovated three medical exam rooms from an existing pod in their Rural Health Clinic. KVH utilizes mobile dental equipment in each of the three operatories. The benefit of this model is that the mobile equipment may be used in other areas of the medical clinic if needed.

KLICKITAT VALLEY HEALTH HISTORY

Klickitat County Public Hospital District No. 1 was formed in 1948, and Klickitat Valley Health, the hospital, opened in 1949. KVH was designated as a Critical Access Hospital in 2002. Over the years, KVH has undergone several renovations and additions. KVH's vision is "to engage in meaningful and lasting partnerships with those in our community to improve health and well-being".

GETTING STARTED

This section covers:

- Community Needs
- Start-up funds
- Dental Encounter Rates
- Clinic Space
- Workforce

Community Needs

The first step in project planning is to understand community access and need for dental services as well as existing resources and barriers. Completing a comprehensive community needs assessment will allow an organization to understand the oral health needs of their population, and the impacts of unmet oral health needs to their organization. Community needs assessments can also focus on specific populations such as people with Medicaid coverage who experience greater unmet health needs, in addition to the community as a whole.

Oral health is often a topic that arises when public hospitals complete Community Health Needs Assessments (CHNA). The Patient Protection and Affordable Care Act of 2010 (ACA) included requirements for Critical Access Hospitals (CAHs) to conduct a CHNA every three years. During the CHNA process, the health system will:

- Assess the demographics of the population served by the hospital
- Work with stakeholders to better understand the perceived healthcare issues impacting the community
- Analyze healthcare issues
- Identify current efforts to address the health care issues
- Formulate a strategic plan to guide future efforts to address health issues

Rural health systems have an important role in community health, including oral health, and a needs assessment is an opportunity to collaborate with stakeholders to understand community needs and formulate plans to address priority health issues. RHCs that are not operated by CAHs can undertake a similar needs assessment process independently of a rural hospital.

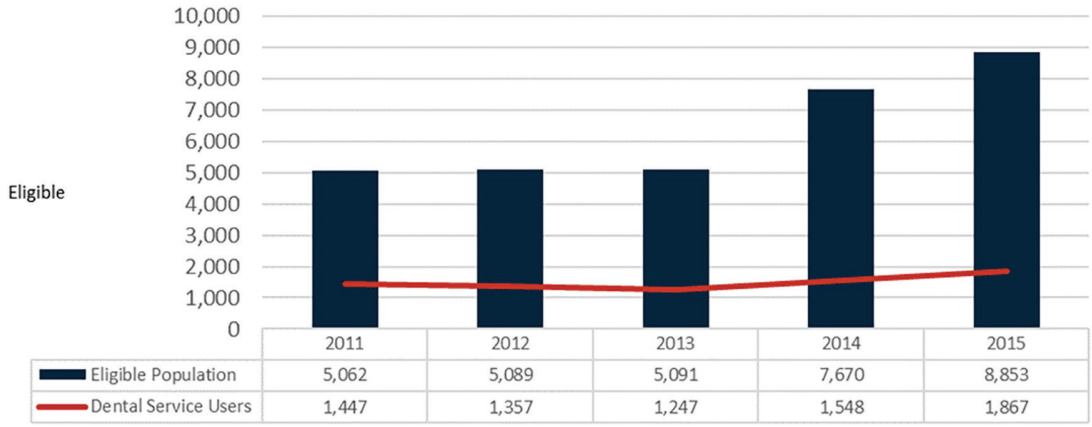
There are many existing resources and toolkits to support needs assessments in rural communities. The needs assessment process is an ideal time to collaborate with local health jurisdictions, the Washington State Office of Rural Health (SORH), and Accountable Communities of Health (ACH), and other community-based stakeholders.

Included below is an example from JH and some of their high-level findings which helped guide their decision-making process as they moved onto next steps for integrating dental services.

JH's Needs Assessment

JH began their community needs assessment by gathering data on dental service utilization by Medicaid Clients in their county (**Figure 1**). The data highlights that the number of people receiving Medicaid-covered dental services remained stable despite the expanded Medicaid Coverage after the Affordable Care Act went into effect. The gap between the eligible population and the dental service users widened throughout this time period.

FIGURE 1. Dental Service Utilization for Medicaid Clients in Jefferson County (all age groups)



	2011	2012	2013	2014	2015
Eligible Population	5,062	5,089	5,091	7,670	8,853
Dental Service Users	1,447	1,357	1,247	1,548	1,867

JH's needs assessment results highlighted that lack of access to dental care was critical for Jefferson County residents with Medicaid.

Throughout the needs assessment process, it also became clear that the need for dental care was a topic of discussion with community health leaders for many years. Part of the CHNA process is gathering input from community members and stakeholders — this can be in a variety of ways, including but not limited to: focus groups, listening sessions, key informant interviews, surveys, and/or townhalls. JH collaborated with the local public

health jurisdiction, Jefferson County Public Health, to complete the CHNA and learn from the community what health issues were their priorities. Four key needs were identified and prioritized for future work:

- mental health and substance use disorder
- chronic disease prevention
- immunizations
- access to healthcare

Within the access to healthcare priority, the need for dental services — specifically for Medicaid clients — was identified as a key issue in the community.

The needs assessment also saw that the impact of untreated dental disease on emergency room visits stood out as a key theme and drove JH forward in their journey to establish a dental services line of care.

Needs Assessment Resources

- **Rural Health Information Hub Guide**
  https://www.ruralhealthinfo.org/topics/rural-health-research-assessment-evaluation

- **Centers for Disease Control and Prevention (CDC) Guide**
  https://www.cdc.gov/publichealthgateway/cha/plan.html

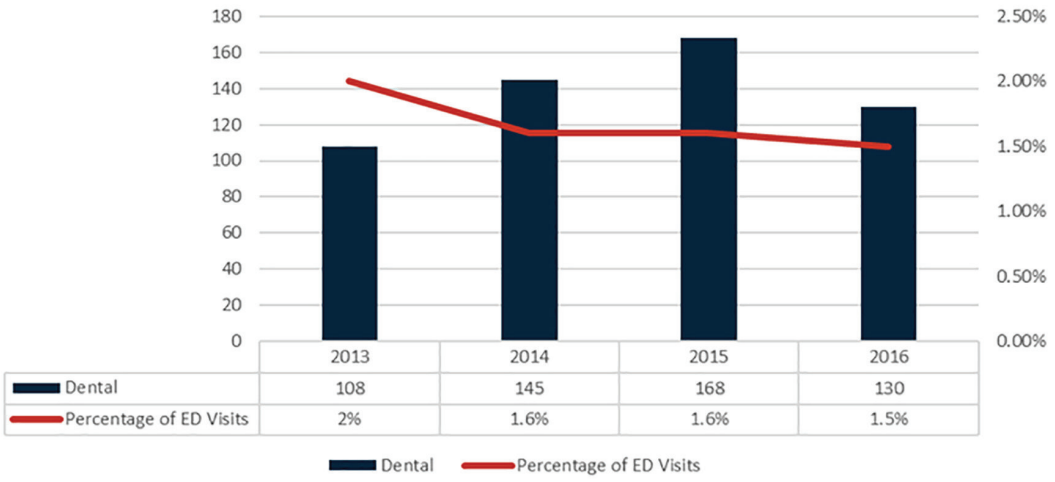
- **National Rural Health Resource Center Guide**
  https://www.ruralcenter.org/resource-library/community-health-needs-assessment-chna-toolkit

- **Washington State Hospital Association Guide**
  https://www.wsha.org/wp-content/uploads/CommEngagementToolkit_1_1.pdf

Impact on the Emergency Department

The needs assessment revealed that the dental crisis in Jefferson County impacts JH's emergency department. The number of emergency department (ED) visits with a dental diagnosis stayed between 1.5% and 2% of the total number of visits annually (**Figure 2**).

