



Dental Therapists: Sinking Our Teeth into Innovative Workforce Reform

Jennifer Minjarez

Policy Analyst with the Texas Public Policy Foundation's Center for Health Care Policy

& Sal Nuzzo

Vice President of Policy, The James Madison Institute

Executive Summary

Florida's licensure regulations create barriers to accessing dental care. The state dental practice act and Florida Board of Dentistry (FBD) control every facet of the dental profession, rendering dental providers unable to adapt to Florida's diverse and changing demand for dental care. The result is millions of Floridians not getting the dental care they need when they need it.



Florida's access to care deficiencies manifest themselves in a variety of ways. To start, there are only 52.3 dentists per 100,000 people in Florida, compared to a national average of 60.8 dentists.¹ Additionally, roughly one in four Floridians – about 5 million – live in areas of the state where there are documented dentist shortages.²

Maximizing access to dental care is not simply a matter of ensuring Florida has enough dental providers, but also ensuring that it has the right types of providers and that they are well-distributed across the state. Government cannot determine which providers are needed in which quantities, yet the state controls the supply of dental providers through licensure regulations.

A few states have identified the relationship between their licensure regulations and low access to dental care. Minnesota, Maine, Vermont, Oregon, and Washington have all broadened their regulatory framework to make room for a new dental workforce model: dental therapy. Dental therapists are mid-level dental practitioners, similar to nurse practitioners in primary care.

Dental therapists are new to the U.S., but have been practicing since the 1920s in other parts of the world and are now in over 50 countries.³ Studies in Alaska and Minnesota show strong correlations between utilizing dental therapists and increasing access to care.^{4,5} They also observe increasing dental utilization rates and patient satisfaction in areas where dental therapists practice.⁶ Overall, dental therapists appear to be practicing safely, and patients are satisfied with the care they provide.

Despite the positive results associated with dental therapy, special interest groups including dental associations oppose the concept because their members fear it will create unwanted competition. After the Commission on Dental Accreditation adopted education standards for dental therapy programs in 2015, the American Dental Association (ADA) released a statement in which they “firmly opposed...allowing non-dentists to perform surgical procedures,” referring to dental therapists.⁷ State dental associations, supported by the ADA, have lobbied extensively in other states to protect their fiefdoms at the expense of patient ac-

cess and higher costs for services.⁸ In the end, patients pay more for dental care and receive less of it.

Florida policymakers should reform licensure regulations to grant dental providers the freedom to innovate. Florida's population is rapidly growing and Floridians' demand for dental care will continue to evolve. The best way to ensure Floridians have access to dental care is to let the market determine the number and types of Florida's dental care providers. Allowing dental therapists the ability to practice would be a significant step in this direction.

Introduction

There are currently 52.3 dentists per 100,000 people in Florida, compared to a national average of 60.8.⁹ One of the ways this lower ratio of dentists to the population is seen is in Health Professional Shortage Areas (HPSAs) – geographic areas, populations, and facilities in which the need for dental care exceeds the number of dental care providers. The U.S. Department of Health and Human Services (HHS) designates HPSAs.

There are currently 224 dental HPSAs in the state of Florida.¹⁰ Over 5 million Floridians reside in these HPSAs. And while the American Dental Association (ADA) provides evidence indicating that the supply of dentists will grow in the next decade, it acknowledges that “Understanding how the total supply of dentists might evolve contributes only partially to the central policy question of whether or not there is likely to be a shortage of dentists in the United States. The issue of provider adequacy is far more complex and, even at the most aggregate level, requires some type of assessment of the demand for dentists.”¹¹ Furthermore, one must consider the type of providers available, what the ADA calls “provider adequacy,” in addition to the quantity of providers when sizing up the shortage.

This means that combatting Florida's dental care shortage is not simply a matter of producing more dentists. Different dental providers have different scopes of practice, availability, and costs. For example, dental hygienists are generally more available than dentists, but their scope of practice is more limited. They can provide basic preventive care, but only dentists can provide permanent restorative care. However, dental hygienists are able to perform basic procedures at lower costs than dentists.

