

**COUNCIL ON DENTAL EDUCATION AND LICENSURE
2011 PERIODIC REVIEW
OF DENTAL SPECIALTY EDUCATION AND PRACTICE**

PEDIATRIC DENTISTRY

**AMERICAN DENTAL ASSOCIATION
Chicago, Illinois**

ADA American Dental Association®
America's leading advocate for oral health

NAME OF RECOGNIZED DENTAL SPECIALTY:

PEDIATRIC DENTISTRY

NAME OF SPONSORING DENTAL SPECIALTY ORGANIZATION:

American Academy of Pediatric Dentistry

NAME OF RECOGNIZED CERTIFYING BOARD:

American Board of Pediatric Dentistry

Information submitted by:

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William C. Berlocher
(Signature – Organization's President)

Date of Submission

Purpose of the Review

In 1992, the ADA House of Delegates adopted Resolution 144H-1992 which directed the periodic (every 10 years) review of dental specialty education and practice beginning in 2001. In 2001, the Council on Dental Education and Licensure forwarded its recommendations from this review to the House of Delegates for its consideration. The 2001 House accepted the report and adopted the following resolutions:

20H-2001

Resolved, that the appropriate Association agency continue to conduct a periodic review of dental specialty education and practice at ten-year intervals, and be it further

Resolved, that the next periodic review of dental specialty education and practice be presented to the 2011 ADA House of Delegates.

21H-2001

Resolved, that the sponsoring dental specialty organizations and ADA recognized dental specialty certifying boards be urged to continue to monitor the number of specialists who are board certified and identify ways to increase the percentage of specialists who see and achieve board certification in light of dental specialty faculty shortages and the Commission on Dental Accreditation's standard requiring that program directors of advanced dental specialty education programs be board certified.

In carrying out the House directive for such periodic reviews, the Council hopes to gather strategic information that will be of value to the Association, the specialty organizations, the profession and the public. The review should clearly focus on changes occurring within the specialty education and practice environments, e.g., disease trends, technology, scope of practice, program enrollments, and demographics. It should address the current environment as well as potential trends for the future and how these will impact the public and the profession. The Council believes that the input and self-assessment of each of the specialty organizations is essential in providing an accurate report to the House of Delegates.

Instructions to the Specialty Organizations: Each specialty organization is being provided with all information and data available from ADA agencies relevant to the review. A copy of the organization's 2001 submission is also provided for reference. Where existing data is available, specialty organizations are asked to analyze the data and comment on trends that have and/or may impact the specialty and the profession. The Council seeks succinct but thoughtful responses to study items to provide a broad assessment of key issues. Each item includes a suggested length for a response. However, the length and nature of responses may vary according to the unique characteristics of the specialty.

The current environment as well as potential trends for the future and how these may impact the public, the profession and practice should be addressed.

A. General Information

1. Provide a copy of the sponsoring organization's strategic plan¹. Provide a brief summary highlighting specific areas of the strategic plan that the specialty wishes to call to the Council's attention as it relates to this review. Briefly comment on efforts the specialty has undertaken to promote quality in the discipline over the past 10 years (e.g., continuing competence, parameters of care, continuing education). (*suggested response - up to one page*)

Through the actions and efforts of the Board of Trustees and its subordinated Councils, Committees, Task Forces and headquarters staff, the American Academy of Pediatric Dentistry continues to be the premier membership organization providing the most current information and educational programs relative to the practice of pediatric oral health care.

The journal, *Pediatric Dentistry*, published six times during the year is the scientific publication for the specialty and serves as a resource to many for access to scholarly and clinical manuscripts. In addition to AAPD members who receive the journal as a member benefit, there are 496 paid outside subscriptions (hospitals, dental schools, individual subscribers, etc.) to the journal nationally and internationally.

In addition to the regular bimonthly issues of *Pediatric Dentistry*, there is an annual special issue titled the *Reference Manual of Pediatric Dentistry*. The oral health policies and clinical guidelines contained in the *Reference Manual* 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 guideline. The manual is continually updated using emerging science and evidence as existing oral health policies, guidelines and quality assurance criteria are each reviewed tri-annually. New policies and guidelines are identified and added annually. This publication reflects the most current information and reference for pediatric oral health care. Clinical guidelines may also be referenced electronically through the National Guideline Clearinghouse (www.guideline.gov).

Scholarly publications are not limited to *Pediatric Dentistry*. Since the merger of the American Society of Dentistry for Children into the AAPD in 2002, the AAPD continues to electronically publish the *Journal of Dentistry for Children* three times per year. In addition to AAPD members receiving this publication as a member benefit, there are 428 additional paid outside subscriptions to the journal nationally and internationally.

Two additional publications are available to the profession and public. The *Handbook of Pediatric Dentistry* incorporates policies and guidelines with emerging science and interdisciplinary practice for daily clinical application and is revised every three to five years. The *Coding and Insurance Manual 2009 – 2010* is an invaluable practice reference for members and auxiliary staff.

¹ Attached

Continuing education programming is an essential member benefit. Academy programs are delivered through a variety of means. The scientific program of the AAPD Annual Session continues to be the primary venue. The Academy has increased its number of continuing education offerings since 2001 when approximately 3 – 5 programs occurred annually. Currently, there are between 9 – 11 continuing education courses throughout the year in a variety of locales in the United States. Most of these courses recur annually and have a proven interest to the membership. In 2007, the Academy collaborated with the American Association of Endodontists (AAE) on the topic of pulp therapy. The AAPD and AAE will again produce a joint program in 2012 focusing on dentoalveolar trauma. The AAPD offers an audiotape series for literature review and an in-house course based on the journal, *Pediatric Dentistry*. One of the more popular courses, the *Comprehensive Review of Pediatric Dentistry* is also available on DVD format along with a posttest to be taken before continuing education units are awarded.

Joint membership categories with the American Academy of Pediatrics (AAP) and ongoing liaison groups between dentistry and pediatric medicine has led to education of members of both organizations regarding the importance of oral health in children and policies for safe and effective dental care for children. These interactions have produced extensive input in the *Bright Futures* guidelines for health supervision for children that includes oral health and the incorporation of dental caries in the *Red Book*, a compendium of treatment of infectious diseases published by the AAP. Working together, the organizations have produced three policy statements: *Establishment of the Dental Home*” and *“Preventive Dental Practices for the Pediatricians”* and *“Guideline for Monitoring and Management of Pediatric Dental Patients During and After Sedation for Diagnostic and Therapeutic Procedures*. In addition, the collaboration of the two associations has influenced national policies for child health to include significant elements devoted to oral health care.

2. Complete the table below and provide overview comments on past and future membership trends forecast for the next 10 years. Comment on how changes in membership will impact public and the profession. (*suggested response – up to two pages including the table*)

MEMBERSHIP CATEGORIES
Pediatric Dentistry

YEAR	ACTIVE	ASSOCIATE	AFFILIATE	LIFE	OTHER
2000	3425	160	18	85	840
2001	3490	160	26	95	849
2002	3627	150	41	103	920
2003	3767	138	566	145	1108
2004	3891	128	454	179	1253
2005	4067	114	434	210	1486
2006	4311	106	434	210	1486
2007	4487	99	464	220	1737
2008	4679	96	600	236	1763
2009	4861	96	636	261	1811

If available, please provide information on the gender and ethnicity of members.

