Special Care Dental Association

“Special Care Dentistry is that branch of dentistry that provides oral care services for people with physical, medical, developmental, or cognitive conditions which limit their ability to receive routine dental care.”
Dental care is the most prevalent *unmet* health need among children with special health care needs.*

A Perfect Storm

- People with special needs
- Psychosocial issues
- Financial constraints, Medicaid cuts
- Cultural challenges
- Lack of training on the part of CHC dental professionals
- Insufficient ROI for treating special needs patients

**Adds up to almost insurmountable barriers to accessing dental care**
So you’re going to be a dentist...

Sometimes I feel that I have the worst job in the world!

Ya...right!
Home is the place where, when you have to go there, they have to take you in.

-Robert Frost-
The Health Home

- Medical Home
- Dental Home
- Social Services
Patient-Centered Medical Home

- Enhanced access to care
- An ongoing relationship with a personal physician
- Whole-person orientation
- A team approach to care
- Coordinated and integrated care
- Commitment to quality and safety.

Remains a work in progress!
The Dental Home

The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate. (Lewis, 2005)
Obstacles

- Reimbursement
- Liability
- Staffing
- Resources
- Lack of dental insurance
- Care coordination model very uncommon in dentistry
- Fear/denial
- Dental culture
- Turf wars
- Educational priorities
- Funding priorities
Dental Case Manager

- Oral health is a priority
- Oral case managers do not conduct comprehensive psychosocial or health assessments
- They do not develop, implement or monitor dental treatment plans
- Can serve a high volume of patients (150-300)
- Patient education, tracking, retention functions result in a reduced no-show rate, position becomes cost effective
**IDP**

- **IEP** - Individualized Education Plan
- **IHP** - Emerging concept in the medical home
- **IDP** - Treatment plan on steroids
- **Formalized long term care plan (Palfrey, 2004)**
IDP

• Emergency treatment
• Preventive program
• Initial treatment
• Future maintenance
Do you have behavioral health specialists?

- **Yes**: 92%
- **No**: 8%
Do you have access to medical records?

Q12

yes 80%

no 20%
“In 1999, 53% of dental schools reported fewer than 5 hours of didactic training in special-care dentistry. Clinical instruction in this area constituted only 0-5% of a predoctoral student’s time. . .”

Dental Education

“The number of dental schools with SPC clinics has not significantly increased in the last decade. Forty percent of the respondent institutions in our survey had designated SPC clinics (compared to 38% in 1999).”

People with special needs........

Come in all shapes and sizes
Developmental Disability
What is a developmental disability?

Impairment(s) in physical or mental abilities that are manifested before 22 years of age, are likely to persist indefinitely, and result in functional limitations in major life activities.*

*The Federal Developmental Disabilities Assistance and Bill of Rights Act Amendments of 1987
Intellectual Disability
What is an intellectual disability?

“Intellectual disability is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.”

www.aaidd.org
Etiologies for ID

- Metabolic disorders
- Neurodegenerative disorders
- Perinatal/postnatal conditions
  - Extreme premature birth
  - Intraventricular hemorrhage
  - Hypoxic-ischemic encephalopathy
  - Traumatic brain injury
  - Meningitis
Etiologies for ID

- Genetic disorders
  - Over 800 syndromes listed in the Online Mendelian Inheritance in Man (OMM) database are associated with ID
- Intrauterine exposure to toxins
  - Fetal alcohol syndrome
  - Some anticonvulsant medications
- Intrauterine infections
  - Congenital cytomegalovirus
  - Congenital rubella
  - Congenital toxoplasmosis
Cognitive functioning refers to IQ levels, with an IQ below 70 indicating an intellectual disability.
Mortality/Morbidity

- Many individuals with ID experience a decreased lifespan due to the underlying etiology for the ID
- ID itself is not associated with a shortened lifespan
- Higher rate of seizure disorders than general public (as high as 20%)
- GI complications including feeding dysfunction, gastroesophageal reflux (GERD)
- Respiratory disease is the most prevalent cause of death in individuals with profound ID
Adaptive skills refer to functional life skills within the following domains:

- Communication
- Self-care
- Home living
- Social & interpersonal skills
- Work
- Use of community resources
- Health & safety
Some genetic disorders have inherent oral manifestations

**Trisomy 21**
*(Down Syndrome)*

- Maxillary hypoplasia (frequently resulting in crowding and/or impactions)
- Class III malocclusion
- Anomalies in tooth number and morphology
- Increased incidence of periodontal disease
- Macroglossia
Trisomy 21 – Physical / Developmental Findings

- Short stature, obesity.
- CNS: Generally moderate to severe mental retardation (mean IQ is about 50).
- Congenital heart defects seen in 40-50% of individuals.
- Impaired immunity; specifically, impaired neutrophil function.
- Hypothyroidism in 16-20% of individuals.
- Atlanto-axial (cervical spine) instability in 14%.
- Airway anomalies are common.
Before the initial oral exam

- Determine if the patient is considered competent to understand informed consent and make decisions concerning dental care
- If not, who is the patient’s legal guardian?
- Thorough medical history, including list of current medications
- If the patient has had past dental experiences, were these positive or negative?
- Has the patient ever required sedation or general anesthesia for dental procedures?
- Does the patient perform his/her own oral hygiene tasks, or are these done with the assistance of a caregiver?
Oral Habits

- Bruxism

- Self-injurious behaviors

- Seen more frequently in individuals with low cognitive function and sensory impairments.
Cerebral Palsy
What is cerebral palsy?

- Cerebral palsy (CP) is a chronic disorder of movement or coordination, caused by injury to the immature brain during the prenatal or perinatal period.

- CP is a *static encephalopathy*; that is, the original brain lesion does not progress or enlarge.


Neuromuscular disorders
(cerebral palsy, muscular dystrophy)

- Malocclusions (anterior open bite, constricted maxilla) secondary to hypotonia
- Persistent drooling (sialorrhea)
- Airway compromise
CP can be classified according to the type of movement disorder involved:

- **Spastic** (70-80%): characterized by increased muscle tone, tightness, stiff, jerky movements
- **Dyskinetic or athetoid** (10-15%): Low muscle tone, loose, uncontrolled body movement
- **Ataxic** (<5%): Affects balance and depth perception
Incidence of CP

- The most common cause of childhood disability in the developed world
- Incidence: 1.7-2.0/1,000 live births
- 12.6/1,000 in twins, 44.8/1,000 in triplets
- About 10,000 infants a year who are born in the U.S. develop CP (CDC 2003)
- According to UCP statistics, the incidence in the U.S. has increased 25% in the last decade
Risk Factors (prenatal)

- Intrauterine infections
- Maternal exposure to toxic or teratogenic agents
- Maternal abdominal trauma
- Multiple births
Risk Factors (neonatal)

- Premature birth (<32 weeks)
- Low birth weight (<2500g)
- Intracranial hemorrhage
- Hypoxia and/or bradycardia
- Infection
- Trauma
- Hyperbilirubinemia
- Seizures
Associated disorders seen in individuals with CP

- Intellectual disability
  - 1/3 have mild impairment; 1/3 moderate to severe impairment
- Seizures (approx 50%)
- Vision and hearing impairment
- Speech impairment
- Dysphagia
- Failure to thrive
- Hip dislocation
- Spinal deformities (scoliosis, kyphosis)
Oral & dental findings associated with CP

- Malocclusions
- Enamel defects
- Increased incidence of dental trauma
- Bruxism
- Sialorrhea (drooling)
Malocclusions, especially anterior open bite and posterior crossbites, are secondary to hypotonia of oral-facial musculature and subsequent poor development of palatal shelves.
Dysphagia

Many individuals with neuromuscular disorders that involve the oral/pharyngeal muscles develop dysphagia (altered swallow reflexes) or aphagia (an inability to swallow).
Any individual with dysphagia is at risk for developing aspiration pneumonia. Use of a rubber dam and diligent high speed suction are a must when providing treatment to these patients.

