

A New Day Coming?

A Productive Discussion on Dental Workforce Change

“For the times, they are a-changin” – Bob Dylan

Bob Russell, DDS, MPH – Oral Health Bureau - IA Dept. of Public Health

Pressures are increasing across the nation for solutions to improve the nagging and ongoing disparities in dental care access for America’s underserved. States are seeking individualized solutions that may address specific issues within the unique confines of a given state, but may not address the needs in others. Various organizations and allied dental groups are developing and promoting new workforce models based on their particular interests.^{1,2} Central to these developments is how divisive this issue has become within the dental profession.

The polarization within the dental community has essentially frustrated, and in many ways paralyzed, progress toward reaching a consensus toward solving the nation’s ongoing problem addressing dental care disparities. Furthermore, the lack of leadership and unity has reduced dentistry into warring camps of opposition and resentment. Rather than assuring the nation that everyone’s oral health was assigned to hands that truly cared about the oral health of every American - the infighting has resulted in stagnation and an image of perpetrated self-interest. What the nation needs is innovation and a commitment not to accept disparities in oral health care. While dentistry alone will not solve the daunting oral health access problem, there is a need for leadership within the profession to move the agenda in the right direction.

A Productive Discussion on Dental Workforce Change (continued)

Professional Paralysis During Times of Change

The failure of a trusted professional dental monopoly charged to meet the oral health access needs of a growing and diverse population is a sure path to irrelevance and extinction. This is certainly true as new and alternative dental delivery systems are independently proposed without the full participation of the dental profession. Without the tremendous knowledge base that exists within the profession being readily available to develop, evaluate, and implement proposed innovations into the existing dental delivery system, such innovations may ultimately prove uncoordinated and destabilizing. The unintended results may further damage the credibility of the profession and ultimately fail to meet the needs of targeted underserved populations.

Dental professionals must be among those proposing innovations and should focus their strength toward addressing the serious dental access issues of the underserved that can be only addressed by a unified strong multi-disciplinary approach. The dental disease prevalence in low-income and diverse populations is higher than upper-income and dentally insurable groups.³ The cost of care and obtaining treatment is prohibitive for

high-risk, low-income groups at market rates. The profession also faces technical issues within the current workforce itself since the majority of current general practice dentists (the primary dental workforce) have limited skills or willingness to treat young children.⁴ All the more if these children come from high-risk populations with rampant dental disease. Other problems exist, but each of these issues alone has negative implications for current strategies, which are limited to only expanding early detection and preventive efforts disconnected from an insufficient treatment system with extremely large gaps. Yet, on the flip side, the current dental workforce provides adequate access and a good margin of care for the majority high income populations.⁵ The current dental workforce is limited, but not broken; however, it does not fully address the changes and challenges facing all Americans.

Change is here! New workforce models are being proposed and scope of practice expansions for dental hygienists and other allied dental auxiliaries are starting to be taken seriously and being implemented. The profession is taking notice. New articles and editorials are emerging within and outside organized dental publications as a wake-up and call-to-action.^{6,7} The time for new and innovative workforce solutions has come. Such evidence of change includes the ADA's proposed Community Dental Health Coordinator as a first round addition toward workforce stratification. While this new model may prove a valuable addition, alone it will not suffice to solve the access to treatment crisis of the underserved. Other workforce models may be necessary to fill the gaps, such as the American Dental Hygienists' Association's Advanced Dental Hygiene Practitioner, the Indian Health Service's Dental Health Aid Therapist model currently used in Alaska, and/or a newly proposed Pediatric Dental Therapist.^{8,9} Is one better than another? Or should multiple provider types working and collaborating within different environments present a solution? Only well-designed evaluations of a prospective new workforce model working with targeted populations provide the answer.

