Policy Statement: Reducing Emergency Department Utilization for Non-Traumatic Dental Conditions
Association of State and Territorial Dental Directors
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Problem

A high level of untreated oral disease persists in the United States, for adults as well as for children.[1] According to data reported in 2015, 91 percent of adults aged 20-64 had a history of decayed, missing or filled teeth and 27% had untreated tooth decay.[2] According to National Health and Nutrition Examination Survey (NHANES) data for 2013-2016, Blacks or African Americans, and Mexican Americans ages 35–44 years experienced untreated tooth decay up to 1.75 times as much as white non-Hispanics.[3] In 2017, among adults ages 18 to 64, 60 percent of Blacks or African Americans, 54 percent of Hispanics, and 65 percent of whites reported having had a dental visit in the past year, according to the National Center for Health Statistics, National Health Interview Survey.[4]

The reasons for these inequalities in oral health and access to care are complex and related to other social determinants of health such as oral health literacy and economic disparities.[5] The misdistribution of dentists within communities can create barriers to care.[6] Other typical reported barriers were cost of dental treatment, distance to a provider and a lack of availability during normal business hours to see a dentist.[7,8,9]

Dental "insurance" is a misnomer because most plans have maximum benefits amounts in the range of $750 to $1500 per year. Beyond those benefits, patients are fully responsible for all costs of dental treatment and many are unable to afford comprehensive dental care. Older adults who may have had dental insurance while employed usually lose this benefit once they retire and may not continue regular dental visits. Medicare does not cover dental care, except in extenuating situations involving specific medical conditions.[10]

Seeking care in emergency departments (ED) for non-traumatic dental conditions (NTDCs) has increased substantially in recent years.[11] The American Dental Association (ADA) reports that dental ED visits increased from 1.1 million visits in year 2000 to 2.2 million visits in 2012.[12,13] Of those who presented for dental ED visits, 65 percent were covered by Medicaid or were uninsured.[14,15] Nationally, Hispanics and other minorities seek care in EDs more often than non-minority groups.[16]

The use of EDs for NTDCs is a poor use of resources. The average cost of a visit to the ED for dental problems is three times as much as a visit to a dentist.[17] EDs rarely have sufficient diagnostic equipment or staff with dental training to properly identify, diagnose and treat dental conditions.[18] In addition, definitive treatment, such as extractions, is generally not provided; the presenting condition is often ameliorated temporarily with a prescription for antibiotics and pain medication, often opioid analgesics; and the underlying condition is not definitively addressed. This can create a recurring situation where patients return for the same dental issue. An analysis of claims in Oregon suggests that of those who visit the ED for dental pain, 39 percent will return once the medications run out, and that 21 percent of those who had one ED dental visit in a year will return two to four more times.[19] ED physicians and midlevel providers are nearly three times as likely to prescribe an opioid for acute dental issues than are dentists.[20] The most frequently dispensed medications within three days after an ED dental visit were

opioid analgesics. They were associated with 56 percent of visits.[21] That these patterns contribute to the opioid epidemic in the U.S. seems inarguable.

Method

Developing quality referral programs for patients who present at EDs will help those who seek care to receive definitive dental treatment. Reports published in 2013 and 2016 by the American Dental Association's Health Policy Institute suggest that about three-quarters of dental ED visits could be diverted, depending on community resources and assessed urgency.[22,23] Unfortunately, there has been little published documentation of solutions to the problem of inappropriate use of EDs. Several programs described in ASTDD's 2015 Best Practice Approach Report, *Emergency Department Referral Programs for Non-traumatic Dental Conditions*[24] may offer useful models and lessons learned, while related reports and guidance on assessing ED data and research may be helpful in developing and assessing local initiatives.[25] There is some evidence that intervention programs are effective in reducing ED visits for NTDCs.[26,27,28] Although local programs may operate effectively, they have not widely shared or published their strategies or results; however, presentations at national meetings highlighting ways that communities are dealing with these issues have become more common.[29]

Creating and enhancing access to community health centers and exploring alternative workforce models that provide comprehensive primary dental care are essential strategies to reduce ED visits. Effective partnerships with dentists in the community are critical for success.[30] An example is a promising practice in Seattle, Washington, with Swedish Medical Center's "Golden Ticket" program, along with their Swedish Community Specialty Clinic (SCSC) and General Practice Residency (GPR) programs. When a person with a NTDC presents at the ED, they are given a referral sheet (the "golden ticket") by the ED physician. The "ticket" directs them to the closest federally qualified health center (FQHC), where they are prioritized in the next morning's walk-in emergency dental clinic. When urgent complex extractions are needed, the on-call GPR dentist at the ED or any of the local FQHCs/CHCs refer patients to SCSC, where definitive surgical care is provided by the GPR program. For emergency cases, care is rendered by the GPR dentist in the ED or the patient is taken to the operating room (OR). SCSC provides definitive specialty dental care at no cost to low-income uninsured and underinsured patients, funded in part by Swedish Medical Center (SMC). This three-part program has been successful in reducing return ED visits for dental issues. From 2010-2018, the program saw a 32% reduction in dental visits to the SMC ED. During that same period, all ED visits at SMC increased by 11%. While this result is encouraging, data collection is ongoing to determine how to further optimize this program.[31,32]

