

Making Oral Health Supervision Accessible

The benefits of oral health supervision can be realized only when children have access to oral health care services. Oral health supervision can occur in a variety of settings, including schools, hospitals, clinics, private dental and medical offices, health maintenance organizations (HMOs), or parent support groups. However, families can gain access to oral health supervision only if they have personal financial resources or if the community provides some support services. Families also need care that is culturally competent.

In all settings, families need to be reassured that the dental professional will take extra measures to help the child feel comfortable. In addition, the dental environment may need to be modified so that it is accessible to children with special health needs. Families also need to feel that their children are being cared for in a *safe* setting—that proper infection control procedures are being used to safeguard their children's health.

Financing Oral Health Supervision

Financial barriers prevent many families from gaining access to oral health care. Although health care expenses for many children are covered by insurance or entitlement programs such as Medicaid, most oral health care expenses are paid out-of-pocket, and many people do not have sufficient financial resources to pay for care. The financial pressures facing most families need to be recognized, and the value (long-term benefits and costs) of various oral health supervision services should always be discussed. Some procedures, such as hospitalization for treatment of children needing general anesthesia, are difficult to finance. For a relatively new procedure such as sealants—which are very effective but can also be costly—families may need to be apprised of the long-term benefits. For services involving orthodontia, families may be weighing perceived self-image issues against other financial pressures. But even for familiar services focusing on caries prevention, families may not have the financial resources or insurance to cover payments.

It is critical that dental and other health professionals be aware of the resources available for care within their community—or know how to find them. In many cases, through coordination and cooperation with families, other health professionals, and social agencies, children can receive care and financial issues can be resolved. In many states, children with special health needs can qualify for oral health care. With recent changes in Medicaid, service arrangements patterned after health management organizations are now permitted, and eligibility for coverage has been expanded. Head Start also supports a thorough oral health intervention component.



Alternative funding mechanisms and sources of care can be found in many communities. Dental societies sponsor access programs that either pay for care directly, sponsor clinics, or organize networks of participating clinicians who serve children. Fraternal or other service organizations may support oral health services for certain children, such as those with special health needs. Many dental education facilities, such as dental schools, have training programs that seek patients with specific needs and conditions, and charge lower fees for service. Clinics that serve particular groups (such as the homeless) also may be available. Some private practitioners will work out payment schedules for families or direct them to financial services that can help work out extended payments. Local and state health departments and dental professional organizations often maintain a list of service clinics and programs that support oral health services in their jurisdiction.

Providing Culturally Competent Care

Experts predict that by the end of the 21st century, no single racial or ethnic group will comprise a majority in the United States. By the year 2000, people of color will comprise the majority in 53 of America's largest cities, and one out of every three Americans will be African American, Hispanic/Latino, Asian/Pacific Islander, or Middle Eastern. By the year 2030, it has been projected that people of color will make up more than half of the U.S. population.¹

To effectively meet the needs of America's children and families, all health professionals need to be attentive to cultural and ethnic diversity in the families they care for. Beginning with the interaction between the dental professional and the family, language differences may be a determining factor in the success of the interview as well as the effectiveness of health promotion and disease prevention education. Decisions concerning prevention strategies or treatments that affect a child's appearance may be based on cultural mores. In giving anticipatory guidance, it is essential to be culturally sensitive and respectful. Anticipatory guidance concerning dietary habits, for example, needs to reflect an understanding of the ways in which different ethnic groups view food and nutrition through unique cultural perspectives, including medicinal, celebrational, and health-promoting perspectives.²

Assuring Children's Comfort and Cooperation

Children and families benefit when oral health supervision occurs in an ongoing relationship with a dental professional. Dental facilities can sometimes be a formidable obstacle for some children and families, inhibiting their participation in oral health supervision. Dental facilities need to be designed to help children feel comfortable and to encourage their cooperation. Using toys and colorful play spaces in the facility, for example, may make the environment more appealing to the child.

The American Academy of Pediatric Dentistry³ and the American Academy of Pediatrics⁴ provide health guidelines that address behavior management and sedation for children, when medically required; these guidelines can be used to develop programs and design facilities. Behavioral approaches such as positive reinforcement, rewards, or distractions can be very effective in assuring children's comfort. For those cases in which pharmacologic and general anesthetic approaches may also be needed, physical facilities should be designed so that nitrous oxide and sedation can be used. Physical facilities should be designed so that behavioral management procedures such as nitrous oxide and sedation can be used, if needed. Some dental professionals find that the best way to handle children with significant behavioral management problems may be to refer these children to specialists such as pediatric dentists and oral and maxillofacial surgeons.

