Are Dental Therapists the Answer to Increasing Care for the Underserved? So Far, the Results Fall Short.

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The position of dental therapist was created to offer the delivery of oral health care by a mid-level provider. A stated objective of adding this provider model to the profession of dentistry was to increase access to dental care for marginalized and/or vulnerable communities while reducing costs.

The New York State Dental Association (NYSDA) has watched other states pursue dental therapy legislation, including nearby Maine and Vermont, and across the country in Minnesota and Colorado. While well intentioned, these laws have not had a significant impact on increasing the number of providers nor increasing access to care for underserved populations. As an example, in Minnesota, where legislation requires that dental therapists practice in underserved areas, only nine are serving the state's rural population of 1.2 million people.[1]

States that have invested significant capital and effort in creating dental therapy programs have not seen the model make substantial strides in improving oral health outcomes. At the end of 2021, there were no dental therapists providing care in eight of the 13 states that had approved dental therapy legislation.[2] For instance, Vermont enacted legislation for dental therapy in 2016, investing nearly $4 million into an educational program that is not operational. Meanwhile, the most recent report from the Vermont DOH indicates that they have fallen short of their goals to increase the number of WIC eligible pregnant woman

receiving care and reduce the percentage of third grade children with dental decay to 30%.[3]

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The use of dental therapists has not proven to reduce the cost of receiving dental care. Dental procedures cost the same regardless of who performs them, and there is no impact on government reimbursement rates paid through programs like Medicaid. In fact, it could be argued that the dental therapy program would ultimately increase the cost of delivery with the creation, regulation, and oversight of an additional licensed professional.

Additionally, introducing dental therapists would create a two tiered-care delivery model, with low-income patients receiving care from a lesser-trained dental therapist, while those who are more affluent will receive care from a doctor of dental medicine or a doctor of dental surgery. Thus, the introduction of dental therapists could result in creating a problem in health care disparities in the provision of dental services.

Alternative Models to Dental Therapy

While I was serving as executive director of the Colorado Dental Association, the CDA commissioned the Wynne Health Group (WHG) to explore alternative models and best practices to address access in oral health care delivery. The WHG produced a report titled *Exploring the Addition of Mid-Level Providers.* The WHG report outlined several alternative models to dental therapists, including but not limited to:

- Community-based dental access programs in New Mexico and California that incorporated teledentistry and interdisciplinary teams demonstrated success in reducing oral health emergency department visits.
- Community Dental Health Coordinators (CDHC), working within communities with a specific skill set in oral health, connect people to dentists in their communities. CDHC programs train registered dental hygienists and dental assistants to understand the socioeconomic conditions of a community while addressing the barriers to care for individualized dental needs.

In a similar fashion, NYSDA developed a program called the Dental Demonstration Project (DDP). The DDP, a state-funded initiative, was created to improve oral health outcomes in underserved populations across New York State. Through one-day service events and community outreach projects, the DDP strives to close the gap on unmet dental needs, improve health literacy, connect patients to dental health homes, and link families to resources in their local communities. To date, over 2,000 New Yorkers have received assistance from dental providers at DDP events and projects across the state.[4]

Investments to expand projects and workforce models such as the DDP and CDHC would directly influence oral health outcomes – by addressing patient needs and guiding patients toward dental health homes and away from emergency departments. While New York is fortunate to have a comprehensive dental benefit for

children and adults, our Association continues to learn of challenges to dental care delivery, including outdated reimbursement rates and unnecessary administrative burdens. These barriers make it difficult for providers to participate in plans designed for the poor and underserved.

In addition to administrative and financial burdens, licensing barriers have limited the number of existing providers in New York. Addressing licensing and certification barriers for dentists, hygienists, and dental assistants needs to be a priority in New York State before new models are explored. Currently, there is only one licensed dental assistant for every 10 dentists, which is severely hampering the ability of dentists to provide care.

The New York State Dental Association encourages stakeholders, including the Departments of Education and Higher Education, to invest in pathways for the existing dental workforce and expand training programs to address access to care delivery in a meaningful way.

Proposed bill S819, in favor of dental therapists, currently remains in committee. As an organization, we do not see this model as a viable solution to address the oral health disparities in New York. As such, NYSDA would most likely oppose any legislation targeted at creating a dental therapist provider. We encourage broader conversation around access to oral health care and the challenges that currently face New York, for both patients and providers.

References

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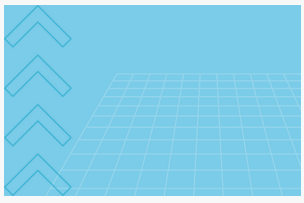

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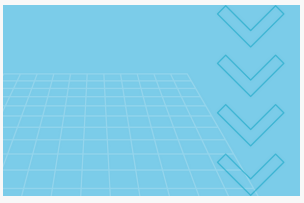

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