Dental Public Health Activity Descriptive Report

Practice Number: 54009
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SECTION I: PRACTICE OVERVIEW

Name of the Dental Public Health Activity:

Swedish Community Specialty Clinic and Golden Ticket Program

Public Health Functions:
Assessment – Acquiring Data
Policy Development – Collaboration and Partnership for Planning and Integration
Assurance – Population-based Interventions
Assurance – Building Linkages and Partnerships for Interventions
Assurance – Building State and Community Capacity for Interventions
Assurance – Access to Care and Health System Interventions

Healthy People 2020 Objectives:
OH-3 Reduce the proportion of adults with untreated dental decay
OH-7 Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
OH-11 Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers each year

State:	**Federal Region:**	**Key Words for Searches:**
Washington		Access to care, planning with partners, emergency department, emergency department diversion, Non-traumatic dental conditions, Federally Qualified Health Center, case management

Abstract:

Our service delivery model for specialty oral surgery care for low-income uninsured and under-insured dental patients is an adaptation of the extremely successful Project Access Northwest medical model that already operates at Swedish Community Specialty Clinic (SCSC). Patients with complex acute oral surgery needs are referred from their safety net clinic provider to Swedish Community Specialty Clinic and Project Access Northwest.

The Project Access Northwest referral and case management system is effective as measured by an impressive 4.3% "no show" rate (the "no show" rate reported for Medicaid/Uninsured patients has been reported to be approximately 30% and approximately 15% for commercially insured patients). Since opening its doors in September 2011 and providing care two days per week, this year the Clinic achieved its goal of being open five days per week (236 days in the 12 months of this reporting period, a 57% increase over 2012-2013). The Clinic is primarily staffed by General Practice Residents (GPR) and their supervising dentists as well as volunteer dentists and oral surgeons.

By December 2014, there were 15,590 teeth extracted. The specialty oral surgery care delivered by the Clinic also includes bone re-contouring surgery and biopsies all with a total donated care value of $4,426,018. The Clinic costs for 2013-2014 are $475,900 with Swedish Medical Center, the Pacific Hospital Preservation & Development Authority and the Seattle-King County Dental Foundation covering the cost of 3.0 FTE paid personnel (two dental assistants, partial FTE dentist, and partial FTE dental director), overhead and supplies.

Prior to the creation of the SCSC, we instituted a 'golden ticket' program with the Emergency Department (ED) physicians at Swedish Medical Center to try to assist them in effectively treating

the growing number of dental patients. When a patient with a non- traumatic dental condition presents at the ED (e.g., there is a non-life threatening abscess/infection or there is pain without visible infection), the patient is given a referral sheet (the golden ticket) from the ED physician. The 'golden ticket' directs them to the closest FQHC where they are prioritized in the next morning's walk-in emergency dental clinic. This program has no cost beyond volunteer dentist time educating the ED physicians on the process and networking with the closest FQHC. HIPPA restrictions and limited ED staff time along with inadequate resources at the FQHC, has made the collection of data on the number of patients who have actually followed through and received care at the FQHC unattainable. In the first 18 months of the program, of the 759 patients who went to the ED for dental, 218 or almost 30% were given a 'golden ticket' and did not receive treatment at the ED.

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SECTION II: PRACTICE DESCRIPTION

History of the Practice:

With January 2011 cutbacks in Washington State's adult Medicaid program and reduced funding to pre-existing safety net programs that deliver oral health care in King County, patients with chronic non-emergent dental disease found themselves with fewer options for receiving dental interventions and the treatment of acute dental pain. In anticipation of these cuts, the Seattle-King County Dental Society convened a task force to begin examining the impact of reduced funding. A significant piece of work the task force completed was a community needs assessment. Among the stakeholders participating in the community needs assessment were the leaders of the community health centers that provide dental services to patients living in King County, WA, Seattle-King County Public Health, the WA Department of Social and Health Services, peer dental societies in WA, and Project Access Northwest (a regional non-profit that works to remove the logistical and financial barriers to specialty medical and dental care for patients and their health care providers). They all shared the common concern that the impending budget cuts would have the worst effect on the uninsured and those with low-incomes, especially when their dental needs are frequently acute and painful. An additional concern expressed by the community health center leaders during the community needs assessment was that tooth extraction would often be the only cost effective way to relieve the acute symptoms and pain experienced by this group of patients with limited financial means, and that the procedures would be complex enough in a significant subset to warrant specialty care.