**MEMEBERSHIP / Gender and Ethnicity
Pediatric Dentistry**

YEAR	Male	Female	White	Black	Hispanic	American Indian	Asian	Unknown
2000	U/K	U/K						X
2001	U/K	U/K						x
2002	U/K	U/K						X
2003	U/K	U/K						X
2004	65%	35%						X
2005	63%	37%						X
2006	62%	38%						X
2007	60%	40%						X
2008	59%	41%						X
2009	58%	42%						X

Membership has continued to grow annually between 4 – 6% throughout the past decade. In the last ten years the Active Membership category has increased 41%. The Active Membership Category includes members who meet the educational requirements for announcement of the specialty of practice of pediatric dentistry reflecting full membership privileges. In 2002 the AAPD merged with the American Society of Dentistry for Children (ASDC). This merger resulted in tremendous growth in the Affiliate Membership Category and created a predoctoral student membership for dental students who are interested in pediatric dentistry. In 2006 the AAPD further expanded its membership categories to include Friends of Pediatric Dentistry for non-dental professionals who support the mission of AAPD and Allied Membership that includes dental office staff. In further clarification of the membership categories AAPD removed the Fellow Membership Category and created a Fellow Status.

The AAPD's commitment to increase the number of pediatric dentists has led to a number of exciting initiatives, one of the most important being expansion of the federal governments Title VII funding for the health professions. This program traditionally provides funds for new and expanded general practice residency and advanced education in general dentistry programs for general dentists, but now includes positions in pediatric dentistry and has for about a decade.

During the 1998-99 academic year there were 197 first year positions available for pediatric dentistry. Over the next ten years, that number grew to 349 available first year positions available in the 2008-09 academic year (American Dental Association. *1999-2000 and 2008-09 Survey of Advanced Dental Education*). This 56% growth rate over a decade is due in large part, to enhanced federal funding for residency training programs.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), two new grant competitions were announced by the Health Resources Services Administration (HRSA) at the time of the filing of this report. Funding will be available for new and continuing programs for residency training in pediatric dentistry. The second grant competition is for equipment to enhance training for health professionals – residency training in pediatric dentistry.

HRSA also announced an additional \$2.5 million dollars for its Faculty Loan Repayment Program specifically geared towards pediatric dentists. It is anticipated that 60 awards will be made to pediatric dentists this year.

It is clear that there is significant public policy appreciation for demand of new positions, particularly since the Report of the Surgeon General on Oral Health in 2000. Title VII funding has increased in the last decade and added dozens of positions to training programs in dental schools and hospital and has funded faculty positions and capital improvements in care facilities serving largely the poor, minority and special needs patient populations.

- Review the following summary of certification and examination data from the CDEL's Annual Reports of the ADA-Recognized Dental Specialty Certifying Boards, 2000-2008. In collaboration with the recognized certifying board, provide overview comments on significant trends for the future. (*suggested response - up to one page including the table*)

CERTIFICATION AND EXAMINATION DATA: 2000-2008

Pediatric Dentistry	2000	2001	2002	2003	2004	2005	2006	2007	2008
Number Certified By Examination Through 2000-2008	1264	1314	1368	1440	1477	1562	1836	2204	2501
Number of Active Diplomates 2000-08	1177	1221	1278	1337	1355	1404	1668	2056	2383
Number of Acceptable Applications Received 2000-08	135	194	154	128	205	270	290	255	336

The summary data presented above reflects the dramatic increase in applications from pediatric dentists beginning in 2004 and continuing through 2009. It also reflects the increase in Diplomates certified by American Board of Pediatric Dentistry (ABPD) beginning in 2004.

ABPD estimates that the number of acceptable applications will continue to increase as new training programs are approved or existing programs increase the number of resident positions.

ABPD estimates an average of 350+ pediatric dentists presenting their credentials for review annually at least through 2014. Based on present examination outcomes, we estimate 350-375 new Diplomates per year will be certified. Based on these estimates, by 2013 there will be over 4100 pediatric dentists certified as Diplomates by ABPD.

Presently 54.8% (2728) of eligible pediatric dentists are certified by ABPD, with an additional 1244 pediatric dentists designated as Board Candidates actively involved in the certifying process.

- In collaboration with the recognized certifying board, provide overview comments on the board eligibility requirements from the CDEL's Annual Reports of the ADA-Recognized Dental Specialty Certifying Boards, 2000-2008. Please note or

any changes and the impact on the specialty. If an eligibility pathway for internationally trained specialists is available, explain the process. (*suggested response – up to two pages*)

**BOARD ELIGIBILITY REQUIREMENTS
Pediatric Dentistry**

Professional	2000	2001	2002	2003	2004	2005	2006	2007	2008
ADA or NDA Membership	No	No	No	No	No	No	No	No	No
Specialty Society Membership	No	No	No	No	No	No	No	No	No
Education									
Years of Advanced Education in Addition to DDS or DMD Degree	2	2	2	2	2-3	2-3	2-3	2-3	2-3
Experience									
Total Years of Specialty Experience Including Advanced Education	3	3	3	2-3	2-3	2-3	2-3	2-3	2-3
Other									
Citizenship	Any	Any	Any	Any	Any	Any	Any	Any	Any
State Licensure	No	No	No	No	No	No	No	No	No
Alternate Pathway to Certification (New Question beginning 2008)									Yes

In 2004, the American Board of Pediatric Dentistry (ABPD) announced that residents in their final year of advanced specialty education were eligible to apply and sit for the Qualifying Examination (QE). Previously the examination was only offered to pediatric dentists after the completion of their formal training.

The QE was developed to validate the candidates advanced training in Pediatric Dentistry. Therefore, allowing the residents to sit for the examination just prior to the completion of training was appropriate.

Furthermore it was becoming evident that for pediatric dentists to provide the full scope of oral health services for pediatric patients, including patients with special health care needs, hospital privileges are a necessity. For medical staff privileges, most hospitals require that dentists have advanced training. Increasingly, hospitals are requiring that specialists be Board certified or in the process leading to certification. Since 2004,

ABPD estimates that more than 95% of all pediatric dentistry residents in their final year apply and sit for the QE.

In 2007, ABPD offered a Revalidation Examination (RE) to those Board Candidates who at one time successfully completed the Comprehensive Written Examination (now the QE), but for a variety of reasons never completed the certifying process. This exam was developed to allow these pediatric dentists, some of whom had been in practice or academics for up to 30 years, to reenter the certifying process by validating their knowledge of contemporary pediatric dentistry. Six hundred, ninety seven (697) pediatric dentists qualified for the RE and over 50% (353) applied to sit for the RE and some choose to sit for the QE. Of the 353 pediatric dentists reentering the certifying process, 247 (69.9%) sat for the RE and 106 (29.9%) for the QE. To date, 224 have been successful and are now eligible to sit for the final step of Board certification, the Oral Clinical Examination.

In 2006, after many inquiries from internationally trained (not trained in a CODA-accredited training program) pediatric dentists to enter the certifying process, ABPD developed two additional pathways:

1. An internationally trained pediatric dentist (from a non-CODA or CDAC accredited specialty program) should contact a program director of a CODA or CDAC accredited training program in pediatric dentistry and request advanced placement or credit by examination leading to certification of completion of the program.
2. An internationally trained pediatric dentist (from a non-CODA or CDAC accredited specialty programs) who has been a full-time faculty member in a CODA or CDAC accredited pediatric dentistry training program for 12 consecutive months during the past 2 years with verification by the department chair in pediatric dentistry may apply.

The pathways were advertised and have been successfully used by five pediatric dentists. All these pediatric dentists are involved in academics. With academic pediatric dentistry having the largest number of faculty vacancies, ABPD hopes that by adding the two pathways in the credentialing process, there may be additional incentives for pediatric dentists to consider academic appointments.