FIGURE 2. Dental Visits* to the JH Emergency Department by Year (number) and as a percentage of total number of ED visits (%)



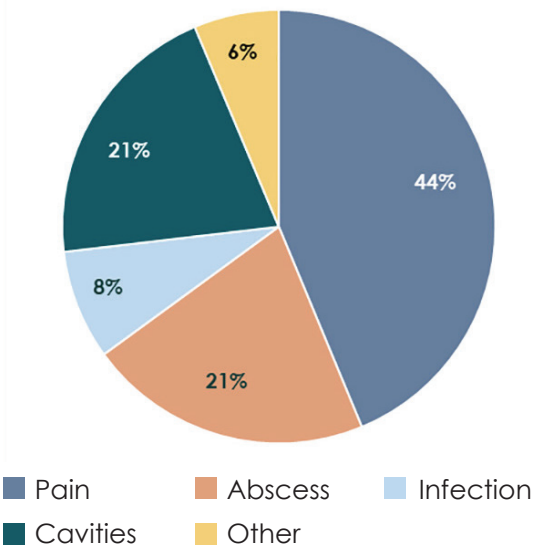
* The data in 2013 only cover June – December due to a change in the electronic medical records system. The data for 2016 includes January – September.

Dental Data Resources

- **Access to Dental Care Data Dashboard**
  https://arcorafoundation.org/access-to-dental-care-dashboard/
- **Healthy Youth Survey – Oral Health Fact Sheet**
  https://www.askhys.net/FactSheets
- **Smile Survey**
  https://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/OralHealth
- **Washington Health Care Authority – Dental Claims Data**
  https://www.hca.wa.gov/about-hca/dental-data

The most common reason for visiting the emergency department for dental issues is dental pain, accounting for 44% of the roughly 150 visits annually (**Figure 3**). Abscesses, general infections, and cavities account for 21%, 8%, and 21% respectively, while more acute issues, such as tooth fractures or other mouth trauma, account for 6%. The data from JH supports national research findings which show that most ED visits for dental diagnoses could be prevented with access to routine and preventive dental services.[1]

FIGURE 3. Dental Diagnoses for Jefferson Healthcare ED Visits (June 2013 – September 2016)



JH realized that emergency room visits are almost entirely preventable, and there were better ways to address dental issues from within their health system. They also found that unsurprisingly, given the lack of dentists who accepted Medicaid in Jefferson County, Medicaid was the payor for almost 60% of visits to the emergency department with a primary dental diagnosis, which highlights the oral health disparities experienced by adults with Medicaid.

Finding Funding

The funding required to implement the provision of dental services in a Rural Health Clinic is a significant investment which may require supplemental funding. Grant funding and legislative support might be necessary to offset the investment required. RHCs can seek grant funding to help with startup costs. Options for funding include state and national dental foundations, state and federal programs, community organizations and associations.

The Arcora Foundation (the foundation of Delta Dental of Washington) offers grant funding opportunities to support safety net dental programs and increase access to dental care for communities who experience oral health disparities. Arcora Foundation provided grant funding to assist JH and KVH with capital expenses when they were in the process of establishing their dental clinics and to support access to dental care in rural areas. Another resource is subscribing to GovDelivery bulletins from the State Office of Rural Health. The SORH uses GovDelivery to communicate information to RHCs including funding announcements from federal and state programs. See the Resources box on the next page for links to the Arcora Foundation website and to subscribe to receive bulletins from SORH.

[1] Emily Shortridge & Jonathan Moore. "Use of Emergency Department for Conditions Related to Poor Oral Health Care." August 2010. http://www.norc.org/PDFs/publications/OralHealthFinal2.pdf

Resources

- **Check the Arcora Foundation website for information about grants to support access to dental care.**
  https://arcorafoundation.org

- **Subscribe to GovDelivery Bulletins from the State Office of Rural Health to receive funding announcements**
  https://public.govdelivery.com/accounts/WADOH/subscriber/new

Establishing an Encounter Rate

For an established RHC, the first step to receive an encounter rate for dental services billing, is to apply for a **Change in Scope (CiS)** with the Health Care Authority (HCA). RHCs must submit a CiS application for a "**Prospective change in scope of services**." This is for a change the RHC plans to implement in the future.

Important Considerations

To submit encounters and include costs for dental care in cost reports, RHCs need to receiving approval from HCA and meet the billing and eligibility requirements in three guides below:

- **Dental-Related Services Billing Guide**
  https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#collapse_14_accordion

- **Access to Baby and Child Dentistry Billing Guide**
  https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#collapse_0_accordion

- **Orthodontic Services Billing Guide**
  https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#collapse_40_accordion

To file an application for a prospective CiS, the RHC must submit projected costs sufficient to establish an **interim rate**. The interim rate is subject to a post-change in scope review and rate adjustment.

You can reach out to FQHCRHC@hca.wa.gov for questions about the process.[2]

RHCs need to prepare the following documentation to include in the CiS application:

1. A narrative description of the proposed change in scope of service that explains how the CiS meets the change in type, duration, intensity, or amounts of services description(s).
    a. The narrative should also include all RHC NPIs and the proposed encounter rate for each RHC site included in the Medicare cost report.
2. The RHC's most recent audited financial statements for the same time period as the cost reports, if an audit is required by federal law.
3. The CiS implementation date.
4. The projected Medicare cost report with the supplemental schedules needed to identify the Medicaid cost per visit for the 12-month period, following the implementation of the change in scope of service.
5. Any additional information requested by HCA.
6. Refer to the RHC Billing Guide[3] for additional details and email the completed application to FQHCRHC@hca.wa.gov.

Decisions are made within 90 days of receipt of a complete application. There may be additional documentation requested by HCA in this process. If the Prospective CiS is approved, an interim rate adjustment will go into effect after the change in services goes into effect. The interim rate can be reviewed and is subject to rate adjustment.

Reminder: RHCs may only submit one Change in Scope (CiS) application per calendar year. Multiple CiS requests including CiS considerations for COVID-19, can be included for consideration within the same application.

[2] For additional detail, State Plan Amendment (SPA) and WAC 182-549-1500 (RHC CiS State Policy) outline the requirements for RHC CiS in WA.

