The Oral Health Workforce in California

BACKGROUND & SIGNIFICANCE

The health care delivery system is changing at a rapid pace. Dentistry as a field has remained relatively separate from the rest of health care, however the dental delivery system faces the same key issues of needing to improve access to high quality care, improve health outcomes while reducing costs. The dental workforce sits at the crux of these care systems challenges.[1] Improving access to oral health care is a multifaceted issue, and having a well-trained, affordable, and accessible workforce is fundamental to system improvement.[2] Understanding our current workforce challenges, and seeking ways to improve it, has been the topic of numerous recent articles,[3,4] reports,[5,6,7] and special issues[8,9,10,11]. While the range of proposed solutions are much debated, there is widespread agreement that the workforce we have now is not adequate to meet the needs of the entire population, particularly those who are vulnerable and underserved.[12,13] This issue brief seeks to summarize the key workforce issues for California.

THE CALIFORNIA DENTAL WORKFORCE

Types & Numbers: Today in California, there are 10 different provider classifications in dentistry: dentists, dental specialists (specialty board-certified DDS'), dental assistants, registered dental assistants, registered dental assistants in extended function, orthodontic dental assistant permits (can be added to RDA or RDAEF), dental sedation assistant permit holders (can be added to RDA or RDAEF), registered dental hygienists, registered dental hygienists in extended function, and registered dental hygienists in alternative practice (RDHAPs). [14]

Distribution: While California has a large number and type of providers, these are not distributed evenly across the state.[15] California has 333 Dental Health Professional Shortage Areas in all but five of California's 58 counties, encompassing over a million children. [16] While this maldistribution has been known for decades, existing policy strategies have been ineffective.[17] A 2004 evaluation of strategies to improve the distribution of providers found that full implementation of all existing programs would reach less than 10% of individuals experiencing access to dental care problems.[18] To exacerbate things further, the debt burden on dental students today due to the rising cost of higher education and dental education is significantly greater than in the past.[19]

Provider Evolution: California has been at the forefront of experimenting with new scopes of practice for dental providers and in expanding roles within the dental team.[20] Utilizing the Health Workforce Pilot Program, California has undertaken 21 dental pilot programs between 1972-1982, with two additional pilot projects resulting in the RDHAP, and one currently underway as part of a teledentistry demonstration project.[21,22,23] Recently, SB694 was introduced in the California Senate to study the feasibility of new workforce models California as part of an oral health infrastructure plan. No details to date are available as to funding or scope of this study. This study comes on the heels of dental therapists being legalized in Alaska and Minnesota, with a dozen other states considering new workforce models.[24]

DENTAL WORKFORCE OF THE FUTURE

Two recent Institute of Medicine reports on oral health concluded that, "In order to meet the oral health needs of all of our nation's people we will need to rely on a diverse and expanded array of providers who are competent, compensated, and authorized to provide evidence-based care, and include collaborative and multidisciplinary teams working across the health care system".[25] This includes expanding the oral health competencies of existing health providers such as nurses and doctors,[26] in addition to exploring new arrangements for care within the dental workforce.

Potential New Arrangements Include:

- Utilizing all existing providers to the full scope of their training
- Reconfiguring how services are provided through the use of telehealth technology to bring care to community based programs
- Expanding the scope of practice of existing dental providers (hygienists, assistants) to increase efficiency within practices
- Expanding the scope of practice of existing dental providers (hygienists, assistants) to increase efficiency within practices
- Creating a new dental provider such as a dental therapist, or a community dental health coordinator who can provide care where none is currently available
- Educating existing providers (nurses, doctors, pharmacists) to better understand and screen for oral disease, risk factors, and referrals to expand access to oral health education and prevention

THE FUTURE OF THE DENTAL WORKFORCE IN THE CONTEXT OF HEALTH CARE REFORM

Federal Initiatives: The ACA recognizes the need to expand the workforce to accommodate the current and growing demand for dental health care. The Act established, but did not fund, a five-year, $4 million, 15-site demonstration program to train or employ alternative dental health care providers.[27] The ACA also created The National Health Workforce Commission. This commission, as well as the National Center for Health Workforce Analysis are integral to the creation of a solid methodological foundation upon which workforce shortages, demand and regulatory oversight must be constructed.[28]

California: California's dental workforce data is collected through dental board licensure surveys.[29] The office of statewide health planning and development (OSHPD) is charged with creating a data warehouse of all health professions (CITE). CA also is at the forefront of setting up health exchange which includes a mandated pediatric dental benefit. This will put increasing pressure on the dental workforce to provide care for California's children,[30] at the same time that adult benefits have been slashed and access to care for poor adults is becoming increasingly difficult.

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