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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Emergency Department Clinicians Respond to Unmet Dental Needs?

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Abstract

The division between medical and dental care exacerbates health inequity and forces many with compromised access to seek oral health care in emergency departments (EDs). Since dentists are best positioned to offer quality care for most patients' oral health problems, this commentary on a case suggests why ED clinicians should offer appropriate oral health referrals and resources to those they serve and why all health professionals should advocate for systems-level policy and organizational changes to increase patients' access to oral health care.

Case

Dr M is working a shift in an emergency department (ED) when Dr M meets Ms O, who presents with stable vital signs but severe oral pain she describes as a recurrent toothache. Dr M notes this ED visit is Ms O's third during the past month for this problem and confirms, upon examination, this patient's extensive tooth decay. Dr M prescribes an antibiotic and urges Ms O to visit a dentist as soon as possible. Ms O starts to cry and states, "I can't afford to see a dentist, that's why I'm here."

Commentary

Access to the health care system is often influenced by social determinants of health, such as poverty, insurance status, race, and ethnicity,[1,2,3,4] because of historically exclusionary and discriminatory practices.[5] The divide between medical and dental care exacerbates inequity in access to care.[6] Bridging this gap between medicine and dentistry is an imperative step to creating a more equitable health care system. One critical location for the development of strategies to bridge this gap is the emergency department (ED), which serves as the safety net of the health care system and often as the primary source of care for vulnerable patient populations.[7]

Ms O presented with 3 ED visits in 1 month without receiving definitive care at any visit and experienced a clear clinical deterioration in her oral health due to delayed dental care. In addition to experiencing personal harm, patients presenting to the ED with dental needs are costly for the system.[8,9] The number of patients like Ms O who lack access to dental care is increasing.[10] Often, these patients are discharged with antibiotics or a palliative care plan without receiving definitive treatment for the root

cause of the oral discomfort,[11] which is most likely why Ms O returned to the ED 3 times in 1 month for the same pain. A possible reason for discharge without definitive treatment is inability to provide the definitive dental procedure within the ED (eg, extraction or cavity filling).[3]

Delayed dental care has ramifications for mental and physical health. Poor oral health is associated with diminished self-confidence and self-control[12]; long-term comorbidities, such as cardiovascular disease, respiratory disease, and diabetes mellitus[13]; and acute infections, such as increased risk of bacteremia and infectious endocarditis.[6,14] Moreover, treating the symptoms of infection and pain instead of treating the underlying problem increases the risk of worsening antimicrobial resistance and overprescribing addictive pain medications. For these sequalae and more, bridging the medical-dental divide to eliminate delayed delivery of dental care is essential and begins with appropriate referrals from the ED and concurrent advocacy to improve policies that will have positive, long-term impact.

Ethical Responsibilities

The ethical dilemma for Dr M is how much dental care and longitudinal follow-up are within the scope of her responsibility as a physician. Dr M most likely does not have the clinical training to provide definitive oral care but nonetheless can help Ms O by following the 4 principles of medical ethics—respect for autonomy, nonmaleficence, beneficence, and justice—in addressing this ethical dilemma.[15] *Respect for autonomy* requires that Ms O be provided the information needed to make an informed decision and to do so by her own will. *Nonmaleficence* and *beneficence* highlight the need to do no harm and actively to do good. *Justice* demands equitable treatment regardless of other factors, which is a vital tenet when factors such as insurance status affect access to care. Justice also obligates Dr M to help improve the system of care for patients like Ms O. Dr M has 2 primary ethical responsibilities toward patients:

1. To care for the patient in the moment.
2. To provide appropriate follow-up referral or care.

Overall, Dr M's care plan for Ms O should ensure that her pain and infection are appropriately treated and that a clear plan is in place to address both current and future tooth decay or to avoid infection. Dr M should investigate the options available to Ms O to access public dental insurance or local dental clinics. Collaborating with a social worker or case manager, if available, might provide Dr M with expert advice on programs for which Ms O is eligible. Depending on the resources of Dr M's ED, a dentist could see Ms O in the ED as well.

Dr M has these same obligations to any other patient with an acute medical need in the ED. However, because dental insurance is not standardly included as part of medical insurance[16,17] and limited (or no) coverage is included in most public insurance plans,[16] accessing dental care is often more challenging than accessing other forms of routine medical care. As a result, patients like Ms O are forced to turn to EDs that often lack dental staffing and are limited to treating pain or acute infection and to providing referrals to area free clinics and dental schools. Because of dental care's specific insurance challenges, ED clinicians must be educated on community resources for the provision of dental care to patients without insurance.

