A Two-Tier Standard

Do the Youngest Citizens of the United States of America Deserve a Two-Tier Standard of Dental Care?

by Rhea M. Haugseth, DMD

Second opinions are common in health care; whether a doctor is sorting out a difficult case or a patient is not sure what to do next. In the context of our magazine, the first opinion will always belong to the reader. This feature will allow fellow dental professionals to share their opinions on various topics, providing you with a "Second Opinion." Perhaps some of these observations will change your mind; while others will solidify your position. In the end, our goal is to create discussion and debate to enrich our profession. — Thomas Giacobbi, DDS, FAGD, Editorial Director, *Dentaltown Magazine*

The 2000 Surgeon General's report on "Oral Health in America" identified a "silent epidemic" of dental disease in certain large groups of disadvantaged children.[1] This report identified dental decay as the most common chronic disease of children in the United States, the majority of this disease found in segments of the population that live in poverty or low-income households and lack access to an ongoing source of quality dental care. Sadly, not much has changed since this report was published. We know that dental disease in children has a negative impact on a child's capacity to learn, receive adequate nutrition, attend school or even achieve a good night's sleep. Untreated dental disease in children also affects their home life, their parents' ability to go to work and their family's health. When a child has dental disease, everyone in the household experiences a lower quality of life. As dentists, we know that optimum oral health is highly correlated with optimum overall or systemic health, and we also know that the reverse of this is true – poor oral health in children has a negative impact on their overall health.

The American Academy of Pediatric Dentistry (AAPD), the recognized authority in children's oral health, advocates for optimum oral health and health-care services for all children, including those with special health-care needs. The AAPD has long focused its attention, resources and advocacy efforts on improving the oral health and access to high quality dental services within the context of a Dental Home for those children who have the highest risk of developing dental decay.

The idea has been proposed that access to care is the root cause of these high-risk children's problems. While access issues, and specifically access to dentists who treat Medicaid or State Children's Health Insurance Program (CHIP) recipients, are a part of the problem, it is not the only concern. Other issues, such as lack of parental knowledge about good oral health practices and the importance of primary teeth, inadequate access to nutritious foods and the belief in oral health "myths" such as "they are only baby teeth, they will fall out anyway," are well documented contributors to poor oral health in this population of children.

A recent AAPD survey showed that more than 70 percent of members treated children who are at the most risk for high rates of dental decay. Because pediatric dentists account for approximately three percent of all dentists in the United States, there are not enough pediatric dentists to treat these children. It's imperative that our profession increase its emphasis on the prevention and early therapeutic treatments to truly impact the high decay rates present in our nation's most vulnerable children.

Inequities often result from underutilization of available dental services. There are numerous barriers to adequate utilization of oral health services, the most notable include:

1. Lack of oral health literacy
2. Cultural beliefs and influences
3. Lack of knowledge of existing services
4. Financial and job-related barriers
5. Geographical barriers
6. Transportation difficulties

Assisting parents in overcoming these challenges will result in an increase in utilization rates and a positive impact on lowering the oral disease rates in children. In addition to the treatment of existing dental disease, dental providers must emphasize education and prevention. Only by following this directive will we have any influence on the "silent epidemic" of oral disease that is affecting our nation's children.

A major component of AAPD's advocacy efforts are focused on the development of oral health policies and

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evidence-based clinical practice guidelines that promote access to and the 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 defined as 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.[2] Such care takes into consideration the patient's age, developmental status and psychosocial wellbeing, and is most appropriate to the needs of the child and family. Children who have a Dental Home are more likely to receive appropriate preventive and therapeutic oral health care.[3]

The AAPD, American Academy of Pediatrics (AAP), American Dental Association (ADA) and Academy of General Dentistry (AGD) all support the establishment of a Dental Home as early as six months of age and no later than 12 months of age. The early establishment of the Dental Home provides time-critical opportunities to offer education on preventive health practices and, subsequently, reduce a child's risk of preventable oral disease. Within the Dental Home, prevention can be customized to an individual child's and family's risk factors. In fact, growing evidence supports the effectiveness of the early establishment of a Dental Home in reducing early childhood caries. Each child's Dental Home should include the ability 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 that a Dental Home is essential for ensuring optimal oral health for all children.[3]

The Dental Home model is based on dentist-directed care; meaning the dentist performs the examination, diagnoses disease and establishes a treatment plan that includes the full range of services that meet a child's individual needs, including preventive services. All services are carried out under the dentist's direct supervision in this model (i.e., physical presence during the provision of care). The dental team also might include allied dental personnel (i.e., dental hygienist, expanded function dental assistant/auxiliary (EFDA), dental assistant) who work under the direct supervision of the dentist to increase the dental office's capacity to serve more children while preserving quality of care.

