



Utah Oral Health Innovation Project

Uintah Basin Emergency Room Diversion project

September 2022 to August 2026



**Department of Health
& Human Services**

**Primary Care
& Rural Health**



Executive summary

Every year, approximately two million visits are made nationally to hospital emergency departments (EDs) for non-traumatic dental conditions, such as abscesses and tooth decay. Because EDs are not

equipped to provide definitive dental procedures, patients often receive only temporary relief through antibiotics and pain medications.¹ Managing only the symptoms creates a cycle of care that is clinically ineffective and financially unsustainable; studies show that nearly 96% of these

“Patients who do not receive routine dental care experience negative health and financial outcomes related to lack of care.”

Okunev, I., Tranby, E. P., Jacob, M., Diep, V. K., Kelly, A., Heaton, L. J., & Frantsve-Hawley, J. (2022). The impact of underutilization of preventive dental care by adult Medicaid participants. *Journal of Public Health Dentistry*, 82(1), 88-98. <https://doi.org/10.1111/jphd.12494>

patients still require follow-up dental work, and roughly one-third of them return to the ED within 30 days when their symptoms inevitably resurface.² The Utah Oral Health Innovation Project (UOHIP) was launched in 2022 to break this cycle by establishing a formal, real-time referral pipeline between hospital EDs and a Federally Qualified Health Center (FQHC).

Through the UOHIP, a referral pathway was developed for ED staff to send a referral from the electronic health record (EHR) directly to a local dental partner, ensuring that vulnerable patients were seen in a dental office within two business days of the dental clinic receiving the referral. This approach has transformed the ED from a dead end for dental pain into a critical gateway for long-term oral health. By facilitating these direct connections, UOHIP ensures that Medicaid and uninsured populations—who represent the majority of dental-related ED visits—receive the specialized care they need, such as fillings, root canals, or extractions, which the emergency setting cannot provide.

¹<https://www.concorde.edu/blog/why-its-important-keep-dental-emergencies-away-er>

²<https://dimensionsofdentalhygiene.com/article/reducing-the-use-of-hospital-emergency-departments-for-dental-care/#:~:text=Plus%2C%20the%20use%20of%20EDs,up%20care%20from%20a%20dentist.>



About the project

To effectively guide its activities, the UOHIP established five primary objectives, each yielding significant outcomes for the state's healthcare landscape. The objectives were to: 1) Increase capacity and knowledge among ED personnel to address oral health concerns in the Emergency Room; 2) Increase capacity for emergency and preventative dental services for uninsured and underinsured individuals; 3) Close the loop and connect individuals seen for oral health concerns in the ED with dental services; 4) Support and increase community education and resources in Dental HPSAs in Utah; and 5) Expand the Office of the State Dental Director.

To improve clinical knowledge, the project developed and implemented a specialized training program for ED personnel titled "Dental Education for the Emergency Department." This initiative involved live training sessions supported by pre- and post-testing to measure knowledge gained, with recorded versions archived for future hospital staff. Continuing education credits were available to those that attended the course in person. This course was also made available to any new ED personnel to watch as part of their onboarding. Parallel to these educational efforts, the project successfully increased service capacity for uninsured and underinsured individuals by expanding Mountainlands Community Health Center's (MCHC) dental clinic. This expansion added three dental operatories and enabled the hiring of a new dentist, hygienist, and two dental assistants, directly increasing access to care.

Closing the gap between EDs and dental care, the UOHIP worked with the Uintah Basin Medical Center (UBMC) and MCHC to develop a seamless referral process integrated into the hospital's EHR. Patients were provided the names of local dental providers that could provide definitive care. Per patient decision, referrals were made to the chosen provider. If MCHC was chosen as the referral site, ED staff instantly transmitted patient referrals to the MCHC dental clinic via fax or email upon discharge. This streamlined communication allowed the dental clinic to contact patients and offer appointments within two business days of receiving the referral, ensuring urgent dental needs are addressed promptly. Beyond the clinical setting, the project prioritized community education in Utah's Dental Health Professional Shortage Areas (HPSAs). The program coordinator collaborated with partners to create and distribute educational materials across social media, through a



local health department, and on a new public webpage, making these resources accessible to all Utahns. The impact of this initiative extends far beyond the initial project timeline; because the referral process is now a permanent fixture within the hospital's EHR, the ED will continue to be able to refer patients to the FQHC electronically, ensuring long-term sustainability and a lasting bridge to oral healthcare.

UOHIP collaborated with the local health department, UBMC, and MCHC to develop tailored health education materials. These educational pieces were strategically disseminated throughout the Uintah Basin to reach underserved populations, encourage positive hygiene practices, and guide residents toward local Safety-Net dental services. To amplify this impact beyond the region, the state Oral Health Program redesigned its website into an accessible, centralized hub. This updated platform ensures all Utahns can easily access educational resources, locate low-cost dental providers, and better manage their oral health.

Finally, the project secured a long-term administrative impact through the expansion of the Office of the State Dental Director. By demonstrating the critical link between oral health and overall wellness, the project facilitated the transition of the state dental director position from a 0.2 FTE to a full-time role. Through strategic integration with other state health department programs, sustainable funding plans have been established to maintain this full-time leadership after the project concludes, ensuring a lasting legacy for oral health in Utah.

UOHIP findings

- 72% of patients that visited the ED wanted a referral to a dental office
- 39% of patients had Medicaid as their primary insurance
- 75% of patients that wanted a referral were seen at MCHC dental clinic for follow-up care
- FQHC dental clinic was able to see 47% more patients and cut patients' wait times for a restorative appointment in half



Project area and partners

The UOHIP selected the Uintah Basin—specifically Duchesne and Uintah Counties, centered around Roosevelt and Vernal—due to severe health disparities and acute shortages in dental resources. Serving a rural population of 55,216³, these communities face significant geographic isolation and economic hardship, ranking near the bottom of Utah’s 29 counties for health outcomes and health factors (25th and 26th, respectively). Access to oral healthcare is drastically constrained by a low workforce ratio—up to 2,240 and 1,955 residents per dentist, respectively, compared to the state average of 1,441:1⁴—and a critical shortage of Medicaid providers, with only 11 dentists in the entire basin accepting Medicaid patients.⁵ Furthermore, 40% of residents go without routine dental checkups.⁶ The region also features sizable Indigenous populations who disproportionately experience poor health outcomes.⁷ These factors strain MCHC’s dental clinic, resulting in extreme wait times of up to 14 months for restorative treatment. Intervening in the Uintah Basin directly addresses an underserved population in critical need of expanded oral health infrastructure.

MCHC is an FQHC serving uninsured and low-income populations across Utah through a patient-centered medical home model. Driven by a multidisciplinary workforce of physicians, dentists, hygienists, nurses, and medical/dental assistants, MCHC delivers comprehensive medical, dental, behavioral health, and pharmacy services regardless of ability to pay. MCHC’s dental clinic is currently housed in the Tri-County Health Department building in Vernal. The Tri-County Health Department provides the space for the dental clinic at a significant discount. Within the Uintah Basin, MCHC’s dental clinic operates six chairs—dedicated to restorative, preventive, and emergency care—with emergencies comprising 25% of daily visits.⁸

UBMC, a core entity of the non-profit Uintah Basin Healthcare system, serves as the primary regional healthcare provider across eastern Utah. Headquartered in Roosevelt

³ <https://www.census.gov/quickfacts/fact/table/duchesnecountyutah,uintahcountyutah/PST045221>

⁴ <https://www.countyhealthrankings.org/health-data/utah?year=2025>

⁵ <https://medicaid-documents.dhhs.utah.gov/Documents/pdfs/UUSOD%20Medicaid%20Dental%20Provider%20Directory.pdf>

⁶ <https://ibis.utah.gov/ibisph-view/indicator/view/RouDenBRFS.html>

⁷ <https://www.ihs.gov/newsroom/factsheets/disparities/>

⁸ <https://www.mountainlands.org/>



with outpatient and urgent care clinics in Vernal, Duchesne, Manila, Altamont, and Tabiona, UBMC provides vital acute, emergency, and primary care to rural and medically underserved communities in Duchesne and Uintah counties. By combining acute hospital capabilities with a broad network of community-based family practice and pediatric clinics, UBMC serves as an essential safety-net healthcare anchor, mitigating geographic access barriers and delivering comprehensive care to residents throughout the Uintah Basin.⁹

