Remote Supervision Dental Hygiene Toolkit

June 2023

Virginia Health Catalyst
The Intersection of Overall Health and Oral Health

United Concordia Dental

Using this Toolkit

The oral health workforce faces challenges to meet the demand for dental care and eliminate barriers to accessing care. Remote supervision dental hygiene is an innovative approach to support the workforce while also meeting the needs of patients. In Virginia, a registered dental hygienist can provide various preventive services in specific community settings without the direct supervision of a dentist.

Community-based care provided by a dental hygienist working under remote supervision meets patients where they live, work, and learn, easing barriers to accessing care while freeing up time for the supervising dentist to treat patients in their offices. Virginians, particularly those living in under-resourced areas or enrolled in the Medicaid program, often cite oral health services as an unmet need. Untreated dental disease can impact overall health and quality of life. Addressing barriers to care through remote supervision dental hygiene can improve access, focus on prevention, and allocate provider time efficiently.

This toolkit explains what remote supervision is, guides providers through the steps to implement remote supervision in the dental office or other place-based care, and provides additional resources for continued learning. It intends to serve as a playbook for dental providers, clinic staff, and health systems to design and implement a community-based dental program using hygienists working under remote supervision.

Table of Contents

SECTION 1

An Introduction to Remote Supervision

What is Remote Supervision?

Remote supervision (RS) occurs when a dental hygienist delivers care to a patient while supervised by a dentist who has not seen the patient before the hyginie visit and is not onsite while the visit occurs. In Virginia, licensed dental hygienists must practice under the supervision of a dentist, however, the type of supervision can take on several forms.

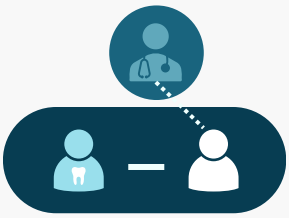
Resources

Remote Supervision Overview and Guidance Document (Virginia Dental Association)
Practice of a Dental Hygienist Under Remote Supervision (Code of Virginia)

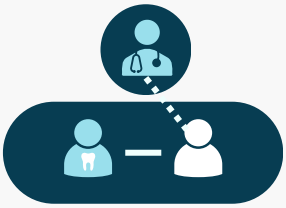
Levels of Dental Supervision for Licensed Dental Hygiene Practice in Virginia

Remote:
An RDH with at least 2,500 hours of dental hygiene work experience who has completed a Virginia Board of Dentistry compliant two-hour Continuing Education course can deliver specific dental care in community settings without the supervising dentist onsite and without an initial examination from the dentist.

General:
An RDH delivers care to a patient that the supervising dentist has seen and has consented to the procedures performed by the dental hygienist. The dentist is not required to be present in the dental office or on the premises.



Indirect:
An RDH delivers care to a patient that the dentist has examined, and the dentist is in the office, authorizes the procedures, and remains there while the dental hygienist performs the procedures.



Direct:
An RDH delivers care to a patient after the dentists personally diagnoses the condition to be treated, authorizes the services the hygienists is to provide, and before the patient is dismissed evaluates the performance of the dental hygienist.

Personal:
This level requires the most supervision; the dentist is personally operating on a patient and authorizes the dental hygienist to aid in treatment by concurrently performing supportive procedures.

Advocacy & Legislation

Key facilitators for the successful implementation of remote supervision programs include effective communication, championship, and collaboration among oral healthcare professionals and community partners.

It is essential to continuously assess opportunities and barriers, implement changes, and evaluate progress. Quality Improvement (QI) tools can help programs and clinic teams better understand their unique assets and identify ways to overcome barriers. Like clinical instruments, QI tools take practice to learn how to use them effectively.

Scope of Remote Supervision Dental Hygiene Services

What exactly is an RSDH allowed to do in Virginia? According to the legislation, an RSDH can:

- Obtain a patient's treatment history and consent
- Perform an oral assessment
- Perform scaling and polishing
- Perform educational and preventive services
- Obtain radiographs as ordered by supervising dentist or consistent with a standing order
- Maintain appropriate documentation in the patient's chart
- Administer topical oral fluorides, topical oral anesthetics, topical and directly applied anti-microbial agents for the treatment of periodontal pocket lesions, and any other Schedule VI topical drug approved by the Board of Dentistry under an oral or written order, or a standing protocol issued by a dentist or a Doctor of Medicine or osteopathic medicine
- Apply sealants
- Perform any other service ordered by the supervising dentist or required by statute or board regulation
- RS dental hygienists are NOT authorized to administer local anesthetic or nitrous oxide

What is the 90-day Follow-Up Rule?

RS legislation requires the RSDH to communicate all findings from the appointment to the supervising dentist and allows the RSDH to continue treating the patient for 90 days. Within 90 days of the initial RS visit, the supervising dentist must conduct a follow-up examination of the patient or refer them to another dentist who can develop a diagnosis and treatment plan. The supervising dentist must review the patient's records at least once every ten months.

The 90-day follow-up rule within the RS legislation is a source of debate and confusion among dental providers in Virginia. Here are a few frequently asked questions about the rule:

If a patient does not have an examination within 90 days of the initial RS appointment, can the dental hygienist still see the patient?

No, unless the supervising dentist authorizes continued treatment from the hygienist. This only happens if emergent circumstances warrant further dental hygiene treatment without an examination by a dentist. The supervising dentist would be responsible for documenting the emergent circumstance and specifying the hygiene treatment to be provided and the completion date.

After a patient receives an initial examination following the initial RS appointment, can the patient be seen again in another RS visit?

