Next Steps in Dental Therapy

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Enabling Dental Therapy Practice to Improve Access to Oral Health Services

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Today's Presentation

- Two parts
- Summary of results from surveys of providers and patients
  - Report will be available on the Oral Health Workforce Research Center's Website within a few weeks
    - https://oralhealthworkforce.org/
- Problems with advancing and implementing the dental therapy workforce model

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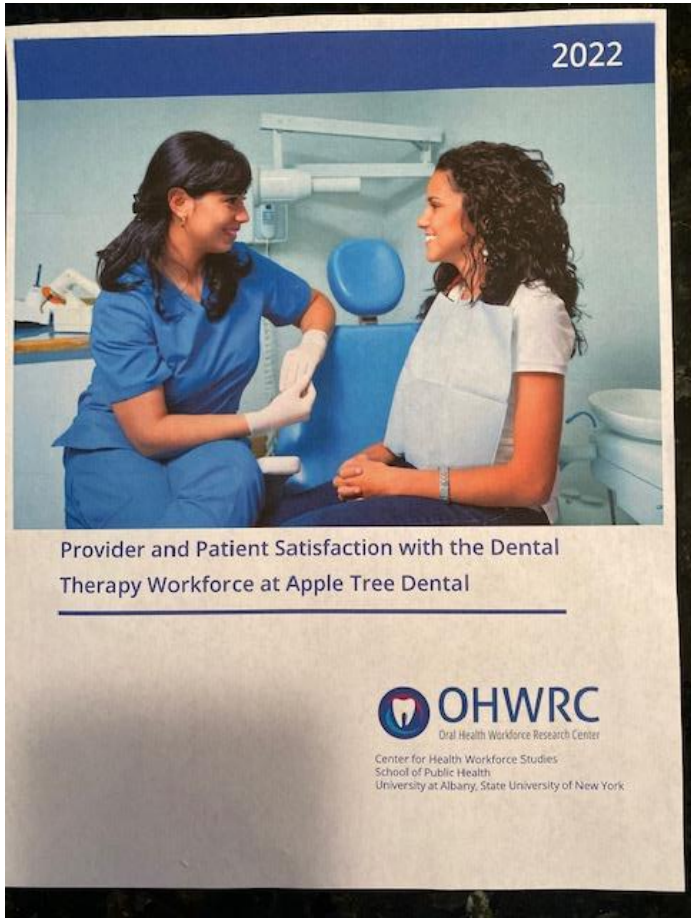
Surveys of Patients and Providers at Apple Tree Dental



- Web based
- Conducted in 2021
- Clinical staff, selected administrative staff
- Stratified convenience sample of patients
- Used validated items from published literature and original questions to describe satisfaction in multiple domains of practice and several categories related to patient satisfaction

Providers Recognize the Benefits of Dental Therapy

- Survey of dental clinicians and administrative staff (response rate 89 (49.5%)
- **"How well do dental therapists fit with the overall team structure at the Apple Tree Dental center where you work?"**
    - Scale of 1 (not at all well) to 5 (extremely well) - Dentists (mean fit 4.47), dental hygienists/assistants (4.77)
  - Regarding quality and efficiency (1= strongly disagree/ 5= strongly agree)
    - Dentists (4.10), dental hygienists/assistants (4.40), and administrators (4.40) agreed that dental therapists perform high quality work and that dentists can work more effectively and efficiently when teamed with a dental therapist.
  - Advanced dental therapists and dental therapists agreed that they experienced professional autonomy in practice (5 point scale)
    - were able to complete patient services from start to finish (4.23)
    - and to direct how they accomplished their clinical tasks (4.86).
  - Dental therapists felt valued as members of the clinical team (5.0)

Patients Express Satisfaction With Services of Dental Therapists

- **Patient satisfaction is recognized as an essential indicator of quality.**
- Survey of patients of all clinicians at Apple Tree Dental.
- Analytic data set included responses from 898 adult and child patients
- Some variation in satisfaction ratings by provider type
  - higher ratings for dental hygienists for information and communication than other provider types
  - dentists received somewhat higher rankings for understanding and acceptance
  - patients who received preventive services were more satisfied with dental therapists
- Average patient ratings of agreement with statements about technical competence and satisfaction with treatment ranged from 4.11 to 4.37 (scale 1 (strongly disagree) to 5 (strongly agree)
- Scores for general satisfaction ("I will come back to Apple Tree Dental) ranged between 4.54 and 4.71 (5 point scale) with no significant differences across provider type.
- Differences in patient satisfaction by provider type were small across all domains and generally not significant.

What is Happening With Dental Therapy in the US?

It’s not Just About Legislation

Instituting a new workforce model is a complex undertaking that requires:

- **legislative action**
- regulatory guidance,
- **establishment of high-quality educational pathways,**
- **creation of a standardized curriculum,**
- **program accreditation**
- professional competency testing and credentialing (similar to that for dentists)
- Employment opportunities
- integration into traditional dental practices that include clinicians with established competencies and bounded skill sets,
- and importantly, acceptance from patients who will benefit from the services of dental therapists.

