Emergency Department Diversion for Patients Presenting with Dental Issues

Purpose: To redirect patients from the Emergency Department to appropriate care for dental issues as well as to partners with community support services who can assist patients with drug seeking behaviors. This model is operational with hospital-based dental clinics and through community partnerships.

Core Clinical and Programmatic Components

- **Leadership:** Administrative leadership, emergency department (ED) and dental clinicians, triage nurses and local Community Service Board representative (case managers, as appropriate).
- **Education:** Triage and call nurses receive oral health education (as well as an emergency flow chart) so that they can diagnose a true dental emergency and direct patients to the correct location for treatment. All staff will receive uniform education of integrated oral health, why integration matters, proposed workflow for care delivery and diversion, baseline data measures and desired outcomes.
- **Patient Population:** Patients presenting to ED for dental complaints.
- **Health Care Services:** A direct referral will be made from the ED to a community dental clinic via a scheduling system. ED blocks will be provided so that ED staff will know exactly where to schedule patients. Blocks will be made in community dental clinics for ED patients so that all patients will be seen at a neighboring dental clinic no more than 12-24 hours after arrival to ED. Unified protocol to assure that patient referrals are followed up on. If pain medication is given, it will be limited to treat symptoms until their scheduled dental appointment (12-24 hours) making patients more likely to keep their dental appointment and less dependent on the narcotic. Community dental providers and ED physicians will collaborate on treatment plans/prescriptions.
- **Communication and Information Sharing:** If no scheduling system is available, appointment cards with set date/time will be provided to ED patients; additional referral method may include use of a community health worker, nurse or other staff to make a direct referral and warm hand-off to the dental clinic to help patients keep their appointments and reduce no-shows.
- **Measures and Assessment**: ICD-10 codes will be used to report both baseline and changes in volume of dental-related ED visits.
- **Infrastructure:** Create a data infrastructure to collect and share patient health information. Ensure appropriate staff and personnel and/or additional education are in place to support referral management and follow-up for ED patients.
- **Financing:** Adults will be offered dental care on sliding fee scale (Medicaid covers extractions and exam).
- **Community Supports:** Identify community supports to ensure that all avoidable dental emergency room visits are prevented via established referral networks.

Key Background Information

- In 2009, dental conditions were responsible for an estimated 830,590 visits to the ER nationwide, which was nearly a 16% increase from 2006.[17]
- Emergency room visits for dental problems doubled between 2000 and 2010, from a reported 1 million cases of mostly adults in 1999-2000, and 2.3 million cases in 2009-10.[18]
- The average cost of these visits is $669, yet no dental treatment is provided; patients presenting at hospital EDs for dental pain are only provided pain medications and antibiotics.
- Between 2007-2009, VCU medical center's emergency department reported that over 4% ED visits were attributable to dental issues.

This document was adapted from care models created through grant funding awarded to Virginia Center for Health Innovation from the Centers for Medicare & Medicaid Services. Citations available upon request: info@vaoralhealth.org.