Patient-Centered Oral Health Care:  
*The Dental Home*

Everyone needs oral healthcare. Who wouldn’t want that care “...delivered in a comprehensive, continuously accessible, coordinated, and family-centered way”?¹

These are the key features of a *dental home* that also provides for “…the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral healthcare.”¹

**Origin of the Dental Home**

In 1992, the American Academy of Pediatrics (AAP) coined the term *medical home* to refer to a pediatrician or other primary care physician who manages all aspects of pediatric care in a manner that is “…accessible, continuous, comprehensive, family centered, coordinated, and compassionate” as contrasted with the episodic and disconnected care provided in emergency departments, walk-in clinics, and some other settings that may be less effective and more costly.² Over the years, the AAP was joined by other primary care provider organizations that supported and expanded on the concept of medical home, extending the list of core attributes needed for a source of health care to be a medical home to seven.³ Such care must be:

- Accessible
- Continuous
- Comprehensive
- Family centered
- Coordinated
- Compassionate, and
- Culturally effective.*

In 2001, the American Academy of Pediatric Dentistry (AAPD) issued its own policy on the *dental home* to “…follow the medical home model as a cost-effective and higher quality health care alternative to emergency care situations.”⁴ AAPD has gone on to define the dental home as “…the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral healthcare delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.”⁴ To make the dental home concept applicable beyond the pediatric population, the American Dental Association’s (ADA) definition denotes the dentist as “the Primary Dental Care Provider” and extends the relationship between the patient and dentist “throughout the patient’s lifetime”.⁵

Like a medical home, a dental home provides a more consistent and effective alternative to dental care obtained through emergency rooms, itinerant mobile clinics, or large-scale screen-and-treat events. While dental care in these other settings can often alleviate pain and suffering in the short-term, they are frequently limited in the amount of preventative and restorative care they can provide. Even when
thorough examinations are performed and treatment plans fully completed, these other dental care settings cannot provide an ongoing, long-term relationship with the patient that addresses their future oral health care needs.

The Challenge of Dental Homes for Underserved Populations

While the majority of the U.S. population is able to routinely obtain oral health care in traditional dental practice settings, a disproportionate number of vulnerable and underserved individuals cannot. An array of providers and population-based public health programs—collectively referred to as the safety net—has emerged through uncoordinated attempts to reach these individuals. However, access to oral health care continues to elude too many Americans.

- Institute of Medicine and National Research Council, 2011, p.2

Access to oral health care for the uninsured, underinsured, and underserved is a problem rooted, at least in part, to the known shortage of dental providers in underserved communities, especially in rural areas. The National Rural Health Association reports that only 14 percent of dentists practice in rural areas. The Pew Center on the States estimates that 46 million people live in federally designated Dental Health Professional Shortage Areas, including 30 million people with no access to a dentist.

Complicating this shortage is the reluctance of many dentists to participate in their state’s Medicaid program, often due to low reimbursement rates that can return less than 60.5 cents on every dollar billed by a dentist. Furthermore, only 16 states provide comprehensive dental benefits in their Medicaid programs, leaving many low-income adults uninsured for dental care.

Establishing new dental services to resolve these problems with access to oral health care in rural and frontier areas can be challenging, especially when the goal is to provide a fully-fledged dental home. The examples of successful dental home initiatives funded by recent HRSA/ORHP Rural Healthcare Outreach grants offer insights into how these rural communities developed innovative approaches to overcome some of these challenges.

Examples of Rural Dental Home Initiatives

2009/2012 Grantee: Northern Dental Access Center – Bemidji, MN

After several years of planning and fundraising, a new community access dental center opened its doors in December 2008, serving people in the Bemidji and Beltrami County area of northwestern Minnesota. This grassroots, collaborative project brought together leaders from all sectors of the region who agreed that access to oral health care by disadvantaged populations is a public health issue. Their dream was a new clinic, one that will not only address critical access needs, but will also become a dental home for people in need.