Florida's dental workforce is not meeting the needs of the marginal patient. Many Floridians, particularly low-income and rural residents, have limited dental care options and face significant challenges every step of the way. They have trouble finding providers, getting to the dental office, and paying the bill. For these reasons, the marginal patient will not actively seek dental care unless it is exceptionally accessible and affordable. For example, they may require a dental practitioner who travels to meet them, or who costs less than a dentist because their scope of practice is designed for routine care.

While there may not be a one-size-fits-all solution to this problem, Florida policymakers should consider supply-side reforms that enable dental providers to fill the market gap. One promising solution is in the practice of mid-level dental providers.

Mid-level dental providers, also known as dental therapists, are utilized in over 50 countries.¹² Dental therapists are relatively new to the U.S., but studies consistently show that access to care and dental utilization rates improve in the areas they serve. That is why over a dozen states have considered dental therapy legislation in recent years, and why they are now practicing in six states.

Dental Therapists

Dental therapists are mid-level dental practitioners whose scope of practice is primarily focused on routine preventive and restorative care. They work within a dental team, under the supervision of a dentist, alongside dental hygienists and assistants.

Dentists and dental therapists work together to determine their expectations, roles, and responsibilities. These are formalized through collaborative management agreements (CMAs) which allow each supervising dentist to specify a dental therapist's scope of practice, supervision levels, emergency protocols, etc.

State legislators and educational institutions determine the level of training and education required for dental therapists. In Alaska, dental therapists must complete a 2-year education program and 400 hours of a supervised preceptorship to apply for certification.¹⁴ The University of Minnesota offers a 4.5-5 year dual-degree program in dental hygiene and dental therapy.¹⁵ Upon completion, students earn a Bachelor of Science in Dental Hygiene and a Master of Dental Therapy. After 2,000 hours of supervised clinical practice, graduates can apply for an Advanced Dental Therapist (ADT) license.¹⁶

In 2015, the Commission on Dental Accreditation (CODA) adopted standards for dental therapy education programs. CODA is the sole agency recognized by the U.S. Department of Education to accredit post-secondary dental education programs.¹⁷ Three years of careful research, public hearings, and stakeholder reviews went into the development of the dental therapy education standards.¹⁸ Several states have incorporated CODA's standards into their dental therapy licensure legislation, as a benchmark for dental therapists' credentials.

Dental therapists' scope of practice is a function of their education and training, authorizing legislation, and their CMAs. State policymakers and dentistry boards determine the maximum legal scope of practice for dental therapists, but supervising dentists can further limit the scope through CMAs. Dental therapists typically perform 80 to 95 procedures, compared to dental hygienists who can perform 40, and general dentists who can perform about 400.

Dental therapists are a unique and innovative addition to the dental team. Their advanced training can prepare them to practice

primarily under "general supervision," which does not require a supervising dentist to remain on the premises. Dentists can expand their practice far outside the office by employing dental therapists. Their ability to travel and perform highly demanded procedures, such as fillings and extractions, makes them particularly accessible for marginal patients. Utilizing dental therapists is also likely to create competition among dental providers, which could lower the cost of dental care for all Floridians.

Alaska was the first U.S. state to use dental therapists. In 1999, oral health surveys revealed drastic oral health disparities in Alaskan Native communities, many of which had no on-site dental services.¹⁹ Without a "comprehensive, long-term delivery structure," the oral health disparity was sure to increase. To combat the dental care shortage in Alaskan Native communities, the Alaska Native Tribal Health Consortium (ANTHC), in collaboration with Alaska's Tribal Health Organizations (THO), developed a pilot program to introduce mid-level dental practitioners. ANTHC and THO took inspiration from dental nurses practicing in New Zealand since 1921 and dental therapists in Canada. In 2003, the first Alaskan dental therapy cohort began training at the University of Otago in Dunedin, New Zealand. Upon completion, the cohort returned to Alaska and began practicing in 2005.