[3] Billing guides are updated frequently, use this link to access the most recent version https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

Clinic Space

Construction, Clinic Space, and Equipment

The decisions about dental clinic construction, space, and layout will often be made based on what is available within existing RHCs and their property. It is helpful to consult with dental professionals and make decisions based on the planned scope and volume of dental services.

JH constructed a 6-operatory clinic, with waiting area, reception, sterilization space, break room, and dentist office in approximately 2,400 square feet of existing RHC property. They chose to use an open operatories lay out because of space constraints and to allow for better workflow for staff. Throughout the construction process there were delays and disruptions to the primary care space. This was the first dental space the contractor had built, so there were some valuable lessons learned. One of these is to be sure to look into special considerations for water and drainage needed for dental clinics. See ***Appendix A*** to see the changes JH made to their floor plan to accommodate a dental clinic.

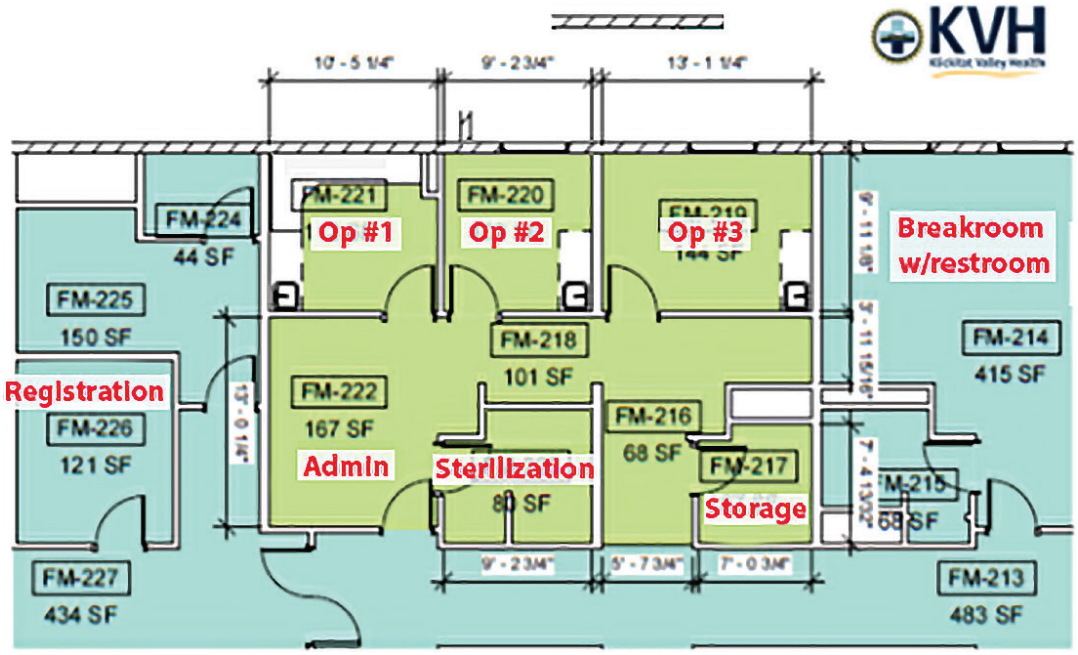
A rendering of JH's new dental clinic waiting room. See Appendix A for changes made to the layout.

KVH utilized a different approach to establishing dental clinic space with minimum construction. KVH utilized an existing pod in their RHC space. The area was previously set up for 3 treatment rooms, a bathroom, and small reception area for a pain management provider. The treatment rooms (which already had sink/handwashing stations in place) became operatories. The reception area became a more general administrative area and the restroom was converted to a sterilization room. The sterilization room also has a pass-through

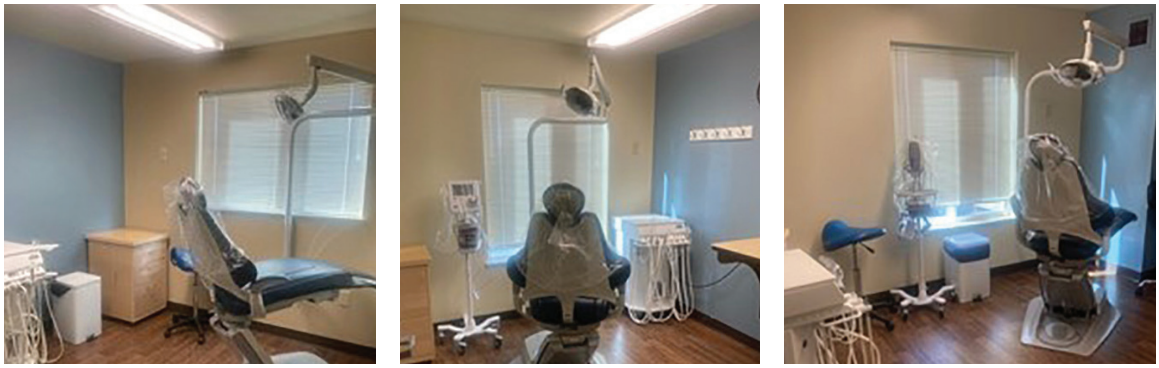
cupboard for the entry of used/dirty instruments. There is no reception or lobby, as that is handled in the family medicine clinic (see ***Integration with Primary Care through Clinic Co-location*** section for more details).

KVH's administrative area

KVH re-purposed a pod when creating their 3-chair dental clinic which minimized construction and renovation work. One of the reasons minimal renovations were possible was their decision to utilize portable equipment. Each operatory is set up with portable equipment which includes a self-contained cart with suction, water, air, and handpiece hoses. KVH selected their patient chair first, and then utilized a template provided by the manufacturer to plan the layout of their operatories, within the size limitations of their space. KVH also utilizes portable handheld x-ray machines with digital sensors.



Using existing space, KVH was able to establish a dental clinic with minimal construction.



KVH's three operatories that utilizes portable equipment.

Portable dental equipment can be a great solution for clinics looking to add dental services without major construction and with a lower start-up cost. Portable equipment can be selected to meet the needs of clinic and fit the space and budget. See ***Appendix B*** for a full list of supplies and equipment for a 3-chair clinic utilizing portable equipment.

For an overview of equipment needed to equip a dental hygiene room as well as items needed for medical exam rooms, visit http://medicaldentalintegration.org/building-mdi-models/building-co-mdi-space/equipment/

Tip: Selecting and ordering equipment and supplies requires dental expertise. Consider working with a consultant unless you have staff available with a dental background.

To be eligible to receive the encounter rate, the dental services must be provided within an RHC or on RHC property.

Workforce

RHCs have experience recruiting and retaining medical providers and staff to practice in rural and underserved areas but recruiting for a dental clinic can present new challenges. It is important to seek dental providers who are committed and driven by community dental health and want to practice in rural and underserved areas.

