Finding Meaning with Interprofessional Oral Health Practice

Our mission is to improve the oral health of all.

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What is “integration”?

- “Integrated” is frequently used to refer to a **package of preventive and curative health interventions for a particular population group**.
- “Integrated health service” can refer to **multi-purpose service delivery points** – a range of services for a catchment population is provided at one location.
  - “Integrated services” to some means achieving continuity of care over time.
- Integration can also refer to the **vertical integration** of different levels of service – for example a regional hospital, health centers and private practice
- Integration can also refer to **integrated policy-making and management** which is organized to bring together decisions and support functions.
- Integration can mean **working across sectors.**
- Integration can mean that **the insurance function and health care provision** are provided by the **same organization.**

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World Health Organization, Technical Brief No. 1, 2008. Integrated Health Services – What and Why?

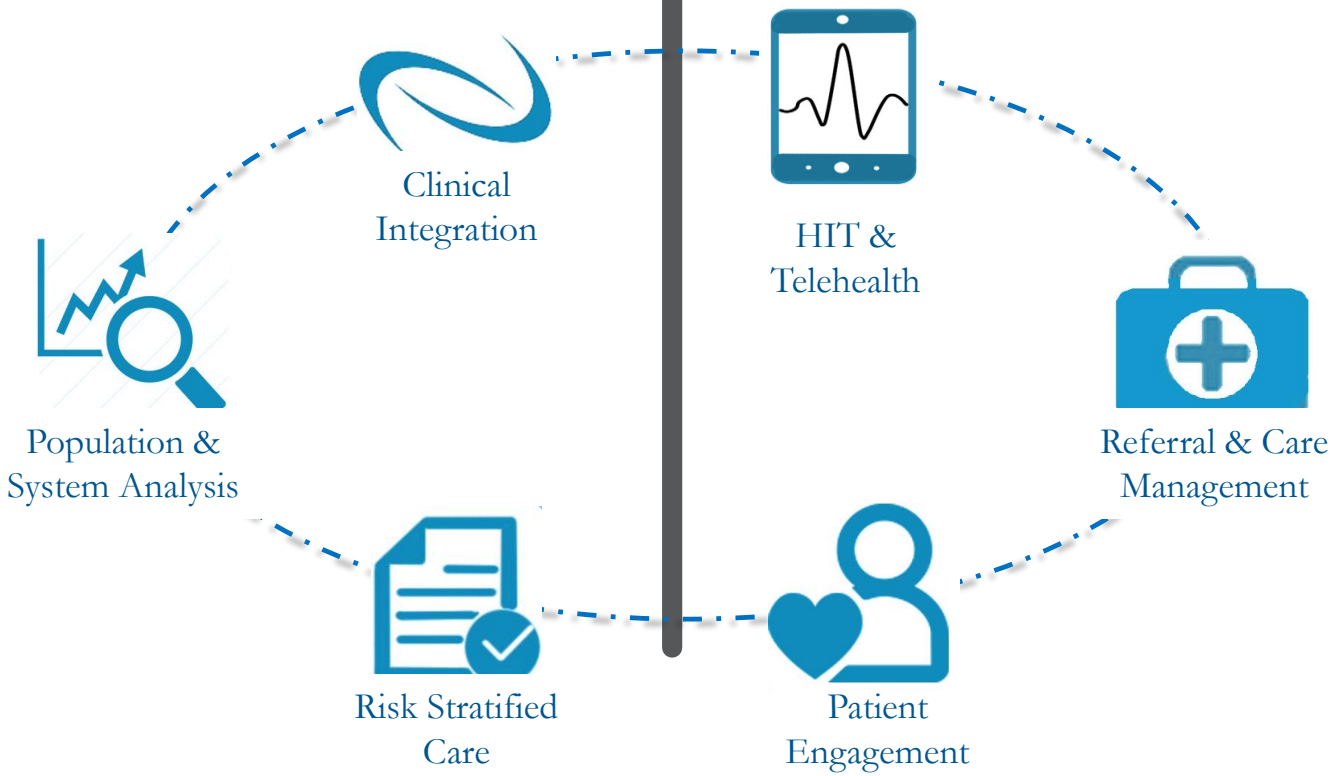
INTERPROFESSIONAL PRACTICE

INTEGRATED CARE

- An interdisciplinary approach to health care that incorporates specific procedures of other disciplines into daily practice.

COORDINATED CARE

- Using a continual care pathway approach that allows the patient easy navigation and understanding their needs within the health care system.



“Healthcare is an exercise in interdependency- not personal heroism... a need for greater teamwork and to ask, what am I part of?”

- DON BERWICK

President Emeritus and Senior Fellow, IHI

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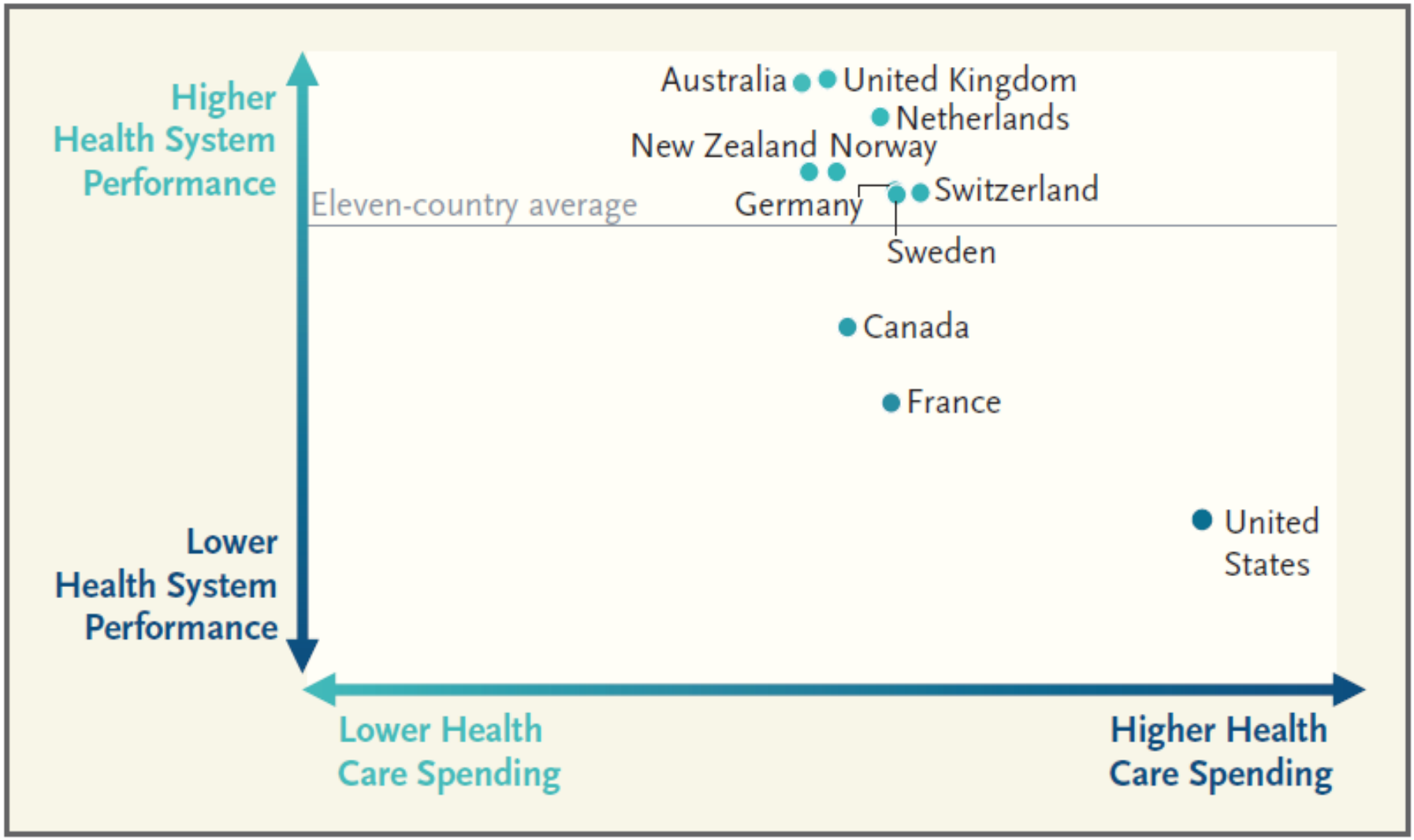

Relative Health Care System Performance and Spending in 11 High-Income Countries.

Where We Are Headed…

From	To
Fragmented Payment	Unified Budget
Hospital as the Center	Home as the Hub
Excellent Soloists	High Performing Teams
Moving People	Moving Knowledge
What is the Matter with You?	What Matters to You?

