CONNECTICUT STATE DENTAL ASSOCIATION

Res: **#29-2009**
From: Board of Governors
Subject: DHAT Pilot Program
Financial Implication: $0
Strategic Plan:

- Item #1 **PROMOTE AN OPTIMAL ENVIRONMENT FOR PROVIDING ORAL HEALTH CARE IN THE STATE OF CONNECTICUT**
- Item #2 **ENSURE THE AVAILABILITY OF ORAL HEALTH CARE FOR ALL CITIZENS OF CT BY IMPROVING ORAL HEALTH EDUCATION, ACCESS TO CARE, AND CAPACITY IN THE ORAL HEALTH CARE SYSTEM.**

Background:
DHAT (**D**ental **H**ealth **A**ide **T**herapist) is an auxiliary model in Alaska, Minnesota, and soon in Washington and California. The model exists entirely in the public health sector. The length of training varies from 2 to 4 years. The 2 year model is being recommended in Connecticut.

Currently the W.K. Kellogg Foundation is supporting Alaska's Dental Health Aide Therapist (DHAT) training program with a four-year $2.8 million grant. DHATs are trained during one year at the University of Washington MEDEX Program, which has trained Physician Assistants since 1976 and another year at the ANTHC DHAT Training Center in Anchorage. 1st year program is a five-day-a-week, full-day curriculum of classroom, laboratory and clinical work. The second year consolidates these skills with preclinical and supervised treatment of patients. Students must pass benchmark exams in order to graduate from the program. After graduation students enter a minimum of 400 hours of preceptorship, where they must demonstrate clinical skills under supervision before receiving certification to practice. In addition, DHATs must demonstrate a capacity to function effectively as a team member. Upon certification, DHATs are assigned to provide basic oral health care services in remote tribal clinics and remain supervised by "hub" based dentists who coordinate, supervise and are responsible for overall oral health care. There have been no "seminal events" reported during the almost four years of DHAT provided treatment.

The Dental Health Aide Therapist must meet the same quality of care standards as a licensed dentist providing the same services. Services include restorative, pulpotomy, prophylaxis, and uncomplicated oral surgery. In addition to meeting training

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requirements and a protracted preceptorship, the DHAT must undergo skill evaluation every two years. Continuing education is also required for recertification.

The Kellogg Foundation and three other funders (Bethel Community Services Foundation, M.J. Murdock Charitable Trust Foundation, Rasmuson Foundation) have funded a two-year comprehensive evaluation of the DHAT program as to how DHAT impacts access and quality of care. This study, by RTI, a North Carolina based research organization, is expected to provide data for creation of evidence-based standards of care for DHAT. Ford, Pew, Allen and RW Johnson Foundations have also been supportive of the DHAT program.

Advantages:

Currently recognized and utilized in over 52 countries. Enjoy an excellent record in other countries for safety and quality of care. The model was developed 80 years ago in New Zealand. Outside evaluators found their work to meet the standards of care in the U.S.

Functions only under the general supervision of a dentist. Functions as an auxiliary, a team member connected to a responsible supervising dentist via teledentistry, including real time video and radiologic oversight as needed. Therapists partner with supervising dentists. Patients who need care beyond the scope of the therapist are referred to the dentist. Dentists are responsible for diagnosis and treatment planning.

Community driven workforce. All applicants are selected from the communities in which they live and in which they will return to practice. Model will work well in Community Health Center and school based settings. It is the only model with a proven track record in improving access.

Two year DHATs cost approximately $60,000 to train, the least of any of the proposed therapist models.

Certification, rather than license. The DHAT is an auxiliary to the dentist and as such functions under the general supervision of a dentist.

Currently it is estimated that Connecticut has 600,000 to 800,000 residents in need of dental treatment and are without the ability to pay for services at usual and customary fees. With less than 3000 general dentists in Connecticut that would mean a minimum of 200+ additional non-paying or reduced fee patients per general practice dentist. Private practitioners are currently not seeing these patients. Their use in public health settings may help alleviate some of the access issues with this population. Data is limited in this regard and may necessitate a pilot project.

Risks:

Requires adequate ongoing government funding. Perception of second tier of care.

