Dental Public Health Project Descriptive Report Form

Name of Project
Advancing Maternal and Child Health Through Integrated Oral Health Care
Executive Summary
The Wisconsin Medical Dental Integration (MDI) project addresses persistent inequities in early preventive oral health care for children and pregnant women, particularly among families with low-income and communities of color. With limited Medicaid dental participation and significant structural barriers, many families struggle to access timely care, resulting in high rates of early childhood tooth decay and unmet dental needs. MDI responds by embedding dental hygienists into primary care teams, allowing children and pregnant women to receive preventive oral health services during routine medical visits. Since launching in 2019, the project has supported clinics statewide with workflow design, electronic health record (EHR) modifications, billing strategies, financial planning, referral network development, and evaluation. To date, 14 clinics across 11 health systems have integrated 18 dental hygienists into primary care teams, collectively reaching more than 17,000 patients. Current goals focus on expanding oral health literacy, strengthening surveillance, training nondental providers, improving data collection, and disseminating findings to support broader adoption. Sustainability relies heavily on Medicaid billing, which provides a stable revenue stream for preventive services delivered in primary care. Clinics are encouraged to use established procedure codes for assessments, fluoride varnish, and other early interventions to maintain financial viability beyond grant funding. The project collects monthly process data and annually reviews CMS-416 reports to compare medical and dental utilization, helping identify gaps in early preventive care. Results are shared through conferences, publications, Children's Health Alliance of Wisconsin (Alliance) communications, and learning collaboratives. Lessons learned highlight the importance of strong medical champions, experienced hygienists, flexible integration models, and robust onboarding. Ongoing challenges include clinic recruitment, staff turnover, and establishing consistent data workflows, but the project continues to refine strategies to support long-term statewide impact
Name of Program or Organization Submitting Project
Children's Health Alliance of Wisconsin (the Alliance)

Detailed Project Description

Project Overview

Early access to preventive oral health care (POHC) is critical to improving maternal and child health (MCH) outcomes. Yet families with low socioeconomic status and those from racial and ethnic minority groups continue to face significant barriers. In Wisconsin, only one-third of dentists accept Medicaid, and many families encounter social and structural obstacles that limit their ability to obtain needed care. These inequities contribute to disproportionate oral health outcomes: one-third of Head Start students experience tooth decay by age 3 and half by age 5. Kindergarteners and third-graders of color have higher rates of tooth decay and more early or urgent dental needs compared with their white peers.

Disparities persist in preventive care. Asian and non-Hispanic Black third-graders are significantly less likely to have dental sealants. Pregnant women, particularly women of color and those with public insurance, are less likely to receive a dental cleaning during pregnancy, despite the well-established importance of oral health for both maternal and infant health.

1. Target population

The goal of the WI MDI project is to increase early access to preventive dental care for children ages 0 to 21 years old and pregnant women by embedding dental hygienists into primary care medical teams.

2. Background information

MDI aims to leverage primary care appointments to provide early dental prevention and intervention services, as well as connect patients with dental homes. Integrating POHC into primary care is a powerful strategy for reducing social and structural barriers and improving access for MCH populations at increased risk for poor oral health.

Building on advocacy efforts that led to 2017 legislative changes which expanded settings where dental hygienists can practice without supervision, the Alliance and the Medical College of Wisconsin (MCW) launched the WI MDI project in 2019.The Alliance and MCW have a long history of partnering to improve children's oral health, supported through multiple successful funding opportunities. Since 2019, the team has collaboratively led statewide facilitation, coaching, and implementation efforts, guiding health systems and federally qualified health centers through both the planning and operational phases of integrating POHC into primary care.

The project supports clinics on workflow planning; documentation and EHR modifications; billing and revenue cycle adaptations; financial sustainability strategies; project evaluation; development of dental referral networks; and connections to the dental hygiene workforce. Dedicated coaching calls support clinics in achieving meaningful progress in implementing MDI.

To date,14 Wisconsin clinics have integrated 18 dental hygienists across 11 health systems, reaching over 17,000 children and pregnant women with integrated POHC. Most clinics started serving children with the goal of expanding services to include pregnant patients.

