The Dental Therapist Movement in the U.S.

Dental Therapists Can Help Improve Oral Health Equity

A Conversation with Frank A. Catalanotto, DMD

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Please note that the opinions I share in this presentation are my own and do not necessarily represent the official viewpoints of any organization with which I am affiliated.

JADE sat down recently for a discussion with Frank A. Catalanotto, DMD, professor of community dentistry and behavioral science at the University of Florida College of Dentistry, about the value of dental therapy in the United States. Dr. Catalanotto began by noting that *"Any discussion of dental therapy in the United States must start with a shared understanding of the facts related to implementation in the United States over the past 20-plus years. When presented with opinions opposing dental therapy, I always say the following, 'Here are my conclusions based on this evidence; if you have other conclusions, let's see your evidence.' "*

He added that when opponents of dental therapy tend to express their thoughts, opinions, and feelings in opposition to dental therapy, they do so without citations, references, or objective data. Opponents use phrases like "irreversible surgical procedures" and anecdotes shared with legislators by specialists who provide dental care to medically fragile patients ignoring the fact that most dentists are reluctant to treat such patients and instead rely on myths and misrepresentation of existing data to argue against dental therapy. Proponents of dental therapy base their support on a long list of publications, reports and objective data[1] plus direct observations of the real-world successes we are seeing every day.

Dr. Catalanotto's responses to a series of questions are below.

Should the dental therapist be a dental hygienist or non-dental hygiene based?

The evidence is clear from both Alaska and Minnesota that both models of dental therapy can provide high quality, safe, and cost-effective dental care.[2,3] The Commission on Dental Accreditation (CODA) dental therapy educational standards and the National Model Act for Licensing or Certification of Dental Therapists do not require training in dental hygiene. It is also important to consider the history of both programs in pondering this question. The Alaska model was developed with a goal of training local people to practice in their communities with accessible and affordable educational requirements; the development of this program was not subject to the compromises and politics of the legislative process. The Minnesota model, while working very well and effectively, resulted from statewide legislative negotiations between at least three disparate factions: the dental association trying to kill the legislation, the dental hygiene association vying to create career pathways for dental hygienists, and the grassroots coalition seeking to improve access to dental care for underserved populations. The compromised result was a four-year master's level dental therapist. I believe there is a tangible cost to students for attending a four-year program compared to a three-year academic year program, such as Skagit Valley in Washington, or the two full-time calendar year program as in Alaska.

It is unclear from the early dental therapy education programs whether in fact university-based programs will or will not be more expensive than state/community college-based programs. For just tuition and fees, the two-year Alaska program costs about $42,370 for tuition and fees while the three-year Skagit Valley program in Washington costs about $112, 923, and the 32-month program at the University of Minnesota costs about $90,000 in tuition and fees plus a year of prerequisites. Finally, the two college-based programs for dental hygienists range between $44,000 and $60,000.

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The Minnesota legislation does not require dental hygiene training; the practical reality is that, going forward, all dental therapists in Minnesota will have dental hygiene training. When regulations require more education than necessary, it may create unnecessary barriers, and it is these kinds of potential barriers that might disproportionately affect those from lower socioeconomic status and people of color. Having said that, the evidence from the University of Minnesota shows that with institutional commitment, it is possible to have strong diversity in a university setting. I also recognize and applaud the fact that dental hygienists in Minnesota can attain dental therapy education in about 18 months, and I anticipate we will see more of this model in other states. My support for the minimal requirements of the CODA standards in no way is meant to criticize the evidence of the successes of the Minnesota model.

What, if any, should be practice restrictions? For example, statewide vs. shortage areas only or direct vs. general supervision?

I see direct advantages in requiring some level of service to underserved populations, such as in Minnesota; this guarantees that the populations most in need will receive care. I have concerns about removing this requirement in Dental Health Professional Shortage Areas because there is no guarantee that those most in need will receive care from the dental therapists.

With respect to supervision levels, to me, the real power of dental therapists lies in general supervision with a collaborative practice management agreement with the supervising dentist. The ability to provide care in remote regions of Alaska or in school-based programs in Minnesota are examples of cost-effective care.

Address educating dental therapists and the standardization of education including CODA guidelines.

The development of CODA dental therapy accreditation standards was a watershed moment, a tipping point, in the evolution of dental therapy as a profession, as was the National Model Act for Licensing or Certification of Dental Therapists. I have been very concerned about the implementation of dental therapy legislation across the country that uses its own model with different educational requirements and different rules for implementation. This will negatively impact portability, which is a critical issue in our mobile society. I can also foresee infighting in the profession with individuals who have different training experiences promoting what is good for them rather than for society.

What amount of education is necessary? For example, certificate, associate, bachelor's, master's, or doctoral degree?

In general, the regulations for dental therapy education should outline the minimal requirements--those that are highly likely to be effective, create the fewest barriers and provide the most good for the most people at the least cost to society. However, programs can always choose to go beyond the minimum requirements if they want or can afford to. We cannot ignore the cost of education when we perform a cost-benefit analysis of health profession expansion. *My bottom-line observation is that dental therapists need the amount of education necessary for them to serve their patients within their scope of practice.* The evidence from Alaska is unequivocal: dental therapists can be successfully educated in a two- or three-year program that meets the CODA standards and with certification or an associate degree. *There is absolutely no need for a higher degree except for those who might seek educational, research or administrative/management positions.* Such a requirement for the practicing dental therapist only serves to make the educational program more expensive and out of reach for the communities we want to attract to the profession.

What are your thoughts on the long-standing model of care by transient dental providers vs. the dental therapist model living in villages or rural areas where they practice?

Philanthropy and episodic care are not models of care. Home grown health care practitioners who live and work in communities of need, such as dental therapists in Alaska, are the right model of care. Enough said.

I have one closing observation. It appears to me that many academic dental institutions have not raised the

topic of dental therapy in their predoctoral curriculum. They have not presented the evidence to their students, and they have not been laboratories for demonstration projects based upon the evidence. They have not offered continuing education courses to practicing dentists. They have not acted on their responsibility to advocate within their communities and with policy makers for this high-quality, cost-effective tool to help achieve equity and access. Why is that? Is it fear of pressure from organized dentistry and alumni? I know this to be true in some cases. Dentistry is supposed to be an evidence-based profession, however the approach of many academic dental institutions to dental therapy would suggest this is not so.

In closing, I would like to point out one of the major advantages of the University of Minnesota dental therapy educational program. It takes place within their dental school so that dental students and dental therapy students learn together in the classroom, laboratories and in clinics. Based on the anecdotal evidence I have seen and heard, this is most likely why Minnesota dentists are enthusiastically hiring dental therapists. This suggests to me that local college-based programs should make efforts to collaborate with dental schools where possible to allow both student groups to work together.

References

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3 Langelier M, Surdu S, Moore J. The Contributions of Dental Therapists and Advanced Dental Therapists in the Dental Centers of Apple Tree Dental in Minnesota. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; August 2020.

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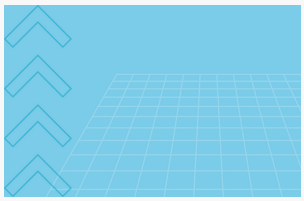

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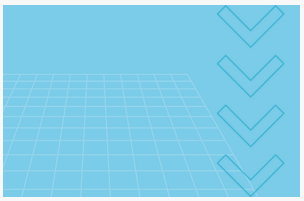

The Dental Therapist: A Century of Controversy