Pediatric Dentistry Specialty as Part of a Longer Continuum of Care: A Commentary

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The transition of teenagers with special needs to young adulthood is a complex period for the children and their families. This transition is especially difficult when it comes to securing needed oral health care. The teenager is forced to transfer from the services of an age defined pediatric dental specialist with training to provide care for individuals with special needs, to 1) general practitioners with limited formal training and often unwillingness to provide care and 2) at a period when most states provide limited or lack of adult dental Medicaid programs. These issues and the need to expand pediatric dental specialist involvement in the general transitional period are reviewed.

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

"Our system of preparing and maintaining our abilities to provide oral health services for an increasing diverse population must be brought up to date to meet the challenges posed by the treatment of young adults with disabilities." [2]

"Most responding dentists (to a national study of pediatric dentists) helped adolescents with and without SHCNs (Special Health Care Needs) make the transition into adult care, but the major barrier was the availability of general dentists and specialists." [3]

PRACTICE LIMITATIONS

General dental practitioners provide the majority of oral health services for children and continue the needed care as youngsters mature into their adult years. By contrast the pediatric dental specialists are technically limited to the patient's early years if they are to maintain status as Board Certified Pediatric Dentists.

The realities, however, are that while pediatric dental residents have received advanced training in the care of youngsters with special health care needs, only recently has there some been some attention directed to predoctoral education of dental school graduates – most of whom will be called upon to provide for youngsters and the not so young with special needs. The Commission on Dental Accreditation wrote a new accreditation standard in 2004 for dental and dental hygiene programs to be implemented starting in January 2006, " Graduates must be competent in assessing the treatment needs of patients with special needs." [4]

> **"Intent:** *An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. The assessment should emphasize the importance of non-dental considerations. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques and assessing the treatment needs compatible with the special need."* [4]

But meeting this standard does not require clinical experience. A study carried out in 2008 and published in 2012 did report that some schools had gone beyond the minimum requirements and provided clinical experience in the care of individuals with special needs. [5] In addition, while many current practitioners do provide the needed care, there are limited continuing education program offerings for these and other practitioners to enhance their abilities to provide for individuals with special needs. For example, attaining Mastership in the Academy of General Dentistry (MAGD), a professional designation within the Academy of General Dentistry that reflects a general dentist's ongoing

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commitment to provide quality care through continuing education, requires a specified minimum number of continuing education hours in a range of subjects, including 'special patient care.' Unfortunately, only a limited number of course presentations are available for practitioners to meet the MAGD requirements. [6]

> "I am one of only two dentists in the State of Oklahoma who devotes a major portion of my practice to caring for patients with special health care needs. The other dentist is in Tulsa (90 miles away). Patients travel from all over the state to come to my office; many having to travel 3 hours or more one way. Some have to stay the night in a hotel because it is too taxing on the patient to travel that far in one day. Many of my referrals come from pediatric dentists who don't feel qualified to provide general dental services to adult patients who often require (endodontics, periodontics surgical extractions, fixed and removable prosthodontics, and implant therapy)." [7]

Note: "The writer refers to the fact that pediatric dentists often are called upon to care for their pediatric patients with special needs who have reached adulthood, but who are unable to find general dentists who are willing and able to provide the needed care." [7]

> "Among the more difficult transitions that you have to make is leaving your child's pediatrician (especially for children with special need). Pediatricians are trained to care for the medical needs of children up to the age of 21…(As to oral health services), typically, only pediatric dentists receive training in working with individuals with disabilities. While attempts are underway to include training for adult dentists, many individuals with Down syndrome continue to see their pediatric dentists in adulthood." [8]

It is quite difficult to secure needed oral health care for adults with special health care needs because of: 1) limited practitioner educational opportunities, 2) limited financial support (e.g. Medicaid programs in most states provide little to no coverage of adult dental services. In fact, studies suggest that fewer than 25 percent of all dentists accept Medicaid patients. [9] One study did report that "… fewer than one half of dentists treated any Medicaid patients in the previous year. [10]), and 3) a general reluctance to provide services to individuals with severe disabilities. The results may be the need for young adults to seek or continue to receive care from pediatric dentist specialists**. However, pediatric dental practice is officially limited to serving children.**

The concept of specific limitations for specialists is not confined solely to Pediatric Dentistry. For example, in 2013 the American Board of Obstetrics and Gynecology (ABOG) commented that an obstetrician-gynecologist (and an associate professor at Boston University School of Medicine) "...was at risk of losing her board certification. Most of her patients are women, but she evaluates and treats men and women alike for diseases of the anus associated with the human papillomavirus (HPV), which causes anal as well as cervical cancer...(the Board's exceptions) would not have applied to obstetrician-gynecologists who treat this condition in gay men…A *New York Times* article about the ABOG policy and Dr. Stier's plight may have nudged the certification board to bend a little. ABOG released a revised version of its obstetrician-gynecologist definition that allows these clinicians to evaluate and manage sexually transmitted infections (for all patients)." [11]

As with special circumstances affecting other specialists, age limitations should be reconsidered when it comes to providing care for young adults with special health care needs.

A CONTINUUM OF CARE

> "The well-being of young adults in the United States today remains an area of key interest to the public and policy-makers alike. This age group faces the well-known challenges of achieving financial and social independence while forming their own households at a time of greater economic uncertainty than in the past. **Better understanding of the achievements and needs of these young adults will inform approaches to best support this exciting and challenging transition to adulthood.**" (Emphasis added) [12]

The teen and young adult years are not separated by immutable walls. The foundations for the adult years are laid in the younger years. Appreciating these experiences and general health conditions and how they affect the later years are the domain of any number of pediatric specialties, including pediatric dentistry. No doubt, there is an infinite set of inter-related factors which can and do affect the efforts of caring family members and health providers. Nevertheless, an overview can provide pediatric dentists and other pediatric specialists with insight into how well their efforts are being maintained (or failing) as young patients reach their early adult years. The 2014 special issue of *American Young Adults* [11] provides a broad view of the social and health parameters that define the setting for the former patients of pediatric specialists.