-Dr. Don Berwick, IHI [NOSORH Annual Session 2016]

HCP LAN
Health Care Payment Learning & Action Network

APM Framework

The Framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

- **Serves as the foundation** for generating evidence about what works and lessons learned
- **Provides a road map** for payment reform capable of supporting the delivery of person-centered care
- **Acts as a "gauge" for measuring progress** toward adoption of alternative payment models
- **Establishes a common nomenclature and a set of conventions** that will facilitate discussions within and across stakeholder communities

Source: HCPLAN

Population-Based Accountability

Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality & Value	Fee for Service – Link to Quality & Value	APMs Built on Fee-for-Service Architecture	Population-Based Payment
	A Foundational Payments for Infrastructure & Operations	A APMs with Upside Gainsharing	A Condition-Specific Population-Based Payment
	B Pay for Reporting	B APMs with Upside Gainsharing/ Downside Risk	B Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		

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Increased Care Coordination: 50 New Patients

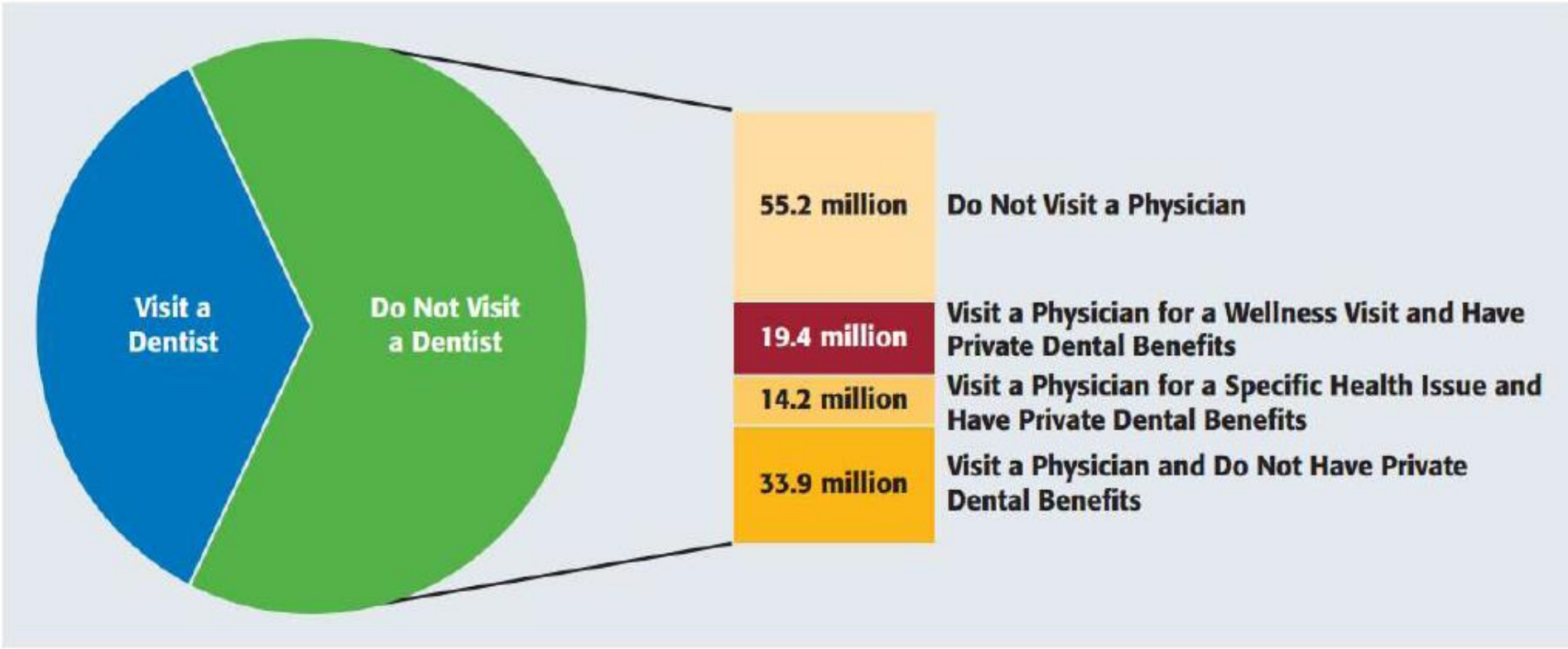
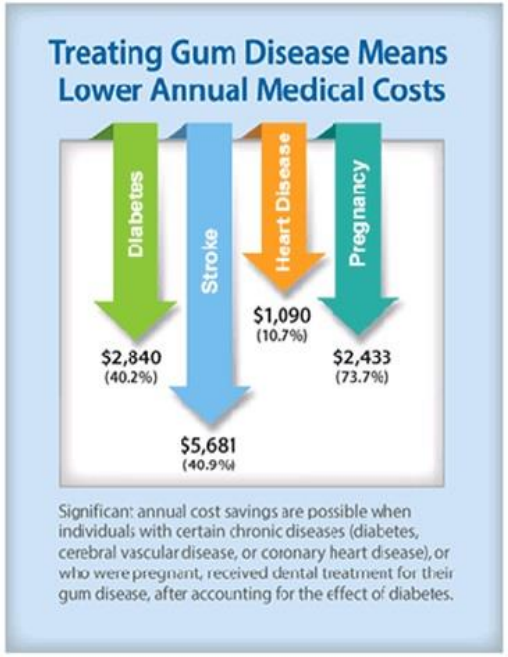
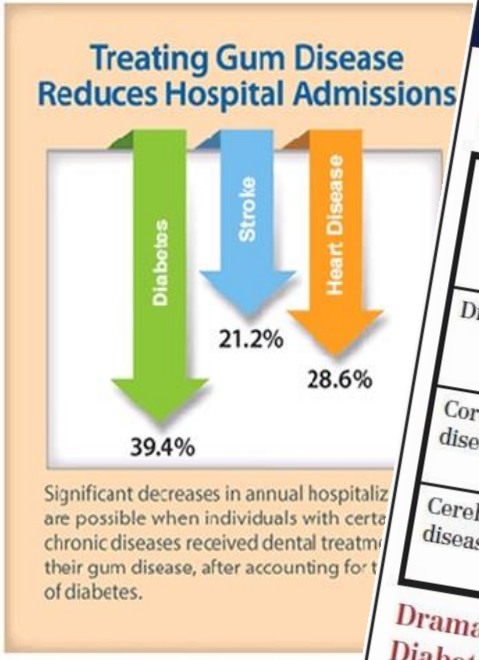


Figure. Breakdown of the US adult population (aged 19-64 years) by whether they visit a dentist or physician during the year and whether they have dental benefits. *Source: Agency for Healthcare Research and Quality.*[17]





Source: Jeffcoat, M., et. al., Periodontal Therapy Improves Outcomes in Systemic Conditions, Abstract, American Association of Dental Research, March 21, 2014

Figure 1: Aetna-Columbia retrospective claim analysis

Episode risk group™ (ERG) scores for diabetes, CAD and CVD participants

	Periodontitis codes	No dental services	Reduction in risk score	Associated reduction in overall medical costs
Diabetes	3.39	4.79	↓ 29.2%	↓ 9%
Coronary artery disease (CAD)	4.68	6.49	↓ 27.9%	↓ 16%
Cerebrovascular disease (CVD)	6.23	8.26	↓ 24.6%	↓ 11%

Dramatic decrease in ERG scores for participants with Diabetes, CAD and CVD

ERG™ is a modeling tool to predict current and future health utilization

"An Examination of Periodontal Treatment and Per Member Per Month Medical Costs in an Insured Population" paper

tion in risk scores resulted when those having periodontal therapy (claims DT "4000" codes) were compared to those having no dental treatment. The edical cost reduction resulted when those having early periodontal care (in of the study) were compared to those having periodontal treatment only in

ADA HPI: Among those newly diagnosed with type 2 diabetes periodontal intervention:

- Lower total health care costs (-$1799)
- Lower total medical costs excluding pharmacy (-$1577)
- Lower total type 2 diabetes healthcare costs (-$408)

“Progress is impossible without change, and those who cannot change their minds cannot change anything.”

- GEORGE BERNARD SHAW

IRISH PLAYWRIGHT, CRITIC, POLEMICIST AND POLITICAL ACTIVIST

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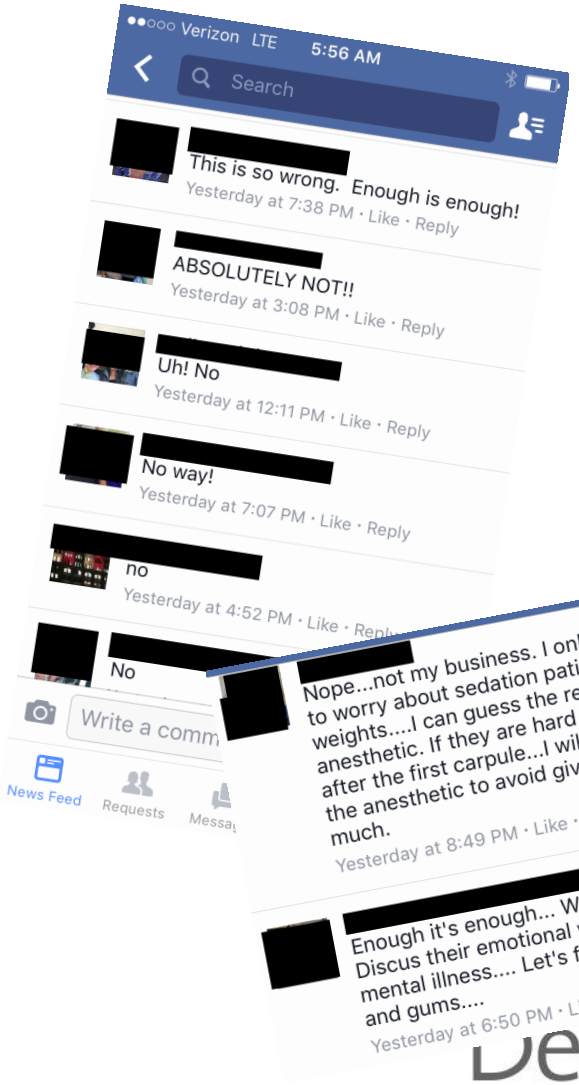
Change is not always easy