JH, as part of a public hospital district and a unionized employer, began by adding new job classifications within their contractual agreement with the union. They experienced challenges due to not being able to compete with private practices for hourly rate and flexibility with additional incentives and offers. They also realized it isn't just hiring dental providers that can be difficult; it can also be challenging to recruit leadership and administrative personnel who understand both dental clinics and hospital systems.

Utilizing per diem dentists may be necessary during planning and early implementation. Shortly after JH opened for dental services, one of their dentists left. In the interim, a per diem dentist was brought in, giving JH the opportunity to recruit and hire a permanent dentist who was finishing up her final year of dental school.

Many dentists are seeking loan repayment opportunities. The average student debt of dentists continues to be the highest among all the clinicians who are eligible for the loan repayment program; the average debt level of dental school graduates of the class of 2020 was $304,824.[4] RHCs are eligible sites for loan repayment through state and federal programs and may be able to recruit dentists and dental hygienists who are seeking loan repayment options.

Dentists practicing general and pediatric dentistry, and dental hygienists are eligible disciplines for a variety of loan repayment programs. National Health Service Corps (https://nhsc.hrsa.gov/nhsc-sites/index.html) program offers loan repayment options for these dentists and dental hygienists. The Washington Student Achievement Council manages the Washington Health Corps program (https://wsac.wa.gov/washington-health-corps) which helps our state attract and retain health professionals to serve in critical shortage areas through loan repayment assistance. Many RHCs and hospital systems are approved sites already and are employing physicians who are accessing loan repayment, the same processes apply for dental professionals.

Despite initial difficulties, JH and KVH have both hired staff who are experienced in community dental health and committed to providing excellent care to their patients. It is possible to recruit and retain exceptional staff in rural areas and RHCs can apply their expertise from recruiting for medical staff to their dental staff.

Resources

- **Contact the Workforce Advisor in the WA State Office of Rural Health. The Workforce Advisor offers recruitment assistance to Rural Health Clinics and hospital systems.** https://www.workforcegateway.org/about-our-work.html

- **Contact the Primary Care Office in the WA State Office of Rural Health for questions relating to HPSA designation or NHSC site applications.** https://doh.wa.gov/public-health-healthcare-providers/rural-health/primary-care-office

[4] American Dental Education Association. (n.d.). Educational Debt. Accessed January 25, 2022, from https://www.adea.org/godental/money_matters/educational_debt.aspx

IMPLEMENTATION

This section covers:

- Dental Clinic Hours of Operation
- Integration with Primary Care
- Electronic Health Records and Dental Software
- Other Considerations

Dental Clinic Hours of Operation

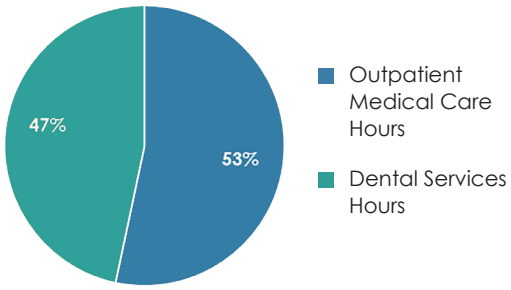
It is important to maintain compliance with RHC regulations throughout the planning and implementation process for adding dental services. One key thing to remember is the guidelines around what qualifies as an RHC service and the hours for delivering care that an RHC has to maintain to be primarily engaged in RHC services. Delivering dental care is allowed, as are other services considered to be specialty care, but an RHC must be "primarily engaged in outpatient health care services" (RHC services are defined as services of physicians, NPs, PAs, certified nurse midwives, clinical psychologists, and clinical social workers).

When determining **dental clinic hours of operation**, remember that dental services are considered specialty services under RHC guidelines. Therefore, to maintain compliance to be "primarily engaged in outpatient health care services" the **dental clinic may only be available/open less than 50% of the total hours of the RHC's operation**.[5]

For example, for an RHC who provides outpatient medical care between the hours of 9 a.m. to 5 p.m., Monday–Friday and also provides dental services from 9 a.m. to 4 p.m. Monday–Friday, the RHC is furnishing 40 hours of standard RHC services, and 35 hours of dental services, for a total of 75 hours. In this example the RHC provides RHC services for 40 hours of 75 total hours, 53% of the total time, therefore, it is "primarily engaged" in providing RHC services (**Figure 3**).

Type of care	Hours of operation	Total hours per week
Outpatient Medical Care	9am – 5pm M – F	40
Dental Services	9am – 4pm M – F	35

FIGURE 3. RHC hours



[5] https://www.cms.gov/files/document/appendix-g-state-operations-manual

Integration with Primary Care through Clinic Co-location

RHCs who add dental services are in a unique position to truly provide whole person health care services. Primary care and urgent or emergency services can refer patients needing dental services to care directly within their own health care system. JH and KVH have experienced reductions in oral health related emergency room visits and improved chronic disease management for their patients.

One important element to successfully integrate dental services within a rural health practice is to determine workflows and referral processes for the patient population. Referrals to the dental clinic come in from primary care, emergency department physicians, care coordinators, and hospitalists.

KVH's model has integration at all levels of their practice. Primary care providers refer patients to the dental clinic when they see untreated dental needs and encourage routine dental care. The dental clinic shares patient registration with the family practice clinic, which is near the dental clinic. When patients check out from their primary care visit, patient registration staff can assist patients with scheduling their dental appointments.

Referrals are bi-directional, the dental providers also refer issues that should be addressed by medical providers and notify patient registration so that a medical visit can be scheduled. The dental visit is an opportunity to make patients aware of untreated or undetected health concerns such as high blood pressure and diabetes. The dental staff communicate with the primary care providers on a regular basis; all staff utilize secure messaging for communication about patients and referrals.

Integration works similarly at JH. The hygienist and dentist are part of the primary care provider group, and the medical and dental providers often consult on patients and their care.

Even if a Rural Health Clinic does not have a co-located dental clinic, they can have an important role and impact on their patients' oral health. Including oral health in primary care visits is important to promote health across the lifespan. Tooth decay and oral diseases can

be associated with cardiovascular disease, diabetes, adverse pregnancy outcomes, and other health conditions. Tooth decay is extremely common in children and can be addressed through primary care interventions. Primary care providers can screen for tooth decay, provide education about oral hygiene, and apply fluoride varnish to protect teeth from tooth decay. For more information see the Mouth Matters link in the Resources box.

Resources

- **The Mouth Matters program – through the Arcora Foundation – provides training, technical assistance, and billing guidance for oral health screening and services from medical providers.**
  https://www.arcorafoundation.org/mouth-matters-resource-center/

- **See the Access to Baby and Child Dentistry Guide for additional details about reimbursement and billing.**
  https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#collapse_0_accordion

Integration with Emergency Care

In addition to primary care referrals, many dental patients present first in the emergency room or urgent/express care for emergent dental care issues. At KVH, if a patient goes to the emergency department for a dental issue, a care coordinator will send the dental clinic a report, and the dental clinic will contact the patient and get them scheduled for the next business day. When patients call in for a same day appointment for a dental issue with express care at the Family Practice Clinic, the registration staff schedules them a same day dental visit instead. Patients are only seen for dental issues at express care if it is on the weekend or outside of business hours for the dental clinic. In those situations, registration also gives the patient information about the dental clinic and schedules a dental appointment.

