SECTION 6

Structuring Referrals to Dentistry

Introduction

Many patients screened during the course of a primary care visit will need dental care, including definitive diagnosis and treatment that only a dental team can provide. Whenever possible, the primary care team should support patients' existing relationships by referring patients who have a regular source of dental care to their respective dentists. It can be expected, however, that many patients seen in the primary care setting will not yet have a relationship with a dentist and will need guidance on referral resources. The basic premise of the Oral Health Delivery Framework (the Framework) is that referrals to dentistry ought to be as smooth as referrals to any other medical or surgical specialist—the burden should not be on the patient to coordinate transitions of care.

This section describes referrals from primary care to dentistry and:

- Presents the goals of a structured referral (relevant for both internal and external referrals).
- Describes the key components of an effective referral process.
- Offers guidance on how practices can build referral networks able to serve the full diversity of their patients.

Structured Referrals

A structured referral is an order for a referral placed in the electronic health record (EHR) to a specific dentist. Just like a medical/surgical referral, it specifies the reason for the referral and contains relevant clinical information, including lists of the patient's medical problems, active medications, and medication allergies. There is an expectation that the dentist will return a consultation note to the primary care team.

"From the patient perspective, what they see is that their healthcare clinicians are adding dentists to the mix, and that sends the message that dental care is critical and important, that they're not separate. It moves patients towards the understanding that oral health and overall health are strongly related."

—Angie Dunn, DDS, Light Dental Studios

Co-Located Dental Services

Primary care practices with co-located dental services have a "built-in" internal referral network. However, field-testing experience shows that practices with co-located dental services have many opportunities to improve referral processes and streamline care. Moreover, many co-located dental practices are at capacity, and will not be able to absorb either the number or type of referrals that may be generated by primary care. For these reasons, we recommend co-located practices do the following:

1. Optimize the internal referral process using the principles of integrated care, as described in this section.
2. Ensure that referral orders include the reason for referral in addition to the other information that needs to accompany it.
3. Recruit external referral partners. This could include local dental practices or other community health center dental practices in the community.



Goals of a Structured Referral to Dentistry

The goals of a structured referral to dentistry include:

1. The patient should leave the primary care office with a referral to a specific dentist or dental office with which the primary care practice has a referral agreement. Instructions should make it clear to the patient what to do, what to expect, and whom to contact if problems arise.
2. An agreed-upon set of information should be sent from the primary care office to the dentist, so the dentist understands the reason for the referral and has sufficient information about the patient's health condition to be able to safely provide appropriate treatment including prescribing medications.
3. The dentist should send the primary care clinician a consultation note documenting when the patient was seen, what was done, and any future treatment plans.
4. All referrals should be documented in the EHR as structured data so they can be tracked by the primary care team and so that the referral process can be monitored to ensure patients found to have active disease are, in fact, referred.