The data

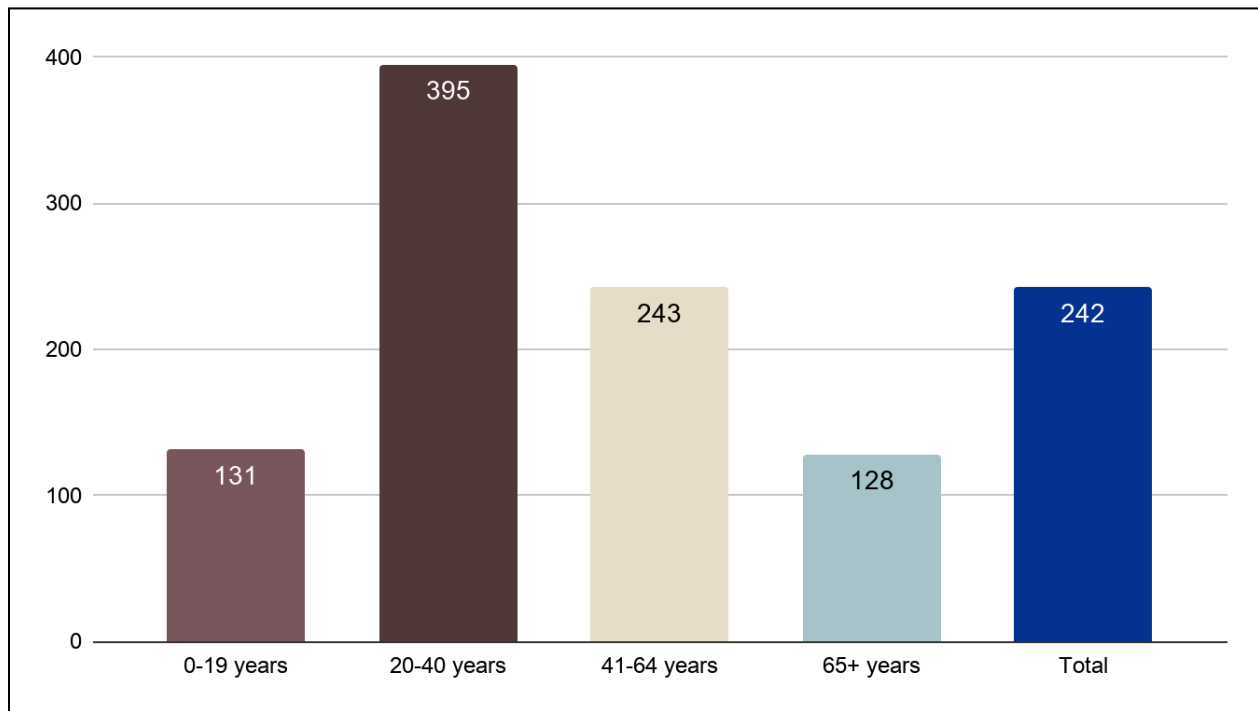
Utah data

State data comes from an agreement between the Utah Oral Health Program and Health Care Statistics Program in the Utah Department of Health and Human Services to obtain deidentified Healthcare Facility Data from the Healthcare Facility Database. This data includes encounter records for all licensed hospitals, emergency departments, and ambulatory surgery centers in Utah with ICD-10 diagnostic and procedure codes and billed charges. UHIOP obtained the data for all emergency department encounters for oral health emergencies in Utah between 2017 and 2025, with select demographic characteristics and billed charges. Oral health emergencies were defined using the ICD-10 codes KO2, KO4, KO8, K11, K12, and M26.

⁹ <https://www.ubh.org/>

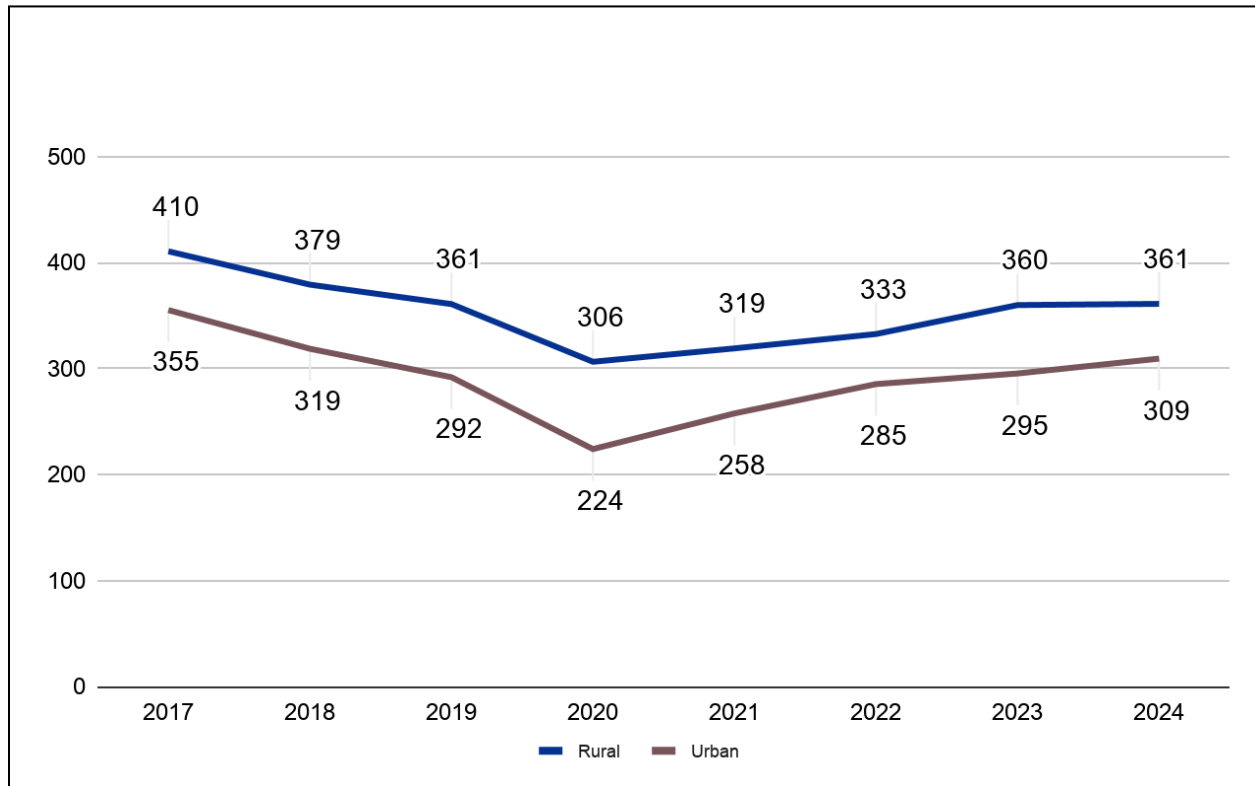


Figure 1: Oral health ED visits in Utah per 10,000 population by age group, 2017-2025



Overall, between 2017 and 2025 the rate of oral health ED visits was 242 visits per 10,000 population. Young adults aged 20 to 40 years account for the highest rate of oral health ED visits by far, with 395 visits per 10,000 population. This is followed by adults aged 41 to 64 years at 243 visits. In contrast, the youngest group (children aged 0–19 years) and the oldest group (65+ years) recorded significantly lower numbers, at 131 and 128 visits per 10,000 population, respectively. Overall, the data highlights that working-age adults aged 20–40 are three times more likely to seek ED care for oral health issues than children or seniors.

Figure 2: Oral health ED visits in Utah per 100,000 population by rural vs. urban hospitals, 2017–2024

