NATIONAL ASSOCIATION OF Community Health Centers®

DENTAL THERAPY RESOURCE GUIDE

November 2022

INTRODUCTION

Federally Qualified Health Centers (FQHCs) are a key component of the nation's health safety net, providing essential primary and preventive care in underserved communities across the United States. Today, over 1,400 health center organizations provide care to 30 million patients at 14,000 delivery sites nationwide.

A core element of health centers' work is providing meaningful access to dental care for their patients, which is why the National Association of Community Health Centers (NACHC) is pleased to provide this Resource Guide with an overview of the important and impactful role dental therapists play in expanding the reach of the health center dental care team. Dental therapists are now working in five states (AK, ME, MN, OR, and WA).

FQHCs are federally funded or federally supported nonprofit, community-directed provider clinics serving as the health home for 1 in 5 Medicaid beneficiaries and 1 in 3 people living in poverty. It is the collective mission and mandate of the 1,400 health center organizations around the country to provide access to high-quality, cost-effective primary and preventative medical care, as well as dental, behavioral health, pharmacy, and other support services that facilitate access to care to people located in medically underserved areas.

Similar to the inclusion of nurse practitioners, physician assistants, and certified nurse midwives on medical care teams, a dental therapist is a dental care team provider who works under the supervision of a dentist. Dental therapists are trained to provide preventive and routine restorative care, which includes filling cavities, placing temporary crowns, and some tooth extractions. The addition of dental therapists to dental care teams allows health centers to expand quality care to more patients and provide treatment to more underserved, at-risk populations. Dental therapists can work in traditional dental offices and clinics or in community settings, such as schools or nursing homes.

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PART I

Oral Health Care Access

Dental Care Access Challenges

Dental health professional shortages in rural and urban communities in the United States demonstrate the urgent need for dental therapists on the health center care team. Workforce shortages, lack of insurance coverage, geographic isolation, and lack of transportation are all contributing factors to why over 67 million Americans live in areas with dental care shortages.[1] According to the National Rural Health Association (NRHA), "Research shows rural populations have lower dental care utilization, higher rates of dental caries, lower rates of insurance, higher rates of poverty, less water fluoridation, fewer dentists." [2,3] Racial disparities in oral health persist.

The prevalence of periodontitis (gum disease) is nearly 20% higher among Hispanics and non-Hispanic Blacks than among non-Hispanic Whites.[4] Dental caries (tooth decay) are the number one chronic disease in children, but the rates of cavities among Non-Hispanic Asian, Hispanic, and Non-Hispanic Black children are higher than in their White counterparts. American Indian and Alaskan Native (AI/AN) children age 3 to 5 years have dental caries close to three times greater than White children and almost half of AI/AN children have untreated caries. These disparities are also seen among adults with higher rates of untreated caries among Non-Hispanic Blacks and Mexican Americans as compared to Non-Hispanic Whites.[5] A major factor in these health outcomes is the absence of accessible dental providers and according to the American Dental Association (ADA), less than half of all dentists participate in Medicaid for children.[6]

Dental Care in Health Centers

By nature of their federal designation as FQHCs, health centers are required to be located in and serve medically underserved areas and populations. Health center inter-professional care teams work to reduce health disparities by providing comprehensive, culturally competent, affordable care to all. Eighty two percent of health centers provide comprehensive dental care. Since 2010, there has been a 31% increase in the number of FQHCs employing dental staff (to 1,123 FQHCs), and a 121% increase in dental staff (to 18,715 full time equivalents).[7]

FQHCs are especially vital for uninsured or underinsured individuals and Medicaid beneficiaries, since the Section 330 grant requires that FQHCs offer services to all, regardless of insurance or ability to pay. In recognition of the role that FQHCs play in serving Medicaid patients, Congress created the Prospective Payment System (PPS) and Alternative Payment Methodology (APM) to ensure that FQHCs are appropriately reimbursed for the care they provide. Although only twenty-four (24) state Medicaid programs currently offer adult dental benefits[8], FQHCs are required by federal law to provide, at minimum, limited preventative dental services to all patients they serve. That is why it is critical for federal and state governments to invest in Medicaid coverage for dental care.

