Registered Dental Hygienists in Alternative Practice (RDHAP): Increasing Access to Dental Care in California

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Lack of access to dental care is a persistent problem for vulnerable populations in California, resulting in extensive dental disease among individuals in underserved communities. State programs to improve dental care access include “provider-targeted” incentives for oral health students and professionals, such as loan repayment and scholarship programs, oral health residency training programs, and licensure by credential for out-of-state dentists and dental hygienists. State programs also include “public-targeted” incentives, such as funding dental benefits for low-income individuals, and expanding the number of public clinics offering dental care. Traditional improvement efforts seek to expand dental care access within the existing delivery models, which consist primarily of private dental offices and community dental clinics. However, newer efforts are underway to promote dental care in non-office settings.

In 1998, California officially recognized a new dental health profession: the Registered Dental Hygienist in Alternative Practice (RDHAP). RDHAPs may practice in homes, schools, residential facilities, and other institutions as well as in Dental Health Professional Shortage Areas. Recent RDHAP licensees (over two hundred since 2003) have set up successful practices with underserved communities.

This study examines the process of development and implementation of the RDHAP in California, and the impact this new provider is having on dental care access for underserved people. The objectives of this study are:

- To profile the current RDHAP workforce and compare it to the traditional Registered Dental Hygienist (RDH) workforce in order to understand the unique practice settings, patient demographics, and services of RDHAPs.
- To explore the practice realities of RDHAPs who enter underserved communities and devise new care delivery models outside of the traditional dental office.
- To discuss laws specific to the RDHAP profession and develop policy recommendations enabling RDHAPs to expand preventive dental care access for underserved Californians.

Methods

This study utilized a mixed methods approach. First, the UCSF investigator conducted a statistical analysis of the 2005-2006 California Survey of Registered Dental Hygienists. The survey sample represented the State’s dental hygiene workforce as of September 2005. The response rate was 74%. Second, the investigator examined legislative histories, current regulations, and comments from the 2005-2006 California Survey of Registered Dental Hygienists. Next, the investigator interviewed practicing RDHAPs, and experts from educational institutions and professional associations involved in the development and regulation of the RDHAP profession. The legislative review included an overview of RDHAP licensure requirements and scope of practice. Sources for the literature review included PubMed and the Office of State Planning and Development (OSHPD) archives.

Findings

The RDHAP was created as an independent dental hygiene practitioner with a key goal of increasing dental care access for underserved people and communities. Data show that RDHAPs are fulfilling this mission during the preliminary stages of practice development. Specifically, the study found that:

- The RDHAP workforce is derived from the broader registered dental hygiene (RDH) workforce, and therefore is similar in overall demographics. However, key differences do exist between the two groups. Generally, RDHAPS are more highly educated and ethnically diverse, work longer hours, and are more likely to work in non-traditional settings than RDHs. RDHAPs are also more likely to see special needs patients, and consult with other health care providers. Finally, RDHAPs are more likely to express a commitment to continuing professional growth, to increasing health care access, and to aiding underserved populations and communities.

- To discuss laws specific to the RDHAP profession and develop policy recommendations enabling RDHAPs to expand preventive dental care access for underserved Californians.
consumer choices for preventive treatments and services. RDHAPs extend services to individuals and communities who need care, but cannot get to a dental office; provide services in settings and at times that are convenient for patients; and, decrease the fear of dental treatment in people who are not accustomed to having dental care needs addressed.

- The patient population assisted by RDHAPs consists of traditionally underserved people, including, but not limited to, homebound and institutionalized elderly, migrant farm workers and their families, pregnant women on Denti-Cal, rural school children, developmentally disabled children and adults, wards of locked state institutions, and low income rural and urban families.

- RDHAPs work across a variety of institutional and organizational settings, such as nursing homes, schools, hospital, and clinics. As RDHAPs integrate their dental services into these existing systems, they open up new avenues for professional collaboration, and new possibilities for positive transformations of care delivery.