Because of quality of care issues, public demands, state licensure requirements, staff memberships in hospitals and peer and personal recognition, ABPD is prepared to provide continuing assurance that Diplomates are actively participating in lifelong learning and quality care leading to maintaining competence throughout their careers. Board certification is not the end of professional growth and self development, but one more step in the lifelong process that assures continuing competence and quality care. To promote lifelong learning and continuous practice quality improvement, ABPD will be launching the Renewal of Certification Process (ROC-P) in 2010.

This four part process will:

1. Verify licensure and status in the profession and community.
2. Provide evidence of a commitment to life-long learning and continuous scholarship.
3. Measure cognitive expertise by examination.
4. Provide evidence of performance in practice.

A web-based tracking system will facilitate Diplomates' understanding of requirements, promote self-reporting, mentoring where indicated and provide continuous information on continuing education courses, recent reports from peer-reviewed articles and publications from state and federal agencies.

5. List areas of major research changes and major technology advances over the last 10 years. Provide an overview comment on how these changes and advances have affected the practice of the specialty. (*suggested response – up to three pages*)

New appreciation and understanding of Early Childhood Caries (ECC).

The last decade was a period of focused attention of health professionals and policy makers on the issue of early childhood caries (ECC). Subsequent to the Surgeon General's Report on Oral Health, new definitions, research initiatives and funding for the study of caries in our youngest patients (pre-school children); it is now apparent that the dramatic caries reductions seen in permanent teeth over the past four (4) decades are not matched by primary tooth caries reduction. A subset of our population still has devastating dental decay. Young patients who exhibit this problem are also those requiring the most complex management techniques, i.e., sedation or general anesthesia, because of extent of the disease and inability to comply with normal outpatient dental procedures. Therefore, quality of life, impact of disease, and cost of care issues surrounding ECC demand additional attention by health providers.

It is anticipated that the new awareness of ECC by policy and funding agencies will result in advances in prevention and care for the pre-school child. This will demand an increased focus for all dentists on the youngest patients, leading to increased need for specialty services as many children will have needs that fall outside the skills and training of general dentists.

The importance of the need for continued research was validated by the Surgeon General's Report on Oral Health that highlighted children's' needs for early and effective preventive and treatment services and also stressed the vital need to train more pediatric dentistry specialists (Oral health in America: A report of the surgeon general. Rockville, MD. U.S. Department of Health and Human Services; 2000). The *National Health and Nutrition Examination Survey (NHANES)* also noted the caries risk in preschool children and the need for prevention in this population (NCHS Health Statistics-2003-2004 National Health and Nutrition Examination Survey (NHANES). Prevalence of Overweight Among Children and Adolescents: United States, 2003-2004. <http://www.cdc.gov/nchs/>).

Advances in Restorative Dental Materials and Treatment.

Advances in adhesive dental technology have radically changed restorative dentistry. The acid-etch technique for enamel bonding led to the development of revolutionary restorative, preventive, and esthetic treatment methods. More recently, developments in resin/dentin bonding have moved adhesive dentistry to an even higher level. (Swift, Jr., E. J. Dentin/enamel adhesives: review of the literature. *Pediatr Dent* (2002) 24 (5): 456-61). New materials (glass ionomers, resin-modified glass ionomers, compomers and composite resins) offer the clinician numerous choices in determining the right material for each individual situation. One can now select a material based on its

appropriateness for the given clinical scenario. (Berg, J. Glass ionomer cements. *Pediatr Dent* (2002) 24 (5): 430-8).

New materials offer the possibility of improved esthetics, more conservative bonded restorations, less intrusive /aggressive preparation designs, fluoride releasing materials used for disease treatment, prevention and restoration. The practitioner today has many choices to select the best material to fit the need and/or situation.

Caries risk assessment and improved therapeutic intervention.

Enhanced appreciation of the microbiological mechanism in early caries development and the importance of the transfer of oral flora from care-taker to child have led to research on more focused early prevention. For example, emphasis on the first dental exam in the first year of life encourages early family education toward prevention, and it communicates therapies for the caretakers to decrease the transfer of their virulent bacterial strains to their children. This is one example of the ability of pediatric dentistry to "customize" prevention based on the particular factors of caries risk found in an individual and family. Good science has led to these advances. Research has also validated the importance of other patient, family and community influences on dental caries initiation, and the importance of a dental home to address non-biologic factors now known to be major influence on oral disease (Fisher-Owens, S. A., et al. Influences on children's oral health: a conceptual model. *Pediatrics* (2007) 120: e510-20).

Additional preventive and therapeutic agents have been proven effective. Chlorhexidine rinses and varnishes, fluoride varnishes, and remineralizing agents have been found to facilitate more conservative, cost-effective approaches to caries management through microbial control and remineralization.

Patient Management and Informed Consent.

Changing state standards for disclosure in informed consent have resulted in a dramatic increase in research concerning parental attitudes about traditional dental behavior management techniques (Eaton, J., et al. Attitudes of contemporary parents toward behavior management techniques used in pediatric dentistry. *Pediatr Dent* (2005) 27: 107- 113). Research into parent's attitudes about the use of behavior management techniques has resulted in increasing interest by dentists to develop additional child behavior techniques (Adair, S.M., et al. A survey of members of the American Academy of Pediatric Dentistry on their use of behavior management techniques. *Pediatr Dent* (2004) 27:159-63) and to abandon more aggressive techniques. The impact on private practice has been the increased use of in-office sedation and more children scheduled to have their dental care provided under general anesthesia. Training for both of these modalities is not a part of the traditional predoctoral curriculum and most general practitioners are not prepared to treat children requiring these approaches to managing behavior. As a result, these children are required to be seen by pediatric dentists.

Data supporting the safety of conscious sedation with proper monitoring as well as research into numerous sedative agents and combinations of agents have produced a broader array of modalities and supported evidence-based decisions in choosing the proper agent for a given clinical situation.

Additionally, the AAPD sedation guidelines were revised in 1995 with a major emphasis on monitoring and resulted in a higher standard of care for sedated patients. (American Academy of Pediatrics and American Academy of Pediatric Dentistry. Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures. *Pediatr Dent* (2009) 31:152-68)

Influence of molecular genetics on our understanding of growth /development and syndromes.

Dramatic advances in genetics have led to a revolution in our understanding of health and disease. Increasingly, diseases such as cancer, high blood pressure or Alzheimer's disease are being linked to a specific gene. The entire genetic sequence of many disease-causing organisms such as *E. coli* and *Candida Albicans* has already been discovered and the entire genetic sequence of humans will be revealed by the Human Genome Project, with implications for disease prevention and treatment.

These advances in genetics have already begun to affect pediatric dentistry. Most of the advances have resulted in better diagnostic capabilities for children with diseases affecting the oral facial complex. Reports of specific gene mutations that result in missing teeth or craniofacial anomalies have appeared in the popular press.

We now know that single base pair changes in many different genes lead to Crouzon, Apert, Jackson-Weiss, Pfeiffer, Saethre-Chotzen, and Papillon-LeFevre syndromes. In the past, many pediatric dentists have contributed to our understanding of these disorders and in the future, pediatric dentists will continue to shape this information with families to answer questions from parents who have children afflicted with these disorders. Genetic testing and counseling is now part of management of children with multiple missing teeth enamel and dentin disorders and craniofacial conditions.

The future holds much promise not only for improved diagnostic capabilities, but also for more effective treatments, reduced medical costs, a better quality of life and increased longevity. Important discoveries related to the genetic basis of enamel formation are continually made. Likewise, we have a better understanding of birth defects that affect the craniofacial complex. Stem cell research and use of primary tooth pulpal cells in various conditions are ongoing. The impact on the practice of pediatric dentistry is that practitioners will need to be more informed about advances in genetics to better serve their patients.

Patient Care for the Medically Compromised and Those with Special Health Care Needs.