Obesity, smoking, drinking and drugs are the quadrangular plague (emphasized repeatedly by the media) as affecting too many of the 31 million young adults. In addition, other realities do exist, including: unemployment, incarceration, near and actual poverty, continuing to live with parents and the need for government supported health care coverage. For many, the "simple" years of childhood, all too often, are replaced by years of uncertainty, over indulgence and hardship. (Chart 1)

These concerns are not beyond the purview of pediatric dentists, if the practitioners know that too many of the youngsters we follow in pediatric practices may continue in the pattern of current young adults. The relationship that the pediatric dentist develops during the treatment years with maturing teenagers affords the opportunity to discuss these difficult issues that will confront the soon to be young adults.

The fact is that pediatric dentistry is more than just oral health care for children. It involves moms, dads, grandparents, any number of other relatives and non-relative care takers. It requires that providers should be aware of difficulties in securing the oral health care of children with special health care needs as they transition to young adults; difficulties related to the limited numbers of practitioners trained and willing to provide the needed care as well as the restricted numbers of states that provide adult Medicaid dental services. If anything, pediatric dentistry is "family dentistry" during the foundation years of a child's life and for those who provide the all important care and support; in particular for children with special health care needs.

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PLANNING

According to the 2011 American Academy of Pediatrics Clinical Report, a planned transition process should begin early in adolescence (ages 12–14 years) for all youth, including those with special health care needs. Starting with a discussion of the practice's policy on transition with youth and parents, the process continues over time to ensure readiness and planning for adult-centered care at age 18 and for transfer to an adult provider, if needed, by the age of 22 years. This transition process goes on until youth and young adults are integrated into an adult model of care. [13]

The extended series of medical specialties for young and older adults with special needs can facilitate transition of teenagers to the care of adult- serving medical specialists. This is not the case in the field of dentistry. Dental transition for teenagers with special needs is trapped by the age defined pediatric dentistry specialty and limited training for general practitioners, as well as a lack of adult dental Medicaid programs in many states. The reality is that there are few options available for families with sons and daughters with special needs who reach the young adult years. The question remains; "How has the dental profession planned for the future with an ever increasing numbers of children and young adults with special needs?"

> "With reasonable biological certainty, most adolescents transition to adulthood. There is much less certainty about the manner in which health care professionals support this transition."[14]

> "If only it took an apple a day to maintain health and wellness, we would all invest in apples. Finding access to adult medical and dental care for individuals with Down syndrome (and other disabilities) takes more than apples. Paying for health care is difficult for adults with Down syndrome than it is for children. Some of us will find obtaining quality care challenging and may have to educate health care professionals and those who care for our children." [8]

REALITIES

No doubt, there are reasonable concerns in permitting board certified specialists to provide services to underserved populations that would place practitioners beyond the boundaries established by their respective boards or state government specialty licensing authorities. The term "underserved populations" can be too vague to establish firm boundaries that should be considered when describing the particular needs of this population. Nevertheless, the infusion of needed financial support would to some extent alleviate this disparity.

By contrast, the potential for limitations in the oral health care for young adults with disabilities is a function of both inadequate financial support and: 1) insufficient training in schools of dentistry (i.e. limited clinical experience) and 2) a lack of continuing education opportunities for current practitioners in the care of individuals with severe disabilities (including young adults).

Until such time that dental professionals (i.e. dentists and dental hygienists) are prepared adequately to provide the needed services for individuals with moderate and severe disabilities, we recommend that Pediatric Dentistry as an age defined specialty (the specialty specifically prepared to care for patients with special needs):

- Adopt a more realistic flexible approach for the oral health care of adults with special health needs that would be in line with the Commission on Dental Accreditation's statement regarding the **Intent** of the training for dental students (as noted above).

Or is it as Dr. Seuss said, "Adults are obsolete children and the hell with them." [15]

Chart 1. Social and health parameters that define the setting for the former patients of pediatric specialists. [12]

Demographics:

- As of 2012, there were 31.1 million young adults 18-24 in the United States.
- Just over 180,000 young adults were imprisoned in state correctional institutes in 2011.

Education:

- In 2013, 84 percent of young adult women and 81 percent of young adult men had completed at least a high school education.
- In 2013, 19 percent of young adults (20-24 years) was neither enrolled in school nor working.

Economic and family circumstances:

- Of the 2 million households headed by a young adult on his/her own in 2011, 42 percent experienced severe costs (housing costs that exceeded 50 percent of income).
- 58 percent of young adult men and 51 percent of young adult women lived with their parents in 2012.
- In 2012, 58 percent of young adults had current private health insurance and 15 percent had Medicaid, the Children's Health Insurance Program or another state program.

Health and personal behavior:

- In 2007–2010, 23 percent of young adults ages 18–24 were obese.
- In 2012, 20 percent of young adult males and 15 percent of young adult females smoked.
- In 2012, 23 percent young adult males and 16 percent of their female counterparts met criteria for illicit drug or alcohol dependence or abuse in the past year.
- In 2011–2012, 30 percent of young adults ages 18–24 met the *2008 Physical Activity Guidelines for Americans* for both aerobic and muscle-strengthening leisure-time activities.
- From 2005 to 2012, the prevalence of Major Depressive Episode during the past year was about twice as high among young adult females ages (ranging from 10 to 12 percent) as among their male counterparts (ranging from 5 to 6 percent).

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