Some individuals with dysphagia or aphagia may receive nutrition via a gastric tube. Although these patients are obviously not at risk for developing dental caries, a side effect of pooling saliva can be extensive calculus deposits throughout the dentition.
These calculus deposits are typical of those that may be seen in a patient who receives nutrition via a gastric tube. In the posterior dentition, the calculus may completely cover all surfaces of the teeth.
Seizure disorders

- Gingival hyperplasia
- Xerostomia secondary to medications
What is a seizure?

- A manifestation of excessive electrical discharges from a population of cortical neurons
- A *clinical seizure* is one in which there are subjective symptoms or objective signs
- An *electrographic seizure* is one in which the discharge is evident only on an electroencephalogram (EEG)
What is Epilepsy?

- A tendency toward recurrent (at least 2) seizures that are unprovoked by a systemic insult
- Derived from the Greek word “epilambanein,” which means “to be seized”
- Seizures that are provoked by a demonstrable systemic insult, such as metabolic imbalance, central nervous system neoplasm or cerebral hemorrhage, are not considered to be epilepsy
Epidemiology of Epilepsy

- Has no geographical, social or racial boundaries
- No gender predilection
- Most frequently diagnosed in infancy, childhood, adolescence and old age
- Up to 5% of the world’s population may have a single seizure at some time in their lives
Prevalence of Epilepsy

- Prevalence is defined as the total number of existing cases of a disease in a specific population at a specific point in time.
- Prevalence of active epilepsy in the U.S. is currently estimated to be 2.7 million.
- 326,000 school-age children have epilepsy.
- 570,000 individuals over age 65 have epilepsy.
Incidence of Epilepsy

- Incidence is defined as the number of new cases of a medical condition that occur in a population during a measure time period.
- 300,000 people in the U.S. have a first seizure each year.
- 200,000 new cases of epilepsy are diagnosed in the U.S. each year.
- Most of these cases are in children under 2 years of age and adults over 65 years.
Epilepsy Risk

- Certain populations are at higher risk of developing epilepsy:
  - Children with intellectual disability (10%)
  - Children with cerebral palsy (10%)
  - Children with both of the above disabilities (50%)
  - Adults with Alzheimer’s Disease (10%)
  - Stroke patients (22%)
<table>
<thead>
<tr>
<th>Commonly used antiepileptic drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felbamate</td>
</tr>
<tr>
<td>Gabapentin</td>
</tr>
<tr>
<td>Lamotrigine</td>
</tr>
<tr>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Phenytoin</td>
</tr>
<tr>
<td>Phenobarbital</td>
</tr>
<tr>
<td>Topiramate</td>
</tr>
<tr>
<td>Valproate</td>
</tr>
<tr>
<td>Zonisamide</td>
</tr>
</tbody>
</table>
Gingival hyperplasia – seen in 25-50% of patients on phenytoin

Hepatotoxicity – associated with phenobarbital, dilantin, valproate

Sedation – all commonly used seizure meds

Other side effects include: rashes, stomach upset, headache, blood dyscrasias, teratogenic effects
Dental Considerations

- Patients with tonic-clonic & atonic seizures are at increased risk for oral trauma
- For patients on Dilantin, watch for gingival hyperplasia in first few months on medication
- Carbamazepine can cause xerostomia & stomatitis
- Valproate can cause bone marrow suppression
  - Impaired wound healing
  - Decreased platelet function
Dental Considerations

What can precipitate seizures in the dental office?

- Even patients who are compliant with medication can have breakthrough seizures.
- Can be precipitated by fatigue, hypoglycemia, physical or emotional stress, pain, hypoxia secondary to vasovagal syncope.
- Intravascular injection of local anesthetic can induce seizure.
Dental Considerations
Drug Interactions

- Some drugs prescribed by dentists can jeopardize seizure control because they interact with antiepileptics
  - Aspirin: Can increase serum valproate concentration; valproate toxicity
  - Fluconazole: Increases plasma concentration of phenytoin
  - Clarithromycin: Increases plasma concentration of carbamazepine
Seizure First Aid

