ADA American Dental Association®

America's leading advocate for oral health

Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce

A Statement from the American Dental Association

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First in a series on

Access to Oral Health

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This document is the first in a series offering the American Dental Association's vision of a healthier, more productive nation, enabled by breaking down the barriers that impede or entirely prevent millions of Americans from enjoying good oral health. It focuses on workforce, an umbrella term for the makeup of the teams comprising dentists, dental hygienists, dental assistants and other existing and proposed providers.

Helping Americans attain the optimal oral health they deserve is a core commitment of the ADA. In recent years a variety of stakeholders have proposed new models for providing oral health care based largely on their interpretation of the size, location and composition of the dental workforce. Certainly an adequate number and appropriate distribution of dentists and allied professionals is one key to improving and maintaining the nation's oral health. That said, access to oral health is a complex issue, and we believe all parties, from dental professionals to educators, charitable organizations to government bodies and other stakeholders must guard against focusing on any one barrier to the exclusion of others that are equally critical.

As the nation's leading advocate for oral health, the ADA believes that we can and will reach the day when no American who needs and seeks the care that leads to good oral health will be denied. We believe that this can be accomplished by enhancing, rather than compromising a proven system of care that has served the oral health needs of generations. This is especially true as more people than ever understand the importance of oral health to overall health and well being.

Not all will agree with our perspective. But we hope they do agree that now is the time to push and push hard to break down the barriers to good oral health. Everyone deserves a dentist. As doctors of oral health, the nation's dentists will continue striving to extend the world's best system of oral care to all those who need it. But we cannot accomplish this alone. When all stakeholders—and we are all stakeholders—set aside lesser differences and recognize our aligned purpose, set ambitious yet realistic short- and long-term goals, and pursue those goals with renewed vigor, we can effectively end untreated dental disease in America.

On behalf of the 156,000 members of the American Dental Association we encourage you to join our efforts to extend the best possible oral health to all Americans.

Raymond Gist, DDS

Raymond Gist, D.D.S.
President
American Dental Association

Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce

Most Americans have access to the best oral health care in the world and, as a result, enjoy excellent oral health. But tens of millions still do not, owing to such factors as poverty, geography, lack of oral health education, language or cultural barriers, fear of dental care and the belief that people who are not in pain do not need dental care. The ADA believes that all Americans deserve good oral health. We are committed to helping dentists, with their teams of allied personnel, provide the best level of care to all Americans who seek it; to increasing the prevalence of oral health literacy, which both prevents disease and educates the public as to how to get healthy and, more important, how to stay healthy; to ensuring that when care is needed it is provided; and to helping government and the private sector work together to end what former Surgeon General David Satcher famously called a "silent epidemic" of untreated oral disease.

With each passing year, science uncovers more evidence of the importance of oral health to overall health. Early diagnosis, preventive treatments and early intervention can prevent or halt the progress of most oral diseases—conditions that when left untreated, can have painful, disfiguring and lasting negative health consequences. Yet millions of American children and adults lack regular access to routine dental care, and many of them suffer needlessly from conditions which are for the most part preventable. Oral health disparities cut across economic, geographic and ethnographic lines. Racial and ethnic minorities, people with disabilities, and the poor are especially hard hit. Until a sense of value and a desire for oral health become the norm, the existing barriers will continue to block any significant progress toward improving the oral health of those who currently lack care.

The nation's dentists have long sought to stem and turn the tide of untreated disease—as individuals, through their local, state and national dental societies, and through other community organizations. To be sure, dentists alone cannot bring about the profound change needed to correct the gross disparities in oral

health. But dentistry must and can provide the leadership that initiates change, or change will not occur.

Ultimately, education and prevention will be the linchpins in eliminating, or at least minimizing untreated dental disease. These signs will mark the birth of the first generation that could grow up essentially free of dental disease: when the day comes that we as a nation decide that oral health is a national priority and provide education to all families of newborns, expand public health measures such as community water fluoridation, and provide a dental home to every child. Until that occurs, the nation will be challenged to meet the needs for preventive and restorative care among large numbers of Americans who do not have dental coverage, cannot afford care or face other barriers that block them from seeking regular oral care and dental visits.

It is critical to understand that addressing only one or even a few of the numerous barriers to care is the policy equivalent of bailing a very leaky boat. Scattershot efforts can provide some measure of relief among some populations for some time. But ultimately, we as a nation must muster the political will to address all barriers to care. Not doing so is a recipe for repeating past failures and missing opportunities to effect lasting, positive change.

It is with that in mind that the ADA offers this paper addressing one of the major barriers to care: the need for an adequate dental workforce, located where it is needed and sufficiently funded to carry out its mission. This includes having adequate numbers and types of allied personnel available to support the dentists who ultimately are responsible for diagnosing, planning treatment and delivering those services that only dentists are adequately educated and trained to perform. It means pursuing innovations with dental team members to broaden dentistry's reach and capacity to treat the great number of people who currently reside outside the oral health care system.

