

ADEA is developing principles that can help programs maintain high standards for the education, preparation, accreditation, and competency of new oral health professionals.

In this month's letter, Dr. Rick Valachovic, Executive Director of the American Dental Education Association, introduces us to the newest members of the oral health care team and shares recent news about these new professionals.



New Oral Health Professionals 101: Meet Your Future Colleagues

Does the term "new oral health professional" ring a bell? Maybe not. There are so many other names out there referring to the different oral health providers that have begun to emerge in recent years. Whatever term our professions finally settle on, these new providers are a prominent topic of discussion and debate right now. For the moment, let's use "new oral health professionals" to discuss the range of new provider types that are being established in pockets around the country.

This year has seen a flurry of activity around these new providers. An ADEA task force is forging agreement on guiding principles for the education of new oral health professionals, Minnesota granted provisional approval for two dental therapy programs in the state, the W.K. Kellogg Foundation released a report evaluating the Alaskan Dental Health Aide Therapist model, and many in organized dentistry engaged in vigorous debate on how they should respond to the development of new provider types. More on all this later. First, I realize many of you may be only vaguely aware of who these new oral health professionals are, so let me introduce you to your future colleagues.

[Dental Health Aide Therapist \(DHAT\)](#)

The [Alaska Native Tribal Health Consortium](#) paved the way for the introduction of new oral health professionals in the United States in 2003. The first ones, called Dental Health Aides, are recruited from the local community, and each is equipped to provide culturally appropriate educational, preventive, and safety net services that are most needed by the residents of Alaska's federally designated territories.

The most highly trained of Alaska's new professionals are Dental Health Aide Therapists (DHATs). DHATs receive two years of post-high school training followed by a preceptorship lasting a minimum of 400 hours. The supervising dentist determines when the DHAT is ready for certification and practice and assigns individual standing orders. These orders typically include a range of preventive services, basic restorative procedures, and uncomplicated extractions under the general supervision of a dentist.

Most tribal health corporations deploy DHATs remotely under a dentist's general supervision, but some corporations have DHATs and dentists working side by side. Both arrangements free dentists to perform higher-level services such as endodontic therapy, prosthodontic care, complicated extractions, and orthodontic interventions that were once precluded in Alaska Native communities by the overwhelming need for basic restorative services.

[Community Dental Health Coordinator \(CDHC\)](#)

The [American Dental Association](#) (ADA) first proposed the creation of a new member of the dental health team in 2006. Three years later, it rolled out a pilot curriculum and began training a dozen students. CDHCs receive 12 months of online course work delivered by [Rio Salada College](#) in Arizona and in-person training at clinics affiliated with academic dental institutions in Oklahoma, Pennsylvania, and California. This course work is followed by a six-month internship. The first group of CDHCs completed training this fall, and the second group is scheduled to graduate next year.

CDHC students come from the same underserved communities in which they will work. Their scope of practice is limited to providing oral health guidance and specific clinical dental services, such as dental screenings and fluoride treatments, under the supervision of a dentist. The pilot curriculum is being tested in three distinct settings: one rural, one urban, and one Native American.

[Advanced Dental Hygiene Practitioner \(ADHP\)](#)

The Advanced Dental Hygiene Practitioner (ADHP) is the [American Dental Hygienists' Association's](#) (ADHA) response to addressing the nation's unmet oral health needs. The ADHA compares the role to that of a nurse practitioner in medicine and defines the ADHP as a licensed dental hygienist educated at the master's degree level "in health promotion and disease prevention, provision of primary care, case and practice management, quality assurance, and ethics, which will provide a comprehensive approach to the delivery of oral healthcare services."

The clinical scope of practice envisioned for the ADHP would build upon a dental hygiene scope and include other preventive and therapeutic services, minimally invasive restorations, and limited prescriptive authority. These professionals are expected to practice in rural and other underserved settings. The model requires that ADHPs work in partnership with dentists for referral and consultation.

[Minnesota Dental Therapist \(DT\) and Advanced Dental Therapist \(ADT\)](#)

In fall 2009, Minnesota enrolled its first cohorts of students in programs designed to produce new oral health professionals who could serve low-income, uninsured, and underserved patients or patients in Minnesota's dental health professional shortage areas. The state's only dental school, the [University of Minnesota School of Dentistry](#) (UMSD) is offering both a bachelor's and a master's degree program designed to prepare DTs.

[Metropolitan State University](#) (MSU) in partnership with [Normandale Community College](#) is offering a combined degree-completion and master's degree program for licensed dental hygienists who want to become licensed DTs and obtain ADT certification. Their curriculum aligns with the competencies for the ADHP described above as well as [ADEA's Competencies for the New General Dentist](#) that relate to the DT and ADT scope of practice.

The Minnesota Board of Dentistry has published scopes of practice for [the DT](#) and [the ADT](#). The DT scope includes a broad range of preventive and educational functions, which may be performed remotely under the general supervision of a dentist, and a number of restorative functions, which must be performed under the indirect supervision of a dentist on site. DTs may also dispense and administer analgesics, anti-inflammatories, and antibiotics. ADTs may perform all DT functions under general supervision. In addition, they may assess dental disease and formulate individual treatment plans authorized by the collaborating dentist. Both DTs and ADTs work pursuant to a collaboration management agreement with a dentist who may place additional limitations on the therapist's scope of practice.

This past summer, the Minnesota Board of Dentistry voted unanimously to grant "provisional approval" for both dental therapist programs. The next step for Minnesota is to develop a clinical licensure examination for these new providers. The Minnesota Board of Dentistry is working on this with the Central Regional Dental Testing Service (CRDTS).

In other new oral health professional news, the [W.K. Kellogg Foundation](#) released an [evaluation report](#) in October that examined the Alaskan DHAT model. Among its key findings:

- Dental therapists are technically competent to perform the procedures within their scope of work and are doing so safely and appropriately.
- They are consistently working under the general supervision of dentists.
- They are successfully treating cariously involved teeth and helping to relieve pain for people who often had to wait months or travel hours to seek treatment.
- Patient satisfaction with their care is high.
- They are well accepted in tribal villages.

In keeping with their concerns about the need for and safety of the DHAT and other new oral health professional models that include restorative functions, the [American Academy of Pediatric Dentistry](#), the [ADA](#), and the [Academy of General Dentistry](#) questioned the validity of the Kellogg study.

Unfortunately, the lack of consensus around new oral health professionals and the inconsistency in defining their roles pose serious challenges for the academic dental community. To begin to address these, the ADEA Board of Directors formed a Task Force on the Education of New Oral Health Professionals in 2010 and charged the group with developing Guiding Principles that can help programs maintain high standards for the education, preparation, accreditation, and competency of new oral health professionals.

In June of this year, draft principles were discussed at the ADEA Invitational Allied Dental Education Summit and the meeting of the ADEA Council of Allied Dental Program Directors. Further discussion took place at the meeting of the ADEA Institute on Policy and Advocacy and our Association's other meetings this fall. The final principles will be presented to the ADEA Board of Directors for approval as interim policy in January 2011, and then will be transmitted for consideration by the ADEA House of Delegates next March. They represent a concrete effort to help our member institutions provide the best possible education to new professionals as they emerge.

As I've said before, developing new workforce models falls outside what you might call ADEA's scope of practice, but we hope the institutions, organizations, and

policymakers that are designing new workforce models will consider ADEA's Guiding Principles during their planning and decision-making. We will be watching closely to see the extent to which each of the new oral health professionals expands access to high-quality oral health care in the years ahead. In the meantime, we all have a stake in seeing that they receive the best education possible.



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