- Clear all instruments away from patient
- Place dental chair in supine position as close to floor as possible
- Place patient on his/her side to minimize chance of aspiration of secretions
- Do not restrain patient
- Do not put anything in patient’s mouth
- Time the seizure
- Call 911 if patient becomes cyanotic at onset or if seizure lasts more than 3 minutes
- Can administer oxygen at rate of 6-8L/minute
When seizure is over

- No further dental treatment that day
- Talk to the patient to evaluate level of consciousness
- Do not allow patient to leave office if the level of awareness not fully restored
- If patient is alone, contact patient’s family
- Brief oral examination to determine if any injuries have occurred
- Depending on post-ictal state, discharge patient home with a responsible person or to an emergency room for further assessment
Long-term medication regimens

- High sugar content of liquid medications
- Reduced salivary flow 2º to psychotropic and anti-seizure medications
- Gingival hyperplasia 2º to dilantin and calcium channel blockers
Increased risk for dental trauma

- Can be secondary to poor muscle control (awkward gait), increased incidence of seizures, malocclusions
Autism
What is Autism?

- **Diagnosis is behaviorally based**
  - No specific genetic, medical or laboratory tests are diagnostic

- **Autism is a spectrum disorder**
  - Individuals can present with a wide variety of behavioral characteristics, ranging from mild to very severe involvement
What is Autism?

The Autistic Spectrum Disorders (ASD), aka Pervasive Developmental Disorders (PDD) are characterized by deficits in 3 major areas:

- Social interaction/relatedness
- Verbal/nonverbal communication
- Restricted interests, repetitive/stereotyped behaviors, resistance to change
Autistic Spectrum Disorders: Classification (DSM IV)

- Childhood Autism or Autistic Disorder
- Asperger Disorder
- Pervasive Developmental disorder, NOS
- Rett Syndrome
- Childhood Disintegrative Disorder
Prevalence of Autism

- In 2000, the CDC reported a prevalence of 4.5-9.9/1,000 in the U.S.
- U.S. Department of Education estimates that the diagnosis of autism is growing at a rate of 10-17% per year
- Worldwide prevalence of autism is consistent, but is 4x more prevalent in males compared to females.
There is no known single cause of autism. Current research is focusing on factors that could influence development of the embryonic brain. The actual etiologies may very well be multi-factorial:

- Genetic?
- Environmental?
- Viral?
Genetic disorders associated with autistic behaviors

- Fragile X
- Rett Syndrome
- Tuberous sclerosis
- Prader-Willi Syndrome
- Angelman Syndrome
- Various deletion, translocation and duplication syndromes
There are no medical tests for autism. The diagnosis is based on observation, and requires that the patient exhibit abnormal behavior in 3 categories:

- Impairment of social interaction
- Impairment of communication skills
- Restricted and repetitive interests and behaviors
Common Characteristics of Autism

- Insistence on sameness; resistance to change
- Stereotypical (repetitive, non-productive) movements
- Not responsive to verbal cues
- Difficulty in expressing needs
- Difficulty interacting in social situations
- Inappropriate attachments to objects
- Little or no eye contact
Medications

- **Hyperactivity**
  - Methylphenidate (Ritalin, Concerta)
    - CNS stimulatn, use vasoconstrictors with caution
    - Side effects: tics, irritability, anorexia, insomnia
    - More effective in children with Asperger than other ASDs

- **Repetitive behaviors**
  - Fluoxetine (Prozac)
  - Sertraline (Zoloft)
  - Side effects of all SSRIs (selective serotonin reuptake inhibitors): agitation, insomnia, increased motor activity
Medications

- Aggressive behaviors
  - Lithium (Eskalith)
    - NSAIDs can increase renal clearance time
    - Increased sedation when used with benzodiazepines
    - EKG changes, weight gain, hypothyroidism
  - Carbamazepine (Tegretol)
    - Decreased WBC and platelet counts
  - Valproic Acid (Depakote, Depakene)
    - Can cause liver function problems
    - Leukopenia, thrombocytopenia, decreased fibrinogen
SO WHERE DO I START?
FIRST VISIT

- Comprehensive Examination
- Consent
  - Is patient own guardian?
- Medical history
  - Check out “big book” for pts with DD/DD
  - Get all MDs info
  - Appropriate consults**
- Vitals
  - Include height & weight
- Radiographs
- Oral cancer screening
- Soft and hard tissue exam
- Comprehensive periodontal exam & diagnosis
- Complete agency consult form if necessary for pts with ID/DD
TREATMENT PLANNING

- Patient centered care
- Start at ideal
- Consider patient’s ABILITIES, WANTS, NEEDS
- Consider patient’s ability to tolerate treatment and maintain restorations
- (ADAPTATIONS, MODIFICATIONS)
Take a behavioral history!