A Role for Dental Public Health

For Dental Public Health, now is the time to embrace change and utilize our essential skills and knowledge to lead this transformation. Escalating health care costs, persistent disparities¹⁰, and rising levels of poverty in a culturally-diverse America compel us to utilize social-behavior modeling, surveillance, evidence-based preventive methodology, economics, and culturally-appropriate oral health promotion to reduce the disease burden in underserved populations. While early detection and prevention are the primary means to reduce the long-term costs and morbidity associated with dental disease, such methods also lead to greater identification of dental treatment needs. This will continue to be the pattern for the foreseeable future until significant reductions in dental diseases occur. Without a means for the underserved to compete with more affluent populations for limited dental resources, this inability will result in frustration and discouragement to seek dental care access among those who need it most.

Many factors complicate seeking an easier path with less divisive means to correct disparities in dental access. Economic principles of supply and demand are constraints that limit traditional approaches to improve access. Effective market-driven demand drives both costs and supply, but not necessarily equally in health care.¹¹ Competing and

differing demands by more affluent populations experiencing less disease and more desire for esthetics with those of less-affluence and experiencing higher disease burden have essentially tilted the balance of access in favor of cosmetics and high end procedures. The profession now caters towards the needs of those with greater resources and more readily able to access a highly-skilled limited supply dental workforce.

Should a financing method be discovered to provide low-income populations with an effective means of accessing the current dental care system, the sheer demand would overwhelm currently available dental providers. Such a demand for extensive and expensive treatment would quickly overwhelm state and federal financial budgets attempting to compensate and adjust to rising competition and market rate pressures.

Efforts that primarily target oral health access via increasing Medicaid rates or other public assistance dollars attempting to chase private market-driven constraints have resulted in mixed and less than adequate results.¹² Long term implications lead to burdened tax-payers, increasing competition for limited dollars with other important health care applications, and/or escalating prohibitive governmental health care costs. Even so, governmental funded programs such as Medicaid would fail to engage all currently available private dental providers to treat the underserved regardless of payment rates. All are doomed to frustration and the ultimate “Catch-22” of managed neglect – the identification of dental care needs without resources to provide definitive care. New ideas and innovations are needed. It is time to seek solutions that work.

During this transition, Dental Public Health can enable both the dental profession and the public to better understand why and how a flexible and adaptable multi-layered dental workforce can be tailored to meet increasing population demand for dental services. Early disease detection, prevention, and access to definitive treatment are essential in establishing a stable oral health care environment for all Americans. Leaders within the dental profession must develop concepts that create solutions that provide positive outcomes for existing providers as well as new ones; target the underserved; and reduce the overall costs of meeting this increasing demand for care. These parameters are challenging, but not insurmountable.

An Argument for Extending the Dental Workforce

A good example of the need for a new mid-level dental provider can be found within the nation’s growing number of federally qualified health centers (FQHCs). Since 2003, the number of FQHCs has increased to meet the growing need of the underserved. New FQHC access points are required to provide dental services; unfortunately, recruitment and retention of dentists to work in these settings is a serious challenge.¹³ A number of factors have been cited regarding dentists’ satisfaction working within health centers.¹⁴ However, one understated reason involves the opportunity to provide the full range of cosmetics and high-end services consistent with the market-driven training a dentist receives in dental school. Given that dentists generally receive training in a wide range of high-end skills and costly cosmetic procedures consistent with demand from the majority of those seen in many private practices, the difference in both low-cost emphasis and

focus on basic restorative and preventive services provided in public health clinical practices may seem restrictive.

Many public health safety net clinical practices are limited by a number of restraints including a mismatch between payment structure and the needs of a large underserved high-risk population. Such clinics focus on the most basic services that address dental disease at lower cost and require less time to provide. Given the financial structure of government supported rural safety nets and FQHCs, these clinics cannot increase revenue potential through the provision of higher-end services unlike private fee-for-service practices. One possible solution would be to develop a less costly mid-level dental provider with a limited educational requirement that focuses training on the types of basic lower-end services most consistently provided in public health and safety net clinics.

Given the enormous student debt incurred with the training of today's dentists, a more focused training program may reduce both the costs and salary requirements of new provider models that will serve to enhance the dental team. The expanded dental team would have more depth and appropriate skills to address the needs of the high-risk underserved populations while dentists serve as team leaders performing advanced services and oversight. This would provide the capacity to increase patient treatment visits at a lower cost and increase capacity to focus on the levels of treatment more consistent with the dental team's training and skills. Such dental teams would not be limited to public health clinics alone, but could be expanded into private practice environments where services are provided to all socio-economic levels and disease risk groups. The cost-savings would be significant for these practices as well.