3. Project goals

The project is centered on making oral health care more equitable and accessible by ensuring children and families receive preventative care as early as possible. The current

limited dental infrastructure in Wisconsin cannot adequately accommodate existing oral health needs in the state. Medical Dental Integration is an innovative and low-cost solution that expands access to preventive dental services through the adoption of 2017 Act 20, which permits dental hygienists to practice without the direct supervision of a dentist in Wisconsin. Deployment of dental hygienists in the primary care setting provides greater access to preventive services. While the goal of the project is to integrate hygienists into medical care teams, clinics that are not yet ready to fully implement MDI can begin with equipping medical providers with oral health knowledge and making oral health risk assessments part of their care. Primary care providers see children most often and are positioned to provide oral health education and identify risks early. To gain a baseline understanding of oral health and disease, we recommend all medical staff complete at least the applicable modules offered through the free online *Smiles for Life Curriculum*.

At the same time, the initiative focuses on increasing oral health awareness among families and caregivers. When parents understand the importance of early prevention and know how to support their child's oral health at home, children are far more likely to avoid preventable disease. Together, these efforts create a stronger, more informed network of providers and caregivers, making early preventative care more accessible and more equitable for all children.

The project goals are measured by a family of common metrics collected at the clinic level and used among all states working on the HRSA-funded MCH-IOHI grant. While implementation has been successful in two clinics under this funding, efficient data collection has been a challenge due to each clinic having different data reporting processes and electronic health records. To reduce the overhead data collection and analysis burden for both clinics and project staff, we contract with a health information technology expert to provide technical support to clinics on data collection. Once data collection is established at the clinic level, the data will be used to coach clinics on quality improvement opportunities.

Resources, Data, Impact, and Outcomes

1. What resources were/are necessary to support the project?

Several key supports are essential for this project to succeed. Meaningful systems change in primary care begins with recognizing the critical role dental hygienists play in delivering early preventative services. Integration of a full-time integrated hygienist is the ideal model for MDI. When considering hiring a dental hygienist, it is important to understand the differences between working in a traditional dental office vs. working in a MDI setting. A MDI hygienist has unique responsibilities that are often not part of a traditional dental hygiene job. The hygienist will work autonomously as the oral health expert on the medical team and thus will benefit from having previous experience working in a dental setting as a dental assistant or dental hygienist. Additional resources for hiring a hygienist, including a sample job description and interview questions, are available in the Wisconsin MDI Implementation Guide.

Clinics have success when they first gain organizational and leadership support by determining the need and demand for integration of dental hygienists within the medical team, as well as ensuring that MDI will align with the organization mission, purpose, and strategic plan. Additionally, determining which medical provider is willing to champion MDI, ensuring operations staff are aware of and support MDI, and engaging IT and billing staff to ensure any changes necessary are in place before MDI begins are necessary first steps.

Long-term sustainability depends on establishing reliable pathways for reimbursement. Medicaid reimbursement offers the most viable route to ensure that preventative oral health services can continue to be delivered consistently and equitably across primary care settings. Some clinics choose to offer MDI visits to patients with commercial insurance or no

insurance as well. However, currently in Wisconsin, clinics can receive reimbursement for dental care provided to patients enrolled in Medicaid and not for those with private or no insurance. This requires working with the clinic's billing department to ensure that these services are submitted for reimbursement as medical claims.

2. **Process measure data are being collected on the following:**

- Oral health risk assessment: Children and pregnant women who received an oral health risk assessment during a primary care visit.
- Oral health evaluation (screening): Children and pregnant women who received an oral health evaluation (i.e., clinical oral health screening) during a primary care visit.
- Fluoride varnish: Children and pregnant women who received a fluoride varnish application during a primary care visit.
- Sliver Diamine Fluoride (SDF): Children and pregnant women who received a SDF application during a primary care visit.
- Self-management goal: Children and pregnant women with an oral health self-management goal established during a primary care visit.
- Urgent referral: Children and pregnant women who received a dental referral for urgent treatment during a primary care visit.
- Closed urgent referral: Children and pregnant women who received a dental referral for urgent treatment during a primary care visit who had a subsequent dental visit (Dental referral sites are up to the implementing clinics to identity).

What outcome measure data are being collected (e.g., improvement in health)?

Outcome measure data are being collected on the percentage of children and pregnant women who receive both medical and dental visits annually. We are still exploring how to monitor longer term outcome data because of MDI. As part of our HRSA project, we are working with a data specialist to help clinics pull data from Epic and intend to track disease rates of children participating over time in the future.

How frequently are data collected?