- Always ask the caregiver about patient’s communication abilities.
- Reactions to sensory stimuli such as noise, touch, and light.
- Stereotypic behaviors.
- Previous dental experiences?

- Does parent or caregiver have any suggestions for techniques that may help to distract patient during treatment?
  - Listening to music.
  - Playing with a portable video game machine.
  - Anything else!!
Physical Disabilities

- ADA requirements
- SPACE
- Transfer?
- Adaptive aids
Physical limitations

- Patient may require adaptive hygiene devices
- Patient may be unable to perform self-care; caregiver may require instruction
Aids to Maintain Mouth Opening

- Rubber or silicon bite blocks
- Molt mouth prop (ratchet device)
- Gauze-wrapped tongue blades
- OPEN-WIDE disposable mouth prop (foam block with handle)
Mouth props
Behavioral issues

- Food used as a frequent reward
- Individual may be uncooperative for daily hygiene regimen
- Individual may display difficult or disruptive behavior in the dental setting
Behavioral Management Techniques

- Tell-Show-Do
- Firm Voice Control
- Physical Restraint
- Sedation
- General Anesthesia
A treatment plan must consider the whole person

- What is this individual’s ability to maintain oral hygiene on a daily basis?
- What is this individual’s ability to sit for prolonged procedures?
- Does the patient’s medical status contraindicate sedation or general anesthesia?
- What is this individual’s ability or willingness to wear a removable prosthesis?
- Are aesthetics an issue for the patient (or the patient’s family)?
Know your patient

What has been this patient’s past experience receiving dental care?

Does this patient have any medical conditions that may impact on dental treatment?
- Antibiotic prophylaxis
- Anesthesia considerations

What medications is the patient taking – do any of them have oral side-effects?

Does this patient have any sensory impairments?
- Hearing loss
- Visual impairment
- Hypersensitivity to sound, touch
Informed Consent

- Grounded in the principle of patient autonomy

  - ADA Principles, Code of Professional Conduct and Advisory Opinions:
    - “The dentist has a duty to respect the patient’s rights to self-determination and confidentiality.”
    - “…professionals have a duty to treat the patient according to the patient’s desires, within the bounds of accepted treatment…the dentist’s primary obligations include involving the patient in treatment decisions in a meaningful way, with due consideration being given to the patient’s needs, desires and abilities…”
Informed consent: the process of communication between a doctor and patient in which a patient grants permission for the proposed treatment based on a realistic understanding of the nature of the illness, description of the procedure, risks and benefits and the treatment alternatives, including no treatment at all.
“Specific” Consent

- removal of body parts, other surgical procedures and anesthesia
- behavior management techniques, especially for restraint
Exceptions

- Emergency Medical Treatment
  - situations that would otherwise lead to serious disability or death do not require informed consent, although an effort to obtain consent should be made as long as it does not unnecessarily delay the treatment of the patient
  - “Reasonable man”
Exceptions

- “Simple and Common” exclusions
  - the risk is so remote or commonly known as to not warrant disclosure (i.e. blood drawing)

- Exceptions to the duty to disclose
  - doctor’s privilege to withhold information for therapeutic reasons
Who May Consent?

- Patient 18 or older
- Parent, if patient is a minor child
- Guardian
  - individuals with MR/DD over 18, parent may not be guardian, may need to seek legal guardianship
  - some states: patient advocates may consent OR involved adult family member
Who May Consent?