In recognition that these adults would begin to increasingly utilize hospital emergency departments for their acute oral health needs, Seattle-King County Dental Society began to look for partners interested in working together to develop a cost-effective way to address this anticipated need. Swedish Medical Center (Swedish) was identified as a promising partner. A few years earlier, Swedish recognized that their Emergency Department (ED) costs were escalating—particularly in the area of uncompensated care and dental-related complaints. To address that, they worked with Seattle Special Care Dentistry to start a dental general practice residency (GPR) program in 2009. These GPR residents are on call for the ED physicians and respond to ED urgent dental cases as well as making referrals to the SCSC. Finally, these GPR residents have a regular rotation through the Clinic where they provide treatment.

As the work began on a GPR program, the Seattle-King County Dental Society and Seattle Special Care Dentistry started a 'golden ticket' program at the Swedish ED. When a patient presented with non-urgent dental pain at the ED, the ED physician would provide the patient with a 'golden ticket.' This ticket referred the patient to the closest FQHC where they were given priority at the next

morning's walk in emergency clinic. This program diverted patients from the ED to a facility that could actually treat the dental pain.

Providing charity care is a core part of Swedish's non-profit mission and they had been providing uncompensated advanced medical specialty care to low-income uninsured and underinsured patients at their Swedish Community Specialty Clinic (SCSC). All of the care delivered at SCSC is by volunteer providers and all of the patients have been referred to the Clinic by Project Access Northwest, one of the participants in the community needs assessment. Project Access Northwest patients live at or below 200 percent of the federal poverty level, and approximately one-third of the patients have limited English language proficiency. In 2011 Swedish entered into a partnership with Seattle-King County Dental Society to expand the specialty services provided at SCSC to include complex oral surgery.

Swedish funded the cost for the infrastructure build-out at SCSC (approximately $100,000 for walls, flooring, paint, plumbing, electrical, data). The SCSC opened its doors in September 2011. The pool of volunteer clinicians providing specialty care at SCSC expanded to include dentists and oral surgeons, and continues to provide quality care at no cost to its patients (Swedish has been waiving the credentialing fees for volunteer dentists and oral surgeons). With the expansion to include oral health, Project Access Northwest caseworkers would be necessary to connect patients with complex oral surgery needs diagnosed at local safety net dental clinics and the emergency department to the volunteer dental providers at SCSC.

In recognition that the workload of care managers would increase, the Seattle-King County Dental Society and Project Access Northwest approached the Pacific Hospital Preservation and Development Authority, to assess their interest in funding an additional case manager to support the oral surgery portion of the SCSC. The mission of the Pacific Hospital Preservation and Development Authority is to champion effective health care for the vulnerable and disadvantaged in King County. Pacific Hospital Preservation and Development Authority support of the SCSC oral surgery service grew in 2012 to include the funding of a second full-time dental case manager to address the volume.

Justification of the Practice:

The region's dental safety net clinics are typically able to meet the needs of low-income adults who present with acute dental pain and/or orofacial infections. Sadly, the extraction of the tooth or teeth causing the acute symptoms is the only treatment option that can cost-effectively eliminate the symptoms. At times, the providers in the dental safety net clinics encounter situations in which the care that is indicated is too complex for their level of training and they often find themselves with no dental specialty referral options, thus compromising the quality of the care the patient receives. This is the niche for the SCSC's oral surgery service. Please see the outputs below to demonstrate the need and the increasing utilization.