Workforce has in recent years come to dominate discussions and debates about improving access to care. We welcome the increased focus on these issues from both new and existing stakeholders, but are disappointed in two unintended consequences of the vigorous discussions about how best to improve the availability of dental care to those who lack it: 1) the degree to which the fixation on workforce, a deceptively "simple" issue to grasp, has distracted policymakers and those who influence them from the much greater number and complexity of other barriers to care; 2) the shrill nature of the debate among various camps, which sinks well below the level of reasoned discourse and saps what should be a collaborative concentration on the factors on which all or most agree. We urge all stakeholders to dispense with accusations of base motivation. We will inevitably disagree on some points. But let us do so in the belief that we all share the same goal: improving the oral health of people who suffer from its lack.

Every group involved in any aspect of solving the nation's oral health disparities latches onto the same statistics, events and trends in order to argue its case: That dental disease is the most prevalent malady affecting the nation's children; that disadvantaged children experience a significantly greater burden of oral disease than other children, accounting for 80 percent of childhood dental disease; that a deplorably small percentage of disadvantaged children and adults see dentists regularly; that a great number of private practice dentists cannot afford to treat patients covered under Medicaid, SCHIP or similar programs; that evidence of links between chronic oral disease and non-oral disease continues to mount. The statistics and phenomena are well known. They do not support or oppose any one point of view. Rather, they are evidence of the numerous barriers that exist and of the inadequacy of some aspects of the current system. They should motivate every stakeholder. They should underlie effective advocacy for the changes that must occur. They are not indicators for any one solution, and attempting to use them as such is disingenuous, empirically unproven and oversimplified.

A statement of beliefs

The ADA bases its policies and goals aimed at breaking down barriers to oral health on these core beliefs: the exemplary quality of dental care in America and the importance of oral health to overall health; that too many Americans do not benefit from this care and consequently do not achieve the good health that they deserve; and that the current system *can* be modified in ways that extend the benefits of good oral health to virtually everyone who needs and seeks it.

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Barriers to Oral Health Care
Source: ADA

On breaking down barriers to access:

- All Americans deserve access to oral health care provided by fully educated and trained dentists and the teams that support them.
- The degree of oral health disparities and the severity of untreated dental disease are unacceptable, especially among children.
- Achieving good oral health is a responsibility shared among dentists, their teams and their patients.
- Community based efforts through both state and federal governments and other groups can help deal with cultural, economic, and other barriers that can interfere with the development of the dental home environment.
- Only through substantial investment can the nation's dental safety net fulfill its purpose of meeting the needs of underserved individuals and communities.
- Realistic proposals to adequately fund the public health infrastructure must be cost-effective and prioritize those patients with the greatest needs and who will reap the greatest benefits.
- We are committed through advocacy and direct actions to identify and implement common sense, market-based solutions that capitalize on the strengths of the existing system while seeking innovations that extend that system to the greatest possible number of people.
- We believe that individual states are the best arbiters of how to improve oral health care delivery within their borders. We support their diverse efforts and seek to transfer knowledge to other states. At the same time,

we believe that the federal government must guide and support the states in their efforts.

- Dentists can lead the way, but no matter how committed the profession is, dentists alone cannot foster the drastic changes needed to extend good oral health to all who seek it. We need the support of law and policymakers, other doctors and allied health professionals, educators, private industry, and ultimately, society at large. That said, dentists must be the go-to resource for all of these groups to ensure clinical quality. We believe that organized dentistry at all levels—local, state and national—must consult, cooperate and collaborate with other stakeholders, especially patients themselves, to create programs *with* people, rather than *for* them.
- Schoolchildren should receive regular oral health assessments to detect disease and allow for referral to dentists for comprehensive examinations and treatment. Oral health assessments should receive the same priority as vaccinations and other medical assessments required for public school attendance.
- Charitable projects sponsored by the ADA and state dental societies provide a tremendous amount of care to low-income adults. But they also point up the terrific need that charity alone can never meet. Medicaid and similar programs should extend the same dental benefits that now are almost exclusively provided to children to all people eligible for those programs.
- The economically disadvantaged are not the only significant populations suffering from poor oral health due to lack of access to care. Millions of vulnerable elderly Americans face the same conditions, as do millions more living in institutions or with chronic, profound disabilities. The increase of the elderly demographic over the next decades could overwhelm the system and further exacerbate the current crisis in access to dental care.

