Oral Health Integration Referral Experiences

Structured referrals from medicine to dentistry, in which clinical information about the referred patient is exchanged between the referring clinician and the dental consultant, are not typical in the primary care setting. Even in practices with co-located dental clinics, it is rare for information to be exchanged in a formal way. A critical component of the Oral Health Delivery Framework (the Framework) is the development of a dental referral network so that as oral health issues are uncovered in the primary care setting, there is a clear protocol to follow to ensure those patients are seen, diagnosed, and treated by a dentist. This case example shares the experience of field testing sites, including those that needed to create a community referral network of dental partners, and those who were able to leverage co-located dental clinics as a referral resource.

For more information about the goals of a structured referral, the key components of an effective referral process, and guidance on how practices can build dental referral networks that meet the need of their primary care patients, refer to the Organized, Evidence-Based Care Implementation Guide.

Community Referral Networks

Among the 19 field-testing sites, ten did not have a co-located dental clinic and needed to develop community referral partners. The methods used to establish referral relationships with dental partners varied, as did the processes they developed to communicate between practices and close the loop on referrals. These case vignettes share descriptions of referral processes from field-testing sites and an early leader in oral health integration.

Bluegrass Community Health Center

The Bluegrass Community Health Center (BCHC) is a federally qualified health center (FQHC) located in Lexington, KY, an urban setting. "In oral health, one of the big struggles is that if we find disease and have trouble referring a patient out, that becomes a frustration and may impact whether you're going to want to do this. We are fortunate in Lexington that we have multiple sites where we can refer patients for dental care. For the most part we're able to get people into dental care when they need it. If we have a child who we know has a horrible caries problem, and we do our best to get them to see the dentist and they get there and six months later they come back for their regular check and they give us a big smile—even if they have silver teeth because they had their caries taken care of, at least we know we've gotten them care. At that point it's on us to continue to re-encourage the good oral health hygiene behaviors," explains A. Stevens Wrightson, MD.

BCHC has a diverse mix of referral partners, including the University of Kentucky, two private dentists, and three other dental organizations (a free dental clinic, an FQHC with dental clinicians, and a dental group that focuses on providing dental care to underserved communities). "We have formal referral agreements with the University of Kentucky's dental clinic (for urgent and routine care), and two private dentists using dental vouchers. We provide vouchers to a patient to get a cleaning or extraction, they bring the voucher to the dentist we refer to, and then the dentist does the work and bills BCHC," explains Wrightson. "The patients we still struggle with in terms of referrals are children who have come here with their families but they were not born in the U.S. There are no, or at least minimal, dental services for undocumented children. I'll sometimes see a family of children and the two youngest ones have beautiful teeth—they were born in the U.S., got enrolled in HeadStart early, and they're getting dental evaluations there. But the 8-year-old born outside of the U.S. has horrible cavities. The parents took them to the dentist once but were told it would cost $2,000 to do any kind of treatment," shares Wrightson.

Closing the referral loop is a process that BCHC is still working on with their referral partners. "KoolSmiles [the dental group that provides care for underserved communities] is the best at getting information back—if we ask for it, they will send it to us,

and sometimes they will send it before we ask," describes Wrightson. "KoolSmiles consistently asks us for medical consults on patients. If they have a patient with more significant medical issues [such as a positive tuberculous test for a refugee patient], they will ask if it's okay to proceed with care. I love that communication!" exclaims Wrightson. "HealthFirst, the fellow FQHC, recognizes the importance of bi-directional communication, and we're piloting a new referral process with them, to see if we can send them information and get information back. We're trying to be really directive with the process. We tell the patients, 'We want you to go here [to HealthFirst],' we make the appointment there for the patient, send the referral, and expect the referral information back. With HealthFirst we put an order in the electronic medical record [EMR] as a 'dental consult' so if the information doesn't come back, staff know they have to go get it. Our EMR has a good tracking system that makes it possible to follow up on the consults that aren't closed," shares Wrightson.