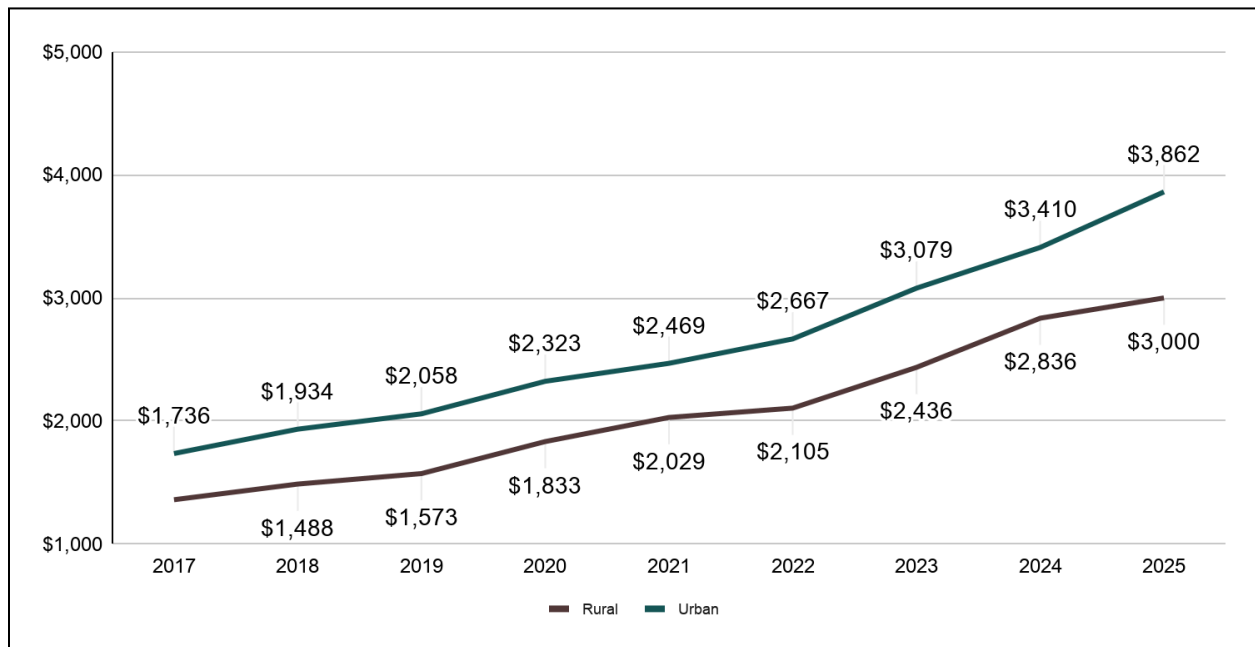


Note: Due to incomplete data, 2025 was not included. Estimates are not age-adjusted.

During 2017–2024, rural emergency visit rates remained consistently higher than urban rates, starting at 410 vs. 355 in 2017. Both reached a brief low in 2020 (306 rural vs. 224 urban, possibly due to the COVID-19 pandemic) before climbing steadily over the next four years. By 2024, the disparity persisted as rural visits reached 361, while urban visits rose to 309.

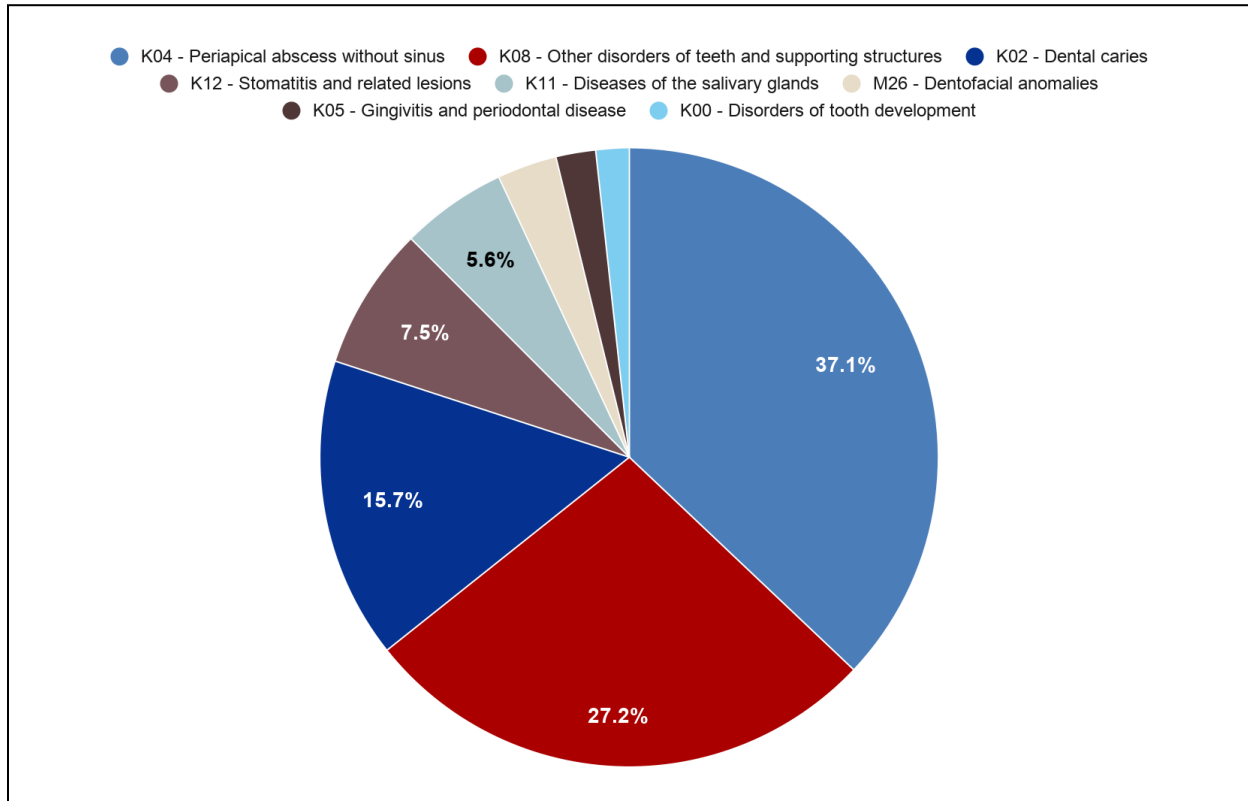


Figure 3: Average charge per oral health ED visit in Utah between 2017-2025, by rural vs. urban hospitals



During 2017-2025, visits to urban hospitals consistently charge more than those to rural hospitals, with charges increasing over time regardless of urban or rural location. In 2017, charges for urban visits averaged \$1,736 compared to \$1,361 for rural visits. By 2025, the average charge for oral health ED visits in urban hospitals reached nearly \$3,900 while rural visits reached \$3,000. This highlights significant inflation in emergency dental care charges over time, regardless of location. Charges reflect what is actually billed to insurance, not necessarily the amount paid.

Figure 4: Primary diagnosis for oral health ED visits in Utah, 2017-2025



During 2017-2025, the most common primary ICD-10 diagnosis code for oral health ED visits was “K04 - Periapical abscess without sinus”, accounting for more than a third of visits at 37.1%. This is followed by “K08 - Other disorders of teeth and supporting structures” at 27.2% and “K02 - Dental caries” at 15.7%. Smaller proportions of ED visits are attributed to “K12 - Stomatitis and related lesions” (7.5%) and “K11 - Diseases of the salivary glands” (5.6%), alongside minor contributions from gingivitis and periodontal disease, dentofacial anomalies, and disorders of tooth development. Overall, severe infections and general tooth disorders drive the vast majority of visits.



Figure 5: Total charges in Utah by diagnosis code from 2017-2025

Primary diagnosis	Total charges	Total distinct visits per diagnosis	Average charge per visit
K04 - Periapical abscess without sinus	\$76,623,694	31,921	\$2,400
K08 - Other disorders of teeth and supporting structures	\$49,228,650	23,466	\$2,098
K02 - Dental caries	\$30,348,000	13,536	\$2,242
K11 - Diseases of the salivary glands	\$19,997,089	4,786	\$4,178
K12 - Stomatitis and related lesions	\$17,053,499	6,464	\$2,638
M26 - Dentofacial anomalies	\$9,140,493	2,677	\$3,414
K05 - Gingivitis and periodontal disease	\$4,242,918	1,789	\$2,372
K00 - Disorders of tooth development	\$2,433,107	1,492	\$1,631

“K04 - Periapical abscess without sinus” recorded both the highest total charge at \$76,623,694 and the highest volume with 31,921 visits, averaging a charge of \$2,400 per visit. In contrast, “K11 - Diseases of the salivary glands” generated the highest average charge per visit at \$4,178, totaling \$19,997,089 across 4,786 visits. “K08 - Other disorders of teeth and supporting structures” had the second-highest total charge (\$49,228,650; 23,466 visits), while “K00 - Disorders of tooth development” saw the lowest average charge per visit at \$1,631 (1,492 visits totaling \$2,433,107 in charges).

Project data

Project data comes from several sources:

- 1) REDCap: Data from emergency room encounters was provided by UBMC emergency departments via a secure REDCap data collection tool that collected basic information about the patient including insurance status and type, whether an oral health assessment was completed, and if and where the patient was referred.