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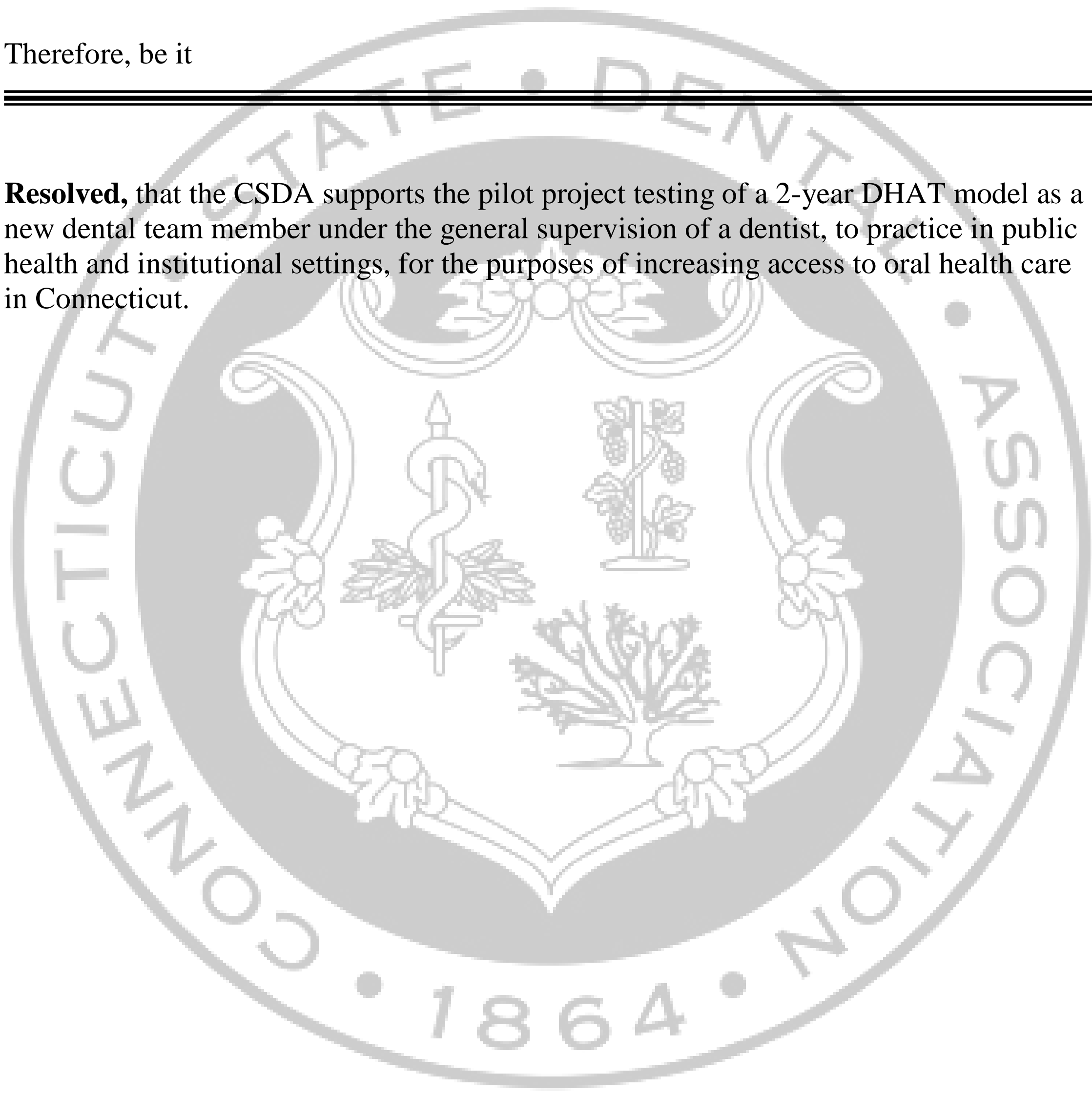
Therefore, be it

Resolved, that the CSDA supports the pilot project testing of a 2-year DHAT model as a new dental team member under the general supervision of a dentist, to practice in public health and institutional settings, for the purposes of increasing access to oral health care in Connecticut.



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