KVH has observed a decrease in dental related ED visits. Prior to dental clinic opening 5% and one year post opening 2.5% of total visits were dental related.

INTEGRATION AT ALL LEVELS

Integration truly happens at all levels across a health system; and process changes and learning, big and small, will happen throughout the whole system. Make sure to include other departments, such as:

- Facilities to assess the structural needs of the hospital system
- Cleaning crew to learn the specific ways to clean a dental office
- Coders and billers to learn how to bill for dental services
- Leadership and administration to update policies and procedures to include dental providers

JH also ensures patients who present in the emergency department have access to the dental clinic and provides same day or next day dental appointments. Emergencies that end up in the emergency department after hours get faxed to the dental office so the dental office can contact the patient for scheduling. Patients who are prescribed antibiotics during their emergency department visit give the dental clinic a window of time for scheduling. The dental assistants will reach out to each patient for a triage to better determine appointment need. If it is an acute dental issue, and during business hours, the emergency department will call the dental clinic directly to squeeze patient in "same day". If a patient is seen for an emergency dental visit, JH will complete the necessary acute treatment and then place patient on the new patient waitlist for future care.

Electronic Health Records and Dental Software

When making the decision about Electronic Health Record (EHR) systems, RHCs should weigh the capabilities of their current EHR with available options that exist for interfacing with dental software. Full integration has many benefits, like having a single shared patient record, that will contribute to ease of use in the long run. RHCs should evaluate short and long term needs as well as the benefits when making decisions about which EHR solution is right for them.

There are many options for dental software and integration with electronic health records. Check out this resource for additional information:

http://medicaldentalintegration.org/building-mdi-models/building-co-mdi-space/ehredr/

JH experienced integration challenges related to the exchange of information between dental and primary care providers. When JH started implementing dental services, their EHR platform, Epic, did not provide dental software. At that time, Epic was in the process of completing Wisdom, a module for dental services, so Jefferson made the decision to use workarounds with the current Epic instead of going with a dedicated dental software because they knew that soon there would be an option to fully integrate with the Wisdom module and the workarounds would just be for a short interim period. The decision to remain with Epic was important to their clinic because of the long-term benefits, known functionality and future seamless integration of dental coding to their larger health system. The Epic Wisdom module became available in late 2018 and JH adopted it shortly thereafter.

EHR Software	Pros and Cons
Open Dental www.opendental.com	Less expensive than other dental EHRs, but requires time/cost to integrate with EMR
Eaglesoft www.pattersondental.com/cp/software/dental-practice-management-software/eaglesoft	Popular with dental clinics with good functionality but it is a stand-alone dental EHR
Dentrix Ascend www.dentrixascend.com	Popular with dental clinics with good functionality but it is a stand-alone dental EHR
Wisdom www.epic.com/software#SpecialtiesAncillaries	Epic's dental module can be completely integrated with the Epic platform, ideal for health systems who use Epic
Custom Solution You can build a custom bridge between your EHR and your choice of dental software.	Custom solutions can be expensive and time consuming to build, but ultimately provide integration and functionality

KVH utilizes Open Dental for their dental software. Open Dental has advantages as an open-source software meaning that end users can download and use the program and have full access to the code so that modifications can be made. Open Dental has suited KVH's needs, for example being able to use it for messaging with the staff at the registration desk which is in the nearby primary care clinic. In the future, KVH may switch to a fully integrated EHR such as Epic, but overall, they were happy with the decision to use Open Dental.

Other Considerations

Patient Population

During the planning and early implementation phases of beginning dental services it is crucial to have a deep understanding of community dental health and the dental needs of your patient population. The patients who present for dental services at RHCs will often have serious dental needs which have been neglected, not by choice, but due to lack of resources and no access to dental care. Many patients may have some, or many, of their permanent teeth extracted and may have prior negative experiences from accessing dental care.

Understanding the patient population impacts many aspects of managing the dental clinic, such as hiring staff who have compassion towards those who have serious and unmet dental needs and making practical decisions about how to schedule visits and manage a waitlist.

KVH has observed that most of their dental patients have not had dental care in 10 or more years. Now, with their dental clinic in operation, if a patent presents in the emergency room or urgent care for a dental issue, the patient will be scheduled afterward for an initial dental visit for treatment of their emergent dental issue. Subsequently, they are encouraged to return for follow up care. Most patients have been receptive to this and return for treatment. Some treatment plans include 10-12 visits due to the severity of the unaddressed dental issues, such as dental abscesses, severe decay, and periodontal infections.

During the clinic's first year and a half, KVH has "graduated" 63 patients. A graduated patient is one who has had a complete exam, finished all needed treatment, completed the needed periodontal cleaning and fluoride, and are now waiting on their 6-month recall appointment.

KVH dedicates time to provide oral hygiene education, since this is a key component of care. KVH understands that their dental patients come into the clinic from all walks of life; some have not had dental care for over a decade, many have not had positive experiences accessing dental care in the past, and others didn't have access to preventive dentistry throughout their lives. They provide person-centered education and meet people where they are with compassion and understanding. Each patient is given individualized oral hygiene instruction, and a take home kit with brush, toothpaste, and floss.

Managing a Waitlist and Scheduling Appointments

JH and KVH opened their dental clinics and immediately had a high demand and a waitlist for services.

JH utilizes a report in their EHR, WISDOM in Epic, to manage a waitlist (see the ***Electronic Dental Records and Dental Software*** section). Staff monitor the waitlist and schedule patients for new patient exams on a weekly basis. If patients are seen for an emergency visit (after presenting in the emergency department), they then get added to the new patient waitlist after

the necessary acute treatment is provided. Additionally, any person who is added to the new patient waitlist is given information about how, if a dental emergency arises while they are on the waitlist, they can call in to the dental clinic instead of going to the emergency room so that it can be addressed.

The process for scheduling appointments requires an understanding that:

- The population served has a high level of dental needs
- The population served experiences barriers due to social determinants of health including but not limited to, lack of childcare, reliable transportation, and/or paid sick leave
- There will be appointment no-shows

The delivery of high-quality care is always the goal. At JH, dentists typically see 10 patients a day; and hygienists see six–eight patients. On some days, up to an additional four patients are seen on an emergency basis, and the dentist provides input about the best time slot to add them in. When time allows, hygienists can provide anesthetizing and restorative procedures, which allows the dentist to see more patients. JH typically schedules 60-minute appointments for dentists and 70-minute appointments for hygiene. The hygienist does not have a dental assistant assigned to them, so a little bit of additional time is needed throughout and to turn over the room and prepare it for the next patient.

KVH typically schedules a 40-minute encounter for each appointment. During the encounter, they utilize the time to accomplish as much of the treatment plan as possible. Typically, this includes either up to two fillings, two extractions, one root canal, one quadrant of periodontal scaling, or an adult prophy.