Research into new treatments for medically compromised patients, such as organ transplants and improved oncology regimens, has resulted in saving and prolonging the lives of children with once fatal diseases. Many of these children have medical conditions which put them at significant, often life threatening risk from untreated dental disease and these children are now seeking care in the private dental sector as their numbers increase. Their dental management requires careful consultations with the medical team, the ability to work within a hospital and an increased level of understanding of the medical disease on the part of the dental provider.

Additionally, children with chronic disabilities such as severe cerebral palsy are receiving medical interventions such as gastrostomy tubes and indwelling tracheostomies which prolong their lives, and subsequently their need for dental care. Again, the dental provider must be trained to understand the risks and benefits routine dental procedures create for these patients and be prepared to consult with the primary physician about dental management of these patients with special needs. Devices that save lives but compromise the integrity of the cardiovascular system have multiplied and many require antibiotic coverage for dental procedures or are subject to electromagnetic modification from dental instrumentation. The impact on private practice has been the need to train a pediatric dentist who is far more knowledgeable about the medical and dental management of these very complex cases. The traditional predoctoral curriculum as defined in the document *Accreditation Standards for Dental Education Programs* (Commission on Dental Accreditation, Revision February 1, 2008) does not adequately prepare the general dentist to care for these children, and their dental care falls most appropriately to the pediatric dentist.

Technological advances in diagnostic methodology.

Improvements in digital radiography have led to smaller sensors appropriate for diagnostics for children. Additional enhancements to this modality will eventually transform radiography and again decrease exposure of patients. Digital enhancement and refinement of radiography and other diagnostic images, such as quantitative light fluorescence and laser fluorescence, is leading to more objective assessment of pathology in both hard and soft tissues. These improvements will enhance our abilities for early detection and therapy.

The Dental Home

In 2001, the AAPD adopted its Policy on the Dental Home. The Dental Home concept is derived from the American Academy of Pediatrics definition of a medical home which states primary pediatric health care is best delivered where comprehensive, continuously accessible, family-oriented, coordinated, compassionate and culturally effective care is available and delivered or supervised by qualified child health specialists. The Dental Home, with a residency-trained pediatric dentist as the leader, is inclusive of all aspects of oral health for infants, children, adolescents and persons with special health care needs. Establishment of the Dental Home is initiated by the identification and interaction of all involved – patient, parents, non-dental professionals and dental professionals. Growing evidence supports the effectiveness of early establishment of a dental home in reducing ECC and its treatment.

Trends in Education

6. Review the summary data collected from the ADA Survey Center's *Survey of Advanced Dental Education Annual Reports* over the past ten years regarding the number of programs and program enrollments. Provide overview comments on past or future trends regarding this information. (*suggested response - one page*)

Pediatric Dentistry	Number of Programs	Total Enrollment
1999-2000	59	413
2000-01	57	442
2001-02	61	480
2002-03	65	509
2003-04	65	543
2004-05	65	579
2005-06	67	621
2006-07	69	658
2007-08	73	686
2008-09	74	710

Since 1999, remarkable growth in the capacity within training programs has resulted in a significant increase in the numbers of new pediatric dentists entering the workforce. The increase in numbers of programs from 59 in 1999 to 74 in 2009 represents a 20% increase. In addition to new programs and the additional training slots they represent, some existing programs have increased the numbers of positions in their programs. Thus the total enrollment has increased from 413 in 1999 to 710 in 2009 or a 72% increase in available training positions. These numbers present a much more positive workforce picture in 2010 than was presented in the projections made in the 2000 re-recognition document.

For the academic year 2010-2011, the number of positions offered and residency positions filled in Pediatric Dentistry surpasses oral and maxillofacial surgery, orthodontics and advanced education in general dentistry. There has been a noticeable and consistent trend toward increasing numbers of applicants to pediatric dentistry programs since the last re-recognition document, (334 in 2001 increased to 562 by 2010) and the academic quality of the pediatric dentistry applicants has greatly improved; in 1998 the mean GPA was 3.12 and in 2010 it is 3.4, reflecting the attraction of the brightest dental students to the specialty.

Presently, 58.5 % of residents are female, the highest number for all the specialties. The vast majority of enrolled residents (88%) are USA residents; 1.8% are from Canada and 9% are from other countries, representing a continuing decline in foreign residents as projected in the 2000 report. Therefore the likelihood of more trained pediatric dentists remaining in the USA workforce is increased. We expect the number of programs and enrolled students to increase over the next 10 years as long as federal and local funding continues. This may be tempered because of limitations placed by projections of faculty shortages and funding availability.

Ongoing workforce analyses and discussions are needed to ensure an appropriate number of pediatric dentists will be available to ensure proper care for children and

especially for children with special health care needs. Dental care continues to be the most prevalent unmet health care need of poor US children of all ages. Today pediatric dentists are the primary providers for specialty pediatric care - children under 3 years, children requiring pharmacologic behavior management, children requiring treatment under general anesthesia, and children with special health care needs. Surveys report that only 26% to 48 % of general practitioners treat infants or young children. Fewer treat children with special health care needs. With only 5000+ practicing pediatric dentists and approximately 68 million children 0-18 years old, can pediatric dentists continue to be the 'safety net' to treat the children that are at highest risk for dental disease? Furthermore, recent studies suggest that the nation's infrastructure for care of very ill children is greatly dependent on pediatric dentistry residency training programs (Ciesla, D., et al. Characteristics of dental clinics in US children's hospitals. *Pediatr Dent* in press).

Match data as reported by the National Matching Services, Inc. in the table below reflects the growth of the specialty. Between the years 2001 – 2010, there was a 59% increase (228 applicants) in the number of applicants participating in the Match; a 62% increase in the number of positions offered; and a 54% increase in the number of Matched / filled positions.

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Applicants Participating	334	362	358	417	407	454	479	480	477	562
Positions Offered	191	200	220	224	246	251	265	290	297	307
Matches / Positions Filled	162	192	214	220	241	242	254	280	285	299

- Review the summary data collected from the ADA Survey Center's *Survey of Advanced Dental Education Annual Reports* over the past ten years regarding the number of full-time and board certified program directors. Provide overview comments on past or future trends regarding this information. (*suggested response - one page*)

Pediatric Dentistry	Director is Full-Time		Director is Board Certified	
	Yes	No	Yes	% Certified
2000-01	48	10	45	78
2001-02	53	7	45	75
2002-03	56	8	52	81
2003-04	55	10	54	83
2004-05	54	11	52	80
2005-06	52	15	51	76
2006-07	58	11	60	87
2007-08	62	11	66	90

Since the 2000 report, the number of full-time program directors has increased from 48 to 62. However, 11 programs do not have a full-time director, and this is problematic.

The complexity of the training programs, the many interactions necessary with other departments, off-site affiliations and the increased paper work mandated by institutions and regulatory bodies demand oversight by full-time program directors. In addition, continuity of support and administration suffers without a full-time director.

Increasing faculty shortages are becoming apparent and have the potential to become a crisis. As many faculty near retirement, there are few young graduates in line to replace them, due in part, undoubtedly, to high student debt, which has been rising steadily since 2000 (American Dental Education Association. *Trends in dental education-average debt among all graduating students by type of school 1990–2007*. Available at: <http://www.adea.org/publications/TrendsInDentalEducation/TDEStudents/Pages/Debt.aspx>. Accessed August 6, 2009). In 2008, the average dental student debt was \$170,000, (Okwuje, I., Anderson, E., Valachovic, R.W. *Annual ADEA survey of dental school seniors: 2008 graduating class*. *J Dent Educ* (2009) 73:1009–1032) and that debt is further magnified during the additional years required for specialty training. Finding adequate numbers of qualified faculty is challenging, and optimal faculty-to-resident ratios are especially important when residents are treating challenging medically compromised or special-needs patients and providing dental care for sedated patients. Federal regulations also mandate specific attending ratios in hospitals. With distance education technology currently available, programs can share curriculum and lectures, relieving the program directors of some responsibilities. However, clinical settings require the on-site presence of well-trained faculty to ensure quality teaching and safe patient care. The low salaries available to new academics paired with the heavy debt load many new graduates carry make it virtually impossible for those graduates to consider a career in academics. The recently introduced faculty loan repayment bill in Congress (H.R. 6551) has the potential to support loan repayment contracts of up to \$250,000.00 in aggregate over five years to faculty. This support could open the doors to academics for interested individuals who otherwise would not have the option.

