Management of Dental Patients with Special Health Care Needs

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Abstract

*This best practice presents recommendations regarding the management of oral health care for dental patients with special health care needs (**SHCN**) rather than treatment for oral conditions. SHCN are defined as any physical, developmental, mental, sensory, behavioral, cognitive, or emotional difference or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs. Nearly 1 in 6 US children has SHCN. The more severe their health conditions, the more likely they are to have unmet dental needs. Individuals with SHCN are at higher risk for poor oral health due to medical status, sensory issues, behavioral challenges, and significant barriers in access to and provision of dental care. Strategies for behavior guidance, sensory adaptations, and advocacy are discussed. Without timely professional preventive and therapeutic dental services, untreated oral disease has the potential to exacerbate systemic medical conditions, cause pain and dysfunction impacting overall quality of life, and increase the need for more complex dental care. This document addresses patients with developmental or acquired orofacial conditions as a special cohort of children with SHCN. Consultation and coordination of care with medical and other dental providers may be necessary for safe delivery of care and to improve long term outcomes for these patients. As children with SHCN approach adulthood, planning and coordinating their successful transition to an adult dental home ensures no disruption in the continuity of oral health care.*

This document was developed through a collaborative effort of the American Academy of Pediatric Dentistry Councils on Clinical Affairs and Scientific Affairs to offer updated information and guidance on the management of dental patients with special health care needs.

KEYWORDS: DENTAL CARE FOR CHILDREN; DENTAL CARE FOR DISABLED; DISABLED CHILD; PEDIATRIC DENTISTRY

Purpose

Providing both primary and comprehensive preventive and therapeutic oral health care to individuals with special health care needs (**SHCN**) is an integral part of the specialty of pediatric dentistry.[1] The American Academy of Pediatric Dentistry values the unique qualities of each person and the need to ensure maximal health attainment for all, regardless of intellectual and developmental disabilities or other special health care needs. These recommendations are intended to educate health care providers, parents[2], and ancillary organizations about the management of oral health care particular to individuals with SHCN rather than provide specific treatment recommendations for oral conditions.

Methods

Recommendations on the management of dental patients with SHCN were developed by the Council on Clinical Affairs, adopted in 2004,[3] and last revised in 2021.[4] This update is based on a review of the current dental and medical literature related to individuals with SHCN. A search was conducted via PubMed/MEDLINE using the terms: (*evidence based dentistry* [**Majr**] OR *pediatric dentistry* [Majr] OR *dental care for children* [Majr] OR *paediatric dentistry* [**Tiab**] OR *dental health services* [Majr] OR *dentistry* [Majr] OR *public health dentistry* [Majr] OR *community dentistry* [Majr]) *and* (*special needs* [Tiab] OR *SHCN* [Tiab] OR *oral health* [Majr] OR *children with disabilities* [Majr] OR *dental care for persons with disabilities* [Majr] OR *handicapped children* [Tiab] OR *education, special* [Majr] OR *special care dentistry* [Tiab] OR *special needs dentistry* [Tiab] OR *treatment accommodation** [Tiab]); fields: all; limits: clinical trial, randomized control trial, systematic review, and English. Papers for review were chosen from the resultant list of 212 articles and from references within selected articles. When data did not appear sufficient or were inconclusive, recommendations were based on expert and/or consensus opinion by experienced researchers and clinicians.

Background

The American Academy of Pediatric Dentistry defines special health care needs as "any physical, developmental, mental, sensory, behavioral, cognitive, or emotional difference or

ABBREVIATIONS
Majr: Medical subject headings major topic. **SHCN:** Special health care needs. **Tiab:** Title and abstract.

* *Used in the PubMed search to identify all terms that begin with this truncated base.*

limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity. Health care for individuals with disabilities or complex medical needs requires specialized knowledge, as well as increased awareness and attention, adaptation, and accommodative measures beyond what are considered routine."[5]

Children and adolescents with SHCN account for a significant portion of the pediatric patient population. Of children ages 0-17 years, 21.5% were identified as having a special health care need according to a 2023-2024 nationwide survey.[6] The Centers for Disease Control and Prevention (CDC) currently reports 1 in 6 children in the US has a developmental disability.[7] Recent increases in prevalence of mental, behavioral, and developmental disorders in individuals aged 3 to 17 years predominantly have been related to anxiety, depression, learning disabilities, developmental delay, and speech or language disorders.[8] Because of advances in medicine, many formerly acute and fatal diagnoses have become chronic and manageable conditions, thus necessitating long-term dental care for individuals with medical complexity.[9] Oral health care is as important as the provision of medical services, and oral health is an inseparable part of general health and well-being.[10(p2)]