Rinehart Clinic

Rinehart Clinic is an FQHC located in Wheeler, OR, a rural setting in the northwest corner of the state. "We have created a memorandum of understanding [MOU] with the health department dental program, about 25 miles away from our clinic. Unless a patient says they have another dentist they're already seeing, we refer people to the health department," explains Keri Scott, Director of Quality. "The MOU outlines the expectations of what we're providing and what they need to provide us." Agreeing on expectations for the referral relationship in advance and creating a document such as an MOU or a referral agreement helps prevent confusion at later points in time, particularly when there is staff turnover. For a template of the topics to discuss, refer to the Referral Agreement Template tool. Scott continues, "The referral is generated during the visit and goes to the referral coordinator. In a best-case scenario, the referral coordinator is able to come in to the exam room during the visit, talk to the patient to determine what they need and where they should go, and then she faxes the information to the dental office. After the patient is seen, the health department dental office faxes the required information back, at which point the medical records person scans it into the electronic health record [EHR] and it goes automatically to the referral coordinator who can then close the referral." It is common for medical-dental referrals to rely on fax rather than EHR communication because even if a primary care office and referring dental partner are on the same EHR platform, most EHR systems are not interoperable across medical and dental versions of the software. Scott explains, "We've done a lot of work in the past on our referral process, so we had an established process that we just mimicked for oral health."

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Coulee Medical Center

Coulee Medical Center is a critical access hospital located in Grand Coulee, WA, a rural town in the north-central part of the state. The program leadership team partnered with the Washington Dental Service Foundation to identify a local dental

referral partner within a reasonable driving distance for patients at the medical center. Gillian Tupling, referral coordinator, describes the referral workflow process: "I give it a week after placing the referral, then I call the dentist's office to ask if the patient has been scheduled. If not, then I make sure it happens. There is good communication with the primary contact at the dental office." In order to effectively track the patients who have been referred to the community dentist, Tupling has developed an Excel spreadsheet to manually track the referral status. Tupling explains, "I keep a spreadsheet with the patient name, referring clinician, who they referred to, the date of the initial referral, reason for the referral, date the referral information was faxed over, the appointment date and time, and whether the patient kept the appointment." The new referral partner accepts patients of all insurance statuses, and the workflow is working well. Wendy Hughes, NP, one of the pilot clinicians, shares, "One of the key things that made it go smoothly was that we had a good streamlined referral process and a referral coordinator in place. We were able to just use that existing process and expand it to include oral health."

HealthCore Clinic

HealthCore Clinic is an urban FQHC recognized as a Level 3 Patient-Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA), located in Wichita, KS. Diane Peltier, PhD, chief operating officer, explains, "We had an existing relationship with a community dental partner, and they are located just a mile and a half down the street, so if patients can make it to our clinic, they can usually make it to the dental clinic, too. We worked out a referral process with them, where we have one contact person on our side who takes care of making the dental referrals, and they have one contact person designated for our person to communicate with." HealthCore and their community referral partner do not share an interoperable EHR, so Peltier describes how they are working around that barrier: "Referrals are made via secure email, and in conjunction with our partner, we help schedule the patient for a dental appointment. If the patient no-shows, the dental clinic lets us know. At this point, we aren't sharing appointment information, but we are currently working on a process for closing that loop." Despite having developed a workflow process that works for both the primary care and the dental offices, barriers remain. Peltier shares, "The challenge is that cost of dental care is a barrier for our patients. The dental clinic is considering creating a sliding scale or a lower flat rate for our patients, but that hasn't been implemented yet. They do accept Medicaid, but the initial assessment fee for an uninsured patient is a really big barrier for our patients. They will choose to suffer with whatever the issue is, until they're in excruciating pain and then they will just go to the emergency department [ED]." This provides an opportunity for education in the primary care clinic, as Peltier explains: "We try to educate the patient to not wait until it's that bad, because what they think they will get in the ED [dental treatment], isn't what they will really get [an antibiotic or pain medication]."