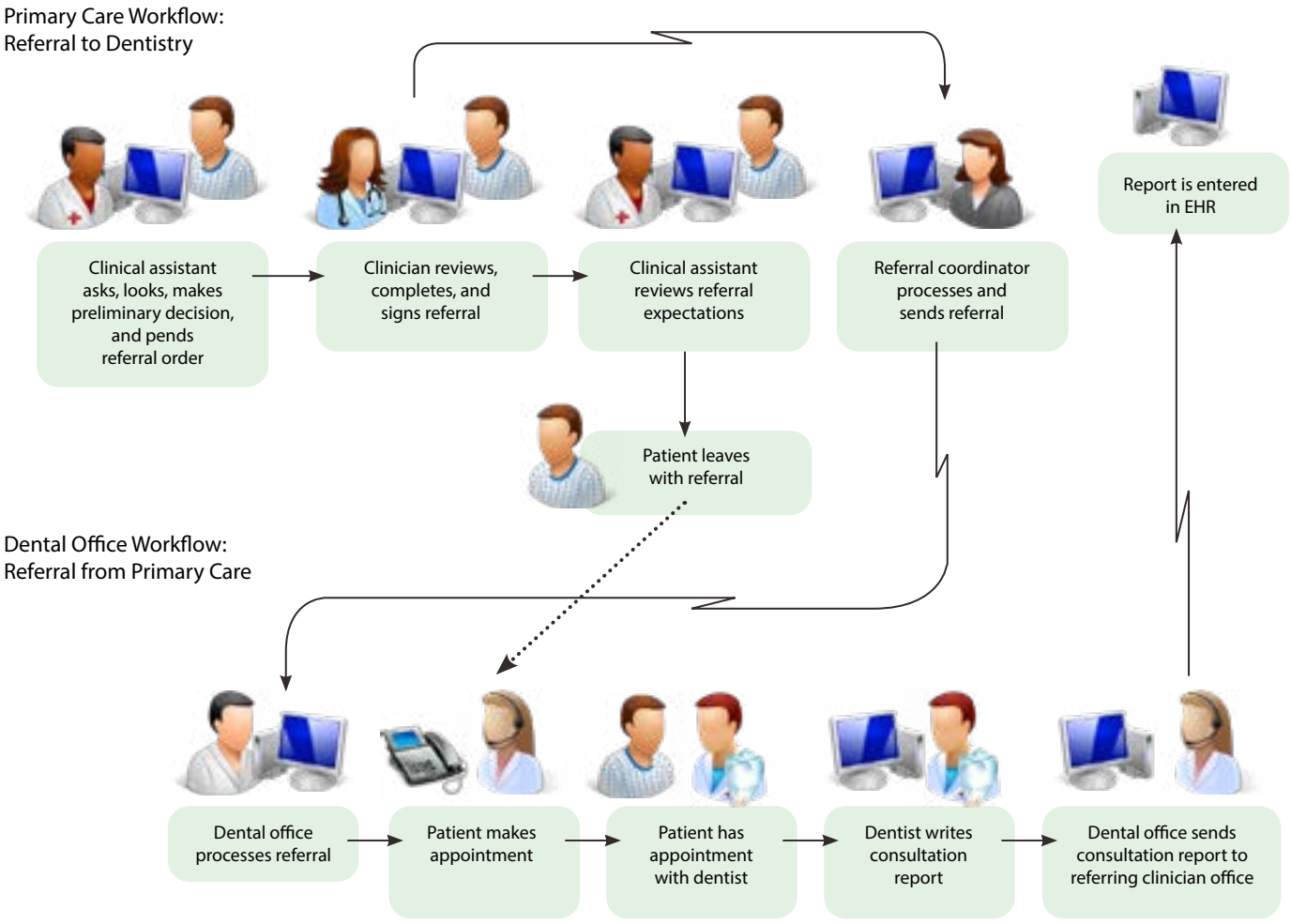
These goals exist irrespective of the patient's dental insurance status and whether or not the patient has a preexisting relationship with a dentist.

Achieving these goals requires that the primary care practice track and support the referral until it is completed when a consultation note is received from the dentist. This process is known as "closing the loop," and it is the gold standard for effective care coordination. For more information on referral tracking, refer to Improving Chronic Illness Care. Moreover, having a process in place to help patients find and make appointments, and receive additional support when needed, is an important component of care coordination. Support needs may include transportation, medical interpretation, or other services. Practices should offer the same level of support for dental referrals as they do for all other medical and surgical referrals.

Primary care referral pathway

Figure 6.1 demonstrates a common workflow for a primary care referral to specialty care, adapted for dental referrals. There are several key features of this workflow as it pertains to dental referrals, described in more detail below.

Figure 6.1: Referral workflow from a primary care practice to a dental practice



Key Features of a Dental Referral

Care coordination is a central element of the Framework. Traditionally this has been a burden placed on the patient, resulting in inefficiencies, a negative experience of care, and potentially even risk to the patient. Primary care teams will need to identify an individual to take responsibility for this process and ensure that referrals to dentistry flow smoothly. Care coordination is often a challenge with medical/surgical referrals, and developing a standard process for dental referrals may help improve care coordination processes for other referrals as well.