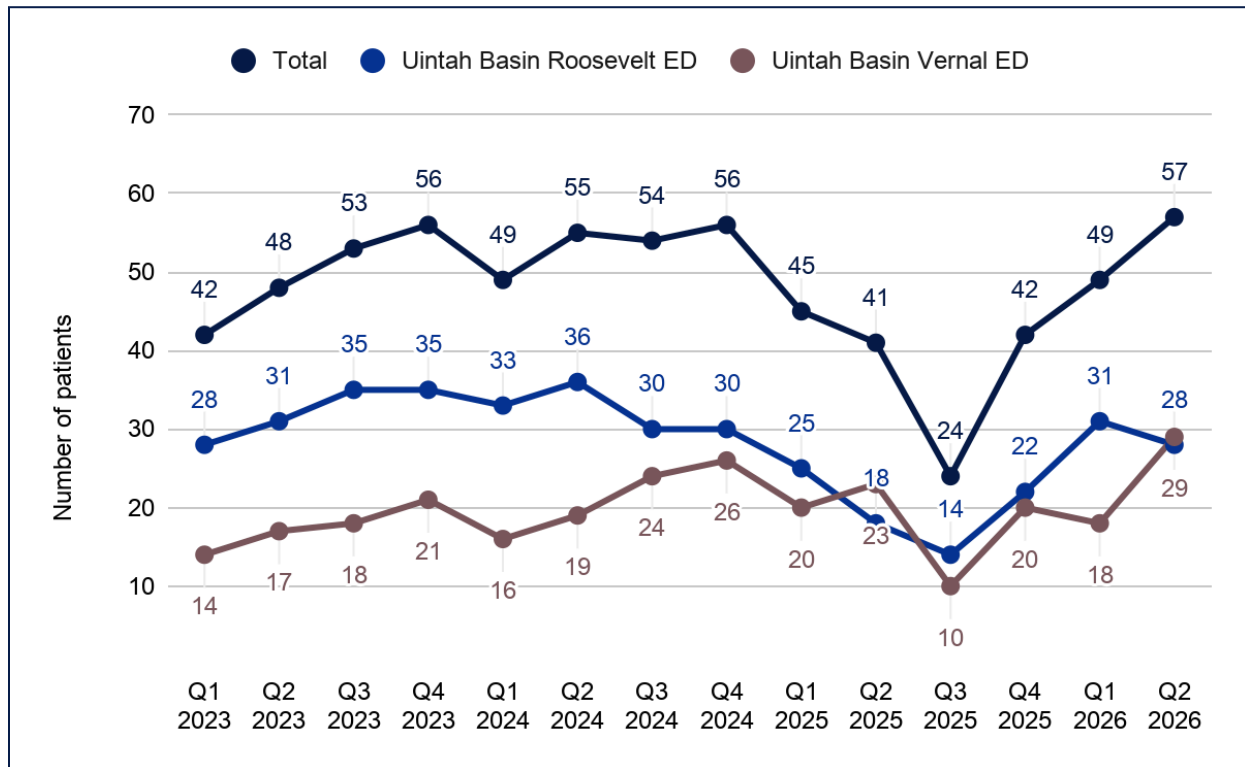
A separate REDCap data collection tool was used by the MCHC to track whether a



referred patient was contacted and offered an appointment, whether the appointment was kept, and whether additional treatment was needed.

- 2) Emergency room reports: To complement the data collected through REDCap, UBMC also provided monthly reports with complete counts of anyone presenting with an oral health ICD-10 code, including the amount charged per visit.
- 3) MCHC wait time reports: To complement the data collected through REDCap, MCHC also provided a weekly report of current emergency, preventive, and restorative appointment wait times. This data includes wait times to see either of the two dentists in their practice.
- 4) REDiHealth: The Oral Health Program executed a contract with REDiHealth (a health analytics consulting firm that focuses primarily on data analytics in rural hospitals to improve care). RediHealth was able to provide valuable insight into historical trends, more complete insurance information, and charges associated with oral health ED visits from the UBMC internal system.

Figure 6: Total patients seen quarterly for a dental problem in the ED

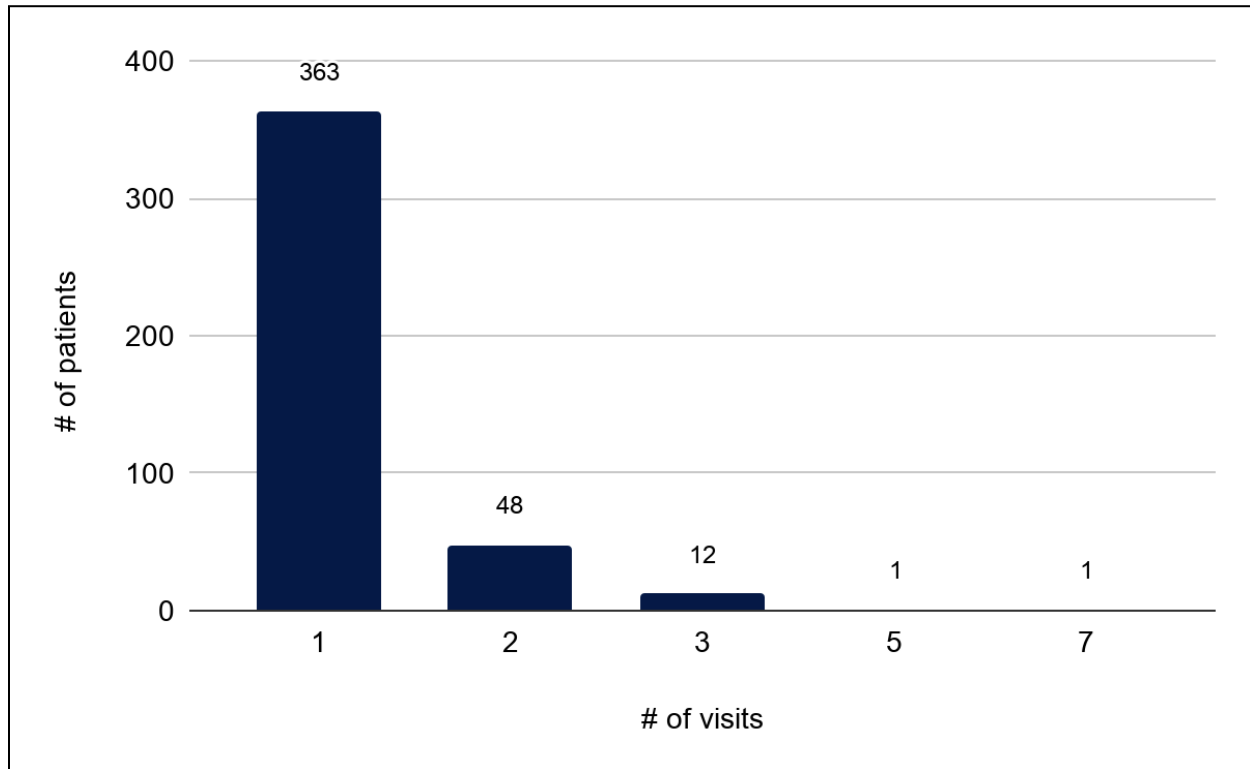


Source: Uintah Basin Medical Center

This data from ED dental visits tracked between Q1 2023 and Q2 2026 showed a clear trend. Combined volume rose from 42 to a peak plateau of 56 in late 2023/2024. Roosevelt led overall (peaking at 36), while Vernal steadily grew to a peak of 26. Visits plummeted to a low of 24 in Q3 2025 following the April 2025 Adult Dental Medicaid Expansion. Vernal briefly surpassed Roosevelt in Q2 2025. However, Q4 2025 saw a sharp, system-wide rebound back to 42 patients with increases over the next two quarters.