A program in Michigan implemented a "pay-it forward" approach with very favorable results. This program referred individuals from the ED to private practice dentists in the community who volunteered to provide dental treatment in their own offices. Individuals "paid" for treatment by providing community service to local nonprofit organizations. ED visits for dental pain decreased 72% over the five years it operated, and local hospitals saved more than $6 million over 4.5 years.[33] With the implementation in 2014 of the Healthy Michigan Plan (the state's Medicaid expansion plan), which offers a dental benefit, the majority of individuals participating in the program qualified for the health coverage that includes the dental benefit, and the local ED dental program ended.[34]

Another promising development is that with the increased prevalence of technology, virtual dental homes and the use of teledentistry are becoming more common. The convenience, cost-effectiveness, enhanced

care coordination and related support systems show teledentistry to have the potential to be an effective strategy in reducing and redirecting visits to EDs for NTDCs.[35,36,37,38]

Expansion of dental benefits for adults in Medicaid and Medicare is seen as a possible management strategy for ED visits for NTDCs. There is a strong link between receiving dental treatment and the reduction of systemic and chronic conditions such as cardiovascular disease, gastrointestinal and colorectal cancer, diabetes and insulin resistance, and Alzheimer's disease, as well as respiratory tract infections and adverse pregnancy outcomes.[39] For example, dental visits for periodontal treatment were associated with a better diabetes status.[40] By including dental benefits in Medicaid and Medicare, there is potential for substantial cost savings in the treatment of these diseases.[41]

Reducing the number of visits to EDs for NTDCs will require multiple strategies. Creating policy changes and additional dental benefits in public programs will require stakeholders including legislators and medical, dental, and public health professionals to explore the potential impacts of adult dental coverage on state and federal budgets and health outcomes. New workforce models can reduce barriers to oral healthcare by increasing access for those who are underserved and making it possible to decrease distance to a provider and wait-times.[42,43] Policy statements and guidelines related to opioid prescription practices, such as those developed by the American College of Emergency Physicians, can also have an impact on ED use for NTDCs.[44] The ADA has published extensively on this issue as well.[45]

Collaboration and effective promotion of federal-state-local partnerships are important investments in efforts to reduce inappropriate dental visits to EDs. The ADA has urged the U.S. Department of Health and Human Services' Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030 to include reducing the number of ED visits for dental pain as a new objective.[46] With this measurement, oral health professionals can analyze data, track success and lessons learned, and create sustainable programs that are designed to reduce ED visits. Partnerships involving state and local health departments, legislators, non-profit organizations, health and hospital systems, and oral health coalitions are crucial to solve this complex health issue by creating programs that encourage patients to seek dental treatment in appropriate dental settings where definitive treatment can be rendered, and facilitate the connections between patients and the care they need.[47]

In addition, ASTDD's Best Practice Approach Report, referenced above, notes the importance of collaborative processes involving a broad range of stakeholders to develop action plans, programs and policies to address oral health issues and inequities, including approaches to reduce NTDC visits to EDs. Stakeholders include local and state dental organizations, private dental practices, community dental public health programs, oral health coalitions, local and state public health departments, health and hospital systems, Medicaid programs, dental managed care organizations, and emergency physician associations. State oral health programs can play a central role in coordinating such efforts. Further, the report concludes:

> The development of ED referral programs should not only reduce the use of hospital EDs for NTDCs, but should also spawn more strategies for disease prevention and affordable care that will lead to quality oral health as the norm for all. The dental community cannot be expected to accomplish reductions in ED visits for NTDCs by itself, but must collaborate with multiple identified partners to address the determinants of oral health and implement successful interventions to prevent dental disease, mitigate its impact, and increase access to affordable, quality dental care.

Concluding Statement

The Association of State and Territorial Dental Directors (ASTDD) supports public-private partnerships and other initiatives that reduce the use of emergency departments for non-traumatic dental conditions and result in directing the greatest number of people to appropriate dental treatment care settings in a timely manner. State and territorial oral health programs can work within these partnerships to support program development, public and professional education, and evaluation.

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Note: links in the following endnotes were correct at the time of publication. If a link does not work, the website location or document name may have changed. Searching for the document by name may be an alternative way to find it.

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