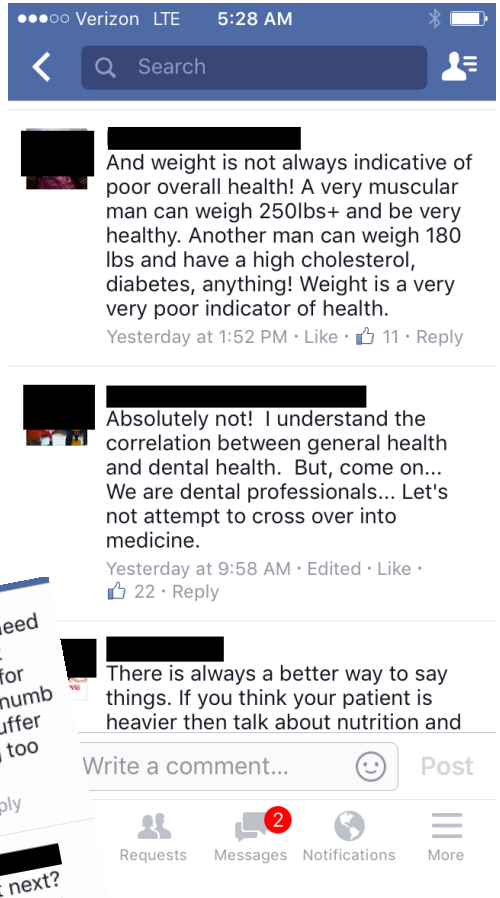


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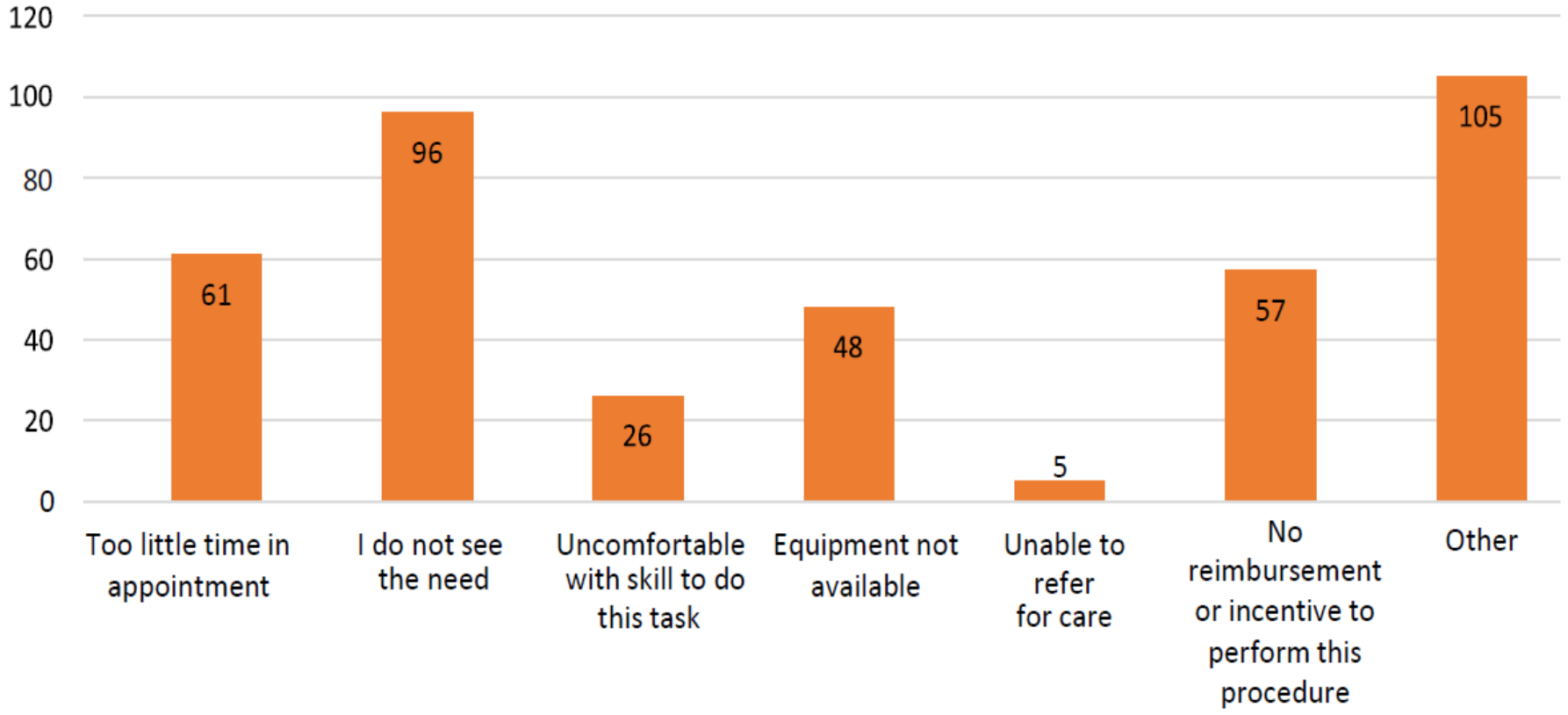
Figure 2. Why do you not take BP readings? (Check all that apply)



MDHHS
Michigan Department of Health & Human Services

http://www.michigan.gov/documents/mdhhs/Oral_Health_Assessment_of_BP-Diabetes__Report_Feb_2017_550635_7.pdf

IPP Analysis: Universite de Montreal & Canadian Institutes for Health Research

"What are the barriers and the facilitators of integration of oral health into primary care in various healthcare settings across the world?"

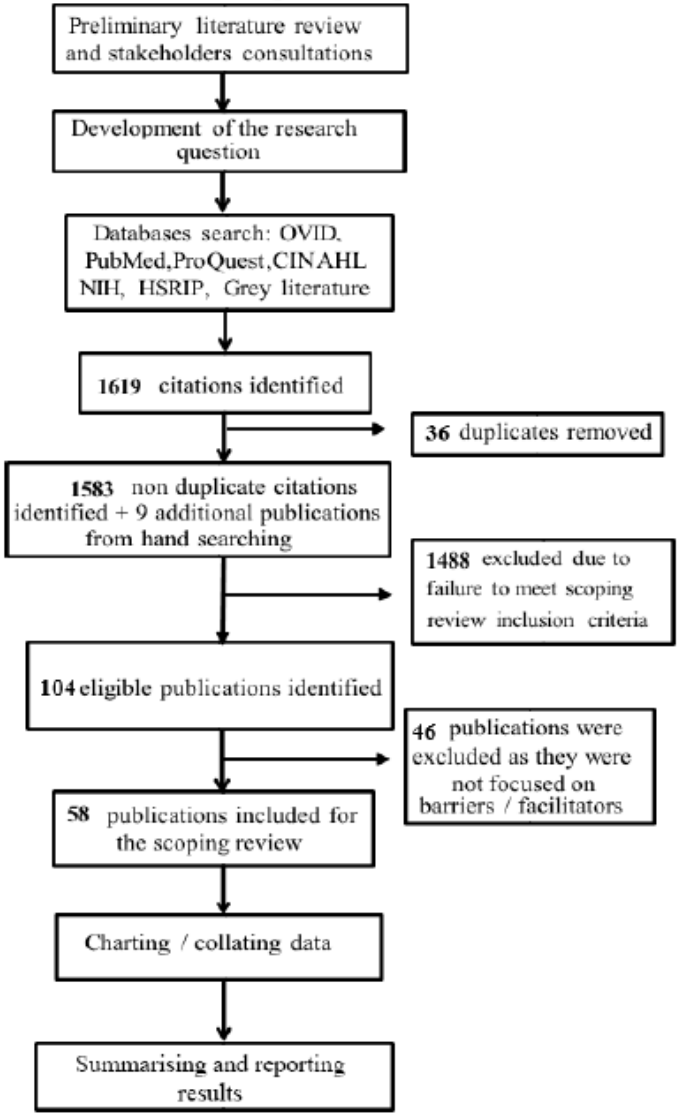


Figure 1 Flow chart of the scoping review.

Harnagea H et al. BMJ Open 2017;7:e016078.

Barriers

- **Lack of political leadership and healthcare policies**
  - Poor understanding
  - Separate medical and dental insurance
  - Separate specific policy interest
- **Patient's oral healthcare needs**
  - Patient's decision to accept or refuse care based on their need perception rather than the assessment of healthcare providers.
- **Lack of effective interprofessional education**
- **Lack of continuity of care / silo practice structures**
- **Implementation challenges**
  - Deficient administrative infrastructure
  - HIT

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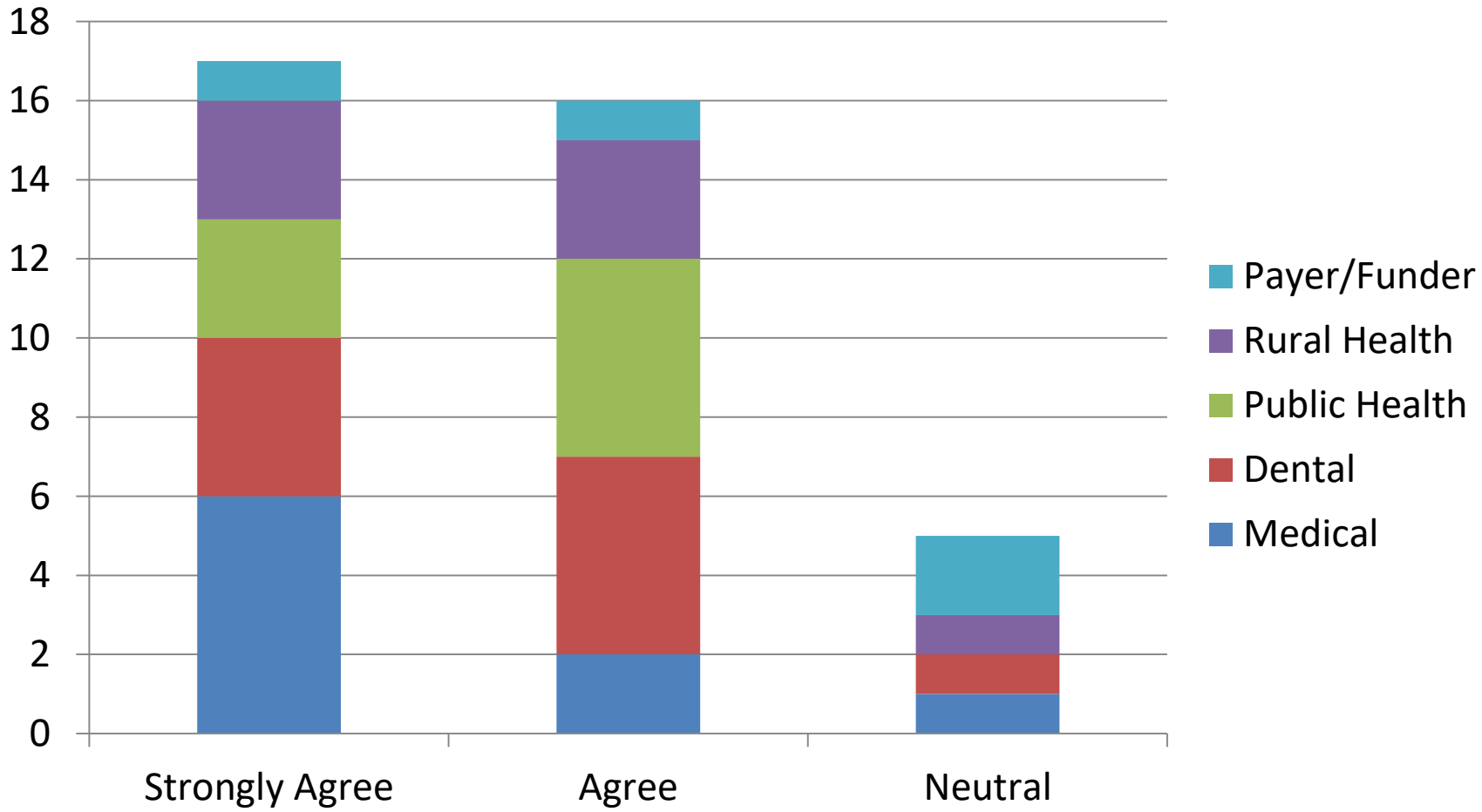
Harnagea H et al. BMJ Open 2017;7:e016078.

