DENTAL THERAPIST

Current trends and recommendations

BACKGROUND

Dental therapists have been proposed as a resource to address the lack of access to dental health care among certain populations in the United States. Dental therapists have provided basic oral health care to children in over 50 countries after training in a 2-year post-secondary curriculum in public health sector sites. Several studies have documented their effectiveness in improving access and quality of care for children. In the United States, dental therapist usage has been complicated by the limitations based on patient group served, the use of these individuals in private rather than public/not-for-profit settings, and the requirement that the dental therapist also be credentialed as a dental hygienist.

ADULT VERSUS CHILD PATIENTS

In the international arena, dental therapists almost exclusively treat children. Treating adults has been strongly opposed by the dental profession, based on 4 significant issues.

Complexity of Adult Care

The treatment of adult dental problems is considerably more complex than that for children. Even though it may be possible for a dental therapist to prepare and restore a cavity on a child's tooth, adult dentistry requires the ability to diagnose, plan treatment for, and provide rehabilitative care for intracoronal restorations or preformed stainless steel crowns. These activities are beyond the training provided for dental therapists.

The care for children is generally preventive in nature and presents less complexity in diagnosis or technique. The basic regimen is amalgams/composites and stainless steel crowns for dental caries, pulpotomy for pulpal disease in primary teeth, and the extraction of primary teeth. These are considerably less complex than the care required for adult dental problems.

Inefficiency of Adult Treatment

To be an efficient addition to the oral health care workforce, dental therapists must be able to practice independently with general dentist supervision. If direct supervision is required, the workforce is not being expanded, which is particularly relevant in areas that are already underserved with respect to dental services.

Safety

Dentists are trained extensively in the biomedical sciences and oral medicine to be able to identify, assess, and manage the general health and well-being of their patients. In contrast, dental therapists receive limited training in these areas and are, therefore, not equipped to evaluate and manage adults whose health is compromised. Although safety is mitigated to a degree when dental therapists are practicing under the direct supervision of a dentist, it is not altered if just general supervision is being used. In addition, most children are healthy and can be safely treated by a dental therapist; this is often not the case with adults.

Ethical Considerations

Children are vulnerable because of their dependent nature and the time-critical nature of their development. Thus societies are judged for worth based on their concern for and care of their children. Children should be a priority when considering who should receive health care, especially when resources are inadequate to provide for all. Dental therapists are therefore best used to address children's needs when ethics are considered.

PRIVATE VERSUS PUBLIC/NOT-FOR-PROFIT SERVICE

Adding a dental therapist to the dental workforce offers the opportunity to address access to dental care for children in the public/not-for-profit sector. However, in the United States, the oral health care of children is primarily delivered through the private practice model and not through the public sector. Often private dental practices do not accept children in their practices if their care is funded by Medicaid and/or the federal Children's Health Insurance Program (CHIP). Thus there remain significant barriers to children receiving oral health benefits. Underserved children tend not to live in affluent geographic areas where private dental practices are located.

Dental therapists have proven effectiveness and cost-benefit data to support their deployment in the public sector to provide access to care for children, often through school-based clinics. Based on their experience in these settings, treatment provided by dental therapists has achieved impressive decreases in decayed teeth and significant cost reductions for dental care. Having health care for children delivered in school settings provides the essential access needed, reduces health inequities, and improves health outcomes. Even preschool children can be brought to school dental therapists for examination, fluoride treatment, and other services. Thus the use of dental therapists in these public/not-for-profit sites is much more likely to achieve goals related to access than having them serve in private dental settings.

Clinical Significance

The evidence-based effectiveness of dental therapists in improving public health is based on them limiting their practice to children, practicing in the public sector, and serving as distinctive members of the oral health workforce with credentials that do not require those of a dental hygienist. Requiring a merging of roles with the dental hygienist and limiting their practice to private rather than public settings are counterproductive when trying to expand patients' access to dental health care. Having them serve in school-based clinics provides an excellent way to reach underserved pediatric patients.

CREDENTIALING AS A DENTAL HYGIENIST

Requiring dental therapists to also be dental hygienists places an unneeded restriction on the expansion of the oral health workforce. Although existing dental hygienists could obtain therapist training over the course of about 1 year and expand their role, this also does not contribute to an expansion of the workforce itself. The American Dental Hygienists' Association (ADHA) promotes the acquisition of dental therapist skills by hygienists in a master's degree curriculum. However, requiring dental hygienist credentialing not only increases the length of training for dental therapists but also raises the cost of training. As with the requirement that dental therapists work directly under the supervision of dentist, the integration of dental therapist and dental hygienist roles does not expand the outreach to underserved populations.

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FINANCING

Changing oral health care delivery and financing

BACKGROUND

Consumers of health care are seeking to secure the best value for their dollar. This demand requires that the providers of goods and services must demonstrate or at least claim value for their product or service. The value of dentistry remains to be determined in many cases and must be seen in the context of the trade-offs, constraints, and opportunities in dental care financing and delivery as well as the federal policy impact on dental care financing.

THREE-PART AIM AND CARE DELIVERY INNOVATION

Currently the traditional value proposition for health care is that providers know what is best for an individual's health and for the payer who funds the care. Both individuals and payers accept that the charges for care are appropriate to the quality, quantity, and potential benefit of the services delivered. Thus more health care equates to better health care, and more costly health care is more valuable than less costly health care. Health care outcomes are directly tied to the care delivered. This forms the 'iron triangle,' in which cost, access, and quality exist in tension with one another as trade-offs. Less or more of any one parameter affects the others, so that lower cost necessitates either reduced access or poorer quality of care and greater access either costs more or mandates poorer care.

The Patient Protection and Affordable Care Act (ACA) of 2010 addressed the cost component of this triangle by providing extensive federal financial subsidies to states, employers, and individuals so that more people could be covered by health insurance that ensured they would receive comprehensive essential health benefits (EHBs) and greater financial access to care. The law then sought to promote more efficient and effective care that would increase the value by improving health outcomes at a lower cost. The goal was to impose a 'triple aim' to replace the iron triangle. In this concept, better individual and population health outcomes were anticipated at a lower cost by having health care personnel work smarter and by assessing conventional treatments for value based on their contribution to the health outcomes. The federal Center for Medicare & Medicaid Innovation (CMMI) was created to advance value-based care rather than volume-based care through grants to states and nonprofit agencies so they could conduct value demonstrations. Programs were rewarded when they demonstrated better health outcomes were achievable at lower cost, with better population health and patient experiences achieved through the redesign of care systems to focus on efficiency and effectiveness.