1 https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas

2 https://www.cdc.gov/tobacco/disparities/geographic/index.htm

3 https://www.ruralhealthinfo.org/topics/oral-health

4 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5497869/

5 https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf

6 https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0820_1.pdf

7 https://cdn1.digitellinc.com/uploads/nachc/articles/efdcabbcb2222c1caf918fa7168b7ac0.pdf

8 https://www.nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/

PART II

Dental Therapists Help Address Access Gaps, Improve Health Outcomes

Dental therapists have been serving underserved at-risk communities and providing access to quality care in over 50 countries for over 100 years. In the United States, they are currently authorized to work in 14 states and now currently practice in 5 states. As outlined below, numerous studies have found that expanding care teams to include dental therapists increases access to dental care services and improves oral health outcomes.

Expanded Access to Oral Health Service

Dental therapists have practiced in Alaska since 2004 and have increased access for over 40,000 Native Alaskans living in rural communities.[1] Dental therapists in Alaska have increased use of preventive dental care among children and adults.[2]

Dental therapists provide services in community and rural settings in more than 370 mobile dental sites throughout Minnesota, including schools, Head Start programs, community health centers, VA facilities, and nursing homes.[3] In 2017, with 77 dental therapists licensed in Minnesota, dental therapists provided an estimated 107,640 patient visits.[4] A 2021 cross-sectional study of 2.6 million adults found that authorizing dental therapy in Minnesota was associated with increases in dental visits among low-income and Medicaid-eligible adults.[5]

An analysis using Kansas data found that the addition of a **dental therapist could increase the Medicaid patient base from 3% to 15%** at a solo private practice.[6]

1 https://www.anthc.org/alaska-dental-therapy-education-programs/

2 https://onlinelibrary.wiley.com/doi/full/10.1111/jphd.12263

3 https://www.health.state.mn.us/data/workforce/oral/docs/2018dtb.pdf

4 Email communication between Michael Scandrett, President, MS Strategies, Minneapolis, MN, and Jane Koppelman, Research Director, Pew Dental Campaign on 12/05/17. http://www.rti.org/sites/default/files/resources/alaskadhatprogramevaluationfinal102510.pdf

5 https://jamanetwork.com/journals/jama-health-forum/fullarticle/2790249#:~:text=The%20absolute%20difference%20in%20the,CI%2C%208.6%25%2D16.4%25

6 https://mk0xituxemauaaa56cm7.kinstacdn.com/wp-content/uploads/2017/02/DentalTherapist_benefits_AFP_12.23.pdf

Improved Oral Health Outcomes

The Yukon-Kuskokwim Health Corporation (YKHC), a part of the Alaska Tribal Health System, serves 25,000 Alaska Natives representing 58 federally-recognized tribes. An analysis from 2006 to 2015 showed that **employing dental therapists was associated with reductions in the number of extractions of the front four teeth in children under age three, increases in preventive care for children under age 18, and fewer extractions and more preventive care in adults**.[7]

A systematic research review was conducted by the American Dental Association Council on Scientific Affairs in 2013, about which J. Timothy Wright stated, ***"The results of a variety of studies indicate that appropriately trained midlevel providers are capable of providing high-quality services, including irreversible procedures such as restorative care and dental extractions."***[8]

In Saskatchewan, the Saskatchewan Health Dental Plan (SHDP) trained and employed dental therapists in school-based clinics to provide basic dental care to all children. **Training and employing dental therapists helped reduce the average number of required fillings by approximately 50% over six years**.[9]

7 https://onlinelibrary.wiley.com/doi/abs/10.1111/jphd.12263

8 http://jada.ada.org/article/S0002-8177(14)60574-2/pdf

9 https://onlinelibrary.wiley.com/doi/10.1111/jphd.12184

PART III

Education and Licensure of Dental Therapists[1]

1 https://www.communitycatalyst.org/resources/2020-tools/DentalTherapyAdvocacyGuide-R1.pdf

All dental therapists must complete rigorous education and training requirements prescribed by the Commission on Dental Accreditation standards for dental therapy.

