

## Partners in Care

**I**n the past 10 years, we have witnessed the introduction of a new category of dental hygienists in California, the registered dental hygienist in alternative practice, or RDHAP. For some, this may be a new term and there may be confusion as to who these new practitioners are. Others may be more familiar with the history of the RDHAPs or have been involved in the legislation surrounding their inception. Regardless of readers' particular level of understanding or interest surrounding RDHAPs, the fact is, they are here and they are affecting the oral health care picture in California. Their numbers will continue to increase as will the role they play in providing dental care. It would be in the best interest of California dentists to take note and to play an active role in the evolution of the RDHAP movement.

It is important to understand what qualifies an individual to hold an RDHAP license and what they can and cannot do by law. An RDHAP must have a valid registered dental hygiene license and have completed 150 hours of coursework in an approved RDHAP program. There are currently two active RDHAP training programs, one at West L.A. College and the other at UOP. Some RDHAPs may be licensed prior to 1997 under the Health Manpower Pilot Project. An RDHAP may perform all the duties a RDH may perform, with some exceptions. They may provide some duties that a RDH can only provide under general supervision but cannot provide those RDH services that require direct supervision. Thus, they cannot prepare bleaching trays or administer local anesthesia or nitrous oxide sedation. They can provide allowed

services in residences of the homebound, schools, residential facilities and other institutions, and dental health professional shortage areas as defined by the Office of Statewide Health Planning and Development.

Further regulations require RDHAPs to have an existing relationship with at least one dentist for referrals and they can only provide care to a patient who presents a prescription from a dentist or physician. This information is available in greater detail through the California Dental Association and is summarized in their RDHAP fact sheet.

In my experience, the majority of dentists have reacted negatively to the creation of the RDHAP position. Perhaps this is residual from a longer-standing, largely adversarial relationship between the dental profession and the dental hygiene profession. While individual dentists and hygienists often forge very positive working relationships, the relationship between the organizations representing the two groups seems to range from one of tenuous co-existence, to one of outright mistrust and poor cooperation.

The arrival of RDHAPs represents yet another change to the oral health care structure. We have come quite a long way from the days when the general dentist had near totalitarian control over all aspects of dental care. Dentists not only performed all procedures now shared by specialists, they also performed their own laboratory work and their own hygiene services as well. This did not



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necessarily represent a state of better patient care. In fact, the opposite can be said; that the addition of dental specialists, laboratory technicians, and dental hygienists have drastically improved the level of care delivered by sharing duties and responsibilities, and allowing general dentists to pursue and master procedures that would have been previously impossible. Nevertheless, most people are uncomfortable with change. It represents a threat to a comfortable and stable state. One must remember that in all change there is opportunity. The greatest threat from change comes when we try too hard to resist it. When we work with change synergistically, then we cross the threshold from being victims of outside circumstances to shapers of the future.

Incorporating RDHAPs effectively into the healthcare system will not come without some effort and growing pains for the profession. Concerns expressed by dentists thus far have validity and must be addressed. Some dentists are critical of the efforts by RDHAPs to eliminate the stipulation that a prescription be required prior to providing care. A proactive response would be for dentists to actively begin forging relationships with RDHAP practitioners in their area and utilize their services as currently outlined by existing law. If it can be demonstrated that the current prescription requirement not only provides for patient protection but is being effectively utilized, then arguments against eliminating this requirement can be made to legislators.

Another fear is that RDHAPs will try to expand their existing allowed duties, providing services which dentists feel are best left in their own hands. Of this we must keep in mind a simple truism. That humans are naturally prone to improve their own lot and expand on their skills and knowledge. RDHAP training programs will naturally evolve over time to include such additional skills and knowledge. Licensees will, in turn, seek to expand their duties accordingly. It was only recently that dentists found themselves in a similar position when the profession attempted, unsuccessfully, to expand the duties of California oral and maxillofacial surgeons. Scope of practice issues do have a profound impact on the delivery of care and protection of the public, however categorically opposing expansion of duties that happen to encroach on our own is likely to be viewed primarily as self-serving.

There are also concerns about risk and liability incurred by individual dentists who choose to establish a working relationship with an RDHAP. On its fact sheet, CDA offers several recommendations regarding dentist responsibilities. These include a properly drafted independent contractor arrangement between the dentist and RDHAP, proper follow-up treatment performed by the dentist including regular examinations and radiographs, and verification of the RDHAP's liability insurance.

With an understanding of this new member of the dental team and an acquired level of comfort with the working relationship, it takes only a little forward thinking to help patients

realize a benefit from their services. When I look at my patients, I see not only a diverse population, but one in transition. Many will live well into their 90s. While some of these individuals will enjoy relatively good health, others will battle chronic and debilitating diseases. They fall somewhere between a younger generation enjoying fewer carious and restored teeth thanks to better preventive services, and an older generation which experienced significant tooth loss and removable prosthetic needs. As such, they will have an extensive need for restorative and preventive dentistry, including hygiene services. Many will eventually be rendered unable to travel to my office for this care. For these patients, I see hope for better oral health with the help of RDHAPs. These oral health care providers can serve as more than just another licensee category in our state and they deserve to be treated not as adversaries, but as partners in care. In this spirit, our patients will benefit; and isn't that the real bottom line result we should all be working toward?

**Correction:** In my commentary, "Not For Sale" (Pages 589-90, August CDA Journal) I referred to a deal between the American Academy of Pediatric Dentistry and Coca-Cola in which the latter provided money to the former to fund research grants. I further mentioned that the AAPD subsequently withdrew from this relationship under member criticism. This is, in fact, not the case. A source informed me that this money was accepted by AAPD and research grants were subsequently awarded. I apologize for the error.

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