1. The referral is a clinical decision that the primary care clinician and the patient/family make together, and is reflected as an order in the electronic health record.
2. The referral order is designed to prompt the ordering clinician to enter the clinical context and any health information the dentist needs to address the reason for the referral. For example, for a referral for gum inflammation, the order would prompt the ordering clinician to include the presence of a systemic disease such as diabetes, or habits like tobacco use, known to accelerate periodontal disease.
3. The clinical assistant or referral coordinator ensures the patient leaves the primary care office with written information on the referral, including contact information for the dentist, what should happen next, and instructions for what to do if there are any problems with the referral. If possible, it may be most efficient to schedule the appointment before the patient leaves the primary care office, to create a "virtual warm handoff." Some sites may be able to include the referral information in the after-visit summary or make it available on the patient portal.
4. Once the clinician signs the referral order, it is commonly routed to a referral coordinator or the staff member responsible for referral management for processing, which may include verification of insurance, and clerical and clinical information accompanying the referral. The referral is then transmitted to the dental office.

> "Having that referral relationship established is great. I feel confident that when I have a patient in the room with a dental issue that needs to be taken care of, I can refer them."
>
> —Wendy Hughes, ARNP,
> Grand Coulee Medical Center

5. The dental office will review the referral. This review may lead to the dentist contacting the referring clinician, either to get more information or, in some cases, to answer the referring clinician's question without having to see the patient.
6. Once the appointment is made and the dentist sees the patient, the dentist will complete the consultation report.
7. The consultation report is sent to the primary care practice, where it will be associated with the referral order and sent to the referring clinician to review.

The manner in which information is sent back and forth between the ordering (primary care) clinician and the consultant (dentist) is subject to available technology. What is most important is the content and timeliness of the messages, and the commitment to share information with one another.

The various technologies that can be used in this workflow include fax, e-fax, traditional mail, asynchronous secure messaging via email, direct messaging of a continuity of care document, or via a health information exchange. Inability to utilize health information exchange options to electronically communicate should not be viewed as a barrier. Opportunities to use health information technology (HIT) to support referrals are described on page 81.

Challenges and barriers

As with all referrals, there are potential barriers that might arise for the patient. These include:

- Transportation difficulties.
- Lack of time.
- Fear of dental care.
- Language barriers.
- Insurance coverage.
- Affordability (e.g., co-pays).

Primary care teams should make every effort to address these in the same manner they would address them for a referral to a medical specialist. Additionally, a patient may encounter challenges once the referral has been completed. The primary care team should provide what support they can to help ensure the patient receives the treatment they need.

If a practice observes that a high number of patients are not following through on referrals, it may be worth determining whether there is a persistent barrier that can be addressed.

Strategies for Building a Referral Network

Primary care practices will need to identify supportive dental partners in order to build a referral network able to serve the full diversity of its empaneled patients. Primary care practices should be prepared to identify multiple referral partners in order to meet the access needs of established patients. Even federally qualified health centers with co-located dental practices may need to partner (or contract) with local dentists or other community health centers in order to meet the access needs of their medical patients.

How can a primary care practice build a referral network? Begin by assessing the specific needs and preferences of the patient population.

- Insurance status, age, prevalence of chronic illness: For example, a pediatric practice will need to secure referral partners able to see very young children (under age 2).
- Location, public transportation options, language preferences, and literacy levels, among other factors. If the practice has a patient and family advisory panel or quality improvement team, ask for their ideas and input.
- Because many patients lack dental insurance, all primary care practices should secure referral partners that accept a mix of referrals, including people enrolled in Medicaid and a limited number of uninsured patients, or offer a sliding fee scale.

