



## **OPTIMAL DELIVERY OF ORAL HEALTH SERVICES THROUGH PRIMARY CARE:**

### **A Comprehensive Workforce Policy Statement**

#### **Academy of General Dentistry (AGD)**

#### **Introduction**

In 2008, the Academy of General Dentistry (AGD) published the “White Paper on Increasing Access to and Utilization of Oral Health Care Services,” calling for the implementation of twenty-five proven methods of improving access to and utilization of oral health care services, from Medicaid improvements and loan forgiveness programs, to oral health literacy and strengthening the dental workforce. In 2012, the AGD’s “Barriers and Solutions to Accessing Care” identified solutions to key areas that presented challenges to the delivery of care, including oral health literacy, converting literacy to action, moving from a treatment mentality to a prevention mentality, social and cultural misperceptions, the economics of sustainable care delivery, distribution of provider populations, and addressing patients with special needs.

Despite the various needs that must be addressed to improve oral health in the United States, state legislation has focused on the issue of workforce, thanks to a few vocal groups that have devoted significant resources solely to the promotion of alternative workforce models that utilize lesser-trained non-dentists to provide surgical care to the most vulnerable populations, in a manner that is neither cost-effective nor shown to have produced positive population health outcomes. As the American Dental Association (ADA) stated in “Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce” (2011), we are “disappointed in... the degree to which the fixation on workforce, a deceptively ‘simple’ issue to grasp, has distracted policymakers and those who influence them from the much greater number and complexity of other barriers to care.”

Therefore, the AGD’s “Optimal Delivery of Oral Health Services through Primary Care: Comprehensive Workforce Policy Statement” (Statement), presented here, does not purport to identify the numerous barriers to care, nor does it purport to offer all their solutions. However, the purpose of this Statement is to present a cohesive perspective on the synergy and symbiosis of the dental workforce required for the optimal delivery of oral health care in the United States.

#### **Executive Summary Statement**

In medicine, the diversification of the workforce away from primary care and toward a proliferation of nurse practitioners and specialists has burdened the taxpayer with increased cost of care and has adversely affected patient health.<sup>1</sup> Conversely, 80% of the delivery of oral health care is provided through primary care – via general and pediatric dentists – enabling a focus on prevention that mitigates more serious and costly health conditions.

The AGD, along with the ADA, the American Academy of Pediatric Dentistry (AAPD), and other professional organizations, have long touted this philosophy of prevention through the concept of the dental home. “The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate” (AAPD, Policy on the Dental Home, 2012).

Unfortunately, many children, especially those who are poor or live in rural communities, have not seen a dentist by the age of 12 months. Moreover, visits to a dentist decline significantly in adult populations.<sup>2</sup> The inclusion of pediatric dentistry but exclusion of adult dentistry in the Essential Health Benefits (EHB) prescribed by the Patient Protection and Affordable Care Act (PPACA) may drive benefits allocations that further distort this statistic. Failure to see a dentist for preventable diseases has produced a heavy cost burden on emergency rooms across our nation. Additionally, economic woes such as unemployment may provoke migration of patient populations that may further affect the longevity and continuity of the relationship between a given dentist and patient. Moreover, the morphology of the dental practice is a complex and unpredictable study, as economic and other considerations drive the eruption of group practices and corporate practices. The AGD’s “Investigative Report on the Corporate Practice of Dentistry” (AGD Practice Models Task Force, 2013), presented many of these complexities and unknowns.

Therefore, while the dental home is at the heart of optimal oral health care delivery, a broader and more cohesive workforce concept must be defined to address the needs of the many who may meander their way into the oral health care system, if at all, through emergency rooms, medical practitioners, public schools, or knowledgeable friends, family members, or others in their communities. This concept is the “dental team concept.” The dental team concept is a comprehensive and optimal primary care model of oral health care delivery, under the supervision of a licensed dentist, and with the dental home at its core.