Health Information Technology systems, and their vendors, are currently a laggard that is stagnating the proliferation of rural IPP:



Facilitators

- **Financial and technical support from governments, stakeholders and non-profit organizations.**
- **Interprofessional education (non-dental providers)**
- **Collaborative practices**
  - Perceived responsibility and role identification
  - Case management
  - Incremental approach
- **Local strategic leaders (champions)**
- **Proximity / Convenience**
  - Increasing consumerism

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Harnagea H et al. BMJ Open 2017;7:e016078.

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Boynes et al. 2017 Rural Interprofessional Oral Health Practice Symposium. BMC Oral Health. [Open Source: In press]

Levels of Integration and IP Practice

Table 1: The Proposed Levels of Integration with Role identification.

Medical Team Tasks	Co-operative Tasks	Dental Team Tasks
PLANNING PHASE: *Complete a readiness assessment *Alteration to practice/site policies and procedures to address changes in care *Develop and implement necessary documentation, electronic management systems, and ancillary changes to operation.	*Initial providers and staff training *Create and finalize business and memorandum agreements that include documentation of capacity limitations, HIPPA, target population agreement, etc.) *Formalization of leadership or point of contact teams.	*Complete a readiness assessment *Alteration to practice/site policies and procedures to address changes in care *Identify and implement necessary documentation, electronic management systems, and ancillary changes to operation.
BASIC LEVEL: *Oral health screenings completed on target populations *Query patients for dental home and last dental visit	*Implement a bi-directional cross referral process *Use of cross promotional propaganda *Appropriate post-care communication *Develop and use an immunization status registry	*Query patients for medical home and last medical visit *Record body mass index, blood pressure, heart rate, respiratory rate on all patients with readiness referral for intervention
MODERATE LEVEL: *Oral health primary and secondary prevention procedures administered to target populations *Basic understanding of oral health disease processes and how they can impact well-being *Nearing or achieving appropriate phase of meaningful use *Complete pediatric oral health integration (patients receiving an oral health risk assessment, anticipatory guidance, fluoride application, prn referral to dental care team)	*Priority populations are receiving care and a strategic plan is completed to determine process for increasing the number of target populations *Establish and engage partnerships or affiliations with community entities assist with community outreach *Begin using a depression screening tool when applicable within the target populations	*Basic understanding of primary care disease management and applied intervention methodology (understanding treatment goals) *Nearing or achieving appropriate phase of meaningful use *Utilize auxiliary personnel to the highest level of their license and scope of practice.
HIGH LEVEL: *Implementation and documentation of oral health quality assurance / quality improvement plans and outcomes *Achieve real time analysis and access for the sharing of oral health benchmarks	*Achieve a high percentage of patients having seen both medical and dental teams each year *Integration of a behaviorist to assist with high risk, low compliance patients in need of behavioral chronic disease management *High level medical and dental screenings are completed that result in accuracy with finding undiagnosed disease. *Regular meeting should take place involving all partners/affiliates/network partners in which updates on care administration and review of performance/quality measurements. Meeting minutes should be completed and disseminated appropriately.	*Implementation and documentation of primary care specific quality assurance / quality improvement plans and outcomes * Achieve real time analysis and access for the sharing of systemic disease treatment benchmarks *Use of the international statistical classification of diseases and related health problems coding system

CREATIVE LEVEL:

- A wide-open level that should encourage innovation, allows creativity, and facilitates professional and patient development
- Population based health planning designed to achieve a geographic distribution of oral health infrastructure
- The use of phase contrast microscopy to identification of poor health as well as the use of salivary diagnostics to assist with periodontal health, general diagnoses, and patient outcome improvement
- Conducting research/analysis/PDSA to design appropriate risk factor measures, encourage changes in insurance coverages as well as marketplace design and improving the standard of care.
- True quality assessment that leads to practice translation and meets identification parameters of the Institute for Healthcare Improvement's Triple Aim Approach to Healthcare

Boynes SG. Finding Meaning with Interprofessional Practice, Part I. Dental Economics. September, 2015.

Medical Team Tasks	Co-operative Tasks	Dental Team Tasks
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https://www.dentaquestinstitute.org/sites/default/files/Finding-meaning-with-interprofessional-practice-part-1_Dental_Economics.pdf

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https://www.dentaquestinstitute.org/sites/default/files/Finding-meaning-with-interprofessional-practice-part-1_Dental_Economics.pdf

How do I get on the path to Creative IPP?

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Medical Oral Expanded Care (MORE Care)

MORE Care aims to address health disparities through the integration of oral health into primary care practice and the development of dependable oral health care networks. Using an improvement-based framework, partners work with key stakeholders in their communities and abroad to create a usable model of interprofessional oral health care. MORE Care serves to:

Develop proficient and efficient integrated oral health networks
INTEGRATION OF CARE

Develop and test solutions to ease burdens associated with interprofessional practice
COORDINATION OF CARE

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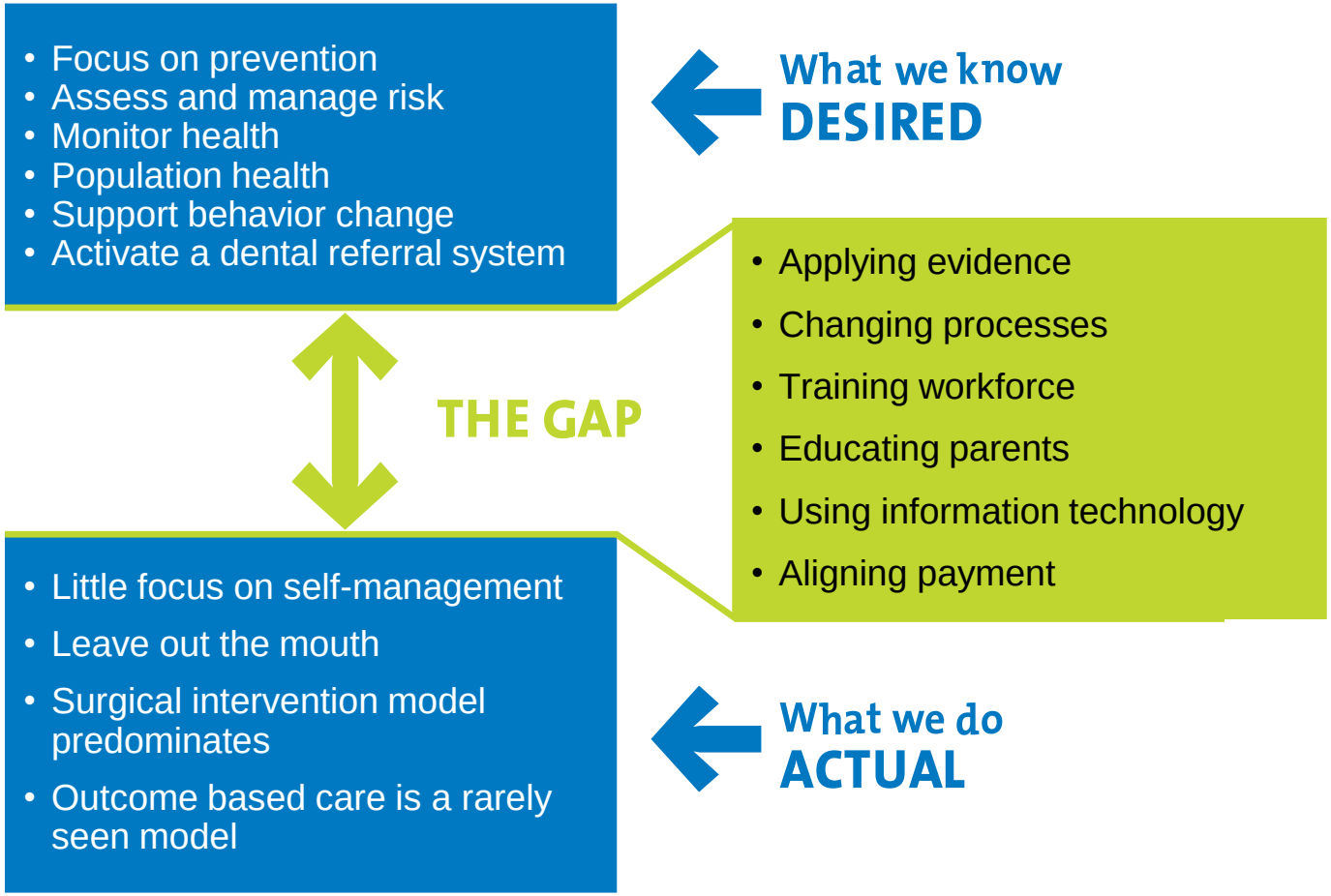
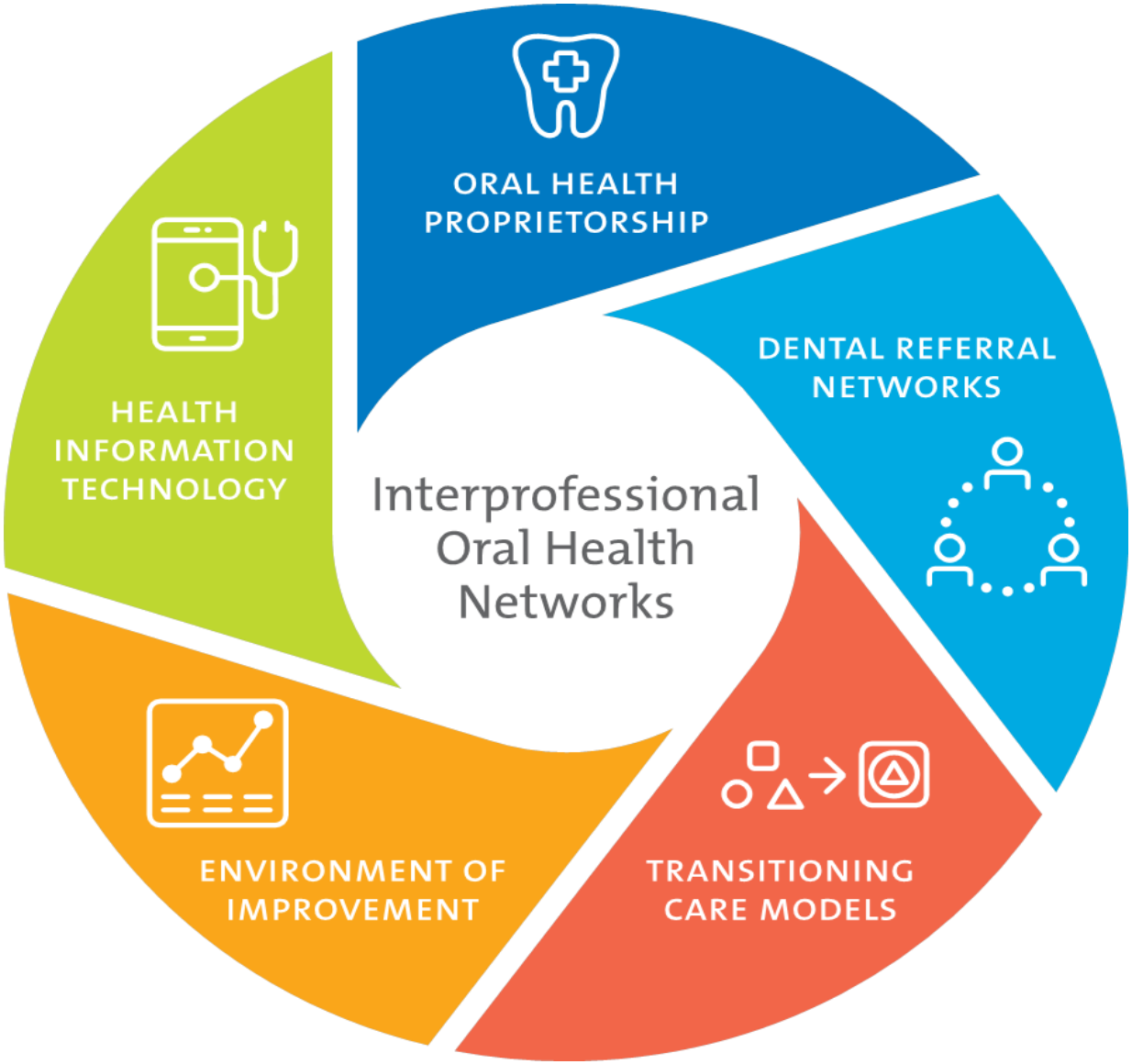
How We Make the Vision



