DELTA DENTAL

DELTA DENTAL OF COLORADO FOUNDATION

Frequently Asked Questions

Dental Hygienist Co-location 2.0

1. What services can an unsupervised Dental Hygienist provide?

Refer to the Dental Practice Act of Colorado for detailed information on Dental Hygienists' scope of service. Specific language regarding unsupervised dental hygienists can be located beginning at Section 12-35-124, page 17 of the Act. The Dental Practice Act of Colorado was updated in 2014, and includes new provisions which can be accessed at the Colorado Dental Hygienists Association.

Some services that an unsupervised dental hygiene can provide include:

a. Screening and assessment

b. Prophylaxis (cleanings)

c. Application of fluorides and sealants

d. Gathering and assembling information including, but not limited to:

- Fact finding and patient history;
- Extra- and intra-oral inspection;
- Dental and periodontal charting; and,
- Radiographic and x-rays survey for the purpose of assessing and diagnosing dental hygiene-related conditions for treatment planning for dental hygiene services.

e. Scaling and root planning

2. What procedure codes can be billed by an independent dental hygiene provider (IDHP)?

The type of procedure codes that an IDHP can bill for will vary based on insurance:

- ***Medicaid.*** Page 5 of the January 2011 Health Care Policy and Financing (HCPF) Provider Bulletin outlines the procedures that can be billed by an IDHP. For more information on the Medicaid Dental Plan Program and Fee Schedule, please refer to: http://www.dentaquest.com/state-plans/regions/colorado/dentist-page/.
- ***Child Health Plan+ (CHP+).*** For information on the CHP+ program, please click: http://www.deltadentalco.com/chp.aspx. If contracted with Delta Dental of Colorado, Dental Hygiene Providers are able to bill for procedures based on the scope of the hygienist's license.

Key Dates

Friday, September 5, 2014
Grant and Budget Applications Due by 5:00 p.m. MDT

Friday, October 10, 2014
Notify Applicants of Awards

November 2014
Grant Period Begins

For additional information, please contact:

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- ***Private Insurance.*** A practice will need to check with individual private insurance carriers to understand what procedure codes can be billed by an IDHP.

3. What is the average salary for a dental hygienist?

Of course, there is variation in the salary of a dental hygienist. For reference, the midpoint salary for a full-time dental hygienist in a federally qualified health center (FQHC) is approximately $71,000/annually. The hourly rate for a hygienist working at the University of Colorado is approximately $32/hour.

4. What activities are included in the start-up period?

Refer to the Request for Applications for a list of activities. The Delta Dental of Colorado Foundation (DDCOF) program team will work closely with practices to complete all program activities during the start-up period and throughout the program implementation and evaluation. If you have specific ideas on how to approach these activities, include your ideas in your proposal. If needed, the program team is available to help you develop your ideas for the program activities. Some of the earliest activities include developing the co-location model, hiring or contracting with a dental hygienist, and identifying a dentist(s) in your community who will be available to refer patients as needed.

5. What equipment will the dental hygienist need?

The equipment needs will vary based on your practice and the type of co-location model. In some models, the co-located dental hygienist may have a close partnership with a dental clinic. In this model, the Registered Dental Hygienist (RDH) may provide a narrower range of services to a broader population in the medical practice (e.g. caries risk assessment, fluoride varnish application, oral health instruction, sealants, etc.)—and provide more comprehensive services in the partnering dental clinic. An example of this could be a FQHC with a dental clinic. In this model, the RDH may need less equipment.

In a different model, the RDH may provide services to the full scope of his/her license within the medical practice. In this circumstance, the RDH will need more equipment. Please include thoughtful rationale as to why or why not resources for dental equipment are being requested.

The program team is available to provide technical assistance to practices unfamiliar with the equipment needs of dental hygienists to help determine appropriate equipment for their proposed model.

6. What is the role of the practices in the evaluation of the project?

The evaluation of the Co-Location 2.0 program will be multi-level: healthcare professional, parent/caregiver, and patient/child. It will be conducted through a partnership between the participating practices and evaluation team. Practice partners will be asked to conduct a variety of evaluation activities that will include such things as:

- Distributing surveys to healthcare professionals' (e.g. through online link)
- Identifying a cohort of families with young children and inviting them to complete a short survey and have their child's teeth examined (e.g. mailed invitation or waiting room recruitment)

- Track various metrics in your patient population (see metrics below)
- Allowing practice staff to participate in various activities such as annual learning sessions

The co-located dental hygienist will partner in the collection of various data including the dental experience of patients served (e.g. decay, plaque, others).

Examples	Baseline*	Year 1	Year 2	Year 3**
# RDH visits				
# RDH examinations				
# caries risk assessments				
# fluoride varnish applications				
# sealants placed				
# x-rays				
# prophys (cleanings)				
Others…				

**in some practices, oral health services may already be provided (e.g. through Cavity Free at Three)*
***we may be interested in collecting data for more than two years*

7. What is the timeline for the evaluation?

The overarching goals of the program are to improve the oral health awareness of healthcare professionals and parents/caregivers, reduce patients' risk for dental disease, and ultimately improve patients' oral health. To do this, we will longitudinally measure these outcomes before your practice co-locates a dental hygienist (baseline) and then one or two times annually for three years. The dental hygienist will be instrumental in helping measure and track these outcomes.