DENTAL THERAPY STATE RULES STATUS AUGUST 2021

	ALASKA	MINNESOTA	MAINE	VERMONT	WASHINGTON	ARIZONA
Date DT Law Passed	Tribal authorization in 2003	2009	2014	2016	2017	2018
DTs in Practice	36: 1st in 2005	100: 1st in 2011	1: 1st in 2021		9: 1st in 2017	
Status of DT Licensing and Rulemaking	CHAP Certification Board (CHAPCB). Standards & Procedures — equivalent to combined statute and rules. Alaska Tribal Health Consortium administers the CHAPCB.	DT licensing integrated into existing Board rules in 2011.	Rules adopted in April 2020.	Interim rules in place that allow for licensure. Draft rules submitted to Office of Professional Regulation for formal rulemaking process.	The Swinomish Indian Tribal Community adopted the Tribal Dental Health Provider Licensing and Standards Code in 2015. Law only authorizes practice in Tribal and related settings with CHAP certification. No state rules.	Draft rules under discussion by Board workgroup. State license not required for practice in Tribal and related settings.
Education and Clinical Hour Requirements	No minimum degree requirement. Alaska DHAT Educational Program or program with training equivalent to CODA standards. 3 months or 400 hours, whichever is longer, under direct supervision for general supervision.	Bachelor's degree for DT. Master's degree for advanced DT (ADT). 2,000 hours under direct supervision to become ADT.	Master's degree. Program that is CODA accredited or approved by BOD rule. 2,000 supervised hours for licensure.	No minimum degree requirement. CODA accredited program. 1,000 hours under direct supervision for general supervision.	No minimum degree requirement. Alaska DHAT Educational Program or a program with training equivalent to CODA standards. 3 months or 400 hours, whichever is longer, under direct supervision for general supervision.	No minimum degree requirement. CODA accredited program. 1,000 hours under direct supervision for general supervision.
Notes	Practice limited to Tribal and related settings. Iḷisaġvik College's DT Program received CODA accreditation in 2020.	Practice limited to safety-net, public health, and non-profit settings, or private practices where 50% of DTs' patients are underserved.	Must be a licensed dental hygienist. On-site ("direct") supervision.	Must be a licensed dental hygienist for initial DT license but not for renewal.	Practice limited to Tribal and related settings.	Must be a licensed dental hygienist for initial DT license but not required for renewal. Practice limited to safety-net, public health, or non-profit settings, or private practices that serve patients referred by community health centers.

https://www.dentaltherapy.org/resources/Model-Dental-Therapist-Rule.pdf

Note: Composed in August 2021 and does not include information from Colorado and Oregon, who have authorized dental therapy. More recent dental therapists in practice data indicates there are now 131 in Minnesota and 8 in Washington.

DENTAL THERAPY STATE RULES STATUS AUGUST 2021

	MICHIGAN	NEW MEXICO	IDAHO	CONNECTICUT	MONTANA	NEVADA	OREGON
Date DT Law Passed	2018	2019	2019	2019	2019	2019	2021 (DT pilot projects began in 2016)
DTs in Practice			1: 1st in 2019 (pending pathway for pre-CODA graduates)				5: 1st in 2017
Status of DT Licensing and Rulemaking	Rules adopted in April 2021.	Rules adopted in May 2021. State license not required for practice in Tribal and related settings.	Rules are in effect as of 2020, pending legislative ratification. DT practice with state license and is limited to Tribal and related settings.	Rulemaking yet to begin. DTs must meet statutory requirements, but no license is required or available.	No state rules. Law only authorizes practice in Tribal and related settings with CHAP certification.	Rulemaking process is underway. Licensure application is published.	Draft rules under discussion by BOD workgroup. State license not required for practice in Tribal and related settings.
Education and Clinical Hour Requirements	No minimum degree requirement. CODA accredited program. 500 hours under direct supervision as part of DT education program.	No minimum degree requirement. CODA accredited program. 1,500 - 2,000 hours for general supervision.	No minimum degree requirement. CODA accredited program. 500 hours under direct supervision for licensure.	No minimum degree requirement. CODA accredited program. 1,000 hours under direct supervision for general supervision.	No minimum degree requirement. Alaska DHAT Educational Program or a program with training equivalent to CODA standards. 3 months or 400 hours, whichever is longer, under direct supervision for general supervision.	No minimum degree requirement. CODA accredited program. 500-1,500 hours under direct supervision for general supervision.	No minimum degree requirement. CODA accredited program.
Notes	Practice limited to safety-net, public health, and non-profit settings, or private practices where 50% of DTs' patients are underserved.	Must be a licensed dental hygienist. Practice limited to Tribal, safety-net, public health, or non-profit settings.	Practice limited to Tribal and related settings.	Must be a licensed dental hygienist. Practice limited to "public health facilities" as defined in state statute.	Scope limited to preventive services. Practice limited to Tribal and related settings. Law sunsets in 2023.	Must be a licensed dental hygienist. Practice limited to safety-net, public health, and non-profit settings, or private practices where 50% of DTs' patients are underserved.	DTs practicing under pilot authority will be eligible for state license; DTs practicing for Tribes will not be required to get licensed. DT pilot project authority sunsets in 2025.

https://www.dentaltherapy.org/resources/Model-Dental-Therapist-Rule.pdf

Note: Composed in August 2021 and does not include information from Colorado and Oregon, who have authorized dental therapy. More recent dental therapists in practice data indicates there are now 131 in Minnesota and 8 in Washington.

