Title V Maternal Health

Signifycommunity and Documentation Training

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Objectives

- Demonstrate new signifycommunity changes
- Review IDPH forms and documentation requirements
- Review MH/OH changes

Why is data collection important?

BRAINSTORM IDEAS

Why is entering data correctly important?

★ QI Reporting
★ Accurate reports
★ Billing
★ Meeting performance measures and year end reports
★ Your data means something!
★ All your hard work counts

Signify Overview

- ★ Opening page (Search and work list)
- ★ Search for a client
- ★ Add Demographics
- ★ Add an Episode - awareness/end, other data
- ★ One episode per pregnancy only

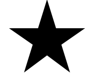
Documenting Maternal Health Services

Charting and Signify

Minimum Charting Needs

Every Chart Needs:

- Client's DOB and Medicaid ID (if applicable) associated with their first and last name
- Income assessment
- Insurance status assessment (medical and dental)
- Allergies/NKDA
- Current medications
- Consent forms
- Release of Information
- Medical Home & Provider documented - (For MH purposes this is who is providing OB care)
- Dental provider is documented

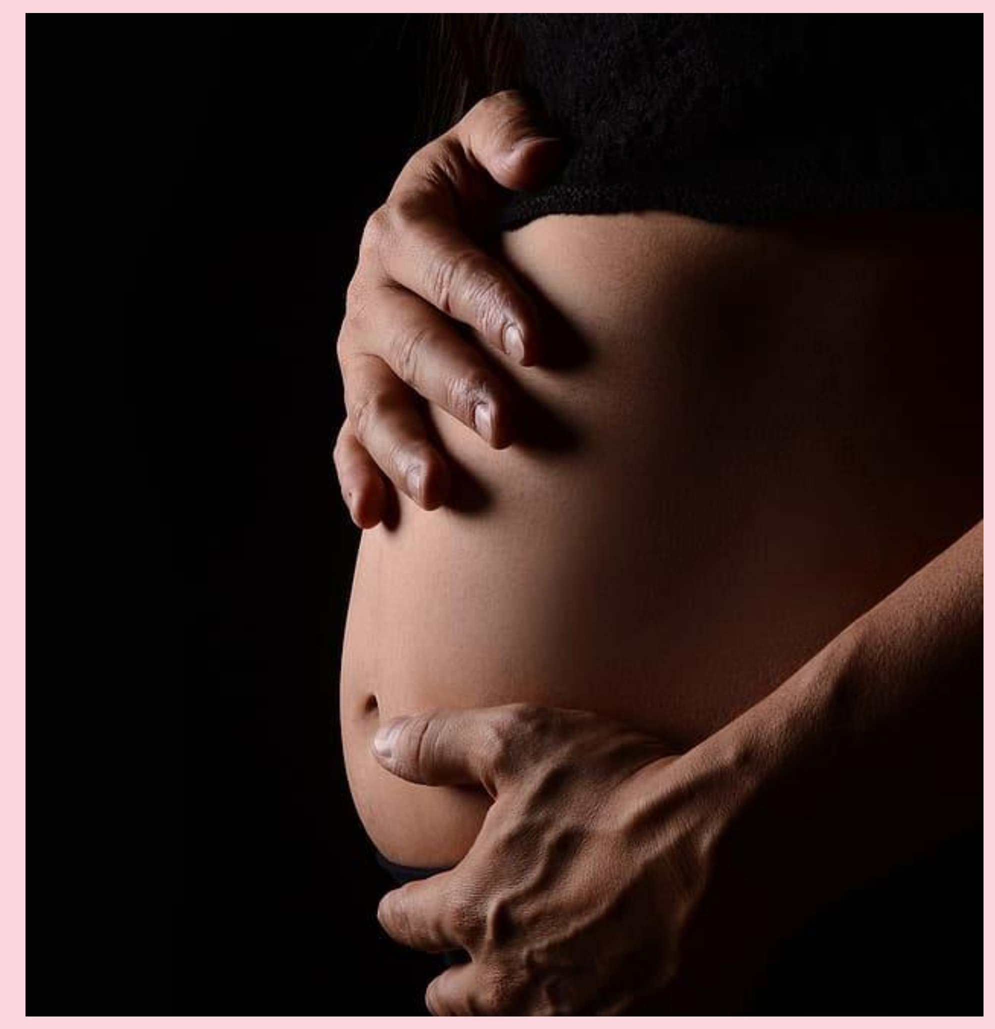


Every Entry Needs:

- Client's First and Last Name on each page
- A service date (ex. 1/1/2001)
- Provider name/ signature/credentials
- Place of service
- Proper error correction

Overview of Forms

- ★ MH Intake Form (Staff fills out)
- ★ Client MH Intake Form (Client fills out)
- ★ MH Visit Summary Form (Every visit)
- ★ MH Education
- ★ MH Psychosocial
- ★ MH Nursing Assessment
- ★ MH Postpartum Home Visit and Postpartum Nursing Assessment
- ★ MH Home Visit Form
- ★ MH Care plan (aligns with the goals section in Signify)
- ★ MH Discharge Form (coming soon!)
- ★ MH Dental Screening Form
- ★ MH Oral consent form (if not using general consent)



Initial Visit - Clinic Setting

Minimum Charting Needs

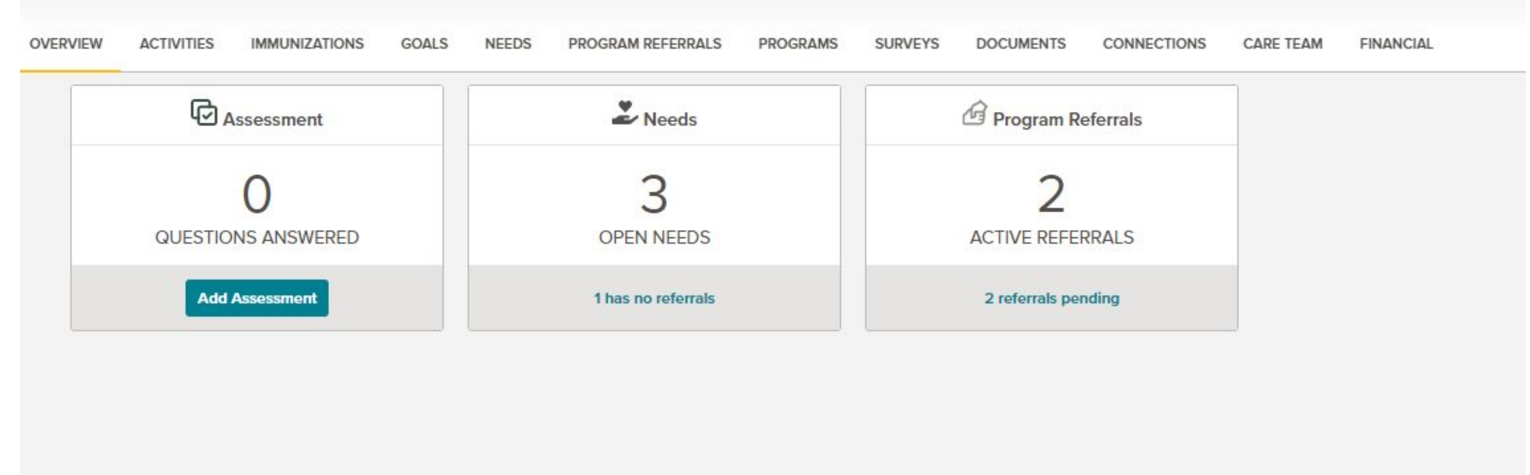
★ Consents and ROI
★ Social, medical and pregnancy history
★ Screenings such as EPDS, AAS, SBIRT and Prenatal Risk Assessment
★ Development of the initial care plan
★ Referrals and plans for follow up
★ Education as needed
★ Narrative - include why the client needs these services
★ See services summary for technical needs such as duration of visit and who can provide the services

Narrative example for initial visit

17 year old female in her 3rd trimester of pregnancy was seen in the women's health clinic today for an initial health education and psychosocial visit. She is has elevated risk factors for this pregnancy related to her age, late entry to prenatal care and poor social situation. She reports living with her parents and feels supported by them, the father of the baby is not involved and has been emotionally abusive to her in the past. She currently feels safe and declines any further needs related to emotional support. Her prenatal risk assessment score is 13, qualifying her for expanded MHC services. Health education was provided as detailed on health ed. form. She verbalized understanding of danger signs, when to call her ob provider and when to go to the hospital. See psychosocial visit form for details of assessment. Client accepted referral to community health center prenatal classes for teens and is interested in the breastfeeding classes offered by our agency as she would like to meet more young mothers. Client's affect was animated and appearance was appropriate. EPDS will be completed at her visit in two weeks.