- Adult patients with temporary loss of capacity OR who once had capacity
  - advance directives (living wills, health care proxies, durable powers of attorney)
  - if patient not adjudicated to be incompetent, retain right to make own tx decisions (including refusal of tx)
  - Exceptions for tx in life threatening situations
Commonly Used Physical Restraints

- Papoose Board or
- Pedi-Wrap
- Sheet
- Velcro or Posey straps
  - (for extremities)
- Additional person
  - (parent or dental assistant)
Types of Sedation/Anesthesia

- Inhalation (Nitrous Oxide)
- Oral
- Intramuscular (IM)
- Intravenous (IV)
- General Anesthesia
Indications for use of physical restraint

- A patient who is unable to cooperate due to lack of maturity.
- A patient who is unable to cooperate due to mental or physical disability.
- In situations when the safety of the patient or practitioner would be at risk without protective use of restraint.
Questionable Capacity

- Mental capacity
- Legal competency
- Consult risk management
Witnessing the Consent

- Attests to the fact that the informed consent process took place
  - patient/guardian had opportunity to ask questions and get answers
Questions to Consider

- Will proposed treatment cause bleeding?
- Will proposed treatment cause bacteremia?
- Will proposed treatment cause stress?
- Will proposed treatment cause a wound?
- What is the patient’s ability to deal with any of the above?
How comfortable are you with interpreting laboratory data? e.g. CBC, hepatic panel, INR, A1-C

Q5

Basic Skill Set Gap
Laboratory Data: CBC/diff

- Hemoglobin (HgB)
- MCV, MCH, MCHC
- Hematocrit (HcT)
- Platelets
- ANC-absolute neutrophil count
- Breakdown of types and percentages of white blood cells
Diagnostic Use

- Patients with anemia
- Patients with immunosuppression
- Patients with infection, allergy
- Thrombocytopenia
- Leukemia
Diagnostic Use

- Not useful for diagnosing HIV/AIDS
- Not useful for assessing bleeding tendency for patients taking Plavix, Aspirin or other platelet anti-aggregants
- Not useful for assessing bleeding tendency secondary to liver disease
Comprehensive Metabolic Panel

- Performed on blood serum
- Provides overall picture of metabolism
- Kidney function
- Liver function
- Blood sugar, cholesterol, calcium levels
- Electrolytes
- Protein levels
Diagnostic Use

- Liver disease (AST, ALT, bilirubin)
- Kidney function (BUN, creatinine)
- Diabetes related complications
- Hepatitis C
- Alcoholism
<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose</td>
<td>95</td>
<td>65–100 mg/dL</td>
</tr>
<tr>
<td>BUN</td>
<td>15</td>
<td>8–25 mg/dL</td>
</tr>
<tr>
<td>Creatinine</td>
<td>1.1</td>
<td>0.8–1.4 mg/dL</td>
</tr>
<tr>
<td>Calculated BUN/creatinine</td>
<td>14</td>
<td>6–28</td>
</tr>
<tr>
<td>Sodium</td>
<td>140</td>
<td>133–146 mEq/L</td>
</tr>
<tr>
<td>Potassium</td>
<td>4.4</td>
<td>3.5–5.3 mEq/L</td>
</tr>
<tr>
<td>Chloride</td>
<td>104</td>
<td>97–110 mEq/L</td>
</tr>
<tr>
<td>Carbon dioxide</td>
<td>22</td>
<td>18–30 mEq/L</td>
</tr>
<tr>
<td>Calcium</td>
<td>10</td>
<td>8.5–10.5 mg/dL</td>
</tr>
<tr>
<td>Protein, total</td>
<td>7.6</td>
<td>6.0–8.4 g/dL</td>
</tr>
<tr>
<td>Albumin</td>
<td>4.7</td>
<td>2.9–5.0 g/dL</td>
</tr>
<tr>
<td>Calculated globulin</td>
<td>2.9</td>
<td>2.0–3.8 g/dL</td>
</tr>
<tr>
<td>Calculated A/G ratio</td>
<td>1.6</td>
<td>0.9–2.5</td>
</tr>
<tr>
<td>Bilirubin, total</td>
<td>0.4</td>
<td>0.1–1.3 mg/dL</td>
</tr>
<tr>
<td>Alkaline phosphatase</td>
<td>103</td>
<td>30–132 U/L</td>
</tr>
<tr>
<td>AST</td>
<td>10</td>
<td>5–35 U/L</td>
</tr>
<tr>
<td>ALT</td>
<td>24</td>
<td>17–56 U/L</td>
</tr>
</tbody>
</table>

BUN, blood urea nitrogen; AST, aspartate aminotransferase; ALT, alanine aminotransferase.
What Are the Existing Dental Care Options Available to Patients with Special Needs?