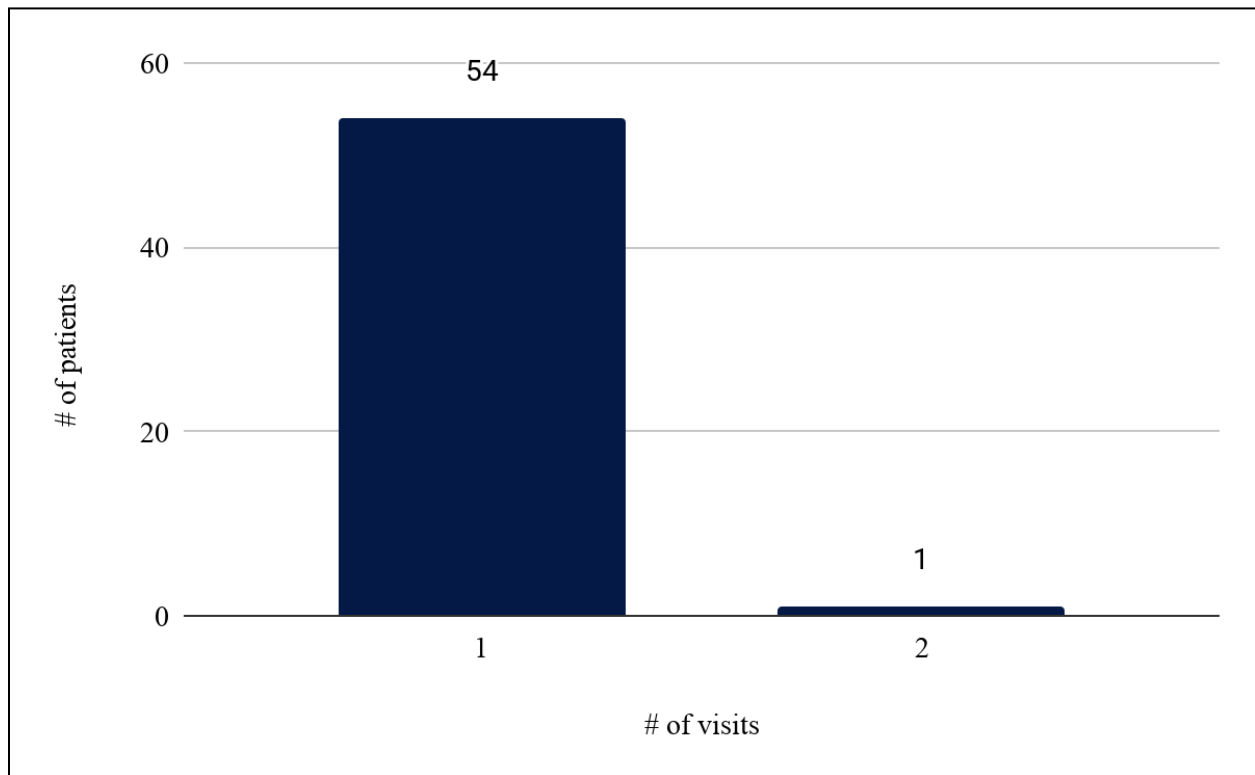


Figure 7: Patients with a recurrent visit to a UBMC ED for a dental problem, 2021-2026



Source: Uintah Basin Medical Center

Figure 8: Patients who received a referral to MCHC with a recurrent visit to the ED for a dental problem, 2024-2026

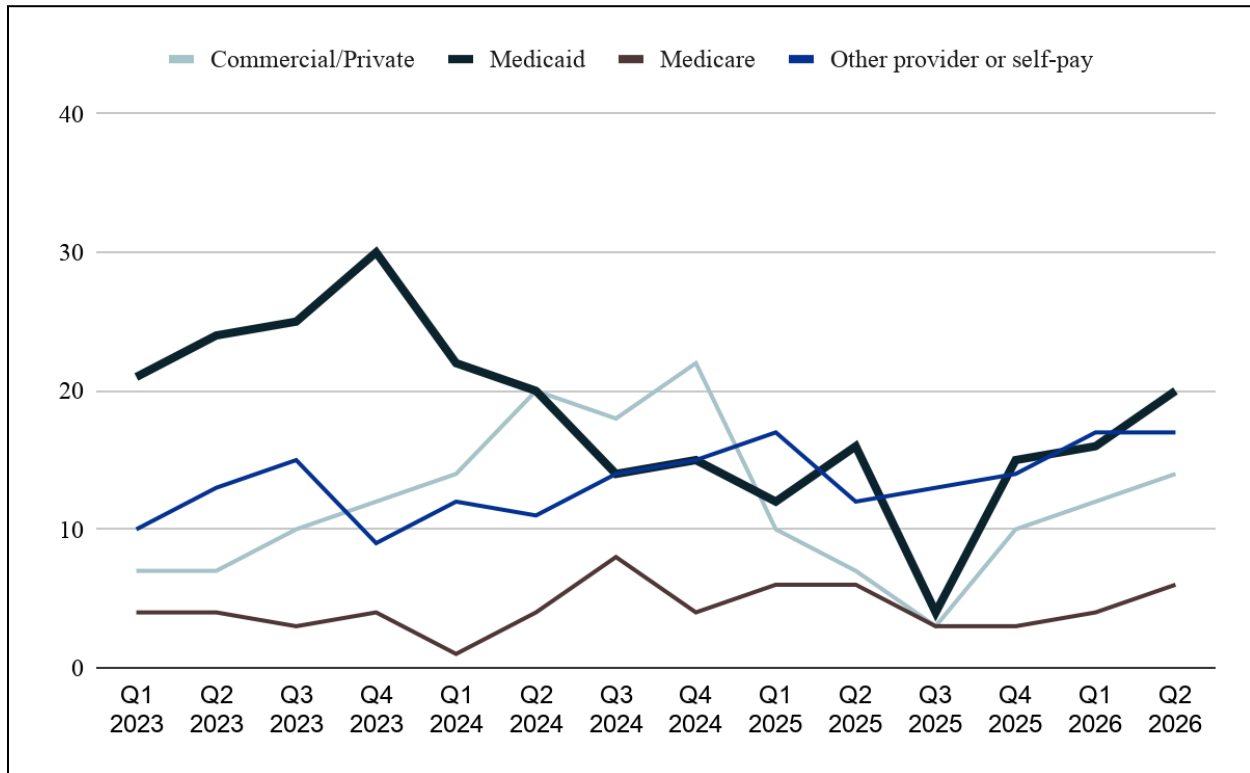


Source: Uintah Basin Medical Center

Figure 7 shows most baseline patients had only one ED visit (363 patients), but a few "super-utilizers" returned multiple times, including individuals with five and seven visits.

Conversely, Figure 8 reveals that among patients referred to the MCHC dental clinic, heavy ED recidivism nearly vanished: 54 patients had just a single visit, and only one returned a second time. This suggests the referral pathway was successful, and in the majority of cases, the oral health issues were treated successfully.

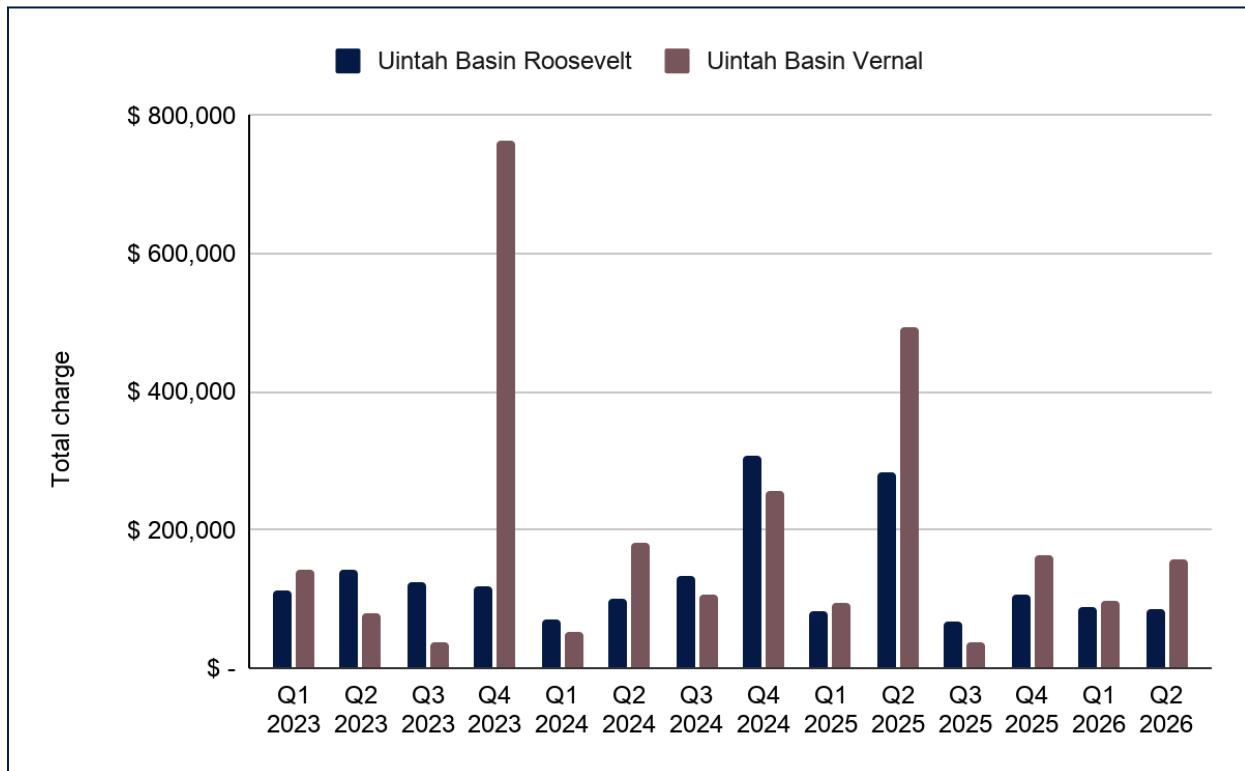
Figure 9: Number of patients with an oral health ED at UBMC visit per insurance type



Source: Uintah Basin Medical Center

Medicaid was the most common insurance type early in the project, peaking at 30 patients in Q3 2024. The count of patients on Medicaid coming to the ED for oral health emergencies significantly decreased over the course of the project (Spearman's Rank Correlation, P-value ≤ 0.01). Utah's April 2025 Adult Dental Medicaid Expansion could explain why numbers dropped, but this project didn't have any way to determine if that was the reason. During the same time period, patients with commercial insurance increased to a peak of 22 patients in Q4 2024 before returning to baseline, while the self-pay category remained remarkably stable, hovering between 10 and 13 patients nearly every quarter. Medicare and other providers consistently saw the lowest volumes, rarely exceeding five patients per quarter. There was no significant change in the count of different insurance types aside from Medicaid over the course of the project.

