



Best Practice Approaches for State, Territorial, and Community Oral Health Programs



A Best Practice Approach Report describes a public health strategy and uses practice examples to illustrate successful/innovative implementation.

Date of Report: Adopted April 2007; Updated June 2021

Best Practice Approach: Oral Health Care of People with Special Health Care Needs

This report is the result of efforts by the ASTDD Best Practices Committee to identify and provide information on developing successful practices that address people with special health care needs. The ASTDD Best Practices Committee extends a special thank you to the primary author, Farah Alam, DDS, FSCD, for her partnership in the preparation of this report.

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Executive Summary

People with special health care needs (SHCN) often have complex medical and behavioral issues that require specialized training and appropriate settings to provide comprehensive oral health care. Barriers to care may include a shortage of adequately trained oral health professionals, especially in rural or less urban communities; poor reimbursement that does not reflect the additional time and staff needed to provide care to people with SHCN; and lack of access to hospital services. To best serve people with SHCN, oral health care should be integrated into primary care, leading to the establishment of a comprehensive health home. Strategic calls to action for improving the oral health care of people with SHCN include:

1. Increase and improve training on how to provide oral health care for people with SHCN as part of pre- and post-doctoral dental and medical education.
2. Offer incentives for oral health professionals to provide oral health care in communities with inadequate access to care for people with SHCN.
3. Increase reimbursement for oral health professionals for the additional time, behavior modification, and appointments needed when providing care to people with SHCN.

4. Advocate for state Medicaid programs to cover comprehensive oral health care for adults, especially for people with SHCN over the age of 21.
5. Advocate for increased operating room (OR) time for dental procedures in the hospital or surgical center.
6. Advocate for third-party payer approval of coverage for anesthesia and dental procedures in the OR and outpatient settings for adults, especially for people with SHCN.
7. Implement a state pilot program that illustrates the effectiveness of a comprehensive health home.
8. Collect data on access to and utilization of oral health care for people with SHCN, especially adults, to develop state policies as needed.

Background and Rationale

Introduction

The Health Resources and Services Administration’s Maternal and Child Health Bureau (MCHB) defines children with SHCN as “those who have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions, and also require health and related services of a type or amount beyond that required by children generally.”¹ Such conditions may be congenital; developmental; or acquired through disease, trauma, or environmental causes that impose limitations in performing daily self-maintenance activities and/or substantial limitations in a major life activity.^{2,3} As these children age, their abilities and needs will change.

Adults who are otherwise healthy can develop conditions suddenly or progressively through disease, injury, trauma, or environmental causes that impose various levels and types of limitations. SHCN serves as an umbrella term for several types of diagnoses that may be temporary or may lead to a lifetime of mild to profound challenges. Some examples of conditions that can classify people as having SHCN are listed in Table 1.

Table 1. Examples of Conditions that People with Special Health Care Needs May Have

Autism Spectrum Disorder/associated disorders	Intellectual and developmental disabilities
Cleft lip and palate	Issues and disorders seen in the aging population
Chronic medical conditions	Other physical limitations
Epilepsy and other seizure disorders	Spina bifida
Feeding and swallowing disorders	Parkinson’s disease and other movement disorders
Genetic and congenital syndromes	Psychiatric/mental disorders
Hearing, speech, and visual impairments	Traumatic brain injury

While attention to basic care, including self-care and professional care, is needed throughout life, at different life stages, people with SHCN may have unique needs and may require individualized and specialized care. This report focuses on the oral health needs of people with SHCN.

Oral health is a fundamental component of physical, emotional, and mental well-being. The term “oral health” encompasses an individual’s ability to eat, speak, and socialize without discomfort or embarrassment.^{4,5} One definition describes it as “multi-faceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow, and convey a range of emotions through facial expressions with confidence and without pain, discomfort, and disease of the craniofacial complex (head, face, and oral cavity). Oral health means the health of the mouth. No matter what your age, oral health is vital to general health and well-being.”⁶

People with special health care needs face challenges in maintaining good oral health.

People with SHCN often have complex medical issues and may exhibit various physical and craniofacial problems. More than one-third of all congenital birth defects cause some type of craniofacial malformation.⁷ Malocclusion and crowding of the teeth occur frequently in people with atypical development. This would include individuals with chronic medical issues that limit movement or motor function who face daily challenges in maintaining good oral health.

Advanced disease in the oral cavity can lead to other systemic issues, such as heart disease and adverse pregnancy complications.^{8,9} Conversely, the state of a person’s systemic health can first manifest in the oral cavity, such as in people with uncontrolled diabetes.¹⁰ [Table 2] See ASTDD white paper, [Integrating Oral Health with Primary Health Care](#).

Table 2. Systemic Issues That Can First Manifest in the Oral Cavity^{11,12}

Cardiovascular diseases	Musculoskeletal disorders
Congenital and developmental disorders	Neoplastic disorders
Diabetes	Nutritional insufficiency
Gastrointestinal issues such as gastroesophageal reflux disease (GERD)	Osteo and rheumatoid arthritis
Hematological disorders	Other diseases that affect bone
HIV and other immunocompromising diseases	Sexually transmitted diseases
Infections such as Epstein Barr virus, mumps, and herpes	Sjogren’s syndrome and other salivary gland disorders

Advanced oral disease can lead to difficulty in speaking and eating; the latter can lead to fatigue, irritability, difficulty concentrating, and in some cases malnutrition and other issues. People with compromised immunity or certain cardiac conditions may be especially vulnerable to the effects of oral disease.¹³ People with cognitive or developmental disabilities may not understand instructions or be able to maintain their own oral health care without assistance, leading to a reliance on others to monitor and maintain their oral health. This may put them at a higher risk for complications stemming from oral disease as compared to those without such compromised immunity or certain cardiac conditions. Untreated oral infections may progress to lesions that necessitate visits to hospital emergency departments (EDs). Visits for oral health-related care make up approximately one percent of ED visits.¹⁴

The majority of EDs are not equipped or staffed with licensed dentists or dental residents and do not have an affiliated dental clinic. In addition, oral health care is not routinely an integral part of medical education, physician networks, medical records, medical policy, or medical payment systems.^{15,1} In these cases, people with and without SHCN presenting with an acute infection are often prescribed pain medication and/or antibiotics and given a recommendation to see an oral health professional, with no mechanism in place to ensure that definitive oral care is accessed.^a

Considerations for Oral Health Care Delivery

People with SHCN need health care, including oral health care, to be a healthy, active part of a family and community. Having SHCN does not mean being unhealthy. However, many people with SHCN have complex medical and behavioral issues and need multiple types of services. Some may be at higher risk than those without SHCN for injury or abuse, but many people with SHCN do not require modifications to receive oral health care in a dental setting. Depending on their limitations, some people with SHCN perform home care and navigate these services on their own, or with assistive devices, while others rely on family or other caregivers who may have competing priorities. Families and other caregivers, as well as community-based organizations overwhelmingly report difficulty in identifying dentists in their communities who are trained, willing, and able to provide care to people with SHCN.^{16,17}

Pre-doctoral students would benefit from education on providing care for people with special health needs as part of their education.

^a Having a single integrated electronic health record could alleviate this issue. This could help remove structural barriers between medical care and oral health care, mitigate any discrepancies (such as duplication or inconsistencies in the medical and dental record), improve communication between medical and oral health professionals, and greatly improve continuity of care. It would offer a clearer picture of health for all individuals, not just PSHCN.

Many factors contribute to the lack of oral health care available to people with SHCN, including the following:

- There is a long history of people with SHCN being viewed by their “disability label” only, which creates misleading stereotypes and does not take into account individual abilities and needs.
- Some people with SHCN may have intellectual, sensory, or anxiety issues that make them apprehensive in the dental setting, resulting in behavior that may impede their safety and the safety of the dental team during procedures; the team may not know how to minimize this anxiety.
- People with SHCN who have behavioral or movement disorders may not be able to maintain the stillness required for intraoral procedures.
- Oral health professionals may be unfamiliar with many of the diagnoses or medical conditions presented to them and may feel unqualified to manage complex situations to provide optimal oral care for people with SHCN.
- People with SHCN may need longer and/or more appointment times.
- People with SHCN may benefit from adaptive equipment and/or stabilization devices that the dental office might not have.
- Oral health professionals may not know how to help transfer and stabilize people with mobility problems who use assistive devices, such as wheelchairs.
- Oral health professionals may not be trained in using behavior management.
- If specialized care using pharmacological techniques (e.g., nitrous oxide, anxiolytic medication, oral and or IV sedation) or referral to a hospital or surgical center for treatment under general anesthesia are needed, those specialty resources may not be available in the local area.

Promising Initiatives

State and local health programs that serve people with SHCN and their caregivers need evidence-based initiatives that focus on education about diet, oral hygiene, and use of fluorides. Policy and program initiatives can relate to workforce, both in terms of training and organization, and to financing of care. It is important to collect and make available data on the oral health of people with SHCN and the workforce capacity needed to address this demand so initiatives can be data-driven.

The increasing use of minimally invasive dentistry (MID) to provide oral health care represents a tremendous opportunity to improve the oral health of people with SHCN. MID treats decayed teeth by eliminating or reducing the removal of tooth structure while preventing or limiting the progression of tooth decay non-surgically. MID is beneficial particularly for people with advanced caries who are unwilling or unable to cooperate sufficiently for conventional treatment requiring an injection and use of a dental drill.

The use of fluorides to prevent tooth decay is an example of a well-established MID approach. The use of silver diamine fluoride (SDF) is a topical antimicrobial and mineralizing agent to treat tooth sensitivity and as a non-restorative treatment to stop the progress of decay on primary and permanent teeth.^b For people with SHCN, the use of SDF has important benefits and some drawbacks.

The most important benefit of SDF for people with SHCN is to treat decayed teeth non-surgically and painlessly. Although the SDF procedure does not restore the tooth to its original form, the tooth decay is halted, making future toothaches unlikely. Another benefit of SDF, when used as a treatment (without tooth restoration), is the low cost compared to the cost of conventional restorative treatment. Treating a person with SDF may mean that they do not need to be treated surgically in the hospital OR, which is expensive, may cause anxiety, and has attendant health risks associated with the administration of general anesthesia. When receiving restorative treatment in the OR is the best option, but there is a long wait for an appointment, SDF treatment can be an effective interim measure. One drawback to using SDF is the resulting black discoloration of the decayed portion of the tooth, which may be objectionable especially on anterior teeth. Also, SDF does not restore the tooth to its original form.

The American Dental Association (ADA) emphasizes that the dentist has a duty to inform the patient of the benefits

^b ADA published a 2018 systematic review that supports the use of SDF and other non-restorative treatments; see Evidence-based clinical practice guideline on non-restorative treatments for carious lesions. <https://doi.org/10.1016/j.adaj.2018.07.002>

and drawbacks of alternative treatments, including SDF and other non-restorative treatment modalities, so patients can make fully informed decisions about their treatment. For many people with SHCN, especially those who have been unable to obtain routine oral health care, SDF treatment may be a better than no treatment at all, traditional “drill and fill” in the dental office, or treatment in the OR. Literature supporting the effectiveness for people with SHCN appears in the Research Evidence section of this report.

Workforce

The Commission on Dental Accreditation guidelines for pre-doctoral education state that “graduates must be competent in assessing and managing the treatment of patients with special needs.”¹⁸ Although these guidelines are an improvement over the previous ones, which state that pre-doctoral students must be competent in *assessing* people with SHCN; the updated guidelines still fall short of requiring such training for all dental students. Current accreditation standards for dental hygiene state that “graduates must be competent in providing dental hygiene care for the child, adolescent, adult, geriatric, and special needs patient populations.” A diverse patient pool should be available to provide students with a wide scope of patient experiences, including working with patients whose medical, physical, psychological, developmental, intellectual, or social conditions may make it necessary to modify patient procedures. Student experiences should be evaluated for competency and monitored to ensure equal opportunities for each enrolled student.

The intensity of training on oral health care for people with SHCN varies significantly depending on the program. Most states do not require general dentists to obtain post-doctoral training on people with SHCN for state licensure. However, some states, such as New York, have recognized the importance of general practice residency (GPR) programs that offer experience in providing oral health care to people with SHCN.

Many dentists do not receive training beyond that received in dental school in providing oral health care for people with SHCN. Fortunately, more dental schools are developing special care clinics. Special care clinics, such as those affiliated with University Centers for Excellence in Developmental Disabilities (e.g., dental clinic at the Montefiore Medical Center in New York) provides comprehensive training in special care dentistry.

The number of pediatric dental specialists compared with general dentists is small. Many specialty dental practices are located in urban areas; people with SHCN living in rural and less-urban areas often lack access to such specialists. Although pediatric dentists may treat both children and adults with SHCN, they may not be knowledgeable about adults with SHCN and the medical issues they face. Simply stated, there is a profound dearth of oral health professionals available to meet the needs of people with complex medical conditions. Schools that offer broad didactic training and have dedicated clinics often attract students with an interest in providing oral health care for people with SHCN, and these students may be supported by student chapters of the Special Care Dentistry Association.

Special care dentistry is now recognized as an area that benefits from specialty training. Advanced training programs have been proposed for care of adults with SHCN. While it is not anticipated that large cohorts of dentists will provide care to people with SHCN or that people with SHCN will be cared for by specialists only, the field needs people who are committed to providing oral health care for people with SHCN to teach both didactic and clinical care, advance the knowledge base through research, and be available for consultation about more complex cases.

Continuing education (CE) courses on special care dentistry are limited in comparison to CE courses on other topics.¹⁶ However online training programs on special care dentistry can be accessed through the Special Care Dentistry Association, the Academy of Developmental Medicine and Dentistry, and through university-based special care programs. States can help oral health professionals by organizing these resources in a concise way, conducting mini-residencies focused on special care, or considering development of virtual learning collaboratives.

Sites of Care

It is important that dentists in the community are comfortable providing care for people with SHCN using evidence-based preventive practices and MID care. States and regions have played a role in developing a hub-and-spoke system so that dentists in the community have referral options, should their ability to meet the person’s treatment needs be insufficient. [Project SANDs](#) (Special Needs Network of Dentists) in South Carolina is an example of such a hub-and-spoke system. While hospitals and dental schools play a critical role in providing oral health care to people with SHCN, a community-based approach is more convenient for people with SHCN and their families who live far from such settings. A community-based approach is cost-effective when it focuses on prevention and

normalizes care for people with SHCN. Dental offices and clinics may wish to consider modifications for their settings, both to comply with the Americans with Disability Act and to address issues of stimulation and body-positioning to create a more comforting setting for people with SHCN to receive care.

Demographic trends suggest that people with SHCN are living longer, which is consistent with a worldwide increase in the numbers of older people.^{19,20} Owing to their complex medical conditions, the aging SHCN population will continue to require an increasingly large amount of care compared to those without SHCN. An article published in 2000 states that “ten percent of general dentists provided oral health care for children with SHCN “very often,” while 70 percent of general dentists rarely or never provided care to children with SHCN.”^{21,22} If there is a shortage of dentists providing oral health care for children with SHCN now, in the future, there will be a shortage of dentists providing care for people with SHCN as they age.

Financing of Special Care Dentistry

Reimbursements to oral health professionals are typically based on procedures completed and not on time spent caring for the patient. A dental restoration for a person with SHCN typically is no different from that provided to any other patient; teeth are teeth. The difference is the amount of time it may take to complete a particular procedure as well as the additional auxiliary staff members needed to assist. For example, a person with Parkinson’s disease or other neuromuscular manifestations, such as spasticity with head and neck involvement or ataxia, may present with uncontrolled movements. Given that the majority of restorative dentistry involves using sharp instruments that require precision, an additional one or two assistants are often required to stabilize the patient.

Financial reimbursements should acknowledge the complexity of the patient and the amount of time needed.

Extra time may be necessary for breaks to enable people with SHCN to tolerate treatment, while other procedures may take multiple visits to complete. Reimbursement rates for dental procedures provided in these situations are insufficient, as they do not adequately take into account the extra staff, time, and visits required. State programs advocating for Medicaid coverage of a behavior management code for adults (D9920) have been successful in eight states, according to the [National Profile of State Medicaid and CHIP Oral Health Programs](#). Other states have advocated for a Medicaid waiver to confer status as an underserved community; such status results in higher reimbursement rates.

Many people with SHCN are enrolled in public insurance plans, such as Medicaid or the Children’s Health Insurance Program (CHIP); however, Medicaid reimburses only modest amounts and covers limited services, often covering operational overhead only.²³ Therefore, a large percentage of dentists do not enroll in these public insurance programs. In addition, most private insurance plans have annual benefit maximums that are quickly exhausted when high-cost hospital-based or complicated dental procedures are needed. State Medicaid programs may consider charges for hospital-based care to be medical and state programs may need to educate and provide guidance to medical programs. While about 30 state Medicaid programs provide dental benefits for adults, others offer little coverage, and in some cases, no coverage for oral health treatment after a child with SHCN reaches the age of 21, which increases the financial burden on caregivers.^{24,25}

Insufficient OR time or anesthesia services for dental procedures are additional challenges for people with SHCN who may need such services. Compared to other surgical procedures, dental procedures are not lucrative for hospitals. In addition, many third-party payers may deem some dental procedures unnecessary, and OR time is often denied.²⁶ Frequently, families need to allocate financial resources for medical therapies, leaving little or no money left to address oral health needs. There may be resources in the community available for people with SHCN (i.e., Katie Beckett waiver, Olmstead decision); however, families need guidance from a care coordinator to avail themselves of such resources.^c

^c The Katie Beckett waiver is a Medicaid waiver that covers medical services for children at home rather than in an institution regardless of parental income. The Olmstead decision upholds the rights of people with disabilities to live in the community rather than be forced to live in an institutional setting.

Establishing Comprehensive Care

Traditionally, dentistry and medicine have been seen as separate professions. This view has been reinforced through legislation, education, service delivery, and payment systems.¹⁵ Dentistry is often imagined as drilling and filling teeth, or smile makeovers, when in fact, it is about a person's oral health, which is intricately linked to their overall health.¹³

The dental home model of care is a comprehensive, continuously accessible, coordinated, and family-centered approach to improving access to oral health care for vulnerable populations by providing a regular source of care. Dental homes should provide outreach to vulnerable populations and their caregivers to optimize oral health at home, which is the best prevention against oral disease. Having a dental home is imperative, as dental homes take into consideration the patient's age and developmental and psychosocial status. Dental home services should be appropriate for the individual needs and risk factors presented by people with SHCN.

A medical home model of care is a patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

People with SHCN would be best served by integrating oral health care with primary care, leading to the establishment of a comprehensive health home that includes medical, oral and behavioral health care, plus enabling services. Such a model would address many of the issues associated with care coordination as all health professionals would be part of the same health home. Each person with SHCN would have a single patient record and payment system. Consolidation of services could reduce care coordinators' non-health-related responsibilities, such as arranging transportation to appointments. This model could solve problems related to children with SCHN transitioning to adulthood, as the health home would be a constant throughout the lifespan. This would include transitioning from pediatric to adult health professionals, including oral health professionals.

Data

Currently, there are limited data that state and local agencies can use to determine the extent of access to and utilization of oral health care for people with SHCN. It is critical to acquire this information to assess impact of care. The Centers for Disease Control and Prevention's Disability and Health Data System (DHDS) provides information about health and wellness of adults with disabilities by state, although oral health data is limited.²⁷ Data from DHDS indicates that adults with disabilities are significantly less likely to report having had a dental visit in the past year. Data is pulled from BRFSS and is available in each state. The Data Resource Center for Child and Adolescent Health collects information about children with SHCN, but not adults.²⁸ Data collected through the Special Olympics, Healthy Athletes Special Smiles Program has similarities to data collected through the ASTDD Basic Screening Survey. States have begun to collaborate to obtain periodic data on the oral health of people with SHCN.

Strategic Calls to Action for Improving the Oral Health of People with SHCN

1. Increase and improve training on how to provide care for people with SHCN for health professionals, including as part of pre- and post-doctoral dental and medical education.
2. Offer incentives for oral health professionals to provide oral health care in communities with inadequate access to care for people with SHCN.
3. Increase reimbursement for oral health professionals for the additional time, behavior modification, and appointments when needed for providing oral health care to people with SHCN.
4. Advocate for state Medicaid programs to cover comprehensive oral health care for adults, especially for people with SHCN over the age of 21.
5. Advocate for increased OR time for dental procedures in the hospital or surgical center.
6. Advocate for third-party payer approval of coverage for anesthesia and dental procedures in the OR and outpatient settings for adults, especially for people with SHCN.
7. Implement a state pilot program that illustrates the effectiveness of a comprehensive health home.
8. Collect data on access to and utilization of oral health care for people with SHCN, especially adults, to develop state policies as needed.

Guidelines and Recommendations

1. American Academy of Pediatric Dentistry, Council on Clinical Affairs [*Policy on Transitioning from a Pediatric-Centered to an Adult-Centered Dental Home for Individuals with Special Health Care Needs*](#) (2016)
This document addresses the transition of young adults with SHCN from a pediatric to an adult dental home. It provides background on the issue, including information about barriers to transitioning young adults with SHCN to an adult dental home and transitioning this population. The document concludes with a policy statement.
2. American Academy of Pediatric Dentistry, Council on Clinical Affairs [*Policy on Third-Party Reimbursement for Management of Patients with Special Health Care Needs*](#) (2017)
This document addresses third-party reimbursement for management of people with SHCN. It provides background on the issue, including information about barriers they face in accessing oral health care. The document concludes with a policy statement.
3. Department of Health and Human Services. [*Oral Health in America: A Report of the Surgeon General*](#) (2000)
This report covers the meaning of oral health, the status of oral health in America, the relationship between oral health and general health and well-being, promotion and maintenance of oral health, prevention of oral diseases, and the opportunities to enhance oral health. A framework for action also is included.
4. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [*Healthy People 2030*](#) (2020)
Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade. It includes 355 core, or measurable, objectives as well as developmental and research objectives. This resource provides objectives, leading health indicators, social determinants of health, data sources and methods, and tools for action, including a promotional toolkit.
5. Maternal and Child Health Bureau. [*Children with Special Health Care Needs*](#) (2020)
This brief provides a 2017–2018 data snapshot of children and youth with special health care needs from the National Survey of Children’s Health (NSCH). It covers types of special health care needs in this population, frequency/degree of activity limitations, prevalence of certain health conditions, key indicators, and effective systems. It also describes the NSCH data collection.
6. National Council on Disability [*Neglected for Too Long: Dental Care for People with Intellectual and Developmental Disabilities*](#) (2017)
The brief provides information on access to oral health care for people with intellectual and developmental disabilities (IDD). The brief introduces the issue and discusses ethics and professional conduct, training, dental school curricula requirements, and Medicaid coverage for this population. A list of programs that train dental students in providing care for people with IDD is included, along with recommendations on how to address lack of access to care.
7. Petek S, Metzker B [*Improving Access to Dental Services for Individuals with Developmental Disabilities*](#) (2018)
This report presents the extent to which oral health care is available for people with developmental disabilities. It discusses problems with access to oral health care, steps taken to address the problems, and causes of the problems. Recommendations for improving access to oral health care are provided.
8. Rosenthal J, Henderson M, Dolatshahi J, Hess C, Tobias C, Bachman S, Comeau M [*Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and the Children’s Health Insurance Program \(CHIP\) \(upd.\)*](#) (2017)
This tutorial provides an overview of Medicaid and CHIP, populations these programs serve, changes the programs are undergoing under health care transformation, and opportunities to improve services for children with SHCN through communication and collaboration with Medicaid and CHIP staff. The tutorial provides an overview of how definitions of children with SHCN may vary by agency or program and major topic areas, including recommendations for Title V programs to build successful partnerships with public insurance programs.

9. Special Care Dentistry [Oral Health for People with Special Health Care Needs: On-Line Education Course](#) (2019)
This course for oral health professionals consists of 16 modules covering topics related to providing oral health care for people with SHCN. Selected topics include an overview of treatment, community-based systems to improve oral health care, abuse and neglect among older adults and dependent adults, overcoming behavioral obstacles to oral health, and preventing oral disease. Each module includes a quiz, and the course includes a cumulative knowledge test. CE credits for completing the course with a minimum score on the test are available.
10. Wong A, Sands W [Quality Resource Guide: Introduction to Patients with Special Healthcare Needs](#) (2018)
This guide for oral health professionals provides information about prevention and treatment of oral disease for people with SHCN. Topics include oral health needs, delivery of care and principles to guide it, developing the oral health care team, scheduling, desensitizing, decreasing acids, additional assistance, special concerns, fluoride and tooth remineralization, and caries arrest with SDF.

Best Practice Criteria

The ASTDD Best Practices Committee has selected five best practice criteria to guide state and community oral health programs in developing their best practices. For these criteria, initial review standards are provided to help evaluate the program's or practice's effectiveness in preventing oral disease.

1. Impact/Effectiveness

- A practice or program enhances the *processes* to improve access to oral health care for people with SHCN.
Example: A pre-doctoral program offers education on providing oral health care to people with SHCN and increases training in the postdoctoral programs by increasing the number of available CE courses on providing oral health care to people with SHCN.
- A practice or program demonstrates *outcomes* that show improved access to oral health care and/or improved oral health status among people with SHCN.
Example: A program increases the number of preventive dental visits it provides and reduces the number of visits by people with SHCN to the ER or urgent care facility for oral infection.

2. Efficiency

- A practice or program shows cost savings resulting from preventing oral disease and/or reducing treatment needs among people with SHCN.
Example: A program implements cost savings practices by providing people with SHCN with appropriate preventive oral health care to reduce the need for invasive and expensive dental procedures.
- A practice or program leverages federal, state, and/or local resources to improve oral health care for people with SHCN.
Example: A program uses existing systems of care and resources as well as partnerships with public and private sectors to support oral health care (e.g., outreach, care coordination, case management, preventive services) for people with SHCN.

3. Demonstrated Sustainability

- A practice or program serving people with SHCN demonstrates sustainability or has a plan to maintain sustainability.
Example: A program demonstrates continuous funding (e.g., agency line item in budget, reimbursement from public and private insurers) to support provision of services to people with SHCN.

4. Collaboration/Integration

- A practice or program establishes and maintains collaborations that integrate oral health efforts into other efforts to enhance oral health care for people with SHCN.

Example: A program located in the state department of health works in collaboration with state agencies to improve systems of integrating oral health care and general and behavioral health care and financing for oral health care (e.g., identifying and implementing models for delivery of care and payment) for people with SHCN.

5. Objectives/Rationale

- A practice or program aligns its objectives with national or state objectives or performance measures to improve oral health for people with SHCN.

Example: A program aligns objectives with Healthy People national objectives to prevent and/or treat oral diseases, including periodontal disease and dental caries, among people with SHCN.

Evidence Supporting Best Practice Approaches

The ASTDD Best Practices Committee takes a broad view of evidence to support best practice approaches for building effective state and community oral health programs. The Best Practices Committee will report on practices that are linked by strong causal reasoning to the desired outcome of improving oral health and total well-being of priority populations. Strength of evidence from research, expert opinion and field lessons fall within a spectrum: on one end of the spectrum are promising best practice approaches, which may be supported by little research, a beginning of agreement in expert opinion, and few field lessons evaluating effectiveness; on the other end of the spectrum are proven best practice approaches, those supported by strong research, extensive expert opinion from multiple authoritative sources, and solid field lessons evaluating effectiveness.

Research may range from a majority of studies in dental public health or other disciplines reporting effectiveness to the majority of systematic reviews of scientific literature supporting effectiveness. Expert opinion may range from one expert group or general professional opinion supporting the practice to multiple authoritative sources (including national organizations, agencies or initiatives) supporting the practice. Field lessons may range from success in state practices reported without evaluation documenting effectiveness to cluster evaluation of several states (group evaluation) documenting effectiveness. For information about the difference between a systematic review and a narrative review: [Systematic vs. Narrative Reviews](#).

Research Evidence

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State Practice Examples

The following practice examples illustrate various elements or dimensions of the best practice approaches for providing oral health care for people with SHCN. These examples should be viewed in the context of the states and program’s environment, infrastructure, and resources. End-users are encouraged to review the practice descriptions (click on a practice name to view the description) and adapt ideas to fit their state and program. Table 3 provides a list of programs and activities submitted by states. Each practice name is linked to a detailed description.

Summary Listing of Practice Examples

Table 3 provides a listing of programs and activities submitted by states. Each practice name is linked to a detailed description.

Table 3. State Practice Examples Illustrating Strategies and Interventions for People with Special Health Care Needs

Practice Name	State	Practice #
Iowa Lifelong Smiles Coalition	IA	18009
Apple Tree Dental	MN	26006
Elks Mobile Dental Program-Dental Care for People with Special Needs in Rural Missouri	MO	28006
Special Care Dental Clinic (SCDC)	NV	31010
Special Care Dentistry Fellowship Program, Rose F. Kennedy Center, Children’s Evaluation and Rehabilitation Program, University Center for Excellence in Developmental Disabilities, Montefiore Medical Center	NY	35007
North Carolina Special Care Dentistry	NC	36006
The Nisonger Center Dental Program-Training of Dental Professional Students to Serve Persons with Disabilities	OH	38005
Special Smiles, Ltd- Assuring Access to Dental Care for Persons with Intellectual Disabilities in Medicaid Managed Care	PA	42003
The South Carolina Dental Web-Based Directory for Individuals with Special Health Care Needs	SC	46002

Virginia Online Directory of Dentists for Individuals with Special Health Care Needs and Young Children	VA	53008
Dental Education in the Care of Persons with Disabilities (DECOD) Program, University of Washington School of Dentistry	WA	54005

The listed state practice examples were updated in 2021. Archived state practice examples are available at <https://www.astdd.org/state-activities/?topic=Access+to+Care%3A+Individuals+with+Special+Health+Care+Needs>

Highlights of Practice Examples

IA [Iowa Lifelong Smiles Coalition](#) (Practice #18009)

The Lifelong Smiles Coalition was formed to address access to oral health care for older adults in Iowa through community learning engagement to form a collective action plan. The coalition works through an actionable knowledge process with the end goal of building capacity and large-scale social impact. Its mission is to increase access to oral health care for older frail adults in Iowa.

MN [Apple Tree Dental](#) (Practice #26006)

Apple Tree Dental was founded as a non-profit dental organization to address lack of access to oral health care for residents of nursing and assisted living facilities in Minneapolis/St. Paul (Twin Cities), MN. Apple Tree's growth over 35 years demonstrates that a non-profit group dental practice with a diversified patient and funding mix can successfully serve older adults including the most dependent who reside in long-term care facilities.

MO [Elks Mobile Dental Program-Dental Care for People with Special Needs in Rural Missouri](#) (Practice #28006)

The Elks Mobile Dental Program began over 50 years ago. The program delivers free oral health care to children and adults with developmental and intellectual disabilities throughout Missouri using two mobile clinics. The program is a partnership between the Missouri Elks Association, the Bureau of Special Health Care Needs of the Missouri Department of Health and Senior Services, and Truman Medical Center.

NV [Special Care Dental Clinic](#) (Practice #31010)

The Special Care Dental Clinic (SCDC) is physically operated out of the University of Nevada, Las Vegas, School of Dental Medicine campus. Dental students are rotated through the SCDC and if patients can be treated without general anesthesia, the dental students perform all aspects of dentistry. Approximately five to eight patients are scheduled for each rotation and approximately five rotations are scheduled per week. As a result of the SCDC, hundreds of patients have been seen who would otherwise have no access to routine oral health care.