What goes in Signify?

1. Client Demographics
   a. Verify client isn’t already in Signify
   b. Create new contact
   c. Enter demographic information
2. Maternal Health Episode
   a. Each pregnancy **requires a new episode**
   b. Includes medical home status, program enrollment, and due date
   c. Oral Health services, including Oral Health Only clients, must be entered under the Maternal Health Episode, not “Oral Health”
3. Initial Visit Bundle
   a. Health Services Activities for all services billed (delete activities for services not billed)
4. Attach surveys to Program Admission Date activity
   a. Intake Survey
   b. All Visits Survey
   c. Oral Health Survey
   d. MH Dental Risk Assessment



Signify Demo!

Subsequent Visit - Clinic Setting

Minimum Charting Needs

★ Social, medical and pregnancy updates
★ Screenings such as EPDS or updates on tobacco/alcohol use
★ Psychosocial and/or Health Education forms
★ Referrals and plans for follow up
★ Care plan updated
★ Narrative - include why the client needs these services
★ See services summary for technical needs such as duration of visit and who can provide the services

Narrative example for subsequent visits

17 yo female client is seen in the women's health clinic for a psychosocial visit. She is in her 3rd trimester and has high risk factors including late entry to prenatal care, adolescent pregnancy and poor social situation. See psychosocial form for details of the visit. EPDS score was 4 today with client reporting that she sometimes felt like she wasn't looking forward to things, but she reported that she was also feeling tired again like she had been in the first trimester. Normal pregnancy changes were discussed. She reported that the father of the baby had reached out, but she had told him she was not interested in talking with him. He was agreeable to it, though she is worried about what will happen when the baby arrives. She has been talking this through with her parents and feels that they will be able to help her and the infant. RN will continue to monitor the situation and provide referral as needed. she reported that her first prenatal class is tomorrow evening. Client will be seen in 1 week for health education visit at she is nearing the end of her pregnancy.

What goes in Signify?

1. Subsequent Visit Bundle
   a. Health Services Activities for all services billed (delete activities for services not billed)
2. Attach surveys to Complete Survey Activity
   a. All Visits Survey
   b. MH Dental Risk Assessment

Postpartum Visit - Clinic Setting

Minimum Charting Needs

★ Will be a Nursing assessment, health education or psychosocial visit form
★ If doing a nursing assessment,include physical assessment as indicated
★ Also complete Discharge form, the All Visit summary form and a narrative
★ Update care plan, referrals and follow up as needed
★ Update ROI and consents as needed for your agency
★ Include narrative summary

Narrative example- postpartum

17 yo postpartum client seen in the maternal health clinic today for postpartum nursing assessment. Client is 12 days post vaginal delivery, and denies any complications with the labor beyond it lasting 28 hours. See nursing assessment form for details of the visit. Client verbalized understanding of POST BIRTH warning signs education and reports that she has taken the infant to the pediatrician with difficulty and is scheduled for the two week check up. Client denies any transportation needs. FOB has been involved, and client reports that he has been supportive and shown no signs of their past emotional abuse concerns. Universal IPV education was provided as well as information about local site for IPV assistance. Client's parents remain supportive and have been supplying her with diapers. She reports that breastfeeding has been going well, though reports symptoms of engorgement at times. Education provided. EPDS score was 6 today. Client reports feelings of nervousness about the infant at times and being tired. Postpartum emotional changes reviewed and client verbalized understanding of when to call her physician. Client will be discharged from the maternal health program today, infant will continue to be seen through child health for developmental and lead screenings as needed. Client was referred to xx home visiting program as she is interested in continuing to work with someone on parenting skills.

What goes in Signify?

1. Postpartum Visit Bundle
    a. Health Services Activities for all services billed (delete activities for services not billed)
2. Attach surveys to Program Discharge Activity
    a. All Visits Survey
    b. Discharge Survey
    c. Oral Health Survey
    d. MH Dental Risk Assessment

Postpartum Only Visit - Clinic Setting

Minimum Charting Needs

- ★ Same requirements as PP clinic visit
- ★ Will also need to include the intake form questions as appropriate
- ★ Narrative will be minimally changed to include other screening narratives as needed

What goes in Signify?

1. Postpartum Only Visit Bundle
   a. Health Services Activities for all services billed (delete activities for services not billed)
2. Attach surveys to Program Discharge Activity
   a. Intake Survey
   b. All Visits Survey
   c. Discharge Survey
   d. Oral Health Survey
   e. MH Dental Risk Assessment

Nursing Home Visit

Minimum Charting Needs

★ Consents and ROI
★ Social, medical and pregnancy history
★ Screenings such as EPDS, AAS, SBIRT and Prenatal Risk Assessment
★ Development of the initial care plan or updates
★ Referrals and plans for follow up
★ Education as needed
★ See services summary for technical needs such as duration of visit and who can provide the services
★ Will utilize both intake forms, home visit form, visit summary and care plan
★ Narrative will look like the initial clinic visit, but will include elements as needed to reflect that the visit was in the home and took the environment into account in the assessment

What goes in Signify?

1. Client Demographics
    a. Verify client isn't already in Signify
    b. Create new contact
    c. Enter demographic information
2. Maternal Health Episode
    a. Each pregnancy **requires a new episode**
    b. Includes medical home status, program enrollment, and due date
    c. Oral Health services, including Oral Health Only clients, must be entered under the Maternal Health Episode, not "Oral Health"
3. Home Visit Bundle
    a. Health Services Activity for Nursing Home Visit Service (S9123)
    b. Delete activities that are not applicable (Admission, Complete Survey, or Discharge)
4. Attach surveys to Program Admission, Complete Survey, or Program Discharge Activity
    a. Intake Survey - first visit only
    b. All Visits Survey
    c. Oral Health Survey - first visit and discharge only
    d. Discharge Survey - discharge only
    e. MH Dental Risk Assessment

Oral Health Services

Forms available

- Maternal Health Consent Form
- Maternal Health Screening Form
- *Maternal Health Dental Risk Assessment Tool*

What goes in Signify?

- Contact demographics:
  - Name
  - Date of Birth
  - Race
  - Ethnicity
  - Interpreter
  - *Medicaid ID (if applicable)

- Maternal Health Episode
  - Episode Status
  - Referral Source
  - Provider Update
  - Program Enrollment *(Maternal Health / Oral Health Only)*
  - Due Date
  - How did you hear about our program?

- Program Admission Date Activity
  - Date client enrolled in program
  - ***Attach Oral Health Survey***

- Program Discharge Date Activity
  - Date client discharged from program

- Dental activity (per dental service)
  - Topic
  - Type of Service
  - Primary Payor
  - Interaction Type
  - Location
  - County of Service
  - Service Provider
  - *Quantity (only if providing sealants)
  - *Diagnosis (only if providing sealants)
  - Documentation Source
  - ***Attach Maternal Health Dental Risk Assessment Survey***

Oral Health Services - Requirements

- ALL Maternal Health Clients:
  - Oral Health Survey

- Only those receiving Oral Health services (Maternal Health or Oral Health Only)
  - Program Admission Date activity
    - *Don’t forget to attach Oral Health survey!*
  - Dental activity(ies)
    - *Don’t forget to attach Maternal Health Dental Risk Assessment survey!*
  - Program Discharge Date activity
    - *Don’t forget to update Episode Status!*
    - *Don’t forget to fill out the ‘Discharge Only’ questions in the Oral Health survey!*

OH Consent Form

Maternal Oral Health Consent Form

Template

Name:			Date of Birth:
Address:		Cell Phone: Other Phone:	
Race:	☐ White ☐ Black/African American ☐ Asian/Pacific Islander	☐ Native American ☐ Other ☐ Undetermined/ Unknown	Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino
Dentist:		Physician:	
Client Medicaid ID number:			

☐ **YES**, I give permission to receive a dental screening and fluoride varnish application. (prophylaxis and x-rays)
If prophys will be provided, more detailed medical history questions must be added to evaluate a client's risk for bacterial endocarditis or other conditions.