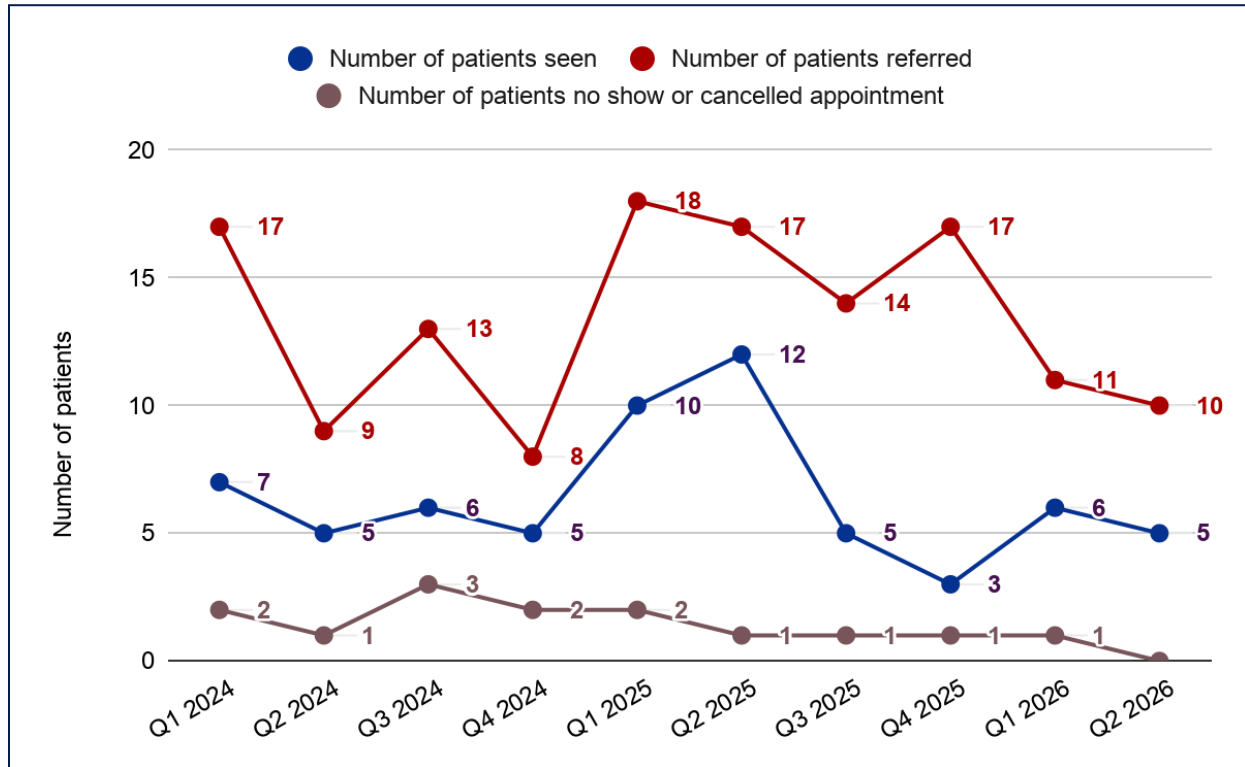
Figure 10: Total charges for oral health problems by ED location



Source: Uintah Basin Medical Center

Total ED oral health charges exhibited extreme baseline volatility, heavily defined by two massive spikes at the Vernal location. While quarterly charges at both facilities typically hovered between \$50,000 and \$150,000, Vernal experienced an historic high of roughly \$760,000 in Q4 2023 and spiked again to nearly \$490,000 in Q2 2025. Outside of these Vernal outliers, charges for Roosevelt maintained a slightly higher, more consistent amount. Both facilities saw uniform drops in Q1 2024 and Q3 2025, mirroring declines in patient volume. By Q4 2025, charges returned closer to historic norms, with Vernal at roughly \$160,000 and Roosevelt near \$110,000.

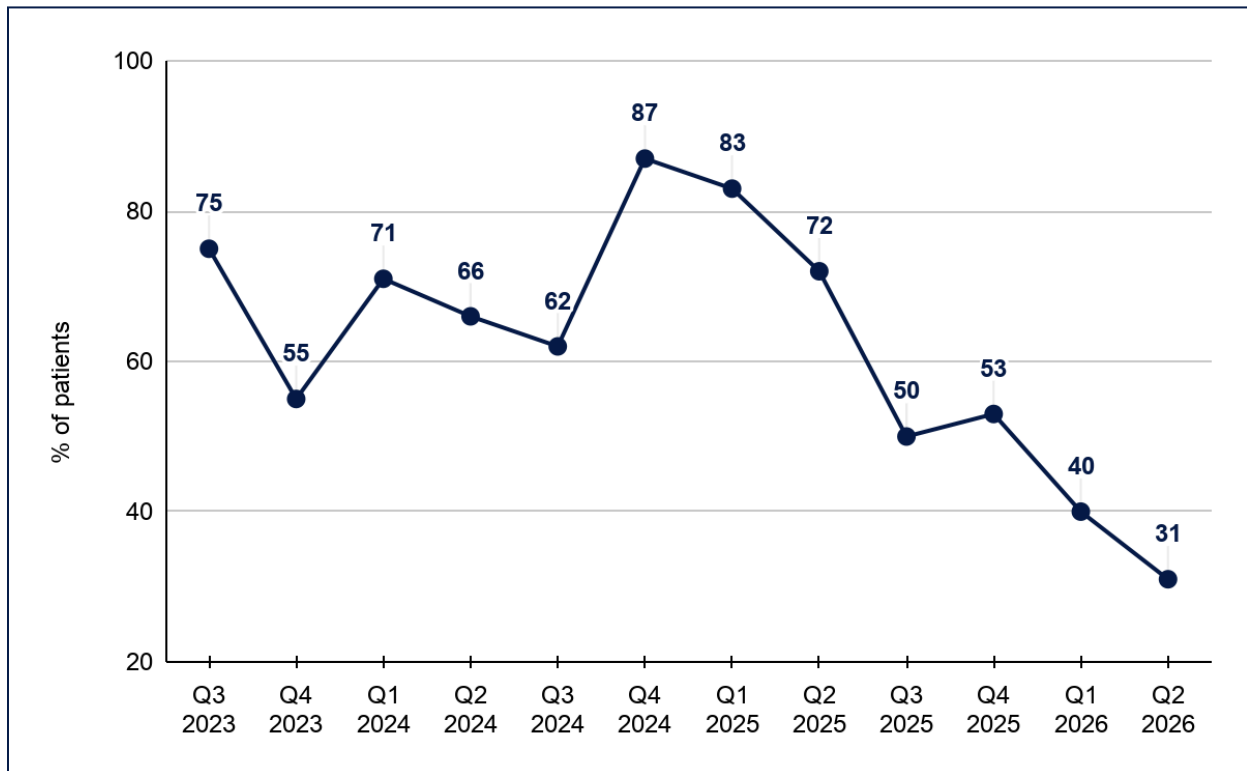
Figure 11: Outcome of patients referred to MCHC dental clinic



Source: REDCap project data

A persistent gap remained between MCHC dental referrals and completed visits. Referrals peaked at 18 in Q1 2025 (yielding 12 visits in Q2 2025) before both declined, stabilizing by Q2 2026 at 10 referrals and five visits. Low no-show rates (0 to 3 per quarter) rule out attrition as the cause. The disconnect peaked in Q4 2025, when 17 referrals resulted in just three visits. The gap between referred patients and seen plus no-show or cancelled patients was heavily driven by communication barriers; MCHC staff frequently could not contact patients due to incorrect or disconnected phone numbers recorded in the EHR or patients simply not answering follow-up calls.

