

Policy on Workforce Issues and Delivery of Oral Health Care Services in a Dental Home

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Purpose

The American Academy of Pediatric Dentistry (AAPD) advocates optimal oral health and health care services for all children, including those with special health care needs. Strategies for improving access to dental care, the most prevalent unmet health care need for disadvantaged U.S. children, and increasing utilization of available services should include, but not be limited to, workforce considerations. This policy will address workforce issues with an emphasis on the benefits of oral health care services delivered within a dentist-directed Dental Home.

Methods

In 2008, the AAPD created a Task Force on Workforce Issues (TFWI) which was charged, in part, with investigating the problem of access to oral health care services by children in the U.S. and analyzing the different auxiliary delivery systems available. The TFWI's findings and recommendations were summarized in a report¹ presented to the AAPD Board of Trustees in 2009. That report serves as the basis for this policy.

This document was originally developed by the Council on Clinical Affairs Committee and adopted in 2011.

Background

Access to oral health care for children is an important concern that has received considerable attention since publication of *Oral Health in America: A Report of the Surgeon General* in 2000.² The report identified “profound and consequential disparities in the oral health of our citizens” and that dental disease “restricts activities in school, work, and home, and often significantly diminishes the quality of life.” It concluded that for certain large groups of disadvantaged children there is a “silent epidemic” of dental disease. This report identified dental caries as the most common chronic disease of children in the U.S., noting that 80 percent of tooth decay is found in 20 to 25 percent of children, large portions of whom live in poverty or low-income households and lack access to an on-going source of quality dental care. The latest research on the topic has shown that the distribution of these disparities may vary by age group.³

The mission of the AAPD, the membership organization representing the specialty of pediatric dentistry, is “to advocate

policies, guidelines, and programs that promote optimal oral health and oral health care for infants and children through adolescence, including those with special health care needs.”⁴ AAPD has long focused its efforts on addressing the disparities between children who are at risk of having high rates of dental caries and the millions of U.S. children who enjoy access to quality oral health care and unprecedented levels of oral health. AAPD's advocacy activities take place within the broader health care community and with the public at local, regional, and national levels.

Access to care issues extend beyond a shortage or maldistribution of dentists or, more specifically, dentists who treat Medicaid or State Children's Health Insurance Program (CHIP) recipients. Health care professionals often elect to not participate as providers in these programs due to low reimbursement rates, administrative burdens, and the frequency of failed appointments by patients whose treatment is publicly funded.⁵⁻⁸ Nevertheless, American Dental Association (ADA) survey data reveals that pediatric dentists report the highest percentage of patients insured through public assistance among all dentists.⁹ Especially when considering the disincentives of participating as Medicaid/CHIP providers, more dentists and/or non-dentist oral health care providers cannot be considered the panacea for oral health disparities.

Inequities in oral health can result from underutilization of services. Lack of health literacy, limited English proficiency, and cultural and societal barriers can lead to difficulties in utilizing available services. Financial circumstances and geographical/transportational considerations also can impede access to care. Eliminating such barriers will require a collaborative, multi-faceted approach.^{10,11} All the while, stakeholders must promote education and primary prevention so that disease levels and the need for therapeutic services decrease.

ABBREVIATIONS

AAP: American Academy of Pediatrics. **AAPD:** American Academy Pediatric Dentistry. **ADA:** American Dental Association. **CHIP:** Children's Health Insurance Program. **EFDA:** Expanded function dental assistant/auxiliary. **TFWI:** Task Force on Workforce Issues.

All AAPD advocacy efforts are based upon the organization's core values¹² which include:

1. Health and health care equity.
2. An effective dental workforce.
3. Effective public programs.
4. Oral health promotion.
5. Child and adolescent welfare.
6. Science, education, research, and evidence-based care.

A major component of AAPD's advocacy efforts is development of oral health policies and evidence-based clinical practice guidelines¹³ that promote access to and delivery of safe, high quality comprehensive oral health care for all children, including those with special health care needs, within a Dental Home. A Dental Home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivery, in a comprehensive, continuously accessible, coordinated, and family-centered way.¹⁴ Such care takes into consideration the patient's age, developmental status, and psychosocial well-being and is appropriate to the needs of the child and family. This concept of a Dental Home was detailed in a 2001 AAPD oral health policy¹⁵ and is derived from the American Academy of Pediatrics' (AAP) model of a medical home.^{16,17} Children who have a Dental Home are more likely to receive appropriate preventive and therapeutic oral health care. The AAPD, AAP, ADA, and Academy of General Dentistry support the establishment of a Dental Home as early as six months of age and no later than 12 months of age.^{13,17-19} This provides time-critical opportunities to provide education on preventive health practices and reduce a child's risk of preventable dental/oral disease when delivered within the context of an ongoing relationship. Prevention can be customized to an individual child's and/or family's risk factors. Growing evidence supports the effectiveness of early establishment of a Dental Home in reducing early childhood caries.^{20,21} Each child's Dental Home should include the capacity to refer to other dentists or medical care providers when all medically necessary care cannot be provided within the Dental Home. The AAPD strongly believes a Dental Home is essential for ensuring optimal oral health for all children.