Yes, as long as it is in accordance with the treatment plan determined by the supervising dentist, which might address both future dental treatment and dental hygiene treatment and the time spans for such treatment. The dentist decides how often to see a patient in accordance with their professional judgment of the patient's dental needs and the resulting treatment plan. The supervising dentist must review the patient's chart at least once every ten months to allow continued RS visits with the dental hygienists.

Resources

Campaign to support Medicare dental benefits (Demand Medicare Dental)
Policy and Advocacy (Virginia Health Catalyst)

The Benefits and Challenges of Remote Supervision

Access to oral health services is an unmet need in the United States. Many Americans have untreated dental disease, which impacts their overall health and quality of life.

The comprehensive adult dental benefit in Virginia's Medicaid program, which went into effect July 1, 2021, provides dental coverage for thousands of adults. RS can bolster the use of this expanded coverage, especially for people who experience barriers to accessing traditional dental care.

Benefits

For Patients

Improve dental care access: Providing dental care in community-based locations like schools, long-term care settings, or medical clinics is convenient for patients. It eliminates barriers to traditional dental care, such as lack of transportation, missed work or school hours, and mobility challenges.

Focus on prevention: Preventive dental services, like those delivered in a RS visit, can stop dental disease from developing or progressing. The requirement of a supervising dentist ensures that direct access to dental hygiene services occurs within a patient-centered dental home model of care delivery. This way, providers can identify serious dental problems early and intervene, saving patients money from costly restorative procedures.

For Providers

Allocate dental staff efficiently: RSDH team members can reduce duplication of efforts while ensuring all members of the oral health team perform at the top of their licenses. It frees up the dentists' time for more hands-on dental treatment in the office.

Increase revenue: Since the remote supervision legislation only changed the level of direction and care setting, not the practice scope for dental hygienists, the supervising dentist can bill for any service that the RSDH legally provides. RS can also increase revenue from the influx of referrals into the practice from new community-based locations; for example, Head Start/school children without a dental home.

Provides new work opportunities: Implementing a RS protocol in a dental office/clinic provides growth and development opportunities for dental hygienists. It offers the RSDH additional training and leadership potential. Also, allowing staff to work in various locations may increase job satisfaction and retention.

Improve community-based relationships: A successful RS program depends on trust and meaningful relationships with partners in the community. As the program continues to grow and deliver dental care to those who need it, the community partnerships will strengthen and lead to more connections and business.

The Benefits and Challenges of Remote Supervision (cont'd)

Challenges

For Patients

Difficulty with timely follow-up care within the limits of the law: Patients may not be able to see the dentist for a full examination within 90 days of the RS visit, making continuity of care and treatment difficult.

Understanding insurance coverage: It is not always clear what services are covered through dental insurance options.

For Providers

Cost: The initial cost for starting a RS program and its sustained maintenance with current pay systems can vary depending on the equipment, software, and technology. It can be done with a small budget, however. See page XX for more cost information.

Regulatory ambiguity and lack of support: The lack of guidance or endorsement of RS from key opinion leaders is inconsistent with the needs of communities. Some regulations make it particularly difficult to implement, such as the mandated 90-day examination in light of transportation, financing, and other barriers. This disincentivizes the use of RS across Virginia.

Logistics of delivering care in a community setting: Depending on the care location, RS programs must be creative to ensure that their space accommodates the equipment and needs of the dental professionals. This includes accounting for using small spaces efficiently, caring for patients with physical limitations, guaranteeing the availability of water, etc.

SECTION 2

Implementing Remote Supervision

Roles and Requirements for Remote Supervision

The key dental team members involved in an RS program are the supervising dentist and the remote supervision dental hygienist (RSDH). However, other staff at the dental clinic and community setting will have crucial roles in ensuring the program's success.

Supervising Dentist
RSDH support: • Supervise up to two RSDHs with a Memorandum of Understanding outlining roles and expectations • Create RS practice guidelines and standing orders • Be available to the RSDH for consultation during the RS dental visit
Follow-up examination: Within 90 days of a new patient's RS visit, the supervising dentist must either perform an examination or issue a referral for the patient to have a dental examination performed by another dentist. If the supervising dentist creates a treatment plan, they must review the patient's chart at least every ten months to enable continued services under RS.

Roles and Requirements for Remote Supervision (cont'd)

Remote Supervision Dental Hygienist
Training and credentialing: • Have at least 2,500 hours of dental hygiene work experience • Complete a Virginia Board of Dentistry-compliant two-hour Continuing Education course on RS
Collaborate with supervising dentist: • Obtain professional liability insurance that is acceptable to a supervising dentist. • Help coordinate a dental examination by supervising dentist or a referral to another dentist 90 days after the first RS dental visit to continue dental treatment within RS provisions. • Ensure the dentist reviews patient records every ten months after the creation of a dental treatment plan to continue dental treatment within RS provisions.
Establish and maintain community partnerships: • Create a Memorandum of Understanding and communication plan with the community-based practice site.
Patient care and record keeping: • Create, maintain, and execute informed consent documents with patients and/or guardians prior to providing dental care. • Provide dental hygiene services within scope of RS provisions and according to practice guidelines and standing orders created with supervising dentist. • Maintain patient records to document assessment findings, treatment progress, and referral or examination plans.

Other Team Member Roles
Clinic Manager, CEO, or Medical Director: These leadership team members play an essential role in achieving complete buy-in of the RS program and garnering the support of all the staff involved. New practices and protocols can be hard to implement, but the facility administrator's enthusiasm, commitment to the program's purpose, and 'all in' support is critical.
Clinic front desk staff: As support for the whole dental team, the front desk staff can act as the liaison between the outside facility and the hygienist/dentist team to schedule patients' follow-up examination and care on the day of services and ensure appropriate billing to maximize treatment within the 90 period.
Dental Assistant: A few key tasks for the dental assistant include set up of equipment and supplies, sterilization and disinfection between patients, retrieval of the patient, assisting during the RS visit, taking radiographs, monitoring supply inventories, documentation, etc.
Community Health Workers (CHW)/Care Coordinators: As trusted members of the community, CHWs can facilitate patients' timely access to services to avoid costly and aggressive intervention at later stages of disease. CHWs can help eliminate barriers to care, such as transportation and finances, as well as provide oral health education to patients.