Due to the encounter-based payment model, when a patient is scheduled for a covered service, they may also receive other dental services deemed beneficial to their care plan (but which may otherwise not be covered) during that same visit. In other words, if at least one service in the encounter is allowable, the visit is eligible for the encounter rate reimbursement. For example, Washington Apple Health (Medicaid) covers only one dental cleaning per year for adults.[6] With the encounter rate payment model, a RHC can schedule a patient for their regular six-month oral exam, which is covered every six months and is an encounter-rate eligible service. However, during this encounter, a dental cleaning (or other needed services) may also be provided. This payment model promotes sustainability for RHCs since the encounter rate has been determined based on their costs of providing care and promotes better oral health for patients through increased access to preventive care and treatment.

[6] Refer to the Dental (https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#collapse_14_accordion) and RHC (https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#collapse_55_accordion) **billing guides for details about dental encounters and covered services.**

Referrals for specialty care

The scope of dental services for RHCs will not cover all dental needs of the patient population so it is important to make connections with dentists, denturists, endodontists, and oral surgeons in the community who will take referrals for specialty care.

KVH works to ensure that patients don't slip between the cracks and can help overcome access barriers by providing transportation arrangements. This is essential in a rural community as some specialty providers can be 70 miles away.

Revenue cycle

In addition to all the new processes that need to be figured out when adding dental services, the revenue cycle is another piece of the puzzle.

JH made the choice to use a local vendor that specializes in dental billing. This decision was made as a team during the planning process, taking into consideration what made sense and would be a successful solution. Their existing staff did not have knowledge about the differences between medical and dental billing. Although there is an additional expense when using a vendor, their specialized knowledge outweighed the cost. Several years into dental implementation, JH continues to use a third-party for billing. They have found that it is the best ongoing solution for their clinic.

KVH runs their dental billing and collections through the main hospital billing department and hired an employee who had previous experience in billing dental services. The dental biller had prior knowledge of dental billing, claims denials, and collections. Additional training was needed on the guidelines for billing Medicaid as an RHC. The billing department receives payments, processes them, rebills insurance claims, and completes the reports associated with operation that the administration needs. They also submit claims through a clearing house, Electronic Dental Services. The clearing house provides a daily report that identifies any claims submitted with incomplete or missing information. These claims are held within the clearinghouse, allowing corrections to be made before sending. This helps to reduce the number of denials, as well as partial payments.

Dental encounter rates (see the ***Establishing an Encounter Rate*** section) are established based on the costs to provide care. Although there are many challenges related to revenue cycle, the dental encounter rate model allows for an RHC to be a successful and sustainable dental care provider for adults with Medicaid coverage.

Emergency Management and COVID-19

In addition to learning how to successfully operate a dental clinic within a Rural Health Clinic and hospital system, JH and KVH also learned how to operate amid the COVID-19 pandemic. Workflows that had just been created prior to COVID-19 had to rapidly change to adapt to the pandemic and follow guidelines from the Centers for Disease Control and Prevention, the American Dental Association, the Governor, and the Washington State Dental Association.

Operating from within a rural hospital system offered some advantages over that of a stand-alone dental office. For example, patients could receive COVID-19 tests through the hospital or clinic before an aerosolizing dental procedure. During the nine-week period between March and May 2020 when the Washington State Governor's proclamation shut down dental services except for emergencies, JH was able to find work in their health system for dental staff and did not have to lay off any positions. KVH had only been open for five months before the Governor's proclamation closed regular dental operations. It was certainly an unforeseen complication to occur in the first few months of opening. They continued to see emergency issues at that time, and then fully reopened as soon as possible.

JH uses an incident command structure for decision-making related to COVID-19 across their health system, in which leaders delegate and provide updates to all departments. During COVID-19 surges, when it was of the utmost importance to keep people out of the emergency room who were presenting for dental issues, the dental clinic would ensure there was extra time built into their daily schedules to accommodate emergent dental needs that may have otherwise sought care in the emergency room or an urgent care. The dentists have a weekly huddle to determine if any routine and preventive dental appointments need to be rescheduled to ensure extra time is available for emergencies. Throughout the COVID-19 pandemic, the JH dental clinic continually made adjustments and was responsive to the needs of the rural health system as a whole and community.

CONCLUSION

Impact

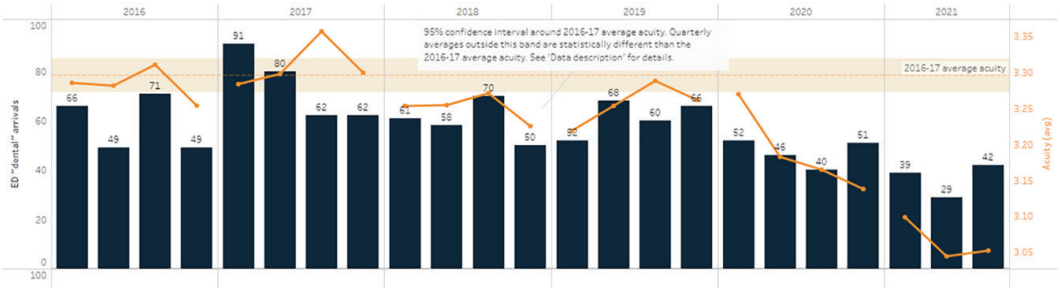
The University of Washington School of Dentistry (UWSOD) has worked with DOH and JH to provide a mixed-methods evaluation of the pre-intervention, growth, and maturation phases of the dental clinics started by RHCs in Washington. The mixed-methods approach incorporates qualitative research from interviews with community-based stakeholders, and quantitative research from Medicaid enrollment and claims data analysis.

Early findings from the evaluation of this project indicate that adding dental service lines in RHCs makes a meaningful difference in access to oral health and oral health status for adults with Medicaid. The clinic is beginning to meet the needs of the community through accessible, high-quality care. UWSOD conducted qualitative research with community members, providers, and administrators from October 2020 – April 2021.

- Community members reported that the clinic provided an affordable, local option for care that was previously unavailable to low-income residents.
- Community members described the clinic as beautiful and clean, and the care as being patient-centered, which included providing oral health education, communicating about treatment options, and preserving rather than extracting teeth.
- Despite being excited about the new clinic, some community members were frustrated with the long wait times to get an appointment.
- Similarly, the main challenge for the clinic was not being able to meet the high demand for care.
- Other challenges include hiring and retaining staff, managing the large number of dental emergencies, and figuring out how to operate a dental clinic within a hospital system.

Despite challenges, since the opening of the dental clinic, the total number of dental related emergency room and express care visits has decreased in volume and in acuity (**Figure 4**).

FIGURE 4. Emergent "dental arrivals" at Jefferson Healthcare



Arrival totals for dental encounters in the Emergency Department . Average acuity values (measured on a 1-5 scale) for all ED encounters shown (orange lines). Quarters shown are complete.

