



Midlevel Dental Providers

The American Association of Oral and Maxillofacial Surgeons (AAOMS) is concerned the unrestricted proliferation of dental midlevel providers could lead to the performance of irreversible procedures, questionable diagnoses or missed pathologies on an already medically compromised segment of the population lacking access to care.

Geographic, educational and financial problems are just some of the factors that impede access to optimum oral healthcare. While proponents of midlevel providers assert their training is comparable to that of a fully credentialed dentist, there are no supportive, longitudinal clinical assessments of health outcomes to support this position. In addition, no studies compare improvements in oral health among targeted populations to outcomes that might have been achieved if the same resources had been directed to providing these patients with care from fully trained and licensed dentists. Proponents claim these midlevel providers can have the skill necessary to fill the gaps to achieve patient care and the judgment to operate within a limited scope of practice to deliver preventative and emergency care, but recent pilot programs call this into question.

For example, a 2018 periodic review by the Oregon Health Authority of the state's midlevel pilot program found dental health aide therapists (DHATs) performed extractions not considered emergencies – something considered outside their scope of practice. An additional two site reviews said extractions performed during the review period were considered surgical in nature, should never have been performed by the DHAT and required the intervention of a dentist.ⁱ

After completing four years of dental school, oral and maxillofacial surgeons (OMSs) complete a minimum four-year, hospital-based residency training program. With at least eight years of advanced training, many OMSs have had cases where teeth they thought were simple extractions turned out to be complex cases due to unforeseen factors. It would be inappropriate to allow a lesser trained professional – such as a dental midlevel provider – to determine what is considered a “simple extraction.”

The addition of midlevel providers who have less education and training than dentists will not improve the situation and, in some instances, may actually exacerbate the problem, particularly in the case of a complex patient with multiple comorbidities, such as diabetes and bleeding disorders. The underserved population in this country deserves better dental care than can be provided by the midlevel provider models being promulgated. Indeed, all Americans deserve good oral health and oral healthcare delivered by fully trained and licensed dentists.

State, local and tribal governments are urged to consider other pathways to attract fully qualified dentists to low-access areas, including the promotion of higher Medicaid reimbursement rates, establishment of geographic reimbursement incentives or enhanced loan repayment programs.

AAOMS and its members as well as dentists throughout the United States are committed to improving the availability of quality dental care provided by those who have the appropriate education and training to deliver oral health education, disease prevention and, ultimately, the appropriate treatment of oral diseases.

Reaffirmed January 2024, AAOMS Committee on Governmental Affairs

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ⁱ Oregon Health Authority. *Quarterly Dental Pilot Project Meeting: DPP 100 Meeting Minutes. April 23, 2018.*