Creating a MORE Care IPOHN



MORE Care Pediatric Pathway

MEDICAL

Oral Health at Well Child Visit

- Review medical/dental histories
- Perform Oral Health Evaluation (HEEN**O**T) Document findings and management plan, including referrals
- Fluoride administration (SDF to be explored)

Oral health – Risk based instruction

- Conduct counseling to decrease or maintain low oral health risk (risk factor identification)
- Set self management goals
- Follow up and develop referral plan

Cooperative Tasks

- Coordinate care with bi-directional referral system
- Initiate, develop and improve interprofessional communication
- Create shared outcomes through collaborative interprofessional practice
- Develop joint treatment planning and record keeping

DENTAL

Dental Care Appointment

- Review medical/dental histories
- Complete Caries Risk Assessment and assign status (Low/Moderate/High)
- Conduct Preventive Dental Care Appointment
- Create treatment plan focused on disease management

Disease Management

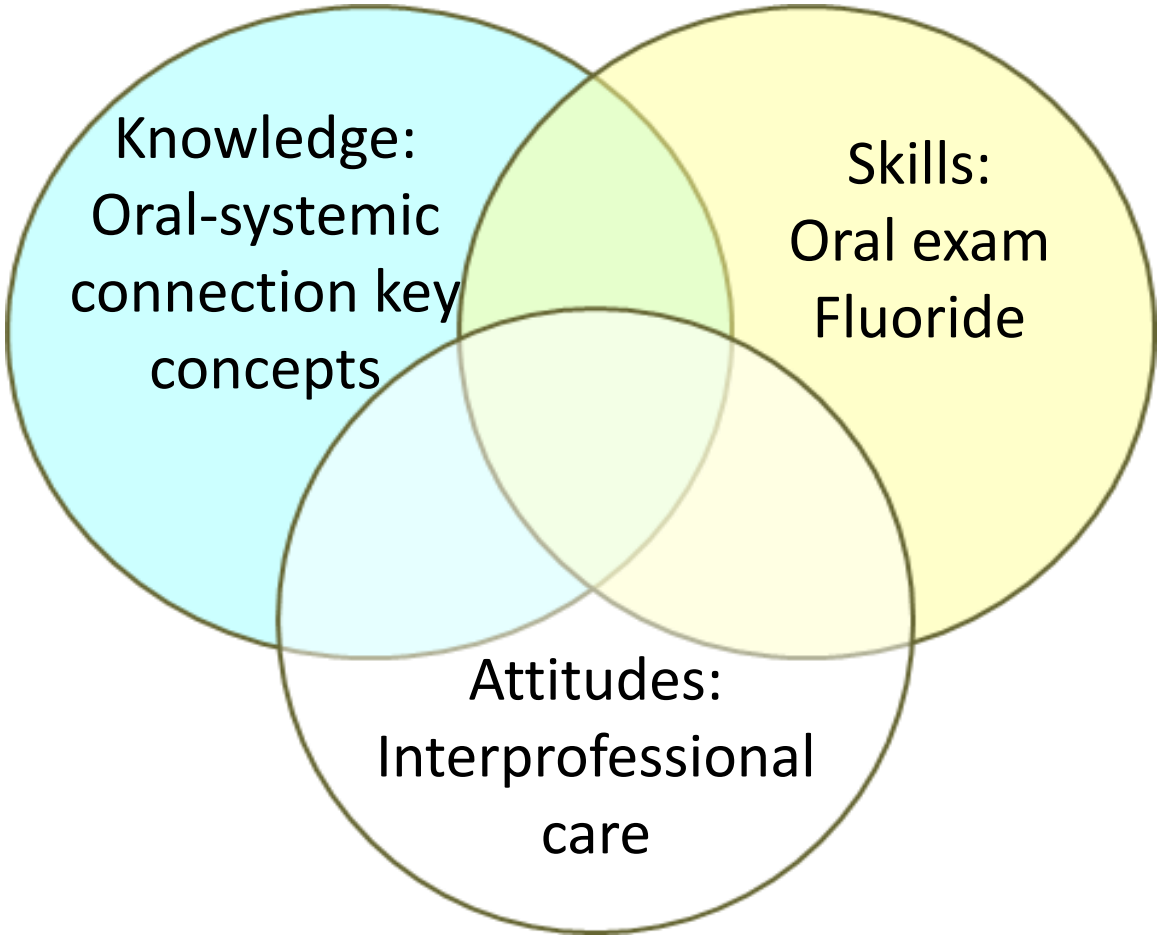
- Complete counseling aimed at prevention and/or stabilization of disease (self management goals)
- Establish re-care appointments according to patient needs
- Initiate and sustain patient-centered interprofessional communication

Measurement Concepts

Fluoride Application*	Self-Management Goal Setting	Oral Health Evaluation (Risk Assessed)	Referral Initiated	Referral Completed

Integrating Oral Health - Medical

Oral Health



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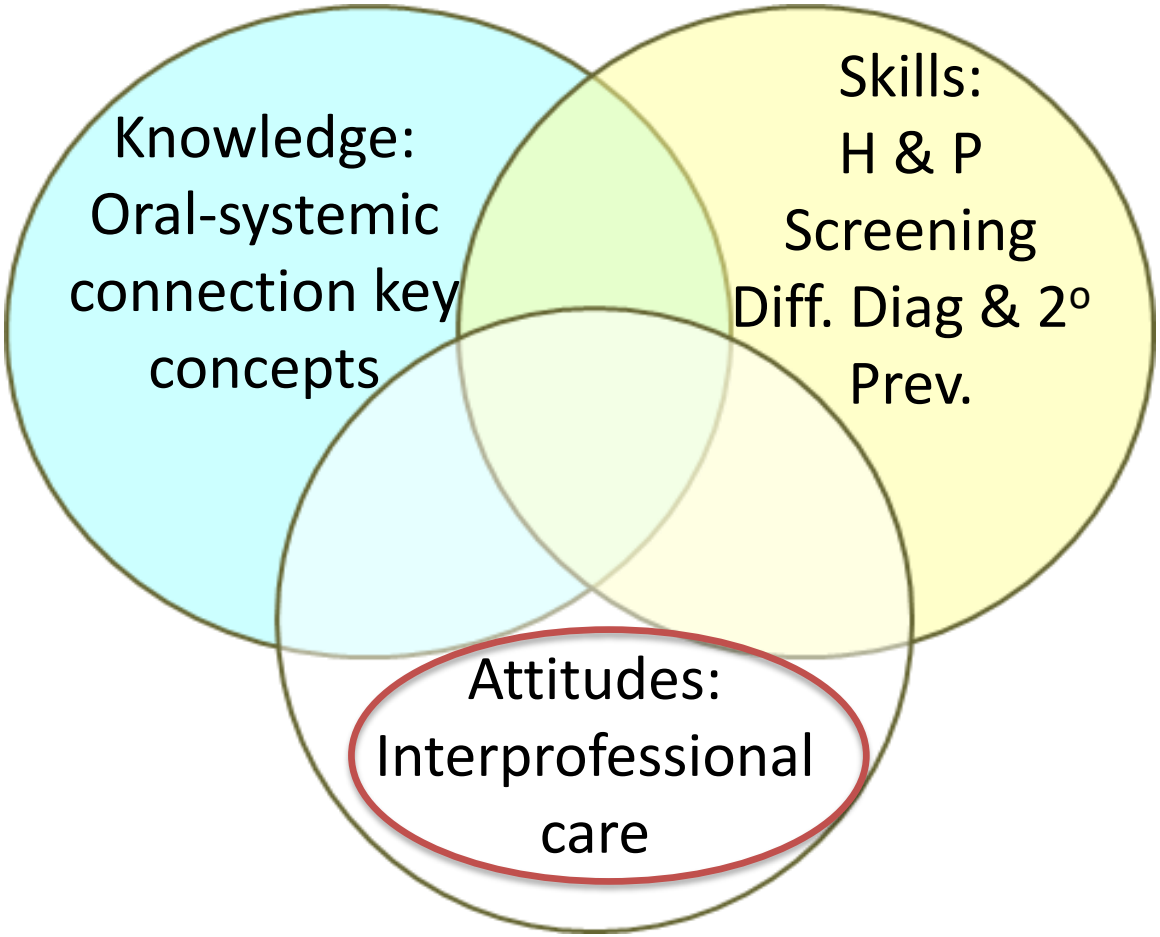
Integrating Oral Health - Dental