Across the state, a small number of dental facilities and practices exist that employ providers with the knowledge base and skills to provide safe, comprehensive dental services to patients with special health care needs. However, the current capacity doesn’t begin to address the need. The responsible parties, usually children or parents, who provide regular support for those patients often search statewide, finding no one, at any price, to treat the dental needs of loved ones.
Community Health Centers

- The perfect “laboratory” for implementing the medical home
- One stop shopping for health care
- Potential for collaborative, interdisciplinary care
The Bottom Line

- Medicaid cuts for people with DD/ID pervasive across many states
- Need to maximize encounters makes seeing people with special needs challenging
- Grants
- Local affiliations
- Mission vs. Reality
Do you or any member of the dental team participate in any collaboratives?

Q6

- yes: 62%
- no: 38%

11 0
What collaboratives do you participate in?

- Diabetes: 35%
- Oncology: 4%
- Smoking Cessation: 22%
- Obesity/nutrition: 14%
- HIV: 15%
- Mental health: 9%
If you were to consider treating special needs in your practice, how important would each of the following issues be?

**Q3**

- **Time**
  - Very Unimportant: 10%
  - Unimportant: 4%
  - Important: 36%
  - Very Important: 50%

- **Cost**
  - Very Unimportant: 9%
  - Unimportant: 15%
  - Important: 45%
  - Very Important: 32%

- **Insurance Coverage**
  - Very Unimportant: 11%
  - Unimportant: 23%
  - Important: 38%
  - Very Important: 27%

- **Liability**
  - Very Unimportant: 13%
  - Unimportant: 19%
  - Important: 40%
  - Very Important: 29%

- **Staff Support**
  - Very Unimportant: 9%
  - Unimportant: 7%
  - Important: 35%
  - Very Important: 49%
What circumstances would influence your decision to include people with special needs in your patient population?

Across the Board Barriers to Inclusion
Other Survey Results from Practicing Dentists in CHCs

- 18% were not familiar with the dental home concept
- 29% did not utilize electronic health records at their facility
- 20% did not have access to medical records
- 8% did not have behavioral health specialists in their CHC
- 38% of the dental team did not participate in any collaboratives
1. Families of CSHCN will partner in decision making and will be satisfied with the services that they receive.

2. CSHCN will receive coordinated, ongoing, comprehensive care within a medical home.

3. Families of CSHCN will have adequate private and/or public insurance to pay for the services that they need.

4. **Children will be screened early and continuously for special health care needs.**

5. Community based service systems will be organized so that families can use them easily.

6. Youths with special health care needs will receive the services necessary to make transitions to adult life, including adult health care, work, and independence.

(Ilda, 2010)
Is Dental Care In This Picture?

- Core outcome number 4 – Screening often and early
- Operationalized by 2 criteria
  - First, all children should receive at least one preventive medical visit on an annual or more frequent basis
  - Second, all children should receive a preventive dental examination annually or more frequently

(McPherson, 2004)
“That which can be counted doesn’t always count; and what counts can’t always be counted.”

Albert Einstein
Resources

Books

Resources

WEBSITES

- Special Care Dentistry. [www.scdonline.org](http://www.scdonline.org)
- Southern Association of Institutional Dentists (SAID). [www.saiddent.org](http://www.saiddent.org)
- American Academy of Developmental Medicine & Dentistry. [www.aadmd.org](http://www.aadmd.org)
- American Association on Intellectual & Developmental Disabilities. [www.aamr.org](http://www.aamr.org)
- United Cerebral Palsy. [www.ucp.org](http://www.ucp.org)