The Restorative Registered Dental Hygiene Pilot (RRDHP):

A Sponsored Research Pilot Program to Evaluate the Impact of an Alternative Workforce Model Relative to the Current National Discussion

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RRDH Pilot: Central Tasks

1. Develop a curriculum to train hygienists in (limited) restorative care;

2. Develop a rigorous evaluation plan that will (a) assess trainee clinical competency and (b) allow a preliminary assessment of their impact on access to care;

3. Train one cohort of 12 to 15 students;

4. Upon completion of training, assess the clinical competency of these providers;

5. Place the trainees in practice settings in underserved communities across the state where, under the direct supervision of a dentist, they will provide restorative care to patients; and

6. Conduct an assessment of the impact of these new providers on utilization of services, clinic productivity, quality of care, and patient satisfaction.

PROPOSED MI RRDH SCOPE OF PRACTICE

***New* procedures RRDHs will be trained to perform**:

- D2140: Amalgam-one surface, primary or permanent
- D2150: Amalgam-two surfaces, primary or permanent
- D1260: Amalgam-three surfaces, primary or permanent
- D2161: Amalgam-four or more surfaces, primary or permanent
- D2330: Resin-based composite-one surface, anterior
- D2331: Resin-based composite-two surfaces, anterior
- D2332: Resin-based composite-three surfaces, anterior
- D2335: Resin-based composite-four or more surfaces or involving incisal angle
- D2391: Resin-based composite-one surface, posterior
- D2392: Resin-based composite-two surfaces, posterior
- D2392: Resin-based composite-three surfaces, posterior
- D2394: Resin-based composite-four or more surfaces, posterior
- D2940: Sedative Filling (intended to relieve pain)

(RRDHs can also provide the full scope of practice of a registered dental hygienist)

MI RRDH Pilot Timeline

DATE	STAGE
Fall 2012	Kellogg planning grant began
Fall 2012 – Spring 2013	Curriculum developed at UD Mercy
Fall 2015	Pilot starts: Trainees begin program (18 months)
Spring/Summer 2016	Data collection begins
Spring 2017	NERB
Spring/Summer 2017	Community Placements begin (1 year)
Summer 2018	Pilot program ends
Winter 2019	Data collection ends

Questions We Seek to Answer

Does the addition of RRDHs to the dental team have the potential to improve access to care for underserved populations, and how might this differ from simply adding an additional dentist?

Specifically:

- Are clinics with RRDHs able to see more patients, or see patients sooner, or in a more efficient or cost-effective manner, than they otherwise would have been?
- Do the treatments provided at these clinics change? With an RRDH on staff does the clinic, or do staff dentists, now provide more of one type of procedure, less of another?
- Would you get more 'bang for your buck' by hiring two RRDHs or one new dentist?
- How do patients and staff respond to these providers?
- How does the quality of care provided by RRDHs compare to that provided by new dentists?

Types of Data to be Collected: Clinic Level

collected monthly
Hours of operation, staffing patterns
Patients seen (including info on: age; gender; race/ethnicity; type of appt; source of payment; DMF/dmf score)
Procedures provided, and by whom
Billable charges and billable hours, by provider
Wait time for appointments (initial, follow-up); number of no-shows
Length of time to complete procedures, by provider
Number of consultations/complications/failed fillings, by provider

Types of Data to be Collected: Individual Level

collected periodically
Patient satisfaction survey
collected twice (beginning and end of placement year)
Provider/management survey (suitability; skill level; working conditions)

Proposed Study Design

1) Comparisons *within* sites: Before/ After

2) Comparisons *across* matched Treatment/Control sites

- The basic "experiment" is to replace (or substitute) dentist hours at some sites with the cost-equivalent number of RRDH hours at others – need to avoid simply measuring the impact of the addition of (any) provider hours
- Might compare: RRDH to *new* DDS; 2 RRDHs to 1 DDS; RRDH to status quo (again, must add or replace manpower similarly)
- eg: Clinic A already has 2 staff dentists and gets 1-2 RRDHs; Clinic B already has 2 staff dentists and gets a dental resident or hires a new young dentist; Clinic C already has 2 staff dentists, and stays that way.

Same data collected at all sites

Participation Requirements

1) **Full-time dentist(s) on-site**

2) **Capacity to accept a new provider, or providers**
   - Chair space
   - Demonstration of unmet need

3) **Commitment to a Rigorous Evaluation**

WE STILL NEED ADDITIONAL COMMUNITY CLINIC SITES!