On the roles and responsibilities of the dental workforce

- The ADA is committed to both seeking funding for and, to the extent possible, sponsoring on its own, studies or evaluations of dental workforce or other oral health care delivery models.
- While innovative use of existing and some new dental team members shows great promise, only dentists should diagnose disease, develop treatment plans and perform surgical/irreversible procedures.
- Pilot programs that test new workforce models should recognize the dentist as the leader of the team and be based on valid assessments of outcomes, cost savings and efficiencies to increase capacity without jeopardizing patients' health.
- The local and national dental communities should take part in all discussions of new workforce models, whether they are offered by public, private or charitable entities, at least to the extent that their views are heard and considered.
- Dental team members involved in pilot programs should be supervised by fully trained dentists, doctors who are responsible, ethically and legally, for patient care.
- The training of any new dental team member should occur through dental or dental-related education programs accredited by the ADA Commission on Dental Accreditation (CODA). CODA is nationally recognized by the United States Department of Education to accredit such programs conducted at the post-secondary level.
- Dentists, in cooperation with appropriate governing bodies, should determine the scope of practice of allied dental personnel with an eye to (1) which functions and procedures can be delegated, (2) what degree of supervision is appropriate for those procedures and personnel, and (3) which require the knowledge and skill of a dentist.
- Appropriate safeguards for patients must be in place when treatment is performed by any member of the dental team.
- Everyone who provides oral health care must have completed appropriate education and training and meet any additional criteria needed to assure competence within the scope of practice approved by authorized licensing bodies.
- State officials charged with governing the delivery of dental care are the ultimate legal arbiters of what constitutes the appropriate scope of practice of the various dental team members.

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The Many Barriers to Optimum Oral Health in America

Funding

The simple, inescapable fact is that improving the oral health of people who currently are not receiving adequate care will require significant, ongoing investment, not only from government, but from the private sector as well. Obtaining substantial new funds for dental programs has always been difficult, now more than ever in the current economic decline. In order to successfully advocate for improved funding, stakeholders must demonstrate not only the human suffering that it can alleviate but also the long-term economic benefits. These include:

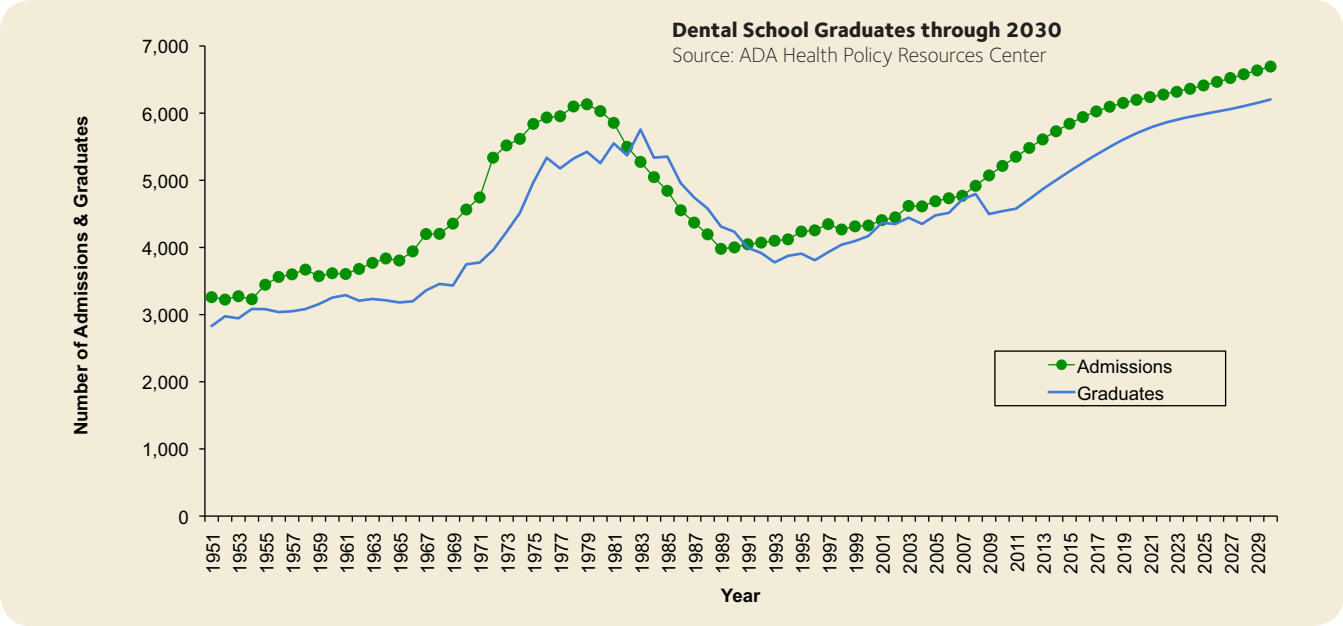
- Reduced health care costs—not just oral care, but also medical care. This is especially significant in light of how little of their Medicaid budgets states tend to allocate toward dental care. Further, it is reason for federal and state governments to fund adult dental Medicaid—now essentially nonexistent—because the adult populations are those most likely to suffer from conditions associated with periodontal disease, such as diabetes.
- Better school performance. Children with untreated dental disease have difficulty learning. They miss more school days than their healthier counterparts. Their social development is impaired. They suffer from low self-esteem. The long-term consequences of ignoring this are apparent. The benefits to be reaped by bringing more children into a continuum of care, while as yet unproven, are extremely promising.
- Increased productivity. Adults suffering from untreated disease are more likely to miss work. Those whose disease has progressed to the point of obvious disfigurement face dramatically diminished employment prospects.