PART IV

The Business Case for Dental Therapy

In addition to dental therapists' ability to expand access to care and improve oral health outcomes, there is now considerable evidence of their positive economic impact, which in turn enables health centers to serve more patients. Dental therapist salaries are lower than dentists' salaries so adding dental therapists to the dental care team can help lower the production costs of providing care and increase revenue which allows the practice to recruit more providers.[1] Dental therapists' ability to practice under general or off-site supervision, enables dental practices to extend office hours or expand to off-site locations such as schools, day care centers, and nursing homes. Evidence that demonstrates dental therapy positive impact on health center finances includes:

Apple Tree Dental Clinic, a non-profit organization in Minnesota, sends a dental team with a dental therapist to provide on-site care at a nursing home for veterans. The dental therapist provides 8-10 dental visits each day which **generates an average additional daily revenue of $3,122.**[2] Dental therapist average employment costs per day are $222 less than the costs for a dentist with total savings of $52,000 per year.[3]

Apple Tree also sends a team with a dental therapist to a rural dental clinic. The dental therapist average daily billing over three years was 94% of the average of the clinic dentist.[4] Although the average billing per visit was close to the average for clinic dentists—within 8 to 15%, the difference in pay **helped to reduce cost/visit and increase overall revenue/visit.**[3]

Dental therapists have been a game-changer *for Scenic Rivers Health Services and our ability to expand access to oral health care services. Our health center has a service area that is size of the State of New Jersey, most of our patients have significant oral health needs and there are few if any dentists in our region who serve people on Medicaid or the uninsured. Adding dental therapists to the oral health team at Scenic Rivers Health Services has made it possible to schedule more appointments and provide more care to more patients. Dental therapy has also had a very positive financial impact for our health center.*

—Michael Holmes
CEO
Scenic Rivers Health Services

1 http://www.pewtrusts.org/en/research-and-analysis/q-and-a/2016/04/5-dental-therapy-faqs

2 http://www.appletreedental.org/wp-content/uploads/2017/09/ADT-LTC-Case-Study-091517.pdf

3 IBid

4 http://www.appletreedental.org/wp-content/uploads/2018/02/ADT-Rural-Jodi-Hagers-Case-Study-022118.pdf

PART V

The Practice of Dental Therapy

Dental therapists are able to perform a limited number of procedures unique to their scope of practice (e.g., preparing and filling cavities, performing nonsurgical extractions), which allows dentists to devote more time to procedures which only dentists are trained to do. The following chart provides a general snapshot of key procedures each member of the dental care team is authorized to perform:

DENTAL SCOPE COMPARISON CHART[1]

	REGISTERED DENTAL ASSISTANT (RDA)	REGISTERED DENTAL HYGIENIST (RDH)	DENTAL THERAPIST (DT)[2]	DENTIST (DDS/DMD)
Education requirement	*Graduation from a RDA program or 15 months of experience as a DA*	*Graduation from an accredited dental hygiene program*	*Graduation from an accredited dental therapy program*	*Graduation from an accredited dental program*
Exams[3]		Oral health screening & preliminary exam	Oral examination, evaluation and diagnosis	X
Taking x-rays	X	X	X	X
Treatment planning		Within their scope	Within their scope	X
Topical fluoride	X	X	X	X
Sealants	X	X	X	X
Polishing teeth	X	X	X	X
Prophylaxis		X	X	X
Scaling & root planing		X		X
Placing orthodontic bands	*			X
General anesthesia/sedation	Monitor patients*	Monitor patients		X
Nitrous oxide	Assist	X	X	X
Local anesthesia		X	X	X
Interim therapeutic restorations		X	X	X

* Allowed if provider completes a course and receives a permit in dental sedation or orthodontics

(chart continues on next page...)

1 Community Catalyst– January 2020

2 The dental therapist scope of practice is based on the recommendations in the National Model Act for Licensing or Certification of Dental Therapists.

3 This is not a comprehensive list of any of the professions' scope. Dental therapists can perform ~60 procedures while dentists can perform ~500.