Authorized Remote Supervision Service Settings

RS is authorized in specific settings to maximize access to dental hygiene services among underserved populations who experience barriers to accessing care in traditional dental settings. This type of place-based care approach involves collaborative partnerships between a clinic team and a convenient patient setting.

The point of contact, clinical services, and RS visit set-up will vary depending on the setting. Find high-level descriptions of these components for certain settings below.

**Programs operated by the Virginia Department of Health are not included in this toolkit.*

Federally Qualified Health Centers (FQHC) or Free, Charitable, or other Safety Network Clinics

- **Community-based point of contact:** Begin conversations with the CEO or the Healthcare Facilities Administrator.
- **Clinical services:** Oral assessment, scaling and toothbrush prophy, topical oral anesthetics and anti-microbial, digital radiographs, fluoride varnish/silver diamine fluoride, and referrals.
- **Set-up:** Bedside option with minimal equipment and clinical supplies on mobile cart; or separate available room with mobile dental unit and equipment, with water supply.

Long-Term Care Facilities

- **Community-based point of contact:** Begin conversations with the CEO, facility administrator or Director of Nursing.
- **Clinical services**: Oral assessment, scaling and toothbrush prophy, topical oral anesthetics and anti-microbial, digital radiographs, fluoride varnish/silver diamine fluoride, and referrals.
- **Set-up:** Bedside option with minimal equipment and clinical supplies on mobile cart; or separate available room with mobile dental unit and equipment, with water supply.

Elementary or Secondary Schools

- **Community-based point of contact:** Begin with a letter or phone call to the District Superintendent, School Principal, or School Nurse of schools in the targeted City/County.
- **Clinical services:** Oral assessment, scaling and prophylaxis, digital radiographs, topical fluoride (varnish or silver diamine fluoride), dental sealants as needed, education and referrals.
- **Set-up:** Any available room (gymnasium, music room, stage in an auditorium, nurse's office, etc.) as close to a water source as possible.

Authorized Remote Supervision Service Settings (cont'd)

Head Start Programs

- **Community-based point of contact**: Coordinate with Health Services Manager, Health Services Specialist, or Program Director.
- **Clinical services**: Oral assessment (w/intraoral camera option), toothbrush prophy, fluoride varnish/silver diamine fluoride, education, and referrals.
- **Set-up:** This can easily be a classroom setting with two chairs next to a counter/table with a supply set-up (disposable mouth mirror, 2x2 gauze, fluoride varnish, toothbrush, toothpaste). Ideally, a water source is helpful, but unnecessary in this setting.

Woman, Infant, Children (WIC) Programs

- **Community-based point of contact**: Initial contact suggestions: VDH District Health Director or the VDH District WIC Coordinator.
- **Clinical services:** Oral assessment (w/intraoral camera option), toothbrush prophy, fluoride varnish/silver diamine fluoride, education, and referrals.
- **Set-up:** Typically in whatever space is available on a particular day, with or without easily accessible water supply.

No matter the setting, clear communication across the dental clinic and community-based staff is essential for the success of the RS program.

Here are a few tips to establish successful communication and collaboration strategies with the point of contact in the community:

- Describe the goal of the RS program, concentrating on the impact of oral health on total health and well-being, performance in school, etc.
- Provide appropriate supportive research regarding care needs of the target population, cost savings
- Use non-technical dental terms with non-dental staff
- Illustrate the overarching strategies for your project, including physical space needed, time frame, options for patient schedules, transportation of patients to the hygienist, and safety protocol standards (CDC, OSHA guidelines, etc.)
- Outline the expected day-to-day responsibilities of their staff and that close collaboration with the dental team is critical to successful implementation.

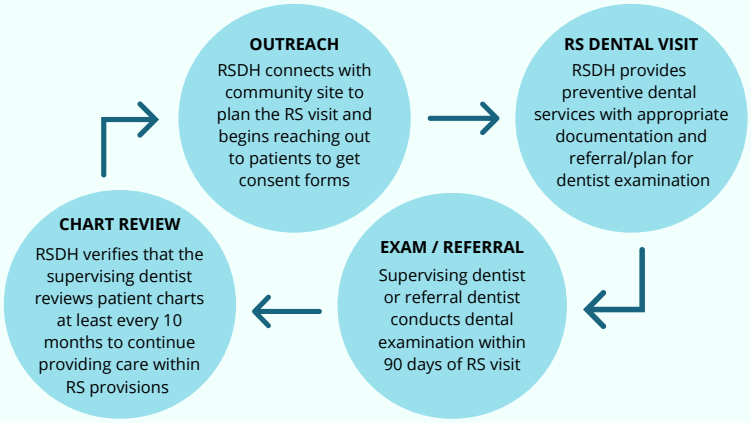
Building a Remote Supervision Workflow

Because RSDH can be applied in several settings and among various populations, no one workflow structure fits every program. Instead, consider the examples and questions in this section to create a workflow that works best for your team.