"Having a good relationship with a dental partner is key to the work. When you reach out, the medical director or someone involved in community relationship-building should begin that conversation and relate it to the common goals the organizations share—the goal in healthcare is always to help people, and that's something that is easy to connect with." —Allie Nicholson, Operations Manager, Heartland Community Health Center

Identifying potential referral partners

There are a variety of options for identifying supportive dental partners. Consider these approaches:

- Build a local culture of collaboration based on personal relationships, and self-identify supportive referral partners. For example:
  - Primary care practice staff can nominate dental practices they know and trust.
  - Consider asking patients with established dental relationships to recommend their dentist.
  - Anecdotal experience suggests that dentists establishing new practices (and those looking to increase their patient base) may be the most willing to accept a mixed stream of patients (commercially insured, Medicaid-insured, uninsured).
- The Insure Kids Now website maintains a searchable, national dentist locator for dentists who see children enrolled in Medicaid and Children's Health Insurance Program (CHIP) programs. It contains general dentists as well as specialty dentists and indicates if they are accepting new patients. This is a starting place for practices focusing on their pediatric population to begin identifying possible dental practices to engage.
- Contact the local and/or state dental society for assistance. Many dental societies maintain a list of dentists open to new patients, including practices that accept Medicaid and/or offer sliding fee scales.
- Some states maintain a searchable website run by the state Medicaid program that enables searches by town or ZIP code for dentists who accept Medicaid plans. Nationwide, 42 percent of dentists participate in Medicaid programs, though there is significant variety from state to state (Health Policy Institute, 2015). Some practices may be able to find multiple referral partners who accept both commercially and Medicaid-insured patients, while others may have fewer options.
- Invite local dentists to an open house to network and connect with the practice team, or to provide an educational lunch-and-learn session for the practice team. This time can serve to both educate care team members on oral health topics and build relationships.
- Contact a local dental school and explore opportunities to create interprofessional education opportunities with dental students, as a means of building relationships with future referral partners.
- Identify an intermediary who can help facilitate conversations and broker referral agreements. This could include a medical society or professional association chapter, state primary care association, office of rural health, local health improvement network, a local foundation, or other neutral party.

Case Vignette: Referral Workflow Development at Brockton Neighborhood Health Center

At Brockton Neighborhood Health Center, a large multicultural health center located just south of Boston in Brockton, MA (population 94,000), referrals are made to a co-located dental clinic. Benjamin Lightfoot, MD, explains, "A referral to dentistry is made by the clinician if there is significant pathology in the mouth, if they're having significant symptoms, or if they haven't seen a dentist in a few years. The referral gets entered in the EHR [electronic health record], and it goes to the dental referral team and they reach out and contact the patient to schedule the appointment." The process of making the referral works well, though challenges arise when it comes to documenting that the referral was completed. "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," admits Lightfoot. The process has evolved over the course of the integration pilot. "Our referral process has improved significantly over the course of the pilot. We're on the same EHR as the dental clinic, but it's not as integrated as I'd like. Patient information flows from the EMR [electronic medical record] to the EDR [electronic dental record], but nothing flows back to the EMR. It would be really nice to be able to get that. We just got a new dental director on staff; I'm planning to ask him to come to some of our oral health integration team meetings so we can build a closer collaboration," shares Lightfoot.

Case Vignette: Referral Challenges and Work-arounds for Heartland Community Health Center