☐ **NO**, I do not give permission to receive a dental screening and fluoride varnish application. (prophylaxis and x-rays)

Please answer the following questions:

1. Do you have a regular source of care for this pregnancy? ☐ Yes ☐ No
2. When is your due date? ____________
3. How did you hear about the program? (circle one)

Doctor/Health Care Provider	Advertising	Child Health	Coordinated Intake	Home Visiting	WIC
Local Community Resource	Hospital	MCO	School Nurse	Walk-In	Other

4. Do you have a regular dentist? ☐ Yes ☐ No
5. When was your last dental visit? (please check one)
   ☐ within 1 year ☐ 1 -3 years ago ☐ more than 3 years ago ☐ never been to a dentist
6. How do you pay for your dental care? (please check one)
   ☐ Self ☐ Medicaid/Dental Wellness Plan ☐ Hawki ☐ Private dental insurance ☐ Other
7. Do you have any oral concerns or problems? ☐ Yes ☐ No Explain: ____________
8. Are you currently taking any medications? ☐ None If yes, please list: ____________
9. Do you have any allergies? ☐ None If yes, please list: ____________

I consent to insert agency name use of email and texting to send me scheduling and maternal health services information.
☐ Yes ☐ No Email address: ____________

OH Screening Form

I-Smile Maternal Oral Health Services Template	Risk Level	Low D0601	Moderate D0602	High D0603
		Duration: min		

Decay:	yes	no
Filled:	yes	no
Gingivitis:	yes	no

Client Name:		Medicaid/Client ID:	
DOB:	Service Site:	Date of Service:	
Translator needed	☐Yes ☐No	Dentist	Physician

	Documentation		*Documentation*
Medical conditions related to oral health		Daily home care	
Current medications, allergies		Eating/snacking habits	
Tobacco, alcohol, or drug use		Fluoride exposure	
Oral concerns		Other	

Oral Screening ☐ D0190 Duration: min

Condition of hard tissue	*Documentation*	*Condition of soft tissue*	*Documentation*
Untreated decay or demineralization		Gum redness, bleeding, exudate	
Visible plaque, calculus or stain		Swelling or lumps	
Decay history (fillings, crowns)		Trauma or injury	
Loose or missing teeth		Recession	
Enamel defects, trauma or injury		Other	

Topic(s) of oral health education provided: ☐ pregnancy gingivitis ☐ morning sickness ☐ daily home care ☐ dietary habits ☐ gum disease & systemic implications ☐ fluoride ☐ regular dental visits ☐ infant oral health ☐ bacteria transmission

Notes:

Products recommended or dispensed: ☐ Toothbrush ☐ toothpaste ☐ Floss ☐ Fluoride Rinse ☐ Anti-Microbial Rinse ☐ Xylitol ☐ Biotene ☐ Sensodyne ☐ Salt water rinse ☐ None ☐ Other:

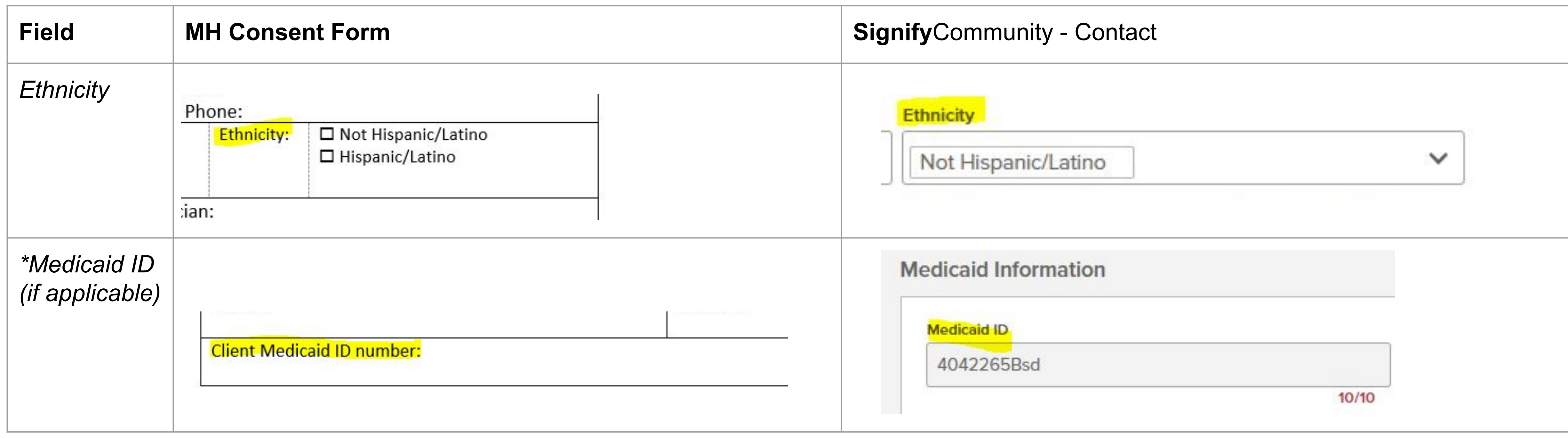
Service		*Documentation/Notes for services provided*		*Duration:*
Fluoride Varnish ☐D1206	☐Not provided	Type and Concentration:		min
Sealants ☐D1351	☐Not provided	Tooth number(s) and surface(s):	Product used:	min
Prophylaxis ☐D1120 ☐D1110	☐Not provided	Notes:		min
Oral Hygiene Instruction ☐D1330	☐Not provided	Notes:		min
Tobacco Counseling ☐D1320	☐Not provided	Notes:		min
Nutritional Counseling ☐D1310	☐Not provided	Notes:		min

Dental Referral / Care Coordination

Contact Demographics

Field	MH Consent Form	**Signify**Community - Contact
Name	I-Smile Iowa Department of Public Health Maternal Oral Health Consent Form Template Name:	First Name * Test Middle Name t Last Name * Test
Date of Birth	Maternal Oral Health Consent Form Template Date of Birth:	Date of Birth 12/01/2017
Race	Race: ☐ White ☐ Black/African American ☐ Asian/Pacific Islander ☐ Native American ☐ Other ☐ Undetermined/ Unknown	Race White

Contact Demographics



Field	MH Consent Form	SignifyCommunity - Contact
Ethnicity	Phone: Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino :ian:	Ethnicity Not Hispanic/Latino
**Medicaid ID (if applicable)*	Client Medicaid ID number:	Medicaid Information Medicaid ID 4042265Bsd 10/10

Field	MH Screening Form	SignifyCommunity
Interpreter Needed?	I-Smile Maternal Oral Health Services Template Risk Level Client Name: DOB: Service Site: Translator needed ☐Yes ☐No Dentist	Interpreter Needed? No

Contact Demographics

- ***Race***: select reported race

Client Reports:	signifycommunity Value
White	White
Black/African American	Black or African American
Asian/Pacific Islander	Other Asian
Native American	American Indian or Alaska Native
Other	Other
Undetermined/Unknown	Unknown
Missing	Declined

Contact Demographics

- ***Ethnicity***: select reported ethnicity

Client Reports:	signifycommunity Value
Not Hispanic/Latino	Not Hispanic/Latino
Hispanic Latino	Other Hispanic Latino
**Missing	Declined

OH Consent Form

Maternal Oral Health Consent Form

Template

Name:	Date of Birth:
Address:	Cell Phone: Other Phone:
Race: ☐ White ☐ Black/African American ☐ Asian/Pacific Islander ☐ Native American ☐ Other ☐ Undetermined/ Unknown	Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino
Dentist:	Physician:
Client Medicaid ID number:	

☐ **YES**, I give permission to receive a dental screening and fluoride varnish application. (prophylaxis and x-rays)
If prophys will be provided, more detailed medical history questions must be added to evaluate a client's risk for bacterial endocarditis or other conditions.