Questions to inform your RSDH workflow:

- What is the goal of your RSDH program?
- Be specific. Include patient populations and measurable outcomes. What specific tasks are assigned to each staff member?
- Think from start to finish - scheduling the appointment through follow-up. Who will collect patient/caregiver consent?
- How will the appointment be scheduled?
- Who needs to be present for the appointment?
- Who will record the notes and track next steps?
- If asynchronous, when will patient photos be reviewed?
- How will you train dental and medical staff on the new technology?
- Who needs to receive training?
- How will you provide technology-related education and assistance to patients?
- How will you follow up with patients?
- How will you inform patients of the new RSDH services available?

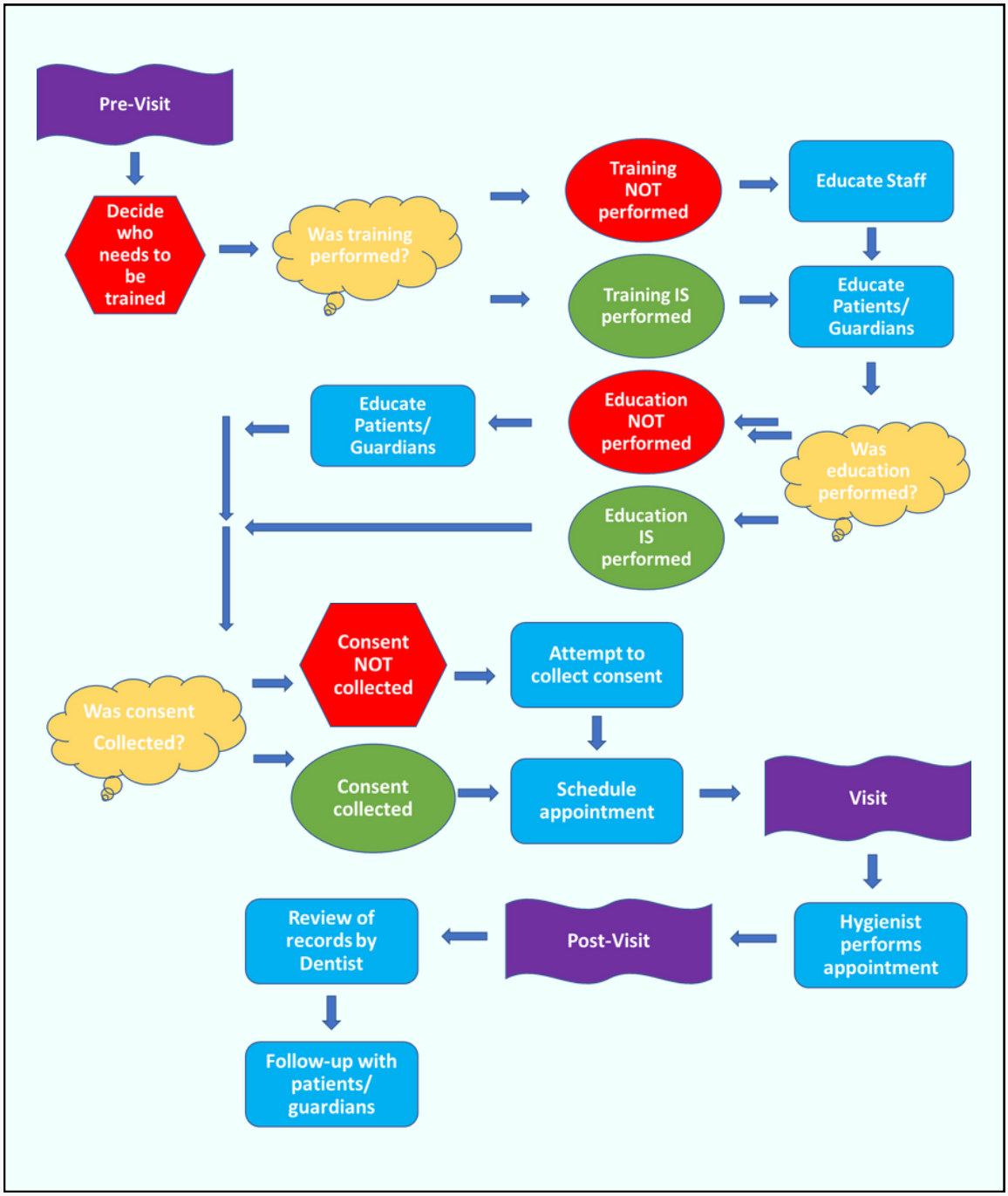
Sample RSDH Workflow
This workflow exemplifies how RSDH can be used in school-based settings. Additional workflow examples are listed on the next page.



The cyclical depiction of the RS workflow below describes the general phases and responsible team members of a RS program. Within each phase of the workflow, the RSDH and supervising dentist can create process maps, practice guidelines, and standing orders to suit the needs of the program based on the setting, patient population, and clinical perspectives of the providers.

Workflow Example

Courtesy of the Community Health Center of the New River Valley, showcasing their school-based oral health programming.



SECTION 3

Remote Supervision in Practice

Resources and Best Practices in Community Settings

The core of this module includes sample documents and best practices for practicing RS in different community settings. Sample documents include protocols and consent forms from peer clinics. Best practices refer to communication and logistical considerations that support RS programs in each setting. These resources serve as examples and should be adapted to specific situations/clinics. Clinical leadership, administrators, and legal counsel should review these documents prior to adoption and use.

Outpatient Health Settings

Remote Supervision practice is authorized in several outpatient settings, including Federally-Qualified Health Centers (FQHCs), Free or Charitable health clinics, other safety net clinics, or Women, Infant, and Children (WIC) Programs. Some outpatient settings may have an active dental program, while others may only offer medical, behavioral, or other health services.