Even ignoring our societal obligations to the most vulnerable among us, the practical returns on greater investment in the dental safety net eventually could benefit everyone.

Better funding for public assistance programs is critical. Lack of funding is perhaps the most important barrier to better oral health in America. An ADA analysis of state children's Medicaid programs developed in 2003 and updated in 2009 demonstrated that when Medicaid reimbursement rates reach levels at which a majority of dentists consider the fees to be acceptable, participation and utilization increase dramatically. This is a tipping point, rather than a steady-scale phenomenon. But even when optimally funded, these programs cannot reach their potential without other significant reforms. These include reducing unnecessary red tape for dentists and patients, and helping patients overcome such related barriers as the needs for transportation, child care or permission to take time off from school or work to receive treatment.

Geography

A consistent refrain among supporters of so-called "midlevel practitioners" is the claim that there are not enough



dentists to care for a major influx of indigent patients and that baby-boom dentists will retire in such numbers as to reduce what supposedly is an already inadequate dentist population. These claims seemingly lack a solid basis. In fact, studies conducted by the ADA and the American Dental Education Association have challenged these assumptions, citing many factors potentially affecting retirement patterns, as well as the potential impact of new dental schools and the continued growth in numbers of allied personnel. The studies indicate that the number of dental schools and graduates will increase steadily through 2030 and that the number of professionally active dentists will increase from its current level of approximately 180,000 to as much as 200,000 over the same period. (Although many factors can affect so large an undertaking as opening a dental school, some observers estimate that there will be as many as 20 new schools by 2020). Further, the report indicates that the age levels of the dental workforce will even out, in part because the dental population of baby boomers is retiring at later ages than its predecessors. This means that the available supply of active dentists will not suffer the major reduction that is commonly predicted.

Dentist workforce *size* is not a problem now, nor is it likely to be in the predictable future. The real problem is where the dentists are in relation to underserved populations. Put simply, the ADA believes that access disparities can be greatly reduced by a combination of getting dentists to the people and getting people to the dentists. Like any other economic sector, health care is market driven. This is especially true with dentistry, whose private practice model has held up so well because of its proven ability to prevent disease and, when disease occurs, intervene early with cost-effective treatment. In the economic sense, the populations in the most common underserved settings—remote rural areas, Native American communities and inner cities—cannot support a dental practice because no one is paying adequately for their care. Even many children who ostensibly are covered by federally or state-mandated programs live too far away from dentists who could provide care. For adults the barriers are two-fold—no coverage and no available dentists.

Several proven models exist to alleviate geographic barriers, and others are being tested. The National Health Service Corps, the Indian Health Service and the loose network of Federally Qualified Health Centers use various combinations of incentives to place dentists in underserved areas, including student loan repayment. Some states also offer tax incentives for practitioners working in underserved areas. Some dental programs join forces with various school or social service entities to help address the need to provide transportation and other support services to help patients keep appointments.

Education, language and culture

The vast majority of dental disease is either entirely preventable or can be easily cured through early intervention. The more educated a population group, the greater the likelihood of its members having a high degree of oral health literacy, a term that may sound deceptively sophisticated, given the simplicity of its concept: They know how to take care of their families' teeth and gums, and they seek (and can afford) regular preventive dental care. They know whether their community water system is fluoridated and how to compensate for nonfluoridated water with supplements or topical applications. They brush regularly with fluoridated toothpaste and use floss.

But too many others simply don't know about basic and largely affordable measures for preventing disease. In some cases this relates to lack of education. Many others have limited English proficiency or may come from countries and cultures with much lower standards of oral health than exist here. Some may not be comfortable interacting with people perceived as authorities. Key to breaking down these barriers is gaining trust, which can be accomplished through intermediaries from the same cultures as the target populations or by providing oral health education to schoolchildren who then can share what they learn with older family members.

Models for change

Even under chronic funding constriction, imaginative people maximized available resources and leveraged natural allies to dramatically improve the abilities of existing programs and systems to deliver care where it is most needed.