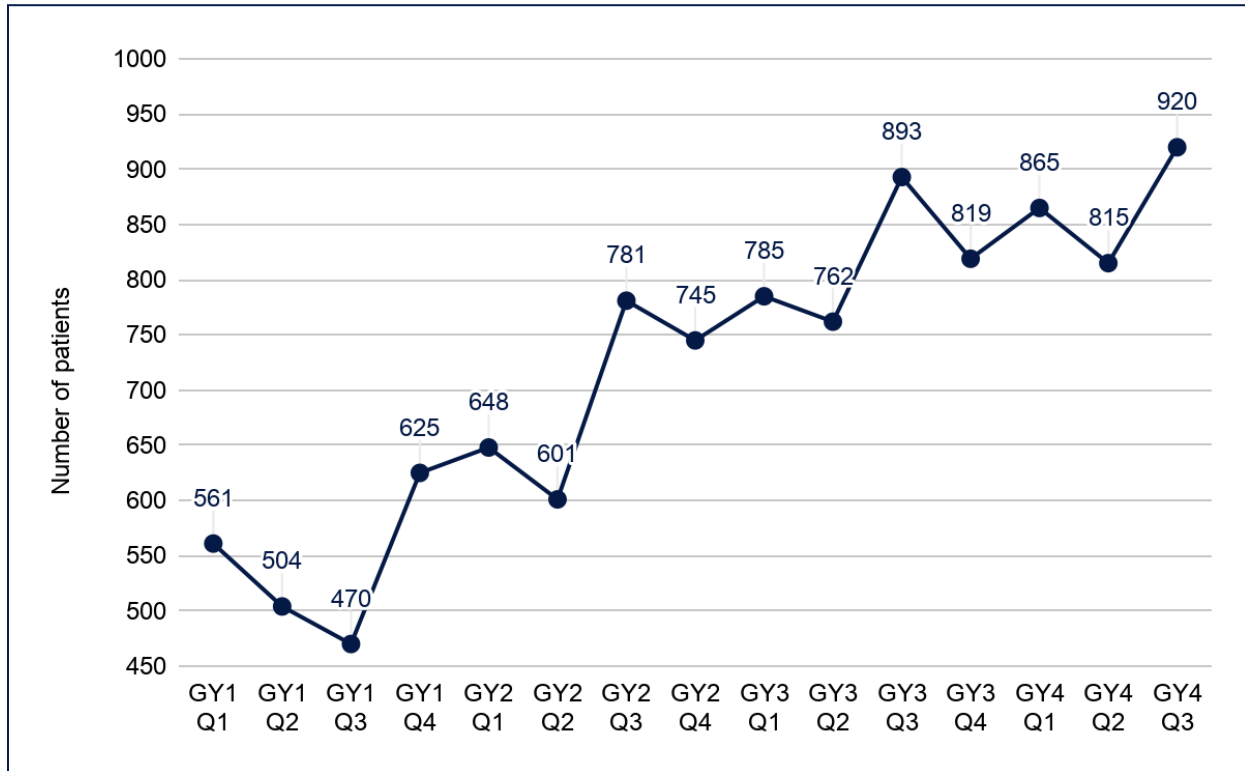
Figure 12: Percent of patients offered an appointment within 2 business days of referral at MCHC dental clinic



Source: REDCap project data

The rate of patients offered an appointment at MCHC within two days of referral fluctuated from 2023 to 2026. Starting at 75% in Q3 2023, the metric experiences initial volatility—which could be driven by a small patient sample size—dropping to 55% in Q4 2023 before rebounding and reaching a peak of 87% in Q4 2024. Following this peak, the percentage enters a sharp downward trend over the next six quarters. Despite a slight temporary rise to 53% in Q4 2025, it drops steadily to an all-time low of 31% by Q2 2026, marking a 44 percentage point overall decrease from the start.

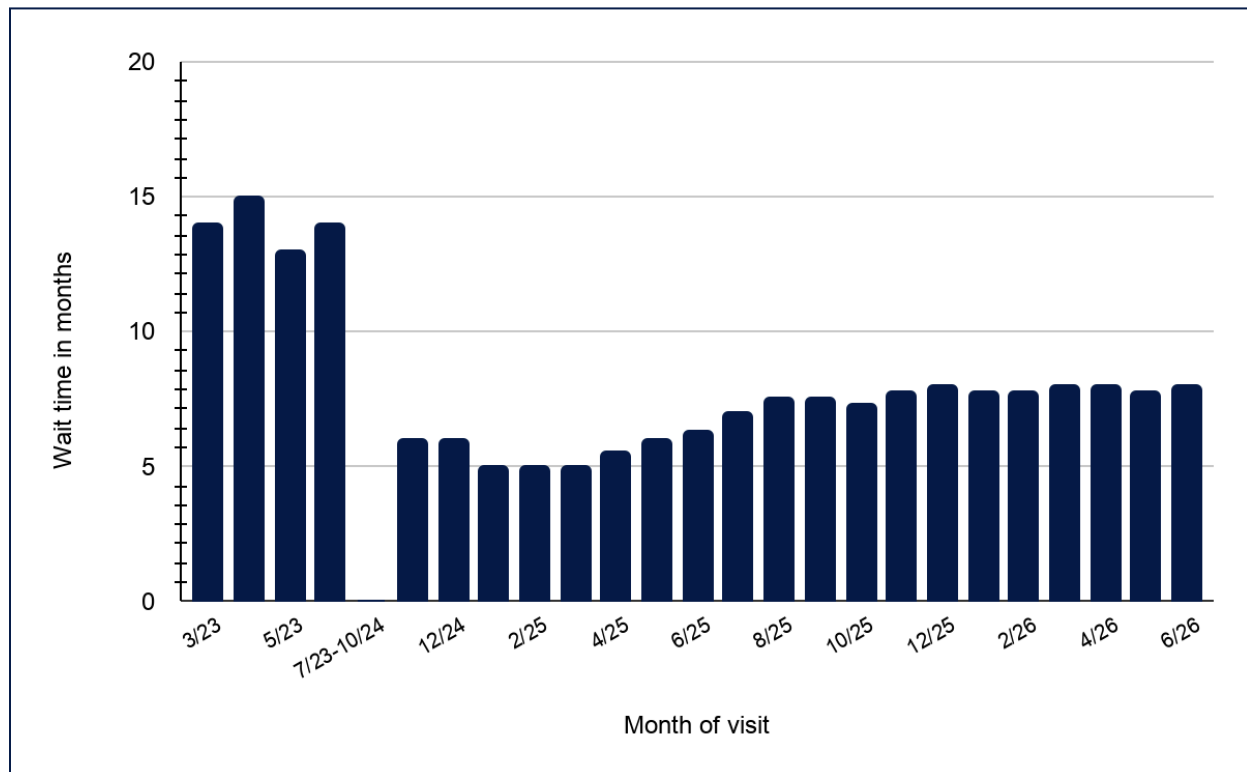
Figure 13: Total number of patients seen at MCHC dental clinic



Source: Mountainlands Community Health Center

Total patient volume at MCHC dental clinic showed a sustained and significant upward trajectory across the tracking period (Spearman's Rank Correlation, P-value ≤ 0.001). The timeline began with a decline from 561 patients in grant year (GY) 1 Q1 to an all-time low of 470 in GY1 Q3 due to a temporary closure for renovations. Upon reopening in GY1 Q4, the clinic hired a new dentist, expanding provider capacity and triggering an immediate rebound to 625 patients. The clinic leveraged this capacity for aggressive growth. The volume of patients MCHC could see grew significantly, breaching the 800-patient threshold in GY3 Q3 to reach a historic peak of 893 patients. Operations remained high, hovering between 815 and 865 visits through the rest of GY3 and into GY4 Q3, which closed at 920 patients. Overall, the clinic achieved a 64% increase in quarterly volume from its GY1 Q1 baseline to GY4 Q3.

Figure 14: MCHC dental clinic restorative wait times



Source: Mountainlands Community Health Center

Average patient wait times for restorative dental treatments at MCHC dental clinic saw a permanent reduction over the tracking period. In spring 2023, wait times were lengthy, peaking at 15 months in April. The tracking of wait times was paused during the period of facility renovation and hiring of the new dentist. The clinic resumed tracking wait times in November 2024, revealing that wait times were reduced to just six months following expansion, eventually hitting a project low of five months in early 2025. Beginning April 2025, wait times began a gradual climb—possibly due to an influx of patients from the state’s adult Medicaid expansion—before stabilizing between seven to eight months through May 2026. Ultimately, these interventions cut historical wait times roughly in half. At its peak, the clinic achieved a 67% reduction in wait times (from 15 months down to 5 months). Long-term stabilization at seven to eight months represents a decrease of almost 50% from the baseline, drastically accelerating patient access to care.



