How Dental Therapists Can Address the Social and Racial Disparities in Access to Care

There is mounting evidence linking poor oral health to poor overall health outcomes, in addition to significant economic impacts through higher health care costs, lost productivity, and lost wages.[1] Yet, oral health care is still treated as separate from the rest of health care. There are myriad systemic barriers to accessing dental services, particularly among the vulnerable, the underserved, and communities of color. An alternative model of dental care delivery that could address racial and social disparities in access to care is dental therapy.

A RACE AND SOCIAL JUSTICE ISSUE

Access to oral health care is an overlooked race and social justice issue, with the inability to access dental services affecting the vulnerable, the underserved, and communities of color at disproportionate rates. In 2010, the Government Accountability Office reported that the most frequent barrier children enrolled in Medicaid faced in obtaining dental care was finding a dentist who would accept Medicaid payment.[2] In 2015, the National Health and Examination Nutrition Survey found that Hispanic (46%) and non-Hispanic Black (44%) children younger than eight years are more likely to have cavities than non-Hispanic White children (31%).[3] The barriers these communities face in accessing care are complex and broad reaching—from social, structural, and cultural, to economic and geographic. It is imperative that we not only look for comprehensive solutions, but also consider the disproportionate burden these communities face when tailoring solutions to address them.

SHORTAGE OF DENTAL PROVIDERS

Currently, there are not enough providers to meet the demands of the general population, with the shortage projected to worsen. A 2015 Department of Health and Human Services–Health Resources and Services Administration report found that by 2025, the supply of dentists is expected to grow by 11 800 full-time equivalents (FTEs), whereas the demand is projected to grow by 20 400 FTEs. Combined with the existing shortages in dental health professional shortage areas, there is a projected national shortage of approximately 15 600 FTE dentists in 2025.[4] There is an even greater shortage of providers who accept Medicaid and are adequately trained for serving the underserved, particularly in the areas where they live.[5] Dental therapists could immediately address these workforce shortages and disparities in access to care.

AN ALTERNATIVE DENTAL CARE DELIVERY MODEL

Dental therapists are early intervention and prevention dental professionals who are trained to provide a limited scope of services under the supervision of a dentist, and are specifically designed to work in underserved areas. Working worldwide since the 1920s, dental therapists have been part of the US dental team for over a decade now. They work in Alaska, Minnesota, and the Swinomish Indian Tribal Community, and were also recently authorized in Vermont and Maine.

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. Long-term evidence and experience have shown that dental therapists can be trained in just two years, which lowers cost and debt burden barriers and increases access to dental therapy education for students, especially those from poor and underserved communities.[3] Additionally, as a result of their training, dental therapists are able to deliver patient-centered care because they understand the history, culture, and language of their patients and provide continuity of care in communities that face recruitment and retention challenges. These factors are critical in building the community's health care delivery capacity and improving oral health outcomes.

In addition to addressing workforce shortages, dental therapists are able to relieve the financial burden that dental practices shoulder as a result of limited resources for oral health care for vulnerable and underserved populations. Because dental therapists are less expensive to hire, dental practices can provide care for more patients on Medicaid even with lower reimbursement rates and still be profitable. According to a 2014 report from the Minnesota Department of Health and Board of Dentistry to the state legislature evaluating the impacts of dental

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therapists in Minnesota, dental therapists served 6338 new patients over a 13-month period, 84% of whom were public program enrollees or from underserved communities. Additionally, the report found that benefits attributable to dental therapists included direct costs savings (estimated between $35 000 and $62 000) and a reduction in wait time for patients, which made it possible for clinics to see more underserved patients.[6] These findings are supported by Community Catalyst's Economic Viability of Dental Therapists report and case studies conducted by Pew, which demonstrated cost-effective benefits for a variety of practices, even when the majority of patients were low-income and Medicaid populations (in Alaska and Minnesota, their salaries account for less than 30% of the revenue they generate).[7] These components would benefit all underserved populations, particularly racial and ethnic minorities, and are critical in addressing the systemic barriers that prevent them from achieving and maintaining access to oral health services.

FUTURE DIRECTIONS

Over a dozen states are pursuing midlevel providers to improve access to care. In 2015, the Commission on Dental Accreditation (CODA), the entity that oversees dentists' education, approved core educational standards for dental therapists and allowed advanced standing for hygienists to become joint dental hygiene–therapy providers. Prior to the CODA standards, state legislatures arbitrarily determined educational requirements, resulting in early adopter states having varying pathways to dental therapy, with most requiring the dual degree therapist–hygienist model necessitating more education time and costs. As states move forward, it is important to adopt the core CODA-approved pathway for dental therapists, as well as the dual degree pathway for advanced standing dental therapists, to ensure that the existing workforce is maximized and to create new opportunities to recruit students from rural, underserved areas and ethnically diverse communities. This core pathway was used in Alaska, resulting in the first group of dental professionals that shared the language and culture of the underserved population being served. The intentional design of the Alaska program offers insight into not just improving oral health care, but successfully building a culturally competent workforce and creating employment opportunities in rural America.

It is imperative to treat access to oral health care as the race and social justice issue it is by expanding and bolstering the traditional dental delivery system to serve underserved communities. Dental therapists have been practicing in Alaska for more than ten years, resulting in more than 45 000 Alaska Natives across 81 communities gaining access to dental care.[7] With dental therapists in Alaska and Minnesota demonstrating that they are increasing access to care—especially for hard-to-reach populations—the implementation of dental therapy programs is clearly in the public interest.

Dental therapy is not a limited or temporary solution. Training a group of dental professionals that are members of, and share the language and culture of, the community that they will serve greatly improves communication, trust, patient satisfaction, and adherence to advice and treatment. It is a solution that can increase access to care for all populations and help achieve equity for those who are disparately affected by barriers to oral health services. AJPH

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