Our 'golden ticket' program in the Swedish ED distributed 218 'tickets' among the 759 patients who presented at the ED for dental pain between January 2011 and June 2012—the first 18 months of the program. While the Swedish Medical Center has been unable to determine quantitatively the impact/effectiveness on the number of dental patients in the ED, there has been anecdotal evidence reported by ED physicians of reduced 'frequent fliers' who come to the ED for dental pain. Because of HIPPA regulations and the thinly stretched staff at the EDs and FQHCs, we have been unable to capture the number of 'golden ticket' recipients/referrals that actually sought care the next day.

Inputs, Activities, Outputs and Outcomes of the Practice:

Since opening its door in September of 2011, the volume of patients receiving complex oral surgery care at the SCSC has been growing. Table 1 provides a summary of the patient volumes (number of patients and encounters), types of treatment delivered and the total dollar value of that care. When comparing the patient volumes, number of treatments and the total value by year (the shaded columns), one can see the large amount of growth across all metrics in 2013-2014 (i.e., 31% increase in the number of patients, 34% increase in the number of patient encounters, 41% increase in the number of simple extractions, 100% increase in the number of complex extractions, 81% increase in torus removal).

Table 1: Summary of the oral surgery care delivered by the Swedish Community Specialty Care oral surgery service and dollar value of care

	2011-12[a]	*2012-13*	*2013-2014 1st quarter*	*2013-2014 2nd quarter*	*2013-2014 3rd quarter*	*2013-2014 4th quarter‡*	*2013-2014*
# of patients	*159*	*847*	*294*	*311*	*292*	*214*	*1,217*
# of patient encounters	*222*	*1,186*	*404*	*469*	*408*	*306*	*1,718*
Simple extractions	*405*	*1960*	*710*	*866*	*633*	*554*	*2,963*
Complex extractions	*146*	*639*	*284*	*353*	*360*	*280*	*1,401*
Torus removal	*8*	*31*	*22*	*10*	*11*	*13*	*60*
Biopsies	*2*	*20*	*5*	*3*	*3*	*1*	*12*
Dollar value of care	*$196,160*	*$1,128,269*	*$426,635*	*$502,961*	*$407,384*	*$313,778*	*$1,779,505*

a. The Clinic opened in September 2011 so the 2011-2012 annual data is for only 9 months, not 12.

Another demonstration of the Clinic's growth can be found in the increases in its accessibility to patients. Table 2 summarizes this increase as a function of the number of clinic days per week the Clinic is open and the total number of days it was open each year (shaded columns are for the Clinic's first two years). One of the goals for 2013-2014 was to have the Clinic open and staffed five days per week. This goal was accomplished in the second quarter of 2013-2014. Data through the fiscal year end of May 2014 show the Clinic has been open 236 days during this reporting period, a 57% increase from 2012-2013.

Table 2: Growth of the Swedish Community Specialty Clinic oral surgery service's capacity

	2011-12[a]	*2012-13[b]*	*2013-2014 1st quarter*	*2013-2014 2nd quarter*	*2013-2014 3rd quarter*	*2013-2014[c]*
# of clinic days/wk	*2*	*3*	*4.5*	*4*	*5*	*5*
# of clinic days	*13*	*150*	*55*	*58*	*62*	*61*

a. The Clinic opened in October 2011 so the 2011-2012 annual data is for only 9 months, not 12.
b. The Clinic increased the number of days/week from 2 to 3 in July 2012.

Budget Estimates and Formulas of the Practice:

Increases in the Clinic's staffing have been needed to keep pace with the demand in services Table 3 summarizes the staffing increases (shaded columns are for the Clinic's first two years).

Table 3: Summary of the Swedish Community Specialty Clinic oral surgery service's pool of volunteers, residents and paid employees

	2011-12[a]	2012-13	2013-2014 1st quarter	2013-2014 2nd quarter	2013-2014 3rd quarter	2013-2014 4th quarter
# of caseworkers (paid FTE)	1	2	2	2	2	2
# of paid dental assistants	0	3	2	2	2	2
# of volunteer dentists	6	11	3	5	5	4
# of general practice residents	3	3	3	3	3	3
# of volunteer oral surgeons	3	4	1	1	1	0
Attending dentist (paid FTE)	0.8	0.8	0.8	0.8	0.8	0.8

Dental Director (paid FTE)	0.2	0.2	0.2	0.2	0.2	0.2

a. The Clinic opened in October 2011 so the 2011-2012 annual data is for only 9 months, not 12.

