

## Coming to California?

BRIAN SHUE, DDS

Imagine a world where a brand-new category of provider is created to meet the health care needs of the underserved. Naturally, many questions will arise. What about patient safety? How would a new class of providers without a doctorate degree provide proper care and protect the interests of the profession and patient? How and in what form is the patient going to receive responsible and reliable care from this new type of health care provider? How can they operate independently in the clinic environment and with what supervision?

This new health care provider would then enter into a world where he or she may not be widely accepted by the profession. There would be arguments about the training and education, and compensation. There would be questions about the pros and cons of independent practice. There would also be questions about whether there is even a need for this type of provider.

That was the story of the birth of the dental hygienist. Do the concerns surrounding the issue sound familiar? Various stakeholders are now searching for a response to oral health access challenges and have produced four models of new providers: community dental health coordinator, dental therapist, advanced dental therapist, and advance dental hygiene practitioner (also labeled “oral health professional” recently in Minnesota). The first two categories are essentially dental team members who are able to perform significant clinical work only under the supervision of a dentist. The latter two categories are midlevel providers and would provide significant clinical care without supervision.



Various stakeholders are now searching for a response to oral health access challenges and have produced four models of new providers.

Midlevel providers were created in medicine in the 1960s to address health care access deficiencies.<sup>1</sup> They are individuals, like nurse practitioners, who hold a master’s degree in addition to their baccalaureate degree and provide care without supervision. Hygiene stakeholders have been advocating for this type of model. However, the dental therapist role that emerged from Minnesota is not a midlevel provider. In other countries, the traditionally defined “dental therapist” receives a two-year training and has a long history of providing care to children, but still operate as members of the dental team though the dentist team leader may provide remote oversight rather than direct supervision.

The concept only recently came to the United States in the form of Alaska’s dental health aide therapist. The American Dental Association initially opposed establishment of this provider category then settled its litigation and agreed to work with Alaska to help address the longstanding absence of oral health care in the remotest regions of that state.

Then there’s Minnesota. For the first time, dental therapists and dental midlevel providers became legal in the continental United States when Minnesota Gov. Tim Pawlenty signed Senate File 2083 on May 16, 2009.<sup>2</sup>

That may be just the beginning.

Currently, there are 12 states that are addressing the dental workforce issue, including California. Additionally, there are 36 states where oral health coalitions have been created, where only five existed just a few years ago, according to Shelly Gehshan, director, Advancing Children’s Dental Health Initiative, PEW Center on the States in a presentation to the California Dental Association’s Board of Trustees on June 6.

What does a dental therapist, as defined by Minnesota, do? Here are the responsibilities:

- Provide preventive services;
- Prep and place restorations;
- Perform pulpal therapies;
- Extract primary teeth;
- Provide care to children and adults; and
- Work with on-site dentist supervision.

The dental therapist will be educated at the University of Minnesota in a four-year bachelor’s of science degree in dental therapy. The dental therapist is essentially a supervised member of the dentist’s staff who can perform many irreversible procedures (even the term “irreversible procedure” stirs up negative connotations among some stakeholders and the use of the term may be on its way out).

With more experience, the dental therapist can become an advanced den-

tal therapist, and can do the following additional duties:

- Extract periodontally involved adult teeth;
- Work without on-site dentist supervision; and
- Create treatment plans that require dentist approval.

The advanced dental therapist must have 2,000 hours of experience as a dental therapist and receive a master's in dental therapy in a 28-month program.<sup>3</sup>

So how did this happen? Organized dentistry had difficulty maintaining a leadership role and early on found itself entrenched in a defensive position against criticisms coming from a large and active public health coalition. The Minnesota Dental Association and the University of Minnesota School of Dentistry created the dental therapist to counter the unsupervised oral health practitioner model, with additional public affairs assistance from the American Dental Association. This collaboration focused on patient safety and dentist supervision; it dramatically altered the outcome.

As can often occur when the legislature gets involved in trying to craft a compromise, the results can leave much to be desired. In this case, the two new models are flawed in the opinion of various stakeholders.

The results? It has been questioned about how much impact the new dental therapist will have, particularly in rural settings, as they were designed to work as part of the traditional dental team and it won't improve access to care if there is no dentist present to begin with. Some have argued that the dental therapist education is too lengthy, as it requires two more years of education compared to the education of therapists from other countries.