AAPD and Healthy Smiles, Healthy Children: the Foundation of the American Academy of Pediatric Dentistry has invested in a master clinician program with the American Dental Education Association and the Academy for Academic Leadership for an intensive faculty development program. The goal is to help recruit and retain pediatric dental faculty from the practicing community and to develop skills to facilitate success in the academic environment. To date, five scholars have completed the program and an additional five new scholars have been selected for 2010.

Certification by the American Board of Pediatric Dentistry has been greatly modified since 2005, so that an educationally qualified pediatric dentist can be certified within 18 months. Additionally, with the majority of newly trained pediatric dentists entering the certifying process upon completion of training, most interested in an academic career will be certified.

8. Review the summary information attached as Appendix 1 and 2. This information has been provided by the Commission on Dental Accreditation regarding general changes in the language common to all advanced specialty education standards and changes in the specialty's discipline-specific accreditation standards. Please provide an overview comment on future trends regarding this information.
(suggested response - up to one page)

The specialty of pediatric dentistry has participated in the development and approval of these cross-specialty changes through its involvement in the Commission on Dental Accreditation and its Pediatric Dentistry Review Committee. In fact, some changes, such as the recommendation for inclusion of patient quality assurance in clinical specialty education and the inclusion of patients with diverse socioeconomic and health needs were initiated by the specialty's representatives to CODA. Pediatric Dentistry is in a unique position, because of its close relationship to medicine and medical training and because of its necessary dedication to alleviating oral diseases in diverse socioeconomic populations of children disproportionately affected, to lead other specialties in broadening the scope of dental practice for the entire profession. Of particular note is the recognition of the importance of patient advocacy by the dental specialties at their February 2010 meeting. Pediatric dentistry has included patient advocacy as its primary mission for at least two decades and in its proposed standards revision (on-going) has made patient advocacy a required competency for all pediatric dentistry graduates.

Many changes in the language common to all specialties, or boilerplate language, have been adopted, implemented and proposed. Some examples of this include clarification of terms, the addition of a standard on professionalism and ethical conduct and training in evidence-based dentistry. Most importantly, the Commission has reviewed how proficiency and competency are measured in advanced specialty education programs. The Commission recognized that current definitions are not being used uniformly and are outdated and no longer appropriate. The Commission has proposed with potential adoption in 2010 that the terminology – proficient, familiarity, and exposed – be eliminated and “competent” and “competencies” be redefined for all advanced specialty education programs. The Commission is also proposing a boilerplate standard on student/resident assessment that will include formative and summative measurements. The AAPD is in support of these proposed boilerplate changes and further believes that formative feedback that encourages self-assessment reinforces good clinical skills and establishes a pattern for lifelong learning and the delivery of high-quality dental care.

Changes in Scope of Practice

9. Highlight recent epidemiological data or studies that establish the incidence and/or prevalence of major conditions routinely diagnosed and/or treated by practitioners in the specialty. Please provide overview comments on how these changes have affected the practice of the specialty and the future practice of the specialty. (*suggested response - up to five pages*)

The rapidly changing demographics of children in the United States are having an effect on the practice of pediatric dentistry. More and more children are living below the poverty level. Low income, low educational level, and unemployment are all associated with a higher rate of health problems, including dental disease. The number of children and adolescents under age 18 in the US is projected to increase from 69.9 in 1998 to 77.6 million in 2020. As the dental and medical professions (ADA, AAP, AAPD and AAPHD) all have endorsed the recommendation for a dental visit during the first year of life, the need for dentists comfortable with infants and very young children will grow with the population.

The defining characteristic of pediatric dentistry is its attention to children and their oral conditions. While these conditions range widely – from acquired infectious diseases to

developmental defects, from the effects of unintentional and intentional trauma to disturbances in growth and development - the major condition most routinely diagnosed and treated by pediatric dentists is dental caries. It is reported that 80% of the dental disease can be found in 20% of the children and unfortunately these are often poor and vulnerable populations. Children with high treatment needs are more likely to require the services of the pediatric dental specialist. Thirty-one percent of Mexican American children aged 6 to 11 years had experienced decay in their permanent teeth, compared with 19 percent of non-Hispanic white children based on data from CDC's National Center for Health Statistics, the report, *Trends in Oral Health Status—United States, 1988–1994 and 1999–2004*. The authors also state that “while we are continuing to make strides in prevention of tooth decay, this disease clearly remains a problem for some racial and ethnic groups, many of whom have more treated and untreated tooth decay compared with other groups.” The same report noted tooth decay in primary teeth of children aged 2 to 5 years increased from 24 percent to 28 percent between 1988-1994 and 1999-2004. The very high and increasing rates in 2-5 year-olds is of particular concern for pediatric dentistry, since children this young are typically referred to specialists for care. Despite significant strides made to improve the oral health of the general population, dental caries rates in children are still on the rise and still the single most common chronic disease of childhood.

In the 2000 report, *Oral Health in America*, the Surgeon General characterized dental disease in children a “silent epidemic” and listed a number of major findings. The Surgeon concluded that: (1) children’s oral health is important to their overall health and well-being; (2) dental disease has a profound impact on children and their families; and (3) vulnerable children have more disease and have significant barriers to care. We now know that dental caries in children has specific far reaching consequences. ECC causes pain and discomfort, generalized infections that can spread throughout the mouth and jaws, a higher risk of new carious lesions in both the primary and permanent teeth later in life, hospitalizations and emergency room visits, increased treatment costs and time, delayed or insufficient physical development (especially in the child’s height and/or weight), and increased days with restricted activity and diminished ability to learn (Casamassimo, P.S., et al. Beyond the dmft: the human and economic cost of early childhood caries. *JADA*, (2009) 140: 650-57). Consequences for parents include distress and interruptions in family function. In a recent study, parents of 3-year-old children reported being upset, feeling guilty, and having to take time off work because of the child’s dental problems. Nationally, nearly 30% of all child health expenditures are devoted to children’s oral health care.

The major consideration in providing care to children is child-behavior and management. Because preschool aged children are carrying the burden of disease appropriate and timely dental care for the pre-school aged child has been a source of concern for parents and dentists for many years. Several treatment modalities exist for these children including in-office conventional care (with or without nitrous oxide), conscious sedation and treatment under general anesthesia (GA). More and more families are opting for dental care from a pediatric dentist under GA. General anesthesia also carries a greater risk of morbidity and mortality than conventional treatment and parents may be less willing to choose this option if they fully understand the risks. However, studies have found that parents of children who undergo GA dental rehabilitation express significant satisfaction with their children’s care in the operating room.