Harborview Medical Center-Women's Clinic

Harborview Medical Center is a Level 1 adult and pediatric trauma and burn center located in urban downtown Seattle, WA. It is owned by King County and managed by the University of Washington. The hospital provides a variety of specialty services, including a women's clinic where the Framework was field-tested among pregnant patients. Prior to field-testing

the Framework, patients at the Women's Clinic faced challenges with access to dental care. The majority of the clinic's patient population is low income and not commercially insured, and often their primary language is not English. Leondra Weiss, RN, nurse manager, describes the referral process. "Our clinical assistant handles making the referrals to dentistry for the patients. We haven't been able to make modifications to our EHR to support referrals, so she has developed a manual system to manage and track referrals. We are referring all patients to dentistry, doing the care coordination, making the appointment, making sure the patient can get there and that barriers are reduced and addressed so patients can get in and be seen." Patients seen at the Women's Clinic live all over the city of Seattle, and sometimes even outside of the city limits, so the clinical assistant uses a lengthy list of community dentists, divided by ZIP code, to determine the best place to refer patients for treatment. Weiss explains, "Our clinical assistant helps them figure out the best place to go based on location, language needs, barriers, and so on. We've also gone out and done site visits at some of the dental clinics. We worked with the state dental society to get a list of all of the dental clinicians that take Medicaid, and then filtered out the ones that wouldn't see pregnant patients —like pediatric dentists." They went a step further with a local community health center that was receptive to creating a partnership. Weiss shares, "We met with the dental director at a local community health center dental clinic, and she gave us her card and set up a process that we could use with them to ensure we could get our patients an appointment. All of the dental clinicians we have reached out to have been very supportive, and they agree the patients need to be seen and are willing to work with us directly to make sure our patients can be seen."

Measures	January–April 2014	January–April 2016
Total pregnant patients seen for an initial OB visit	60	98
Number of patients given oral health assessment during initial OB visit	0	61
Number of patients referred to a community dentist	1*	52
Number of patients scheduled for dental appointment	1*	28

"I think it would be really helpful for a site beginning this work to get together with the dental clinicians right at the beginning of the work. This lunch and learn we have planned to spread the project would be a great way to launch everything. There is so much better collaboration and connection when you see someone in person." —Deborah Nalty, MD, Providence Medical Group -Monroe Clinic

Lowell Community Health Center

Lowell Community Health Center (LCHC) is a large FQHC recognized as a Level 3 PCMH by the NCQA, located in Lowell, MA, a small community northwest of Boston. LCHC does not have a co-located dental clinic, and the closest safety-net dental practice is 30 miles away. They discovered that there are some community dental clinicians who accept Medicaid, but access is a challenge. Samantha Jordan, DMD, MPH, dental director, explains, "We talked with the Massachusetts League of Community Health Centers [MLCHC] about collaborating with the state dental society to have a lunch and learn and build relationships with community dentists, but we have tabled that for now while we work on EHR modifications that will be needed to support a structured referral. One concern the clinicians share about creating a formal referral process in the EHR is that the process for closing referrals requires receiving a note back from the dentist." The primary care clinicians are anticipating that it could be difficult to get consultation notes returned from the dental partner, since this is a brand new process." Jordan continues, "If it is challenging to get notes back and confirm that patients were seen with an external dental partner, it would create a lot of additional work for the primary care team, and we would end up with many open referrals that would be a ding against the department's quality measure." The program team evaluated what they could do to improve their referral process. "We had an old list of community dentists that was outdated, so we decided to update it. We started with the list that the state publishes of dental practices that accept Medicaid, and we called each of the offices to ask if they would be willing to be on our referral list and confirmed that they were accepting new patients. We also asked about the type of practice—pediatric, general—, the ages they accept, what languages were available, and whether they had experience with special-needs patients or could provide more significant restorative care. Only one dentist that we reached out to didn't want to be referred to, and a couple weren't accepting new Medicaid patients, but by and large the dental clinicians were open to being on our list. Now if a patient needs a referral, we give them this more updated list for them to choose from to make their appointment," describes Jordan. LCHC is not yet tracking their referrals or collecting data on it, but that may change in the future as the program develops.