- Michigan's Healthy Kids Dental Medicaid demonstration program is a partnership between a state Medicaid program and a commercial dental plan, with the plan managing the dental benefit according to the same standard procedures and payment mechanisms it uses in its private plans. The proportion of Medicaid eligible children who saw a dentist at least once increased from 32 percent to 44 percent in the pilot program's first

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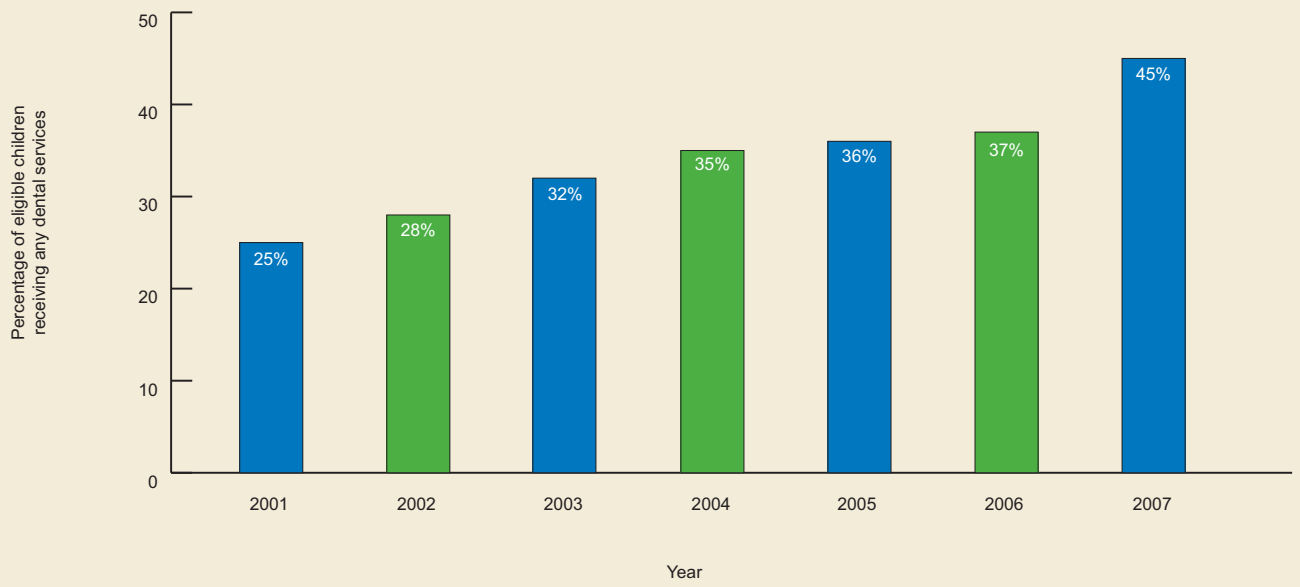
year. It also cut the number of counties with either no dentist or no dentist able to accept new Medicaid patients in half—from 19 to 10. This model demonstrates how contracting with a single commercial entity that 1) has a strong existing dental network; 2) offers competitive market-based reimbursement and 3) streamlines administration to mirror the private sector, can substantially improve access to care for Medicaid beneficiaries. In each succeeding year from program inception in 2000 through 2007, the proportion of the children enrolled for 12 months in a calendar year with at least one dental visit has continued to increase, with the access levels approaching 70 percent in children 7 through 10 years old, by 2007.

- Tennessee's TennCare program was the first attempt by a state to move its entire Medicaid population into a statewide managed-care system. The impact on dental services was disastrous. The number of participating providers dwindled from its 1984 level of more than 1,700 down to 386 general and specialist dentists available to treat the more than 600,000 TennCare eligible children. In 2002, the legislature enacted a statutory carve-out of dental services, which mandated a contract arrangement between the state and a private dental carrier to administer benefits for children (under age 21). The state retained control of reimbursement rates and increased them to market-based levels.

  The new rate structure, in combination with administrative reforms, patient case management strategies and a requirement that the carrier maintain an adequate provider network, has substantially improved TennCare's provision of dental services. In just two years, the utilization rate among eligible beneficiaries increased from 24 percent to 47 percent. (Private sector utilization ranges from 50 percent to 60 percent.) As of June 2004, about 700 dentists were participating in the program, with 86 percent of participants accepting new patients.

- Alabama reformed its state-administered dental Medicaid program in 2000 to reimburse dentists at rates equivalent to those paid by commercial insurers. (The program still reimburses dentists at year 2000 rates.) The changes included creation of the Smile Alabama! initiative, which encompassed administrative reforms, a case management program, and increased outreach

Smile Alabama! (Medicaid) Service Improvements Under New Rate Structure
Source: Centers for Medicare and Medicaid Services, US DHHS



to both patients and dentists. As a result of the Smile Alabama! initiative, there has been a 216% increase (from 151 to 477) in the number of dentists who see more than 100 Medicaid patients a year, while the number of counties with one or no Medicaid dental provider had declined from 19 to three by September 2009. The effort resulted in an 84.3 percent increase in dental utilization, from 25 percent (103,630) of eligible children in FY2001 to 45 percent (190,968) of eligible children in FY 2007.

Each of these initiatives made it possible for more patients to receive care from the same population of dentists that existed before the programs were launched.