Heartland Community Health Center, a federally qualified health center located in Lawrence, KS (population 88,000), began its oral health integration work with a community oral health partner that is a safety net dental provider. They had already been referring patients to them, and had an established referral process that worked smoothly. "Our referral coordinator helps the patient complete the necessary paperwork so they can get a dental appointment. Once we fax the paperwork to the dental clinic, they reach out to the patient to schedule the appointment. If they can't reach the patient, they ask our referral coordinator for help. Once the patient is seen in the dental clinic, they fax a note back to us so we can close the referral. Our referral coordinator tracks the referrals on our end too, so she can reach out if necessary to ensure we always get the information or know if the patient no-shows," explains Lanaya Henry, quality assurance coordinator. However, entering into the oral health integration work, the Heartland team expected referrals to be a challenging issue due to cost barriers. "We have a great community dental partner, but we can't change their fee structure, and dental care is expensive for our patients," admits Allie Nicholson, operations manager. "Starting out, our pilot clinician was eager and excited to begin. After a couple of months when we checked back in, she was feeling frustrated. She was doing the screening, exam, and education, but she didn't feel like she could do anything for the patients because connecting them to care was such a challenge due to the financial barriers as well as the psychological barriers associated with dentistry." The leadership team made a decision to begin offering fluoride varnish as a preventive intervention, so the primary care team would have something tangible and useful to offer patients. "Our pilot clinician began to feel more energized by having something she could do in the office to help patients. Then, we learned that we received a dental expansion grant from HRSA, so we will be able to bring in a co-located and integrated dental program, and that was very exciting for our pilot team to hear," explains Nicholson. "We had been delaying spread because of the frustration around financial barriers for our patients, and we didn't want to spread in that state. But we know now that dental care is coming and will be more accessible for our patients, so we will be spreading to all care teams for their patients with diabetes, and to pediatrics as well, so that all clinicians and the clinic as a whole are familiar with the oral health integration process." Nicholson expects that having an integrated clinic will help reinforce the importance of oral health for patients, as they receive education about it from the clinical assistant, clinician, and dental hygienist during a single office visit. "We expect there will be more motivation to continue with oral health integration in the primary care setting since we can do live referrals and warm handoffs to dentistry. We don't want to just co-locate, we want to fully integrate."

To learn more about how some of our field-testing sites approached referral network development, see the Oral Health Integration Referral Experiences case example.

Once identified, outreach is often most successful when conducted by a call from a clinician to a dentist, or a clinic administrator to dental administrator. A compelling introduction to the collaboration proposal is to share the reason for outreach, such as "I'm reaching out to explore collaborating on patient referrals because most of my clinical staff are your patients and recommended you highly" or "Our practice is interested in partnering with yours to support patient referrals because many of our patients already see you and we'd like to support their oral health." It may take multiple outreach attempts to connect with the right person at the dental practice, and relationship building can take some time.

Screening potential referral partners to ensure that they provide the types of care to the types of patients seen in the primary care setting is important. The American Academy of Pediatrics (AAP) has developed a modifiable screening tool, Creating a Relationship with a Dental Home: Questions to Ask When Calling a Dental Provider, for use during the initial outreach conversation to help the primary care practice gather information about what the dental specialty is (cosmetic, restorative, etc.) and what type of insurance they accept.

Field-testing sites that sought community dental partners found that most were open to partnering once the oral health integration pilot was explained. They were reassured to learn that a mix of commercial- and Medicaid-insured patients would be referred and that the volume of patients was not likely to be high at first because the size of the target population was relatively small during the pilot test of change. Over time, as practices spread, the volume of referrals will grow, so practices may need to identify multiple referral partners to handle patient volume as well as to ensure referral options for all patients in their population.

"We're reaching out to the community dental offices to figure out a workflow so we can get a consult to them and they can send it back to us. We've connected with a couple of community dentists who feel excited about working with us. They like that now they have someone to reach out to if they need medical support (like if a patient needs a blood pressure before oral surgery)." —Practice Manager in an urban federally qualified health center

The referral agreement

Referral agreements are an important step in building a shared understanding of roles and responsibilities for communication and care coordination between clinicians. They provide an opportunity to discuss protocols and processes in advance to ensure smooth communication and clear expectations of the referral process. Specifically, they help clarify each party's role in meeting the expectations of a closed-loop referral. As relationships and trust develop over time between medical and dental clinicians, referral efficacy and patient access to care is increased.

Referral agreements include agreement on:

General expectations

- Clinical and administrative information that will be sent from the referring clinician to the consultant in preparation for the consultation visit.
- Clinical and administrative information that will be sent from the consultant to the referring clinician each time the patient is seen by the consultant.
- Availability for brief phone or email consults (consults involving a question about a potential clinical issue).

Access expectations

- Reasonable timeframe for routine, urgent, and emergency consultations.
- Referral volume (if necessary), maximum number of referrals per week/month.
- No-show policy and how it will be communicated to patients.
- Dental fee schedule and willingness to use a sliding fee scale for uninsured or low-income patients.
- After-hours care and support.