Each day, pediatric dentists see thousands of children suffering from serious dental caries that has a direct impact on their ability to eat, learn, sleep, and live. The 2000 U.S. Surgeon General's report *Oral Health in America* highlighted that dental disease is the leading childhood disease – five times more common than asthma and 20 times more common than diabetes. A 2007 report by the Centers for Disease Control and Prevention (CDC) revealed that the rate of preschoolers with cavities has spiked to more than one in every four children between the ages of two and five. A September 2008 report by the U.S. Government Accounting Office (GAO) indicated that relatively few children covered by Medicaid receive recommended dental services and inadequate reimbursement is the most significant reason why dentists do not participate in Medicaid. It is critical to recognize that pediatric dentists serve Medicaid children at a disproportionately higher rate to the percentage of pediatric dentists in the dental population.

Pediatric dentists are frequently called upon to treat "special needs" children whose overall health is compromised by disease or disability. Among these children, even greater percentages have a parentally identified unmet dental need. Twenty-four percent of special needs children who are uninsured have an unmet dental need. Because dental caries is progressive with age, all children with identified unmet needs ultimately require care. The large pool of children who need but have not obtained care will likely be a continuous reservoir of children who present with extreme disease and urgent treatment needs and who are frequently referred to the pediatric dentist for management. There are indications that the proportion of children with special health care needs is increasing. As their numbers increase, the need for pediatric dentists to provide their routine dental care will also increase. For example, the National Institute of Allergy and Infectious Diseases report a rapidly rising number of children with asthma. Children with significant asthma require dental care from those most comfortable handling their overall presentation. Additionally, the reported rates for children with autism are also on the increase. In February 2007, the Centers for Disease Control and Prevention issued their ADDM autism prevalence report. The report, which looked at a sample of 8 year olds in 2000 and 2002, concluded that the prevalence of autism had risen to 1 in every 100 American children, and almost 1 in 94 boys. The pediatric dental specialty is uniquely trained to provide optimal dental care to children and families affected by autism. Ever more sophisticated and lifesaving medical treatments for fragile infants are increasing the number of children with residual chronic health problems.

In summary, significant epidemiological and associated demographic trends will impact the near future of pediatric dentistry, especially in relation to dental caries - the major and most routinely managed disease by pediatric dentists.

These include:

- 1) Growing number of children in the US and a demographic shift toward higher-risk sub-populations.
- 2) Growing number of children affected by autism and other special health care needs surviving into childhood and adolescence.
- 3) Increasing rates of dental caries in vulnerable and very young child populations
- 4) Continued high rates of dental caries.
- 5) Increasing severity of dental disease in very young children requiring extensive dental treatment.
- 6) A widely recognized need for dental care in a significant population of special needs and behaviorally affected children.

10. According to the 2007 *Survey of Dental Practice*, responding specialists (includes all specialties) reported that general practitioners provided most of their referrals (57.5%), followed by their patients (25.3%). Describe referral patterns and who normally refers patients to practitioners in this specialty and how this might have changed in the past ten years.

Referrals to pediatric dental offices come from a variety of sources as revealed by the results of a 2009 survey of active members of the American Academy of Pediatric Dentistry. Two-thirds of the respondents reported that members of the health care provider network are the sources of referral for about 50% of the patients making up their practices. The two main sources of referral are pediatricians and general dentists. Two-thirds of responders reported that approximately 15% of their patients are referred by pediatricians, and three-quarters report that 15% are referred by general dentists. Other dental specialists and other health care providers are the source of additional referral from the health care community. Three quarters of respondents reported that other dental specialists refer up to 10% of the patients in their practices and 59% reported that referrals from other health care providers contribute up to 10% of the patients in their practices. The remaining 50% of their patients come from referral from other sources not identified in the survey, but the assumption is that they are outside the network of health care providers and most likely are patients and parents of patients.

These numbers seem to represent an increase in referrals from general dentists and from health care providers in general over the past ten years. This is probably due to the increasing numbers of children with more complex medical needs surviving and living in the community where their dental needs must be met. In addition, it likely reflects the dramatic and documented increase in early childhood caries in very young children. This trend reflects the importance of the specialty training that pediatric dentists have to care for these children and the importance of having pediatric dentists available for referral from other members of the health care community involved in their care.

Parents have become increasingly aware of the parallel between the pediatric dentist and the pediatrician in being uniquely trained to provide optimal care to children and the parallel of being a primary care provider as well as specialty care provider. In 2008, the American Academy of Pediatrics (AAP) listed oral health among its top three research priorities. This coupled with the AAP adoption of the age one dental visit will only increase the number of referrals made to pediatric dentists. Recently, parenting magazines and other lay media have encouraged parental adoption of the age one visit. *USA Today's* "2006 Annual Report" identified a dentist visit as third on the "Top 15 Things You Must Do for Your Infant." In 2005, *Redbook* included in "Mommy Strategies" instructions to take a child to a dentist by age 1. This coverage in the lay press promoted a demand for infant dental services among the general population and led to more parental referrals into practices at an earlier age. Additionally, public health programs such as Early HeadStart, HeadStart and Women, Infant and Children's program have integrated oral health components in their programs and have increased dental referrals.

11. Identify the principal health services provided to the public by individuals in this area of practice and whether this has changed in the past ten years. If this has changed, what has been the impact on profession and public?

As an age-defined specialty, the services provided by pediatric dentists relate primarily to populations rather than specific procedures. The very young, the troubled patients and families, the developmentally disabled and medically compromised patients, and children with complex dental, medical, or communication needs form the basis for practicing pediatric dentistry. In addition, normal well-child check ups are a vital part of prevention for the very young. The pediatric dentist is uniquely qualified to provide ongoing, quality primary care in this population with specific knowledge and experience to guide the child into a lifetime of responsible dental care. The concentration of early childhood caries into a young patient population requiring advanced behavior guidance has created a constellation of dental and medical care requisites that only the pediatric dentist can provide. Similarly, demographic and societal shifts resulting in a predominance of the parent-child-dentist care model makes the pediatric dentist best able to address a more complex system to provide treatment and anticipatory guidance.

12. Identify the setting(s) in which these services are customarily provided and whether this has changed in the past ten years. If this has changed, what has been the impact on profession and public?

Pediatric dental care continues to be offered in private and public clinics as well as in hospital outpatient clinics and operating rooms. There is an increasing trend to have deep sedation or general anesthesia for children performed in freestanding surgical centers and/or in clinics served by anesthesiologists and anesthesiologists. This trend reflects an interest in controlling costs of care in hospital settings. The increased acknowledgement that complex dental care for complex patients is best delivered under general anesthesia has led to better access to hospital type services for pediatric dentistry patients. Legislation in many states now mandates insurance coverage for general anesthesia care related to dental treatment as a part of any medical insurance provided to families. Such trends in hospital service lead to a need for more specialists who are comfortable and credentialed working in these medical settings.

13. Provide any other information that the specialty believes may be relevant to the study of the specialty area of practice. (*suggested response - one page*)

Head Start Dental Home Initiative

In 2007, the AAPD entered into a contract with the Office of Head Start and are partnering at the national, regional, state, and local level to develop a national network of dentists to link Head Start Children with dental homes.

A dental home means that each child's oral health care is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist.

A national network of pediatric dentists and general dentists will be created to provide quality dental homes for Head Start (HS) and Early Head Start (EHS) children; train teams of dentists and HS personnel in optimal oral health care practices; and assist HS programs in obtaining comprehensive services to meet the full range of HS children's oral health needs. This partnership will also provide parents, caregivers and HS staff with the latest evidence-based information on how they can help prevent dental caries and establish a foundation for a lifetime of oral health.

AAPD Leadership Institute

For years, key leaders within the AAPD discussed the urgency of nurturing and supporting leadership within the ranks of the Academy's membership. Leadership, with its many different connotations, embodies the skills and vision necessary for effective representation on AAPD governance bodies, involvement in organized dentistry, and advocacy outside the dental office in complex social organizations and contributing to personal development. Healthy Smiles, Healthy Children is proud to partner in this endeavor with the Kellogg School of Management at Northwestern University and Ultradent Products, Inc.