- This example, the smallest in scale, is in many ways the most intriguing, embodying a diverse group of local entities crafting a solution uniquely suited to local needs. In 2001, in Brattleboro, Vt., Head Start, the state health department, school officials and hospital administrators collaboratively established a fee-for-service, for-profit dental center to address the needs of the underserved in a rural community. The organizers raised $450,000 in three months and built a three-chair, state-of-the-art facility with sufficient infrastructure to expand to five chairs. Now in its tenth year, the Estey Dental Center serves both private paying and public assistance patients and pays a percentage of non-Medicaid revenues to the non-profit contracting entity (the community partners). In its first two years of operation, the clinic cleared a huge backlog of children with acute and chronic dental needs and began to increase adult utilization as well.

These diverse initiatives share common elements. All of them utilized existing workforce models. They wrought significant, positive change through relatively minor funding increases combined with dramatic changes in administration. Each made it possible for more patients to receive care from the same population of dentists that existed before the programs were launched. Unfortunately, unlike Brattleboro's small-scale program, none of the state-wide systems provide care to adults in any meaningful way.

Alternative workforce solutions

Multiple groups have offered models intended to provide clinical services—including surgery—to underserved populations. They are largely targeted toward serving people in remote rural areas, with the justification being that there are not and never will be sufficient dentists able to practice near enough to those areas to serve their residents. To a lesser extent, backers of these models also claim that they will care for other underserved populations, including people in inner cities and Native American tribal lands.

The designers of these models often cite various dental therapist programs in other countries in which non-dentists perform such surgical procedures as "simple" extractions, restorations and even pulpotomies.

Both of these suppositions fail to withstand scrutiny. The assertion that no dentists will serve these populations risks becoming a self-fulfilling prophecy. Advocacy and finances directed toward experimental programs in which non-dentists perform surgical procedures undoubtedly will sap resources away from proven programs—such as the US Health Resources and Service Administration's National Health Service Corps, Indian Health Service, the Public Health Service, loan forgiveness and tax incentives, and public/private partnerships, all of which are proven to place dentists where they are most needed.

Claims that the efficacy of therapists has been "proven" in other countries are simply deceptive. The mid-level programs in these countries differ so dramatically in scope of practice, populations served and degree of dentist supervision, that referring to them en masse is misleading at best. In fact, if you've seen one foreign midlevel program, you've seen one foreign midlevel program. Further, these claims largely lack longitudinal clinical assessments of health outcomes. We know of no study comparing any improvements in oral health among targeted populations to the potential outcomes had the same resources been directed to providing these patients with care from dentists. They are touted as brilliant successes with very little empirical evidence to support those claims.

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Dental midlevel models often are compared to physician assistants or nurse practitioners, generally omitting the significant differences among those models. Physician assistants and nurse practitioners require up to six years of post high school education, not the two years or less suggested for many dental therapist models. Significant differences also are present among various dental midlevel models, most notably in their proposed scopes of practice and degree of supervision. They share, however, a critical attribute that the ADA opposes unequivocally: *Allowing non-dentists to perform surgical procedures, often with little or no direct supervision by fully trained dentists*.

Three midlevel models dominate the current discussion of these personnel:

1. The Alaska Dental Health Aide Therapist (DHAT) model receives the most attention, as it is the only dental midlevel program in operation in the US. It was designed to mirror its New Zealand counterpart. At its inception, program participants were even trained in New Zealand, in part because the program's authors did not identify a US dental school that would participate in training non-dentists to perform surgical procedures. The program has since worked out a training curriculum with the University of Washington (although it is worth noting that the relationship is with the University's medical school and not its dental school). Now in its fifth year, the Alaska DHAT program is fielding a modest number of therapists who are providing care.

   In a case study released in October 2010, the WK Kellogg Foundation declared the program a resounding success, even as the study's principal author admitted that the evaluation did not assess the overall impact of therapists' work. The study also failed to address the economic basis for or sustainability of the DHAT model.

   Kellogg's release of this study was a prelude to its larger purpose—the rollout of plans to create DHAT programs in five additional states: Kansas, New Mexico, Ohio, Vermont and Washington. However, the Alaska program benefitted from the federal government's power of preemption, enabling the DHAT program to circumvent the jurisdiction of the state's legislature, courts and board of dentistry. Kellogg presumably must convince policymakers in the five targeted states, each of them with unique rules and policies governing education and health care, to allow DHAT programs to begin. The foundation has committed $16 million to setting up the program. It is unclear how much (if not all) of that sum will go toward the political activities needed to legalize DHAT practice and how much will be devoted to actually launching educational and training programs.