Central to the Dental Home model is dentist-directed care. The dentist performs the examination, diagnoses oral conditions, and establishes a treatment plan that includes preventive services, and all services are carried out under the dentist's supervision. The Dental Home delivery model implies direct supervision (i.e., physical presence during the provision of care) by the dentist. The allied dental personnel [e.g., dental hygienist, expanded function dental assistant/auxiliary (EFDA), dental assistant] work under direct supervision of the dentist to increase productivity and efficiency while preserving quality of care. This model also allows for provision of preventive oral health education by EFDAs and preventive oral health services by a dental hygienist under general supervision (i.e., without the presence of the supervising dentist in the treatment facility) following the examination, diagnosis, and

treatment plan by the licensed, supervising dentist. Furthermore, the dental team can be expanded to include auxiliaries who go into the community to provide education and coordination of oral health services. Utilizing allied personnel to improve oral health literacy could decrease individuals' risk for oral diseases and mitigate a later need for more extensive and expensive therapeutic services.

In addition to promoting quality oral health care through its policies and guidelines, AAPD advocacy efforts, in part, include:

1. Improving perinatal and infant oral health by training pediatric and general dentists to perform infant oral health examinations.
2. Representing pediatric dentists on an advisory committee to the Bureau of Health Professions, promoting funding for pediatric and general dentistry residency programs and faculty loan repayment.
3. Conducting annual workshops which train pediatric dentists from across the country to educate legislators on strategies to improve access to pediatric dental care.
4. Working with the ADA to identify non-financial barriers to oral health care and develop recommendations to improve access to care for Medicaid recipients.^{22,23}
5. Partnering with federally funded agencies to develop strategies to improve children's oral health.²⁴
6. Utilizing a Task Force on Workforce Issues (2008-2009) to examine the various non-dentist (also known as mid-level) provider models that exist and/or are being proposed to address the access to care issues.²⁵

The AAPD Task Force reported that a number of provider models to improve access to care for disadvantaged children have been proposed and, in some cases, implemented following the Surgeon General's report.¹ At the heart of the issue with each non-dentist provider proposal is ensuring ongoing access to dental care for the underserved. Therefore, practice location and retention of independent non-dentist providers are important considerations. When providers are government employees, assignment to areas of greatest need is possible. However, the current U.S. proposed models are private practice/non-government employee models, providing no assurances that independent providers will locate in underserved areas. Moreover, evidence from several developed countries that have initiated mid-level provider programs suggests that, when afforded an opportunity, those practitioners often gravitate toward private practice settings in less-remote areas, thereby diminishing the impact on care for the underserved.²⁶

In all existing and proposed non-dentist provider models, the clinician receives abbreviated levels of education compared to the educational requirements of a dentist. For example, the dental health aid therapist model in Alaska is a two year certificate program with a pre-requisite high school education,^{27,28} the educational requirement for licensure as a dental therapist in Minnesota is a baccalaureate or master's degree from a dental therapy program,²⁹ and proposed legislation for

dental therapists in Vermont requires a two year curriculum including at least 100 hours of dental therapy clinical practice under the general supervision of a licensed dentist.³⁰ Building on their college education, dental students spend four years learning the biological principles, diagnostic skills, and clinical techniques to distinguish between health and disease and to manage oral conditions while taking into consideration a patient's general health and well-being. The clinical care they provide during their doctoral education is under direct supervision. Those who specialize in pediatric dentistry must spend an additional 24 or more months in a full time post-doctoral program that provides advanced didactic and clinical experiences.³¹ The skills that pediatric dentists develop are applied to the needs of children through their everchanging stages of dental, physical, and psychosocial development, treating conditions and diseases unique to growing individuals.

While most pediatric dental patients can be managed effectively using communicative behavioral guidance techniques, many of the disadvantaged children who exhibit the greatest levels of dental disease require advanced techniques (e.g., sedation, general anesthesia).^{32,33} Successful behavior guidance enables the oral health team to perform quality treatment safely and efficiently and to nurture a positive dental attitude in the pediatric patient.³⁴ Accurate diagnosis of behavior and safe and effective implementation of advanced behavior guidance techniques necessitate specialized knowledge and experience.

