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AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth®

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American Academy of Pediatric Dentistry

The oral health policies and best practices in *The Reference Manual of Pediatric Dentistry* are developed under the direction of the Board of Trustees, utilizing the resources and expertise of its membership operating through the Council on Clinical Affairs. The Council on Scientific Affairs provides input as to the scientific validity of a policy or recommendation.

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AMERICA'S PEDIATRIC DENTISTS
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Introduction



Overview
Strategic Plan
Research Agenda

Overview

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Definitions and scope of pediatric dentistry

“Pediatric dentistry is an age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.”¹

To become a pediatric dental specialist, a dentist must satisfactorily complete a minimum of 24 months in an advanced education program accredited by the Commission on Dental Accreditation of the American Dental Association. Such programs “**must** be designed to provide special knowledge and skills beyond the D.D.S. or D.M.D. training...”² The curriculum of an advanced program provides the dentist with necessary didactic background and clinical experiences to provide comprehensive primary oral health care and the services of a specialist. Pediatric dentists provide care, conduct research, and teach in a variety of clinical and institutional settings, including private practice and public health. They work in coordination with other health care providers and members of social disciplines for the benefit of children.

The primary focus of most dental specialties is a particular area of dental, oral, or maxillofacial expertise. Pediatric dentistry encompasses a variety of disciplines, techniques, procedures, and skills that share a common basis with other specialties but are modified and adapted to the unique requirements of infants, children, adolescents, and those with special health care needs. By being an age-specific specialty, pediatric dentistry encompasses disciplines such as behavior guidance, care of patients with medical conditions and physical and developmental disabilities, supervision of orofacial growth and development, caries prevention, sedation, pharmacological management, and hospital dentistry, as well as other traditional fields of dentistry. These skills are applied to the needs of children throughout their ever-changing stages of development and to treating conditions and diseases unique to growing individuals.

The American Academy of Pediatric Dentistry (AAPD), founded in 1947, is the membership organization representing the specialty of pediatric dentistry. Its members put children first in everything they do and aim to achieve the highest standards of ethics and patient safety. They provide care to millions of our nation’s infants, children, adolescents, and persons with special health care needs and are the primary contributors to professional education programs and publications on pediatric oral health.

The AAPD, in accordance with its vision and mission, advocates optimal oral health for all children. It is the leading national advocate dedicated exclusively to children’s oral health. Advocacy activities take place within the broader health care community and with the public at local, regional, and national levels. *The Reference Manual of Pediatric Dentistry* (<https://www.aapd.org/research/oral-health-policies--recommendations/>) is one of the components of the AAPD’s advocacy activities.

Intent of *The Reference Manual of Pediatric Dentistry*

The Reference Manual of Pediatric Dentistry is intended to encourage a diverse audience to provide the highest possible level of care to children. This audience includes, but is not limited to:

- pediatric dentists.
- general dental practitioners and other dental specialists.
- physicians and other health care providers.
- government agencies and health care policy makers.
- individuals interested in the oral health of children.

The Reference Manual of Pediatric Dentistry is divided into five sections: (1) Definitions, (2) Oral Health Policies, (3) Recommendations, (4) Endorsements, and (5) Resources. Oral health policies are statements relating to AAPD positions on various public health issues. Recommendations are developed to assist the dental provider in making decisions concerning patient care. This section has two subcategories, Clinical Practice Guidelines and Best Practices, distinguished by the methodology employed to develop the recommendations. Adherence to the recommendations increases the probability of a favorable practice outcome and decreases the likelihood of an unfavorable practice outcome. The endorsements section includes clinical recommendations relevant to the practice of pediatric dentistry that have been developed by organizations with recognized expertise and adopted by the AAPD. Resources contains supplemental information to be used as a quick reference when more detailed information is not readily accessible, as well as clinical forms offered to facilitate excellence in practice.

Proper utilization of *The Reference Manual of Pediatric Dentistry* necessitates recognizing the distinction between standards and recommendations. Although there are certain instances within the recommendations where a specific action is mandatory, *The Reference Manual of Pediatric Dentistry* is not intended nor should it be construed to be either a standard of care or a scope of practice document. *The Reference Manual of Pediatric Dentistry* contains recommendations for care that could be modified to fit individual patient needs based on the patient, the practitioner, the health care setting, and other factors.

Definitions

For the purpose of this document, the following definitions shall apply:

Standards: Any definite rule, principle, or measure established by authority. Standards say what must be done. They are intended to be applied rigidly and carry the expectation that they are applied in all cases and any deviation from them would be difficult to justify. The courts define legal standards of care.

Clinical practice guidelines (CPG): “statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.”³

CPG are intended to be more flexible than standards. They should be followed in most cases, but they recognize that treatment can and should be tailored to fit individual needs, depending on the patient, practitioner, health care setting, and other factors. Deviations could be fairly common and could be justified by differences in individual circumstances. CPG originate in an organization with recognized professional expertise and stature. They are designed to produce optimal outcomes, not minimal standards of practice.

Best practices: “the best clinical or administrative practice or approach at the moment, given the situation, the consumer’s or community’s needs and desires, the evidence about what works for this situation/need/desire, and the resources available.”⁴ Like CPG, best practices are more flexible than standards and originate in an organization with recognized professional expertise and stature. Although they may be unsolicited, they usually are developed following a stated request or perceived need for clinical advice or instruction.

Must or shall: Indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

Should: Indicates the recommended need and/or duty; highly desirable.

May or could: Indicates freedom or liberty to follow a suggested alternative.

Parent: Unless otherwise indicated, the term parent as used in these oral health policies and recommendations has a broad meaning encompassing:

1. a natural/biological or adoptive father or mother of a child with full parental legal rights,
2. a person recognized by state statute to have full parental legal rights,
3. a parent who in the case of divorce has been awarded legal custody of a child,
4. a person appointed by a court to be the legal guardian of a minor child,
5. a person appointed by a court to be the guardian for an incapacitated adult,
6. a person appointed by a court to have limited, legal rights to make health care decisions for a ward,
7. or a foster parent (a noncustodial parent caring for a child without parental support or protection who was placed by local welfare services or a court order).

Development of oral health policies, best practices, and clinical practice guidelines

The oral health policies, best practices, and clinical practice guidelines of the AAPD are developed under the direction of the Board of Trustees (BOT), utilizing the resources and expertise of its membership operating through the Council on Clinical Affairs (CCA), the Council on Scientific Affairs (CSA), and the Evidence-based Dentistry Committee (EBDC) of the AAPD Pediatric Oral Health Research and Policy Center. CCA and CSA are composed of individuals representing the five geographical (trustee) districts of the AAPD, along with additional consultants confirmed by the BOT. The EBDC is comprised of two members from each of these councils as well as the AAPD’s editor-in-chief. Council/committee members and consultants derive no financial compensation from the AAPD for their participation in development of oral health policies, best practices, and clinical practice guidelines, and they are asked to disclose potential conflicts of interest. The AAPD has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

Proposals to develop or modify oral health policies and best practices may originate from four sources:

- the officers or trustees acting at any meeting of the BOT.
- a council, committee, or task force in its report to the BOT.
- any member of the AAPD who submits a written request to the BOT as per the AAPD Administrative Policy and Procedure Manual, Section 9 (the full text of this manual is available on the Members’ Only page of the AAPD website).
- officers, trustees, council and committee chairs, or other participants at the AAPD’s annual strategic planning session.

Regardless of the source, proposals for oral health policies and best practices are considered carefully, and those deemed sufficiently meritorious by a majority vote of the BOT are referred to the CCA for development or review/revision. The CCA members are instructed to follow the specified process and format their development. Oral health policies and best practices utilize two sources of evidence: the scientific literature and experts in the field. The CCA, in collaboration with the CSA, performs a literature review for each document. When scientific data do not appear conclusive or supplemental expertise is deemed beneficial, authorities from other organizations or institutions may be consulted.

The CCA meets on an interim basis to discuss proposed oral health policies and best practices. Each new or reviewed/revised document is deliberated, amended if necessary, and confirmed by the entire council. Once developed by the CCA, the proposed document is submitted for the consideration of the BOT. While the Board may request revision, in

which case it is returned to the council for modification, once accepted by majority vote of the Board, it is referred for Reference Committee Hearing at the next Annual Session. The Reference Committee Hearing is an open forum for the membership to provide comment or suggestion for alteration of the document. The CCA carefully considers all remarks presented at the Reference Committee Hearing prior to submitting its final document for ratification by a majority vote of the membership present and voting at the General Assembly. If accepted by the General Assembly, either as proposed or as amended by that body, the document then becomes the official AAPD oral health policy or best practice for publication in *The Reference Manual of Pediatric Dentistry* and on the AAPD's website (<https://www.aapd.org/research/oral-health-policies--recommendations/>).

The EBDC provides oversight and management of the CPG development process. The topic for each guideline is recommended by the EBDC and approved by the BOT. Once a topic has been affirmed, the process begins with searches for an existing CPG from another organization with recognized expertise and for related systematic reviews. The EBDC will evaluate available publications and recommend either endorsement of an existing guideline or development of a new CPG. If a CPG is to be developed, the EBDC recommends to the BOT individuals for the guideline workgroup. Workgroup members are respected clinicians (end users), authors of peer reviewed publications in the topic under review, and methodology experts. All workgroup members should be capable of knowledgeably assessing a body of evidence using criteria approved by the EBDC. The duties of each workgroup may include:

- develop a research protocol.
- develop the PICO (Patient, Intervention, Comparison, Outcome) question for each guideline.
- select studies for full-text retrieval and extraction, and extract for each study selected.
- perform evidence synthesis: meta-analysis or narrative synthesis.
- grade evidence (based on GRADE criteria⁵).
- write a systematic review.
- review and edit a guideline.
- modify a guideline according to external review recommendations.

AAPD may choose to develop CPG in collaboration with other organizations of recognized expertise and stature. Such joint guidelines would undergo a similar development process and be based on a systematic review of the evidence.

Each proposed CPG is circulated to the CCA, CSA, and BOT for review and comment prior to submission for publication. These documents, however, do not undergo ratification

by the General Assembly. Rather, once finalized by the EBDC, the document becomes an official CPG of the AAPD for publication in *Pediatric Dentistry*, reprinting in *The Reference Manual of Pediatric Dentistry*, and posting on the AAPD's website (<https://www.aapd.org/research/oral-health-policies--recommendations/>).

Review of oral health policies and clinical recommendations

Each AAPD oral health policy, best practice, and clinical practice guideline is reviewed for accuracy, relevance, and currency every five years, and more often if directed by the BOT. After completing a new literature search, reviewers may recommend reaffirmation, revision, or retirement of the document. Policies and recommendations of other organizations that have been endorsed by the AAPD are reviewed annually to determine currency as well as appropriateness for the AAPD's continued endorsement.

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The American Academy of Pediatric Dentistry Strategic Plan

Reaffirmed

2023

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Vision

Optimal oral health for all children.

Mission

To advance optimal oral health for all children by delivering outstanding service that meets and exceeds the needs and expectations of our members, partners, and stakeholders.

AAPD Culture

Our members put children first in everything they do, and at the highest standards of ethics and patient safety. As such, the American Academy of Pediatric Dentistry (AAPD) is THE leading national advocate dedicated exclusively to children's oral health. We are the embodiment of our members' expertise as the big authorities on little teeth.

Strategic Objectives

Clinical Expertise

We equip our members and all other providers with data, knowledge, competencies, and skills to provide safe, high-quality, evidence-based patient care in the context of a dental home.

- Provide and promote continuing clinical education that meets the changing needs of patients and their caregivers.
- Use the authority and expertise of our members to advocate for patient safety, improved outcomes, and intelligent regulatory oversight.
- Invest in pre- and post-doctoral education by supporting training programs, advising accreditation boards, and sponsoring programs to enhance success throughout their career.

Patient Care and Access

We help members address barriers to care, such as parent oral health literacy and affordability; reduce administrative burdens for payment/reimbursement; and invest in community-based initiatives providing care to underserved children.

- Support research that identifies the scope of dental need in the United States (U.S.) and supports the best clinical practices for patient care.
- Advocate for legislative reforms to reduce the administrative complexity of reimbursement for dental treatment.

- Support and promote programs that provide care to those in need.

Workforce and Practice Transformation

We support the pediatric dental workforce, expanding its reach and to better address children's oral health needs. We develop practical tools and resources to help all members in any practice setting build and sustain high-functioning dental care practices to the benefit of their patients and their communities.

- Support research to examine the distribution and profiles of providers, to help members make informed decisions about their practices.
- Develop and provide tools that enable our members in all practice settings to provide optimal care.
- Offer education courses in nonclinical areas of dental practice.
- Assist members in achieving a healthy work-life balance so they can enjoy a sustained career in pediatric dentistry.
- Provide opportunities to develop leadership skills that will help our members in their practice as well as in volunteer positions in the AAPD.
- Sponsor programs to manage student debt.

Advocacy

We take a solutions-based approach to educating the broader dental profession, local, state, and national policy makers, and consumers/parents about critical issues affecting child oral health in the U.S.

- Advise and influence public policy through direct advocacy as well as by training members to be advocates in their practices and their communities.
- Educate the public on key children's oral health topics through public service messages, media interviews by AAPD-trained spokespersons, contributions to parent blogs, and other communication opportunities as they occur.
- Help members to exchange information on legislative issues.
- Exchange information with other healthcare and children's organizations.

Operations

We maintain organizational effectiveness by meeting and exceeding accepted professional association management standards.

- Nurture an efficient and effective governance structure that incorporates a variety of experiences so that all viewpoints are represented. The structure creates a network of experts so that AAPD can quickly respond to emerging issues.
- Help volunteer leadership concentrate on issues by providing full administrative support and strategic advice.
- Coordinate marketing and public relations for a consistent message to members and the public.
- Select and develop the best talent.
- Provide solid financial analysis and direction for all activities of the AAPD.

The American Academy of Pediatric Dentistry Research Agenda

Latest Revision

2022

How to Cite: American Academy of Pediatric Dentistry. The American Academy of Pediatric Dentistry research agenda. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:12.

The American Academy of Pediatric Dentistry (AAPD) recognizes that high-quality evidence is the foundation of the science and practice of pediatric dentistry. Clinical care should be based on evidence-based dentistry (EBD) principles. Where there is insufficient evidence, relevant research should be conducted to help fill scientific gaps and better inform clinical practice. The AAPD Council on Scientific Affairs is charged with updating and affirming the AAPD Research Agenda.

The AAPD Research Agenda highlights strategic research topics relevant to the mission of pediatric dentistry. To help improve individual patient and population oral health outcomes, the AAPD urges academic, state, federal, philanthropic, and corporate funding agencies to devote resources to the following areas:

- **Clinical research:** Improving diagnosis, prevention, and management of dental and craniofacial conditions (e.g., emerging dental caries management agents, precision/personalized oral health care, technologies and strategies to monitor and promote health and self-care).
- **Interdisciplinary research:** Understanding, addressing, and eliminating oral health disparities to promote oral health (e.g., basic behavioral and social determinants of

health, basic science of craniofacial development, microbiology and microbiome research, development of evidence-based public health interventions, clinical trials focusing on children and vulnerable populations, integration of dentistry into the broader health care delivery system, bioinformatics, quality of care, models of interprofessional collaboration, big data, data mining and sharing, interdisciplinary care teams, and telehealth/teledentistry).

- **Translational research:** Moving scientific knowledge into practice and policy (e.g., dissemination and implementation of evidence-based care principles into clinical practice, barriers to dissemination and implementation, policy and practice partnerships).
- **Operational safety and environmental impact research:** Increasing understanding of health and safety issues within the established and remote practice of dentistry and the protection of pediatric patients and dental/healthcare professionals from risks of infection transmission (e.g., infection control, personal protective equipment, waterline disinfection, sterilization techniques, environmental impact to/from dentistry).



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- ✓ Upside Gains in Retained Ownership
- ✓ LPS vs. Do-It-Yourself & Small Advisors
- ✓ Six to Ten or More Bidders
- ✓ Highest EBITDA Calculation
- ✓ Full Knowledge of Risks & Rewards
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"I was about to sign an offer I had in hand for \$8 million from an IDSO I really liked. Chip convinced me to go through the LPS process to see my other options. LPS delivered nine bidders and the \$8 million became \$11 million from the same group!" -Dr. T.S., Tennessee

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-Dr. S.L., Indiana

"I never could have achieved this value or completed this deal without you. Thank you for everything."

-Dr. J.N., Maryland
Achieved 12.2x EBITDA in 2023

Definitions



Special Health Care Needs
Dental Home
Medically-Necessary Care
Dental Neglect

Definition of Special Health Care Needs

Latest Reaffirmation

2020

Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or 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.

How to Cite: American Academy of Pediatric Dentistry. Definition of special health care needs. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:15.

Health care for individuals with special needs requires specialized knowledge, as well as increased awareness and attention, adaptation, and accommodative measures beyond what are considered routine.

This definition was developed by the Council on Clinical Affairs and adopted in 2004. This document is a reaffirmation of the previous version, revised in 2016.

Definition of Dental Home

Latest Revision

2023

How to Cite: American Academy of Pediatric Dentistry. Definition of dental home. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:16.

The 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. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate.

This definition was developed by the Council on Clinical Affairs, adopted in 2006, and last revised in 2018.

Definition of Medically-Necessary Care

Latest Reaffirmation

2019

Medically-necessary care (MNC) is the reasonable and essential diagnostic, preventive, and treatment services (including supplies, appliances, and devices) and follow-up care as determined by qualified health care providers in treating any condition, disease, injury, or congenital or developmental malformation to promote optimal health, growth, and development. MNC includes all supportive health care services that, in the judgment of the attending dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care. These services include, but are not limited to, sedation, general anesthesia, and utilization of surgical facilities.

How to Cite: American Academy of Pediatric Dentistry. Definition of medically-necessary care. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:17.

MNC must take into account the patient's age, developmental status, and psychosocial well-being, in addition to the setting appropriate to meet the needs of the patient and family.

Dental care is medically-necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfiguration or dysfunction.

This definition was developed by the Clinical Affairs Committee on and adopted in 1997. This document is a reaffirmation of the previous version, revised in 2015.

Definition of Dental Neglect

Latest Reaffirmation

2020

How to Cite: American Academy of Pediatric Dentistry. Definition of dental neglect. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:18.

Dental caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function. These undesirable outcomes can adversely affect learning, communication, nutrition, and other activities necessary for normal growth and development.

Dental neglect is willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection.

This definition was developed by the Child Abuse Subcommittee of the Clinical Affairs Committee and adopted in 1983. This is the sixth reaffirmation of the 1992 version.

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Oral health policies

Oral health policies represent the American Academy of Pediatric Dentistry's positions on various public health issues

Policy on the Role of Pediatric Dentists as Both Primary and Specialty Dental Care Providers

Latest Revision

2023

How to Cite: American Academy of Pediatric Dentistry. Policy on the role of pediatric dentists as both primary and specialty dental care providers. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:21-2.

Purpose

The American Academy of Pediatric Dentistry (AAPD) emphasizes that health care providers and interested third parties must recognize the dual role that pediatric dentists play in the provision of professional preventive and therapeutic oral health care, which includes both primary and specialty care services, to ensure oral health care is accessible.

Methods

This policy was developed by the Council on Clinical Affairs, adopted in 2003¹, and last revised in 2018². This revision was based on a review of *Accreditation Standards for Advanced Specialty Training Programs in Pediatric Dentistry*³ and the AAPD position paper⁴ on the role of pediatric dentists as primary and specialty care providers. An electronic search was conducted using the terms pediatric dentist, pediatric specialist, primary care provider, dual care provider, and specialty care provider.

Background

The Commission on Dental Accreditation defines pediatric dentistry as “an age-related specialty that provides both primary and comprehensive preventive and therapeutic oral health needs for infants and children through adolescence, including those with special health care needs.”³ The American Dental Association^{3,5} and the American Academy of General Dentistry^{6,7} recognize the pediatric dentist as both a primary care provider and specialty care provider. The dual role of pediatric dentists is like that of pediatricians, gynecologists, and internists in medicine. Within the medical profession, clinicians and third-party payors recognize these physicians in a dual role and have designed payment plans to accommodate this situation.

The AAPD respects the rights of employers to negotiate health care benefits for their employees. If third-party payors do not recognize pediatric dentists as primary care providers, access to pediatric dentists may be restricted. When oral health care is not accessible, the health implications, effects on quality of life, and societal costs are enormous.⁸ For children who have reached a predetermined age and/or who may be best served by specialized oral health care providers, requiring a specialty referral to a pediatric dentist prior to evaluation may delay or prohibit the most beneficial and cost-effective care. Using National Health Interview Survey data, researchers “found that more people reported financial barriers to dental care than to

any other health care, regardless of age, income level, or type of insurance.”⁹

Policy statement

The AAPD recognizes that infants, children, adolescents, and individuals with special health care needs have the right to quality oral health care. The AAPD encourages third-party payors to recognize pediatric dentists as both primary and specialty oral health care providers and to refrain from age-related restrictions when a parent or referring clinician desires to utilize the services and expertise of a pediatric dentist to establish a dental home or for limited specialized care.

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ABBREVIATION

AAPD: American Academy of Pediatric Dentistry.

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Policy on Ethical Responsibilities in the Oral Health Care Management of Infants, Children, Adolescents, and Individuals with Special Health Care Needs

Latest Revision

2020

How to Cite: American Academy of Pediatric Dentistry. Policy on ethical responsibilities in the oral health care management of infants, children, adolescents, and individuals with special health care needs. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:23-4.

Purpose

The American Academy of Pediatric Dentistry (AAPD) believes that all infants, children, adolescents, and individuals with special health care needs (SHCN) are entitled to oral health care that meets the treatment and ethical standards set by our specialty.

Methods

This policy was developed by the Council on Clinical Affairs and adopted in 2003.¹ This document is a revision of the previous version, revised in 2015.²

Background

Dentists have an obligation to act in an ethical manner in the care of patients with consideration of the virtues of ethics including autonomy, beneficence, nonmaleficence, and justice. Autonomy reflects the patient's or, when the patient is a minor or an intellectually disabled adult who lacks capacity to give consent, the parent's³ or guardian's right to be involved in treatment decisions. The caregiver must be informed of the problem and that treatment is recommended. Beneficence indicates the dentist has the obligation to act for the benefit of the patient in a timely manner even when there may be conflicts with the dentist's personal self interests. Nonmaleficence dictates that the dentist's care does not result in harm to the patient. In situations where a dentist is not able to meet the patient's needs, referral to a practitioner capable of providing the needed care is indicated. Justice expresses that the dentist should deal fairly with patients, colleagues, and the public.^{4,5}

Denial of care by the provider because of age, behavior, inability to cooperate, disability, or medical status can result in unnecessary pain, discomfort, increased treatment needs and costs, unfavorable treatment experiences, and diminished oral health outcomes. If a dentist is unable to provide medically-necessary care⁶, he has an ethical responsibility to refer the patient to a practitioner or facility capable of providing the care.

Oral health care practitioners may offer services for children and individuals with SHCN in a variety of settings (e.g., solo practice, general dentistry group practice, specialty group practice, dental service organization, educational institution, hospital, public health or military clinic). Although each entity will have its own administrative policies and procedures to which practitioners must adhere, each provider also must be aware of and follow established standards and evidence-based guidelines promulgated by organizations with recognized professional expertise and stature.

Dentists are held responsible for their clinical and ethical decisions regardless of who holds the responsibility for business decisions.⁷ The "ultimate responsibility for compliance with state laws and regulations falls upon the practicing licensed dentist."⁸ All patients must receive dental care consistent with the moral, ethical, and evidence-based standards of care regardless of the care setting. The treating doctor's clinical judgment should not be influenced by financial considerations of the business entity.

Patients/parents need to play an active role in decision making with their doctors and must be informed about their medical and dental problems and treatment options.⁴ Evidence-based knowledge and treatment options are evolving at a rapid pace. As a result, patients/parents and health care providers are seeking second opinions so that more informed decisions based on the risks and benefits can be made for treatment. A provider has an ethical obligation, subject to privacy regulations, on request of either the patient or the patient's new provider to furnish records, including radiographs, or copies of them. These may be beneficial for the future treatment of that patient.⁴ Health Insurance Portability and Accountability Act (HIPAA) privacy rules⁹ and state laws apply to all exchanges

ABBREVIATIONS

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

of health care information. Educating the patient/parent regarding the diagnosis and available treatment options, including their risks and benefits, should be the goal of a second opinion consultation. Health care providers may disagree on the best treatment for an individual patient. Any opinion should be rendered only after careful consideration of all the facts and with due attention given to current and previous health status of the patient. When presented with requests for second opinions, practitioners should consider the legal implications of such requests. Health care providers rendering second opinions unwarily could be involved in litigation, either on behalf of the patient or in defending themselves against other practitioners as a result of the consult. The fact that one is the second or third consulted professional does not mean that the provider is exempt from liability.¹⁰ Parents and patients should be fully advised of their health status without disparaging comments about their prior treatment or previous provider.

Policy statement

Infants and children through adolescence, including those with special health care needs, have a right to dental care. The AAPD believes it is unethical for a dentist to ignore a disease or condition because of the patient's age, behavior, or disabilities. Dentists have an ethical obligation to provide therapy for patients with oral disease or refer for treatment patients whose needs are beyond the skills of the practitioner.

The AAPD encourages all entities and practitioners who provide oral health care services to children to follow evidence-based clinical practice guidelines and best practices developed by organizations with recognized professional expertise and stature. Under no circumstance should the business or corporate entity interfere with the clinical judgment of the treating dentist.

A patient/parent has a right to a second opinion. A provider who is trained and experienced in diagnosing and treating the condition is encouraged to provide the second opinion. When presented with requests for second opinions, practitioners must consider the legal implications of such requests. Patients/parents should be fully advised of their health status without disparaging comments about their prior treatment or previous provider.

The AAPD advocates legislation or regulation at the federal and state levels to ensure that dentists are free to exercise individual professional clinical judgment and render appropriate treatment to their patients without undue influence or infringement by any third-party business and entity.^{11,12}

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Policy on a Patient's Bill of Rights and Responsibilities

Latest Revision

2023

Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes that pediatric oral health care should be rendered under conditions acceptable to both the patient and the dentist. The expectation is that oral health care providers, their staff, patients, and parents¹ of patients will support this policy, thereby enhancing patient care.

Methods

This policy was developed by the Council on Clinical Affairs, adopted in 2009², and last revised in 2019³. For this revision, literature searches of PubMed®/MEDLINE and Google Scholar databases were conducted using the following parameters: terms: patient freedoms, patient's bill of rights, bill of rights, consumer bill of rights; fields: all; limits: within the last 10 years, human, English, and birth through age 18. The search returned 386 articles that met these criteria. The articles were evaluated by title and/or abstract and relevance.

Background

The AAPD is the leader in representing the oral health interests of infants, children, adolescents, and persons with special health care needs.⁴ Effective oral health care requires collaboration between pediatric dentists, patients and their parents, and other health care professionals. Optimal patient care requires open and honest communication between provider and patient, mutual respect for personal and professional values, and sensitivity to differences.⁵

Often, the delivery of contemporary pediatric oral health care can be confusing to parents. For parents to have expectations about their child's proposed care is normal. Yet, that these parents have realistic expectations as well as a clear understanding of their responsibilities in the delivery of care to their children is essential to the assurance that patient care and services are delivered in an appropriate manner.

A patient's bill of rights is a statement of the rights to which patients are entitled as recipients of medical/dental care. It articulates the positive rights that health care providers and facilities should provide patients, thereby providing information, offering fair treatment, and granting them autonomy over health decisions.

The collaborative nature of health care requires that patients, or their families/surrogates, participate in their care. The effectiveness of care and patient satisfaction with the course of treatment depend, in part, on the patient's fulfilling certain responsibilities. As such, the AAPD proposes this *Policy on a*

How to Cite: American Academy of Pediatric Dentistry. Policy on a patient's bill of rights and responsibilities. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:25-6.

Patient's Bill of Rights and Responsibilities in the planning and delivery of pediatric oral health care.

Policy statement

The AAPD encourages oral health care providers to tailor this bill of rights and responsibilities to their patient community by translating and simplifying it as necessary to ensure that patients and their families understand their rights and responsibilities. These rights and responsibilities can be exercised on the patient's behalf by a parent if the patient is a minor, lacks decision-making capacity, or is legally incompetent.

Patient's rights

The patient has the right to:

- choose an oral health care provider, including designating a pediatric dentist as the primary oral health care provider for a child;
- know the identity, education, and training of providers involved in direct patient care, as well as when those involved are students, residents, or other trainees;⁶
- receive treatment within a dental home that provides comprehensive, considerate, safe, and respectful care without undue influence of biases or discrimination based on, but not limited to, race, gender, or socioeconomic status;
- courtesy, dignity, and timely attention to health needs;⁷
- have oral health diagnoses made by a dentist;
- participate fully in all treatment decisions;
- receive accurate, relevant, current, and easily understood information concerning diagnosis, treatment, and prognosis;
- discuss and request information related to specific procedures and/or treatments, including accompanying risks and benefits, and the medically-reasonable alternatives. Life threatening emergency care could be an exception;
- make decisions about the plan of care prior to and during the course of treatment, to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the health consequences of this refusal.⁸ In case of refusal, the patient is entitled to other appropriate care and services that the pediatric dentist offers or to transfer to another dentist;

ABBREVIATION

AAPD: American Academy of Pediatric Dentistry.

- consent to or decline to participate in proposed research studies affecting care and treatment or requiring direct patient involvement and to have those studies explained fully prior to consent. A patient who declines to participate in research is entitled to the most effective care that the dentist can otherwise provide;
- expect reasonable continuity of care;
- emergency care as needed for acute dental trauma and oral infections;
- know the immediate and long-term financial implications of treatment choices, insofar as they are known by the provider. The patient has the right to be informed of the charges for services and available payment methods;
- be informed of the provider's policies and practices that relate to patient care, treatment, and responsibilities. This includes available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in an organization;
- have privacy considered in every interaction. Case discussion, consultation, examination, and treatment should be conducted in a way that best protects each patient's privacy;
- advise staff regarding specific privacy concerns or questions;⁹
- expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law (e.g., suspected abuse, public health hazards);
- expect that the provider will emphasize the confidentiality of information released to other parties entitled to review this information and to be informed of breaches of confidentiality;
- review the records pertaining to all provided health care and to have the information explained or interpreted as necessary, except when restricted by law;
- request amendments to personal healthcare records; and
- ask and be informed of the existence of business relationships among institutions, other health care providers, or payors that may influence the patient's treatment and care.

Patient's responsibilities

The patient is responsible for:

- providing, to the best of one's knowledge, accurate and complete information about past illnesses, medical conditions, hospitalizations, medications, and other matters related to the patient's health status;
- requesting additional information or clarification about health status or treatment when information or instructions are not fully understood;
- accountability of actions if treatment is refused or if instructions of the provider are not followed.⁶ It is the patient's responsibility to inform dentists and other caregivers of anticipated problems in following prescribed treatment, including follow-up treatment instructions;
- keeping appointments and, when unable to do so, notifying the dental office as soon as possible;
- being considerate of the rights of other patients and health care workers.¹⁰ This includes not interfering with

the functioning of the facility, avoiding profane or derogatory behavior, and minimizing noise;

- personal conduct with staff. The patient must resolve conflicts using available institutional mechanisms. Verbal and physical abuse of staff is prohibited;¹¹
- following Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines including not taking images, recordings, or videos of people and/or protected health information; and
- providing accurate insurance information and for fulfilling the financial obligations associated with the services rendered.

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Policy on Patient Safety

Latest Revision

2021

How to Cite: American Academy of Pediatric Dentistry. Policy on patient safety. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:27-31.

Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes patient safety as an essential component of quality oral health care for infants, children, adolescents, and those with special health care needs. The AAPD encourages dentists to consider thoughtfully the environment in which they deliver health care services and to implement practices to improve patient safety. This policy is not intended to duplicate safety recommendations for medical facilities accredited by national commissions such as The Joint Commission or those related to workplace safety such as Occupational Safety and Health Administration.

Methods

This document is a revision of the policy developed by the Council on Clinical Affairs, adopted in 2008¹, and last revised in 2018². This policy is based on a review of current dental and medical literature, including search of the PubMed®/MEDLINE database using the terms: patient safety AND dentistry, fields: all; limits: within the last 10 years, humans, English. Four hundred seventy-seven articles met these criteria. Papers for review were chosen from this list and from the references within selected articles.

Background

All health care systems should be designed to provide a practice environment that promotes patient safety.³ The World Health Organization (WHO) defines patient safety as “the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum.”⁴ The most important challenge in the field of patient safety is prevention of harm, particularly avoidable harm, to patients during treatment and care.⁴ Dental practices must be in compliance with federal laws that help protect patients from preventable injuries and potential dangers such as the transmission of disease.⁵⁻⁷ Laws help regulate hazards related to chemical and environmental factors (e.g., spills, radiation) and facilities (e.g., fire prevention systems, emergency exits).⁸ The AAPD’s recommendations and oral health policies provide additional information regarding the delivery of safe pediatric dental care.⁹⁻²² Furthermore, state dental practice acts and hospital credentialing committees are intended to ensure the safety of patients and the trust of the public by regulating the competency of and provision of services by dental health professionals.²³⁻²⁵

Patient-centered health care systems that focus on preventing errors are critical to assuring patient safety.^{25,26} Some

possible sources of error in the dental office are miscommunication, interruptions, stress, fatigue, failure to review the patient’s medical history (e.g., current medications, allergies), and lack of standardized records, abbreviations, and processes.^{3,25,27} Treating the wrong patient or tooth/surgical site, delay in treatment, disease progression after misdiagnosis, inaccurate referral, incorrect medication dosage ordered/administered, breach in sterilization, waterline contamination, and unintentional swallowing, aspiration, or retention of a foreign object are examples of patient safety events that occur in dentistry.²⁸⁻³² Adverse events may be classified in terms of severity of harm (e.g., none, mild, moderate, severe, death).³³

Standardized processes and workflows help assure clerical and clinical personnel execute their responsibilities in a safe and effective manner.²⁷ Policy and procedure manuals that describe a facility’s established protocols serve as a valuable training tool for new employees and reinforce a consistent approach to promote safe and quality patient care.²⁷ Identifying deviations from established protocols and studying patterns of occurrence can help reduce the likelihood of adverse events.¹³

Safety checklists are used by many industries and health-care organizations to reduce preventable errors.^{34,35} Data supports the use of procedural checklists (e.g., pre-sedation) to minimize the occurrence of adverse events in dentistry.³⁶⁻³⁹ In addition, order sets, reminders, and clinical guidelines built into an electronic charting system may improve adherence to best practices.³² Zero harm, the concept that a patient will not experience preventable harm or injury, is a goal in medicine today.⁴⁰ The medical profession generally has embraced the systematic approach to safety change, but the dental profession has been slower to adopt this approach.⁴¹⁻⁴³ The journey to achieve zero harm does not occur without effort. For change to occur in dental practices and organizations, it is important that dental professionals publicly commit to the establishment of a safety culture, encourage effective teamwork, and promote effective communication and training.^{43,44} Reducing clinical errors requires a careful examination of adverse events^{27,32,45} and near-miss events^{26,46}. In a near-miss event, an error was committed, but the patient did not experience clinical harm.^{26,46} Detection of errors and problems within a

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **WHO:** World Health Organization.

practice or organization may be used as teaching points to motivate changes and avoid recurrence.⁴⁷ A root cause analysis can be conducted to determine causal factors and corrective actions so these types of events may be avoided in the future.^{34,40,44,48} Embracing a patient safety culture demands a nonpunitive or no-blame environment that encourages all personnel to report errors and intervene in matters of patient safety.^{26,48} Alternatively, a fair and just culture is one that learns and improves by openly identifying and examining its own weaknesses; individuals know that they are accountable for their actions but will not be blamed for system faults in their work environment beyond their control.^{40,44} Evidence-based systems have been designed for healthcare professionals to improve team awareness, clarify roles and responsibilities, resolve conflicts, improve information sharing, and eliminate barriers to patient safety.^{40,49,50}

The environment in which dental care is delivered impacts patient safety. In addition to structural issues regulated by state and local laws, other design features should be planned and periodically evaluated for patient safety, especially as they apply to young children. Play structures, games, and toys are possible sources for accidents and infection.^{51,52}

The dental patient would benefit from a practitioner who follows current literature and participates in professional continuing education courses to increase awareness and knowledge of best current practices and public health concerns. Scientific knowledge and technology continually advance, and patterns of care evolve due, in part, to recommendations by organizations with recognized professional expertise and stature, including the American Dental Association, The Joint Commission, WHO, Institute for Health Improvement, and Agency for Healthcare Research and Quality. Data-driven solutions are possible through documenting, recording, reporting, and analyzing patient safety events.^{30,41,53} Continuous quality improvement efforts including outcome measure analysis to improve patient safety should be implemented into practices.^{32,54} Patient safety incident disclosure is lower in dentistry compared with medicine since a dental-specific reporting system does not exist in the United States.^{41,42} Identifiable patient information that is collected for analysis is considered protected under the Health Insurance Portability and Accountability Act (HIPAA).⁵⁵

Dental practitioners should be aware of and minimize the potential for patient fire during procedures when an ignition source, fuel, and oxidizer are present simultaneously.⁵⁶⁻⁵⁸ (Figure) Patient fire is rare but can result in injury and death.^{56,57} Sparks from burs, lasers, and electrosurgical units can serve as an ignition source.⁵⁷ Combustible agents (e.g., dry gauze, throat pack, paper and cotton products; hair; petroleum-based lubricants; alcohol-based products; rubber dam and nitrous mask) can act as a fuel.⁵⁷ Delivery of nitrous oxide and/or oxygen, both of which are oxidizers, can produce an oxidizer enriched atmosphere (OEA).

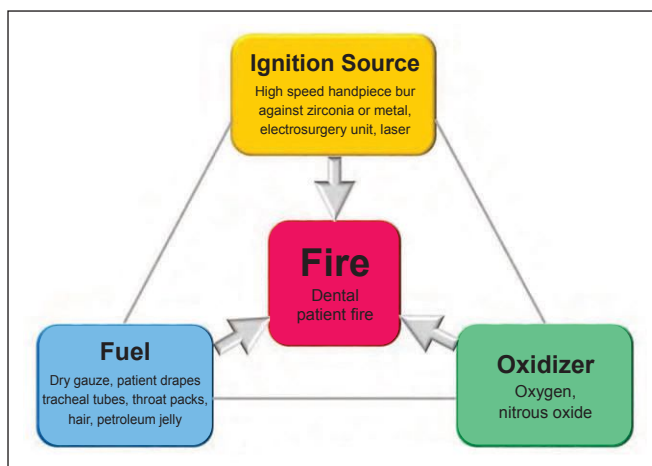


Figure. Dental fire triangle: dental fire may result when all three factors are present simultaneously.

Policy statement

To promote patient safety, the AAPD encourages:

- patient safety instruction in dental curricula to promote safe, patient-centered care.
- professional continuing education by all licensed dental professionals to maintain familiarity with current regulations, technology, and clinical practices.
- compliance with and recognition of the importance of infection control policies, procedures, and practices in dental health care settings in order to prevent disease transmission from patient to care provider, from care provider to patient, and from patient to patient.⁴⁻⁶
- routine inspection of physical facility in regards to patient safety. This includes development and periodic review of office emergency and fire safety protocols and routine inspection and maintenance of clinical equipment.
- recognition that informed consent by the parent, and assent from the child when applicable, is essential in the delivery of health care¹⁰ and effective relationship/communication practices can help avoid problems and adverse events. The parent should understand and be actively engaged in the planned treatment.
- accuracy of patient identification with the use of at least two patient identifiers, such as name and date of birth, when providing care, treatment, or services.
- an accurate and complete patient chart that can be interpreted by a knowledgeable third party.²¹ Standardizing abbreviations, acronyms, and symbols throughout the record is recommended.²¹
- an accurate, comprehensive, and up-to-date medical/dental history including medications and allergy list to ensure patient safety during each visit. Ongoing communication with health care providers, both medical and dental, who manage the child's health helps ensure comprehensive, coordinated care of each patient.

- a pause or time out with dental team members present before an invasive procedure to confirm the patient, planned procedure, and tooth/surgical site are correct.
- inclusion of fire prevention and management protocols in procedure and emergency plans. A time out may be used to assess the fire potential⁵⁷ of a procedure when nitrous oxide or oxygen is to be used. If an ignition source and fuel are present, risk of a patient fire may be reduced by monitoring the flow of gases and using high volume suction for at least one minute prior to the use of a potential ignition source.^{57,59} In addition, maintaining a moist working field and avoiding cutting dry can decrease fire risk.^{58,59}
- appropriate staffing and supervision of patients treated in the dental office.
- adherence to AAPD recommendations on behavior guidance,⁹ especially as they pertain to use of advanced behavior guidance techniques (i.e., protective stabilization, sedation, general anesthesia).
- standardization and consistency of processes within the practice. A policies and procedures manual, with ongoing review and revision, could help increase employee awareness and decrease the likelihood of untoward events. Dentists should emphasize procedural protocols that protect the patient's airway (e.g., rubber dam isolation), guard against unintended retained foreign objects (e.g., surgical counts; observation of placement/removal of throat packs, retraction cords, cotton pellets, and orthodontic separators), and minimize opportunity for iatrogenic injury during delivery of care (e.g., protective eyewear).
- minimizing exposure to nitrous oxide by maintaining the lowest practical levels in the dental environment. This includes routine inspection and maintenance of nitrous oxide delivery equipment as well as adherence to clinical recommendations for patient selection and delivery of inhalation agents.
- minimizing radiation exposure through adherence to the as low as reasonably achievable (ALARA) principle, equipment inspection and maintenance, and patient selection criteria.
- all facilities performing sedation for diagnostic and therapeutic procedures to maintain records that track adverse events. Such events then can be examined for assessment of risk reduction and improvement in patient safety.
- dentists who utilize in-office anesthesia providers take all necessary measures to minimize risk to patients. Prior to delivery of sedation/general anesthesia, appropriate documentation shall address rationale for sedation/general anesthesia, informed consent, instructions to parent, dietary precautions, preoperative health evaluation, and any prescriptions along with the instructions given for their use. Rescue equipment should have regular safety and function testing and medications should not be expired. The dentist and anesthesia providers must communicate during treatment to share concerns about the airway or other details of patient safety.
- ongoing quality improvement strategies and routine assessment of risk, adverse events, and near misses. A plan for improvement in patient safety and satisfaction is imperative for such strategies.⁴⁰
- comprehensive review and documentation of indication for medication order/administration. This includes a review of current medications, allergies, drug interactions, and correct calculation of dosage.
- vigilance in monitoring public health concerns (e.g., severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]). This includes taking appropriate steps to ensure patient and staff safety as recommended by local and national sources with recognized expertise.
- promoting a culture where staff members are empowered and encouraged to speak up or intervene in matters of patient safety.

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Policy on Infection Control

Latest Revision

2020

How to Cite: American Academy of Pediatric Dentistry. Policy on infection control. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:32-4.

Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes the importance of infection control policies, procedures, and practices in dental health care settings in order to prevent disease transmission.

Methods

This policy was developed by the Infectious Disease Control Subcommittee of the Clinical Affairs Committee and adopted in 1989.¹ This document is a revision of the previous version, revised in 2019.² The revision of the policy is based upon a review of current dental and medical literature related to infection control, expert opinion, and best current practices. Literature searches of PubMed®/MEDLINE and Google Scholar databases were conducted using the terms: dentistry infection control AND health care and infection control AND dental; fields: all; limits: within the last 10 years, English, humans, comparative study, meta-analysis, multicenter study, systematic reviews, and validation study. The search returned 365 articles that matched the criteria. The articles were evaluated by title and/or abstract and relevance to dental care for children and adolescents. Twenty articles were chosen from this method and from references within selected articles.

Background

The application of standard precautions regarding infection control during dental treatment is paramount. The environment in which dental care is delivered impacts both patient and provider safety. Knowledge of current best practices in infection control can help reduce exposure to and contamination risks from infectious materials. This would include body substances, contaminated supplies, equipment, environmental surfaces, water, and air. Some infection control practices routinely used by health-care professionals cannot be rigorously evaluated by clinical trials for ethical and logistical reasons.³

Many resources are available to aid dental providers in creating checklists, standard operating procedures, or other quality assurance mechanisms for use in daily practice. The Centers for Disease Control and Prevention (CDC)^{4,5} and the Occupational Safety and Health Administration (OSHA)⁶, as well as state and local regulatory boards or agencies and equipment manufacturers, provide guidance for patient care, laboratory procedures, and equipment management. Such entities can serve as valuable sources for current infection control recommendations. Until more is known about severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a

combination of standard precautions, contact precautions, and droplet precautions may be utilized when performing patient care.^{5,6}

The possibility of contamination within the internal components of dental handpieces has led to the recommendation^{4,6} that all dental handpieces, including low-speed motors and removable prophylaxis angles, undergo heat sterilization between patients. Following instructions for sterilization provided by the manufacturer of reusable equipment can help ensure effectiveness of sterilization techniques³ and compliance with current standards⁴⁻⁶.

Infections associated with microbial transmission from dental waterlines have been reported.⁷⁻¹² To help prevent such infections, it has been recommended that practitioners “follow manufacturer guidelines to disinfect waterlines, monitor water quality to ensure recommended bacterial counts, use point-of-use water filters, and eliminate dead ends in plumbing where stagnant water can enable biofilm formation.”¹⁰ In 2015, an outbreak of *Mycobacterium abscessus* odontogenic infections in children receiving pulpotomy treatment from a pediatric dental clinic was investigated.¹⁰ The source of the *Mycobacterium* was contaminated water from dental unit waterlines.⁹⁻¹⁴ In California, 22 confirmed and over 70 suspected non-immunocompromised pediatric dental patients had a diagnosis of *Mycobacterium abscessus* odontogenic infections following pulpal therapy.^{8,9,14}

Water from the dental operatory units is subject to the standard for safe drinking water set by the Environmental Protection Agency, the American Public Health Association, and the American Water Works Association.³ A water management plan that includes routine maintenance procedures for dental unit waterlines (according to the manufacturer’s instructions) and monitoring water quality can help keep bacterial counts low.¹⁵ The CDC states “conventional dental units cannot reliably deliver sterile water even when equipped with independent water reservoirs containing sterile water because the water-bearing pathway cannot be reliably sterilized.”¹⁶ Sterile water and sterile saline have been recommended for use as a coolant or irrigant during oral surgical procedures.^{3,15,17} When a pulp exposure occurs and pulp therapy is indicated,

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **CDC:** Centers for Disease Control and Prevention. **OSHA:** Occupational Safety and Health Administration. **PPE:** Personal protective equipment.

irrigants should not come from dental unit water lines. A single-use disposal syringe should be used to dispense irrigants for pulpal therapy.

Although no adverse health effects have been reported with use of saliva ejectors, the CDC cautions dental health care providers to be aware of the possibility of suctioned fluids in tubing flowing back into the patient's mouth.³ This can happen when:

1. the pressure in patient's mouth, as a result of closing their lips and forming a seal around the tip of the ejector, is lower than the pressure in saliva ejector;
2. the suction tubing attached to the ejector is positioned above patient's mouth; or
3. the saliva ejector is used at same time with other high-volume suction.

Policy statement

The AAPD:

- acknowledges the *Centers for Disease Control and Prevention's Guidelines for Infection Control in the Dental Health-Care Setting—2003*³, *Guidelines for Disinfection and Sterilization in Healthcare Facilities—2008*¹⁸, *Updated CDC Recommendations for the Management of Hepatitis B Virus-infected Health Care Providers and Students—2012*¹⁹, and *Statement on Reprocessing Dental Handpieces—2018*²⁰, as in-depth reviews of infection control measures for dental settings and supports the strategies therein.
- encourages dental practitioners to follow current literature and consider carefully infection control measures in their practices to minimize the risk of disease transmission.
- encourages providers to heat sterilize all dental handpieces, including low-speed motors and reusable prophylaxis angles, between patients.³
- encourages providers and their dental teams to be proactive in addressing infection control concerns. Staff may benefit from additional training to better answer questions from parents regarding the infection control practices in their treatment facility.
- encourages practitioners to develop a water management plan that includes routine maintenance procedures for dental unit waterlines (according to the manufacturer's instructions) and monitoring water quality to help keep waterline bacterial counts low.
- encourages practitioners to use irrigants for operative and surgical procedures that are consistent with CDC recommendations. Because conventional dental units cannot reliably deliver sterile water even when equipped with independent water reservoirs, a single-use disposable syringe should be used to dispense irrigants for pulpal therapy and oral surgical procedures.
- encourages clinicians to take necessary precautions to prevent potential backflow associated with use of saliva ejectors.

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Policy on the Dental Home

Latest Revision

2023

How to Cite: American Academy of Pediatric Dentistry. Policy on the dental home. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:35-7.

Purpose

The American Academy of Pediatric Dentistry (AAPD) supports the concept of a dental home¹ 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 2001², and last revised in 2018³. 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 care⁸ complemented with caries-risk and periodontal-risk assessments, anticipatory guidance, and periodic supervision⁹. 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 children¹⁰⁻¹² 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 six 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 (i.e., physical presence during the provision of care) of allied dental personnel by the dentist. The allied dental personnel (e.g., 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 (i.e., 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

ABBREVIATIONS

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

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 home¹⁸, it can expand the reach of a dental home for time-sensitive traumatic injuries^{19,20}, oral health screening²¹, consultations²⁰⁻²², caries triage and detection²⁰⁻²², treatment planning^{20,21,23}, patient education^{20,21}, dental referrals^{20,21,23}, and dental treatment monitoring²³ with populations who face barriers to oral health services.²²⁻²⁴ Access to oral health care providers may be limited due to financial barriers, special health care needs, workforce shortages, transportation issues, and residing in rural or remote areas²²⁻²⁴, as well as during times when dental clinics are closed due to local unforeseen circumstances (e.g., 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 healthcare 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 practice²⁸.

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 assessment³² and a periodontal disease risk assessment¹⁴.
- 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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Policy on Child Identification Programs

Latest Revision

2022

How to Cite: American Academy of Pediatric Dentistry. Policy on child identification programs. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:38-9.

Purpose

The American Academy of Pediatric Dentistry (AAPD), recognizing the role that dental records play in forensic identification, encourages dental practitioners and administrators of child identification programs to implement simple practices that can aid in identification of unknown infants, children, and adolescents. The AAPD recommends that parents establish a dental home, where clinical data is gathered, stored, and updated routinely and can be made available to assist in identification of missing and abducted persons.

Methods

This document was developed by the Council on Clinical Affairs, adopted in 2003¹, and last revised in 2017². This policy revision included a new literature search of the PubMed®/MEDLINE electronic database using the terms: child, forensic, dental, and identification; fields: all; limits: within the last 10 years, English. One hundred twelve articles matched these criteria. Papers for review were chosen from this list and from references within selected articles. When information from these articles did not appear sufficient or was inconclusive, policies were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

Nearly 350,000 reports of missing children and approximately 900 unidentified person records were submitted to the Federal Bureau of Investigation's National Crime Information Center in 2021.³ Since the passage of the Missing Children Act in 1982 and the creation of the National Crime Information Center, the dental profession has provided much of the information used to compare missing persons with unidentified individuals.^{4,5} The *Manual of Forensic Odontology*, produced by the American Society of Forensic Odontology, demonstrates the vital role of dentistry in identification of missing and unknown persons.⁵ Numerous cases have been published in which law enforcement agencies called upon dentistry to provide information that proved vital to the identification process.^{6,7} Dental records used for identification purposes have included dental radiographs⁸, facial photographs, study casts, bite registrations, dental examinations documenting teeth present and distinguishing features of oral structures, and histories documenting appliances (prosthetic and orthodontic) in place, orthodontic treatment, and restored surfaces with materials used.⁹⁻¹¹

Nondental sources of distinguishing information currently include fingerprints, photographs, physical descriptions, and DNA from blood, saliva, and other tissue.¹² Some nondental sources have practical limitations. Few children have fingerprint records. DNA sampling, while being state of the art, can be difficult to access as well as protracted and costly.¹³ While not routinely collected, saliva may be a useful tool in profiling age and gender determination for forensic experts.¹⁴ Dentists may provide many non-invasive tools that help in the identification and tracking of children.¹⁵

Many programs have been developed and sponsored by community groups that use various child identification methods. Examples are:

- Child Identification Program (CHIP), sponsored by the Masons. This program gathers a physical description and features fingerprinting, several still photos of various profiles, a video recording or mannerisms with voice interview, and various DNA samples collected on dental impressions and/or cheek swabs.¹⁶
- New England Kids Identification System (KIDS) sponsored by the Massachusetts Free Masons and the Massachusetts Dental Society, which incorporates dental bite impression and cheek swabs to gather DNA material into the CHIP events.¹⁶⁻¹⁸
- The National Child Identification Program, sponsored by the American Football Coaches Association. They provide an identification kit which includes an inkless fingerprinting card with a DNA collection site.¹⁹
- The Federal Bureau of Investigation (FBI) has a free mobile telephone application (app) "FBI Child ID"²⁰. This application provides an easily accessible means to electronically store photos and vital information about children. Additionally, there is a special tab on the app that allows quick and easily access to e-mail to send information to authorities, if necessary.

Policy statement

The AAPD recognizes the importance of dentistry's role in the provision of data for identification of missing or deceased children and encourages dental professionals to assist in

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **app:** Application. **CHIP:** Child Identification Program. **FBI:** Federal Bureau of Investigation.

identifying such individuals through dental records and other mechanisms. The AAPD also encourages community identification programs to include a dental component documenting the child's dental home²¹ and encouraging consistent dental visits. A dental home should be established for every child by 12 months of age.^{21,22} A detailed dental record, updated at recall appointments, economically establishes an excellent database of confidential, state-of-the-art child identification information that can be retrieved easily, stored safely, and updated periodically. The dental record may contain a thorough description of the oral cavity documenting all anomalies, a record of restorative care delivered including materials used, appropriate dental radiographs²³, photographs, study casts, and bite registration.

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Policy on Medically-Necessary Care

Latest Revision

2019

How to Cite: American Academy of Pediatric Dentistry. Policy on medically-necessary care. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:40-5.

Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes that dental care is medically-necessary for the purpose of preventing and eliminating orofacial disease, infection, and pain, restoring the form and function of the dentition, and correcting facial disfiguration or dysfunction.

Methods

This document was developed by the Council on Clinical Affairs and adopted in 2007. This document is an update of the last revision from 2015. It includes an electronic search with Scopus® and PubMed®/MEDLINE using the terms: medically-necessary care, systemic disease AND oral disease, dentistry as medically-necessary care, periodontal disease AND cardiovascular disease, oral health AND pregnancy, oral health AND respiratory illness, oral health AND quality of life, pediatric dentistry, general anesthesia, and nutritional deficiency cognitive development; fields: all; limits: within the last 15 years, human, English. The reviewers agreed upon the inclusion of 76 articles that met the defined criteria.

Background

The AAPD defines medically-necessary care (MNC) as “the reasonable and essential diagnostic, preventive, and treatment services (including supplies, appliances, and devices) and follow-up care as determined by qualified health care providers in treating any condition, disease, injury, or congenital or developmental malformation to promote optimal health, growth, and development. MNC includes all supportive health care services that, in the judgment of the attending dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care. These services include, but are not limited to, sedation, general anesthesia, and utilization of surgical facilities. MNC must take into account the patient’s age, developmental status, and psychosocial well-being, in addition to the clinical setting appropriate to meet the needs of the patient and family.”¹

MNC is based upon current preventive and therapeutic practice guidelines formulated by professional organizations with recognized clinical expertise. Such recommendations ideally are evidence based but, in the absence of conclusive evidence, may rely on expert opinion and clinical observations. Expected benefits of care should outweigh potential risks. MNC increases the probability of good health and well-being and decreases the likelihood of an unfavorable outcome. Value of services is an important consideration,

and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment.²

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfiguration or dysfunction. Following the United States Surgeon General’s report³ emphasizing that oral health is integral to general health, the United States Department of Health and Human Services recommended changing perceptions of the public, policy makers, and healthcare providers so that oral health becomes an accepted component of general health.^{4,5} Oral diseases can have a direct and devastating impact on overall health, especially for those with certain systemic health problems or conditions.

Caries is the most common chronic disease of childhood.³ Approximately 60 percent of children experience caries in their primary teeth by age five.⁶ Between 1988-1994 and 1999-2004, prevalence of caries in primary teeth increased for youths aged two to 11 years, with a significant increase noted for those in the two to five year age range.⁷ By 17 years of age, 78 percent of children in the United States have experienced caries.⁵ As much as 90 percent of all caries in school-aged children occurs in pits and fissures. Caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function. These undesirable outcomes can adversely affect learning, communication, nutrition, and other activities necessary for normal growth and development.⁸ Rampant caries is associated with insufficient development in children who have no other medical problems.⁹ Children with early childhood caries (ECC) may be severely underweight because of the associated pain and disinclination to eat. Nutritional deficiencies during childhood can impact cognitive development.^{10,11}

Other oral conditions also can impact general health and well-being. Gingivitis is nearly universal in children and adolescents, and children can develop severe forms of periodontitis.¹² A relationship may exist between periodontal disease and cardiovascular disease¹³⁻¹⁵ as well as periodontal disease and adverse pregnancy outcomes,^{16,17} including pregnancy hypertension.¹⁸ An association between oral health and respiratory diseases has been recognized.^{18,19} Oral health, oral microflora, and bacterial pneumonia, especially

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **CC:** Chronic condition. **ECC:** Early childhood caries. **MNC:** Medically-necessary care.

in populations at high risk for respiratory disease, have been linked. The mouth can harbor respiratory pathogens that may be aspirated, resulting in airway infections.²⁰ Furthermore, dental plaque may serve as a reservoir for respiratory pathogens in patients who are undergoing mechanical ventilation.²¹ Problems of esthetics, form, and function can affect the developing psyche of children, with life-long consequences in social, educational, and occupational environments.^{22,23} Self-image, self-esteem, and self-confidence are unavoidable issues in society, and an acceptable orofacial presentation is a necessary component of these psychological concepts.^{24,25}

Congenital or acquired orofacial anomalies (e.g., ectodermal dysplasia, cleft defects, cysts, tumors) and malformed or missing teeth can have significant negative functional, esthetic, and psychological effects on individuals and their families.^{26,27} Patients with craniofacial anomalies often require specialized oral health care as a direct result of their craniofacial condition. These services are an integral part of the rehabilitative process.²⁶ Young children benefit from esthetic and functional restorative or surgical techniques and readily adapt to appliances that replace missing teeth and improve function, appearance, and self-image. During the period of facial and oral growth, appliances require frequent adjustment and must be remade as the individual grows.

Professional care is necessary to maintain oral health,^{3,4} and risk assessment is an integral element of contemporary preventive care for infants, children, adolescents, and persons with special health care needs.²⁸ The goal of caries-risk assessment is to prevent disease by identifying and minimizing causative factors (e.g., microbial burden, dietary habits, dental morphology) and optimizing protective factors (e.g., fluoride exposure, personal oral hygiene, sealants).^{29,30} Ideally, risk assessment and implementation of preventive strategies would occur before the disease process has been initiated.

Infants and young children have unique caries-risk factors such as ongoing establishment of oral flora and host defense systems, susceptibility of newly erupted teeth, and development of dietary habits and childhood food preferences. Children are most likely to develop caries if *Mutans streptococci* is acquired at an early age.³¹⁻³³ High-risk dietary practices are multi-factorial.³⁴ Food preferences appear to be established early (probably by 12 months of age) and are maintained throughout early childhood.³⁵⁻³⁶ Adolescence can be a time of heightened caries activity and periodontal disease due to an increased intake of cariogenic substances and inattention to oral hygiene procedures.³⁷⁻³⁹

An analysis of caries risk includes determination of protective factors, such as fluoride exposure. More than one-third of the United States population does not benefit from community water fluoridation.³ Fluoride contributes to the prevention, inhibition, and reversal of caries.⁴⁰ Therefore, early determination of a child's systemic and topical fluoride exposure is important. Children experiencing caries as infants and toddlers have a much greater probability of subsequent caries in both the primary and permanent dentitions.¹⁰ An

individualized preventive plan based on a caries-risk assessment is the key component of caries prevention. Because any risk assessment tool may fail to identify all infants at risk for developing ECC, early establishment of the dental home is the ideal approach for disease prevention.⁴¹ Early diagnosis and timely intervention, including necessary referrals, can prevent the need for more extensive and expensive care often required when problems have gone unrecognized and/or untreated.⁴²⁻⁴⁴

When very young children have not been the beneficiaries of adequate preventive care and subsequently develop ECC, therapeutic intervention should be provided by a practitioner with the training, experience, and expertise to manage both the child and the disease process. Because of the aggressive nature of ECC, restorative treatment should be definitive yet specific for each individual patient. Conventional restorative approaches may not arrest the disease.⁴⁵ Areas of demineralization and hypoplasia can cavitate rapidly. The placement of stainless steel crowns may be necessary to decrease the number of tooth surfaces at risk for new or secondary caries. Stainless steel crowns are less likely than other restorations to require retreatment.^{45,46} Low levels of compliance with follow-up care and a high recidivism rate of children requiring additional treatment also can influence a practitioner's decisions for management of ECC⁴⁷ and may decrease success of a disease management approach to ECC.⁴⁸

Sealants are particularly effective in preventing pit and fissure caries and providing cost savings if placed on the teeth of patients during periods of greatest risk.⁴⁹ Children with multiple risk factors and tooth morphology predisposed to plaque retention (i.e., developmental defects, pits and fissures) benefit from having such teeth sealed prophylactically. A child who receives sealants is 72 percent less likely to receive restorative services over the next three years than children who do not.⁵⁰ Sealants placement on primary molars in young children is a cost-effective strategy for children at risk for caries, including those insured by state Medicaid programs.^{51,52} Although sealant retention rates initially are high, sealant loss does occur.⁵³ It is in the patient's interest to receive periodic evaluation of sealants. With follow-up care, the success rate of sealants may be 80 to 90 percent, even after a decade.⁵³

Sealants are safe and effective, yet their use continues to be low.⁵³⁻⁵⁵ Initial insurance coverage for sealants often is denied, and insurance coverage for repair and/or replacement may be limited.^{55,56} While all Medicaid programs reimburse dentists for placement of sealants on permanent teeth, only one in three reimburses for primary molar sealants.⁵⁷ While some third-party carriers restrict reimbursement for sealants to patients of certain ages, it is important to consider that timing of dental eruption can vary widely. Furthermore, caries risk may increase at any time during a patient's life due to changes in habits (e.g., dietary, home care), oral microflora, or physical condition, and previously unsealed teeth subsequently might benefit from sealant application.^{53,58}

The extent of the disease process, as well as the patient's developmental level and comprehension skills, affect the practitioner's behavior guidance approaches. The success of restorations may be influenced by the child's response to the chosen behavior guidance technique. To perform treatment safely, effectively, and efficiently, the practitioner caring for a pediatric patient may employ advanced behavior guidance techniques such as protective stabilization and/or sedation or general anesthesia.^{59,60} The patient's age, dental needs, disabilities, medical conditions, and/or acute situational anxiety may preclude the patient's being treated safely in a traditional outpatient setting.^{61,62} For some infants, children, adolescents, and persons with special health care needs, treatment under sedation or general anesthesia in a hospital, outpatient facility, or dental office or clinic represents the only appropriate method to deliver necessary oral health care.^{59,63} Failure by insurance companies to cover general anesthesia costs, hospital fees, and/or sedation costs can expose the patient to multiple ineffective, potentially unsafe, and/or psychologically traumatic in-office experiences. The impact of chronic conditions (CC) status and CC severity increases the odds of receiving dental treatment under general anesthesia.⁶⁴ Although general anesthesia may provide optimal conditions to perform restorative procedures, it can add significantly to the cost of care.⁶⁵ General anesthesia may be required in the hospital setting due to the extent of treatment, the need to deliver timely care, or the patient's medical history/CC (e.g., cardiac defects, severe bleeding disorders, limited opening due to orofacial anomalies). General anesthesia, under certain circumstances, may offer a cost-saving alternative to sedation for children with ECC.^{66,67}

Reimbursement issues defined by the concept of MNC have been a complicated topic for dentistry. Pediatric dental patients may be denied access to oral health care when insurance companies refuse to provide reimbursement for sedation/general anesthesia and related facility services. Most denials cite the procedure as "not medically-necessary."⁶⁸ This determination appears to be based on arbitrary and inconsistent criteria.⁶⁹⁻⁷⁴ For instance, medical policies often provide reimbursement for sedation/general anesthesia or facility fees related to myringotomy for a three-year-old child, but deny these benefits when related to treatment of dental disease and/or dental infection for the same patient. American Dental Association Resolution 1989-546 states that insurance companies should not deny benefits that would otherwise be payable "solely on the basis of the professional degree and licensure of the dentist or physician providing treatment, if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure."⁷⁴

Patients with craniofacial anomalies often are denied third-party coverage for initial appliance construction and, more frequently, replacement of appliances as the child grows. The distinction between congenital anomalies involving the orofacial complex and those involving other parts of the body is often arbitrary and unfair. Often, medical insurance

companies interpret dental appliance construction to be solely esthetic, without taking into consideration the restorative function. For instance, health care policies may provide reimbursement for the prosthesis required for a congenitally missing extremity and its replacement as the individual grows but deny benefits for the initial prosthesis and necessary periodic replacement for congenitally missing teeth. Third-party payors frequently will refuse to pay for oral health care services even when they clearly are associated with the complete rehabilitation of the craniofacial condition.^{75,76}

Policy statement

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfigurement or dysfunction. MNC is based upon current preventive and therapeutic practice guidelines formulated by professional organizations with recognized clinical expertise. Expected benefits of MNC outweigh potential risks of treatment or no treatment. Early detection and management of oral conditions can improve a child's oral health, general health and well-being, school readiness, and self-esteem. Early recognition, prevention, and intervention could result in savings of health care dollars for individuals, community health care programs, and third-party payors. Because a child's risk for developing dental disease can change over time, continual professional reevaluation and preventive maintenance are essential for good oral health. Value of services is an important consideration, and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment.

The AAPD encourages:

1. oral health care to be included in the design and provision of individual and community-based health care programs to achieve comprehensive health care.
2. establishment of a dental home for all children by 12 months of age in order to institute an individualized preventive oral health program based upon each patient's unique caries risk assessment.
3. healthcare providers who diagnose oral disease to either provide therapy or refer the patient to a primary care dentist or dental/medical specialist as dictated by the nature and complexity of the condition. Immediate intervention is necessary to prevent further dental destruction, as well as more widespread health problems.
4. evaluation and care provided for an infant, child, or adolescent by a cleft lip/palate, orofacial, or craniofacial deformities team as the optimal way to coordinate and deliver such complex services.
5. the dentist providing oral health care for a patient to determine the medical indication and justification for treatment. The dental care provider must assess the patient's developmental level and comprehension skills, as well as the extent of the disease process, to determine the need for advanced behavior guidance techniques such as sedation or general anesthesia.

Furthermore, the AAPD encourages third-party payors to:

1. recognize malformed and missing teeth are resultant anomalies of facial development seen in orofacial anomalies and may be from congenital defects. Just as the congenital absence of other body parts requires care over the lifetime of the patient, so will these.
2. include oral health care services related to these facial and dental anomalies as benefits of health insurance without discrimination between the medical and dental nature of the congenital defect. These services, optimally provided by the craniofacial team, include, but are not limited to, initial appliance construction, periodic examinations, and replacement of appliances.
3. end arbitrary and unfair refusal of compensation for oral health care services related to orofacial and dental anomalies.
4. recognize the oral health benefits of dental sealants and not base coverage for sealants on permanent and primary teeth on a patient's age.
5. ensure that all children have access to the full range of oral health delivery systems. If sedation or general anesthesia and related facility fees are payable benefits of a health care plan, these same benefits shall apply for the delivery of oral health services.
6. regularly consult the AAPD with respect to the development of benefit plans that best serve the oral health interests of infants, children, adolescents, and persons with special health care needs, especially those with craniofacial or acquired orofacial anomalies.

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Policy on Social Determinants of Children's Oral Health and Health Disparities

Revised

2022

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Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes the influence of social factors on children's oral health including access to care, dental disease, behaviors, and oral health inequalities. The AAPD encourages oral health professionals and policymakers to formally acknowledge the role social determinants of health (SDH) have in producing and perpetuating poor oral health and oral health inequalities in children. Moreover, AAPD encourages the implementation of oral health promotion strategies that account for SDH and appropriate clinical management protocols informed by and sensitive to SDH. All relevant stakeholders (e.g., health professionals, researchers, educators, policy makers) are encouraged to develop strategies that incorporate SDH-related knowledge to improve oral health, prevent dental disease, and address oral health inequalities in children.

Methods

This policy, developed by the Council on Clinical Affairs and adopted in 2017¹, is based on a review of the current literature, including a search of PubMed®/MEDLINE database using the terms: social determinants AND dental; fields: all; limits: English, birth-18 years. A total of 1485 articles matched these criteria. Articles for review were selected from this list, the references within selected articles, and other articles from the literature.

Background

The World Health Organization defines social determinants of health as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life”.² Life circumstances are heavily influenced by social behaviors, cultural practices, government policies, and economic and political systems.³ The term SDH implies that improving social conditions is a necessary to optimize health outcomes for vulnerable populations, narrow inequalities, and achieve health equity and social justice. Health equity may be defined as the “fair and just opportunity to be as healthy as possible”⁴, a concept that requires elimination of those societal factors (e.g., poverty, discrimination, lack of access to healthcare) that unfairly result in poorer health for at-risk social groups. Social groups can be identified by many characteristics including ethnicity, religion,

socioeconomic status, gender identity, age, disability status, sexual orientation, or geographic location.^{5,6} From a social justice perspective, addressing SDH is essential to achieving improved oral health outcomes and reducing inequalities for children from historically disadvantaged groups.⁵ One strategy is to prioritize interventions, programs, and policies that properly acknowledge and account for SDH.

Past work has demonstrated gradients in oral health outcomes based on socioeconomic position.^{3,7,8} Measures of socioeconomic position include income, educational attainment, occupation, and race/ethnicity.⁹⁻¹¹ SDH are influenced by socioeconomic position and more broadly embody the social environment and context in which individuals live and make health-related decisions over the life course.^{3,12} Various conceptual models from dentistry include SDH as upstream factors that influence oral health behaviors, dental disease rates, and oral health outcomes.¹³⁻¹⁸ In 2013, the American Academy of Pediatrics published a policy statement that acknowledged the influence of SDH on chronic diseases including dental caries.¹⁹ Since then, the body of scientific research addressing SDH and oral health has grown substantially. Findings from the social determinants of children's oral health literature can be organized into categories that provide guidance on how dentists, other health professionals, researchers, educators, and policy makers can account for SDH to improve children's health outcomes. Examples are provided of past efforts and future opportunities to address children's oral health inequalities through SDH-based interventions, programs, and policies.

SDH commonly are measured at the caregiver or household level. The same SDH that affect a caregiver's oral health outcomes also affect his children's oral health directly and indirectly.²⁰ Caregiver level of education influences both material and nonmaterial components of a child's oral health, including access to and utilization of preventive services, dental knowledge, and oral health behaviors.^{12,21-23} Socioeconomic status was found to mediate the influence of maternal psychological factors (e.g., depression, external locus of control, self-efficacy)

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **SDH:** Social determinants of health.