NY [Special Care Dentistry Fellowship Program, Rose F. Kennedy Center, Children's Evaluation and Rehabilitation Program, University Center for Excellence in Developmental Disabilities, Montefiore Medical Center](#) (Practice #35007)

The Rose F. Kennedy University Center for Excellence in Developmental Disabilities dental program provides: (1) clinical dental services to patients with developmental disabilities, (2) training in special care dentistry to postgraduate dental residents and fellows, and (3) outreach to patients and caregivers in promoting oral health maintenance procedures and practices. The Special Care Dentistry Fellowship Program, incorporated into the dental program, is a national program that provides comprehensive training in all aspects of special care dentistry from training in genetics through the provision of treatment under general anesthesia.

NC [North Carolina Special Care Dentistry](#) (Practice #36006)

Access Dental Care is a non-profit organization whose mission is to provide on-site, quality comprehensive dental services, via mobile equipment and trained professionals, to the intellectually disabled/developmentally disabled and frail elderly populations in long-term care facilities (nursing and group homes), community-dwelling individuals with disabilities, Program for All-Inclusive Care of the Elderly centers and regional HIV clinics.

OH [The Nisonger Center Dental Program – Training of Dental Professional Students to Serve Persons with Disabilities](#) (Practice #38005)

The Nisonger Center Dental Program, located on the health sciences campus of the Ohio State University, but separate from the College of Dentistry, is a University Center of Excellence on Developmental Disabilities. The

center uses an interdisciplinary approach to training and providing oral health care to children and adults with disabilities and their families.

PA [Special Smiles, Ltd.- Assuring Access to Dental Care for Persons with Intellectual/Developmental Disabilities in Medicaid Managed Care](#) (Practice #42003)

Special Smiles, Ltd. provides services for people with developmental disabilities who are covered by Medicaid and may not be able to receive treatment in a dental office due to maladaptive behaviors and physical limitations requiring sedation or general anesthesia for treatment. Technical assistance is provided through the state Medicaid agency. Three managed care organizations in the Philadelphia area contracted with a private dental practice to establish Special Smiles, Ltd.

SC [The South Carolina Dental Web-Based Directory for Individuals with Special Health Care Needs](#) (Practice #46002)

The purpose of the Special Needs Network of Dentists (SANDS) online directory (<http://sandsc.org>) is to increase access to care for individuals with special health care needs by making it easier to identify dentists who are willing and able to provide a wide variety of dental services. The directory is available to individuals, parents and other caregivers, and health and social service professionals as well as those who assist patients in finding appropriate oral health services. The online directory is not password protected.

VA [Virginia Online Directory of Dentists for Individuals with Special Health Care Needs and Young Children](#) (Practice #53008)

The Virginia Online Directory of Dentists for Individuals with Special Health Care Needs (ISHCN) and Young Children began with survey responses from dentists willing to provide services for ISHCN. This was the first step in developing an electronic database for people to locate dentists to serve ISHCN. VDH provides oral health trainings for direct service providers (DSPs) working in the Department of Behavioral Health and Disability Services (DBHDS) group homes for ISHCN and continuing education (CE) courses for dental providers regarding oral care for ISHCN. The Virginia Department of Health provides oral health trainings for direct service providers (DSPs) working in the Department of Behavioral Health and Disability Services (DBHDS) group homes for ISHCN and continuing education (CE) courses for dental providers regarding oral care for ISHCN.

WA [Dental Education in the Care of Persons with Disabilities \(DECOD\) Program- University of Washington School of Dentistry](#) (Practice #54005)

The Dental Education in the Care of Persons with Disabilities (DECOD) Program was established by the University of Washington School of Dentistry in 1974 with the aim of increasing access to oral health care for people with disabilities via training for oral health professionals. With a \$1,126,223 budget and legislative support from the state of Washington, DECOD provides 4,000–6,000 visits per year to adults with developmental and acquired disabilities. Training initiatives include those at the pre-doctoral level, as well as fellowship and residency training programs.

Acknowledgements

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an annual award totaling \$1,000,000 with no funding from nongovernmental sources. This information or content and conclusions are those of the author(s) and should not be construed as the official policy of HRSA, HHS, or the U.S. government, nor should any endorsements be inferred.

Suggested citation: Association of State and Territorial Dental Directors, Best Practices Committee. Best Practice Approach: Oral Health Care of People with Special Health Care Needs [monograph on the Internet]. Reno, NV: Association of State and Territorial Dental Directors; 2021. p.15 Available from: <http://www.astdd.org>.

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Please note that all links within the text of this paper and following in the Endnotes were correct at the time of publication. If a link does not work, the website location or document name may have changed. Searching for the document by name may be an alternative way to find it.

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