Oral Health



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Attitudes: Interprofessional Care

- Oral health is part of overall health and within physician's scope of care
- Oral exams can be readily included in routine clinical care
- Oral health risk assessment is done just like other risk assessments in primary care
- Systemic evaluation is a vital component of a dental encounter
- There is no contra-indication to dental treatment during pregnancy
- Physicians and dentists should communicate with each other about patient care

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Based on content by Dr. Mark Deutchman, University of Colorado – School of Medicine

The Role of Quality and Real Time Data

"We're not just relying on our guidelines and what's been published… we are able to start looking at using data-driven methods that are much more concurrent and in real time."

- JUDY MURPHY
Chief Nursing Officer, IBM

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Why We Measure…

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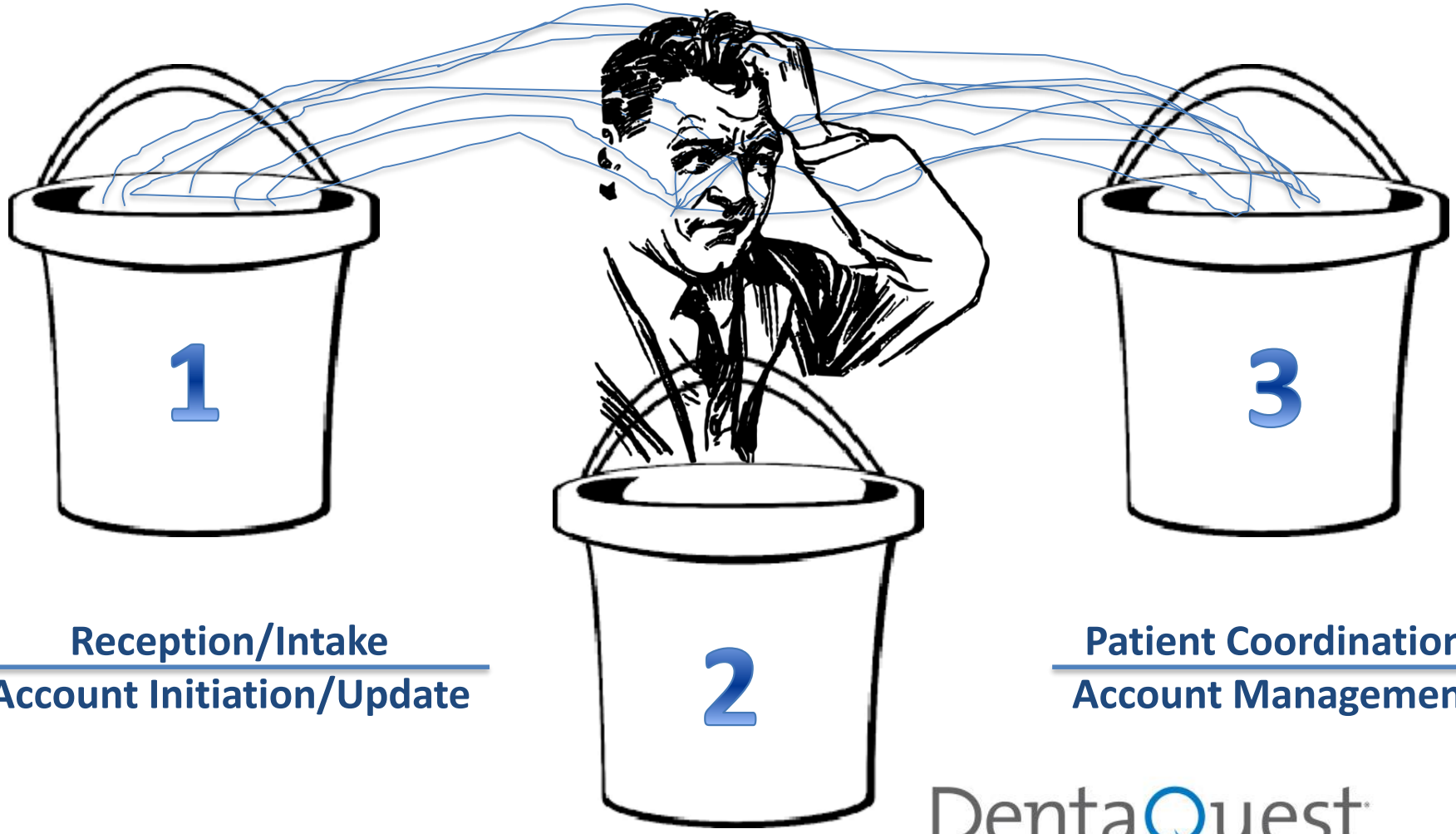
Lessons from Medicine [QC > QI]



Reception/Intake
Account Initiation/Update

Clinical Care

Patient Coordination
Account Management

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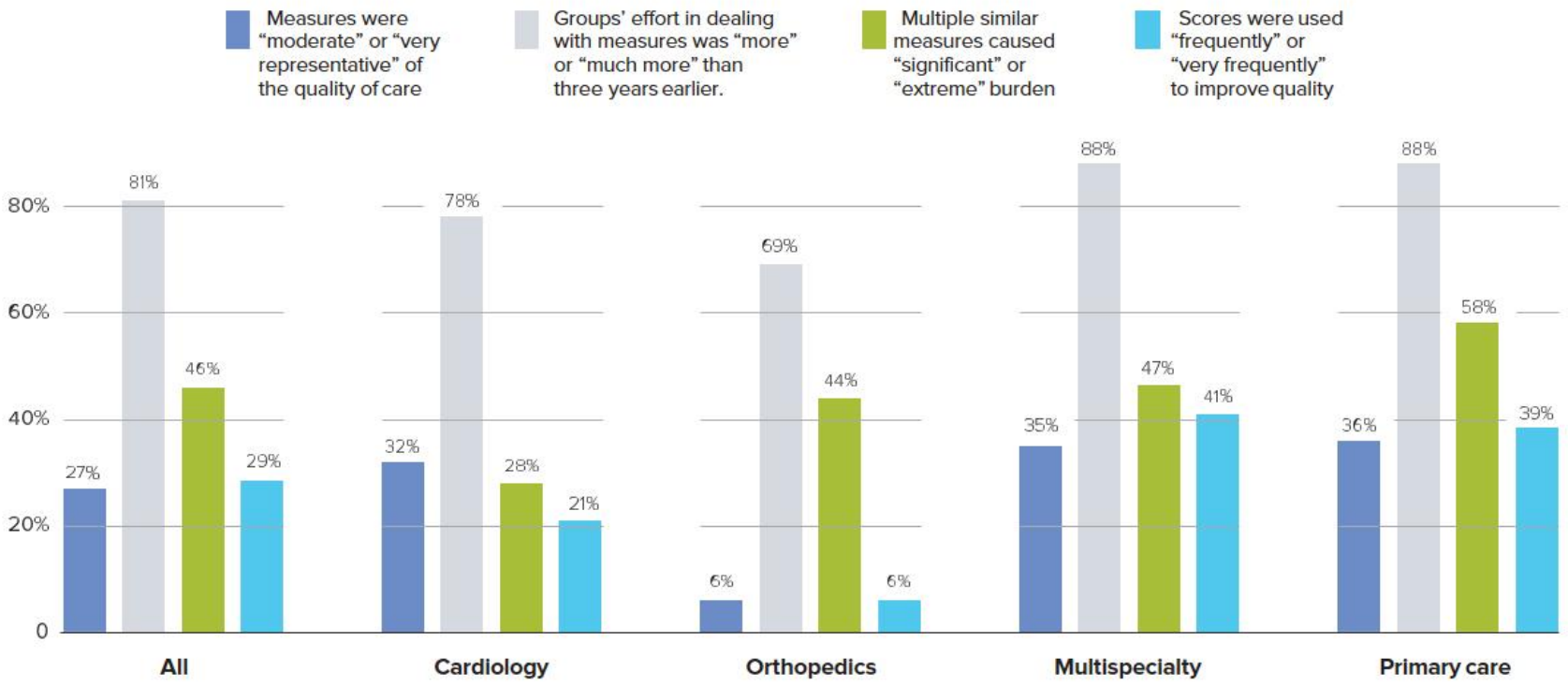
Providers Spend $40,000 Per Physician on Quality Reporting

A recent survey estimates that physician practices spend spends about 15 hours per physician per week on data entry and management — or 785 hours each year. That effort translates into about $40,000 per clinician annually. Physicians are required to submit quality data to Medicare, Medicaid and insurance companies in the push for digital health records, performance measurement and data accountability. More than 80 percent of all respondents said the effort required to submit that data is "more" or "much more" than it had been three years ago.