☐ **NO**, I do not give permission to receive a dental screening and fluoride varnish application. (prophylaxis and x-rays)

Please answer the following questions:

1. Do you have a regular source of care for this pregnancy? ☐ Yes ☐ No
2. When is your due date?
3. How did you hear about the program? (circle one)

Doctor/Health Care Provider	Advertising	Child Health	Coordinated Intake	Home Visiting	WIC
Local Community Resource	Hospital	MCO	School Nurse	Walk-In	Other

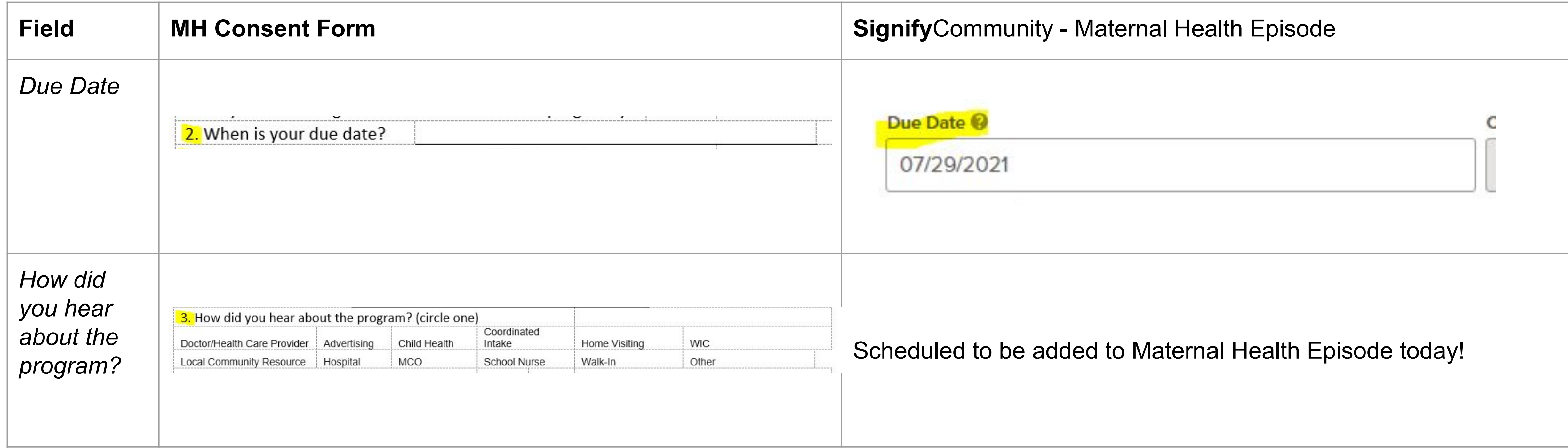
4. Do you have a regular dentist? ☐ Yes ☐ No
5. When was your last dental visit? (please check one)
   ☐ within 1 year ☐ 1 -3 years ago ☐ more than 3 years ago ☐ never been to a dentist
6. How do you pay for your dental care? (please check one)
   ☐ Self ☐ Medicaid/Dental Wellness Plan ☐ Hawki ☐ Private dental insurance ☐ Other
7. Do you have any oral concerns or problems? ☐ Yes ☐ No Explain:
8. Are you currently taking any medications? ☐ None If yes, please list:
9. Do you have any allergies? ☐ None If yes, please list:

I consent to insert agency name use of email and texting to send me scheduling and maternal health services information.
☐ Yes ☐ No Email address:

Maternal Health Episode

Field	**MH Consent Form**	**SignifyCommunity - Maternal Health Episode**
Program Enrollment	N/A *Are they receiving all Maternal Health services (='Maternal Health'), or just oral health services (='Oral Health Only')?*	Program Enrollment Maternal Health
Episode Status	N/A *Are they an active member (='Member')?*	Episode Status * Member
Provider Update	1. Do you have a regular source of care for this pregnancy? ☐ Yes ☐ No	Provider Update Medical Home - No

Maternal Health Episode



Field	MH Consent Form	**Signify**Community - Maternal Health Episode
Due Date	2. When is your due date? ______	Due Date 07/29/2021
How did you hear about the program?	3. How did you hear about the program? (circle one) Doctor/Health Care Provider · Advertising · Child Health · Coordinated Intake · Home Visiting · WIC Local Community Resource · Hospital · MCO · School Nurse · Walk-In · Other	Scheduled to be added to Maternal Health Episode today!

OH Consent Form

Maternal Oral Health Consent Form

Template

Name:	Date of Birth:
Address:	Cell Phone: Other Phone:
Race: ☐ White ☐ Black/African American ☐ Asian/Pacific Islander ☐ Native American ☐ Other ☐ Undetermined/ Unknown	Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino
Dentist:	Physician:
Client Medicaid ID number:	

☐ **YES**, I give permission to receive a dental screening and fluoride varnish application. (prophylaxis and x-rays)
If prophys will be provided, more detailed medical history questions must be added to evaluate a client's risk for bacterial endocarditis or other conditions.

☐ **NO**, I do not give permission to receive a dental screening and fluoride varnish application. (prophylaxis and x-rays)

Please answer the following questions:

1. Do you have a regular source of care for this pregnancy? ☐ Yes ☐ No
2. When is your due date?
3. How did you hear about the program? (circle one)

Doctor/Health Care Provider	Advertising	Child Health	Coordinated Intake	Home Visiting	WIC
Local Community Resource	Hospital	MCO	School Nurse	Walk-In	Other

4. Do you have a regular dentist? ☐ Yes ☐ No
5. When was your last dental visit? (please check one)
   ☐ within 1 year ☐ 1 -3 years ago ☐ more than 3 years ago ☐ never been to a dentist
6. How do you pay for your dental care? (please check one)
   ☐ Self ☐ Medicaid/Dental Wellness Plan ☐ Hawki ☐ Private dental insurance ☐ Other
7. Do you have any oral concerns or problems? ☐ Yes ☐ No Explain:
8. Are you currently taking any medications? ☐ None If yes, please list:
9. Do you have any allergies? ☐ None If yes, please list:

I consent to insert agency name use of email and texting to send me scheduling and maternal health services information.
☐ Yes ☐ No Email address:

Oral Health Survey - Intake

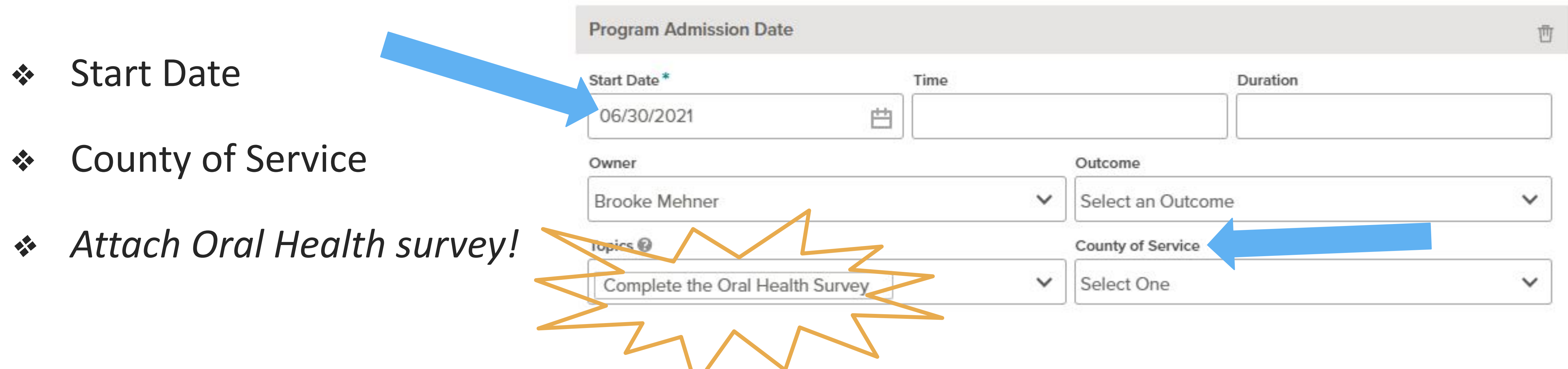
Field	MH Consent Form	**Signify**Community - Oral Health Survey
Do you have a regular dentist?	4. Do you have a regular dentist? ☐ Yes ☐ No	Intake Only # / Question / Answers 1 Do you have a regular dentist? Yes / No / Unknown
When was your last dental visit?	5. When was your last dental visit? (please check one) ☐ within 1 year ☐ 1 -3 years ago ☐ more than 3 years ago ☐ never been to a dentist	2 When was your last dentist visit? Choose...
How do you pay for dental care?	6. How do you pay for your dental care? (please check one) ☐ Self ☐ Medicaid/Dental Wellness Plan ☐ Hawki ☐ Private dental insurance ☐ Other	3 How do you pay for your dental care? Choose... 4 If Other, please specify:

Oral Health Survey - Intake

Field	MH Consent Form	**Signify**Community - Oral Health Survey
Do you have oral concerns or problems?	7. Do you have any oral concerns or problems? ☐ Yes ☐ No Explain:	5 Do you have any oral concerns or problems? Yes No 6 If Yes, please specify

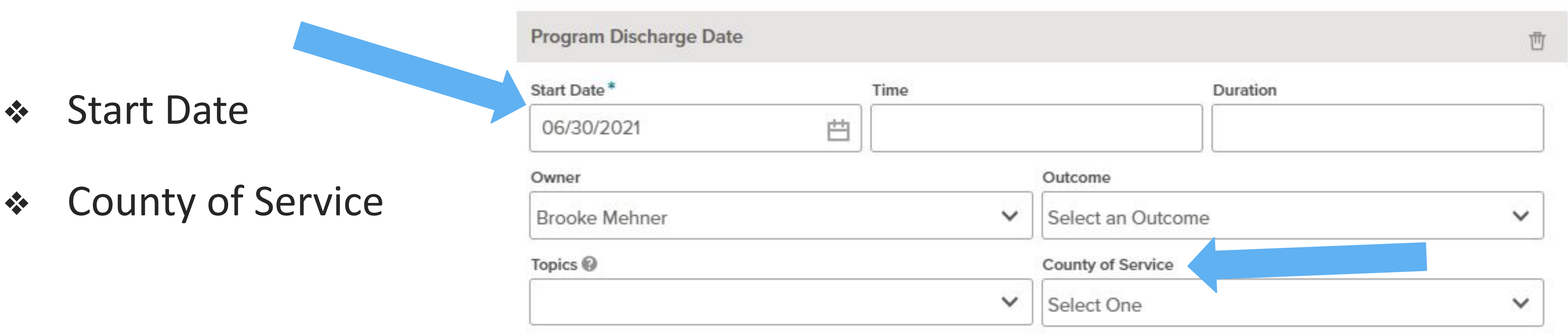
Program Admission Date Activity

- ❖ Start Date
- ❖ County of Service
- ❖ *Attach Oral Health survey!*



Program Discharge Date Activity

- ❖ Start Date
- ❖ County of Service



❖ *Don't forget:*
- ➢ *to fill out the 'Discharge Only' questions in the Oral Health survey!*
- ➢ *to update the Episode status!*

OH Screening Form

I-Smile Maternal Oral Health Services Template

Risk Level	Low D0601	Moderate D0602	High D0603
	Duration:	min	

Decay:	yes	no
Filled:	yes	no
Gingivitis:	yes	no

Client Name:		Medicaid/Client ID:	
DOB:	Service Site:	Date of Service:	
Translator needed	☐Yes ☐No	Dentist	Physician

	Documentation		Documentation
Medical conditions related to oral health		Daily home care	
Current medications, allergies		Eating/snacking habits	
Tobacco, alcohol, or drug use		Fluoride exposure	
Oral concerns		Other	

Oral Screening ☐D0190 Duration: min

Condition of hard tissue	*Documentation*	*Condition of soft tissue*	*Documentation*
Untreated decay or demineralization		Gum redness, bleeding, exudate	
Visible plaque, calculus or stain		Swelling or lumps	
Decay history (fillings, crowns)		Trauma or injury	
Loose or missing teeth		Recession	
Enamel defects, trauma or injury		Other	

Topic(s) of oral health education provided: ☐ pregnancy gingivitis ☐ morning sickness ☐ daily home care ☐ dietary habits ☐ gum disease & systemic implications ☐ fluoride ☐ regular dental visits ☐ infant oral health ☐ bacteria transmission

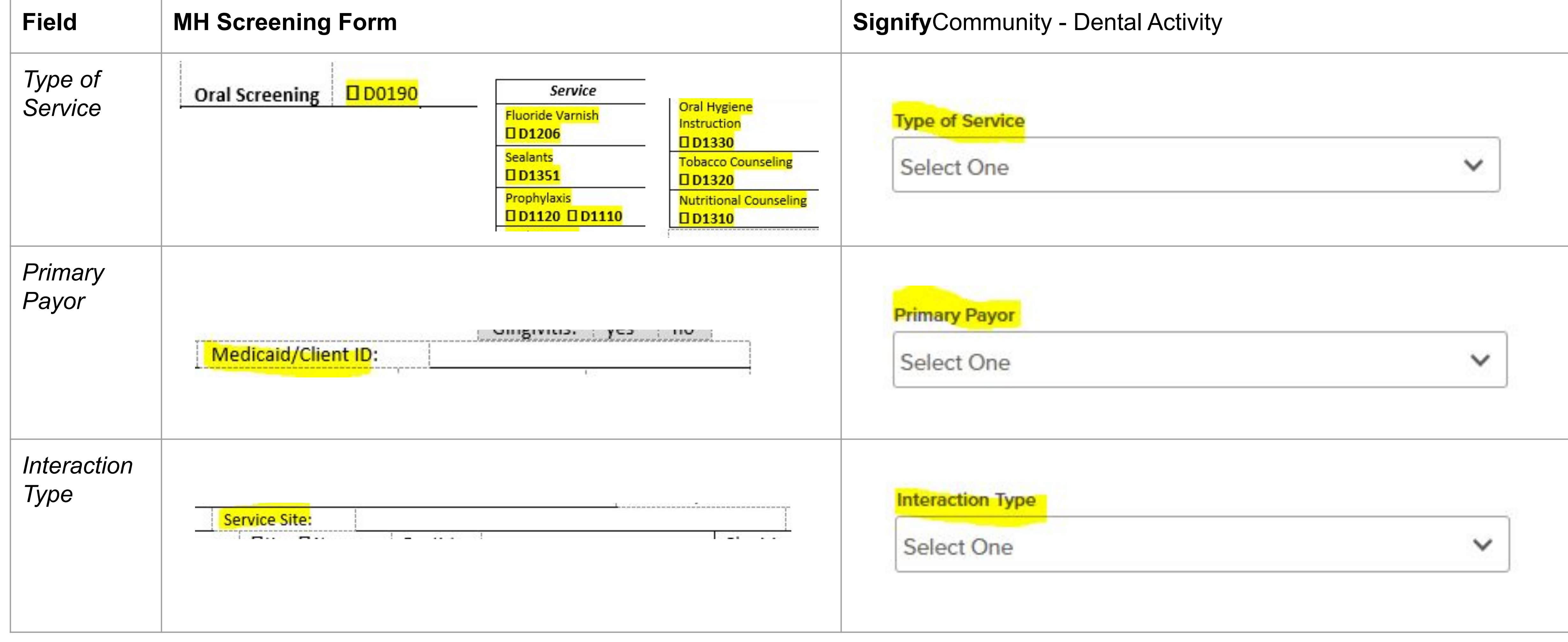
Notes:

Products recommended or dispensed: ☐ Toothbrush ☐ toothpaste ☐ Floss ☐ Fluoride Rinse ☐ Anti-Microbial Rinse ☐ Xylitol ☐ Biotene ☐ Sensodyne ☐ Salt water rinse ☐ None ☐ Other:

Service		*Documentation/notes for services provided*	*Duration:*
Fluoride Varnish ☐D1206	☐Not provided	Type and Concentration:	min
Sealants ☐D1351	☐Not provided	Tooth number(s) and surface(s): Product used:	min
Prophylaxis ☐D1120 ☐D1110	☐Not provided	Notes:	min
Oral Hygiene Instruction ☐D1330	☐Not provided	Notes:	min
Tobacco Counseling ☐D1320	☐Not provided	Notes:	min
Nutritional Counseling ☐D1310	☐Not provided	Notes:	min

Dental Referral / Care Coordination

Maternal Health ‘Dental’ Activity



Field	MH Screening Form	**Signify**Community - Dental Activity
Type of Service	Oral Screening ☐ D0190 Service Fluoride Varnish ☐ D1206 Sealants ☐ D1351 Prophylaxis ☐ D1120 ☐ D1110 Oral Hygiene Instruction ☐ D1330 Tobacco Counseling ☐ D1320 Nutritional Counseling ☐ D1310	Type of Service Select One
Primary Payor	Medicaid/Client ID:	Primary Payor Select One
Interaction Type	Service Site:	Interaction Type Select One

Maternal Health ‘Dental’ Activity

- ***Type of Service***: D code for service provided
- **Oral Screening:**
  - Only D0190 code
- **Additional services:**
  - Duration *required*; Time In and Time Out are not
  - Sealant service added
    - Tooth number(s) and product *required* for this service
    - Only billable for clients through age 18

Oral Screening ☐D0190 Duration: min

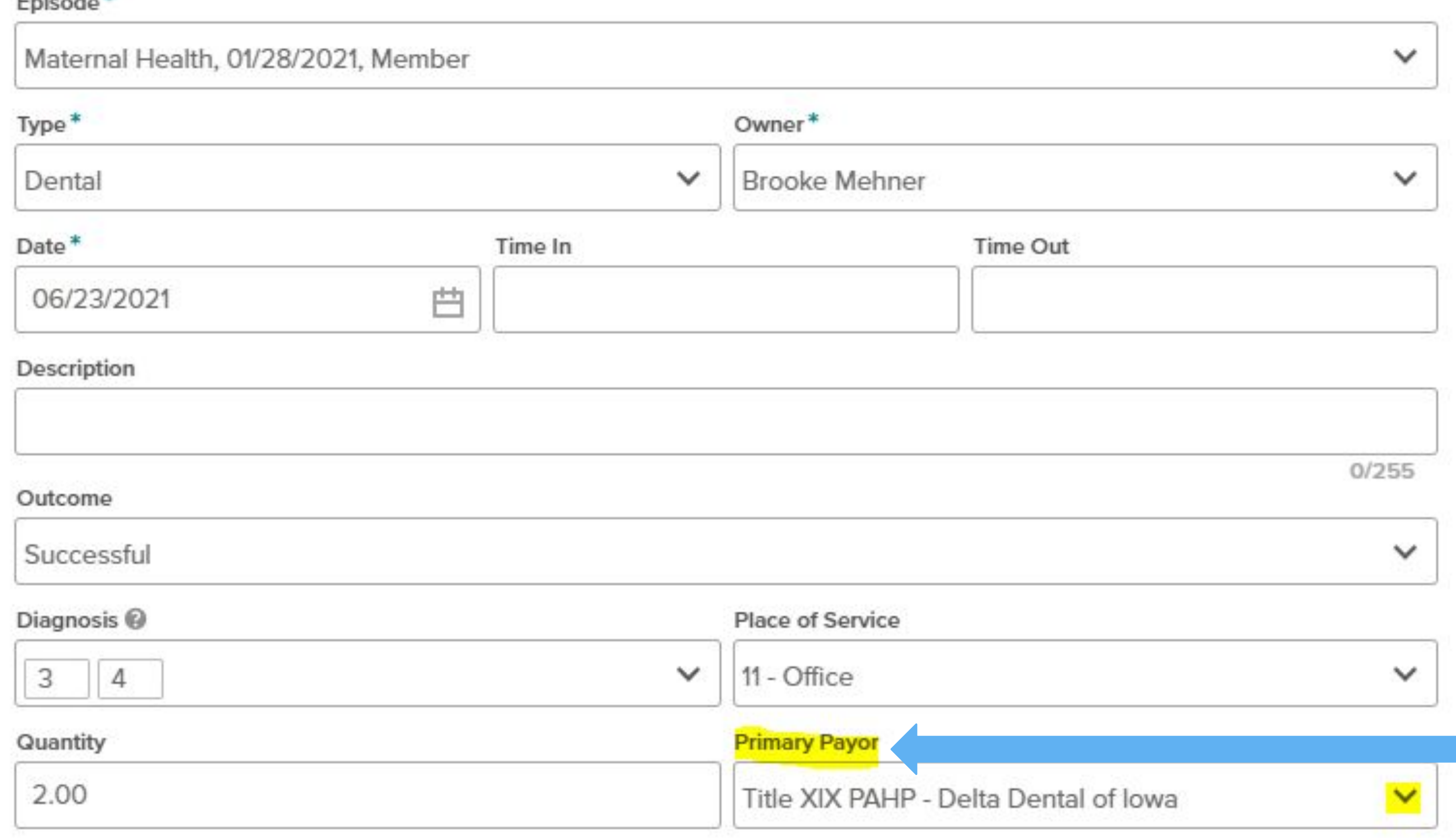
Condition of hard tissue	*Documentation*	*Condition of soft tissue*	*Documentation*
Untreated decay or demineralization		Gum redness, bleeding, exudate	
Visible plaque, calculus or stain		Swelling or lumps	
Decay history (fillings, crowns)		Trauma or injury	
Loose or missing teeth		Recession	

Service		*Documentation/Notes for services provided*		*Duration:*
Fluoride Varnish ☐D1206	☐Not provided	Type and Concentration:		min
Sealants ☐D1351	☐Not provided	Tooth number(s) and surface(s):	Product used:	min
Prophylaxis ☐D1120 ☐D1110	☐Not provided	Notes:		min
Oral Hygiene Instruction ☐D1330	☐Not provided	Notes:		min
Tobacco Counseling ☐D1320	☐Not provided	Notes:		min
Nutritional Counseling ☐D1310	☐Not provided	Notes:		min

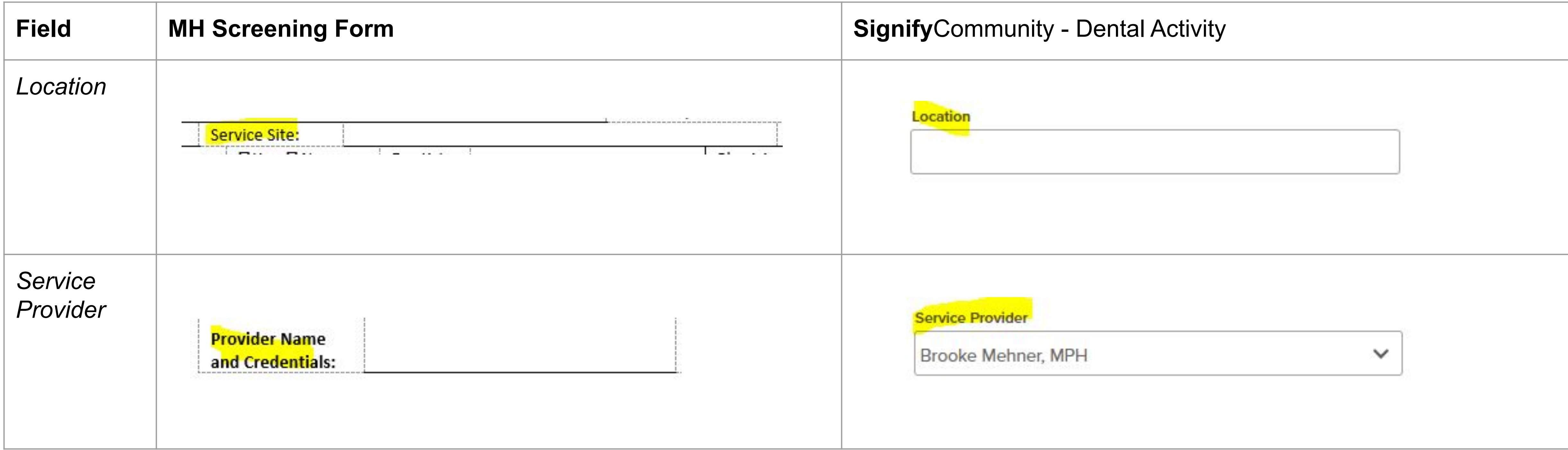
Maternal Health ‘Dental’ Activity

- ***Primary Payor***: How client is paying for service

- **Options Changed:**
  - Early Childhood Iowa
  - Title XIX - Fee for service
  - Title XIX PAHP - Delta Dental of Iowa
  - Title XIX PAHP - Managed Care of North America, Inc.
  - Title V/Uninsured
  - Other