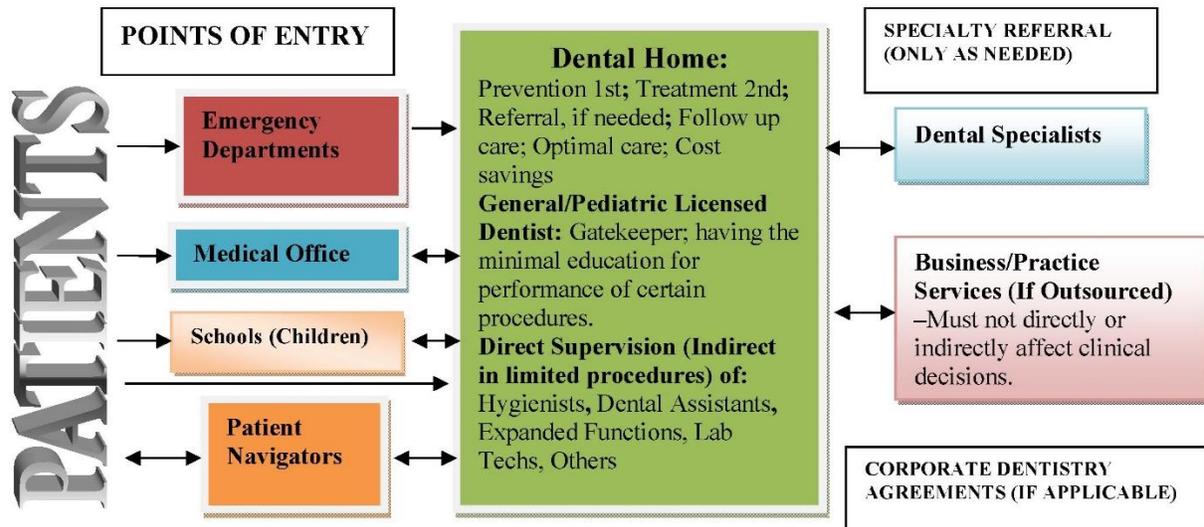
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1 In the United States, an increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons; adults with a primary care physician rather than a specialist had 33% lower costs of care after adjusting for demographic and health characteristics (Starfield, 2006). Patients with a regular primary care physician have lower overall health care costs than those without one (Weiss & Blustein, 1996; De Maeseneer, De Prins, Gosset, & Heyerick, 2003). Higher ratios of primary care physicians to population are associated with reduced hospitalization rates (Parchman & Culler, 1994). Patients with a regular primary care provider have 19% lower mortality (Franks & Fiscella, 1998), are 7% more likely to stop smoking, and are 12% less likely to be obese (Arora, et al., 2009). Advisory Committee on Training in Primary Care Medicine and Dentistry. *The Redesign of Primary Care with Implications for Training*. Eighth Annual Report to the U.S. Department of Health and Human Services and to the U.S. Congress. January, 2010.

2 According to 2011 statistics provided by the U.S. Centers for Disease Control and Prevention, while 81.4% percent of children ages 2-17 had at least one dental visit in the previous year, that percentage dropped to 61.6% for adults ages 18-64. Retrieved from <http://www.cdc.gov/nchs/fastats/dental.htm> (January, 2014).

## **Reference Diagram:**

The following diagram provides a visual representation of the dental team concept to include a snapshot of contemporary considerations in the delivery of oral health care and the role of the dental home therein. However, the points of entry or other representations in the diagram are not intended to be limiting in the scope of the concept or in the position of the AGD.



## **Definitions:**

**General Supervision:** The level of supervision in which dentist is not present in the dental office, but has authorized the procedures and they are being carried out in accordance with his/her diagnosis and treatment plan.

**Indirect Supervision:** The level of supervision in which the dentist is in the dental office, authorizes the procedure and remains in the dental office while the procedures are being performed by the auxiliary.

**Direct Supervision:** The level of supervision in which the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and, before dismissal of the patient, evaluates the performance of the dental auxiliary.

