EDITORIAL

A New Day Coming?

A Productive Discussion on Dental Workforce Change

Bob Russell, DDS, MPH

"For the times, they are a-chagin"
– Bob Dylan

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 developing issues is the historically divided house that represents 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 proactive indication if dentistry is going to solve the daunting oral health access problem.

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 dental delivery systems are independently created outside the profession as a destabilizing- though well intended – response to a growing access crisis. Without proper design, evaluation, and implementation into the existing dental delivery system, new innovations will produce unintended results that may further damage the credibility of the profession and ultimately fail to meet the needs of targeted underserved populations.

Dentistry must focus its 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.

The challenge under the current workforce design is filling the lack of skill sets in the current highly saturated general dental educational system and lowering the cost barriers to access treatment. 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 being implemented. Fortunately, there are positive signs on the horizon. The profession is taking notice. New articles and editorials are starting to emerge within and outside organized dental publications as a wake-up and call-to-action.[6,7] The time for new

[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.

[3] GAO/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.

DOI: 10.1111/j.1752-7325.2008.00097.x

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 crisis of the underserved. Other workforce models may be necessary to fill the gaps, such as the American Dental Hygiene 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? Only a well-designed evaluation of workforce models working with targeted populations will 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. The ominous signs of escalating health care costs, persistent disparities[10], 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 lead to greater identification of dental treatment needs. The more underserved individuals are screened – the more dental disease is detected. This will continue to be the pattern for the foreseeable future until significant reductions in dental diseases occur. Without a means 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 the easy path and 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 with those of less-affluence and experiencing higher disease burden have essentially tilted the balance of access. Those with greater resources are more readily able to access a highly-skilled limited supply dental workforce.

Should a way be discovered to provide low-income populations with an effective means of accessing dental care, 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. 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 unify and return dentistry toward seeking 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. While no single solution will meet the dental needs of everyone, dental leaders must develop concepts that increase the number of dental providers; decrease potential negative impact on the current dental workforce; target the underserved; and reduce the overall costs of meeting this increasing demand for care. These parameters are challenging, but not insurmountable.

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 scope of treatment opportuni-

[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.

ties consistent with the training a dentist receives in dental school. Given that dentists generally receive training in a wide range of skills consistent with demand from the majority of those seen in market driven private practices, the difference in both demand and available 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 inadequate public funding, inability to charge more for services based on complexity or number of services provided per visit to low–income patients, and 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 a FQHCs single rate per visit payment structure, 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 dental provider with a limited educational requirement that focuses training on the types of 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 encounters 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 socioeconomic levels and disease risk groups. The cost-savings would be significant for these practices as well.

In focusing on the crucial divide that causes disparities in dental care access, such as low-income, limited education, cultural and language barriers, and a lack of knowledge regarding importance of oral health care; this conglomeration of issues result in inequitable demand in the current oral health care system. 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 gap can be bridged by simply attempting to fill it with public money. A less costly means and targeted system of meeting the new demand is required. Safety net clinics, public health practices, and private practitioners working together can fill the void if a suitable and adaptable workforce is made available to all.

An effective solution to close the access gap would require a means to both expand access to early detection, prevention, educational outreach and disease-focused basic treatment needs. Organized dentistry and allied dental organizations 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 that are thoroughly evaluated 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.

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