In November 2014, all practices will receive confirmation if their funding proposal was approved. Funding is available for up to ten medical practices. Since it takes a lot of resources to support practices during the start-up period, we will be phasing practices into the program in two phases:

- ***Phase I:*** Of the ten practices funded, five practices will be selected to co-locate a dental hygienist in late 2014. In Phase I practices, we will measure baseline outcomes very early in the program start-up timeline. In some practices, we will start measuring them before the hygienist is co-located; in others the co-located hygienist will help measure these outcomes.
- ***Phase II:*** The remaining five practices will co-locate a dental hygienist in 2015. These Phase II practices are very important and can increase the rigor of the evaluation. Practices willing to be Phase II practices will NOT be at any disadvantage in being selected to receive funding support. We would like to track the program outcomes in Phase II practices during 2015 before they co-locate hygienists.

If you would like to be considered as a Phase II practice, please let us know. In your proposal, please include your willingness to help/coordinate the collection of baseline measures before co-located care is provided.

8. How much funding is being made available to fund Co-location 2.0? How many years of funding can we request?

Funding is available to support medical practices to implement this program by providing salary support and equipment. While there are many factors that impact the amount of funding requested, we anticipate that funding requests will be in the range of $50,000 - $150,000 depending on the type of model and scope of services offered. Funding requests may be more or less based on individual circumstances such as the type of equipment requested or the amount of salary support needed to attain sustainability.

Organizations can apply for up to two-years of funding to support co-location. It is anticipated that funding requests for year one will be greater than year two, as services reach a level that enables billings and revenue that will enable sustainability.

9. Are we supposed to submit our budget in a certain format?

As outlined in the RFA, please submit a three-year program budget that includes all projected expenses and revenue that shows how the co-location program will become self-sustaining. Though you can only ask for up to two-years of funding, please provide a three-year budget to demonstrate your sustainability plan.

There is not a required format for your budget; however if you need a starting place, here is a template. Please also include a budget narrative that describes the detail of the budget spreadsheet.

10. Can I still submit a proposal if I didn't submit a Letter of Intent?

Yes. Letters of Intent help us plan the review of proposals and range of interest but are not mandatory.

11. What are some important considerations in developing a business model and budget?

An important objective of Co-location 2.0 is to build sustainable, integrated medical-dental business models. The goal is that the RDH is an embedded provider in your practice. As you think about your co-location model, think about what you would need to do to add another medical provider to your practice, for instance, building them a schedule template to which your staff can appoint patients or including their patients in the list of other patients you recall/remind, etc. We look forward to the creative business models that you are developing.

When developing your RDH business model, here are some questions to consider:

- What will your costs be?
- What expenses will the medical clinic cover as a part of this program?
- What will the RDH wage/salary/benefits be? Will the dental hygienist be an employee or contractor who has his/her own independent practice? If a contractor, will she need salary support initially until s/he is generating enough revenue to support her/his own salary?
- What supplies will the RDH need?

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- What aspects of co-location will be integrated within the medical clinic (e.g., scheduling, record keeping, billing)?
- Who will schedule the patients? Will you build another provider template for her/him into which your current schedulers can appoint patients?
- What revenue will the RDH generate?
- Who will the RDH see in your practice?
- What % of your patients are children? Adults?
- What types of insurances do your patients have? Medicaid? CHP+? Private? Uninsured?
- What do these insurances reimburse for dental services?
- What percentage of patients already have a dental provider?
- If you are a FQHC/CHC, what is your dental encounter rate?
- If you are a private practice, what kind of contract will you need to negotiate with a co-located hygienist? Perhaps you already have worked through some of these issues with a co-located behavioral specialist or nutritionist?
- How long do you think it will take for a hygienist to build up a patient panel?
- What will be the estimated realization rate of the RDH?

Below are two examples of some assumptions you might make in your business model.

Federally Qualified Health Center

The Dental Hygienist…

- ☑ Is a salaried employee
- ☑ Provides services including: risk assessment/oral health evaluation, fluoride varnish application, sealants, scaling and root planing, x-rays (dependent on availability of space)
- ☑ Sees 75% children under 18 years of age; 25% adults
- ☑ Sees 50% Medicaid, 25% CHP+, 25% Private
- ☑ Sees patients 4-5 days/week
- ☑ Schedules 15 patients/day
- ☑ Bills at dental encounter rate
- ☑ Assumes a no-show rate typical to specific FQHC
- ☑ Assumes a 6-12 month period to establish a patient population and reach capacity
- ☑ Needs a start-up period before s/he has a patients panel

Private Practice & Independent Hygienist Model

The Dental Hygienist…

- ☑ Is a salaried employee or contractor of the medical clinic with salary support until claims reimbursement supports salary cost
- ☑ Becomes an established Medicaid/CHP+ provider

- ☑ Provides services including: risk assessment/oral health evaluation, fluoride varnish application, sealants, scaling and root planing, x-rays (dependent on availability of space)
- ☑ Sees 75% children under 18 years of age; 25% adults
- ☑ Sees 50% Medicaid, 25% CHP+, 25% Private
- ☑ Sees patients 4-5 days/week
- ☑ Schedules 15 patients/day
- ☑ Bills independently
- ☑ Assumes a no-show rate typical to medical clinic
- ☑ Assumes a 6-12 month period to establish a patient population and reach capacity
- ☑ Need a start-up period before s/he has a patients panel
- ☑ Potentially needs billing support staff

These are just a few things to consider when building your business model.

12. What supplemental materials should we include in our grant application?

If possible, please include photographs of the proposed space that will be used to co-locate the dental hygienist.

For additional information, please contact:

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