Access to dental care has increased dramatically in Alaskan Native communities. Utilization rates and oral health outcomes have improved, and patients report high levels of satisfaction with the care they receive (see next section). Over a dozen states have considered dental therapy legislation, hoping to emulate Alaska's success. Dental therapists can currently practice in Alaska, Oregon, Washington, Minnesota, Maine, and Vermont.

Positive Effects of Dental Therapy

The success of the dental therapy model hinges on the ability to improve access to dental care. Because the profession is new to the U.S., there are only a few seminal studies on its results. However, the studies that exist are powerful. They reveal the dramatic, positive effects dental therapists have in their communities, and provide optimistic outlooks for the future.

In 2008, the W.K. Kellogg Foundation, the Rasmuson Foundation, the Bethel Community Services Foundation, and ANTHC commissioned an independent study on the early effects of dental therapy in Alaska. RTI International published the study in 2010. The study surveyed Alaskan Natives living in rural villages served by dental therapists. The majority of respondents were highly satisfied with the care that they received.²⁰ Their responses indicated they felt access to care had improved and that their dental problems were addressed more quickly. The study also included a "blind" evaluation of restorative procedures performed by dental therapists and dentists. Fewer deficiencies were observed for dental therapists than dentists.

Seventy-eight percent of the survey respondents, Alaskan Native parents, reported that their child had received treatment from a dental therapist in the previous year.²¹ Since 2005, dental therapists have increased access for over 40,000 Native Alaskans living in rural communities, many of whom previously had no regular source of dental care.²²

A professor at the University of Washington published the first long-term study of Alaskan dental therapists in August 2017. The study compared outcomes between communities with very high access to dental therapists and communities with none. It found that children in communities with a strong dental therapist presence had fewer front tooth extractions and more preventive care. Adults had fewer permanent tooth extractions and also more preventive care.²³ Overall, the study shows a very strong association between use of dental therapists and improved oral health outcomes in underserved communities.

In 2014, the Minnesota Department of Health (MDH) and Minnesota Board of Dentistry (MBD) produced a report for the Minnesota Legislature on the early impacts of dental therapists. Dental therapists have been practicing in Minnesota since 2011. A total of 15 clinics employing dental therapists participated in the evaluation from August 2012 to December 2013. At the time of the study, there were 32 licensed dental therapists, six of whom were certified ADTs.²⁴

The report found that the dental therapists had treated 6,338 new patients during the evaluation period, 84 percent of whom were enrolled in public health insurance programs.²⁵ One third of patients experienced a reduction in wait time, and some saw a reduction in travel time for their appointments, both more pronounced in rural areas. There were no complaints filed against the dental therapists relating to patient safety issues, and the report contained preliminary findings that suggest, “Dental therapists offer potential for reducing unnecessary ER visits for non-injury dental conditions.”²⁶

MDH and MBD’s report included a survey of the clinics employing dental therapists. Overall, they reported experiencing “personnel cost savings, increased dental team productivity, and improved patient satisfaction.”²⁷ Utilizing dental therapists allowed them to expand their practices to treat more underserved patients. Furthermore, most of the clinics employing dental therapists for at least a year intended to hire more dental therapists. Overall, the evaluation concluded that dental therapists were “fulfilling statutory intent by serving predominantly low-income, uninsured and underserved patients,” and appeared to be practicing safely.²⁸

Two case studies commissioned by the Delta Dental of Minnesota Foundation and conducted by Wilder Research explore private, for-profit clinics’ experiences with dental therapists. The clinics observed were Grand Marais Family Dentistry (GMFD) and Midwest Dental in Minnesota. Both clinics are located in rural

areas and designated HPSAs.