Studies addressing the technical quality of restorative procedures performed by non-dentist providers have found, in general, that within the scope of services and circumstances to which their practices are limited, the technical quality is comparable to that produced by dentists.^{35,36} There is, however, no evidence to suggest that they deliver any expertise comparable to a dentist in the fields of diagnosis, pathology, trauma care, pharmacology, behavioral guidance, treatment plan development, and care of special needs patients. It is essential that policy makers recognize that evaluations which demonstrate comparable levels of technical quality merely indicate that individuals know how to provide certain limited services, not that those providers have the knowledge and experience necessary to determine whether and when various procedures should be performed or to manage individuals' comprehensive oral health care, especially with concurrent conditions that may complicate treatment or have implications for overall health. Technical competence cannot be equated with long-term outcomes.

The AAPD continues to work diligently to ensure that the Dental Home is recognized as the foundation for delivering oral health care of the highest quality to infants, children, and adolescents, including those with special health care needs. The AAPD envisions that many new and varied delivery models will be proposed to meet increasing demands on the infrastructure of existing oral health care services in the U.S. New Zealand, known for utilizing dental therapists since the

1920's and frequently referenced as a workforce model for consideration in the U.S., recently completed its first nationwide oral health status survey in over 20 years. Dental care is available at no cost for children up to 18, with most public primary schools having a dental clinic and many regions operating mobile clinics.³⁷ Overall, one in two children in New Zealand aged two–17 years was caries-free. The caries rate for five-year-olds and eight-year-olds in 2009 was 44.4 percent and 47.9 percent respectively.³⁸ These caries rates, which are higher than the U.S., United Kingdom, and Australia, help refute a presumption that utilization of non-dentist providers will overcome the disparities.

As technology continues to improve, proposed models may suggest dentist supervision of services outside the primary practice location via electronic communicative means to be comparable in safety and effectiveness to services provided under direct supervision by a dentist. Health care already has witnessed benefits of electronic communications in diagnostic radiology and other consultative services. The AAPD encourages exploration of new models of dentist-directed health care services that will increase access to care for underserved populations. But as witnessed through the New Zealand oral health survey, a multi-faceted approach will be necessary to improve the oral health status of our nation's children.

Policy statement

The American Academy of Pediatric Dentistry remains committed in its core values and mission to address the disparities between children who lack access to quality oral health care and those who benefit from such services. AAPD believes that all infants, children, and adolescents, including those with special health care needs, deserve access to high quality comprehensive preventive and therapeutic oral health care services provided through a dentist-directed Dental Home. In the delivery of all dental care, patient safety must be of paramount concern.

AAPD encourages the greater use of expanded function dental assistants/auxiliaries and dental hygienists under direct supervision by a dentist to help increase volume of services provided within a Dental Home, based upon their proven effectiveness and efficiency in a wide range of settings.³⁶⁻⁴² The AAPD also supports provision of preventive oral health services by a dental hygienist under general supervision (i.e., without the presence of the supervising dentist in the treatment facility) following the examination, diagnosis, and treatment plan by the licensed, supervising dentist. Similarly, partnering with other health providers, especially those who most often see children during the first years of life (e.g., pediatricians, family physicians, pediatric nurses), will expand efforts for improving children's oral health.

The AAPD strongly believes there should not be a two-tiered standard of care, with our nation's most vulnerable children receiving services by providers with less education and experience, especially when evidence-based research to support the safety, efficiency, effectiveness, and sustainability of such delivery models is not available.

AAPD will continue its efforts to:

1. Educate families, health care providers, academicians, community leaders, and partnered governmental agencies on the benefits of early establishment of a dental home.
2. Forge alliances with legislative leaders that will advance the Dental Home concept and improve funding for delivery of oral health care services and dental education.
3. Expand public-private partnerships to improve the oral health of children who suffer disproportionately from oral diseases.
4. Encourage recruitment of qualified students from rural areas and underrepresented minorities into the dental profession.
5. Partner with other dental and medical organizations to study barriers to care and underutilization of available services.
6. Support scientific research on safe, efficacious, and sustainable models of delivery of dentist-directed pediatric oral health care that is consistent with AAPD's oral health policies and clinical practice guidelines.

Furthermore, AAPD encourages researchers and policy makers to consult with AAPD and its state units in the development of pilot programs and policies that have potential for significant impact in the delivery of oral health care services for our nation's children.

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