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And if we legislate it …will they build it?

- Building “new” workforce model on a state by state basis
  - Some foundational guidance on model
  - Common driver is increase in access to services
  - Divergent views on how to achieve desired outcomes
  - Difficulty finding educational programs with the resources to educate the workforce – including operatory space for clinical instruction
  - Issues of overlapping competencies with existing professions and their acceptance
    - competition vs complementarity
  - Concerns about quality
  - Uncertainty about scope and supervision
  - Struggling with fit – dental hygiene model?
  - **Professional resistance**, **legislative hesitancy**, **urgency of need**

Is Dental Therapy the Result of Natural Evolution, a Troublesome Disruption or a Necessary Innovation?

- Differing attitudes about the need for the workforce produce impediments to adoption downstream
- Currently, a variety of stakeholders with varying opinions about the safety and efficacy of the model
  - Patient advocacy groups, safety net dental providers often are strong proponents of its necessity
  - Concerns within legislative and regulatory agencies about legislating change while adequately protecting the public safety and preventing disruptions within the delivery system
  - Reluctance within organized dentistry to embrace the introduction of new workforce with overlapping competencies of existing workforce

Attitudes Towards the Model Affect the Pace of Adoption

- Oral health is poised for transformation but it is slowed by the status quo
- The innovation culture (Birch et al.) in oral health has resulted in
  - new technologies, new materials, innovative service delivery models. . .yet
  - workforce planning is sluggish, expectations that existing workforce is able to respond to gaping needs, planning continues to occur in professional siloes
- Humans are the most adaptive of all species (Vedantam) yet
    - We are highly resistant to change, have a tendency to inertia
    - See the need for change but we like the reliability of things as they are
- Inertia in the past – perhaps finally at a tipping point

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The Current Status of Dental Therapy

- Legislation passed in 13 states, many others have considered or are considering
- One constant is variation
- Variation in titles
  - Dental health aide therapist (AK), dental therapist (MI, MN), advanced dental therapist (MN), dental hygiene (removed from law in 2019) therapist (ME), advanced oral health clinician, advanced dental hygiene practitioner
- Varying education requirements
  - CODA three year curriculum, Minnesota (bachelor's/master's degree), Maine (master's degree), Connecticut (18 months beyond DH license)
  - Only two functioning education programs in continental US (Minnesota)
  - Vermont Technical College anticipates admitting students this year
  - Clinical practice requirements vary – as little as 400 to as much as 2,000 hours- some can be acquired during training/ others post graduation, NV has three diff requirements depending on status at licensure

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The Current Status of Dental Therapy

- Native American initiatives from tribal councils in sovereign nations
  - Swinomish tribe (WA) built dental clinic with 4 rooms for DT clinical education program
  - Lummi tribe set up licensure mechanisms independent of state licensing authority (WA)
- Dental hygiene model (ME, VT, AZ, CT, NV, NM, OR) versus entry level training (MI, Tribal communities)
  - NV – Dental hygienist must have a public health endorsement to qualify
- Supervision
  - Direct/indirect (ME, MN) , general (MN, NV, NM, CT, VT, MI, and in states with tribal authorization (ID, MT, OR, WA), collaborative practice agreement (MN, ME, NV, etc.)
- Limits on Practice
  - Targeted settings (FQHCs, prisons), geographies (DHPSAs, rural), patient populations
  - VT is the only state without limits on practice settings or patient type
  - Maine removed the original limits on settings and patient type in 2019
- Good news – some constants are emerging

As We Move Forward, Can We Learn from History Or Are We Just Repeating It ?

- Learn from the evolution of the NP and PA model over the last 50 years
- **Variation in education requirements accompanied by a period of educational creep in allied health**
- Differences in titles, supervision, scope and prescriptive authority
- A wide spectrum of discourse –
  - Can a certified nurse midwife sign a birth certificate?
  - Can a nurse practitioner or a physician assistant sign a disability form or a death certificate?
- These workforce models are now relatively consistent across states
  - Forming licensure compacts that enable portability and locum tenens – important during recent public health emergency
- It's important to consider the resources consumed in arriving at conformity on an "iterative" basis

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Conclusions

- Dental therapy is an innovation in the US health care system that is showing promising impacts on oral health access for many
- Need to arrive at some consensus on the appropriate minimum standards for the model to encourage adoption in every state and portability/ licensure by endorsement
- This is supported by
  - Significant evidence base internationally
  - Emerging body of literature in the US from Alaska's and Minnesota's experiences
- Model legislation developed by the National Dental Therapy Standards Consortium https://www.dentaltherapy.org/resources/file/Dental-Therapist-National-Standards-Report-and-Model-Act_FINAL.pdf
- The Commission on Dental Accreditation developed recommended training standards and accreditation standards for dental therapy education programs (degree agnostic)
- Professional association now exists, American Dental Therapy Association

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Questions?

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