Founded in 2004, the AAPD Leadership Institute was the first of its kind among dental and medical organizations and has since been emulated. Each year, 30 individuals participate in an educational activity focusing on an array of topics important for leadership development. Although others have leadership programming, none have established an ongoing commitment with the financial resources to continually support a leadership focus of and for the organization.

Perinatal and Infant Oral Health Project

The American Academy of Pediatric Dentistry and Children's Dental Health Project have implemented *Improving Perinatal and Infant Oral Health Project*, a five year initiative funded by the Maternal and Child Health Bureau. The Project seeks to promote oral health for pregnant women, infants, and toddlers, and to increase public awareness of the importance of perinatal and infant oral health. The Project works to educate providers on the safety and importance of oral health care during pregnancy and early childhood. It serves to increase the provider's knowledge, skills and practices to improve access to oral health care; educate families and maternal and child health organizations. Others who come into contact with children and families about the importance of oral health also benefit. The Project also promotes education on dental caries and its prevention to the public at large, increasing public awareness of the importance of oral health. The Project partners with diverse stakeholders such as clinical, maternal and child health, policy-related and others, to improve perinatal and infant oral health on the local, state, and national level.

AAPD Master Clinician Program

As a method to address the growing faculty shortages at the dental school and residency program level, the AAPD has developed its Master Clinician Program.

The Master Clinician Program is geared towards mid- to late career practitioners considering a transition to academics. The practitioners may have been or currently have some form of faculty appointment at a dental school or residency program; others are just beginning consideration. Participants in the program have the opportunity to attend the Academy for Academic Leaders' *Institute for Teaching and Learning* (ITL) program and attendance at the AAPD continuing education course, *Comprehensive Review of Pediatric Dentistry*. The ITL provides professional development in the areas of classroom presentation, learning styles, test construction, evaluation and other topics relative to teaching. The Comprehensive Review provides an update of all areas of pediatric dentistry.

To defray some of the costs of attendance at the ITL and Comprehensive Review, the AAPD has partnered with its foundation, Healthy Smiles, Healthy Children, to offer a Master Clinician Scholarship Program. This competitive program, now in its third year, offers five (5) scholarships to pediatric dentists to participate.

COMMISSION ON DENTAL ACCREDITATION
Document Revision History 2000 - 2008

Accreditation Standards for
Advanced Specialty Education Programs in Pediatric Dentistry

Date	Item	Action
July 30, 1998	Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry	Adopted
January 1, 2000	Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry	Implemented
January 29, 1999	Accreditation Status Definitions	Revised and Adopted
July 1, 1999	Accreditation Status Definitions	Implemented
July 23, 1999	Standards on Program Director and Teaching Staff and Program Duration (Standards 2-2, 2-3.1, 2-3.2, and 4-2)	Revised and Adopted
January 1, 2000	Standards on Program Director and Teaching Staff and Program Duration (Standards 2-2, 2-3.1, 2-3.2, and 4-2)	Implemented
January 28, 2000	Intent Statements added to Selected Standards	Adopted and Implemented
July 28, 2000	Intent Statements added to Selected Standards	Adopted and Implemented
January 30, 2001	Mission Statement	Revised
January 30, 2001	Policy on Advanced Standing	Revised and Adopted
July 27, 2001	Standard 6-1 Intent Statement	Revised, Adopted and Implemented
July 27, 2001	Standard on Advanced Standing	Revised and Adopted
July 1, 2002	Standard on Advanced Standing	Implemented
February 2, 2002	Initial Accreditation Status Definition	Adopted
January 1, 2003	Initial Accreditation Status Definition	Implemented
August 1, 2003	Intent Statement deleted from Standard 1, Program Administrator	Revised, Adopted and Implemented
August 1, 2003	Policy on Enrollment Increases in Dental Specialty Programs	Adopted
January 30, 2004	Policy on Enrollment Increases in Dental Specialty Programs	Implemented
January 30, 2004	Intent Statement to Standard 1 on Major Change ("student enrollment" deleted)	Revised and Adopted
January 30, 2004	Intent Statement and Examples of Evidence to Standard 2	Adopted and Implemented
July 30, 2004	Standard 2-3.1	Revised, Adopted, and Implemented

<i>January 28, 2005</i>	<i>Examples of Evidence to Standard 2 (for non-board certified directors)</i>	<i>Revised, Adopted, and Implemented</i>
<i>July 29, 2005</i>	<i>Term and Definition Student/Resident</i>	<i>Adopted and Implemented</i>
<i>July 29, 2005</i>	<i>Standards to Ensure Program Integrity (Standards 1, 2, and 5)</i>	<i>Adopted</i>
<i>January 1, 2006</i>	<i>Standards to Ensure Program Integrity (Standards 1, 2, and 5)</i>	<i>Implemented</i>
<i>January 27, 2006</i>	<i>Intent Statement to Standard 2</i>	<i>Adopted and Implemented</i>
<i>January 27, 2006</i>	<i>Intent Statement to Standard 2-1.2</i>	<i>Adopted and Implemented</i>
<i>July 28, 2006</i>	<i>Examples of Evidence for Standard 1 Intent Statement for Standard 5</i>	<i>Adopted and Implemented</i>
<i>July 26, 2007</i>	<i>Standards to Ensure Program Integrity Examples of Evidence Modified (Standard 1)</i>	<i>Adopted and Implemented</i>
<i>July 26, 2007</i>	<i>Name Change: The Joint Commission on Accreditation of Healthcare Organizations changed to The Joint Commission</i>	<i>Adopted and Implemented</i>
<i>February 1, 2008</i>	<i>Revised Definition of Terms and usage of Examples of Evidence</i>	<i>Adopted and Implemented</i>
<i>January 31, 2009</i>	<i>Revisions to Preface, Definitions of Terms, and Boilerplate Standards 1, 4 and 5 (Eligibility and Selection, and Evaluation)</i>	<i>Adopted</i>
<i>July 1, 2009</i>	<i>Revisions to Preface, Definitions of Terms, and Boilerplate Standards 1, 4 and 5 (Eligibility and Selection, and Evaluation)</i>	<i>Implemented</i>

American Academy Pediatric Dentistry 2009-12 Strategic Plan

Revised

2009

Goal 1—Optimal Health for All Children and Persons with Special Health Care Needs

Objective 1.1: An oral disease-free population.

- Strategy 1.1.1 Promote universal acceptance of anticipatory guidance and preventive oral health care in a dental home beginning no later than age 1.
- Strategy 1.1.2 Support water fluoridation efforts and appropriate use of other topical and systemic fluoride vehicles.
- Strategy 1.1.3 Increase public and governmental awareness and education regarding pediatric oral health strategies.
- Strategy 1.1.4 Encourage and support research in oral disease prevention and evidence-based care.
- Strategy 1.1.5 Employ risk assessment and tailored interventions.

Objective 1.2: Access to appropriate oral health care for all children and persons with special health care needs.

- Strategy 1.2.1 Recognize and address barriers to access and quality care.
- Strategy 1.2.2 Assure adequate and appropriate financing in public sector programs.
- Strategy 1.2.3 Recognize and support appropriate provision of care by safety net providers.
- Strategy 1.2.4 Increase the availability of reimbursement for medically necessary care (general anesthesia and sedation).

Goal 2—Valued and Worthwhile Membership Services

Objective 2.1: An informed membership.

- Strategy 2.1.1 Provide valuable continuing education.
- Strategy 2.1.2 Communicate through *Pediatric Dentistry Today* and other appropriate venues Academy activities and programs on behalf of the membership.
- Strategy 2.1.3 Produce respected scientific publications
- Strategy 2.1.4 Maximize utilization of information technology.

