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Dr. Marc B. Cooper

CAN'T GET THERE FROM HERE

The Futile Attempt to Resolve the Access Issue

Access to dental care has been declared a public health issue. Addressing barriers to access began early in 2008 in California since this state demonstrated the most prominent access issues for its population of 36 million. Over half of California's population consists of ethnic minorities. There are only 4,000 dentists available to serve the patients who qualify for Medi-Cal and another several thousand dentists willing to serve the over-million-plus children through their CHIP (California Children's Health Insurance Pro-gram). But due to California's woeful economic situation, many of these programs are being severely cut. Add to this another 10 million Californians who do not have dental insurance and it has been reported that over 300 areas have been designated as dental professional shortage areas. In short, California has a very large population in need of dental care and significant obstacles to accessing care.

So the CDA began to address the access problem in October 2008, throwing workforce groups, taskforce groups, subcommittees, including public health and well regarded academicians at the access problem. With California's lead, access to dental care soon became a nationally recognized issue which then prompted national, state and regional dental organizations to become engaged.

Shortly after, a national group known as The Boston Group was formed. Observing the legislative process that created another kind of dental provider in Minnesota to address their access problems, California, Washington and Oregon explored more proactive approaches to alter the dental workforce in these states. Soon Connecticut, Maine, Massachusetts, Minnesota, New Hampshire, Rhode Island and Vermont, and later Missouri and New Mexico, joined this Boston Group. Representatives from each of these state dental organizations met several times in Boston.

This group reviewed the duties of dental assistants (DAs), registered dental assistants (RDAs), expanded function dental auxiliaries (EFDAs), and registered dental hygienists (RDHs). They proposed new models of care delivery including Advanced Dental Hygiene Practitioners or Oral Health Practitioners (OHPs) and Mid-level Dental Providers. They received lots of presentations, engaged in off-line, electronic and network conversations, and then made recommendations.

In March 2009, the ADA convened an Access Summit with representatives from a number of communities interested in the issue of access and improving oral health. The purpose of this summit was to address what the profession was going to do to assure oral health through prevention and treatment for underserved populations. They were able to articulate a common vision, identify new approaches to address the disparities in access and began to draft an implementation plan.

In May 2009, The PEW Charitable Trust released a report "Help Wanted: A Policy Maker's Guide to New Dental Providers." The report recommended improving access through expansion of the dental workforce. Their conclusion, "New thinking and actions are needed to respond to the serious dental access problem facing the United States."

So, at this time, everyone recognizes we have a dental access problem and we need to address it. Everyone understands this is a serious public health issue. Recommendations and a number of activities abound, but little is really being done. Why? Because dentistry is dominated by dentists in private practice and what is not being addressed is the current culture and context of the over 140,000 dentists and the institutions and organizations that directly support them.

The context of practicing dentists is not public health. The context and culture which private practice dentists think, act and operate within is small, for-profit business. Nearly all dentists are acculturated and trained in doing highly technical work to restore health and beauty to patients who can pay for it. The dental schools, graduate programs, national and state dental meetings, the CE programs, the consultants, the journals, magazines and periodicals, the vendors and suppliers all promote and reinforce this culture and strengthen this context. Inside this context, inside this culture, access is not an issue.

Context is decisive. Culture is superior-ordinate. Ideologies, philosophies, commitments, language, and perceptions are clearly different between the two domains of business and public health. Few dental students graduating today have any intention of addressing the access issue. What they are primed for is private practice and making a good living. What do you think will be dentists' attitude about creating other forms of providers in dentistry, such as super hygienists or mid-level providers? Look at history - denturists, independent RDAs, dentists from other countries or even other states. What is the predictable response?

Sure there are hundreds of community clinics and thousands of volunteer activities in many dental communities. But when it comes to access, the number of clinics and the real level of dental care available through volunteerism are woefully inadequate to address the access issue. What's being done today is analogous to trying to put out a burning ten story building with a few buckets of water.

Ultimately what is needed is a transformation of the system, a shift in context. And given what the stakeholders with the money currently have invested in the current system, access will remain an issue until the Federal government brings its heavy hand down on the profession and makes it do something.

CAN'T PUT IT BACK IN THE BOTTLE

The Push for New Dental Professionals

It's a done deal. Game over. One more stake in the ground. You can add to the new classes of dental professionals, California's registered dental assistants who are now enabled to deliver extended services (RDA-EF2). These new dental providers will have the widest scope of functions of any dental assistants in the country.

Starting January 1, this new category of assistants will be able to place all types of restorations - direct and indirect, alloy and composite - and even endodontic points. In short, these RDA-EF2s can do anything a dentist does to restore a tooth except administer anesthesia and remove tooth structure.

A recent report states there are currently 1,400 RDA-EFs in California that can take impressions and place provisional crowns, but not deliver permanent restorations. Two schools in California are offering courses to become an RDA-EF2: the University of California, Los Angeles and Sacramento City College.

The requirements to become one of these mid-level providers, however, will not come easily. To become an RDA, you will have to complete a series of courses and pass an exam. If you then want to add extended functions, you must take an additional 388 hours of instruction and pass an exam. Current RDA-EFs who want to become RDA-EF2s will have to take 280 additional hours and pass an exam.

The scope of dental assistant practices varies dramatically from state to state. Utah, for example, forbids assistants place any type of restoration, whereas Ohio expressly allows most of what the California RDA-EF2s can do, except place endodontic points.