Vulnerable Populations

It has been estimated that atraumatic dental pain is responsible for 1.8% of all ED visits at a cost of upwards of $2.4 billion annually.[18] High users of the ED for oral health care are more likely to identify as non-Hispanic Black and be young adults (19-34 years old) than low users (3 or less ED visits within 2 years).[1] Patients who are medically uninsured[1,2] or have public medical insurance[3,4] are also more likely to use the ED for dental complaints, along with patients experiencing homelessness.[4] As of 2018, the dental uninsured rate was estimated to be 2.5 times higher than the medical uninsured rate.[6] Given that 93% of Americans with private dental coverage in 2018 had dental insurance through their employer or other group program[17] and that the COVID-19 pandemic might drive unemployment rates higher, the number of patients without dental insurance is likely to rise.

Expanding public insurance to include dental care could decrease barriers to visiting the dentist for atraumatic dental pain and routine dental care.[3] Ideally, dental practices would accept every patient who presents for care regardless of insurance. Financially incentivizing dental practices to accept both private and public insurance and implementing an accountability system to guarantee that practices accept adequate numbers of publicly insured patients are essential steps to ensure that increased insurance coverage translates into increased access. However, expanding dental insurance coverage is necessary but not sufficient to reduce disparities in oral health[19] because social determinants of health, such as transportation,[20] food insecurity,[21] income,[22] and education,[19] also play a significant role in patients' access to quality dental care. Additionally, people might underutilize dental care because of mistrust, unfamiliarity with dentistry, or inability to take time off work during the day.[20]

Planning for Ms O's follow-up dental care within the current system will take time and resources while Ms O is in the ED. Ideally, Ms O would be linked with an outpatient dental clinician who can assess her acutely and then follow her longitudinally. It has been shown that patients with fair-to-poor oral health status can have more misconceptions about oral health and lower dental literacy than other groups.[23] Physicians and dentists can encourage manageable habits, such as flossing, brushing, dietary changes, and use of fluoridated water and regular dental appointments, to help prevent additional oral health deterioration. It is critically important for clinicians to recognize social factors that may make it challenging for patients to follow advice (eg, food insecurity that makes dietary changes impossible or limited hours of dental clinics).

Assisting With Access to Care

Dr M could use this patient story and others like it to advocate for the expansion of hospital facilities and resource navigational systems. One potential institutional improvement would be a staffed dental clinic within the hospital that would accept patients from the ED when they present with atraumatic dental pain. This arrangement would allow for immediate and appropriate dental care. While the patient is receiving care in the hospital's dental clinic, a social worker, case manager, or community health worker could connect the patient with a free clinic or, if the patient has insurance, with a community-based dentist who would accept the patient's insurance. Familiarizing patients with dental care through the hospital clinic dentists, in addition to the warm hand off, might improve follow-up rates and ensure that patients receive rapid access to definitive care. Such a clinic was opened in a hospital in Maine and staffed by a dental hygienist for patients presenting to the ED with a dental need.[24] If the patient required higher-level care from a dentist, the clinic connected the patient to a local dental office willing to take the patient.

If a clinic like this is not feasible, the ED could partner with community dental practice that would provide acute care for patients presenting to the ED with dental caries or cavities. A few such partnerships exist. For example, in Detroit, the VINA Community Dental Center accepts patients with dental needs referred from local EDs, and about half of the patients referred acutely from the ED were followed longitudinally by dentists at the clinic.[25]

While working to implement the aforementioned institutional changes, the ED could build a database of resources to help physicians develop knowledge of community-based options for patients, especially if social workers or case managers are unavailable. In particular, helping patients understand how to access these resources and what they need to demonstrate eligibility (eg, necessary form of identification, referral paperwork) would streamline follow-up care.

For example, when a patient sprains an ankle, the ED physician could refer the patient to a sports medicine clinic they frequently work with. Cultivating and reinforcing similar connections with dental practices would not only allow for better care for the patient, but also streamline the referral process. Setting these expectations for quality clinical care as early as medical school would yield new generations of doctors and dentists who view medical and dental care as cohesive forces that should work together.

Conclusion

Dr M and Ms O's clinical scenario is an unfortunate reality that many clinicians and patients experience. Ms O was repeatedly failed by a fragmented system that perpetuates an existing gap between medicine and dentistry. This gap harms patients' physical and psychological health and is costly for the system. With immediate understanding of community resources, Dr M could guide Ms O to quality dental care when she initially presents to the ED; and with long-term advocacy for improved dental coverage and care, Dr M could help improve the current system to prevent future patients from experiencing what Ms O did.

Major institutional adjustments, such as opening dental clinics within hospitals, would provide the most seamless bridge to integration but would face significant limitations within the current insurance structure. Expanding dental insurance coverage and building relationships between EDs and community dentists are crucial steps to integration as well. Ensuring that enough quality dental clinics committed to accepting public insurance exist in areas where they are needed most is a necessary supplement to coverage expansion that would effectively reduce barriers to care. Addressing broader social determinants of health, such as income and education disparities, will also improve oral health outcomes.

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Editor's Note

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