Remote Supervision in an Existing Comprehensive Dental Program

For outpatient settings with an existing comprehensive dental program, implementing RS protocols can expand the scope of services a dental hygienist can provide on days when a dentist is not in the clinic due to emergent or planned time off. The RS program can help clinics avoid one of the most common barriers to care for new patients: waiting months to receive their first dental visit. Using RS, the hygienist can provide hygiene services at the patient's first visit, even if a dentist is not on site to perform the initial examination. New patients benefit from preventive services and experience less frustration with a schedule that does not depend on the dentist's availability.

Best Practices
Team trust and collaboration: Implementing a RS program requires trust and mutual respect between clinical providers (the dentist and dental hygienists) and the support staff (dental assistants and care coordinators), as well as administration/leadership (dental and medical directors, etc.). It is helpful to emphasize the common goals of the RS program: expanding access to preventive and hygiene services for new patients and ensuring they can make the most of their first dental visit. Dental and/or medical directors should support all staff in training and quality improvement efforts when challenges arise.
Patient-centered communication: Clear communication with the patient when scheduling, confirming, and checking in for the appointment. They will not receive a dental examination that day and will need to return with the dentist and any subsequent treatment. Present the RS consent form to the patient before their visit or at check-in for the appointment. Care coordination staff should be familiar with the unique aspects of RS visits to answer patients' questions.
Specific RS protocols: Utilizing a custom code to track RS visits may be helpful in coordinating a post-RS visit dental examination. Describe and train on the practices, documentation, and workflows specific to RS visits, like the unique consent forms, patient education, and services provided. Use quality improvement components (see Appendix) to make these more efficient as time goes on.

Sample Documents
Southwest Virginia Community Health Systems/Southwest Virginia Regional Dental Center

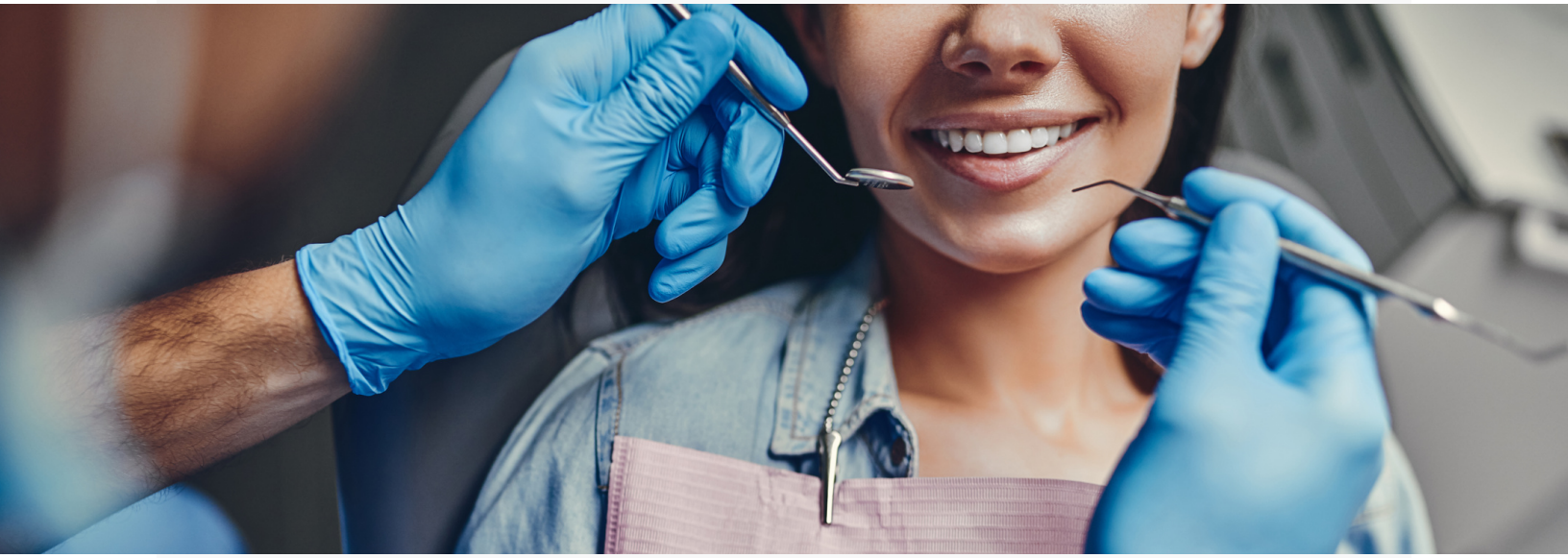
Outpatient Health Settings (cont'd)

Remote Supervision without an Existing Comprehensive Dental Program

For outpatient settings that do not have an oral health program, implementing RS protocols can open access to preventive dental services and connect patients to comprehensive dental care through a dental home.

Best Practices
Many of the same best practices from implementing a RS program in an existing comprehensive dental program also apply to outpatient clinics without an existing dental program. The trust and collaboration between the dentist and hygienist are even more important since these two individuals may not work together in the same location.
Clear understanding across the team: The care coordination staff at both the clinic where RS services are provided and where a dental examination will occur should be confident in their understanding of the program and how to support patients who need to access care between clinics.
Coordination with community setting: The RSDH needs to coordinate with the staff in the place-based setting to create a unique workflow of dental treatment. Share information on the value of oral health as a key component of overall health and well-being, and illustrate the links between oral health and systemic conditions like diabetes or heart disease; this is essential for buy-in and sustainability.

Sample Documents
Crossover Clinic RS Protocol



Outpatient Health Settings (cont'd)

Long-Term Care Facilities (LTCFs) offer healthcare and social support to older adults through independent living apartments to skilled nursing or memory care units. Some residents of LTCFs are independent and may still access dental care in the traditional community dental office setting. However, others have mobility, transportation, or medical complexity limitations that make onsite dental care critical to their health.