	REGISTERED DENTAL ASSISTANT (RDA)	REGISTERED DENTAL HYGIENIST (RDH)	DENTAL THERAPIST (DT)[1]	DENTIST (DDS)
Preparing enamel by etching for bonding			X	X
Preparing restorations			X	X
Placing restorations		Polish & contour filling material	X	X
Temporary crowns	Fabricate, adjust, cement & remove	Fabricate, adjust, cement & remove**	Fabricate, adjust & cement	X
Placing dressings	X	**	X	X
Removing dressings	X	X	X	X
Removing sutures	X	X	X	X
Pulp vitality testing	X	**	X	X
Pulp capping			X	X
Pulpotomies			X	X
Extractions of primary teeth			X	X
Extractions of permanent teeth			Simple extractions	X
Root canals				X
Crowns				X
Implants				X
Bone grafts				X
Bridges				X
Dentures				X

* Allowed if provider completes a course and receives a permit in dental sedation or orthodontics

** Depending on year licensed, may require additional education/licensure as RDA

1 The dental therapist scope of practice is based on the recommendations in the National Model Act for Licensing or Certification of Dental Therapists.

I love working in an FQHC where anyone can receive care regardless of insurance or lack thereof. I especially enjoy oral health promotion and disease prevention.

My typical day includes helping to complete same day sealants, orchestrate new patient assessments, increase HPV vaccine awareness, and run daily pediatric exam and operative schedules. ***With my advanced certification I can cover when dentists are out sick, or on leave, enabling clinics to stay open and continue patient care.***

—Kathlyn Jean-Kelly Leiviska, cADT, MDT, BS, Southside Community Health Care

When dentists and therapists work collaboratively, patients receive comprehensive care from a team where each member is able to contribute services according to their scope of practice. *Dental therapists handle direct fill restorations for patients of all ages and all care on primary teeth as well as assisting with limited and periodic exams. Dentists are able to focus on advanced procedures such as Endodontics, Oral Surgery, Crown and Bridge and Removable Prosthodontics which expands access to treatment and services for health center patients. A team approach to emergent care means that the dental therapist can initiate diagnosis and treatment and anesthetize the patient before they are seen by the dentist for an extraction.*

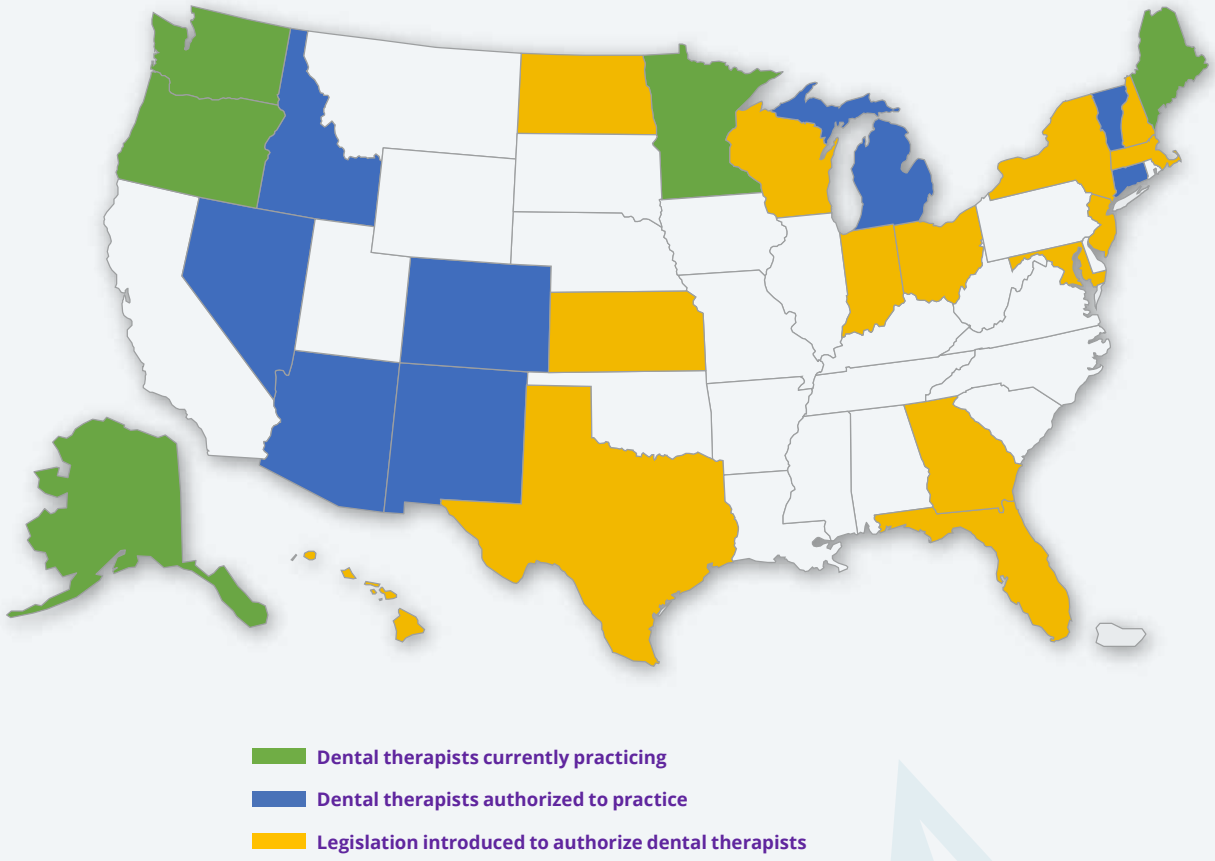
—Brian Quinlan
Southside Community
Health Services

