Processes and Perspectives: The Work of ADHA's Task Force on the Advanced Dental Hygiene Practitioner (ADHP)

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Since ADHA disseminated a document outlining specific competencies for an advanced dental hygiene practitioner (ADHP) in March 2008 (hereafter called "the ADHP competency document"), questions have arisen regarding the model underlying the ADHP's scope of practice and educational level, as well as reasonable paths for currently licensed dental hygienists to achieve these competencies.[1] The paper published in the current issue of JDH[2] serves as the most recent description of an alternate model for an oral health mid-level provider; the author questions certain aspects of ADHP education and practice. Certainly, members of the ADHA Task Force would agree with many statements in the paper, especially that existing literature and a long history of practice in other countries strongly suggest that non-dentists can learn to provide care using treatment procedures traditionally limited to dentists, at a level of quality equal to dentists.

In comparing the 2 proposals and evaluating the feasibility of each within the United States health care system, however, a critical reader must consider carefully: 1) processes used to develop the ADHP document and content of both proposals; 2) existing needs for dental care within U.S. populations likely to be served by the mid-level provider; 3) the cultural context of educational and care delivery systems into which the new U.S. mid-level provider must fit; and, 4) pragmatic issues surrounding adoption of a new provider. Thus, the purpose of this paper is to provide additional background regarding the processes and certain crucial perspectives used in developing the ADHP competency document.

Development of the ADHP Document

Work on the ADHP competency document stretched over 3 years, and began with the vision of extending primary oral health care to all. The ADHP Task Force of ten dental hygienists represents 9 different states (ID, MD, MI, MN, NJ, NM, TN, VA, WA); its composition reflected the current range of dental hygiene educational settings and legal definitions of dental hygiene practice. Early and often, the group reviewed: 1) relevant published literature, particularly research and evaluation; 2) curricula for existing mid-level dental providers in other countries and for expanded dental hygiene practice within the U.S.; 3) governmental and organizational policies likely to affect the new provider; and 4) other materials that provided information important for creation and acceptance of the ADHP. Examples of these latter materials included: Data on dental needs, demand for care, and dental personnel trends; history and current education of the nurse practitioner; and expert opinion on future dental scenarios.

The Task Force began by identifying competencies the ADHP must possess, if the provider is to help resolve current impediments to access. Periodically, drafts were submitted to an advisory group comprised of persons representing diverse backgrounds and holding a range of beliefs regarding mid-level providers, as well as to the ADHA Board of Trustees and to ADHA members. The Task Force received numerous comments from these multiple reviewers, thoughtfully considered all of them, and revised the document accordingly. Ultimately, the ADHA House of Delegates approved the Task Force's work, with its clearly defined competencies, scope of practice, and educational requirements. Thus, the existing ADHP competency document was reviewed by a large and diverse group of stakeholders and gained approval from the legislative body of ADHA.

The ADHP competency document builds on existing dental hygiene education and practice and the dental hygienist's unique orientation toward prevention; it adds procedures and competencies that can benefit those who currently experience difficulty in accessing the dental care system in the United States. Collaboration with other members of the health care team is emphasized. Because the ADHP expands substantially the scope of traditional dental hygiene practice, it requires acquisition of additional

knowledge and skills—all carefully specified in the document disseminated by ADHA. In contrast, the proposal for an oral health therapist remains a concept paper, with brief mention of curricular length.[2] That proposal limits its goal of improved access to a small proportion of those who need dental attention (i.e., children), and does not define an academic model that can serve as a robust foundation for an entirely new mid-level practitioner within the United States.

Existing Needs for Dental Services

As described by the Task Force, the ADHP will focus on providing services within community settings, such as school clinics, long-term care facilities, hospitals, and primary care clinics—thus, promoting the addition of oral health services within traditional health care organizations and leading to more diverse delivery of dental hygiene care. The sample curriculum encourages ADHP students to gain specialized knowledge appropriate for a particular population or setting.

The most recent oral health data from the National Health and Nutrition Examination Survey (NHANES)[3] offer a useful snapshot of those who are likely to have the most extensive oral health needs. The proportion of the poorest Americans (i.e., <100% of the federal poverty level) who reported a dental visit within the preceding year varied markedly by age: 57% of youths ages 2-11; 62% of adolescents ages 12-19; 44% of adults ages 20-64; and 30% of seniors age 65 and older. Likewise, the prevalence of untreated dental caries varied by age among these poorest Americans. One-third of youth ages 2-11 had untreated decay in their primary teeth, while just 12% of youth ages 6-11 had untreated decay in their permanent teeth; for adolescents ages 12-19, the prevalence (in permanent teeth) was 27%. Among adults ages 20-64, the prevalence of untreated decay was 44%, and it was 33% among dentate seniors age 65+--thus, among the poorest, the prevalence of untreated decay was exactly the same for primary teeth among youth and for dentate elders. Those groups who reported seeing a dentist least often were adults ages 20-64, and they also were found to have the highest prevalence of untreated decay. In addition, 14 and 17% of the adults and dentate seniors, respectively, met the case definition for periodontal disease. As more knowledge is gained regarding the associations between oral disease (particularly, periodontal diseases) and systemic diseases such as diabetes, pneumonia, and certain inflammatory diseases, it becomes unwise to ignore the health of the oral cavity--at any age.