The American Dental Association does not formally recognize Geriatric Dentistry as a dental specialty. This means that clinical practice guidelines are not as well delineated in these settings, even though numerous predoctoral, postdoctoral, and continuing education opportunities teach providers how to accommodate to the unique needs of older adults.

Since dental services are not included in Medicare without the purchase of a supplementary Dental Advantage Plan, many older adults need to pay for care out of pocket. Besides Medicaid dental coverage for qualifying adults, two additional payment mechanisms have been described for older adults residing in LTCF's
(1)VA-DMAS Guidance on Patient Pay Adjustment (DMAS-225 Form)
(2)ADA Guidance on Incurred Medical Expenses

Best Practices
Help them meet their standards of care: Federal regulations require LTCFs to meet a variety of dental needs of their residents. Highlighting how the RS program helps them meet these regulations may encourage a long-lasting and mutually beneficial partnership.
Find a RS program champion: There are many demands on staff at LTCFs to meet their residents' complex health and social needs, making it hard to prioritize oral hygiene and dental services. Before implementation, develop a relationship with the Director of Nursing, LTCF Administration, and/or resident/dental patient champions to assist with integrating a RS program. Outline all expectations in the Memorandum of Understanding with the facility, including space requirements, communication expectations, assistance with transport/transfer of patients, and any liability considerations.
Communicate early and often: Advance communication with patients and facility staff supports a smooth RS service day and onsite. Having a liaison at the LTCF that is available as a point of contact for pre-RS service day communication as well as on the day of RS services helps the dental team integrate into the overall care team. Developing healthy feedback communication opportunities after RS service days assist in troubleshooting any challenges that can impede the sustainability of a RS program.

Sample Documents
Sample Facility Consent Form
Sample Hygiene Consent Form
VDHA Sample Implementation Plan for LTCFs

Schools and Head Start Locations

State or local health departments often conduct oral health services in schools across Virginia, such as oral health screenings or fluoride varnish and sealant programs. Several public health activities, such as hearing and vision screenings, occur at schools because they are easily accessible for children. In recent decades, private and non-profit organizations also began offering dental services in schools, often employing dental hygienists and dentists to provide comprehensive dental services.

In Virginia, RS programs may operate within Head Start preschool programs and elementary or secondary schools.

Best Practices
VDHA Remote Supervision Guidelines for Head Start Settings
VDHA Remote Supervision Guidelines for School Settings

Sample Documents
Virginia Remote Supervision Dental Hygiene Practice Protocol Agreement: Head Start Template and School Setting Template (Virginia Dental Hygienist Association)
School-Based Dental Preventive Services Program Consent Form (VDH)
Dental Hygiene Care Consent Form (Virginia Dental Hygienist Association)
Dental Sealant Consent Form (Ohio example)
Silver Diamine Fluoride (SDF) Consent Form (DentaQuest)

Supplemental Clinical Innovations

There are several clinical and community innovations to use in conjunction with a RS program to support the program's overall effectiveness and sustainability. Explore these resources to offer synergistic benefits to the RS program:

Mobile Care Delivery	Teledentistry
Using Portable Dental Equipment to Provide Dental Care in Schools (Virginia Health Care Foundation)	Teledentistry in Virginia Implementation Toolkit (Virginia Health Catalyst)
American Mobile and Teledentistry Alliance	Other teledentistry resources (Association for State and Territorial Dental Directors)
Mobile Dental Units/Portable Dental Programs Toolkit (National Network of Oral Health Access)	

Engaging Community Health Workers/Care Coordinators

- Health Center Oral Health Program Promising Practice: Community Health Workers for Integrated Care Coordination (National Network for Oral Health Access)
- Community Dental Health Coordinator (American Dental Association)
- The Role of Community Health Workers in Oral Health (Oral Health America)

SECTION 4

Conclusion

The Remote Supervision Dental Hygiene Toolkit offers a versatile and innovative solution to enhance access to oral health care. While it cannot fully replace in-person procedures and preventive services, it provides dental providers with the means to reach patients and particularly underserved populations. Overall, the Remote Supervision Dental Hygiene Toolkit has the potential to improve the oral health of Virginians and serve as a model for other states to follow.

In the face of workforce challenges experienced by dental clinics, remote supervision empowers existing dental providers and staff to optimize their expertise and provide preventive services without the level of supervision required in a typical setting. However, successful implementation requires collaborative efforts, equipment procurement, workflow adjustments, data collection planning, staff training, and effective patient communication to ensure the utilization of these new services.

For dental providers in Virginia embarking on their remote supervision dental hygiene journey, this Toolkit stands as a valuable resource. It offers guidance and support to those in the initial stages of planning and integrating remote supervision into their practice.

The dedicated team at Virginia Health Catalyst is committed to fostering a future where comprehensive healthcare, including oral health, is accessible to all Virginians. Remote Supervision serves as one vital component in the broader systems-level changes required to move closer to this overarching goal. By harnessing the potential of remote supervision dental hygiene, Virginia takes a significant step forward in improving oral health outcomes and ensuring equitable access to care for its residents.