Furthermore, the dental team can be expanded to include auxiliaries who go into the community to provide outreach to families who might not be familiar with the current dental delivery care system and increase oral health literacy through education to parents, children and other caregivers. Allied personnel can also assist families in accessing a Dental Home through coordination of care and case management. Using allied personnel to improve the oral health literacy of this nation could decrease individuals' risk for oral diseases and mitigate a later need for more extensive and expensive therapeutic services.[3]

The AAPD is supportive of state practice laws that would allow EFDAs who are currently employed by dental practices in the community and schools for the provision of limited preventive services and screening; parent and caregiver education; and coordination/case management to build the family's relationship with the Dental Home. An increase in early prevention and oral health instruction, facilitated by outreach into the community to children and caregivers, will decrease decay rates in children most at-risk for oral disease. The AAPD believes by utilizing allied personnel to improve oral health access and literacy and the subsequent decrease in risk for oral disease, this will decrease the need for more costly restorative treatments, thereby reducing the overall cost for dental care. The few available peer-reviewed studies of the use of EFDAs and a great deal of anecdotal information from our members support this hypothesis.[4,5,6]

The idea of EFDAs practicing within the context of a true Dental Home, under the supervision of a dentist is contrary to other proposed non-dentist provider models purported by some to improve the access to care for disadvantaged children. Some of these models have even been implemented in a few select states, which has allowed for the limited study of these models.

Unlike the EFDA model, these proposed models need this – others are employed based on independent practice models, whereby the allied personnel are allowed to perform diagnosis and treatment normally reserved for the dentist. These models offer no assurances that independent non-dentist providers will be located in underserved areas. In fact, in countries that have employed such models, evidence shows these providers often end up practicing in less remote areas, decreasing their impact on access to the underserved.

In all existing and proposed models, the non-dentist provider receives significantly less education and training than a dentist. General dentists attend four years of dental school after completing their college education. Dentists who specialize in pediatric dentistry must spend an additional 24 months or more in a full-time postdoctoral program, which provides advanced skills

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in treating conditions and disease unique to children, as they grow into adulthood.

The few, limited 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. 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.[3]

It is essential that policy makers recognize evaluations that demonstrate comparable levels of technical quality which merely indicates 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 healthcare safely. The AAPD supports the use of EFDAs in providing this technical competence as a part of the dental team representing a true "Dental Home."

The New Zealand model is often looked at as a successful model for non-dentist providers as it has been in existence for many years. However, in New Zealand's recent official government report of the oral health status survey, the caries rate in New Zealand is higher than that of the United States, United Kingdom and Australia.[7] Given this data, why do some individuals and organizations continue to view this model as successful? The AAPD believes the greater use of EFDAs, under the direct supervision of a dentist, will help increase the volume of services provided within a Dental Home. This will have a much greater impact on access to care, prevention of dental disease and lowering the cost of treatment to at-risk children.

The AAPD strongly believes that a two-tiered standard of care should not exist for our nation's most vulnerable children. Services to this high-risk group should not be provided independently by non-dentists or "mid-level 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.

Ask yourself – would you allow your children or grandchildren to be treated by a non-dentist provider with less education and training than a dentist? My guess is the answer to this hypothetical question would be a resounding "No!"

In closing, I implore you to reject a two-tiered standard of dental care for our country's youngest and most vulnerable citizens. AAPD members believe every child deserves a healthy smile and 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. ■

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Author's Bio

Rhea M. Haugseth, DMD, is president of the American Academy of Pediatric Dentistry. Haugseth has been an AAPD member for 29 years and has maintained a private practice in Marietta, Georgia. She attended dental school at University of Louisville and received her pediatric dental certificate from Case Western Reserve University. She has served as the AAPD's president-elect (2010-2011), vice president (2009-2010), secretary-treasurer (2008-2009), parliamentarian (2005-2006) and the AAPD's District III trustee (2002-2005). Haugseth is a fellow of AAPD and a diplomate of the American Board of Pediatric Dentistry, as well as a fellow of the American College of Dentists, International College of Dentists, Pierre Fauchard Academy and the Academy of Dentistry Internationale. She is also past president of the Southeastern Society of Pediatric Dentistry (2010-2011). Dr. Haugseth's AAPD presidential agenda will focus on welcoming all dialogue that will advance its efforts in the fight for children's oral health. Through its dedicated advocacy endeavors, the AAPD will continue to provide a voice for all children, so that a foundation for a lifetime of oral and overall health is established in every home.