Data are collected on an ongoing basis, but one of the most important measures we rely on is the annual review of the CMS-416 report. This report allows us to compare how many children receive medical visits versus how many receive dental encounters. Looking at these numbers side-by-side helps us understand where gaps in early preventive oral health care still exist and where additional support or integration efforts may be needed. Over time, these comparisons give us a clearer picture of whether more children are accessing preventative services earlier and more consistently.

3. **How are the results shared?**

Progress and outcomes from this work are being shared widely across statewide and professional conferences and through publications in academic journals. These results are also used in conversations with clinics that are considering adopting this model, helping them understand its impact and feasibility. One of the key components of the learning collaborative is connecting clinics interested in MDI with other clinics that have implemented the model. Sharing lessons learned between health systems and fostering partnerships has led to additional clinics joining the project.

To reach families, providers, and community partners, outcomes are highlighted through the Alliance blog and social media channels, making the successes and lessons learned accessible to a broader audience.

As part of our learning collaborative, we aim to empower clinics to use their own data for internal quality improvement. We encourage them to reference evidence-based resources, such as the article published in the *Journal of Dental Hygiene* (June 2023) titled "Medical Dental Integration in Wisconsin: Integrating dental hygienists into pediatric well child visits and prenatal care" to guide their efforts and strengthen their approach to early preventative oral health care.

Budget and Sustainability

1. What is/was the budget for the project?

The project supports expansion of Wisconsin's MDI program by providing clinics with small stipends for data collection and participation in a learning collaborative, while clinics employ and pay dental hygienists directly. A critical component of sustaining MDI long term is ensuring that clinics can reliably bill Medicaid for preventive oral health services delivered during integrated visits. The MDI model is supported with an upfront profit-generating strategy, with hygienist expenses typically covered by treating about 17 Medicaid patients per day.
Clinics are encouraged to use preventive procedure codes that align with services commonly delivered by dental hygienists in primary care, such as assessments, fluoride varnish applications, and other early interventions. These codes have established Medicaid reimbursement rates, which vary across the state and in pilot counties, and form the financial backbone of integrated care. While some procedures require additional equipment, they also offer higher reimbursement potential, helping clinics offset startup costs over time. Because reimbursement rates can change, clinics should verify current Medicaid rates through the Medicaid Interactive Fee Schedule. For broader insight into commercial insurance reimbursement, clinics may reference tools such as Fair Health Consumer. By building a billing structure that reflects the value of preventive oral health services, clinics can maintain integrated care models well beyond initial implementation, ensuring children continue to receive early, accessible, and equitable oral health prevention.
This model also yields long-term cost savings by reducing emergency and inpatient care related to serious oral health conditions. Implementation is supported by the Alliance, which offers resources and technical assistance to clinics to ensure success.

2. How is the project funded?

Federal support through the HRSA Maternal and Child – Improving Oral Health Integration project currently provides the primary funding for Medical-Dental Integration (MDI) efforts in Wisconsin, enabling the state to expand integrated POHC and advance long-term sustainability. There have been a variety of funders supporting this work since its inception in 2017 to allow for development of the program, implementation and spread. The Alliance provides ongoing system-level technical assistance and data collection for programs.

Funding for the individual clinics implementing MDI is supported primarily through Medicaid funding. Financial models developed by the Alliance show that funding from Medicaid can support and even be revenue generating for programs by seeing as few as two Medicaid patients an hour.

3. What is the sustainability plan for the project?

The Alliance and the MCW have significant experience convening partnerships and driving systems change. The success of WI MDI is possible because of collaboration among the Wisconsin Department of Health Services (DHS), the Wisconsin Dental Hygienists Association, the Wisconsin Primary Health Care Association, the Wisconsin Academy of Family Physicians, the Wisconsin Dental Association, the Wisconsin Oral Health Coalition, and the Wisconsin Chapter of the American Academy of Pediatrics.

In support of MDI, the DHS Oral Health Program helps guide resource allocation and collaborates with the Division of Medicaid Services and the MCH Section to strengthen oral health surveillance. It also works to identify and maximize resources and community ownership to sustain services beyond federal funding. State medical and dental associations connect clinicians to project implementation, adaptation, and dissemination.

Sustainability remains a central priority. Through an environmental scan, the Alliance and the MCW identified Medicaid reimbursement in specific clinic settings as a key pathway to long-term viability, along with the potential for private insurers to expand reimbursement. Once clinics fully implement the model, Medicaid billing becomes the primary mechanism for sustaining integrated POHC, making it essential to address billing barriers and broaden payer participation.