2. The American Dental Hygiene Association (ADHA) has for some years advocated the creation of an Advanced Dental Hygiene Practitioner (ADHP), a dental midlevel who, after earning a two-year Master's degree, would be allowed to practice independent of dentist supervision. In addition to the existing scope of hygiene practice, ADHPs would diagnose oral disease, create treatment plans and perform "limited restorative procedures," including preparing and placing restorations, extractions and pulpotomies. Like the DHAT, the ADHP is expected to distinguish between complicated and uncomplicated treatments and refer the former to a fully trained dentist. Here again, the ADHA cites the use of various midlevels in 40 countries as evidence that a midlevel model will work in the US, without acknowledging the great variations in training and scope of practice among those providers.

3. In 2009, the Minnesota legislature, facing formidable pressure to enact an ADHP model, opted instead for a compromise worked out with the state's dental school, in which the school will train two levels of dental therapists. Dental therapists would graduate from an education program with either a baccalaureate or a master's degree. Dental therapists graduating with a four-year degree would practice under the direct or indirect supervision of a dentist for surgical procedures and could perform some non-surgical procedures under general supervision. Those qualifying for advanced therapist status must have completed 2,000 hours of practice as a (four-year) dental therapist, and have graduated from a master's-level advanced dental therapy education program. Advanced dental therapists will then be allowed to perform certain surgical procedures under a dentist's general supervision with a written collaborative management agreement, that is, without a dentist actually on site with the therapist.

The models above share some basic flaws. They overload midlevel providers with more responsibility than they should be expected to bear. Their proponents consistently refer to certain procedures, including extractions, as "simple," saying that of course more complex cases will be referred to dentists. However, fully trained and experienced dentists argue that midlevels' training cannot adequately prepare them to distinguish between "simple" and "complex" cases. In fact, even fully trained dentists do not conclusively pronounce a procedure as simple until it has been *successfully* completed.

A second weakness rarely mentioned is the midlevel's questionable ability to distinguish between teeth that cannot be saved and should be extracted and those that could be saved by restorative methods beyond the midlevel's training. If your only tool is a hammer, every problem looks like a nail.

A greater and broader weakness among proponents of midlevel practitioners is their near-obsessive focus on midlevels as the ultimate solution to access problems. Differences in opinion about the appropriate scope and supervision of various dental team members aside, arguing so vehemently for any single workforce model, while failing to place equal or even greater emphasis on the numerous other barriers to care is either naïve or disingenuous. In some ways, these models are a solution in search of only one part of a problem.

Shifting from the clinical to the policy point of view, we know of no empirical studies of the economic feasibility of dental midlevels. Proponents of these models either imply or assert that care from these providers will somehow be less expensive than that delivered by dentists, because they will earn less than dentists. We know of no evidence to support this. Compensation is a relatively small percentage of the costs of establishing and maintaining a dental facility. The difference between the salary of a dentist and that of a therapist or advanced hygienist would likely be offset by their lower productivity compared to a fully trained dentist and have a minimal effect on the overall cost of delivering care.

A different approach to augmenting the dental team

The ADA also is piloting a new dental position, the Community Dental Health Coordinator (CDHC), but one that represents a completely different philosophy. Modeled on the community health worker, which has proven extraordinarily successful on the medical side, CDHCs will function primarily as oral health educators and providers of limited, mainly preventive clinical services. Another significant function answers the need to treat patients with acute clinical needs without relegating those patients to surgery by non-dentists. They instead help these patients navigate the system, including ensuring that the patient clears the red tape that can complicate their receiving the care to which they are entitled, finding dentists, booking appointments and helping to provide critical logistical support such as securing child care, transportation and permission to miss work in order to receive treatment.

The CDHC is based on some of the ADA's key principles for breaking down barriers to care: education, disease prevention and maximizing the existing system. Rather than focusing strictly on treating disease, the CDHC provides education and preventive services. At its essence, oral health education is prevention at the most effective level. Models that focus exclusively or almost exclusively on performing procedures ignore these critical success factors.

The Community Dental Health Coordinator is based on some of the ADA's key principles for breaking down barriers to care: education, disease prevention and maximizing the existing system.

In many cases, underserved populations also face cultural barriers. This is nowhere more evident than among Native American communities that, in addition to their often remote locations and grinding poverty, often have difficulty interacting with people from the American mainstream. Similarly, increasing numbers of people living throughout the country have limited English proficiency or come from cultures that lack awareness of basic oral hygiene. CDHCs are recruited from these same communities, ideally not just similar communities but the actual communities to which they return and work. This critical factor can minimize

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and even eliminate these barriers that, though not often associated with access to oral health care, can affect it profoundly.

Public Health Interventions and Safety Net Delivery Systems

Efforts that emphasize disease prevention, such as community water fluoridation, sealant initiatives and school-linked health education and care programs are critical for improving the public's health, especially over the long term. But they are no substitute for comprehensive care provided by dentists to diagnose and treat disease.

Federal law requires all community health center applicants, as a condition of receiving federal funding, to demonstrate that they will provide dental services to the population served by the facility either on site or through a contractual arrangement. Unfortunately, these requirements have not significantly improved access to dental services for the underserved—the Federally Qualified Health Center system remains troubled. The dental safety net services provided through community health centers remain limited, and retaining dental providers through traditional means i.e., hiring dentists and dental auxiliaries on staff is challenging.

