American Dental Hygienists' Association

444 N. Michigan Ave.
Suite 3400
Chicago, IL 60611
P: 312/440-8900
F: 312/467-1806
www.adha.org

DATE: February 18, 2015

TO: ADHA Board of Trustees

FROM: Ann Battrell, MSDH, ADHA Executive Director
Ann Lynch, ADHA Director of Governmental Affairs
Pamela J. Steinbach, RN, MS, ADHA Director of Education & Research

SUBJECT: Oral Preventive Assistant (OPA) Background

ADHA has prepared this memo to provide further clarity and guidance to states as new workforce models are discussed across the country. This information has been prepared for your use. Please disseminate as you deem appropriate.

The ADA first introduced the OPA and the Community Dental Health Coordinator (CDHC) models in 2006. Neither the CDHC nor OPA are "new" ideas. Given the recent adoption of the Accreditation Standards for Dental Therapy Education Programs by the Commission on Dental Accreditation (CODA), it is not surprising that there has been a recent flurry of activity surrounding the American Dental Association's (ADA) OPA model as well as an ongoing push for the Community Dental Health Coordinator model.

What is an Oral Preventive Assistant?

Duties assigned to the OPA may vary from state to state but are expected to build on the dental assistant scope to include collection of diagnostic data such as medical histories, vital signs, and charting; radiographs; preventive services for all types of patients, including preventive and oral hygiene instruction, application of fluoride and sealants, coronal polishing for all patients, scaling for plaque induced gingivitis patients; application of topical anesthetic and general office duties including facilitating basic legal and regulatory compliance, e.g., HIPAA compliance, maintaining patient treatment records, and managing a recall system. States will determine eligibility, training, and certification and/or licensure requirements. The OPA services may be provided by the creation of a new category of allied dental personnel or added to an existing certification/licensure category (dental assistants). The ADA offers details at http://www.ada.org/en/education-careers/careers-in-dentistry/dental-team-careers/proposed-dental-team-careers/oral-preventive-assistant-faq.

Why Dental Hygiene-based workforce models make sense

The ADHA is committed to advocating in support of new dental hygiene-based models for oral health care delivery. Dental hygienists are educated, prepared and an available asset to the workforce. The educational infrastructure is in place, with 335 dental hygiene programs presently educating students across the country. Dental hygienists are currently working in a variety of settings, and the public will benefit from a practitioner who can provide both preventive and restorative services.

The ADHA supports workforce models that culminate in:
- Graduation from an accredited institution
- Professional licensure
- Direct access to patient care[1]

Direct access allows a dental hygienist the right to initiate treatment based on his or her assessment of a patient's needs without the specific authorization of a dentist; to treat the patient without the presence of a dentist; and to maintain a provider-patient relationship.

Creating a New Provider

The ADHA has defined a Mid-level Oral Health Practitioner as follows:
A licensed dental hygienist who has graduated from an accredited dental hygiene program and who provides primary oral health care directly to patients to promote and restore oral health through assessment, diagnosis, treatment, evaluation, and referral services. The Mid-level Oral Health Practitioner has met the educational requirements to provide services within an expanded scope of care and practices under regulations set forth by the appropriate licensing agency.[2]

The CDHC and OPA models do not conform to ADHA policy on workforce models.

As the national association representing the interests of more than 185,000 dental hygienists across the country, the ADHA is often asked to evaluate or provide guidance on proposed models and pending legislation. There is not one single definition for all mid-level dental providers, because each state that has pursued a mid-level practitioner has created its own variation based on the needs, composition of the workforce and demographics of that respective state.

State associations, educational institutions and/or dental hygiene educators are encouraged to contact ADHA for further state specific assistance if the CDHC or OPA models and/or legislation are being discussed in your state. Our staff can work with your state and/or educational leadership to determine your approach and strategy in addressing these issues. Please contact Ann Lynch at annl@adha.net or Pam Steinbach at pams@adha.net for further assistance.

---

[1] ADHA Policy Manual: Access 4S-09.
[2] ADHA Policy Manual: Glossary 2-10, Mid-level Oral Health Practitioner.