**Personal Supervision:** The level of supervision in which the dentist is personally operating on a patient and authorizes the auxiliary to aid his/her treatment by concurrently performing a supportive procedure

**Dental Auxiliaries** – Persons including dental assistants, dental hygienists, dental laboratory technicians, expanded function dental assistants or hygienists, and dental therapists or other ‘midlevel providers’ in states where they are sanctioned by law, and all other individuals who are not licensed dentists, but otherwise provide oral health care.

Dental Home - “The ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate” (AAPD, Policy on the Dental Home, 2012)

Dental Team Concept - A comprehensive and optimal model of oral health care delivery, with a focus on primary care dentistry under the supervision of a licensed dentist, and with the dental home at its core.

### **Policy Statement**

The AGD believes that the dental team concept provides the optimal model of oral health care delivery, and further, that the dental team concept must be consistent with the following workforce principles:

1. The dental home, where dental services are provided only by or under the direct or indirect supervision of a licensed dentist, is the core principle of the dental team concept regardless of the economic or rural status of the patient, or the size, structure, or business agreements of the dental practice.
2. Dental procedures that are surgical and irreversible must only be administered by a licensed dentist (personal supervision) and not relegated to an auxiliary. A procedure is surgical and irreversible if an attempt of performance of the procedure carries with it any risk of an irreversible adverse consequence. Therefore, excavation of decay would fall within a surgical and irreversible procedure.
3. Increased number and use of auxiliaries within the dental home, including expanded function auxiliaries, whereby the auxiliaries act only within the direct or indirect supervision of the licensed dentist when providing dental services, increases the capacity of the dental home.
4. Dental disease is preventable, and prevention creates a lesser cost burden to the patient and the public than treatment. Accordingly, resources should be dedicated to establishing patient navigators within communities, whereby the duties of patient navigators are increasing oral health literacy, converting literacy to action, and providing patient transportation, and not the provision of dental care without the education and license of a dentist.
5. Emergency department dentistry adds a significant economic cost to the patient and the public, and must be mitigated by use of the dental home. Accordingly, the dental team concept requires collaboration between hospitals, medical practitioners, and the dental home, to ensure a transition of the patient from a treatment cycle to a prevention focus. The dental team concept requires referral to and follow-up care by the dental home after dental-related visits to medical practitioners or hospitals, and continued communication between the dental home and patients’ medical practitioners.
6. Any agreements between a dental practice and outside entities for the management of business or practice services must not, directly or indirectly, transfer clinical decisions to one who is not a dentist licensed in the state. Indirect transfer is a transfer that could result from provisions that place necessary clinical decision-making for optimal patient care in conflict with business protocols for continued employment or income of the practicing dentist or auxiliaries.

7. The dental team concept consolidates the oral health care needs of the patient through the dental home, and therefore, provides continuity to the patient's care. Where access and utilization have been identified as challenges, this consolidation creates a lesser burden on the patient to know where to go for care. On the other hand, increased specialization and implementation of unsupervised or generally supervised practitioners operating outside of the dental home, fragments care and places the burden on the patient to seek multiple points of entry into the oral health care system. In the dental team concept, the general or pediatric dentist serves as a gatekeeper of referral needs and the central nervous system of the patient's oral health care network.

## **Conclusion**

In considering the current debate concerning the dental workforce, the AGD remains vigilant in its recognition that patient needs for better oral health, for quality care, and for treatment by those who are sufficiently educated to provide proper care, cannot be compromised. Further, as an organization of dedicated and educated professionals with a responsibility to the public, the AGD strongly feels that it would be negligent to refer this responsibility to the political tides of each state legislature. The AGD believes its core principles and values are in the best interest of its patients and the profession and is pleased to have had this opportunity to address the evolving face of dentistry, and find a cohesion within that evolution to enable dentistry to expand its reach as the beacon for low-cost patient-first preventive healthcare in the United States.