Additionally, the new advanced dental therapist provider, which will require six years of education while earning a master's

As seen in Minnesota,  
legislation can move  
forward to enact change  
whether or not it is  
supported by dentistry.  
The CDA is well-prepared  
to tackle this issue.

degree, will not be part of a dental team, and will operate in an autonomous fashion just like the nurse practitioner. While this compromise has calmed activity for the time being and "bought" a certain amount of time, it may have created a minimally effective new provider as well as another totally unnecessary provider. Time will tell.

Access to care has been the issue getting the most attention by the ADA of late.<sup>4</sup> The ADA's answer to the workforce dilemma is the community dental health coordinator workforce model, but note it is far different and limited in scope when compared with the enacted legislation in Minnesota. The community dental health coordinator will assist in coordination and navigation of care, as well as providing community education.<sup>5</sup>

Also, the community dental health coordinator can provide preventive services, including sealants, temporary fillings without decay excavation and "selective scaling for plaque-induced gingivitis" under the supervision of a dentist.<sup>6</sup> This newly created dental team member is currently undergoing pilot tests at three underserved sites across the United States.

It remains to be seen if this ADA model will be accepted by various oral health stakeholders across the country as a sufficient solution toward providing access to care. Unfortunately, it wasn't seen as such in Minnesota, where other stakeholders went directly to legislation to enact change.

Is this going to happen in California? Here is a better question: Is the CDA leadership ready to respond to this issue?

Yes. CDA participates in various activities to evaluate and understand this workforce movement and remains well aware of the challenges that it may face including the various interests and intent of other stakeholders in oral health care. As seen in Minnesota, legislation can move forward to enact change whether or not it is supported by dentistry. The CDA is well-prepared to tackle this issue.

The CDA Board of Trustees has held various informational presentations on this issue since last year by several national workforce experts in the field. The CDA Executive Committee and Board of Trustees are to be commended for their foresight into the matter.

Another example is the CDA Workforce and Forecasting Taskforce that began this March, led by Patrick J. Ferrillo, Jr., DDS, dean of Arthur A. Dugoni School of Dentistry. "The purpose (of the taskforce) is to look at the need for access issue and to identify how California can solve this problem," Ferrillo said in a phone interview.

Another great link is our CDA Foundation chair, Lindsey A. Robinson, DDS, who also holds the position of chair, ADA Council on Access, Prevention and Interprofessional Relations. In March, she hosted the first ADA Access to Dental Care Summit in Chicago; and at the most recent Board of Trustees meeting, she identified and discussed the various stakeholders in access to care issues, which include dental special-interest groups, dental education and research communities, finance partners, advocacy groups, health care policymakers, dental industry/business community, nondental health workers federal agencies, safety net dental providers, ADA leadership, state

CONTINUES ON 512

**ASSOC. EDITOR, CONTINUED FROM 510**

dental association executive directors and volunteer dental leaders. All of these entities may or may not have views congruent with the CDA.

The CDA leadership has also participated in several oral health workforce conferences throughout the country, including an ongoing 12-state Boston Workforce Meeting. “We want to be proactive instead of reactive,” said Ferrillo, adding, “While ensuring the citizens will get good oral health.”

We need to continue to study these workforce issues and carefully examine all options — while they are still options — and participate in stakeholder meetings. We need to identify our opportunities, but remain wary of unintended consequences. Much can be learned from what happened in Minnesota.

CDA needs to continue to represent its members while remaining true to its commitment for oral health care for California. Our vision states: “The California Dental Association is the recognized leader for excellence in member services and advocacy promoting oral health and the profession of dentistry.” Nothing could be closer to the truth. ■■■■■

**REFERENCES**

1. [bhpr.hrsa.gov/healthworkforce/reports/scope/scopel-2.htm](http://bhpr.hrsa.gov/healthworkforce/reports/scope/scopel-2.htm). Accessed June 18, 2009.
2. K Fox, Minnesota governor signs dental therapist legislation. *ADA News Today*, [ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=3612](http://ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=3612), June 3, 2009. Accessed June 18, 2009.
3. [www.dentistry.umn.edu/programs\\_admissions/](http://www.dentistry.umn.edu/programs_admissions/). Accessed June 18, 2009.
4. Berry J, ADA on access to care. *JADA* vol. 139, page 1539, November 2008.
5. Grove J, Issue faced by community health centers. *J Calif Dent Assoc* 37(5):339-43, May 2009.
6. Fox K, CDHC advances: workforce model pilot project gains House support. *ADA News Today*, [ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=3293](http://ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=3293), Nov. 6, 2008. Accessed June 18, 2009.

*Address comments, letters, and questions to the editor to [kerry.carney@cda.org](mailto:kerry.carney@cda.org).*