Children with Special Health Needs

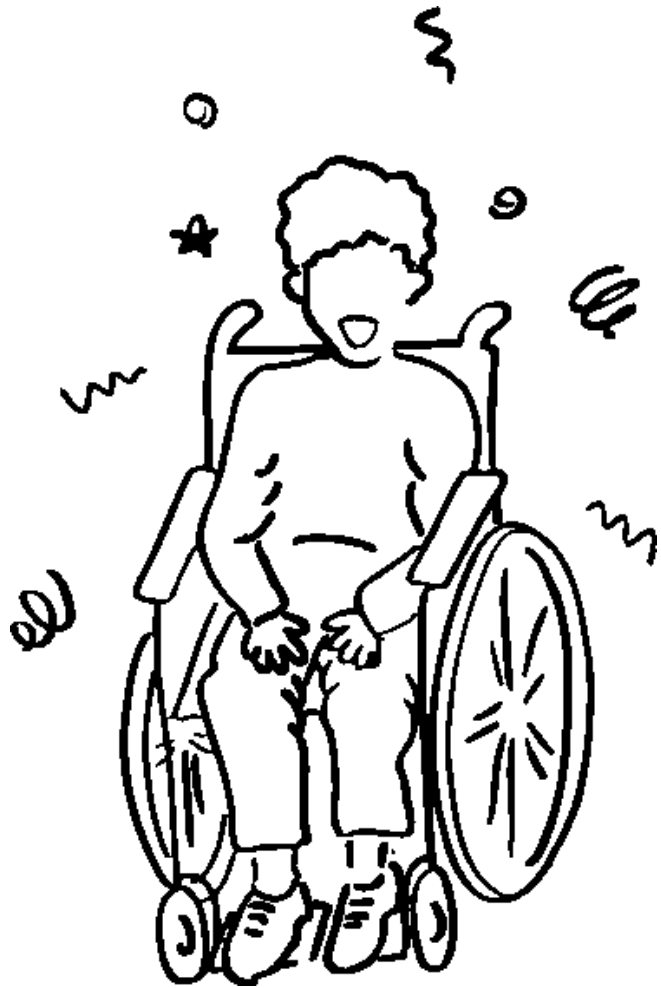
Oral health needs vary considerably among children with special health needs. Many children with special health needs are experiencing a reduction in dental caries; however, some continue to have unique problems. One primary concern is that because these children have a number of other needs, oral health supervision may not be regarded as a priority. Other risk factors for this population are considerable, and may include daily medications, modified dietary habits, decreased saliva flow, inability to clean teeth thoroughly on a daily basis, variations in tooth anatomy and tooth structure, and lack of access to preventive care.

Dental facilities need to be fully accessible to children with special health needs, including those with congenital or developmental disabilities, acute and chronic medical conditions, hereditary disorders, and acute situational anxieties. Office staff who are knowledgeable about children with special health needs and can adjust flexibly to meet their unique requirements are essential in providing effective care. Scheduling appointments for children with special health needs at a time when they are rested and have had any necessary medications is important. In addition, physical barriers that impede access to parking or to the dental treatment setting may need to be modified in accordance with the Americans with Disabilities Act.

Dental professionals may need more information from the parents or caregiver about a child's specific needs. Additional information can be obtained from the child's health professional, the child's school, or the special program that provides an assisted work environment. By talking with others involved in caring for the child, the dental pro-

fessional will be better able to make an assessment and provide appropriate, attainable recommendations for the child and family.

A child with special health needs may require an adaptive treatment plan. A child, for example, with a severe neuromuscular disorder who requires a modified diet, needs assistance with daily oral hygiene, and has uncontrollable head movements and increased perioral sensitivity will not be a candidate for comprehensive orthodontic treatment. Similarly, a child with cleft lip and/or palate will



need care by a variety of health professionals such as physicians, orthodontists, nutritionists, and speech and language therapists to determine the best overall management of this multifunctional condition. The dental professional, the parent, and, when possible, the child (or adolescent) should discuss treatment within the context of helping the developing child to achieve the healthiest and most functional teeth possible.

Once the initial assessment has been made, the dental professional and the parents or caregivers must choose the most appropriate setting and method for treatment. If needs are extensive, the dental professional might recommend that treatment be provided in a hospital setting. An alternative choice might involve referring the child to a dental professional trained in treating children with special health needs, such as a pediatric dentist or a general dentist who has completed a hospital-based general practice residency.

Children with special health needs should receive preventive dental care as early as possible. Because these children are at increased risk, dental professionals, health professionals, parents, advocacy groups, and institutions need to be advised early of the importance of care. Follow-up care for the child with special health needs, as for all children, will depend on the individual child's risk of disease. Some children may be able to maintain a very healthy oral environment with semiannual or annual oral health supervision visits; others may require more frequent care.

Infection Control Procedures

Infection control procedures must be followed to prevent the potential spread of infectious diseases such as the common cold, pneumonia, tuberculosis, herpes, hepatitis B, and HIV. The Centers for Disease Control and Prevention (CDC) and the American Dental Association have published guidelines that provide a comprehensive review of infection control procedures for dental environments (see Appendix C).

It is important to note that the Occupational Safety and Health Administration (OSHA) has mandated standards on occupational exposure to bloodborne pathogens, and all dental delivery sites are mandated by law to comply with these standards. The OSHA standards, however, are designed to protect the employed providers of care rather than the children and adolescents receiving care.

Endnotes: Making Oral Health Supervision Accessible

- 1 Healthy Mothers, Healthy Babies Coalition. 1993, August. *Unity Through Diversity: A Report on the Healthy Mothers, Healthy Babies Coalition—Communities of Color Leadership Roundtable*. Washington, DC: Healthy Mothers, Healthy Babies Coalition.
- 2 Eliades DC, Sutor CW. 1994. *Celebrating Diversity: Approaching Families Through Their Food*. Arlington, VA: National Center for Education in Maternal and Child
- 3 American Academy of Pediatric Dentistry. 1994. Reference Manual, 1994–1995. Guidelines for Behavior Management [Special issue]. *Pediatric Dentistry* 16(7).
- 4 American Academy of Pediatrics. 1992. Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures. *Pediatrics* 19:1110–1115.

