ASDA Midlevel Provider Talking Points

ASDA's stance on midlevel providers

ASDA identifies a midlevel provider as an individual, who is not a dentist with four years of post-collegiate education (three years in the case of University of the Pacific School of Dentistry), who may perform irreversible procedures on the public. The association believes the dentist is the only dental provider that should perform the following functions:

- Diagnosis and treatment planning
- Prescribing work authorizations
- Performing surgical/irreversible dental procedures
- Prescribing drugs and/or other medications

History of midlevel providers in the United States

- Barriers to care limit or prevent people from receiving adequate health care. The most common are:
    - financial hardship
    - geographic location
    - pressing health needs
    - poor oral health literacy
- There are 5,833 Dental Health Professional Shortage Areas (HPSAs).
- More than 10,635 practitioners are needed to meet every HPSAs' need.
- Midlevel Providers were created in response to barriers to care and the HPSA crisis. A key attribute of a midlevel provider is that he/she was intended to primarily work in settings that serve populations with minimal access to dental care (1).
- Dental therapists were first authorized to practice in Minnesota in 2009, with the Minnesota Board of Dentistry licensing its first dental therapist in 2011 (1).

Midlevel provider models:

- International perspective: Proponents of midlevel providers oftentimes reference midlevel models from Canada and New Zealand. Here are some key facts of those programs:
    - Canada:
        - The Canadian dental therapy program ended in 2011 (2).
        - These providers were established for nearly 40 years, but it was deemed to be an unsustainable option for increasing access to care.
        - 70% of dental therapists were not practicing within the areas of need.
    - New Zealand:
        - Has an established program.
        - In a publication, it presented that only 3% of children aged 5 to 11 had untreated tooth decay (3). However, when examined, New Zealand data only included permanent dentition (adult

teeth). When including primary dentition (baby teeth that will exfoliate), that number spiked to 17%. This number is much more consistent with the 20% represented by the United States (4).
        - Pediatric philosophy is different than general practice. When primary teeth have decay, the situation is taken into consideration. If the tooth with decay is expected to be lost prior to the lesion progressing to a point, many times pediatric philosophy will choose to actively observe the lesion to minimize treatment on the patients.

- Midlevel providers in the United States: State governments are responsible for adopting legislation to define the certification process, scope of practice and practice settings for midlevels in their states. Midlevel provider models vary greatly across the country. Here are models highlighting the variances:
    - Alaskan midlevel program:
        - The Alaskan program is comprised of two years of training and a 400 hour preceptorship.
        - In this program, one can only practice on tribal lands (Washington or Oregon programs have similar programs for tribal lands only).
        - The provider must be recertified every two years.
    - Arizona's midlevel program:
        - In AZ, dental therapists must be a Registered Dental Hygienist first and then complete three additional years of training.
        - Their scope is restrictive to tribal settings, Federally Qualified Health Centers, Community Health Clinics and charitable settings.

Midlevel provider topics of interest:

- Standard of care:
    - Dentists complete four years of postgraduate education to learn how to provide comprehensive care.
    - Midlevel providers are trained to perform specific, surgical and oftentimes, irreversible procedures in Dental Health Professional Shortage Areas.
    - Patients in these areas might not receive regular oral health care and might present underlying complications during treatment.
    - It is imperative for these patients to receive treatment from a dentist that can address complications that may become apparent with comprehensive care.

- Providing access:
    - Proponents of midlevel providers argue that the introduction of midlevel practitioners will create new providers to work in HPSAs and alleviate barriers to care.
    - More research will need to be completed to determine the effectiveness of the various kinds of midlevel providers. Looking at America's longest standing dental therapist program in Minnesota, we know that:
        - Only 9 of the 86 dental therapists that are licensed in Minnesota practice in rural areas (4).
        - The program intended for them to practice in settings that serve populations with minimal access to dental care.

- Financial impacts:
    - Emergency Rooms visits:
        - Emergency room visits for dental care are expensive and oftentimes don't support continuation of care for patients. For example, the "Early Impacts of Dental Therapists in Minnesota" reports

that emergency rooms are an expensive last resort for patients and had a three-year tab of $148 million between 2012–14 (4).

- According to the Academy of General Dentistry, midlevel provider programs were promoted as a way to reduce the number of emergency room visits for dental–related issues. In the case of Minnesota, there is no evidence that the emergence of dental therapists has resulted in any cost savings to the state (5).

- Government subsidies:
  - Dental therapy programs seem to require significant government subsidy to operate. Here are state and international examples:
    - Vermont Technical College received a $400,000 federal grant following legislation that established the dental therapist role with no funding mechanism.
    - Funding for the oral healthcare portion of the Non-Insured Health Benefits Program (NIHB) in Canada cost $219.1 million from 2011-2012. The Canadian government defunded the program because "The high costs of funding the education program with little perceived return on the investment overshadowed the benefits of continuing to fund dental therapy programs" (2).

What does ASDA recommend to improve access to care?

- Community Dental Health Coordinators (CDHCs):
  - Many individuals face barriers when trying to access a dentist, like transportation, geography and poverty.
  - The American Dental Association relays that CDHCs were launched in 2006 to provide community-based prevention, care coordination, and patient navigation to connect people who typically do not receive care from a dentist in underserved rural, urban and Native American communities. CDHCs connect patients to available, but underutilized, dental care. (6)

- Expanded Function Dental Assistants (EFDAs) are a viable alternative to dental therapists.
  - These associates do not participate in irreversible dental procedures. Instead, they may fill a preparation after the dentist has drilled on the tooth, operate radiographic equipment, or place sealants. This can improve the efficiency of dentists and provide an increase in access to care.
  - Researchers from the University of Colorado in a study, A Pilot Study to Determine Barriers to Implementing Productivity Enhancement Strategies in Dental Practices found that when high delegation dentists were asked how delegation had affected their practice, they responded that they believed that expanded delegation had:
    - increased the number of patients seen
    - increased productivity and income
    - reduced the stress of practicing dentistry
    - permitted reduced hours without a decrease in income (7)

- Emergency room referral programs:
  - Emergency room visits are oftentimes expensive and a last resort for patients that haven't received regular dental care.

    - Most hospitals can't provide patients with comprehensive dental care. Referral programs help patients navigate their care away from the emergency room and to a dentist.

- Teledentistry: Research from the journal of Health Affairs indicates that teledentistry can effectively reduce barriers to dental care for underserved populations (8).

- Medicaid:
    - Expansion of Medicaid dental benefits: Increasing access to preventative dental care can reduce overall healthcare costs by lowering emergency room visits for dental issues.
    - Increase of Medicaid reimbursement rates: According to the ADA Health Policy Institute, numerous studies show a positive correlation between increasing Medicaid reimbursement rates and dental care utilization. In other words, more patients visit the dentist when reimbursement rates are increased (8).

- Programs like the National Health Service Corps encourages new graduates to practice in rural and low-income areas. Much of the access to care issue is concentrated in these areas. Many new graduates are drawn to urban areas, and this Rural Scholarship Program is aimed at better distribution of providers.

Sources:

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