The Dental Therapist Movement in the U.S.

Dental Therapists: A National Resource for Improved Oral Health?

By

Richard W. Valachovic, DMD, MPH
Clinical Professor and Director
NYU Dentistry Center for Oral Health Policy and Management

Here is something on which we can all agree: Americans lack sufficient access to dental care. In 2000, a landmark report from the U.S. Surgeon General's office made clear that "What amounts to 'a silent epidemic' of oral diseases is affecting our most vulnerable citizens – poor children, the elderly, and many members of racial and ethnic minority groups."[1] A follow-up report in 2021 noted that, despite an increase in oral health providers in the preceding 20 years, 60 million mostly rural Americans continued to live in areas "where there are too few oral health professionals to meet local needs."[2] One possible solution? Encouraging the spread of new workforce models, including dental therapy.

Dental therapists (DTs) are relative newcomers to U.S. health care. They practice in isolated pockets of the country and face limits on which patients they can treat. But in the communities where they practice, they are making a tangible difference. Working as part of a team and under the supervision of a dentist, they are serving communities with limited access to dental care by providing a limited range of restorative procedures and encouraging prevention.

Lessons from NPs and PAs

DTs are often compared with nurse practitioners (NPs) and physician assistants (PAs). In some ways the comparison misses the mark. Today's NPs and PAs must earn a master's degree or clinical doctorate from an

accredited program to enter their professions. They have access to hundreds of educational programs and are licensed to practice in all fifty states. In contrast, there are only five U.S. DT programs, and they represent widely different ideas of what constitutes an adequate education for DTs. Two programs take three years to complete and culminate in an associate degree. A third program is structured as a 36-month, year-round, dual degree program in both dental hygiene and dental therapy. The remaining two programs require a baccalaureate in dental hygiene for entry and culminate in a master's degree in advanced dental therapy.

In other ways, the comparison is quite apt. The NP and PA professions were both created in 1965 to address a need for more primary care providers. The initial cohort of NPs were public health nurses whose additional training allowed them to better meet the individual care needs of people living in remote areas of Colorado.[3] Dental therapy was imported from overseas, but like nurse practitioners, DTs were seen as means to address the needs of remote communities. In 2005, the Alaska Native Tribal Health Consortium (ANTHC) sent eight Alaska Native students to New Zealand to train as dental therapists and brought them home to fill local gaps in dental care on Tribal land.

The first PAs were Navy Hospital Corpsmen who received additional medical training to address concerns about a shortage of primary care physicians. According to the American Academy of Physician Associates, formerly known as American Academy of Physician Assistants (the profession is in the process of changing its name), the medical community welcomed the new profession and spurred the development of accreditation standards, a national certification process, and continuing education requirements.[4]

The dental community has been slower to embrace DTs. In January 2006, the American Dental Association (ADA) and Alaska Dental Society filed a lawsuit against the ANTHC in an attempt to prohibit DTs from filling and extracting teeth, procedures they characterized as "irreversible." The suit did not succeed, and DTs quickly demonstrated their ability to safely deliver care within their scope of practice – just as they had been doing in New Zealand since the 1920s and in dozens of other countries.

For the record, DTs work under the supervision of a dentist, and many of the "irreversible" procedures they perform affect primary rather than permanent teeth. After graduating, DTs must complete hundreds of hours of directly supervised practice before they are certified. In addition, DTs are limited in the dental procedures they perform, and they may only perform them under general supervision (without a dentist present on site), if their supervising dentist has authorized them to do so.

That a range of academic institutions – from community colleges to dental schools – can establish successful programs gives me hope that we will see the number of DT graduates begin to rise. This is a critical first step, but it will take many more actions before DTs become a national resource. ...The experience of NPs and PAs is instructive. It took more than 20 years before these professionals were recognized as Medicare-covered providers in all settings and

authorized to practice in all fifty states. In many of those states, they are still engaged in battles to remove practice barriers, as are pharmacists and other advanced practice registered nurses.

The ADA's initial opposition to dental therapy notwithstanding, the association recognized the need to expand the dental team. In 2006, the ADA established an alternative role, the Community Dental Health Coordinator (CDHC) who would focus on community-based prevention, care coordination, and patient navigation to link underserved people with dental health resources.[5] These providers may be helpful in their own right, but they cannot coordinate or help patients navigate care in communities where dental providers do not exist. As advocates for dental therapy have long pointed out, prevention is all to the good, but it will not treat dental disease that already exists. That requires the care of someone with restorative capabilities.

Developing a National Presence

Despite early challenges to the profession, DTs are slowly gaining ground in the United States. Since Minnesota became the first state government in the U.S. to authorize the licensing of dental therapists in 2009, another twelve states have followed suit, and advocates are pursuing authorization in six more.

There has been progress on the educational front as well. The Commission on Dental Accreditation (CODA) established standards for DT programs in 2015. Three programs have received CODA accreditation, two are currently seeking accreditation and new programs are under development in Michigan and Vermont.

That a range of academic institutions – from community colleges to dental schools – can establish successful programs gives me hope that we will see the number of DT graduates begin to rise. This is a critical first step, but it will take many more actions before DTs become a national resource. Here again, the experience of NPs and PAs is instructive. It took more than 20 years before these professionals were recognized as Medicare-covered providers in all settings and authorized to practice in all fifty states. In many of those states, they are still engaged in battles to remove practice barriers, as are pharmacists and other advanced practice registered nurses.

With fifty states, the District of Columbia, U.S. territories, and Tribal governments all setting policy independently, change happens slowly in the United States. Does that mean it has to take another 40 years before DTs become as established as NPs and PAs?

The lack of urgency to accelerate change is frustrating. In major metropolitan areas, insured consumers and those who can afford to pay out of pocket typically have their pick of dental providers, but what about everyone else? Dental care is simply too expensive for many Americans, and reimbursement through Medicare and Medicaid is insufficient to incentivize most dentists to provide care in areas with few privately insured patients.

DTs can fill this gap if the dental profession and policymakers choose to embrace this solution. So, what can we, as dental educators, do to help to advance progress? As educators, we can inform our students about the

value DTs bring to the dental team, foster an ethos of respect and collaboration among health professionals, and advocate for DT programs within our institutions and practice authorization in our home states. Maybe then the students we are educating now will be practicing along with DTs and other dental professionals, and we will see a significant increase in the number of people with access to the care they need.

References

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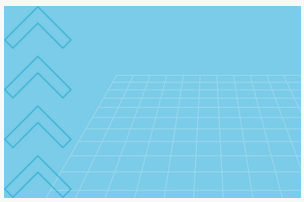

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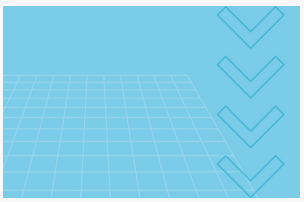

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