What if someone asks you “Aren’t Mid-level Dental Providers the solution to access?”
A good question- but we have several concerns

• Providing dental treatment to children on Medicaid and CHIP is challenging both due to the systems and the higher level of disease.

• Our pediatric dentistry training is two additional residency years after dental school, yet mid-level proponents assert less is more in a world of expanding scientific knowledge.

• We refuse to write off some children as never being able to have a true dental home with a dentist, accepting a two-tiered system of care?

• Solutions that sound cheap and easy are usually neither!
AAPD Focus is on What’s Best for Children

• Is “something” really better than nothing?
• Should policymakers also consider establishing a medical home for children absent a pediatrician? (how would a mom feel about this??)
• Diagnosis is pretty important in quality healthcare.
What’s Best for Children?

• Will parents/guardians receive a false sense of security after a mid-level bills for a cleaning and fluoride varnish treatment?

• How to distinguish this intervention from Medicaid skimming operations?

• Should a provider who cannot perform a diagnosis be the “gatekeeper” to the dentist?
AAPD Task Force on Workforce

- Looked at the various mid-level dental provider models throughout 2008 – both existing and proposed.

- Chaired by former AAPD President and Tennessee Head Start Dental Home Project Leader Dr. Pitts Hinson.
AAPD Summary

- The paper Analysis and Policy Recommendations Concerning Mid-level Dental Providers synthesizes Task Force findings and additional evidence, and provides policy recommendations. Key drafting by AAPD Child Advocate and Head Start Project Director Dr. Jim Crall.
AAPD Summary

- AAPD suggests the burden of proof from studying such models is to first show they actually work, versus trying to implement nationwide based on “what harm can they do/something is better than nothing” analysis.

- Experiences and populations in other countries are not necessarily comparable to or replicable in the U.S.

- “Something” that drains away resources and provides less comprehensive care for children could in fact be worse than doing nothing.
AAPD Policy Recommendations

- AAPD supports greater use of EFDAs based on extensive evaluations of their effectiveness and efficiency in a wide range of private and public settings as part of dental teams.
AAPD Policy Recommendations

- AAPD recommends further evaluation of Dental Therapist and CDHC (Community Dental Health Coordinator) models prior to policy decisions regarding their use.
AAPD Policy Recommendations

• AAPD joins others in rejecting the ADHP model on the basis of its incompatibility with the principle that dental care should be provided directly by or under the supervision of a dentist.
AAPD Policy Recommendations

- AAPD supports the use of mid-level dental providers who perform or assist in the delivery of specified reversible procedures and certain surgical procedures under the general supervision of a dentist, provided that such arrangements have been thoroughly evaluated and demonstrated to be safe, effective, and efficient and to not compromise quality of care in similar settings.
FYI ONLY-
Don’t air dirty laundry on Capitol Hill

• A state-by-state battle fueled by PEW and Kellogg.
• AAPHD given Kellogg grant to write curriculum for dental therapist.
• IOM study with stacked committee deck will endorse the concept.
• Efforts to obtain federal funding for demonstration projects, per health care reform provision that we oppose. But it’s loved by many in the public health bureaucracy. And what’s not to love? A program that takes years to get up and running, costs a ton of money, requires more bureaucracy, and “sticks it” to the man – in this case, the dentist.
OUR MANTRA

• Dental HOME, Dental HOME, Dental HOME
  – We think that poor children deserve a dentist that you and I take for granted
  – Medicaid dental reforms that do work and solve the problem with dentists – the existing skilled workforce.