PART VI

State Action on Dental Therapy

Authorization for dental therapists is ultimately driven by state-level action, specifically through laws passed by state legislatures. Dental therapists have been working in the United States since 2004 and are now currently able to practice in various settings in 14 states.

DENTAL THERAPISTS—STATE-BY-STATE AUTHORIZATION



This map is based on NACHC research using data from state legislative websites and input from dental therapy stakeholders.

CONCLUSION

Dental therapists have an important role on health center dental care teams and expanding access to oral health care. The addition of dental therapists to FQHC dental care teams, along with expanding access to dental care, provides the opportunity to "grow our own." Traditionally, the education pathway for dental therapists was developed so that community members become dental therapists through accessible and achievable training programs and can return to their communities to provide care under the general supervision of a dentist in a few years.[1, 2] Recruiting from the community provides opportunities to have a workforce that reflects the population served.

Please consult with your state primary care association or NACHC, cmo@nachc.org, if you are interested in learning more about their role for your health center. You can also learn more about dental therapist initiatives from Community Catalyst Dental Access Project and National Partnership for Dental Therapy.

Community Catalyst Dental Access Project

https://www.communitycatalyst.org/initiatives-and-issues/initiatives/dental-access-project/dental-access-project

National Partnership for Dental Therapy

https://www.dentaltherapy.org

1 https://www.dentaltherapy.org/blog/expert-panel-dental-therapy-can-help-undo-racism-in-oral-health-care

2 https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2016.303641#:~:text=Access%20to%20oral%20health%20care%20is%20an%20overlooked,underserved%2C%20and%20communities%20of%20color%20at%20disproportionate%20rates

mpca THE VOICE OF COMMUNITY HEALTH CENTERS

Michigan Community Health Center
Medical & Dental Assistant Training Program

SUMMARY

Michigan Community Health Centers, like other Healthcare providers, have seen unprecedented workforce labor shortages over the COVID-19 Pandemic. The most critical labor shortages Health Centers have experienced have been in unlicensed health care professional roles, mainly Medical and Dental Assistants. To transcend this period of critical workforce shortages, MPCA has actively engaged with State and Regional workforce development agencies and training partners to develop a collaborative training model which pairs an online training program with an on-the-job training experience to produce qualified medical and dental assistants to fill existing vacancies and sustain a stable workforce to meet the growing need for healthcare access in some of Michigan's most underserved communities.

TRAINING SOLUTION

Through a 7.6 Million Dollar workforce investment through the Michigan Department of Health and Human Services, Michigan Health Centers will train and employ up to 300 new Medical and Dental assistants between June 2022 through September 2024. Health Centers that participate in the funding program receive funding to cover employer costs, including tuition and student wages, training equipment, and supplies such as practice models, laptops, and extra supplies for lab-based learning. Funds also support mentor and supervising staff costs.

MPCA has partnered with Career Step to provide a low-cost, high-quality training option to health centers and support the collective success of students and participating Health Centers. Students will earn as they learn online and on-the-job free from student debt or prohibitive tuition costs. Health Centers establish service-term agreements with their sponsored trainees o retain the return on investment in building the Health Center workforce.

IMPACT

This will significantly impact current acute workforce shortages and meet expanding needs. Health Centers will immediately benefit from the relief of additional trainees while building their internal capacity for sustaining their role in training healthcare professionals beyond the end of this funding. This investment will bolster Health Centers' capacity to provide access to critical primary care and oral health services, reduce health disparities, and prevent costly care from preventable conditions.

For more information on this program, contact:

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