GMFD’s motivation for hiring a dental therapist was to reduce the dentist’s caseload and increase the clinic’s ability to treat patients enrolled in public health insurance programs. The clinic’s average number of patient visits increased, and the proportion of patients enrolled in public health insurance programs increased from 27 to 33 percent.²⁹ Overall, patients were very satisfied with the care they received from the dental therapist.³⁰ The clinic also reported a reduction in wait times from four weeks to one week.³¹ After hiring the dental therapist, the dentist performed fewer restorative procedures and more high-fee procedures, such as orthodontic and periodontal procedures.³² Finally, GMFD experienced a 13 percent net increase in average monthly revenue.³³

Midwest Dental wanted to hire a dental therapist because they had difficulty recruiting a dentist in a rural area. The clinic’s average number of patient visits increased from 328 to 408 per month, and 71 percent of the dental therapist’s patients were enrolled in public health insurance programs.³⁴ The majority of the dental therapist’s patients had not visited a dentist in two or more years, and overall they rated the care they received highly.³⁵ After hiring the dental therapist, the dentist performed less restorative procedures and more complex procedures, such as oral surgery and emergency care.³⁶ Finally, Midwest Dental’s average monthly revenue increased 2.4 times after hiring the dental therapist.

GMFD and Midwest Dental had positive experiences with dental therapists. Dentists seemed to have complementary relationships with their dental therapists, rather than competitive relationships. The evidence suggests that dental therapists benefit the clinics in which they work, and make the dental team more productive overall.

The dental therapy workforce continues to grow in the U.S. and there is good reason to be optimistic about its impacts. In the private sector, innovation is an effective way to combat market shortage. However, dentists are not free to innovate because dentistry is a heavily regulated industry. Utilizing dental therapists would allow Florida dentists to innovate within their practices and discover new ways to solve the dental care shortage. Florida should join Alaska and Minnesota at the frontline of dental care innovation by allowing dental therapists to practice.

Special Populations

Florida is home to a number of special populations that have unique oral health needs. Understanding these needs will help lawmakers understand the marginal patient populations in their state and craft a dental care delivery system with dental therapists that best serves those populations.

Older Adults

Individuals' dental needs change drastically as they get older. It is common for older adults to lose multiple if not all of their permanent teeth, which can make it difficult to chew, swallow, or speak.³⁷ Older adults also have a higher risk of contracting dry mouth, root and coronal caries, and periodontitis.³⁸ They may be hypersensitive to the drugs used in dentistry, partly due to the various prescriptions and over-the-counter medications they take. Older adults may also have cognitive impairments, including dementia, which affect their ability to maintain healthy oral habits, putting them at a higher risk for dental disease, oral infections, and complications relating to treatment.

Florida has the highest percentage of older adults in the country, as it is a popular destination for snowbirds and retirees.³⁹ Over 4.1 million Floridians are 65 years or older, amounting to 20 percent of the state's population. Population projections estimate the number of older adults will more than double by 2020, increasing to 42 percent of the state's population.⁴⁰ The rapid growth of Florida's older population will likely contribute to a future dental care shortage if workforce trends remain the same.

According to the Florida Department of Health (FDH), 19.2 percent of Floridians aged 65 and older have lost all their permanent teeth.⁴¹ Of the older adults who have at least one tooth, 23 percent have untreated dental decay, 17.2 percent have a need for periodontal care, and five percent have a need for urgent dental care.⁴² Because they have a greater need for dental care, older adults typically have higher dental-related costs than younger populations.

Rural Populace

Of Florida's 67 counties, 30 are designated rural areas.⁴³ The total population of these counties is approximately 710,000, and an additional 1.1 million people live in rural portions of Florida's urban counties. However, only 2.4 percent of general dentists practice in rural counties, many of whom do not accept Medicaid or CHIP.⁴⁴ Thus, rural populations have significantly less access to dental care than urban populations.

In addition to having a limited selection of providers, the closest available provider could be many miles away from rural residents, a substantial challenge for those with limited transportation. Rural residents also have more difficulty affording dental care than urban residents. The average per-capita income for Florida's rural residents is \$33,557, compared to \$44,822 for urban residents.⁴⁵ The poverty rate in rural Florida is 19.5 percent, compared to 14.6 percent in urban Florida.