"All of the dental clinicians we have reached out to have been very supportive, and they agree the patients need to be seen and are willing to work with us directly to make sure our patients can be seen."

— Leondra Weiss, RN, Harborview Medical Center-Women's Clinic

Co-located Referral Partnerships

Among the 19 field-testing sites, nine had a co-located dental clinic or dental hygienist on staff and focused on leveraging their internal referral opportunities. While some expected the process to be simpler with an internal referral, challenges arose even in a co-located setting.

Brockton Neighborhood Health Center

Brockton Neighborhood Health Center (BNHC) is a large, nonprofit multicultural community health center located south of Boston, MA. Benjamin Lightfoot, MD, describes the referral process that the pilot team at BNHC developed: "A referral to the co-located dental clinic is made by the clinician if there is significant pathology in the mouth, if the patient is having significant symptoms, or if they haven't seen a dentist in a few years. The referral gets entered in the electronic health record. It is sent to the dental referral team, and they reach out to contact the patient to schedule the appointment." This is a new process, but has been working well. Lightfoot continues, "The real trick is closing the loop; someone has to go in and check and see if the patient kept their appointment and completed the referral. There's not an automatic process to close the loop and get the information back. It is being closed, but it's not happening as quickly as we'd like." BNHC shares a single electronic health record with an integrated EMR and an electronic dental record (EDR). However, even this situation does not create a seamless flow of information. Lightfoot explains, "Patient information flows from the electronic medical record to the electronic dental record, but nothing flows back to the EMR. It would be really nice to be able to get that." Lightfoot shares that when thinking about the next steps in the oral health integration program development, "We just hired a new dental director, and I'm planning to ask him to come to some of our oral health integration team meetings so we can build a closer collaboration. Our referral process has improved significantly over the course of the project, but it's not as integrated as I'd like."

Hilltown Community Health Center

Hilltown Community Health Center (HCHC) is a small FQHC located in central Massachusetts, serving a rural population. They began the oral health integration process believing that it would be fairly straightforward because of their co-located dental clinic. Michael Purdy, MD, chief clinical and community services officer, explains, "Our previous referral system was that a clinical assistant would walk their patient across the hallway to make the appointment. It wasn't a formal referral. At first we started out by trying to come up with a way to do an internal referral within the EHR which was unique to this work, and it took a long time to figure out how to implement that system." Eventually the program leadership determined that they needed to take a different path. Purdy explains, "In the end, we wound up creating a work-around where we enter the referral into the EHR as though it is an external referral. We had to enter every dentist in the area, as well as the internal dentists at the co-located clinic, into the referral log. Internal referrals now go to our referral department; they transfer the referral to a dental employee at the co-located dental clinic, who takes over and schedules the appointment with the patient." Changing a system that was working well from the clinician point of view is not always a smooth transition. Purdy shares, "We were all used to the previous process, and it has been a challenge to get the clinicians to make structured referrals for oral health. They feel like it slows down care since there is now a delay of about a day to make the appointment. Before, the patient would get the appointment before they left the clinic. But there are benefits," admits Purdy. "Before, we didn't know who was keeping their appointments; now we'll be able to track that. Because of HRSA requirements and changes in funding, we have to track these things formally."

About the Oral Health Integration in Primary Care Project

Organized, Evidence-Based Care Supplement: Oral Health Integration joins the Safety Net Medical Home Initiative Implementation Guide Series.

The goal of the Oral Health Integration in Primary Care Project was to prepare primary care teams to address oral health and to improve referrals to dentistry through the development and testing of a framework and toolset. The project was administered by Qualis Health and built upon the learnings from 19 field-testing sites in Washington, Oregon, Kansas, Missouri, and

Massachusetts, who received implementation support from their primary care association. Organized, Evidence-Based Care Supplement: Oral Health Integration built upon the Oral Health Delivery Framework published in Oral Health: An Essential Component of Primary Care, and was informed by the field-testing sites' work, experiences, and feedback. Field-testing sites in Kansas, Massachusetts, and Oregon also received technical assistance from their state's primary care association.

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