In light of the current epidemiology of oral diseases, the ADHP competencies exclude no age groups, and no particular health history. They are not tailored to existing funding streams for oral health care. Instead, the focus is on identifying those with oral health needs where they seek health care, functioning as part of a multi-disciplinary health care team, and referring to appropriate practitioners whenever circumstances dictate (then following up, to ensure that care has been received). Increasingly, many children present with complex medical issues, stemming from conditions such as diabetes and asthma. Would the oral health therapist not provide care for such patients?

Cultural Context of U.S. Educational and Care Delivery Systems

The majority of dental hygienists now receive an Associate Degree (or its equivalent) at the completion of their entry-level education, a degree often not commensurate with the credit hours actually completed. By the time many dental hygienists are graduated from these associate-degree programs, their credit hour totals resemble those required for a baccalaureate degree.[4] Most dental hygiene education now occurs in community colleges or technical schools, isolated from the education of dentists or even from that of other health professionals within the same institution--who complete their clinical education in hospitals or other health care facilities, learning to interact with and respect those from multiple disciplines. Baccalaureate dental hygiene programs within dental schools have declined markedly over the past 20 years, and relatively few student dental hygienists now receive instruction from faculty members of dental schools. Given the value that Americans place on the baccalaureate degree as a "college education," it is important to move dental hygiene education closer to the norm of other health professionals with comparable responsibility. In order to participate fully—and be respected—within the multidisciplinary health care system, the ADHP must present education similar to other mid-level providers.

For these reasons, the ADHP Task Force developed parameters for a provider with a master's degree, similar to other mid-level professionals within health care, e.g., nurse practitioner, physical therapist, pharmacist, speech and language pathologist. In fact, a current trend in these professions is to move toward doctoral studies. In order to prepare dental hygienists adequately at the advanced level, it will take the equivalent of 2 years of full-time study beyond the baccalaureate degree, culminating in a Master of Science in Dental Hygiene. Many institutions have the capacity to deliver part of this instruction via distance education, reaching students within their own communities and promoting their acceptance into these local health care networks. Indeed, many uni-

versities already offer baccalaureate and graduate degree coursework through distance-learning options. As academic choices proliferate, this career path can only become more available to dental hygienists.

In the United States, the majority of dental care is provided in private practices--even when payment comes from governmental sources such as Medicaid or SCHIP, the provider most often is a private practitioner. Employed dental personnel, functioning within governmental systems to provide dental care for defined groups, are rare in the United States, but more common internationally. Providers cited as models for the oral health therapist were created many years ago, by dentists in those countries, to meet the needs of certain populations--much as a dentist in the U.S. created dental hygienists to accomplish prevention that was unavailable to school children early in the 20th century. These international providers often are educated within dental schools, by dental faculty, with substantial restorative resources available and upon graduation, they assume positions within the governmental system. So far, this level of consensus does not exist, regarding mid-level dental providers in the United States. Almost certainly, the first ADHP graduates will need to find or create positions in locations that do not fit current patterns for private dental practices. Thus, it would benefit the ADHP to resemble other mid-level providers within the U.S. health care system.

Pragmatic Issues Surrounding Adoption of the ADHP

Employment of dentists is not expected to keep pace with the increased demand for dental services.[5] In contrast, the number of dental hygienists is projected to increase significantly.[6] The ADHP, as detailed in the ADHA competency document, could help fill this forecasted need in the delivery of dental care.

Existing Masters' degree programs, many with established distance education options, could incorporate the ADHP curriculum and its thoroughly developed set of competencies to expand the dental hygienist's role in health care. The Task Force expected that the model would be implemented and evaluated to determine the ADHP's impact on access to oral health care and on the population's oral health status. As important milestones occur in implementation of the ADHP competency document, updates will be published in ADHA periodicals.

Summary

Although multiple strategies will be required to craft a lasting solution for existing and future access problems, the ADHP could contribute important knowledge and skills to address unmet oral health needs of the public. The concept of a mid-level practitioner is widely accepted in medicine and already integrated into current systems of health care; the ADHP offers a comparable, cost-effective model for provision of oral health care within diverse health care settings. Clearly, a professional with the ADHP competencies, functioning within the existing health care system, could offer underserved populations access to a provider who focuses on prevention, alleviates pain and infection, and coordinates more specialized care when needed, working collaboratively with dentists and other health professionals.

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