Objective 2.2: A membership adept at adapting to changes in delivery of care and technological advances.

- Strategy 2.2.1 Provide contemporary guidance in practice administration, communication, and marketing skills in pediatric dentistry.
- Strategy 2.2.2 Assist in disseminating information concerning member career transitions and business opportunities, including those designed for the new pediatric dentist.
- Strategy 2.2.3 Involve the Academy in the dissemination of information regarding new products and techniques.

Objective 2.3: Maximized membership dues value.

- Strategy 2.3.1 Support the personal issues of Academy members.
- Strategy 2.3.2 Provide office brochures and other valuable materials.
- Strategy 2.3.3 Monitor and evaluate membership benefits on a continuing basis.

Objective 2.4: Effective response to crucial pediatric dental issues.

- Strategy 2.4.1 Identify and anticipate emergent membership issues.
- Strategy 2.4.2 Develop and maintain a protocol and mechanism for responding to the public, media, and membership on anticipated and unanticipated critical issues.
- Strategy 2.4.3 Develop and maintain a network of trained spokespersons.

Objective 2.5: Strong pediatric dental organization representation.

- Strategy 2.5.1 Development of international membership.
- Strategy 2.5.2 Sustain recruitment and retention efforts, including programs and policies directed to the new pediatric dentist and dental faculty.

Goal 3—Recognized Authority in Pediatric Oral Health

Objective 3.1: Optimal care, including translation of science into clinical practice.

- Strategy 3.1.1 Develop optimal care through our oral health policies, clinical guidelines, and other venues.
- Strategy 3.1.2 Promote optimal care through our oral health policies, clinical guidelines, and other venues.
- Strategy 3.1.3 Maintain optimal care through our oral health policies, clinical guidelines, and other venues.

Objective 3.2: Expert resource on children’s oral health recognition.

- Strategy 3.2.1 Build and maintain coalitions with other healthcare organizations.
- Strategy 3.2.2 Anticipate and respond effectively to changes in the clinical and scientific environment.
- Strategy 3.2.3 Identify and support areas of clinical and scientific research important to pediatric oral health.
- Strategy 3.2.4 Communicate to the profession and the public issues about pediatric oral health.
- Strategy 3.2.5 Encourage and support volunteer leadership by pediatric dentists in all organizations involved in oral health or child welfare.

Objective 3.3: Effective advocate of public policy.

- Strategy 3.3.1 Coordinate all elements of advocacy resources, including the congressional liaison, child advocate, political action committee (PAC), Children’s Dental Health Project (CDHP), volunteer advocates, and lobbyists.
- Strategy 3.3.2 Identify public policy issues, conduct policy research and development, and develop implementation strategies.
- Strategy 3.3.3 Develop an effective advocacy network.

Goal 4—Satisfy Workforce Issues

Objective 4.1: Enlarged and appropriately distributed pediatric dental workforce.

- Strategy 4.1.1 Encourage effective geographic distribution of pediatric dentists.
- Strategy 4.1.2 Expansion of pediatric dental residency and fellowship programs.
- Strategy 4.1.3 Innovate and support programs to assure a well-qualified applicant pool for pediatric dental training.

Objective 4.2: Greater engagement of the general dentist and dental specialists in the treatment of children.

- Strategy 4.2.1 Improve pre-doctoral education and experience in pediatric dentistry.
- Strategy 4.2.2 Development of continuing education programs.
- Strategy 4.2.3 Promote the value of the Affiliate membership category.

Objective 4.3: Appropriate and optimized utilization of allied dental health professionals.

- Strategy 4.3.1 Development of continuing education programs.
- Strategy 4.3.2 Identify appropriate roles for allied dental health professionals which include dental assistants, expanded function dental assistants (EFDA), and hygienists.

Objective 4.4: Appropriate and effective utilization of non-dental healthcare providers.

- Strategy 4.4.1 Development of continuing education programs.
- Strategy 4.4.2 Identify appropriate roles for physicians and non-dental health care providers.

Goal 5—Meet Dental Education Needs

Objective 5.1: Academic faculties of excellent caliber and sufficient number.

- Strategy 5.1.1 Educate AAPD membership on academic crisis issues.
- Strategy 5.1.2 Foster a fundraising campaign for academic support.
- Strategy 5.1.3 Foster improved business practices in teaching clinics.
- Strategy 5.1.4 Foster academic career loan forgiveness programs.
- Strategy 5.1.5 Foster creative use of private clinics and practitioner mentors in residency programs.
- Strategy 5.1.6 Foster effective modeling, mentoring, and education for potential academicians.
- Strategy 5.1.7 Foster development of shared basic information distance learning modules.
- Strategy 5.1.8 Increase the transition of “master clinicians” into teaching, including full time positions.
- Strategy 5.1.9 Foster dissemination of “best practice” models.

Objective 5.2: Physical plants of educational institutions adequate to support educational objectives.

- Strategy 5.2.1 Aid and support facility development programs.
- Strategy 5.2.2 Support legislation to secure capital funding for pediatric dentistry education facilities.

Objective 5.3: Increased standardization of pre- and post-doctoral training experiences.

Strategy 5.3.1 Implement consistent standards in pre- and post- doctoral programs.

Objective 5.4: Appropriate accreditation standards for the pre- and post- doctoral level.

Strategy 5.4.1 Support Academy initiatives on pre- and post- doctoral curriculum standardization.

Goal 6—Efficient and Effective Organization

Objective 6.1: The structure of the Academy serves and represents its membership.

Strategy 6.1.1 Increase communication between membership and leadership.

Strategy 6.1.2 Review the mechanism of accountability of the headquarters office to leadership.

Objective 6.2: Adequate funding for Academy operations, programs, and initiatives.

Strategy 6.2.1 Offset expenses by appropriately maximizing corporate and other outside support of Academy projects and endeavors.

Strategy 6.2.2 Assure an appropriate dues structure and other sources of income.

Objective 6.3: Efficient headquarters office operations.

Strategy 6.3.1 Assure a technologically-advanced communication to the membership.

Strategy 6.3.2 Provide an appropriately-sized and adequately-equipped facility for business operations.

Strategy 6.3.3 Support a qualified and well-motivated staff in appropriate numbers and responsibilities to accomplish Academy business operations.

Objective 6.4: Effective volunteer leadership.

Strategy 6.4.1 Assure appropriate leadership training.

Strategy 6.4.2 Assure objective assessment of the volunteer leadership.

Strategy 6.4.3 Assure a fair and equitable process to identify and select individuals at all volunteer leadership levels.

Objective 6.5: Effective tripartite organizational structure.

Strategy 6.5.1 Clarify and enhance the role of District Trustee in Academy operations.

Strategy 6.5.2 Promote efforts to strengthen effectiveness and number of district organizations and state units.

Strategy 6.5.3 Explore opportunities for increased membership participation in Academy decision making.

Objective 6.6: Effective relationship between the Academy and its Foundation.

Strategy 6.6.1 *Healthy Smiles, Healthy Children: The Foundation of the American Academy of Pediatric Dentistry* will function as the tax-exempt charitable research, education, and service arm of the Academy.

Strategy 6.6.2 Reflecting the AAPD Research Agenda and to further developments in the specialty, *Healthy Smiles, Healthy Children: The Foundation of the American Academy of Pediatric Dentistry* will sponsor research grants and awards, along with professional and public education opportunities.

Objective 6.7: Effective relationship between the Academy and the American Board of Pediatric Dentistry (ABPD).

Strategy 6.7.1 Sponsor and support a strong and vital American Board of Pediatric Dentistry.