Midlevel providers: Risky business or access-to-care cure?

ADA-sponsored reports prompt more discussion

By Robert Selleck, Managing Editor

A focus on midlevel dental providers as a core response to dental care access challenges might be better directed elsewhere because the business models in play aren’t sustainable. That’s what the American Dental Association is saying based on a consulting company’s examination of three midlevel workforce models under consideration in five states.

But at least two dental organizations responding to the report’s conclusions show there are plenty of other opinions about the viability of a midlevel-provider workforce and the benefits such professionals can provide to underserved populations.

The American Association of Public Health Dentistry (AAPHD) and the American Dental Hygienists’ Association (ADHA) issued statements that question the ADA’s conclusions. Both organizations ask why dental-school-graduate numbers are expected to increase, workforce expansion is the wrong strategy to use to address the shortage of dentists in the aggregate, and because dental-school-graduate numbers are already practicing. Various other questions about the research methodologies and underlying assumptions also were raised by the two organizations.

The ADA-commissioned report examines proposed midlevel workforce models in Connecticut, Kansas, New Hampshire, Vermont and Washington. It itemizes detailed financial projections for various business models for Dental Health Aide Therapists (DHAT), Dental Therapists (DT) and Advanced Dental Hygiene Practitioners (ADHP). Revenue and expense projections are based on different combinations of public and private payment-for-services scenarios. The midlevel provider’s education debt also is factored into the analysis.

The ADA has consistently fought the midlevel provider concept, arguing that it is not in the best interest of patients to permit irreversible dental procedures, such as tooth extractions and major restorative work, to be performed by non-dentists. It also has argued that because there is no midlevel provider concept, arguing that it is not in the best interest of patients to permit irreversible dental procedures, such as tooth extractions and major restorative work, to be performed by non-dentists.
‘Turn off that phone!’

How do managers deal with cell phone usage in the office?

By Heather Colicchio and Teresa Duncan, MS, FAADOM

The membership of the American Association of Dental Office Managers (AADOM) is composed of individuals who have first-hand experience dealing with situations that would make many people cringe. Some of the most common questions that emerge on our AADOM member forum deal with the rise of text messaging and personal calls in the office. We love text messaging and phone calls, but not so much among our staff.

We asked several of our AADOM members to answer this hot potato question.

How do you handle your team when excessive texting and phone calls are an issue? Is there an example you’d like to share?

Melanie Duncan: To text, or not to text—that is the question! I love technology, but sometimes it can be a detriment to your team. Believe me I have seen it all! There is the hygienist who is texting while a patient watches a CAESY video or the team members have to keep their phones on them in case of an emergency. Really? Are they trying to say that the front office team cannot handle passing on a message? The answers are simple.

1) Make sure there is a policy in your employee manual that is clear and to the point.
2) Have the employee sign an agreement to leave his or her phone in the break room.
3) Expect 100 percent compliance!
4) Address any situation immediately with no exceptions allowed.

There will be a list of excuses, but as long as you are consistent with your actions, technology will once again be your friend.

Lisa Spradley: Our office allows cell phones and text messaging as long as it does not interfere with your patient flow. However, when cell phones were first brought into the practice there were problems with rampant usage. We would have employees coming into the office with the cellphone to their ear and clocking in, and they would stay on the phone until they were ready to seat the patient. This was unacceptable.

After a discussion with the doctor, we decided that while we did not want to completely ban cell phones, we did need some basic guidelines. When employees come into the office and click in, they should not be on their phones. Also—while texting in between patients is OK—it must not delay patients being seated or rooms being cleaned.

No one is allowed to be on their cell phone or texting if they have a patient in the room. These guidelines helped to keep our patients as the No. 1 focus in our practice.

Deanna Alexander: Simply put, it is stated in our office manual. No cell phones are allowed in our work area. Each staff member has his or her own personal cubby space in the staff lounge area, this is where the cell phones belong. Everyone respects this policy.

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PRACTICE MATTERS

Access-to-care problems. Acknowledging that the recently released reports are simply a “first step,” ADA representatives said that the detailed economic analysis was a new way of analyzing the viability of various midlevel provider models as a possible solution to access-to-care challenges for uninsured populations. The work was described as the most comprehensive economic analysis to date.

The Academy of General Dentistry issued a statement that “applauds” the ADA’s position that mirrored the ADA’s take that increasing the number of providers may not be the best way to address access-to-care challenges because of a more critical need to address Medicare reimbursement shortfalls, transportation issues and inadequate prevention education.

Supporters of midlevel-provider licensing said they agree with the ADA and AGD positions regarding many of the access-to-care challenges that will continue to exist due to success or failure of efforts to create a midlevel workforce.

In April the W.K. Kellogg Foundation released findings from a review of clinical outcomes experienced by dental therapists practicing in 34 countries using such providers to address access-to-care challenges. The report’s principal author, David Nash, DMD, MS, EdD, is the William R. Wilsosn professor of dental education and a DMD, MS, EdD, who is the William R. Wilford professor of pediatric dentistry at the College of Dentistry at the University of Kentucky. Nash said, “None of the 1,100 documents reviewed found any evidence of compromise to children’s safety or quality of care. Given these findings, the profession of dentists should support adding dental therapists to the oral health care team.”

In December 2010 the Pew Center on the States released a report that was favorable toward the concept of using dental therapists to improve access to dental care, especially for Medicaid patients.

The ADA and AGD both questioned a number of underlying assumptions and data on dental practice operations and demand for services and other aspects of the research methodology in both organizations’ reports.

The Comprehensive Dental Reform Act of 2012, introduced in June by Sen. Bernard Sanders, I-Vt., and Rep. Elijah Cummings, D-Md., proposes a variety of programs to enable dental professionals to deliver care to people outside of current care-delivery models—including the use of midlevel dental care providers. While supportive of the act’s intent, the ADA and AGD have challenged its midlevel provider provisions.

(Sources: AADOM, ADA, ADAH, AGD, W.K. Kellogg Foundation, Pew Center on the States)

The ADA and AGD agree that gathering more information is a first step in assessing the viability of midlevel dental professionals.

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