Rural residents who are dependent on Medicaid have even fewer options. An analysis by Georgetown University's Health Policy

Institute found that "Medicaid covers a larger share of children and adults in small towns and rural areas than metropolitan areas."⁴⁶ From 2008 to 2015, child Medicaid and CHIP enrollment increased from 43 to 57 percent in rural Florida.⁴⁷ Rural adult Medicaid enrollment increased from 10 to 17 percent over the same period.⁴⁸ The lack of dentists participating in Medicaid and limited coverage for dental services make accessing dental care particularly difficult for rural residents.

Hospital Emergency Room Visits

One of the most expensive places to receive dental care is at a hospital emergency room (ER). In fact, dental-related care in an ER can cost up to five times more than equivalent or superior care in a dental office.⁴⁹ Unfortunately, many uninsured and underinsured patients seek dental treatment from ERs because they know they will receive immediate care. Some wait until their dental disorders escalate to an emergency, others visit the ER regularly for non-traumatic dental conditions (NTDCs).

A recent study by Dr. Scott Tomar, professor at the University of Florida's College of Dentistry, examines NTDC-related ER visits and hospital admissions in Florida. He found there were 166,997 NTDC-related ER visits in 2016.⁵⁰ Total hospital charges for these visits amounted to over \$322 million, or \$882,000 per day. The most frequent primary payer for the visits was Medicaid (38.8 percent), and the second most frequent was self-pay (31.4 percent).

In 2015, there were 179,420 NTDC-related ER visits, 163,638 of which had a unique patient identifier. Those visits were made by 128,566 patients, 83.2 percent of whom had a single visit, and 16.7 percent of whom had two or more. In other words, 21,638 patients sought dental treatment more than once from an ER, accounting for 34.7 percent of all the NTDC-related visits that year. Total charges for the visits were \$274 million, 30.4 percent of which applied to patients with multiple visits.

Dr. Tomar's study also found that there were 4,307 NTDC-related hospital admissions in 2016, with charges exceeding \$195 million.⁵¹ Medicare paid for 24 percent of the admissions, while Medicaid paid for 23 percent.

Dental-related ER visits are usually preventable with routine treatment from a dental practitioner. Dr. Tomar explains, "[ERs] generally are not equipped or staffed to provide definitive dental services, and most patients attending for a dental complaint receive only temporary palliative care in the form of analgesics and antibiotics."⁵² It is imperative that Florida policymakers find a solution to address overuse and inappropriate use of ERs, as they are costly to patients and taxpayers, and they do not offer comprehensive dental services.

The Influence of Organized Dentistry in Florida

In line with its national counterpart, the Florida Dental Association (FDA) actively opposes the authorization of dental therapists. The FDA's chief argument is that dental therapists are not sufficiently trained to provide safe, effective care.⁵³ Studies of dental therapy outcomes, such as the ones described in this paper, present plenty of evidence to the contrary. Even a systematic review by the ADA's Council on Scientific Affairs concluded, "Adding a tier of oral health care providers who perform restorations and extractions can increase the number of restorations being placed and decrease the number of decayed teeth."⁵⁴

Organized dentistry's opposition to dental therapy traces back to the 1940s. In 1949, a program was established in Boston, Massachusetts to train dental hygienists in restorative care. The ADA pressured the state legislature until it eventually shut the program down.⁵⁵ Florida lawmakers can expect a similar reaction from the ADA and FDA toward dental therapy legislative efforts. In fact, the FDA has a long-standing record of anti-competitive behavior, even towards initiatives that expand access to dental care.

In the 1990s the University of Florida (UF) owned and operated several dental clinics across Florida and formed partnerships with several community health centers and other safety net clinics. Approximately 90 percent of the patients treated in these clinics belonged to underserved populations.⁵⁶ UF students would travel and practice at these clinics in two-week intervals, performing within a limited scope of practice. The program gave UF students the opportunity to gain clinical experience in public health settings and treat underserved patients. It was also a way for UF to experiment with an alternative delivery system to expand access to dental care.

