Policy on the Dental Home

Latest Revision

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Purpose

The American Academy of Pediatric Dentistry (**AAPD**) supports the concept of a dental home[1] for all infants, children, adolescents, and persons with special health care needs (**SHCN**). A dental home is fundamental to helping patients achieve optimal oral health.

Methods

This policy was developed by the Council on Clinical Affairs, adopted in 2001[2], and last revised in 2018[3]. For this revision, literature searches of PubMed/MEDLINE and Google Scholar databases were conducted using the terms: *dental home*, *medical home in pediatrics*, and *infant oral health care*; fields: all; limits: within the last 10 years, human, English, meta-analysis, and systematic reviews. The search returned 774 articles that matched the criteria. The articles were evaluated by title and/or abstract and relevance to the establishment of a dental home. Expert opinions and best current practices were relied upon when clinical evidence was not available.

Background

A dental home is "the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a safe, culturally-sensitive, individualized, comprehensive, continuous, accessible, coordinated, compassionate, and patient- and family-centered way regardless of race, ethnicity, religion, sexual or gender identity, medical status, family structure, or financial circumstances. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of optimal oral health."[1] Establishment of the dental home is initiated by the identification and interaction of these individuals, resulting in a heightened awareness of all issues impacting the patient's oral health. Interaction of the dental team with early intervention programs, early childhood education and child-care programs, schools, members of the medical and dental communities, and other public and private community agencies can help ensure awareness of age-specific oral health issues and establishment and maintenance of a dental home for all infants, children, adolescents, and persons with special health care needs.

The dental home concept is derived from the American Academy of Pediatrics' (**AAP**) 1992 policy statement defining the medical home.[4] Health care provided in a patient-centered medical home environment has been shown more effective and less costly in comparison to emergency care facilities or hospitals.[5,6] Family-centered care has been identified by the AAP as an important characteristic of an effective medical home as the family is the primary source of strength and support for the child.[7] Patient- and family-centered approaches promote more positive health outcomes.[7] Strong clinical evidence exists for the efficacy of early professional dental care[8] complemented with caries-risk and periodontal-risk assessments, anticipatory guidance, and periodic supervision[9]. The establishment of a dental home follows the medical home model as a cost-effective measure to reduce the financial burden and decrease the number of dental treatment procedures experienced by young children[10-12] and serves as a higher quality health care alternative in orofacial emergency care situations.[13]

Children who have a dental home are more likely to receive individualized preventive and routine oral health care thereby improving families' oral health knowledge and practices, especially in children at high risk for early childhood caries.[8] Referral by the primary care physician or health provider has been recommended, based on risk assessment, as early as 6 months of age and no later than 12 months of age.[14-16] This provides time-critical opportunities to implement preventive health practices and reduce the child's risk of preventable dental/oral disease.[16] Periodicity of reappointment also is based upon risk assessment.[9]

Central to the dental home model is dentist-directed care. The dentist performs the examination, diagnoses oral conditions, and establishes a treatment plan that includes individualized preventive services, and all services are delivered under the dentist's supervision. The dental home delivery model implies direct supervision (ie, physical presence during the provision of care) of allied dental personnel by the dentist. The allied dental personnel (eg, dental hygienist, expanded function dental assistant/auxiliary, dental assistant) work under direct supervision of the dentist to increase productivity and efficiency while preserving quality of care. Depending on state regulations, this model may also allow for provision of preventive oral health education and preventive oral health services by allied dental personnel under general supervision (ie, without the presence of the supervising dentist in the treatment facility) following the examination, diagnosis, and treatment plan by the licensed, supervising dentist. Furthermore, the dental team can be expanded to include auxiliaries who go into the community to provide education and coordination of oral health services. Utilizing allied personnel to improve oral health literacy could decrease individuals' risk for oral diseases and mitigate a later need for more extensive and expensive therapeutic services.[17]

Although teledentistry complements and does not serve as a substitute for the establishment of a dental home[18], it can expand the reach of a dental home for time-sensitive traumatic injuries[19,20], oral health screening[21], consultations[20-22], caries triage and detection[20-22], treatment planning[20,21,23], patient

ABBREVIATIONS

AAP: American Academy of Pediatrics. **AAPD:** American Academy of Pediatric Dentistry. **SHCN:** Special health care needs.

education[20,21], dental referrals[20,21,23], and dental treatment monitoring[23] with populations who face barriers to oral health services[22-24]. Access to oral health care providers may be limited due to financial barriers, SHCN, workforce shortages, transportation issues, and residing in rural or remote areas[22-24], as well as during times when dental clinics are closed due to local unforeseen circumstances (eg, fire, natural disaster) or a pandemic[18,25].

A coordinated transition from a pediatric to an adult dental home is critical for extending the level of oral health and the health trajectory established during childhood. This transitioning period is potentially stressful for parents and adolescents and for young adults with SHCN as resources for acquiring adulthood health care are insufficient for this population[26,27]. Education and preparation before transitioning to a dentist who is knowledgeable and comfortable in both adult oral health needs and managing SHCN are important. Until the new dental home is established, the patient can maintain a relationship with the current care provider and have access to emergency services. In cases in which transitioning is not possible, the dental home can remain with the pediatric dentist who is ethically obligated to recommend referrals for specialized dental care when the needed treatment exceeds the practitioner's scope of practice[28].

Policy statement

The AAPD encourages parents and other care providers to help every child establish a dental home no later than 12 months of age. The AAPD recognizes a dental home for pediatric patients should provide

- safe, culturally-sensitive, individualized, comprehensive, continuous, accessible, coordinated, compassionate, patient- and family-centered care regardless of race, ethnicity, religion, sexual or gender identity, medical status, family structure, or financial circumstances.[1,7,29-31]
- comprehensive assessment for oral diseases and conditions.
- comprehensive evidence-based oral health care including acute care and preventive services in accordance with AAPD periodicity schedules.[9]
- individualized preventive oral health program based upon a caries-risk assessment[32] and a periodontal disease-risk assessment[14].
- anticipatory guidance regarding oral hygiene practices, oral/dental development and growth, speech/language development, nonnutritive habits, diet and nutrition, injury prevention, tobacco/nicotine product use, substance misuse, human papilloma virus vaccinations, and intraoral/perioral piercing and oral jewelry/accessories.[9]
- management of acute/chronic oral pain and infection.[33,34]
- management of and long-term follow-up for acute dental trauma.[35-37]
- information about proper care of the child's teeth, gingivae, and other oral structures. This would include the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function, and esthetics of those structures and tissues.[38]
- dietary counseling.[39]
- referrals to dental specialists when care cannot directly be provided within the dental home.[28]
- effective transition from a pediatric to an adult dental home including early recommendations to caregivers and collaboration, communication, and coordination between the pediatric and adult oral health care teams to ensure uninterrupted comprehensive care.[40,41]

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