The target patient base for this clinic is people who are enrolled in Minnesota’s Medicaid/CHIP programs such as Medical Assistance or MinnesotaCare. A cadre of fifteen dentists from around the state provides dental care here, some are volunteers and others are paid contractors. A core staff of dental assistants, hygienists and schedulers are here to welcome families and providing continuity of care.
Overall, the fundamental approach is to provide an atmosphere that is respectful, welcoming and caring. Many people we seek to serve are accustomed to being denied access, made to feel like they are judged only on what’s billable—not what they need, or feel rushed through like they are on an assembly line. We slow things down a bit, get to know our patients and really become a dental home for them. With a treatment coordinator on staff who can sit down with patients, face to face, and discuss treatment plans and options. This ‘vertical dialog’ (rather than while lying in a dental chair) helps build personal ownership in the treatment plan and helps to identify and address any barriers to success.

Rural health care services outreach grants have made additional supports possible, including mental health screenings (and referrals where necessary), insurance counseling, and community support referrals to help further reduce barriers to care. Beltrami County Health and Human Services has public health nurses on site providing child and teen screenings/check-ups on site, as well as to provide information and referral for families needing other services. Community Resource Connections has a satellite office in the clinic, providing insurance counseling and information and referrals for families who may need other community services.

We know that there are thousands of people in pain who need our help. If we are successful, we will make that experience positive enough that they will return for preventive services and they will learn more about their own power in improving the health of their families.

2009/2012 Outreach Grantee: Granite County Medical Center – Philipsburg, MT

Granite County, with its 3,079 residents scattered across a distance of 1,027 miles, is beyond rural and actually classified as “frontier.” Remote and mountainous, it remains one of the most isolated communities in western Montana, not to mention the United States. In this medically underserved area, GCMC is the sole service provider, with the next nearest medical facility at least 30 to at most 80 miles away. Access to healthcare is more difficult in winter, which can last for six months a year and make for hazardous road conditions.

Without a single dental practice in the entire county, the focus of the grant program was to provide access to dental care for the residents of Granite County, creating a dental home that offers comprehensive oral healthcare for targeted underserved populations: Medicaid, uninsured, and at-risk populations, including children, those in poverty, and the elderly. In 2009, the project began with the deployment of a mobile dental van to provide dental care around the county, removing transportation barriers for many patients. The mobile dental van worked well during the warmer months, but severe winter weather made it almost impossible to keep the dental van operating without freezing for much of the year. Beginning in the winter of 2010, the project piloted a temporary fixed dental clinic. Using portable dental equipment from the mobile unit, a one-chair dental exam and treatment room was outfitted at the Granite County Medical Center, the only hospital in the county. Over the remainder of the grant project period, from November 2010 to April 2012, the temporary clinic provided 459 encounters to 209 patients (unduplicated).

With a second Rural Health Care Services Outreach grant beginning in May, 2012, the temporary dental clinic was replaced with a traditional 2-chair fully equipped with permanent equipment. Replacing the former mobile unit, the new permanent clinic offers enhanced dental capabilities in a comfortable and inviting environment. The new clinic now operates 2 days per week, with an additional day most weeks for dental hygiene services. The clinic is projected to achieve a financial “break-even” level of sustainability by the end of the present 3-year grant.
Dental Home Resources

American Academy of Pediatric Dentistry

   Online Dental Home Resource Center
   http://www.aapd.org/advocacy/dentalhome/

American Dental Association

   Dental Quality Alliance

National Maternal and Child Oral Health Resource Center

   Resource Highlights: Focus on the Dental Home
   http://www.mchoralhealth.org/highlights/dentalhome.html

Rural Assistance Center (raconline.org)

   Rural Oral Health Tool Kit
   http://www.raconline.org/communityhealth/oral-health

   Topic Guide on Oral Health
   http://www.raconline.org/topics/dental-health