The Florida Dental Association (FDA) strongly opposed UF's program, claiming the clinics were "disruptive" to the dental association and private practitioners.⁵⁷ The FDA did not want UF's clinics competing with its members. The FDA demanded that UF faculty sign a 10-point agreement to stop its clinical program until a "special oversight board" was formed and granted permission to continue. It also recommended that UF shut down all of its off-campus clinics by December 1, 1997, and include the FDA in all future decisions related to the program. If their demands were not met, the FDA threatened to retract its support and funding to UF, pressure university officials, and lobby the state legislature to shut the program down.⁵⁸

After months of tension, the Federal Trade Commission (FTC) intervened. The FTC supported UF fully on the grounds that the FDA's actions were blatantly anti-competitive. The FTC even told UF that it would be liable for restricting trade if they succumbed

to the FDA's demands.⁵⁹ The FDA withdrew its opposition shortly after.

The FDA has enormous influence over Florida dental providers and in the state legislature. It will be actively lobbying the legislature to reject any dental therapy proposals. It remains to be seen whether legislators will make evidence-based decisions in considering dental therapy authorization.

In the spring of 2017, a new coalition formed to move the dental therapy campaign forward in Florida. Floridians for Dental Access comprises dentists, dental hygiene educational programs, safety net clinics, and advocacy groups. Among them are the Florida Dental Hygiene Association, Florida Rural Health Association, Palm Beach State College, Florida Public Health Association, United Way of North Central Florida, and others.⁶⁰

Floridians for Dental Access unites the people willing to educate, hire, and work with dental therapists—to make dental therapy a reality in Florida. The only thing standing in their way is Florida's restrictive licensure regulations.

The state dental practice act (Chapter 466) and the Florida Board of Dentistry (FBD) control every facet of Florida's dental profession. First, the dental practice act does not recognize dental therapy as a profession. Second, dentists can only do what the FBD explicitly authorizes them to do. Everything outside of the FBD's regulations is prohibited, including activities that are not explicitly prohibited. Currently, the regulations are silent on dental therapists, rendering them off-limits.

The demand for dental therapists arose naturally, and it will continue to grow naturally. Florida might have had dental therapy 70 years ago, possibly earlier, if licensure regulations and organized dentistry's political clout had not made it impossible. It is time for anti-competitive special interests to step aside and let Florida policymakers allow dental therapists to practice freely along dental providers.

Getting the Most out of Dental Therapy

Dental licensure regulations form the framework in which dental therapy must reside. They largely influence the effect dental therapists can have in expanding access to care in Florida. If the framework is too rigid, many underserved Floridians will go without dental care. If the framework is flexible, dental therapists will be accessible enough to meet the needs of marginal patients, and lower the cost of dental care through competition.

The following table lists key components of the dental therapy workforce model, and offers insight into how corresponding policy might influence dental therapists' effectiveness.

Component	Description	Policy Considerations
Supervision	<p>Dental therapists (DTs) must practice under the supervision of a dentist; there are multiple “levels” of supervision as defined by the Florida Board of Dentistry:</p> <p>Direct supervision — requires a dentist to examine the patient, diagnose a condition, authorize a procedure, remain on the premises while the procedure is performed, and approve the work performed prior to the patient’s departure</p> <p>Indirect supervision — requires a dentist to examine the patient, diagnose a condition, authorize a procedure, and remain on the premises while the procedure is performed</p> <p>General supervision — requires a dentist to examine the patient, diagnose a condition, and authorize a procedure</p>	<p>Supervision requirements determine how independently DTs may practice.</p> <p>Flexible (e.g. general) supervision requirements allow DTs to travel outside the office and bring the most needed treatments to rural and underserved areas without being accompanied by a dentist.</p> <p>Rigid supervision rules that require dentists to be on premises when dental therapists are practicing rule out the ability of dental therapists to travel alone to schools, nursing homes, and other community sites to deliver care within their scope of practice without a dentist present. This rigidity would not allow dental practices to extend their reach without having the expense of deploying a dentist to supervise allied staff.</p>
Education Level	<p>The minimum length and type of education and any educational credentials required to apply for a DT license</p>	<p>In the U.S., DT training ranges from a two-year associate degree, as the Alaskan DT model prescribes, to masters-level training, as Minnesota requires for advanced dental therapists (ADTs), with few differences among proposals in scope of practice.</p> <p>Higher costs associated with longer educational requirements that are not necessary to produce competent practitioners will raise the cost of providing dental care and create entry barriers to the profession. Thus, rigid education requirements can impede access to care and prescribe an inefficient level of education for DTs.</p> <p>Flexible education standards give educational institutions and dental educators the ability to determine which curriculum is right for DTs. If they design a fast and efficient program, Floridians will have better access to dental care faster.</p>
Scope of Practice	<p>The procedures and services DTs may legally perform</p>	<p>Scope of practice regulations define the procedures DTs are allowed to conduct. The more DTs’ scope of practice aligns with the greatest needs of marginal patients, the more effective they can be. This includes initiating a treatment plan and extracting badly diseased permanent teeth.</p> <p>Broad scopes of practice enable DTs to provide routine preventive and restorative care. If marginal patients have access to a wide range of treatments, they are less likely to experience severe dental disorders and seek treatment from a hospital ER.</p> <p>Narrow scopes of practice limit DTs’ effectiveness. If DTs’ scope of practice closely resembles that of dental hygienists, they will not dramatically affect access to dental care.</p>

