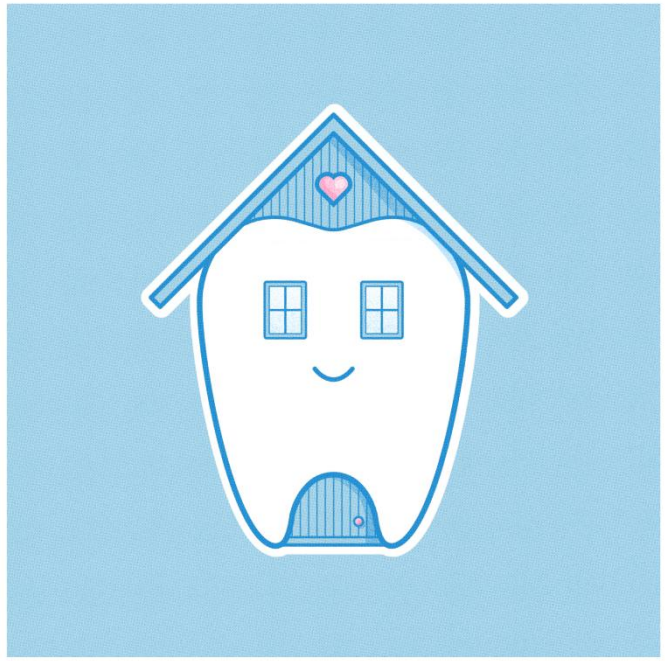


the

Dental Home

concept

ASOCIATIA NATIONALĂ DE STOMATOLOGIE PEDIATRICĂ
A.N.S.P.R.
DIN ROMÂNIA

Medical care of children of all ages is best managed when there is an established **relationship between a practitioner who is familiar with the child and the child's family** (American Academy of Pediatrics, 1992).

This also **applies to dental care - AND to special oral care**

Dental care is the most prevalent unmet health care need among children with special health care needs (CSHCN) (*, **).

Children with greater limitations attributable to disability have significantly greater odds of unmet dental care needs (**).

Children with a personal doctor or nurse are significantly less likely to have unmet dental care needs (*).

(*) Newacheck, 2000
(**) Lewis et al, 2005

International Caries Detection and Assessment System (ICDAS, 2002)

International Caries Classification and Management System (ICCMS™)

guidance statement:

Preserve tooth structure and restore only when indicated

Based on 4 main elements :

1. HISTORY TAKING
2. CARIES CLASSIFICATION
3. DECISION MAKING – matrix for Caries Risk and Likelyhood at patient level
4. MANAGEMENT – Personalized Caries Care Plan

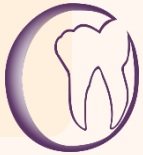
Best done when the ***patient*** is ***already well-known*** to the dental team – and viceversa

Dental Home

IDEAL CHARACTERISTICS AND PRACTICAL ADVANTAGES OF A DENTAL HOME

as described by Nowak AJ and Casamassimo PS, JADA 2002

Accessible	- care provided in child's community - dentist – familiar with community needs and resources
Family-centered	- low parent & child anxiety
Continuous	- same primary care providers from infancy through adolescence - appropriate recall intervals - coordination for complex dental care (e.g. trauma) - connection between dental team and medical providers - interdisciplinarity
Comprehensive	- care/advice available 24/7



IDEAL CHARACTERISTICS AND PRACTICAL ADVANTAGES OF A DENTAL HOME

as described by Nowak AJ and Casamassimo PS, JADA 2002

Comprehensive	- care/advice available 24/7
Coordinated	- information and records are centralized (e.g. link with speech therapy for clefts)
Compassionate	- relationship between child and dentist, family and dentist; familiarity reduces anxiety
Culturally competent	- cultural background recognized, valued, respected

Can Dental Home influence Caries Risk in children with Special Health Care Needs?

Caries Risk can be assessed by evaluating a series of factors that may influence the child's **vulnerability to decay**.
These factors can be biological, social (family background and literacy), behavioural, clinical etc.

The ratio between risk factors and protective factors, corroborated with clinical findings, gives an image of the caries risk category (low/ moderate/ high) a child fits in.

Professional forums like American Dental Association (ADA) and American Academy of Pediatric Dentistry (AAPD) elaborated **dedicated forms** in the attempt to make Caries Risk Assessment easier for every day practice.

For example:

Caries-risk Assessment Form for 0-5 Years Old
(as given by the American Academy of Pediatric Dentistry: The Reference Manual of Pediatric Dentistry, pg. 221)

Factors	High risk	Moderate risk	Low risk
Risk factors, social/biological			
Mother/primary caregiver has active dental caries	Yes		
Parent/caregiver has life-time of poverty, low health literacy	Yes		
Child has frequent exposure (>3 times/day) between-meal sugar-containing snacks or beverages per day	Yes		
Child uses bottle or non-spill cup containing natural or added sugar frequently, between meals and/or at bedtime	Yes		
Child is a recent immigrant		Yes	
Child has special health care needs		Yes	
Protective factors			
Child receives optimally-fluoridated drinking water or fluoride supplements			Yes
Child has teeth brushed daily with fluoridated toothpaste			Yes
Child receives topical fluoride from health professional			Yes
Child has dental home/regular dental care			Yes
Clinical findings			
Child has non-cavitated (incipient/white spot) caries or enamel defects	Yes		
Child has visible cavities or fillings or missing teeth due to caries	Yes		
Child has visible plaque on teeth	Yes		

Circling those conditions that apply to a specific patient helps the practitioner and parent understand the factors that contribute to or protect from caries. Risk assessment categorization of low, moderate, or high is based on preponderance of factors for the individual. However, clinical judgment may justify the use of one factor (e.g., frequent exposure to sugar-containing snacks or beverages, more than one decayed missing filled surfaces [dmfs]) in determining overall risk.

Overall assessment of the child's dental caries risk: High ❒ Moderate ❒ Low ❒

Corroborating elements from Caries Risk Assessment forms as recommended by ADA and AAPD:

authority / factor	American Dental Association (ADA)		American Academy of Pediatric Dentistry (AAPD)	
	Age < 6 y	Age ≥ 6 y	Age < 6 y	Age ≥ 6 y
SPECIAL HEALTH CARE NEEDS	**HIGH**	**HIGH**	**MODERATE**	**MODERATE**
CHEMO/ RADIO THERAPY		**HIGH**		
REDUCED SALIVARY FLOW		**MODERATE**		**HIGH**
DENTAL HOME	**LOW**	**LOW**	**LOW**	**LOW**

➔ Dental management of children with SOCN through a Dental Home may contribute to lowering Caries Risk

(How) Does the Dental Home Concept impact on the Quality of Life (QoL)?

Dental Home

Personalized, more efficient prevention (*)

+

anticipatory guidance to parents (*)
→ aware of
- child's growth & development
- possible risk factors

Early interception of emerging problems

Less complex treatment needs

Lower costs

Less dental fear
better dental compliance of CSOHCN (**)

probably a **Better Quality of Life**

* Nowac AJ, Casamassimo PS: The dental home. A primary care oral health concept. JADA 2002 January, 133: 93-98
** Vinereanu et al. Dental behaviour of mentally challenged Romanian children. 9th Congress EAPD, Dubrovnik, 2008

The Dental Home concept emerged in the US.

Conditions for creating national frameworks for Dental Home **vary** between countries and require a lot of work, time and public health authority involvement. This can be particularly difficult in countries where 95% or more of the dental care is based on private care, even for children (such as Romania).

BUT raising **awareness** among **parents** and **dental practitioners** regarding the benefits of a Dental Home can be a good step forward in **implementing the concept on a smaller – even individual – level**, and that can make a big, increasing, welcome difference.

CONCLUSION

dental home for children with SOCN has to be a philosophy embraced by the dental practice.