Closing Thoughts

There are many causes for disparities in dental care access including low-income, limited education, cultural and language barriers, and a lack of knowledge regarding importance of oral health care. These causes are inherent for many in America and the nation's oral health care system must be responsive to these barriers. The divide that separates those able to access care from those that cannot is widening as the cost of health care escalates and the number of uninsured Americans increase.¹⁵ It is highly unlikely that this growing gap can be bridged by simply attempting to fill it through increased spending of public money. Innovation and a less costly means of meeting the new demand are required. Safety net clinics, public health practices, and private practitioners working together can fill the void creating a suitable and adaptable dental workforce available to all.

An effective solution to close the access gap would require a means to expand access to early detection, prevention, educational outreach and disease-focused basic treatment needs. Organized dentistry, allied dental professionals, and primary health care providers across the health care spectrum should seek to promote and partner with dental safety nets and public health dental practices to increase access to the needed services required by high-risk underserved populations. Introducing new and innovative workforce models using evaluation to determine effectiveness and impact would be the least prohibitive means of doing so. It is time to make lemonade out of the lemons of dissatisfaction that

currently exists within the fragmented dental community and offer refreshing access to all.

Bob Russell, DDS, MPH

¹ ADHA Seeks Input on Updated Draft Curriculum for the Advanced Dental Hygiene Practitioner (ADHP). Accessed 9-8-06.

<http://www.adha.org/news/05312006-adhp.htm>

² American Public Health Association Governing

Council Resolution : Support for the Alaska Dental Health Aide Therapist and Other Innovative Programs for Underserved Populations. Passed November, 2006.

³GAO/HEH-00-72. Oral Health in Low Income Populations. April, 2000. Available from:

<http://www.gao/archive/2000/he00072.pdf>

⁴ McQuistan MR, Kuthy RA, Damiano, PC. General Dentists' Referral of Children Younger Than Age 3 to Pediatric Dentists. *Pediatric Dentistry*. 2005; 27:277-283

⁵ Brown LJ. Dental Work Force Strategies During a Period of Change and Uncertainty. *Journal of Dental Education*. 2001; 65:1404 – 15.

⁶ Fisher-Owens SA, Barker JC, Adams S, Chung LH, Gansky SA, Hyde S, Weintraub JA. Giving Policy Some Teeth: Routes to Reducing Disparities in Oral Health. *Health Affairs* 27, No. 2 (2008): 404-412.

⁷ Wendel OT, Glick M. Lessons learned: Implications for workforce change. *JADA*. 2008;139:232-234

⁸ Nash DA, Nagel RJ. A Brief History and Current Status of a Dental Therapy Initiative in the United States. *Journal of Dental Education*. 2005; 69: 857-9.

⁹ Smith EB. Dental Therapist in Alaska: Addressing Unmet Needs and Reviving Competition in Dental Care. *Alaska Law Review*. 2007; 24:105-43.

¹⁰ Flores G, Tomany-Korman SC. Racial and Ethnic Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children. *Pediatrics*. Volume 121, Number 2. February 2008.

¹¹ Guay AH. Access to Dental Care: The triad of essential factors in access-to-care programs. *JADA*. 2004;135:779-785

¹² National Academy of State Health Policy 2008 Report. The Effects of Medicaid Reimbursement Rates on Access to Dental Care. Available from: http://www.nashp.org/Files/CHCF_dental_rates.pdf

¹³ Hurley R, Felland L, Lauer J. Community health centers tackle rising demands and expectations. *Centers for Studying Health System Change*. No. 116, December 2007

¹⁴ Bolin KA, Shulman JD. Nationwide survey of work environment perceptions and dentists' salaries in community health centers. *JADA*.2005; 126, 214-20.

¹⁵ Gilmer T, Kronick R. It's the Premiums, Stupid: Projections of the Uninsured Through 2013. *Health Affairs Web Exclusive*; April 2005