Table 4 outlines the operating costs for the Swedish Community Specialty Clinic's oral surgery service and compares them to those needed in the Clinic's first year (2011-2012). It also shows how the partners are contributing the resources needed to run the Clinic. Swedish provided the funding to support operations; personnel and supplies to SCSCs oral surgery service during the program start up in 2013-1014. A commitment to providing a significant amount of uncompensated care is a part of Swedish' s non-profit mission, and their support of the oral surgery service is commensurate with their support of the advanced medical specialty care delivered to low-income uninsured and underinsured patients at the Swedish Community Specialty Clinic.

Table 4: Operational cost comparison; 2011-2012 (Start-Up) vs. 2013-2014

Costs	2011-2012	2013-2014
Facilities		
Construction	$100,000	$0
Equipment	$253,252	$0
Overhead	$13,939	$33,900
Personnel		
Dental	$0	$313,000*
Non-Dental	$51,149	$100,000
Supplies	$9,000	$30,000
Totals	**$427,340**	**$475,900**

While the clinical care is delivered by volunteers and residents, Table 4 describes two part-time paid dental FTEs (Dental Director and an oral surgeon). Non-dental personnel are the caseworkers.

Both Swedish and the Seattle-King County Dental Society apply for grants (e.g., the Pierre Fauchard Foundation) for additional equipment needs as they arise. The Swedish Foundation is also exploring ways to financially support the oral surgery service. All of the partners are committed to working together to garner ongoing funding.

There was no budget for operational costs for the 'golden ticket' program. This program was set up by volunteer dentists who educated the ED physicians about the program and negotiated the process with the nearby FQHC. Given that there was no budget, there has been no ability to capture the number of patients who actually followed through with the referral on a sustainable basis. Utilizing a student volunteer, we were able to create the snapshot of results that were mentioned earlier in this document. However, that analysis was a one- time only opportunity, and, even that analysis suffered from incomplete recording by the ED physicians. We believe, based on anecdotal discussions with physicians, for example, that many more golden tickets were issued than were captured in the system.

Lessons Learned and/or Plans for Improvement:

SCSC Program

- Performing a community needs assessment is critical to the success of such a program. The Dental Society learned from the community and its stakeholders. We did not have the time or the resources to do a scientifically based assessment. Rather, we gathered all the County CHC dental directors and their administrative leads in a room along with our partners and made a list of what was needed and then prioritized the needs. This earned the Dental Society additional trust and was critical in the formation of an effective coalition with a shared vision.
- The dental safety net clinics are not referring their routine cases. A majority of the extractions being referred to the SCSC are quite challenging. Similarly, they are referring complex third molar extractions and pathology cases to the SCSC.
- Patients often need more than one appointment to complete the required care. Our initial assumption was that the patient needs would typically be met in a single appointment. Given the poor oral health of many of the referred patients, multiple appointments are often needed to complete the treatment plan. Additionally, a block of time needed to be included into the Clinic's regular schedule to follow-up with patients who were experiencing anxiety about their healing.
- Many patients want to be "knocked out" for their extractions. Moderate sedation, deep sedation and general anesthesia cannot be accommodated in this model of acute care

delivery. SCSC does offer minimal sedation with oral agents and nitrous oxide sedation. Some patients are willing to proceed with minimal sedation, while others refuse.