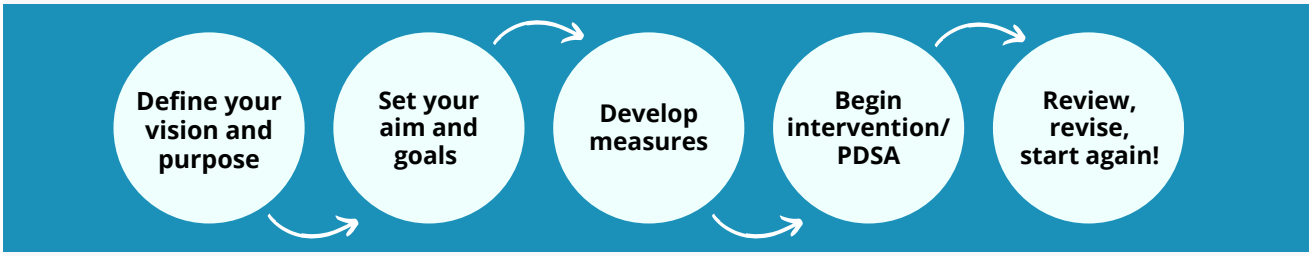
Resources

Quality Improvement and Evaluation

Evaluating your program will reveal the effectiveness of your program's protocols and processes and if it has the intended impact on your patient population. An evaluation plan and measures may include:

- Tracking the frequency and type of services provided;
- The number of patient recall (90-day) visits following the RSDH encounter;
- The number of referrals provided; and
- Patient satisfaction surveys.

QI tools like process mapping and need assessments can help you develop a successful RSDH program. They also identify areas of improvement. Use these tools during your implementation planning and execution phases to make small, incremental changes that improve the RS program's efficiency and outcomes. The process below can help guide a team through the QI process.



Aim Statement

Like the organizational mission and vision statements, an aim statement identifies the key outcome of interest and guides a program to accomplish this goal. An aim statement is an explicit description of a team's desired outcomes, which are expressed in a measurable and time-specific way. Questions that can help guide the creation of a strong aim statement include:

- **Why is this important?**
- **Who is the target population?**
- **When will this be completed?**
- **What is our measurable goal?**

Tip: An aim statement should be concise and easy to understand. Start small, making the goal achievable, and not confining the aim to the end of the project can help.

Informed Consent

Before delivering oral health services within an RS visit, RSDHs must inform the patients and/or caregivers about RS policies/procedures and receive their written consent for care. The patient's consent must be documented in the patient's health record.

RS visits require two unique acknowledgments within the informed consent form:

- Care provided by an RSDH does not replace a dental examination
- Patients do not already have a dentist or dental home

It may also be helpful to include an acknowledgment of the scope of services that can and cannot be provided by a dental hygienist within an RS dental visit and ensure the patient understands that they must have a dental examination within 90 days to continue receiving RS dental hygiene services.

Example consent form courtesy of the Community Health Center of the New River Valley

Remember:
Anytime a dentist or RSDH shares information that can be linked back to patients, it is Protected Health Information, or PHI, and must be handled accordingly. Existing medical privacy laws, like the Health Insurance Portability & Accountability Act (HIPAA), protect patients regardless of whether they seek a virtual, community-based, or in-office dental consultation.

Remote Supervision Equipment

The equipment and supply needs for RS visits will vary depending on the physical space in the dental clinic or community setting, the dental services provided, and the needs of the patient population. Billing procedures and policies at the dental clinic will also determine what is necessary for RS implementation.

***Tip**: No special equipment is needed outside the day-to-day dental equipment and clinical operations software when a RS visit occurs in the clinical setting.*

For RS conducted outside the dental clinic, portable equipment and operational tools are necessary to deliver and record care. The following list is not meant to be exhaustive; neither does it suggest that an effective RS program must use all of this equipment:

- Portable Hygiene Unit with tray table, compressor with ultrasonic scaling capability, high and low-speed handpiece adapter, air/water, high and low suction adapters
- Portable patient chair, portable operator stool and assistant chair
- Computer with webcam
- Hand-held x-ray system, including digital sensors
- Intraoral camera
- Sterilization and ultrasonic units – on or off-site
- Digital camera(s)
- Video conferencing software and devices (tablets, iPads, laptop, phone)
- Encryption software for sending electronic patient information
- Electronic consent forms & electronic intake/patient forms
- Ability to create electronic documents
- Ability to print, complete, scan and upload paper documents
- HIPAA-compliant communication platforms

Budget Examples

	$3,000	$5,000	$20,000
Laptop, case, mouse	✓	✓	✓
Microsoft 365 software	✓	✓	✓
Teledentistry platform software	✓	✓	✓
Remote desktop software		✓	✓
Dental management software		✓	✓
Teledentistry software with a subscription			✓
Portable dental cart		✓	✓
Portable patient chair		✓	✓
Portable dental unit		✓	✓
Portable hygiene unit			✓
Portable operator's chair			✓
Hand-held x-ray system			✓
Intraoral camera			✓

Commonly Used Dental Treatment Codes in Remote Supervision Dental Visits

The provider is responsible for tracking dental procedure codes according to their clinical judgment and understanding of the definition of each procedure code. Below is an example of procedure codes that may coincide with the dental treatment that a dental hygienist provides within a RS dental visit.

Visit type: Initial New Patient Remote Supervision Dental Visit

CDT Code	Description
D0191 **Assessment of a Patient**	A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.
D0180 **Comprehensive Periodontal Assessment**	This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.
D0601/2/3 **Caries Risk Assessment**	Caries Risk Assessment with a finding of low (1), moderate (2), or high (3) risk.
D1330 **Oral Hygiene Instructions**	Counseling/instruction on oral hygiene techniques and products.
D1310 **Nutritional Counseling**	Nutritional counseling for control and prevention of oral disease.

Commonly Used Dental Treatment Codes in Remote Supervision Dental Visits (cont'd)

Visit type: Initial New Patient Remote Supervision Dental Visit

CDT Code	Description
D1206 **Fluoride Varnish Application**	Topical fluoride varnish
D1110/1120 **Dental Prophylaxis**	Adult (1110) or child (1120) prophylaxis.
D4355 **Full Mouth Debridement**	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit.
D4346 **Scaling in the Presence of Gingival Inflammation**	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation. The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. [It] should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.
D4341/D4342 **Scaling and Root Planing**	Scaling and root planing of four or more teeth (4341) or three or fewer teeth (4342) in a quadrant.
D02XX **Dental Radiograph Codes**	Individual or series radiographs.
D0350 **Intraoral Images**	Oral/facial photographic image for diagnostic purposes.
DXXXX **Dummy Code to Prompt 90-day Exam/Referral**	Code to prompt tacking 90-day timeframe after RS dental visit.

Commonly Used Dental Treatment Codes in Remote Supervision Dental Visits (cont'd)

Visit type: Recall Remote Supervision Dental Visit

CDT Code	Description
D4910 **Periodontal Maintenance**	This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site-specific scaling and root planing where indicated and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.

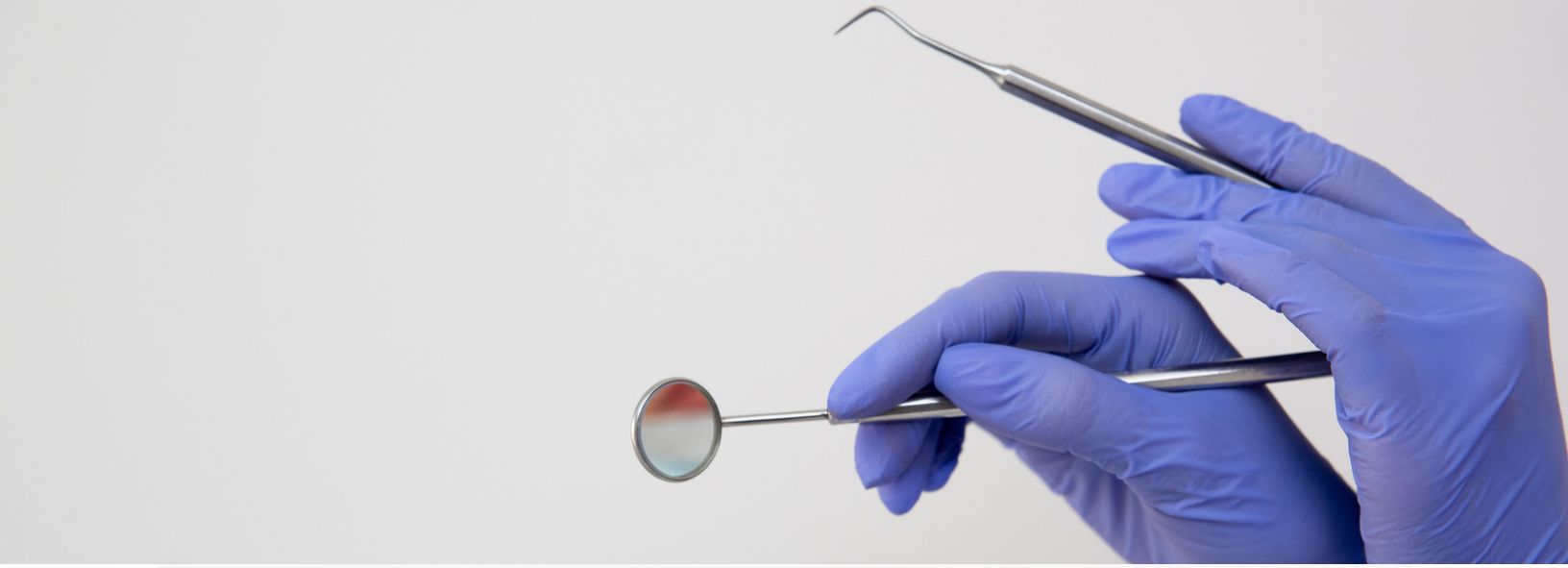
Visit type: Place-Based Care (21+ yo)

CDT Code	Description
D9410 **House Call/ Extended Care Facility Visit**	House calls/visits to nursing homes, long-term care facilities, hospice sites, institutions, and other types of extended care facilities.($78.65)

Resources

1. Sample consent forms
2. Professional liability resources for dental hygienists (American Dental Hygienists Association)
3. Procedure Outline: General and Remote Supervision of Dental Hygienists (Eastern Shore Rural Health, Inc)
4. Fluoride Varnish and Silver Diamine Fluoride: A Resource Guide (National Maternal and Child Oral Health Resource Center)

QI Roadmap (NAACHO)
Setting Aims (Institute for Health Improvement)
Process Mapping (Institute for Health Improvement)
Flowchart (Institute for Health Improvement)
PDSA Cycle (Institute for Health Improvement)
Root Cause Analysis (ASQ)
Root Cause Analysis Fishbone Tool (CMS)
Impact Effort Matrix (ASQ)
Testing Changes (Institute for Health Improvement)
Program Evaluation (CDC)



Acknowledgments

Thank you to United Concordia for generously supporting the development of the Remote Supervision Dental Hygiene Toolkit. The mission of Virginia Health Catalyst (Catalyst) is to ensure all Virginians have equitable access to comprehensive health care that includes oral health.

Thank you to the following members of the Catalyst staff and our partners that participated for their significant contributions to this toolkit:

Lyubov Slashcheva, DDS, MS
Brooke Crouch, RDH
Susan Pharr, RDH
Erika Slagel-Perry, LPN
Gabby Stowers, DA
Chao Yi Zhang, DDS
Serena Canterbury, RDH
Kirsten Estep, RDH
Stacie Dietz, DDS
Evan Garrison, DDS
Lisa Spitzer, RDH

Catalyst staff:
Brita Allen, MPH
Ericca Facetti, BS
Sarah Holland, MS
Isabelle Stitt-Fredericks, BS
Chloe Van Zandt, MPH