Looking Ahead

Additional RHCs are in the process of implementing dental services and expanding access to oral health care for rural populations in their service areas. Columbia County Hospital System opened a dental clinic in July 2021 as part of their Columbia Family Clinic, an existing Rural Health Clinic in Dayton, WA.[7] There was a severe access to care issue in their community for adults with Medicaid dental coverage as there are no private practice dentists who accept Adult Medicaid. Their health system recognizes that oral health impacts a person's overall health and quality of life. Their clinic will focus on seeing patients with Medicaid, as well as older adults on Medicare who do not have dental coverage.

Astria Sunnyside Hospital is in the process of adding dental services to one of their RHCs in Sunnyside, WA. Sunnyside Hospital identified many unmet dental needs among their patients, despite being in an area where there are Federally Qualified Health Center (FQHCs). The FQHCs are at capacity for dental services and are not accepting new dental patients from outside of their clinics. This has left a gap for oral health services for the adults with Medicaid who use Sunnyside's RHCs for medical care. Sunnyside formed a strong community partnership with a local dentist who is dedicated to reducing access barriers and providing dental services to underserved populations. Their dental clinic is anticipated to open in 2022.

We anticipate that the RHC dental services model will continue to grow and gain traction across Washington state. RHCs provide rural communities with valuable, much needed health services. By expanding to deliver oral health services, they can truly move forward toward meeting the goal of whole person health care.

[7] https://www.daytonchronicle.com/story/2021/07/08/news/columbia-family-dental-clinic-ribbon-cutting-and-grand-opening/1979.html

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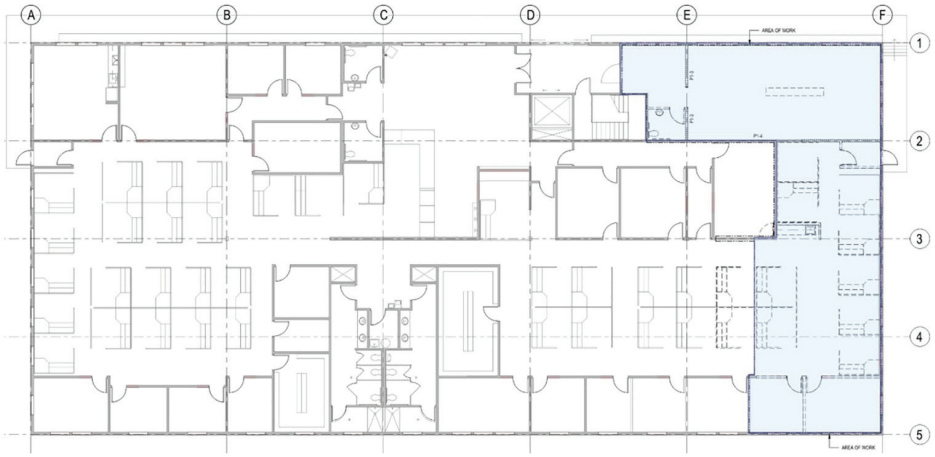
Additional gratitude goes to JH and KVH who have generously shared their experiences and lessons learned and serve as models for other RHCs seeking to expand access to oral health care for their patients.

APPENDIX A

Original floorplan - Jefferson Healthcare Sheridan Building



New floorplan with dental clinic

APPENDIX B

KVH equipment list

Category	Quantity	Equipment	Quote	Tax	Ship	Total
	3	DCI Series 5 Dental Chair, ErgBack Plush	$5,107.00		$350.00	$15,671.00
	3	Ultra leather on patient chairs	$361.00			$1,083.00
	3	Swing mount light pole	$557.00			$1,671.00
	3	Series 5 light w/DC setting	$2,030.00			$6,090.00
	1	StatClave G4 Autoclave	$6,769.00	$511.43	$50.00	$7,330.43
	1	Hydrim C61 W G4 Instrument washer	$5,231.00			$5,231.00
	1	Hydrim cleaning detergent, CS-HIPCU/ 8/case	$139.99		$ -	$139.99
	2	XTG Handheld x-ray	$5,082.00			$10,164.00
	3	ASI carts	$10,950.00		$1,485.00	$34,335.00
	3	Arm, 16" white	$450.00			$1,350.00
	3	Amalgam Separator	$175.00			$525.00
	1	Quick Connect Kit-waste purge	$75.00			$75.00
	3	workstations laptops	$3,000.00			$9,000.00
	1	Open Dental 12 months	$1,825.20	$136.89		$1,962.09
	1	Dentimax imaging	$2,644.00	$ -	$ -	$2,644.00
	1	Vitals machine	$1,922.61	$ -	$ -	$1,922.61
	1	Vitals machine, additional	$1,922.61			$1,922.61
	3	Supply cart	$500.00			$1,500.00
	1	Turbo Sensor Ultrasonic	$889.99			$889.99
	1	Acclean Ultrasonic insert IF-50 slim 30kHz	$89.99			$89.99
	1	Sterilization load gun	$147.47			$147.47
	1	Sterilization label	$26.20			$26.20
	2	stools recovered	$200.00			$400.00
	1	Ultrasonic Cleaner kit	$197.99			$197.99
	1	Ultrasonic Cleaner	$349.79			$349.79
		Misc from Koch office				$8,000.00
	3	chair controller	$450.00			$1,350.00
	3	Maxima Pro 2S HSP Handpieces	440.99			$1,322.97
	2	Maxima pro Multiflex coup 4 hole	193.49			$386.98
	1	Roll out laundry bin	$175.00			$175.00
	1	Laundry rack	$150.00			$150.00

APPENDIX B (continued)

Category	Quantity	Equipment	Quote	Tax	Ship	Total
Amalgam	1	Amalgam 2 spill, titan	$649.00			$649.00
	1	Wizard Wedges	$34.41			$34.41
	1	matrix band 13 .0015	$6.79			$6.79
	1	matrix band 2 .0015	$6.79			$6.79
	2	matrix band 1 .0015	$6.79			$13.58
Anesthetic	1	needles 30g blue, short	$8.79			$8.79
	1	needles 27g, yellow long	$8.79			$8.79
	1	recap cards	$16.19			$16.19
	4	Topical anesthetic, strawberry	$4.99			$19.96
	4	Citanest 4% Forte	$53.99	$0.21	$2.74	$215.96
	1	Citanest Plain	$47.99			$47.99
	2	HurriCaine Topical liquid	$10.49			$20.98
	1	extra short needles 30g,	$13.73			$13.73
	1	Intraligamental syringe	$29.99			$29.99
Burs	1	557	$130.99			$130.99
	2	557 Surg	$15.49			$30.98
	2	830-012M diamond	$20.29			$40.58
	2	886-012M Diamond	$20.29			$40.58
	2	856L-016M diamond	$20.29			$40.58
	2	379-023M Diamond	$20.29			$40.58
	2	61 a Lab	$8.29			$16.58
	2	88A lab	$8.29			$16.58
	3	7613 Finishing	$22.49			$67.47
	4	7902 Finish	$22.49			$89.96
	4	7406 finish	$22.49			$89.96
	3	4 latch	$14.79			$44.37
	2	2	$16.79			$33.58
	3	44563	$16.79			$50.37
	7	Bur Blocks, 12 bur	$8.09			$56.63
	1	Storage case, 18 grid	$10.99			$10.99
	6	Magnetic bur blocks	$11.99			$71.94
C&B	1	Structure temp crown A2	$109.99			$109.99