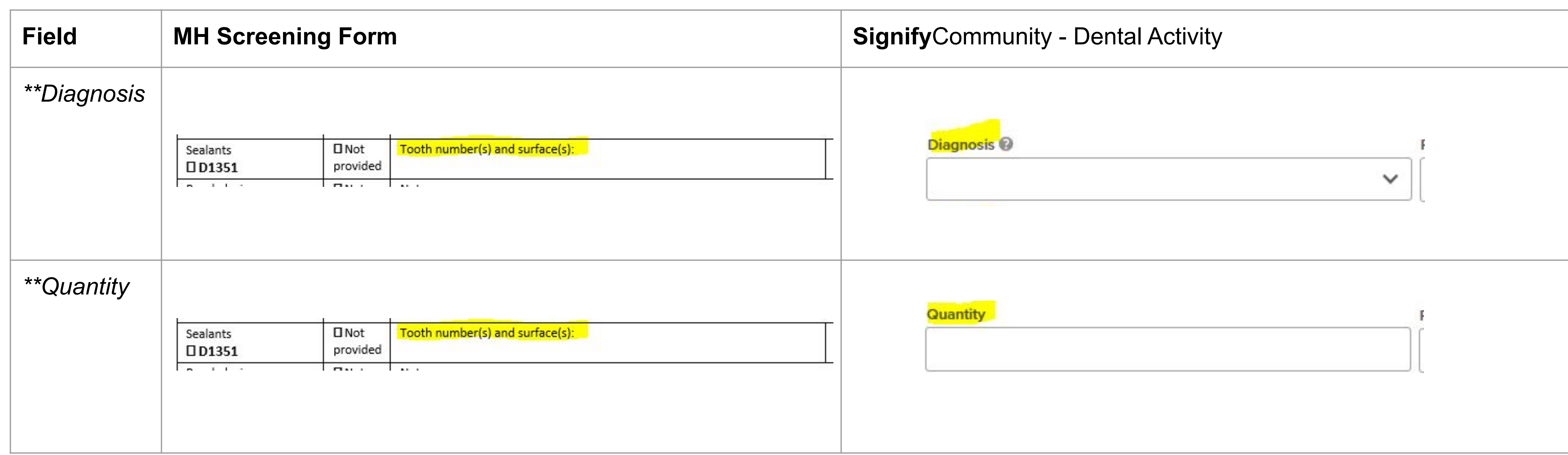


Maternal Health ‘Dental’ Activity



Field	MH Screening Form	**Signify**Community - Dental Activity
Location	Service Site:	Location
Service Provider	Provider Name and Credentials:	Service Provider Brooke Mehner, MPH

Maternal Health ‘Dental’ Activity



Field	MH Screening Form	**Signify**Community - Dental Activity
***Diagnosis*	Sealants ☐ **D1351** | ☐ Not provided | Tooth number(s) and surface(s):	Diagnosis
***Quantity*	Sealants ☐ **D1351** | ☐ Not provided | Tooth number(s) and surface(s):	Quantity

*****Only required when documenting sealants.***

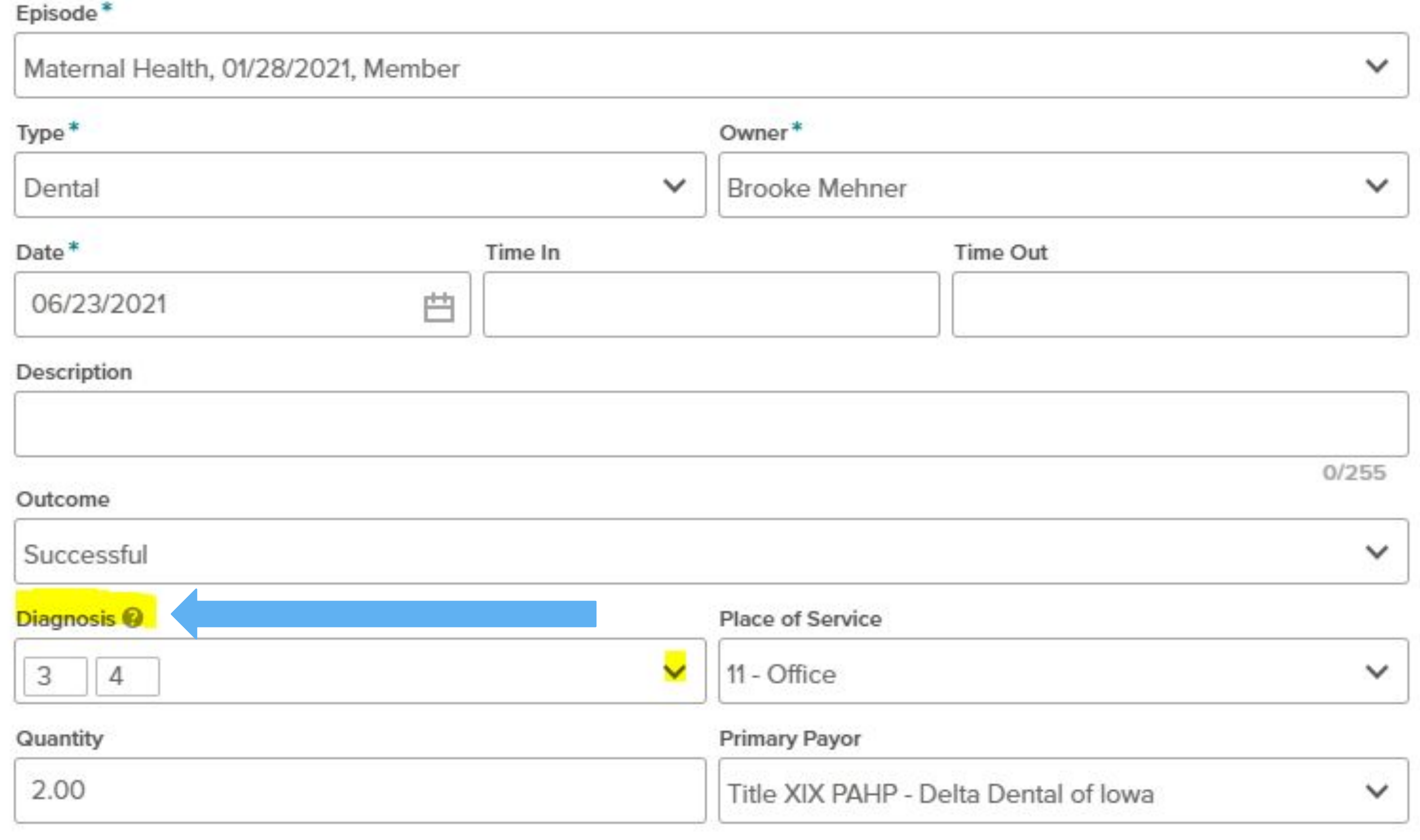
NOTE: Sealants are only billable for children through 18 years of age

Maternal Health ‘Dental’ Activity

- ***Diagnosis***: Tooth Number(s)/Letter(s) when providing sealants (D1351)

If providing sealants (D1351), **all teeth where sealants are provided need to be entered in the ‘Diagnosis’ field**, a multiselect field with all tooth numbers and letters listed.