- An "on-site" dental director (the part-time position) is essential. The director monitors the skill and comfort levels of the volunteers, and steps in should volunteers need assistance with complex procedures or if there are no volunteers available.
- There have been barriers for patients needing initial consults in the FQHC dental safety net clinics. Some patients find their sliding scale fee to be an obstacle. We have been working with the dental safety net clinic dental directors and referral coordinators to resolve such barriers.
- Many of the referred patients have such poor oral health that they require full mouth extractions. Because there is limited funding for dentures, some patients have been reluctant to have the recommended number of teeth extracted. In recognition of this patient concern, the Seattle-King County Dental Society has received funding to include the University of Washington School of Dentistry in the partnership. Following a full mouth extraction at Swedish Community Specialty Clinic's oral surgery clinic, the patient would be referred to the School of Dentistry's pre-doctoral removable prosthodontics clinic for denture fabrication. This program began in the fall of 2014 and has been recently funded for a second year.
- The dental assistant position was originally supervised by Project Access Northwest and had some caseworker duties. It is our experience that the skill sets of a caseworker and of a dental assistant cannot be successfully combined and need to be two different positions.
- Finding the optimal balance of patients for a caseworker to manage each quarter is important to the program's success, especially as measured by the engagement of the volunteers. In this model, a caseworker who is dedicated exclusively to dental patients can successfully manage 450 patients per year (approximately 150 referrals per month from the dental safety net clinics).

Golden Ticket Program

- This program is challenged by working with ED physicians. As these individuals are extremely busy while working, it is difficult to get their attention in order to explain the program to them. Additionally, given the tight time constraints under which they work, their reporting of patient outcomes was often not complete.
- Due to lack of funding for statistical analysis, it has not been possible—beyond anecdotal reports by the ED physicians—to measure the true effectiveness of this program.
- It is important to note that, of the 759 patients during the reporting time, only 14 of them were in enough dental distress to be admitted to the hospital—a determination made by the GPR residents on call.
- Swedish Hospital has been unable to measure quantitatively how this program impacted ED utilization for dental patients.

Available Information Resources:

We believe this program can be adapted by other communities provided that careful attention is given to understanding the needs of the uninsured and underinsured patients and the network of providers who treat them and manage their care. There are benefits for everyone involved. For example, while it is difficult to demonstrate in a large metropolitan area like Seattle that a program like this reduces the volume of patients seen in the hospital emergency department, and subsequently reduce their expenses, hospitals are interested in exploring this options (we have been approached by two different hospital systems interested in replicating our model). The FQHCs are also likely to want to explore the value added by having such a program to refer their complex oral surgery cases, thus ensuring that they "do no harm" by referring such patients to those with advanced skills. Additionally, the FQHCs do not have to hire an oral surgeon with the accompanying costs for equipment if they can simply refer the patients that the general dentist does not have the skill to treat. The feedback from our network of referring dental safety net clinics has been extremely positive about having a place to send their complex oral surgery cases. The membership of our Dental Society has embraced this idea as a way to meet a real need in our community. With very little soliciting, we have over 30 active volunteers in the Clinic and another 14 going through the credentialing process.

The biggest challenge to adapting this to other communities in a manner that is effective and sustainable is the case management and financial screening. We are fortunate that function is being met in our community by Project Access Northwest. For those looking to replicate this model, it is suggested that they look to the medical providers in their community to see if they are working with a similar case management organization that is experienced in the uncompensated care arena. This was the process used to find Project Access Northwest.

Finally, a critical piece has been the part-time dental director and assistants. While the bulk of the patient care in our program is provided by dental residents and volunteers, the paid staff is critical to "holding the program together" and providing support, assistance, back-up and relief when necessary.

We believe that our Society-wide emphasis on the importance of providing uncompensated care will naturally garner more volunteers. We believe that the membership's awareness of the magnitude of the cuts in adult dental Medicaid funding and the mid-level provider initiative are motivating them to participate. This awareness and their concern with the government's efforts to "solve" the access problems for them are inspiring them to volunteer their efforts to "solve" the problem in a demonstrable and scalable way that they believe will actually be effective.

With the help of many partners and stakeholders, the Swedish Community Specialty Clinic's oral surgery service has developed into a model operation of which we are extremely proud. It began as a simple conversation in a parking lot in February of 2011, was opened in September of that year and volumes began to accelerate by February of 2012. It is now a full-time (5 days a week) uncompensated care clinic. In this very short time, it has exceeded expectations in terms of the quality of care, the engagement of volunteer dentists, positive reviews by FQHCs and, of course, the growing number of patients who have had their acute pain eradicated. These patients are now healthier and less likely to require emergent visits to the hospital emergency departments; both goals from the outset of the program's development. This is a model that works, and those who are involved feel very honored to have contributed to its success.