Perceptions physician practices had on external quality measures in 2014, by specialty



Source: "U.S. Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures," by Lawrence Casalino, et al, in March 2016 issue of Health Affairs

By Janie Boschma, POLITICO Pro DataPoint

Drinking the Quality Juice

- **Quality Planning**
  - Spending time to bring the design and goals of the system into alignment
  - Understanding the needs
- **Quality Control**
  - Monitor, review and standardize
- **Quality Improvement**
  - Make changes to achieve goals
- ***Quality Assurance***
  - *External view to determine if meeting targets/goals*

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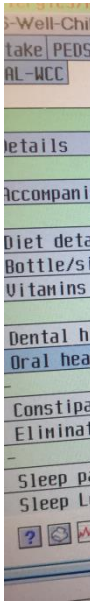
Better Professional Development

Applying Evidence	• Caries Risk Evaluations • Effective Communication/Motivational Interviewing • Fluoride Varnish application
Changing Processes	• Incorporate Oral Health Evaluations • Oral Health Workflow • Referral Communication
Training Workforce	• Smiles for Life • First Tooth • Quality Improvement • Effective Communication
Educating Families	• Flipbooks, Grosser Books • Take Home Kits

Better System Performance



MORE care

CONCEPT: ORAL HEALTH EVALUATION/RISK ASSESSMENT	
CHANGE IDEA	**TEST DETAIL**
1. Utilize a recognized oral health risk assessment tool and train all providers to ensure consistency	• Investigate existence of in-state tra • Investigate local/state American Ac resources and/or training, includin • Train providers with online Smiles • Encourage all staff to have one or t conversation not a list of questions or MD)—this is a team effort • Clinics leadership use staff/provide systemic health
2. Edit electronic health record to include documentation of completed oral health risk assessment and findings	• Start by using paper risk assessmer before integrating electronically in EHR) • Build a template that automatically (which helps with reporting) • Build risk assessment fields into EH
3. Ensure all completed oral health risk assessments are accurately documented in electronic health record	• Assessment data is documented in • Paper assessment documents are s • Data for risk assessments comes fr • Use risk assessment data to guide
4. Document patient's dental provider or dental home in electronic health record	• Document dental provider on the a • Document dental provider in visit • Document dental provider in free t • Create a pull-down list of local dental providers within the EHR for easy selection by the medical provider during the well child visit. If provider not listed, free text can be used • Clinic leadership reviews data during staff/provider meetings
5. Identify process for monitoring optimal medication list for patients	• No tests to document

The Primary Care Guide to Creating Interprofessional Oral Health Networks

Why Oral Health in Primary Care?

Tooth decay is a preventable, infectious disease that impacts millions of Americans every year. It is a disease that has *systemic connections*, and can impact multiple areas of overall health and well-being. Although the dental workforce works to treat dental disease, access to dentists in all areas of the country is not sufficient to meet the needs, particularly the needs of the country's most vulnerable populations. Interprofessional strategies are necessary for keeping patients' mouths healthy and triaging patients that are in need of dental care.

What Can Primary Care Do About Tooth Decay?

This is not a problem that can be solved by dentists alone. A coordinated, integrated approach to addressing oral health in primary care can be implemented with four key components:

- EVALUATE AND MONITOR PATIENTS' ORAL HEALTH RISK
- REINFORCE AND CO-DESIGN HEALTHY ORAL HEALTH STRATEGIES FOR PATIENT AT-HOME CARE
- COMPLETE APPROPRIATE PREVENTIVE ACTIVITIES (APPLY FLUORIDE AGENTS)
- COORDINATE CARE WITH DENTAL PROVIDERS WHEN NECESSARY

MORE care

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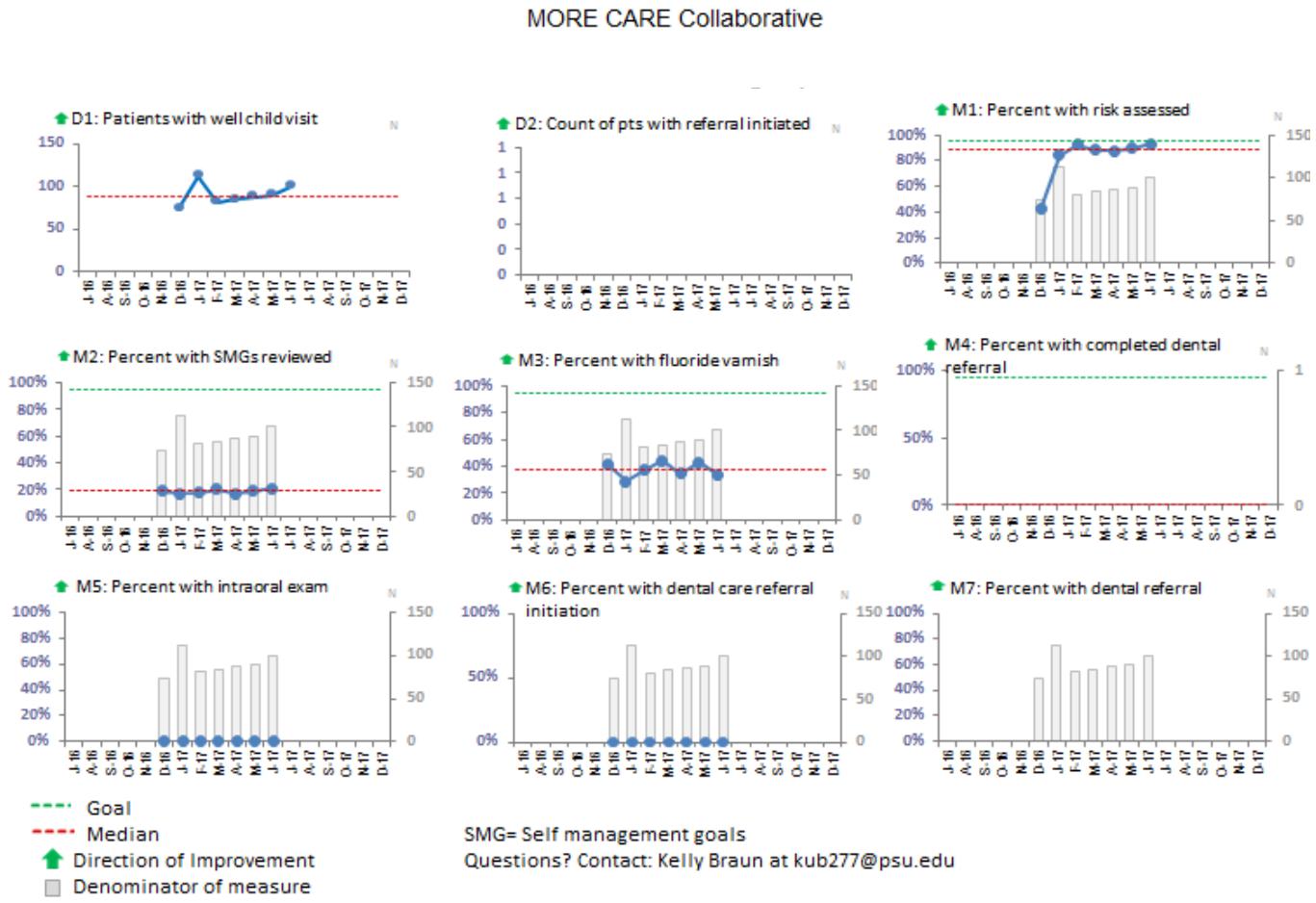
Better Patient Outcomes



Sealant Retention Rates

- **The yearly expected sealant retention rate has been reported to range from approximately 50-83%.**
  - A 55-80% yearly retention rate was found with school based placement on children from low income backgrounds
- **Identified variables include:**
  - Tooth location
  - Isolation techniques
  - Age of patient
  - Operator experience
  - Field of view
  - Number of operators

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Venker et al. Journal of public health dentistry. 2004 Dec;64(4):191-7.
Mickenautsch S. Journal of oral science. 2017;59(2):263-72.

Quality Application/ Practice Translation

- **Even though retention was at approx. 85% per quarter: The FQHC site felt event to address was loss of sealant**
- **Dental Teams should replace each sealant that is lost (3 year maintenance)**
  - Increase time and cost of materials
    - Lost revenue
  - Caries susceptibility
- **Next step was to identify variables & possible issues to improve these percentages – PDSA it!**
  - Manually looked at patient base – overweight/obese patients made up approximately 50% of patient's with lost sealants in first year
    - **PRACTICE TRANSLATION– patients that fit Obese/OW status when possible have team to place sealants**

Understanding the Other Side & Effective Communication

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What's the current state of affairs?

- **Medical and dental professionals are trained separately and then they practice how they are trained - separately.**
- **The "hidden curriculum" about oral health in <u>medical</u> training:**
  - Oral health means teeth
  - Teeth are the domain of dentistry
  - I know very little about teeth
  - Dentists know little about the rest of the body
  - Why are you (dentist) asking me about something related to teeth?
  - Why is this patient coming to ME about their mouth?
  - Why can't I get a dentist to see this patient?

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What's the current state of affairs?

- **Medical and dental professionals are trained separately and then they practice how they are trained - separately.**
- **The "hidden curriculum" about oral health in dental training:**
  - Oral health means dental care
  - Teeth are the domain of dentists
  - I do not see a need to know about treating systemic diseases
  - Physicians consider us as an inferior "doctor"
  - Surgical intervention gets me to graduation & pays the bills after
  - Why is this patient coming to ME about their health?
  - Team, what team? I'm holding my own suction over here.

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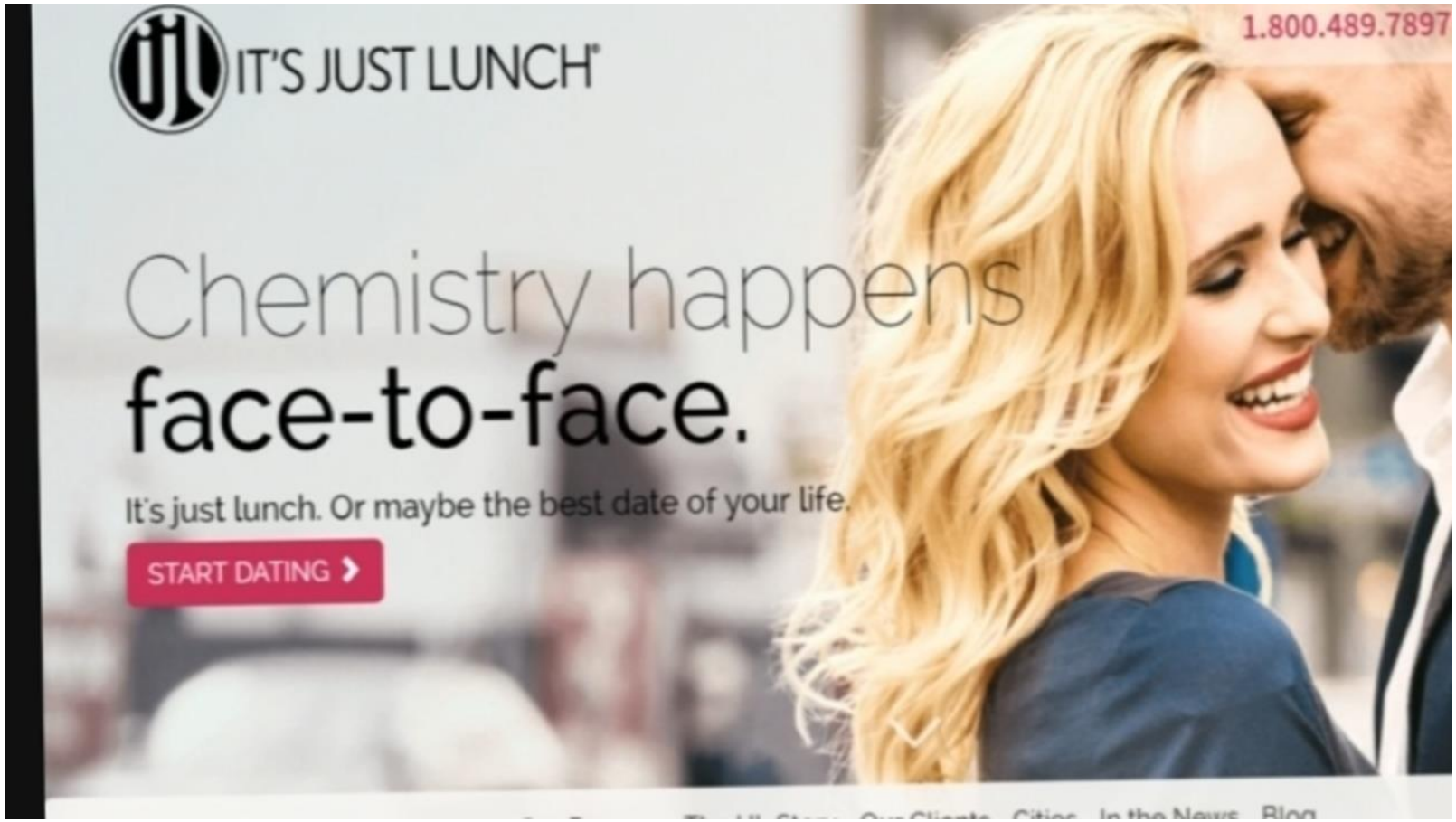
What a great idea: let's go to lunch ……



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OREGON ORAL HEALTH COALITION

Ready, Set, Implement

Oral Health Screening in the Medical Office

1. Determine who will deliver the services

    a. History/risk assessment: _____
    b. Screening (provider): _____
    c. Anticipatory guidance/patient education (oral hygiene, nutrition):_____
    d. Fluoride varnish education: _____
    e. Fluoride varnish application: _____

2. Decide when the services will be delivered (ex: Coordinate fluoride varnish with immunizations/well-child visits 6 mo, 9 mo, 12 mo, 15-18 mo, 24 mo, 36 mo. Separate visits for high-risk patients).

    _____
    _____
    _____

3. Identify an oral health champion in the office to:

    a. Order supplies (varnish and materials) and oral health education materials _____
    b. Identify and incorporate prompts for providers and patients _____
    c. Ensure new employees receive training_____

4. Create plan for fluoride varnish and oral health education materials
    a. Who will order: _____
    b. Where will they be stored: _____
    c. For patient visit, who will get supplies ready (ex: clip dose to chart): _____

5. Who will coordinate dental referrals and ensure that dental referral information is in exam room or at front desk _____

6. Establish process for documentation (ex: for paper charts- stickers or other prompts, intake form, exam form, determine location for tracking-immunization flip tab, dental tab, graphs, history section, etc.)

7. Create process for eligibility determination (ex: flag chart) and billing

https://static1.squarespace.com/static/554bd5a0e4b06ed592559a39/t/55a7d5afe4b02daf94e0b386/1437062575153/Ready+Set+Implement.pdf

Communication and Navigation

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USDHHS and Oral Health Referral

- **USDHHS set forth the following competencies for coordination of interprofessional oral health care:**
  - exchange meaningful information that benefits care delivery
  - apply patient and population- centered interprofessional practice principles; as well as,
  - facilitate patient navigation and provide appropriate referrals.
- **-also advises medical provider teams to consider a dental care referral "…equal to a referral to any other type of specialist."**

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US Department of Health and Human Services. Integration of oral health and primary care practice. 2014.
US Department of Health and Human Services. Considerations for oral health integration in primary care practice for children. 2012.

Let's Review Current Referral Use Analyses…

- **ADA Health Policy Institute**
  - Found that a significant disconnect exists between medical and dental care referral systems.
  - Physicians who participated in the analysis stated an overall dissatisfaction with the current process
- **Electronic Referral Process**
  - When primary care teams used an electronic referral tool, the receipt of timely patient information between the referral partners was three times higher compared to non-electronic
    - Most dental PMS lack interoperability
- **FQHC Dental Referral**
  - Patients were surprised by the high level of IPP provider communication and preferred the IPP process to previous care experiences.
  - Medical providers stated that they felt more empowered to address oral health needs with a dental care referral network in place.

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Gandhi TK et al, J Int Med 2001; 15:626-631.; Boynes SG et al, Int Med Rev 2016; 1:14-20.; Miloro MB et al, ADA Health Policy Institute: Research Brief. March, 2016.

Our Study (DQI and MUSC)…

- The continuing education program was offered at ten national, regional, and state meetings during April through September 2016
- Attendees were invited to complete an on-site paper survey, “Evaluation of Interprofessional and Oral Health Related Referral Systems,” created by the study principle investigator at the end of the training.

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The Participant Sample*

- A total of 673 people participated in the study.
  - Resulting sample size was 559 - 560
- Demographics
  - Dental: 60%; Medical: 40%;
  - Rural: 43%; Suburban: 32%; Urban: 25%
  - Clinical care: 30%; Leadership: 13%; Support staff, FLHWs: 57%
- Motivated population
- The last 9 questions were dichotomized to Agree (Agree, Strongly Agree) and Disagree (Disagree, Strongly Disagree, Neutral)
    - Unknown and N/A answers were discarded

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‘The Participant Sample’

	FQHC	Other
Medical providers at our site, or part of our network, are administering fluoride varnish and identifying oral health risk factors in the majority of patients seen.	**62.8%**	**72.8%**
Dental providers at our site, or part of our network, are pre-screening or screening for systemic disease (ex: diabetes, high blood pressure) in the majority of patients seen.	**20.4%**	**51.5%**
Our site sees significant issues with no-shows / broken appointments (15% or more) among referral patients.	61.5%	45.8%

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The Dependability of Coordination

- **Business Model**

Indicator		Odds Ratio	Confidence Interval	*P* Value
Organization variables	Organization type (*RHC as referent group*)			
	ACO	5.72	1.66-19.74	< .001
	FQHC	3.04	1.13-8.17	
	Private Practice	2.07	0.68-6.35	

- **Satisfaction and ease of Electronic Health Record use**

Indicator		Odds Ratio	Confidence Interval	*P* Value
Referral variables	Ease of EHR for making dental referral (*Agree/strongly agree as referent group*)			
	Disagree/strongly disagree	6.67	3.61-12.17	< .0001

- **No-Show Rate (15% or more)**

Issue with no shows (*Agree/strongly agree as referent group*)			
Disagree/strongly disagree	1.99	1.29-3.10	.01

https://www.ncbi.nlm.nih.gov/pubmed/28913876

The Dependability of Integration (Medical)

- **Health Information Technology / Electronic Health Record**
  - Respondents who reported EHR ease were **2.4 times** more likely to administer fluoride varnish and conduct risk assessments
    - Embedded risk assessment
    - Ease of reporting and monitoring

Referral system variable: Type of agreement with the following statement: "Our electronic health record makes medical-to-dental referrals easy"			<0.0001
Agree	19 (14.5%)	112 (85.5%)	
Disagree	156 (36.4%)	272 (63.6%)	

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The Dependability of Integration (Medical)

- **Medical to dental referral capability**
  - Respondents signifying a dependable medical to dental referral system were **4.5 times** more likely to administer FL/RA/SM

Referral system attributes	Has a successful network for medical-to-dental referrals (disagree/strongly disagree as referent group)			<0.0001
	Agree/strongly agree	4.54	2.79–7.39	
	Referral directionality (one directional, medical to dental only as referent group)			0.7826
	No referral system	0.65	0.18–2.39	
	Bidirectional	0.91	0.50–1.63	
	Referral method (electronic health record as referent group)			0.0009
	Warm handoff	0.22	0.10–0.51	
	All other methods	0.26	0.12–0.54	
	No method	0.54	0.13–2.29	
	Ease of electronic health record use for making dental referral (disagree/strongly disagree as referent group)			0.0054
	Agree/strongly agree	2.37	1.29–4.37	

https://www.ingentaconnect.com/content/cscript/fmch/2018/00000006/00000002/art00004?crawler=true&mimetype=application/pdf

Questions?

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