

Private Linkages to Provide Dental Care: A Model

In the early 1970's, the system of institutionalization of the developmentally disabled population in New York State was exposed for what it was: a repugnant and shameful warehousing of incredible proportions where dignity of the individual was unknown.

As the status quo was called into question, a number of private agencies such as United Cerebral Palsy Associations, the ARCs and others were approached by New York State to aid in the process of deinstitutionalization. The intent of this movement was to mainstream those who were formerly kept in large institutions by placing them into community residences (CR) where the residents could take advantage of habilitation programs in centralized locations, learn useful skills and regain some measure of meaning in their lives. Dental and other services were to have been provided by community resources; ie, private practices or clinics, with the payor, in most cases, Medicaid.

The drawback was that many private practices were unwilling or unable to fill the breach in providing the scope of services needed.

Urban areas or areas with access to hospital clinics or teaching facilities with special needs clinics fared somewhat better than rural or outlying areas where no such support existed. In these latter areas, patients were forced to travel sometimes considerable distances, do without care, use local hospitals for emergency care or utilize such care as might be available in local practices.

This was the state of affairs in Putnam County, New York, a rural area 75 miles north of New York City. Because of its rural location and the siting of a number of campuses in the vicinity that were operated by the New York State Office of the Mentally Retarded and Developmentally Disabled, the effect of deinstitutionalization caused hundreds to be placed in CRs in the Hudson Valley region. The dental support infrastructure was hopelessly inadequate to meet the demand. Although the Dental Services of the local hospitals provided a substantial amount of care, the demand far out paced their ability to provide what was needed. Local private practices, where care was given, contributed emergency care and not much else.

The net result was that access to dental care for the developmentally disabled was minimal: limited locations for care provided limited services. Continuity of care was virtually nonexistent. The need to match special care providers with special care patients was urgently needed but no source existed.

To remedy this situation, the solution that evolved forms the basis of this presentation. A private sector linkage, a partnership, was forged between a sponsoring human services agency and a local practitioner to construct the mechanism which connected the special needs population with the special care provider.

Hudson Valley Community Services, a division of the United Cerebral Palsy Associations of New York State, Inc., had been granted a certificate by the New York State Department of Health to operate an Article 28 Diagnostic and Treatment Center in the town of Patterson, New York in Putnam County.

Having had ten years experience treating hundreds of special needs patients in my private practice but reaching the limit of what my practice could provide with a still greater demand in the community at large, Hudson Valley Community Services approached me with a request to assist in founding a service charged with the mission of delivering quality dental care to the developmentally disabled in the Putnam County area as well as to the neighboring areas of

Dutchess and Westchester Counties. Besides direct care, the dental service was to be a consultation and education resource for the region and, where necessary, to coordinate dental care with other health care providers.

Now, with this collaboration, patients no longer need to rely on the haphazard patchwork of multiple disconnected providers delivering virtually random "generic" dental services but now have access to a systematic method of care that combines the best aspects of the private practice delivery system by scheduling individual appointments; assuring continuity of care by having the patient see the same provider who has developed a comprehensive treatment plan within a system that is, from its very inception, oriented to meeting the needs of the special care population.

In 1992, with funding finally available to begin this endeavor, the Dental Department of Hudson Valley Community Services, a Division of United Cerebral Palsy Associations of New York State, Inc. Was established.

Initially, the clinic operated three half days a week with one dentist, one dental assistant-manager and one operatory until the growth of demand drove the facility's hours of operation to full-time with need to add a hygienist and an appointments clerk. A second operatory was built and a third is being planned. A satellite clinic with a part-time dentist and assistant was located on the campus of Green Chimneys Children's Services, a residential treatment facility for emotionally disturbed children. A local practitioner agreed to provide orthodontic care. At both sites, specialty services are provided by the staff dentists, as far as they are able, or through referral to the Dental Department of Westchester County Medical Center, Blythedale Children's Hospital or Danbury Hospital. Over 1,400 patients are being seen with 25 to 40 new patients per month enrolling for care.

The local dental society has become involved providing some financial support as well as donations of equipment and supplies.

Over the past two years, this model has proved successful enough to be exported to three additional locations in New York State. The need to provide dental care for special needs patients was just as pressing in other rural and under served areas in New York State as it was in Putnam County. Through the network of information exchange that existed in the statewide United Cerebral Palsy Associations structure, the success of the Putnam County model became known. Rather than reinventing the wheel, the Dental Service at Hudson Valley Community Services became the prototype for dental clinics in Rockland County (Jawonio United Cerebral Palsy Association), Sullivan County Diagnostic Treatment Center (Sullivan County UCP) and the United Cerebral Palsy and Handicapped Persons Association of Utica. In each case, a community dentist was approached and asked to take the lead in organizing a dental service for the parent association which provided the funding, space and infrastructure. The community dentist/dental director went about recruiting staff, arranging the design and layout of the dental facility, bidding out the equipment and supply needs, setting up the specialist support that would be needed and in general turning the concept into a reality.

The growth patterns in each facility (except Sullivan County which is still in development) were similar; that is, part time operation in the early stages expanding to full-time as the demand grew. As the mission of providing care for the developmentally disabled was met, the patient base was expanded to try to meet the needs of the Medicaid population at large within the community. Each of these units is serving a multi-county area. In April, at the time the abstract for this paper was written, approximately 2,000 patients were being treated at these three sties.

Today, the number is approaching 2,300 and fourth site is in development. The linkage of the private practitioner to a sponsoring agency has a proven track record.

There is a match of a skilled special care practitioner with the special needs population. In the works of Dr. Phillip Ziring, "generic care" is now replaced by care specifically designed to meet their special requirements.

Continuity of care is assured by creation of a dedicated site instead of a widespread patchwork of individual practices.

Coherent access to specialists within the context of a treatment plan is provided for as well as access to specialty services like general anesthesia, sedation and hospitalization.

The system is not tied to the typically urban location of a teaching facility but is readily exportable to suburban, rural and outlying areas. Where one doesn't have a training program or hospital based program handily nearby, one can now look to community resources for solutions. There may be an advantage in something other than a student or resident based provider system in that productivity and continuity of care are enhanced.

The community linkages model may provide an advantage over mobile van care in that there is a fixed site with regular, predictable hours providing a means for emergency care and with routine and speciality needs more easily accessed.

Community practitioner/directors are locally based and may be in a better position to seek out solutions by tapping into community resources as well as providing continuity to balance the inevitable turnover of staff.

Finally, this system provides anew cadre of advocates for the special needs population.

On the other hand, there is no doubt that the community based modality does not satisfy all needs and has its own limitations.

There is an absolute requirement that the state must have some provision for dental benefits in its Medicaid program in order for a system such as this to operate.

There is a need for a sponsoring agency to provide funding and a site for a dental service and that agency must be interested in and committed to the provision of dental care.

Staffing may be problematic in remote areas.

This model is clearly not a universal solution but is one more alternative to be considered by those interested in caring for special needs patients or an indigent/Medicaid population.