SECTION III: PRACTICE EVALUATION INFORMATION

Impact/Effectiveness

How has the practice demonstrated impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence, outcomes of the practice and/or evaluation results)?

The patients treated by the SCSC range from 19 to 90 years of age with the majority (57%) being 45 years of age or younger. The gender of the patients is evenly split between males and females While 36% of patients do not report race, 31% were reported to be white, 33% were non-white (black, Asian, Native American/Alaska Native, Pacific Island Native or more than 1 race), and 14% were Hispanic (28% recorded as non-Hispanic and 58% did not report).

The primary goal of the Swedish Community Specialty Clinic oral surgery service has been to provide specialty care for uninsured and underinsured adults living at or below 200% of the federal poverty level. A majority of the patients were uninsured (71%) and under 100% of the federal poverty level. These patients, even with a partial reinstatement of adult dental Medicaid, continue to be challenged to find care.

Efficiency

How has the practice demonstrated cost and resource efficiency where expenses are appropriate to benefits? How has the practice demonstrated realistic and reasonable staffing and time requirements? Provide unit cost analysis or cost-benefit analysis if appropriate.

Demonstrated Sustainability

How has the practice showed sustainable benefits and/or how has the practice been sustainable within populations/communities and between states/territories? What mechanisms have been built into the practice to assure sustainability?

Even with the reinstatement of some Medicaid adult dental funding, the SCSC continues to receive between 200-300 patient referrals each month. The demographics of that referral population continue to be primarily uninsured or underinsured adults.

While Swedish Hospital has been unable to capture quantitatively the impact of the SCSC and the 'golden ticket' on its ED, it believes it has reduced the number of dental patients. They are so

convinced of this fact that the Hospital is absorbing more and more of the cost of operating the SCSC and recently agreed to increase the number of GPRs from 3 to 4.

Collaboration/Integration

How has the practice built effective partnerships/collaborations among various organizations and integrated oral health with other health projects and issues? What are the traditional, non-traditional, public and private partnerships/collaborations established by the practice for integration, effectiveness, efficiency and sustainability?

The six partners (Swedish Medical Center, Seattle Special Care Dentistry, Project Access Northwest, Pacific Hospital Preservation and Development Authority, Seattle-King County Dental Society and the Seattle-King County Dental Foundation) also approached the Washington Dental Services Foundation (a non-profit funded by Delta Dental of Washington) to fund some of their equipment needs and supplies for the new oral surgery service at Swedish Community Specialty Clinic. The Washington Dental Service Foundation is committed to lasting approaches to improving the oral, and overall health, of people in Washington State, and provided approximately $200,000 in funding. Burkhart, a local dental supply company, helped with the build-out and provided significant discounts for dental equipment.

The Swedish Community Specialty Clinic's entry into the oral surgery specialty arena is the result of learning from the community about their needs and forging partnerships with many healthcare stakeholders in King County, WA. As part of its mission to serve the community, the Dental Society regularly meets with the dental directors of the King County FQHCs to discuss community needs and to facilitate open communication. Through the success of this program, there is now regular reporting to the Dental Society Access Committee (DSAC) along with monitoring of performance and outcomes. Many of the FQHCs send representatives to the DSAC meetings as well.

There are 27 FQHCs in the county which are operated by four organizations, the county public health department, and the Native American health clinic. The 'golden ticket' program was added after discussions at the DSAC about dental patients in the ED. A local FQHC, Neighborcare Health, that operates the closest dental clinic to the ED, volunteered as a pilot site for the "golden ticket' program.

Objectives/Rationale

How has the practice addressed HP 2020 objectives, met the National Call to Action to Promote Oral Health, and/or built basic infrastructure and capacity for state/territorial/community oral health programs?

- Reduce the proportion of adults with untreated dental decay
- Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
- Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers each