

Oral Health for US Children with Special Health Care Needs



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KEYWORDS

- Children with special health care needs (CSHCN) • Access to dental care
- Unmet dental care needs • Tooth brushing • Diet
- Behavioral determinants of oral health • Oral health promotion interventions

KEY POINTS

- One-in-five US children have a special health care need but there are no comprehensive studies on the clinical oral health of children with special health care needs (CSHCN).
- The lack of high-quality data on tooth decay prevalence, oral health behaviors, and evidence-based interventions is a barrier to oral health promotion in CSHCN.
- Oral health researchers should work with other health care providers and behavioral and social scientists to develop, implement, evaluate, and refine clinical interventions for CSHCN.
- Pediatric health care providers are well positioned to help promote the oral health of CSHCN in clinical practice.

INTRODUCTION

One-in-five children in the United States have a special health care need,¹ which is equivalent to nearly 15 million children nationwide. The US Maternal and Child Health Bureau defines children with special health care needs (CSHCN) as “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”²

Anecdotal evidence suggests CSHCN are at increased risk for poor oral health. However, research supporting this assertion is sparse. To date, there are no known comprehensive studies on the clinical oral health of CSHCN. Only a few studies have documented tooth decay rates in CSHCN, most of which focus on use of professional dental care services and caregiver-reported unmet dental care need. Even less

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is known about oral hygiene behaviors, fluoride exposure, and dietary risk factors, particularly sugar intake, which is one of the main behavioral determinants of oral health in this pediatric population. The dearth of research is a barrier to progress and prevents the field from generating scalable evidence-based interventions, clinical practice guidelines, and health policies that could prevent dental disease and promote the oral health of CSHCN.

This article focuses on the oral health of CSHCN with the goal of providing insight on what is currently known and the barriers to progress. First, a brief update will be presented on tooth decay epidemiology, oral health status, and the behavioral determinants of oral health for CSHCN. Next, the limitations of research to date will be highlighted, with an emphasis on problems associated with the current conceptualization of special health care needs and other methodologic challenges. Cystic fibrosis (CF) and autism spectrum disorders (ASD) will be used as case studies to elucidate problems, solutions, and lessons learned. Broader recommendations will be made on ways to improve future research. Finally, drawing on the best available scientific evidence, clinical recommendations will be made to help guide pediatricians and other health care providers committed to the oral health of CSHCN. The goal is to advance the field through high-quality science, evidence-based standards of clinical care, and behavior change strategies that promote the oral and systemic health of CSHCN.

TOOTH DECAY EPIDEMIOLOGY

Tooth decay (dental caries) is the most significant oral health problem in children, including CSHCN. Dentists spend most of their practice time treating tooth decay. However, there are no national or state-level data on dental caries epidemiology in CSHCN. A pilot study from Washington State focused on enrollees in 2 Head Start centers, a school readiness program for preschool-aged children aged 3 to 5 years from low-income households. The mean number of decayed, missing, and filled primary tooth surfaces for Head Start children was 5.8 ± 11.2 surfaces compared with the US mean of 2.6 surfaces.^{3,4} Head Start children with a developmental delay were 1.26 times as likely to have tooth decay compared with those without a developmental delay ($P = .04$). Similarly, clinical studies have focused on small subgroups of CSHCN identified by medical condition or diagnosis, with mixed findings on tooth decay rates compared to children without special health care needs.^{5–12}

ORAL HEALTH STATUS AND UNMET DENTAL CARE NEEDS

In the absence of comprehensive tooth decay data for CSHCN, relevant studies focus on caregiver-reported measures of dental disease, oral health status, or unmet dental care needs. The main source of US data on CSHCN is the National Survey of CSHCN, which includes caregiver-reported oral health measures. Dental care was first documented as the most common unmet health care need for CSHCN in 2000, a finding replicated a decade later.^{13,14}

Based on the 2007 National Survey of CSHCN, 22.8% of caregivers reported having a child younger than 18 years with any cavities in the previous 6 months.¹⁵ About 15% to 18.7% of caregivers of CSHCN reported their child as having a toothache in the previous 6 months.¹⁶ At least 4 studies have documented higher levels of caregiver-reported unmet dental care needs for CHSCN when compared with their medically unremarkable peers.^{17–19} However, a study from West Virginia found comparable rates of caregiver-reported unmet preventive and orthodontic dental care needs by special needs status.²⁰

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