

*What about people living in areas where there aren't enough dentists? While concerns are voiced about all alternative providers, if we don't answer this question, others will.*

*In this month's letter, Dr. Rick Valachovic, Executive Director of the American Dental Education Association, provides an update on efforts to use alternative providers to expand access to oral health care.*



## **Absent a Dentist, What's the Alternative?**

The issue of how to insure millions of Americans currently without medical or dental insurance has received a lot of attention lately in all of the discussion about national health care reform. That's great, and this year's inclusion of a dental benefit in the Children's Health Insurance Program (CHIP) is a victory to be celebrated. But even if everyone in the United States were insured, we would still have to ask, what about people who live in areas where there simply aren't enough dentists? What are governments and our professions doing to help these people gain access to care?

In March, the American Academy of Pediatrics (AAP) was acknowledged by the ADEAGies Foundation with a William J. Gies Award for Outstanding Vision for its advocacy of oral health education, screening, and referral by pediatricians. While we welcome the efforts of our colleagues in medicine to improve oral health, their actions point to the sad fact that dental care is inaccessible for many. According to the federal government, 49 million Americans lived in 4,091 [Dental Health Professions Shortage Areas](#) as of March 31, 2009. An estimated 32 million of these people were not getting the oral health care they needed.

In the face of this demonstrated need, the high cost of educating dentists, and evidence suggesting that new graduates are sometimes reluctant to practice in remote areas, several states and professional associations have proposed employing alternative, mid-level providers to address the access to care problem.

Among these is the American Dental Association (ADA), which proposed the creation of a new member of the dental team in 2006. The [Community Dental Health Coordinator](#) (CDHC) would provide patient education, preventive services, and referrals. This winter, the ADA rolled out a pilot curriculum, and 18 students will be trained as CDHCs in the coming school year at four academic dental institutions.

CDHCs will not be trained to perform restorative functions or extractions, yet the position has met with opposition from some quarters. Concerns have been—and continue to be—voiced about all alternative providers, both established and emerging. What procedures should they be allowed to perform? What constitutes adequate education? What level of supervision will best serve patients?

Answers to these questions run the gamut. In the absence of general agreement on an appropriate national solution, states and other jurisdictions are pursuing a variety of approaches to solving their access problems. While most solutions will emerge at the state level, one federal entity has been a leader in this regard.

The Alaska Native Tribal Health Consortium (ANTHC) has taken the lead in this regard. It is now in its fourth year deploying mid-level providers to serve the Native Alaskan population in the remotest regions of the state. [Dental Health Aide Therapists](#) (DHATs) are equipped to provide the educational, preventive, and safety-net services that are most needed by the residents of Alaska's federally designated territories. Their scope of practice includes the full range of preventive services, basic restorative procedures, some extractions, and other procedures as determined by a dentist when a dental emergency cannot be resolved with palliative care. DHATs function under the general supervision of a dentist who individually assesses each DHAT's competencies and assigns a scope of practice through standing orders.

At the 2009 ADEA Annual Session in March, Dr. Mark W. Kelso, Director of the Norton Sound Health Corporation Dental Program in Nome, Alaska, reported that DHATs have had a dramatic impact on his practice. He said that dentures for teenagers, which were once commonplace, have become rare now that DHATs are providing basic

dental care to the population. Their presence has also given him time to perform other procedures, including endodontics, prosthodontics, and orthodontic interventions as well as more complicated extractions.

The debate around mid-level providers is currently playing out in the state of Minnesota. Last year the legislature authorized the licensure of a mid-level provider (no sooner than 2011) and appointed a [work group](#) to advise on the education, training, scope of practice, and supervision requirements for the new practitioner. Three ADEA members served on the work group: Dr. Patrick M. Lloyd, Dean of the School of Dentistry at the University of Minnesota (UM); Prof. Christine M. Blue, Director of the UM Division of Dental Hygiene; and Dr. Colleen M. Brickle, Interim Dean of Health Sciences at Normandale Community College.

The Minnesota Department of Health released the work group's report in January 2009, and while its members agreed that the new practitioner must be required to practice in settings that serve low-income, uninsured, and underserved patients or are located in dental health professional shortage areas, they did not achieve consensus regarding the education, scope of practice, or level of supervision for the new provider. As a result, two bills came before the 2009 Minnesota legislature. One would create an oral health practitioner to be educated through the Minnesota State Colleges and University system (MNSCU) dental hygiene programs. This practitioner would perform all preventive, most restorative, and some surgical procedures (including extraction of permanent teeth) under the general supervision of a dentist. A second bill would create a dental therapist (DT) with a more limited scope of practice. The dental therapist would be educated at a CODA accredited dental school and would be required to work in a facility with a dentist on site. The bills also differed in how they would ensure that the new providers would serve those most in need.