Medicaid reimbursement provides a consistent revenue stream for preventive services such as risk assessments and fluoride applications, ensuring integrated care remains financially viable.

Other sustainability components include the Wisconsin Medical Dental Integration: Integration Guide to Integrate Dental Hygienists into Primary Care Teams, coaching calls, the Advisory Council, learning collaboratives, and ongoing data collection and evaluation.

Lessons Learned

What lessons were learned that would be useful for others seeking to implement a similar project?

A common concern raised by health systems early on was the belief that integrating preventive oral health services would take too much time in an already packed clinic schedule. But as highlighted in the Hygiene Rising podcast, early adopters like Thomas Huffer, MD, MS, FAAP, and Olivia Morzenti, RDH, CDHC, MS, of Preventive Health discovered the opposite once they began implementing the model. They found that when workflows are designed well and hygienists practice at the top of their license, the process is efficient and far less time-intensive than clinics initially feared. Their experience shows that integrating preventive oral health care is not a burden; it is a sustainable approach that strengthens care without slowing clinics down.

In 2024, the Alliance and MCW received funding to conduct patient interviews of caregivers who had a child with a MDI visit. Patients reported that the hygienist coming in the exam room filled the gap of time when they would typically wait for the provider. All of the families interviewed reported a positive experience with their MDI visits, noting convenience, increased oral health knowledge, and referral to a dental home as some of the key positive outcomes.

As implementation progressed, it became clear that clinics benefit from a flexible approach. A tiered model allows clinics to adopt the level of POHC that aligns with their staffing, structure, and patient needs, ranging from basic screenings and fluoride varnish to full integration of a dental hygienist within the primary care team.

MDI implementation has also revealed challenges that inform ongoing improvement. Securing a medical champion helps drive workflow adoption and team engagement, and hiring a hygienist with prior clinical experience leads to smoother implementation than onboarding a new graduate**.** Staff turnover in medical clinics remains a recurring challenge, making strong onboarding essential so new staff understand the hygienist’s role and how to collaborate effectively. Early implementation can be slow as hygienists build visibility and integrate into workflows. This internal “marketing” is a key part of systems change and helps establish the hygienist as a trusted member of the care team.

Unanticipated outcomes

Recruiting dental hygienists can be a challenge. Because the MDI model allows hygienists to practice without direct dentist supervision and serve as the primary oral health provider, new graduates may struggle in this environment. In contrast, hygienists with prior clinical experience adapt more successfully, supporting stronger sustainability and retention. This model is particularly attractive to hygienists seeking greater autonomy or a change in practice setting.

Another challenge has been the timeframe required for clinics to fully implement the model. Internal factors, such as competing priorities, hiring delays, and broader organizational demands, require adjustments to original timelines. Extending the implementation period ultimately allowed clinics to adopt the model more thoughtfully and positioned them for long-term success.

We have experienced limitations in data collection. Each clinic operates within a different health system, requiring unique processes for requesting and setting up data reports. This has caused delays while systems are being established, and manual data entry has been required instead of automated reporting. To address this, we contracted with a health IT expert to standardize data collection and join coaching calls to support clinics. Our goal is for clinic data to be pulled monthly in a uniform report, reducing administrative burden on clinic staff.

Overall clinic recruitment remains challenging. System change is complex, and clinics need time, support, and internal alignment before committing to a new model of care. Onboarding clinics into this transformation requires patience and sustained engagement, as each organization must navigate its own priorities, capacity, and readiness for change.

Is there anything you would have done differently?

Identifying clinics for MDI participation was initially based on which sites had the capacity to commit within the required timeframe. As we plan future recruitment, we are taking a more data-informed approach. We are working with the state epidemiologist to map areas where children enrolled in Medicaid attend well-child visits but lack a dental home. This analysis will help identify high-need regions and more strategically target clinics where MDI can have the greatest impact.

Patient voice remains a top priority for the Alliance. We continue to build on insights from previous efforts, including CareQuest Institute for Oral Health's Elevating Community Voice project, which helped partners better understand patient experiences with MDI. This work continues to shape strategies for embedding community voice, and while challenges remain, we are committed to elevating patient perspectives in all aspects of implementation.

Resources

List resources developed by this project that may be useful to others (e.g., guidelines, infographics, policies, educational materials). Include links if available.
Children's Health Alliance of Wisconsin – Wisconsin Medical Dental Integration

References

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