That said, dental clinics, whether government funded, private or nonprofit can have a critical role in communities that for whatever reason cannot attract sufficient private dental practices. In some communities these clinics may be the only resource available for dental care, and they often are overwhelmed. Many dentists who dedicate their careers to working in them do so out of powerful sense of social responsibility.

But the system cannot sustain itself relying solely on doctors who, upon completing grueling years of education and training, to say nothing of attempting to borrow and repay the cost of completing dental education, choose such selfless career paths. To attract and retain more dentists to work in these facilities, these positions must pay competitively. Equally important, clinics need to implement new ways to partner with private practitioners, who not only can adjust to varying public sector caseloads, but who can confer a degree of efficiency on the system of care beyond the capabilities of clinics under their current administrative and compensation structures.

Dental schools also can be instrumental in improving the availability of dental services for communities. Their clinics and off-site training programs provide needed care to patients who otherwise could not afford it. The possibility exists that some dental school clinical practices could expand these services, using their medical school counterparts' faculty practice model, increasing the numbers of patients served, creating greater revenues for the schools, and providing greater clinical training opportunities for students and residents. Ninety-one percent of schools now require students to complete a rotation in a clinic or other underserved community setting. In 2008 through 2009, 57 dental schools reported over 260 average hours of community based clinical care provided by their students as part of their dental education.

There are a number of creative approaches being used by dental schools to provide community outreach and care for the underserved. One such example is the collaboration of the NYU College of Dentistry with the Henry Schein Cares Foundation which places dental students, faculty, residents and hygienists in clinical settings operated by Caring Hands of Maine (one of a number of domestic and international sites covered by the program), in an effort to establish sustainable oral health systems. Programs like this also offer the ancillary benefit of bringing students into direct contact with communities of people who have a demonstrable need for oral health care and the real impact they can have in providing that care as practicing dentists. Here again, any such training must be conducted under the appropriate supervision of fully trained dentists, for the benefit of both patients and students.

Conclusion

The preceding discussion takes place in a terrible context: an ongoing epidemic in the most powerful country in the world, one that corrodes lives, robs children of otherwise bright futures, aggravates chronic and expensive-to-treat medical conditions and even, as in the case of 12-year-old Deamonte Driver, kills.

Untreated dental disease in America is a national disgrace. The silent epidemic owes in part to a failure to speak up. Dentists have carried the burden of advocating and caring for the underserved, mostly alone, for decades, with only limited success. Perhaps most frustrating is that real change is within reach. The system of clinical care is essentially in place, one that has proven to be a model for the larger sphere of health care—patient education, focused prevention and, when needed, early intervention to restore optimal health. When brought into this system, patients are empowered to be stewards of their own health.

Changes to the dental workforce can be a key factor—though far from the only factor—in extending good oral health to millions of people whose wellbeing is diminished because they lack it. The use of expanded function dental assistants, oral preventive assistants and patient navigators like the Community Dental Health Coordinator can greatly improve efficiency and capacity.

That other sectors of society are becoming increasingly vocal and passionate about the issue can only help. Disagreement among the new and old players in the field is natural and ultimately healthy. But one thing is sure—efforts to end the epidemic of untreated dental disease that do not position dentists as leaders and guides are doomed to fail. Expending precious resources on workforce experiments that ignore the experience and inarguable success of the existing delivery system would be a costly trip down the wrong road. The people we all want to help deserve better, and the dental profession stands ready to continue our work, aided by our new allies, toward our common goal of a healthier, more productive nation.

As the nation's leading advocate for oral health, the ADA:

- Urges both new and existing stakeholders to work more collaboratively, recognizing that our shared values and goals greatly outweigh any differences in how we believe those goals should be pursued.
- Invites the broader community to join our movement. Educators, faith based and charitable groups, additional doctors' and other health associations, and private industry all have roles to play. The more diverse the group, the greater its chances for success.
- Asks all stakeholders to collaboratively set ambitious yet realistic goals for the short and long-term as a first step toward pooling resources and working in aligned purpose to effectively end untreated dental disease in America.

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Ultimately, education and prevention will be the linchpins in eliminating, or at least minimizing untreated dental disease.

ADA American Dental Association®

America's leading advocate for oral health

The not-for-profit American Dental Association (ADA) is the nation's largest dental association, representing more than 156,000 dentist members. The premier source of oral health information, the ADA has advocated for the public's health and promoted the art and science of dentistry since 1859. The ADA's state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive. The ADA Seal of Acceptance long has been a valuable and respected guide to consumer dental care products. The monthly *Journal of the American Dental Association* (*JADA*) is the ADA's flagship publication and the best-read scientific journal in dentistry.

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