- RDHAPs report a diversity of activities within their individual practices. They provide preventive clinical care and dental health education, as well as case management and referral coordination. Other activities include business development, community outreach, and development of institutional relationships.

- Unlike most professions, where licensure is based solely on proven qualifications, RDHAPs are mandated to have a “documented relationship” with a dentist as a prerequisite for licensure. While collaborative practice agreements do have precedent (i.e. Nurse Practitioners), it is unusual to require this type of agreement for an occupation practicing within its own professional scope. Additionally, patients are required to get a prescription for preventive services performed by an RDHAP. Patients must provide documentation of having seen a dentist or physician within 18 months of visiting an RDHAP in order to continue preventive care.

- The business issues facing RDHAPs are start-up costs, business planning and marketing, building awareness of a new profession, and developing new collaborative practice models with dentist and medical practitioners in their communities.

- Financing systems for dental care, such as Denti-Cal and grant-funded programs, are central issues for RDHAPs as these systems are designed for many of the patients they serve.

- The education system for alternative practice hygiene is responding to the needs of RDHAPs, and the system currently has the capacity to meet the training demand for this profession.

- Our study also revealed that developing RDHAP as a new health provider category was hindered by a slow bureaucratic process, and intra-professional conflict. The RDHAP took 23 years (1980-2003) to develop. The process included initiating a Health Manpower Pilot Project (HMPP) study, overcoming two lawsuits, engaging in political compromises to enact legislation, implementing two university-based training programs, and instituting a licensure and certification process with the state.

**Policy Recommendations**

Alternative low cost care delivery models, such as the RDHAP, are essential to improving oral health and reducing health disparities in California’s diverse population. Public policy should create an environment supporting innovation and creativity in meeting patients’ dental health needs. Policy should also enhance consumer choice while focusing on prevention-oriented solutions and ensuring patient safety.

- **The State should grant licensure for RDHAPs based on qualifications, and should eliminate prescription requirements for dental hygiene services provided by RDHAPs.** Patients should have their choice of a dental hygiene care provider, and the public should not need a prescription to receive basic preventive care.

- **The State should appoint an independent committee to review and make recommendations to the legislature on “scope of practice” matters.** This practice allows for a less politicized review of efforts to increase the capacity of the health workforce, and it is operating successfully in many other states and countries. In addition, the State should encourage competency based health care practice models which are flexible and responsive to community health care needs. The State should also restructure professional boards in a way that allows each profession to regulate its own members.

- **The State should encourage reciprocity across state lines for all new dental workforce models.** New models include the Advanced Dental Hygiene Practitioner model developed in Minnesota, and the Dental Health Aide Therapist model.
developed in Alaska. New models for dental and hygiene education can help ensure a high quality workforce.

- **Denti-Cal should maintain reimbursement rates at levels that sustain dental hygiene services, and should expand reimbursement to RDHAPs for non-clinical services, such as case management, health education, and prevention services.** RDHAPs should be able to bill for their services as a corporation.

- **Denti-Cal and Medi-Cal should be integrated to develop a comprehensive data infrastructure.** Such an infrastructure would be capable of tracking health care expenditures, health care utilization, health diagnoses, and health status. Integration could lead to new research for quality of care improvements, and shed light on health care savings attributable to preventive dental care (i.e. examining health cost savings for diabetes treatment resulting from preventive dental care treatment). Policy makers might consider incentives for the oral health community to develop better quality of care measures, such as developing health outcomes measurements.

- **The State should revise regulations within long-term care and skilled nursing facilities to include more specific oral health standards, and allow more flexibility to meet these standards through collaborative dental service models.** RDHAPs should be eligible to fulfill the Title 22 provider requirement for a dental program in nursing homes. RDHAPs are well suited, both in skill set and practice model, to be on-site primary dental care practitioners, providing preventive and educational services in these settings.

- **The State should encourage doctors and dentists to work with underserved populations.** For RDHAPs, working with underserved populations is a practice requirement. A set of similar mandates for other dental practitioners may go a long way towards improving access to the restorative and surgical treatments needed by many underserved individuals.

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