The list of states allowing hygienists to do restorations is longer. According to the American Dental Hygienists' Association, Colorado, New Jersey, and Washington allow hygienists to place temporary crowns and fillings and permanent amalgam and composite resin fillings. Hawaii, Texas, Utah, Louisiana, and Delaware, on the other hand, bar hygienists from all of these procedures. Most other states allow some restorative work, but not all. Several states neither explicitly forbid, nor clearly allow, auxiliaries to perform restorative procedures, leaving their scope of duties open to interpretation.

Dentists in California resisted the notion of mid-level providers until recently. And the CDA stood firmly against this kind of dentistry. But due to the access issue and lack of available dental providers, the CDA caved. Now the CDA has rationalized their support by saying these RDA-EF2 providers will actually enhance private practices by providing more care and allowing them to make more money. Nice spin. They've created a new definition, "four-handed dentistry," whereby the dentist relies on assistants to do a larger portion of the work they would traditionally do for a fee.

Context is decisive. Disruptive change causes a shift in context. Access to dental care has now been recognized as a public health issue. Access to dental care has move to the political arena. And this public and political declaration is causing a disruptive change.

Once there has been a contextual shift, things can never go back. Personally, I see this as a huge business opportunity. Given that my work is educating and coaching dentists to become highly competent leaders, owners and managers of a business enterprise, growing dentists to develop a business that includes mid-level providers is clearly achievable. I currently have a number of clients who own and manage large dental operations as well as number of community clinics on my lines. With my background in corporate consulting, I can envision a number of exciting possibilities.

The biggest problem for the majority of today's practicing dentists will be their weakness as managers. This weakness might explain why most dentists practice solo, why the number of solo practices has remained relatively constant for decades. The solo practice has few people to manage. Dentists like to work with teeth, not people. But it will be those dentists who can master management, allowing dental care to be delivered through others, who will succeed in this new context.

Given that training and developing dentists as effective managers is my primary job, guess I won't be retiring for a few more years.

REFERENCES

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Overview of Mid-Level Provider Models by Michael Payne;
http://www.asdanet.org/uploadedFiles/The.../Dental%20Therapist%20Article.doc

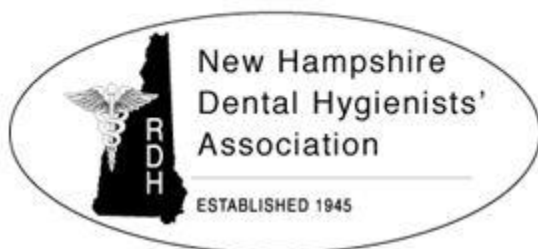
California Dental Association Website;
http://www.cda.org/advocacy_&_the_law/issues_&_policies/denti-cal_government_programs/

Dr Bicuspid; http://www.drbicuspid.com/index.aspx?sec=def

AS THE WORLD TURNS

Legislation is Paving the Way

Health care legislation has passed. Access as a problem will become very real. Addressing access through mid-level providers will most certainly occur. In fact, it's picking up speed. Inertia is increasing. Announcements like the one below are appearing more and more frequently.



Last week, the Joint Legislative Committee on Administrative Rules (JLCAR) approved a rule that will allow dental hygienists under public health supervision to apply sealants, without a prior examination by a dentist. The rule went to JLCAR after a 7 to 1 vote by the Board of Dental Examiners (BODE) in September, after more than a year and a half of study, subcommittee meetings and work sessions.

Now that JLCAR has given its stamp of approval, the last procedural step before the sealants rule takes effect is for the BODE to file the final rule with the Office of Legislative Services. We expect that will happen shortly.

The adoption of the sealants rule is a huge step forward for preventive dental healthcare in the state of New Hampshire. According to the Center for Disease Control, "...only about one-third of children aged 6-19 years have sealants. And, although children from lower income families are almost twice as likely to have decay as those from higher income families, they are only half as likely to have sealants." NH hygienists will soon be able to provide services to more children who now needlessly suffer from tooth decay.

NHDHA applauds both JLCAR and the BODE for their consideration and approval of this important preventive measure.

Susanne Kuehl, President
New Hampshire Dental Hygienists' Association

What does this mean to long-established, traditional dental practice? Everything! Can dentists succeed in this new context? Yes. They can if they become outstanding managers. The biggest obstacle is that most practicing dentists detest management and are only happy when they're working at the chair. Management is something they 'have' to do, not something they 'want' to do. Management is the first thing they want to give away to some staff member. Almost a decade of data from our "Dentist Satisfaction Assessment" reveals that most dentists consider management their weakness and not their strength.

Commonly, management is the area of the practice which is least developed and the most neglected. In our Staff Satisfaction Surveys and our Dentist Performance Reviews, staff invariably rates management the lowest. Can you imagine adding numbers of mid-level providers and support staff to an area that is already poorly performing? Talk about a bigger mess!

My work with clients in the arena of management has always been successful because it begins by transforming who dentists are as managers. I shift how the dentist sees management from a burden to an opportunity. And in my experience, unless this fundamental shift occurs, it doesn't matter how many techniques, scripts, job descriptions, performance reviews or any methods or materials you have, management can never be made to work.

These changes in dentistry will occur over the next few years. How will they exactly look, no one is sure. But one thing I am sure of is those dentists who master management and who become truly effective managers will succeed.

RECOMMENDATION

If you are interested in beginning to explore becoming a more effective manager of a dental practice, I suggest you start by reading the following:

- Mastery the Business of Practice - Cooper
- Valuocity – Cooper & Silberg
- The Five Dysfunctions of a Team – Lencioni
- The Three Signs of a Miserable Job - Lencioni
- The One Minute Manager – Blanchard

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