APPENDIX B (continued)

Category	Quantity	Equipment	Quote	Tax	Ship	Total
Composite	1	Etch	$10.29			$10.29
	1	Epic U	$86.99			$86.99
	1	Bean matrix	$32.79			$32.79
	1	plastic matrix bands	$11.19			$11.19
	2	Finishing strip Med/fine	$14.29			$28.58
	1	GrandioSo D3	$83.79			$83.79
	1	GrandioSo A3	$83.79			$83.79
	1	GrandioSo A2	$83.79			$83.79
	1	FuturaBond U Dual Cure	$131.19			$131.19
	1	Beautifil Flowable A3	$35.19			$35.19
Disposables	1	Cotton tip applicators 6"	$10.79			$10.79
	1	Cotton rolls	$16.79			$16.79
	2	NEO dry lg, reflective	$14.39			$28.78
	1	Bibs, lavender	$21.29			$21.29
	10	Evac tips	$3.29			$32.90
	10	Saliva ejectors	$2.99			$29.90
	10	A/W, evac, HV, covers	$9.59			$95.90
	3	Chair Covers	$15.99			$47.97
	1	2x2 Exodontia sponge	$48.29			$48.29
	2	Micro brush, green, 2mm	$7.49			$14.98
	1	Infusor yellow tip	$34.99			$34.99
Endo	1	Cavit E	$30.39			$30.39
	1	Eugenal	$24.23			$24.23
	1	K file 15-21	$7.29			$7.29
	1	K-file 10-21	$7.29			$7.29
	1	RC sealer, Tubli-Seal	$83.99			$83.99
	1	RC Prep	$35.99			$35.99
	1	closed end irrigation needle	$61.59			$61.59
	1	maxima K-file size 20 25mm	$7.48			$7.48
	1	maxima K-file size 10 25mm	$7.48			$7.48
	1	Maxima K-file size 15 25mm	$7.48			$7.48

APPENDIX B (continued)

Category	Quantity	Equipment	Quote	Tax	Ship	Total
	2	Edge Taper 25mm	$28.95			$57.90
	1	classic gutta percha F1	$11.99			$11.99
	1	Classic Gutta Percha F2	$11.99			$11.99
	1	Classic Gutta Percha F3	$11.99			$11.99
	1	Calcium Hydroxide powder	$21.83			$21.83
	1	System B Cordless heat unit/Endo	$338.39			$338.39
		EndoSequence 2 Cordless Endo motor	$894.88			$894.88
Hygiene	1	Prophy Paste	$50.29			$50.29
	1	Acclean Prophy Angle	$31.49			$31.49
	1	HS sealant	$23.79			$23.79
	1	floss threaders	$26.39			$26.39
	4	waxed floss	$3.19			$12.76
	1	Titan sonic scaler with 5 tips	$971.99			$971.99
	2	Acclean ultrasonic insert IF-1000 30kHz	$89.99			$179.98
	2	Acclean ultrasonic insert IF-50 30kHz	$89.99			$179.98
Instruments	2	Double sided mirror head	$41.59			$83.18
	2	Burnisher 27/29	$9.79			$19.58
	4	Amalgam carrier Med/x-lg	$14.29			$57.16
	1	BW sensor holder	$64.29			$64.29
	1	anterior sensor holder	$64.29			$64.29
	6	Cleoid Discoid 3/6	$13.99			$83.94
	1	Code-A-Color	$57.99			$57.99
	4	Posterior sensor holder	$64.29			$257.16
	1	20 instrument	$29.99			$29.99
	5	20 instrument	$29.99			$149.95
	1	15 instrument	$124.99			$124.99
	1	10 instrument	$139.99			$139.99
	1	5 instrument	$52.99			$52.99
	1	A/W tips metal	$29.97			$29.97
	1	Double sided mirror	$37.00			$37.00
	2	Root tip pick	14.79			$29.58
	2	Curv elevator	$14.79			$29.58

APPENDIX B (continued)

Category	Quantity	Equipment	Quote	Tax	Ship	Total
	1	Periotome anterior	$31.03			$31.03
Maintenance	3	Water disinfection canister	$215.00			$645.00
	2	Spay and Clean Lubricant	$13.79			$27.58
	1	Keep Clear Enzyme	$54.50			$54.50
	2	Amalgam Separator	$102.50			$205.00
	1	Amalgam recycle kit	$199.00			$199.00
Misc	1	Lime-Lite	$30.79			$30.79
	1	Quick Stat clear	$39.59			$39.59
	1	IRM	$84.49			$84.49
	1	Temp Cem	$27.79			$27.79
	1	Ketac Cement	$156.29			$156.29
	4	Mixing pads 3x3	$2.49			$9.96
	1	Corrugated bin boxes	$44.53			$44.53
	1	3 ring binder, 1 inch	$6.62			$6.62
	4	Mr. Thirsty attachment hose	$68.87			$275.48
	1	Mr. Thirsty small	$223.24			$223.24
	2	Mr. Thirsty large	$69.82			$139.64
	6	Magnetic Bur block	$11.99			$71.94
Oral Surgery	1	Dry socket paste	$118.99			$118.99
	1	1/4 " Iodoform gauze	$3.99			$3.99
	1	suture 3-O BBS	$17.79			$17.79
	1	12 blades	$8.79			$8.79
	1	15 Blades	$8.79			$8.79
	2	Luxator Periotome 1L/3C 3mm	$107.99			$215.98
	1	Surgical handpiece	$359.99			$359.99
	1	suture	$17.97			$17.97
PPE	6	face masks, blue, level 2	$7.79			$46.74
	10	Med non latex glove, Criterion CR	$10.49			$104.90
	20	ex Large non latex gloves	$10.49			$209.80
	1	patient safety glasses	$13.05			$13.05
	6	NeoSoft Chloroprene gloves Lg	$11.99			$71.94
Sterilization	1	autoclave gloves, lg	$19.49			$19.49

APPENDIX B (continued)

Category	Quantity	Equipment	Quote	Tax	Ship	Total
	2	CRS wrap 15x15	$16.79			$33.58
	2	CRS wrap 18x18	$17.29			$34.58
	2	Sure-check strips	$15.03			$30.06
	1	Spore Check	$258.39			$258.39
	2	5.25x10 Sterilization pouch	$11.99			$23.98
	1	2.25x4 Sterilization pouch	$6.79			$6.79
	4	.75x9 Sterilization pouch	$8.99			$35.96
	3	Steam indicator tape	$4.99			$14.97
	1	MaxiSpray Plus 1 gal	$23.49			$23.49
	24	MaxiWipe x-large	$12.39			$297.36
						$127,209.95