Care management expectations

- Seamless transition of care for patients and families/caregivers.
- Shared pain management protocol and shared information about pain medication prescriptions.
- A plan to manage recommended follow-up appointments.

Patient communication expectations

- Protocol to ensure that patients leaving the referring clinician's office have written information that includes the name and contact information for the dental consultant to whom they have been referred, what to expect as the next step in the referral process, and what to do if the next step does not occur within a specified timeframe.
- The process for tracking referrals and following up with the patient.

A modifiable referral agreement template is provided as an example.

The referral order

Both primary care clinicians and dentists should take care to use language free from specialty terms and acronyms in their communication, to ensure clear understanding on both sides.

What information needs to accompany a referral from primary care to dentistry?

The information needed to accompany a dental referral is the same as the information that accompanies a medical/surgical referral. That information includes:

- Service requested of the dentist/reason for referral.
- Demographic information.
- Additional relevant clinical information, such as:
  - Problem list.
  - Relevant past medical/surgical history (e.g., temporomandibular joint dysfunction [TMJ] disease or sinus surgery).
  - Current medication list.
  - Current allergy list.
  - Immunizations.
  - Pertinent labs and imaging.

Primary care practices typically have a template for medical/surgical referrals. This should be modified, as needed, and used for dental referrals as well.

Implications for dental practices

Dental practices will need to be able to identify the referred patient and his/her primary care clinician (so that the dentist and dental care team are aware that a summary/consultation note is required), and have a process in place to ensure that the summary document is sent to the primary care clinician consistent with the terms of the referral agreement.

What information needs to accompany a consultation note from dentistry to primary care?

- Date the patient was seen.
- What was found (e.g., caries in multiple teeth, or severe periodontal disease in three quadrants).
- What was done (e.g., procedures, medications prescribed).
- Brief treatment plan (e.g., three-quadrant scaling).
- Follow-up arranged.

A modifiable referral form and a sample completed form are provided as tools for practices to begin.

For referral coordinators

The role of the referral coordinator is particularly important here, as they will likely be the primary contact person for the dental referral partners. If a practice does not have a staff member with this title, then this role refers to the care team member who manages this work. Key concepts to review include:

- Ensuring that a protocol is in place to track the patients who are referred to dentistry, including where they are referred if multiple referral partners exist.
- Establishing a method of communication with the referring partners, and a primary contact at those offices. During the initial pilot it can be helpful to arrange regular check-in calls with the primary contact at the referring partners to do a quick review of the referral workflow and ensure that referrals are proceeding as expected.
- Coordination with the data reports to ensure effective referral tracking and identification of any obstacles early in the process.

Health Information Technology Support for Structured Referrals

Health information technology (HIT) supports structured referrals to dentistry in three ways:

1. A formal order to dentistry.
2. Sharing administrative and clinical information between the clinicians.
3. Referral tracking.

The referral order

A referral order to dentistry provides structure to the referral process. If there is no dental referral in the electronic health record (EHR), it will be necessary for the HIT department to create one. That structure is used to ensure that:

- The ordering clinician is prompted to include all necessary clinical information in the referral.
- The ordering clinician specifies to which dentist or dental office the referral is made. If the practice has an in-house dental service, it is necessary to distinguish between "internal" and "external" referrals. External referrals will be easier for clinicians to use if they include a drop-down list of names and contact information for dentists in the referral network.
- The referral order is processed by the referral coordinator, who verifies that insurance information is valid and that the referral is sent to the correct dental clinic.
- Information the patient needs to make an appointment with the dentist is included in the after-visit summary.
- The clinic's referral tracking workflow is activated. Most EHRs have a feature to help clinics track referrals from the time they are ordered until the report from the consultant arrives at the clinic and is entered into the EHR.

Information exchange between medicine and dentistry

In most settings, practices (even those with co-located dental practices) do not have EHRs that can communicate with electronic dental records (EDRs).