Colleen Brickle, who is now the Interim Dean of Health Sciences at Normandale Community College, was a Professor and Department Chair in 2005 when the overwhelming needs of patients visiting Normandale's dental hygiene clinic prompted her to ask what more hygienists could do to expand access. At that time, she and the former Dean of her Division approached Metropolitan State University (MSU), a sister MNSCU institution, to propose the creation of a degree completion program and a master's degree for dental hygienists, modeled on the [advanced dental hygiene practitioner](#) (ADHP), which had been developed by the American Dental Hygiene Association. MNSCU approved their proposal, setting the ball in motion for the creation of a mid-level provider in the state.

This fall, [Metropolitan State University](#) will accept its first class of nine students to begin work on masters' degrees in dental hygiene. The MSU curriculum is still based on competencies defined for the ADHP, but the new curriculum also incorporates those competencies for general dentists that fall within the scope of practice for the mid-level provider as defined by the pending legislation.

In February 2008, the [University of Minnesota School of Dentistry](#) (UMSD) announced that it, too, would offer a program to train the state's new mid-level provider. As the only CODA-accredited dental school in the state, UMSD believes it is well equipped to teach the dentistry that falls within the new provider's scope of practice.

In preparation for this new endeavor, a UMSD-led delegation representing a range of expertise visited dental therapist education programs in Saskatchewan, Canada; Dunedin, New Zealand; and Sheffield, England. Dean Lloyd was impressed by the ability of dental therapists working in the British system to improve access to care by working in partnership with dentists.

"In parts of the Northwest Territories and Alaska," Patrick Lloyd told me, "there are communities so small and remote they cannot sustain a traditional dental practice. Such is not the case in Minnesota, where no two dentists are separated by more than fifty miles. Therefore, our model has the dentist and dental therapist practicing together to increase the capacity of the existing network of providers to care for more patients."

Colleen Brickle says that she does not oppose the DT model, but she is concerned that both models move forward so students have the opportunity to be educated at the university and program of their choice and be positioned to provide care where it is needed. Minnesota is one of many states that have revised their practice acts to expand the scope of responsibility for registered dental hygienists who have graduated from accredited programs. The state has more than 150 dental hygienists who practice in urban and rural areas under the general supervision of a dentist through collaborative agreements; yet, she says, the problem of inadequate care persists. "These collaborating hygienists are identifying decay, making referrals to dentists, and coming back six months later to find out that there's been no follow-up," she told me. "That's why we need mid-level providers in underserved areas. We have to close the loop to take care of the disease that's out there."

Christine Blue, Director of the UM Division of Dental Hygiene, has a different perspective. She prefers the DT model, which positions the new provider alongside dentists and hygienists in the same office, and she believes that UMSD is well positioned to foster the model's development.

"During our travels, the most successful models that we saw—those where DTs had the greatest longevity and effectiveness—trained the DTs in conjunction with dentists and hygienists," she says. Both the didactic and clinical education of these two professionals is already highly integrated at UMSD. This gives Chris confidence that the new DT program will find a good fit at UMSD.

Chris told me that she felt privileged to serve on the work group and left with a new appreciation for the complexity of the issues they studied. Despite the existence of conflicting views on how Minnesota should proceed, she believes everyone is united in their desire to improve access to care.

This unity has been tested of late, as the legislature has debated the merits of the proposed provider models. Last Friday, the legislature announced that it wanted to move forward with a single provider model, and put the onus on UMSD and MNSCU to work through the issues surrounding education, scope of practice, and supervision that remain unresolved.

Two years ago, UMSD began requiring that its dental students spend two months caring for patients in one of its six outreach clinics; the two largest are in rural communities. Patrick noted that the school is already seeing a greater percentage of its students choosing rural practice upon graduation. Likewise, MNSCU has made an important contribution to improving access to care by expanding opportunities for hygienists to pursue advanced education. While our colleagues in Minnesota may be struggling to work through the details, their leadership deserves our admiration for grappling with the challenges of expanding access.

So where does this leave us? Developing new workforce models falls outside what you might call ADEA's scope of practice, but we should help our member institutions prepare to provide the best possible education to alternative dental providers as they emerge. We all have a stake in ensuring that programs created to provide access to dental care maintain rigorous academic standards and meet accreditation criteria.

This was one of the lessons Patrick Lloyd took away from his travels to alternative provider programs. In February 2009, he published his reflections in an article in *Northwest Dentistry*, the journal of the Minnesota Dental Association. In conclusion, he said, "I came to recognize that the most significant advantage a dental school-based education program has is its ability to train to a single standard of care, thus ensuring public trust and the respect of the profession."

Public trust is critical to the advancement of all proposals to expand access to care. It behooves our communities to look for common ground, appreciate the diverse contributions of every member of the oral health team, and maintain the standards of excellence that make that public trust meaningful.

If we don't, it's likely that others will step forward to fill the need. In fact, they already have. Two medical residency programs in Maine began educating primary care physicians to perform basic dental procedures in 2005.



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