Project limitations

While the project successfully achieved its core objectives, several limitations regarding scope, data collection, and system integration should be considered when interpreting the findings:

- **Small sample size and geographic scope:** Because the priority population size was very small, the findings may not represent broader trends across other hospital systems in the state. The small sample size can also contribute to high variability in data trends. Since participation was limited to one of two hospital systems in the Uintah Basin, the project lacks insight into the practices and workflows of the other facility in the area.
- **Data suppression and patient tracking constraints:** Due to small sample sizes, certain data points were suppressed to protect participant privacy. Because only one regional hospital system participated, we could not determine if patients visited neighboring facilities for oral health problems before or after their visit. Furthermore, tracking limitations made it impossible to verify whether patients still lived in the service area after their ED visit. Finally, referrals to dental offices other than MCHC were not tracked, leaving the ultimate care outcomes for those patients unknown.
- **Staff turnover and low protocol buy-in:** High staff turnover among clerks and nurses created ongoing challenges for maintaining protocol consistency. This was further compounded by low buy-in and competing job responsibilities from ED personnel regarding the data entry process, which resulted in a significant number of missing entries.
- **Manual data entry and human error:** Much of the project's data relied on staff at both the hospital and the dental clinic manually inputting information into a dedicated collection program. This reliance on manual workflows increased human error and data inconsistency.
- **EHR incompatibility:** The hospital and the partner dental clinic utilize different EHR systems. Because these systems could not directly communicate or automatically share data, staff were forced to bridge the gap manually, exacerbating the data entry burden and limiting seamless tracking.



Recommendations

Addressing oral health needs within the ED requires a proactive, multi-faceted approach that bridges clinical care, staff education, and community integration. The following evidence-based recommendations outline key strategies to enhance ED capacity, promote holistic patient wellness, and strengthen interprofessional collaboration with local dental providers.



Educate ED personnel on oral health issues and their treatments

Collaborate with the Department of Health's Oral Health Program to conduct a high-quality training course for the team. To ensure consistent care, this course should be a mandatory requirement for all ED personnel, including doctors, nurses, and clerks. Adding this training to the monthly in-service rotation will help maintain staff skills and ensure that all new hires are properly trained.



Integrate oral health assessments in all ED visits

Train nurses, CNAs, and doctors to perform basic oral health risk assessments for all patients who visit the ED, regardless of the presenting reason for seeking care in the ED. These assessments should be a standard part of the ED visit, with an exception for a life-threatening emergency. Along with the assessment, staff should educate patients on the importance of routine oral health care to their overall health and wellness.



Build relationships with dental offices in the area and create a referral pathway between the ED and dental providers

Utilize Community Health Workers (CHW) to bridge the gap between local dental providers and the hospital. Building interprofessional relationships is mutually beneficial. Dental providers can assist in the training of ED providers on how to manage patients who present with oral health related issues. Direct referral pathways can be developed to get patients from the ED to the specialized care they



need. To make this process seamless, the ED's EHR system should be updated to automatically send referrals via fax or email to the chosen dental clinic. Once the referral is received, the dental clinic can call the patient to schedule an appointment.

Implementation plan for an oral health referral program

This implementation plan outlines the strategic roadmap for executing an oral health referral program in your hospital. By establishing dedicated leadership, providing staff training, and integrating direct referral pathways into the EHR system, this roadmap ensures a structured rollout to improve patient outcomes and post-ED care continuity.

1. **Form a leadership group:** Create a committee of ED employees who will lead the oral health project and oversee the transition.
2. **Request training resources:** Reach out to your State Oral Health Program to find training materials and courses for your staff.
3. **Schedule staff meetings:** Plan two in-person training sessions so that each member of the ED team can attend at least one.
4. **Adopt an assessment tool:** Use a standard guide, like the AAP Caries Risk Assessment, to help staff identify dental issues quickly and accurately.
5. **Host a hands-on workshop:** Invite a dental professional to your staff meetings to demonstrate exactly how to perform an oral health risk assessment on a patient.
6. **Update the EHR system:** Build a list of local dental offices that have agreed to accept referrals directly into your EHR system.
7. **Train on referrals:** Teach staff the correct way to send digital referrals once a patient is discharged from the ED.
8. **Ensure follow-up care:** Have CHWs check in with patients after their visit to make sure they successfully saw a dentist and received the care they needed.



Appendices

MCHC data collection form

Confidential Page 1

Mountainlands Patient Report

Please complete the survey below.

Thank you!

Please enter the FIN from the referral form that was sent by Uintah Basin Emergency Department

Referring Emergency Department ☐ Uintah Basin (Vernal)
☐ Uintah Basin (Roosevelt)
☐ Ashley Regional

Patient gender ☐ Male
☐ Female
☐ Other

Age of patient

Patient race ☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Other Racial or Multi-Racial

Patient ethnicity ☐ Hispanic
☐ Non-Hispanic

Patient zip code

Date referral was received by Mountainlands

Was this patient contacted? ☐ Yes
☐ No

Please make any relevant field level notes for this patient that was not contacted

Please confirm this patient was not contacted ☐ Confirm non-contact and Exit

Date of initial patient contact

Appointment offered date and time

Was the patient offered an appointment within 48 hours of initial contact? ☐ Yes
☐ No

Was the appointment kept? ☐ Yes
☐ No, but the appointment was rescheduled
☐ No, the patient was lost to follow-up

07/30/2026 4:37pm projectredcap.org



Confidential

Page 2

Please enter any important notes on this patient who was lost to follow-up

Confirm this patient was lost to follow-up

☐ Confirm and Exit

New appointment date

Please confirm the date the patient was seen by Mountainlands

Was the patient issue resolved?

☐ Yes
☐ No
☐ Additional appointments required

Were the additional appointments made with Mountainlands or was this patient referred to a specialist?

☐ Additional appointments with Mountainlands
☐ Patient referred to a specialist

How many referrals have you received for this patient for this issue?

☐ One referral
☐ Two referrals
☐ Three or more referrals

Does the patient have health insurance?

☐ Yes
☐ No

What type of health insurance does this patient have?

☐ Medicaid
☐ Private
☐ Tribal
☐ Other

Does the patient have dental insurance?

☐ Yes
☐ No

What type of dental insurance does this patient have?

☐ Medicaid
☐ Private
☐ Tribal
☐ Other

Dental Codes or Severity

☐ Generic
☐ Mild
☐ Severe
☐ Immediate

Additional Important Information Notes



UBMC data collection form

Uintah Basin ED/OH Referral Form		Page 1
Please complete the survey below.		
Thank you!		
Please enter the FIN from the referral form that was sent to Mountainlands Community Health Center		
Please identify the Emergency Department	☐ Uintah Basin Vernal ☐ Uintah Basin Roosevelt	
Date of ED Encounter		
Time of ED Encounter		
Patient Gender	☐ Female ☐ Male ☐ Other	
Patient Age		
Patient Race	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other Racial or Multi-Racial	
Patient Ethnicity	☐ Hispanic ☐ Non-Hispanic	
Patient Zip Code		
Did this patient receive an oral health assessment in the emergency room?	☐ Yes ☐ No	
Patient Assessment Result	☐ No Pain no Swelling ☐ Pain no Swelling ☐ No Pain with Swelling ☐ Pain with Swelling	
Were antibiotic given?	☐ Yes ☐ No	
Were any pain medications given, including dental blocks, acetaminophen, ibuprofen, or narcotics?	☐ Yes ☐ No	
Types of pain medication given (select all that apply):	☐ Dental block ☐ Acetaminophen ☐ Anti-inflammatories: such as Ibuprofen/naproxen ☐ Narcotic	



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Does the patient have health insurance?
☐ Yes
☐ No
☐ Unknown

What type of health insurance does this patient have?
☐ Medicaid
☐ Private
☐ Tribal
☐ Other
☐ Unknown

Does the patient have dental insurance?
☐ Yes
☐ No
☐ Unknown

What type of dental insurance does this patient have?
☐ Medicaid
☐ Private
☐ Tribal
☐ Other
☐ Unknown

Was the patient referred for follow-up care?
☐ Yes
☐ No

Where was the patient referred?
☐ Mountainlands Community Health Center
☐ Other Medicaid Provider
☐ Indian Health Service
☐ Other Provider

Has this patient been seen for a dental problem at the ED before?
☐ Yes
☐ No

Patient declined referral?
☐ Yes
☐ No

Was this at the Roosevelt or Vernal campus, or both?
☐ Vernal Campus
☐ Roosevelt Campus
☐ Both Vernal and Roosevelt Campuses

Please make any relevant field level notes for this patient