Sending information from the ordering clinician to the dentist

In the absence of such an ideal state in which both medical and dental teams use the same EHR, the referral request generated by the referral order is the most useful medium for transmitting information from the ordering clinician to the dental consultant. The exact informational content will be subject to the referral agreement, but most of the time it will include at least:

- Administrative data, including demographic and insurance information.
- Clinical context for the referral and the specific request.
- Key lists from the EHR: problem list, medication list, and allergy list.

Methods of data exchange

As standards for EHR interoperability become more widely adopted and expand to include dentistry, information for dental referrals will likely be handled using electronic health information exchange like any other referral. In the meantime, most practices will need to get started using less advanced methods of information exchange, such as secure email, standard mail, and fax.

Sending information from the dental consultant to the ordering clinician

Information to be included in the dental consultation will be determined in the referral agreement. It is likely that the information will be text, limited to information about the date the patient was seen, what work was performed, including any medications ordered, and the general care plan. This report is likely to be received at the clinic as a letter or fax.

Closing the loop

Once the consultation report is received in the primary care clinic, it should be electronically attached to the referral order and sent to the clinician's in-basket. This method ensures that when the clinician wishes to review the consultant's note in the future, it can easily be found and attached to the order for the referral. As with all referrals, it is important to have a process to ensure that the consultant's note has come back and been entered in the EHR before closing the order, so that teams are able to identify orders that are still outstanding.

Referral tracking

Most EHRs have a feature that is designed for tracking referrals and a recommended workflow for using this feature. Many practices do not use their EHR referral tracking features for a variety of reasons:

- It may not have been installed.
- It may be inadequate to meet the practice's referral tracking needs.
- It may require redesigning the referral workflow in ways the practice is not prepared for.
- Referral tracking may not be a priority.

If using the EHR to track referrals is not an option, it is reasonable to create a standalone system using an electronic spreadsheet. The referral coordinator is probably the person best suited to operate it, because referrals go out through the referral coordinator and consultant reports usually are routed to the referral coordinator as soon as they arrive in the clinic. A referral tracking spreadsheet can be set up to document the date of key events, including:

- Referral ordered.
- Referral sent to consultant.
- Date the patient was seen.
- Consult report received.
- Consult report attached to referral order and routed to ordering clinician.

For most delivery systems, very little HIT modification is required to activate dental referrals, although structured referrals to dentistry may represent an opportunity to establish an optimized referral workflow in the absence of a historical process. Oral Health Referral Workflow Optimization is an interactive PowerPoint tool for a practice to use to optimize their existing referral process and customize it for oral health referrals.

Click here to jump to Section 7: Using Data for Quality Improvement.

Supporting Materials, Section 6

Referral Agreement Template: This modifiable form walks a practice through the content that might be included in a referral agreement. Practices can use the form as a prompt for discussions with referring partners and remove, modify, or add elements they agree upon. A good practice is for both the primary care practice and dental practice to sign and retain copies of the agreement to refer back to as the referral workflow and processes are worked out.

Referral Template for Primary Care Referrals to Dentistry: This modifiable form provides a template for a primary care practice and dental practice to use to communicate the essential information back and forth. The top half is intended to be filled out by the primary care practice and then sent to the dental practice (via secure email, fax, etc). After the patient is seen, the dentist completes the bottom half and sends it back to the primary care practice's designated contact.

Sample Completed Referral for Primary Care Referrals to Dentistry: This is a sample completed referral form from a fictional practice to show what the information might look like when completed.

Oral Health Referral Workflow Optimization: This PowerPoint presentation is designed to be conducted as a 60–90-minute webinar with the primary care and dental staff involved in the referral process. It is based on the overall oral health workflow mapping process, and focuses specifically on the steps involved in making a referral to dentistry, and communicating the results of that referral back to primary care for referral tracking purposes. This "micro" workflow within the larger oral health integration workflow may need some adjusting and refining as referrals start to happen, including regular check-ins between the staff designated as the primary referral contacts.