Individuals with SHCN experience significant obstacles to achieving optimal oral health; understanding the barriers to oral health care will improve advocacy and policy design for this population. Unmet dental needs are associated with SHCN status and complexity.[11,12] Children affected with more severe conditions have increased risk of having unmet dental needs.[9, 12,13] Barriers to care for children with SHCN may include limited access to a dentist willing to provide care or who accepts their insurance, limited access to a professional with experience and expertise, the child's inability to tolerate dental procedures, transportation issues, school absence policies, and discriminatory treatment.[14-16] Social determinants affect care coordination for these patients, and health care providers need to understand family characteristics to improve health care delivery.[17] Because of the increased risk of unmet dental care needs, establishment of a dental home is critical to provide comprehensive, coordinated oral health care for this population.[18,19]

Optimal health of children is more likely to be achieved with access to comprehensive health care benefits.[20] Common barriers for medically necessary oral health care include financial constraints.[14-16,21-24] Insurance plays an important role for families with children who have SHCN, but it still provides incomplete coverage of dental care.[14,15,21-23] Many individuals with SHCN rely on government funding to pay for medical and dental care and lack adequate access to private insurance for health care services.[25] Lack of preventive and timely therapeutic care may increase the need for more extensive and costly care and exacerbate systemic health issues.[26]

The disconnect between medically-necessary oral health care and insurance coverage is readily apparent in the challenges faced by individuals with orofacial anomalies. Medical health benefits may not provide for needed dental procedures or specialty care, even when timely dental interventions will positively affect growth and development, esthetics, psychosocial well-being, and overall oral health-related quality of life.[27]

Nonfinancial considerations such as language barriers, cultural differences, psychosocial characteristics, and structural norms may interfere with access to oral health care.[14,21] Children whose parents are non-English speaking and have lower levels of education are less likely to receive preventive oral health services.[13] Psychosocial factors associated with access for patients with SHCN include oral health beliefs, norms of caregiver responsibilities, and past dental experiences of the caregiver. Limited oral health literacy and attitudes can serve as impediments to oral care.[28] The caregiver's oral health promotion efforts and interest in oral health-related education have been positively correlated with the level of function, capabilities, and independence of an individual with SHCN.[29,30] Parental and physician lack of awareness and knowledge in the management of children with SHCN may hinder an individual with SHCN from seeking preventive dental care.[29,31] Other health conditions may take precedent over dental health, especially when the relationship between oral health and general health is not well understood by the caregiver.[32]

Dental disease and other oral conditions can have a direct and devastating impact on quality of life. Attention to the oral health status of patients with SHCN is warranted to optimize their general health. Knowledge of oral health risk factors particular to an individual's particular medical condition can inform anticipatory guidance, treatment planning, and any required modifications to dental management.

Individuals with SHCN are at higher risk for dental caries, periodontal disease, hard tissue defects, malocclusion, hypo/hyperdontia, anomalous tooth morphology, parafunctional habits, trauma, erosion, oral aversion, and reduced tolerance to procedures in the dental setting.[9] Oral manifestations of individuals with SHCN will vary in etiology, frequency, and severity.

Patients with cognitive or developmental disabilities which impact their ability to understand, assume responsibility for, or cooperate with preventive oral health practices are at increased risk for oral disease.[33] When sensory processing is overwhelmed by interaction within dental environment (eg, noise, light, sound, smells, tastes, textures), individuals may be defensive or unaccepting of dental procedures.[34] Other sensory impairments (eg, blindness, deafness, olfactory dysfunction) can impact care delivery and often require the dental provider to consider alternative methods for communication, adapted environments, and individualized approaches for these patients.

Some psychiatric conditions can increase risk for poor oral health status. Attention-deficit, conduct, and behavior disorders can impact a patient's ability to consistently perform home care or successfully complete dental appointments and potentially increase risk for dental trauma. Medications commonly

used for psychiatric disorders, including stimulants and antidepressants, can cause dry mouth and increase caries risk.[35] Depression can negatively affect oral hygiene, self-image, and motivation to maintain oral health. Understanding pharmacologic and behavioral health risk factors related to an individual's mental health status can guide conversations regarding oral health practices and preventive strategies.

A wide range of systemic conditions present challenges to oral health. Medical fragility makes oral health care of utmost importance to prevent infection, pain, or loss of function. Generally, conditions that disrupt typical fetal developmental processes (eg, premature birth, congenital heart disease, syndromes) can result in dental conditions that increase vulnerability to oral disease. More direct are developmental or acquired disorders affecting the orofacial complex (eg, ectodermal dysplasia, amelogenesis imperfecta, dentinogenesis imperfecta, craniofacial anomalies, oral cancer, hypophosphatasia). Enamel and dentin defects, missing teeth, and malocclusions result in complex dental restorative challenges that alter the course of typical oral health care. These individuals may be at an increased risk for poor oral health and higher incidence of dental caries throughout their lifetime.[9,10(p2),36-40]

Physical disabilities may limit an individual's ability to execute age-appropriate oral hygiene practices increasing risk for caries and periodontal issues. Neuromuscular disorders that affect movement, tonicity, and balance (eg, cerebral palsy, muscular dystrophy, spina bifida, seizures) increase risk for malocclusion, attrition, erosion, and dental trauma.[41,42] Dysphagia can contribute to heavy calculus accumulation, a common finding in individuals fed by gastrotomy tubes, and higher risk of aspiration pneumonia from deposits breaking free and entering the airway.[43]

Medical management of systemic conditions can also contribute to oral health risks. Medications may induce gingival hyperplasia (eg, antiepileptics used for seizure disorders), xerostomia, mucositis (eg, chemotherapeutics used for cancer), or a host of other side effects.[44,45] Sweetened oral medications that are taken frequently contribute to higher caries risk.[45] Patients who require frequent feedings for metabolic reasons or feeding disorders may have increased exposure to cariogenic substances (eg, nutritional shakes).[47] Children with a history of prolonged intubation or early life surgeries may show increased occurrence of dental defects, dental trauma, or orthodontic issues.[48]

Oral health promotion emphasizes preventive measures to avoid dental caries and other oral health problems. Education of parents/caregivers is critical for ensuring regular supervision of daily oral hygiene. The dental professional can develop an individualized oral hygiene program to accommodate the unique disability of the patient. Assistance from other health professions (eg, occupational therapy) may be beneficial. Brushing with a fluoridated dentifrice twice daily helps prevent caries and gingivitis. If a patient's sensory issues cause the taste or texture of over-the-counter toothpaste to be intolerable, a nonfoaming toothpaste, a fluoridated mouthrinse, or an alternative may be applied with the toothbrush to clean teeth.[49] Toothbrushes can be modified to enable individuals with physical disabilities to brush their own teeth. Electric toothbrushes and floss holders may improve patient compliance. Caregiver assistance becomes necessary to provide optimal oral care when the patient is unable to do so adequately.

A noncariogenic diet is an essential component of a caries-prevention program.[50] When a diet rich in carbohydrates or the use of high-calorie supplements is medically necessary (eg, to increase weight gain), individualized preventive strategies to mitigate the caries risk are indicated. Likewise, individuals with sensory challenges that cause preferences for specific tastes and textures or who have problems with oral clearance may benefit from counseling on oral health risks and preventive strategies.

Patients with SHCN should be offered and provided traditional dental care and, when clinically indicated, they may benefit from sealants,[51] topical fluorides[52] (eg, sodium fluoride, silver diammine fluoride), and interim therapeutic restoration (ITR) using materials such as glass ionomers.[53] In cases of gingivitis and periodontal disease, chlorhexidine mouthrinse may be useful.[54] Use of a toothbrush to apply the chlorhexidine is an option if caregivers are concerned about the child's potentially swallowing the antiseptic or if the child is unable to expectorate an oral rinse. An increased recall frequency for patients having severe dental disease is indicated.[55] Patients with aggressive periodontal disease require referral to a periodontist for evaluation and treatment if the treatment needs are beyond the treating dentist's scope of practice.

Preventive strategies for patients with SHCN include traumatic injury prevention. This includes anticipatory guidance regarding risk for trauma (eg, seizure disorders, motor skills/coordination deficits), mouthguard fabrication, and what to do if dentoalveolar trauma occurs. Additionally, children with SHCN are more likely to be victims of physical abuse, sexual abuse, and neglect when compared to children without disabilities.[56,57] Craniofacial, head, face, and neck injuries occur in more than half of the cases of child abuse.[57] Because of this incidence, dentists need to be aware of signs of abuse and mandated reporting procedures.[56,57]

Indications for an orthodontic evaluation include facial asymmetry, abnormalities in nasal breathing, obstructive sleep apnea, malocclusion, and difficulties with chewing, swallowing, speech, and/or oral functioning. The primary motivation for parents to have their child with SHCN undergo orthodontic therapy is to improve the child's esthetics, oral function, and quality of life.[58,59] The decision to initiate orthodontic treatment includes consideration for the child's ability to tolerate treatment and the expected outcomes of care. Expectations of families may not align with anticipated outcomes. Understanding atypical patterns of growth and development in patients with skeletal disorders is important when making recommendations for orthodontic treatment.

When patients with SHCN reach adulthood, their oral health care needs may extend beyond the scope of the pediatric dentist's practice.[60] The successful transition from pediatric to adult dental care is integral to continuity of care and improved

long-term outcomes of children with SHCN.[61,62] Finding a dental home for older adolescent and adult patients with SHCN can be challenging.[62,63] Pediatric hospitals, by imposing age restrictions, can create another barrier to care for these patients. This presents difficulties for pediatric dentists providing care to adult patients with SHCN patients who have not yet transitioned to adult primary care. Outpatient surgery centers and in-office general anesthesia may be alternatives, although they may not provide immediate access to resources and/or ancillary services for patients with complex medical needs.[60,64] The Commission on Dental Accreditation requires dental schools to ensure that curricular efforts focus on educating students on assessment of treatment needs of patients with SHCN.[65]

Recommendations

The goals of optimal oral health care for individuals with SHCN align with those for all children, with careful consideration of the risks, benefits, and prognosis of the proposed plan to the individual's condition. In order to facilitate safety and optimization of oral health care for individuals with SHCN, oral health professionals should

- enable establishment of a dental home[66] beginning with preappointment screening at the time of scheduling to determine the presence and nature of any SHCN. The office staff, under the guidance of the dentist, should determine the need for an increased length of appointment and/or additional auxiliary staff to accommodate the patient in an effective and efficient manner. They also should consider the best time for the appointment (eg, morning, first appointment of day, number of patients in waiting room) and discuss need for introductory visits.[38] The dental team should document the need for increased time or other customized services in the dental record to better prepare for each subsequent visit.[67]
- comply with Americans with Disabilities Act regulations applicable to dental practice, including provision of physical access to the dental office (eg, wheelchair ramps, parking spaces).[68]
- develop a treatment plan that recognizes the patient's/family's health care priorities and optimizes both general and oral health outcomes.
- adhere to laws regarding informed consent, including the presence of a health care guardian for dental services when patients are unable to provide their own consent. When possible, oral health care professionals should facilitate supported decision-making practices between patients and health care guardians.[69]
- understand the patient's physical and cognitive development, hypersensitivities, cooperation in medical settings, triggers to negative behavior, soothing strategies, adherence to schedule or routine, and current therapies[70(p366)] and employing basic and advanced behavior guidance strategies conducive to the patient's individual needs.[71,72]
- communicate with patients at a level appropriate for their cognitive development.[70(p366)] The dentist should not assume that patients with impaired communication have associated intellectual disability, unless specified.[70(p366)] For patients with hearing or visual impairment, nonverbal communication, sign language interpreters, or cues with the help of the caregiver may be required.
- obtain a thorough medical history for each patient and consult with patient's medical providers regarding pre- and perioperative management for dental procedures. Considerations include, but are not limited to
  - review of the patient's medications and their potential for interaction with drugs administered during dental procedures. The practitioner should have a thorough knowledge of indications and contraindications for the use of pharmacologic agents (eg, antibiotics, analgesics, sedatives, anesthetics) in relation to the patient's medical condition.
  - provision of a detailed regimen for medication use pre- and postoperatively, including any modifications to standardized NPO recommendations, withholding of medications preoperatively, and timing of any resumed regimens after dental treatment.
  - recognition of anatomic or pathophysiologic conditions which present with higher risk of complications during dental procedures, protective stabilization, sedation, or general anesthesia and determination of conditions for which patients are best treated in a tertiary care setting or require high level specialist care.
  - accommodations for comfort and safety tailored to the individual's unique medical conditions (eg, ambulatory support, modified chair positioning, protective padding, instrument/equipment coverings). During dental prophylaxis, care must be taken to avoid aspiration of calculus, water, or other debris in patients with swallowing disorders. Latex materials should be avoided in children with spina bifida who present for dental care due to increased risk of allergy.
- emergency preparedness, including access to rescue medications, monitoring equipment, and protocols for activating emergency medical services.
- timely and comprehensive dental treatment for patients undergoing medical care (eg, cardiac surgery, transplantation) or other medical interventions (eg, chemotherapy) which can be complicated by untreated oral disease in order to reduce risk of infection and optimize medical management.[73] Untreated dental disease can lead to systemic infection and should receive prompt attention, particularly in immunocompromised individuals or those with conditions at high risk for infective endocarditis.[74,75]
- coordinated delivery of services by the various health care providers or health care teams for patients with orofacial conditions. Oral health care professionals should advocate for third-party health insurance coverage for dental care for these individuals[76] and should work with the insurance industry to recognize the medical necessity for such treatment in these cases.

- promotion of oral health prevention through education of parents/caregivers, oral hygiene instruction, dietary counseling, and preventive dental care that acknowledges and modifies standard oral health advice according to the individual needs of each patient. Delivery of anticipatory guidance should address concerns specific to the child's medical status (including risk for caries, periodontal conditions, dental trauma, and orthodontic problems), and likely need for advanced dental specialty care.
- education and preparation before transitioning to a dentist who is knowledgeable and comfortable in both adult oral health needs and managing SHCN.[62,77,78] Until the new dental home is established, the patient is encouraged to maintain a relationship with the current care provider and have access to emergency services.[79] In cases where transitioning is not possible or desired, the dental home can remain with the pediatric dentist who recommends appropriate referrals for specialized dental care as needed.[60,63]

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