

Aged Out and Lost! Establishing a Dental Home for Adults with Special Healthcare Needs



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BACKGROUND

Patients with special healthcare needs (SHCN) have chronic physical, behavioral, and developmental conditions that require health services that are beyond what is generally required in general dental practices¹⁻³. Patients with special healthcare needs (SHCN) because of significant disabilities face multiple hurdles transitioning from pediatric dental care.²⁻³

- Finding providers to provide services to adults
- Navigating health transitions without the integrated care teams seen in pediatric care settings
- Patients age into majority and become responsible for healthcare decisions

Without a transition pathway, challenges seeking care quickly escalate, leading patients to withdraw from receiving regular dental care.⁴

OBJECTIVE: This project aimed to evaluate the existing processes and identify potential improvements to support the transition of patients aging out of the Children's Hospital Colorado (CHCO) Pediatric Dental Clinic to the Senior & Special Care Clinic (SSCC) at the CU School of Dental Medicine.

METHODS

A working committee was established to review existing processes for new patients transferring from Children's Hospital of Colorado. Patients were identified by the screening code D0190 completed in Axium from Jan 2020 to June 2024. The chart review identified a significant number of patients becoming lost to follow up. Multiple reasons were identified:

- Limited scheduling window of 28 days put the onus on the patient/caregiver to call and schedule 3-6 months after their visit.
- Patients/caregivers were unaware of the need for certain documents (guardianship paperwork) and were rescheduled due to lack of an identified responsible to consent for treatment.
- Transferring patients were sent to either the SSCC- or GPR-based upon suggestive sedation needs in the transferring documents.

The working committee reconvened after initial data review to develop several strategies to implement to improve patient transfer from CHCO Pediatric Dental Clinic. Several of these strategies are operationalized in Figure 1.

Charts were reviewed for new patients seen in the SSCC between January 2024 through August 2024 to assess the feasibility of the initial implementation process.

RESULTS

Based upon the initial review, the working committee identified the following gaps.

- Limited scheduling window of 28 days put the onus on the patient/caregiver to call and schedule 3-6 months after their visit.
- Patients/caregivers were unaware of the need for certain documents (guardianship paperwork) and were rescheduled due to lack of an identified responsible to consent for treatment.
- Transferring patients were sent to either the SSCC or GPR based upon suggestive sedation needs in the transferring documents.

Based upon these results, the development of new processes and the establishment of key personnel were identified and implemented, which included the following:

- A dedicated patient navigator
- Procurement of necessary medical/ dental/financial/responsible party information prior to initial appointment
- Expand ability to schedule > 28 days
- Schedule next appointment prior to patient dismissal
- Specialized referral form to include medical/dental/behavioral history

After receipt of the referral, the patient navigator reviews provided documents, contacts CHCO to procure additional information, if needed, and contacts the patient to schedule.

Following implementation of new processes, there was:

- **78.3%** (n=18) increase in patient retention,
- **91.3%** (n=21) increase in obtaining medical/dental & responsible party information pre-appointment,
- **91.3%** (n=21) increase in patients scheduled for next appointment prior to dismissal

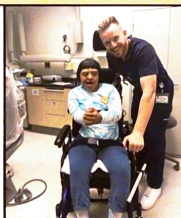
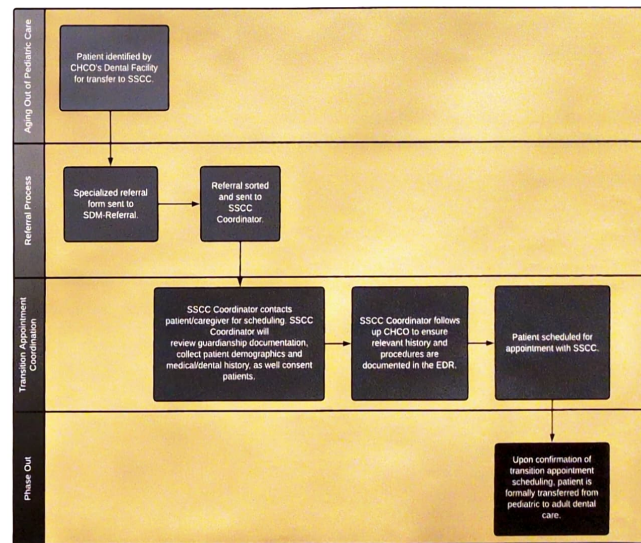


Figure 1. Stages of the Pediatric to Adult Dental Care Transition Process



CONCLUSIONS

- A streamlined process for transitioning patients with SHCN out of pediatric dental care has strengthened the transfer process.
- This framework can be expanded to other institutions, reducing the burden on patients transitioning to adult care.
- Gaps were identified in routine follow-up post-OR visits.
- New processes are in development to establish a permanent dental home within SSCC, avoiding reliance on OR-associated lists for ongoing care.

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