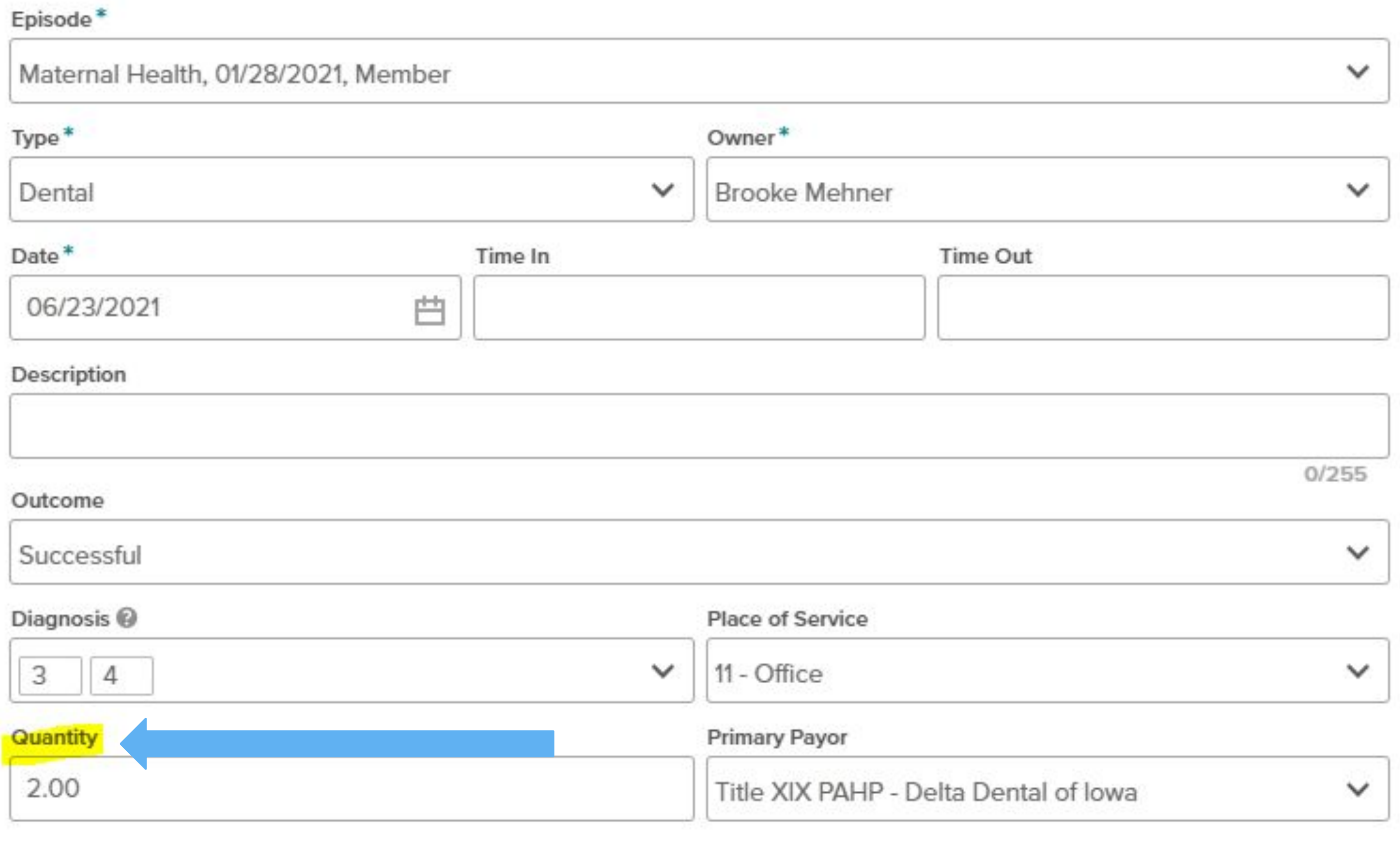
***Sealants are only billable for clients through age 18.*



Maternal Health 'Dental' Activity

- ***Quantity***: Number of teeth sealed when providing sealants (D1351)

If providing sealants (D1351), **the total number of teeth provided sealants needs to be entered in the 'Quantity' field**.



OH Screening Form

I-Smile Maternal Oral Health Services Template	Risk Level	Low D0601	Moderate D0602	High D0603
		Duration:		min

Decay:	yes	no
Filled:	yes	no
Gingivitis:	yes	no

Client Name:		Medicaid/Client ID:	
DOB:	Service Site:	Date of Service:	
Translator needed	☐Yes ☐No	Dentist	Physician

	Documentation		*Documentation*
Medical conditions related to oral health		Daily home care	
Current medications, allergies		Eating/snacking habits	
Tobacco, alcohol, or drug use		Fluoride exposure	
Oral concerns		Other	

Oral Screening	☐ D0190	Duration:	min

Condition of hard tissue	*Documentation*	*Condition of soft tissue*	*Documentation*
Untreated decay or demineralization		Gum redness, bleeding, exudate	
Visible plaque, calculus or stain		Swelling or lumps	
Decay history (fillings, crowns)		Trauma or injury	
Loose or missing teeth		Recession	
Enamel defects, trauma or injury		Other	

Topic(s) of oral health education provided: ☐ pregnancy gingivitis ☐ morning sickness ☐ daily home care ☐ dietary habits ☐ gum disease & systemic implications ☐ fluoride ☐ regular dental visits ☐ infant oral health ☐ bacteria transmission

Notes:

Products recommended or dispensed: ☐ Toothbrush ☐ toothpaste ☐ Floss ☐ Fluoride Rinse ☐ Anti-Microbial Rinse ☐ Xylitol ☐ Biotene ☐ Sensodyne ☐ Salt water rinse ☐ None ☐ Other:

Service		*Documentation/Notes for services provided*		*Duration:*
Fluoride Varnish ☐D1206	☐Not provided	Type and Concentration:		min
Sealants ☐D1351	☐Not provided	Tooth number(s) and surface(s):	Product used:	min
Prophylaxis ☐D1120 ☐D1110	☐Not provided	Notes:		min
Oral Hygiene Instruction ☐D1330	☐Not provided	Notes:		min

MH Dental Risk Assessment Survey

Field	MH Screening Form	**Signify**Community - MH Dental Risk Assessment Survey
Decay	Decay: | yes | no	# | Question | Answers 1 | Decayed teeth? | Yes | No
Filled	Filled: | yes | no	2 | Filled teeth? | Yes | No
Gingivitis	Gingivitis: | yes | no	3 | Gingivitis? | Yes | No
Risk level	Risk Level | Low D0601 | Moderate D0602 | High D0603	4 | Risk level? | High | Moderate | Low

ORAL HEALTH RISK ASSESSMENT FOR MATERNAL HEALTH

Oral Screening Indicator	Risk Level	Dental Referral	Follow Up
Abscess, pain, or large decay	High	Immediate	Care coordination Follow up with patient within 3 months to ask about completion of treatment from a dentist
Untreated decay	High	Within 3 months	
Moderate to severe gum disease (moderate to severe redness, swelling, bleeding, exudate; loose teeth)	High		
Mild gum inflammation (slight gum redness, swelling, and/or bleeding)	Moderate	Within 6 months	Care coordination, as needed
Poor oral hygiene	Moderate		
Deep pits/fissures	Moderate		
Restorations	Moderate		
Orthodontia	Moderate		
Dry mouth	Moderate		
Vomiting	Moderate		
Tobacco use or drug/alcohol abuse	Moderate		
Eligible for government programs (e.g. Medicaid, WIC)	Moderate		
Dental visits – less than annual	Moderate		
Frequent exposure to sugar/carbohydrates	Moderate		
If none of the high or moderate risk factors are present, client is considered low risk.	Low	Within 12 months	Care coordination, as needed

Assign risk level according to the highest oral screening indicator identified (high→low).