Component	Description	Policy Considerations
Collaborative Management Agreements (CMAs)	Employment contracts between DTs and their supervising dentists	<p>CMAs ensure that dentists retain control and responsibility of their practices. They also ensure that dentists feel safe and comfortable with the role DTs play in their offices.</p> <p>Flexible CMA requirements leave decisions in the hands of dentists, allowing them to run their practices as they see fit.</p> <p>Rigid CMA requirements tell dentists how they can and cannot utilize DTs. Too many mandates could make employing DTs less desirable and cost-effective for dentists.</p>
Multiple Mid-Levels	The availability of multiple mid-level practitioner statuses and licenses	<p>Minnesota licenses DTs and ADTs. Licensed DTs may obtain an ADT license once they have completed 2,000 hours of clinical practice. ADTs have a slightly broader scope of practice than DTs.</p> <p>Licensing multiple mid-levels gives patients more provider options. It also gives dentists more options for expanding their practices.</p>
Supervision of Dental Auxiliaries	The ability of DTs to supervise dental hygienists and dental assistants in place of a dentist	<p>Minnesota allows DTs to supervise dental assistants and dental technicians. However, supervising dentists must explicitly permit DTs to do so in their CMAs. DTs may not supervise more than 4 dental assistants at a time.</p> <p>Allowing DTs to supervise dental auxiliaries gives their supervising dentist more flexibility. Dentists can delegate the supervision of simple tasks and spend more time on complex procedures. Allowing dentists to decide the supervision terms via CMAs maintains their authority and freedom.</p> <p>FL might consider expanding on MN's legislation by allowing dentists to delegate the supervision of dental hygienists to DTs.</p>
Patient Requirements	Requiring DTs to treat a specific number or proportion of patients with special characteristics	<p>MN's legislation requires DTs to "primarily [practice] in settings that serve low-income, uninsured, and underserved patients or in a dental [HPSA]." In other words, more than 50 percent of DTs' patients must fit the above description. The provision is meant to ensure that DTs improve access to dental care for those who need it most.</p> <p>Flexible patient requirements allow dentists to utilize DTs as they see fit, maintaining their practitioner freedom. However, DTs may not have an optimal effect on access to care for marginal patients.</p> <p>Rigid patient requirements are mandates. They limit the decision rights of providers by requiring them to prioritize the underserved.</p>



Dental therapy is not a one-size-fits-all solution. It is a market-based, supply-side reform that empowers dental providers and offers patients an alternative care delivery system. For many marginal patients, utilizing a dental therapist is more accessible than visiting a dentist and possibly the only way they will receive dental care. Furthermore, dental therapy has the potential to decrease the cost of dental care by creating competition among dental providers and allowing them to reduce their fees due to lower labor costs. If Florida lawmakers want dental therapists to serve the underserved, they ought to ensure that the licensure regulations are not too cumbersome.

Conclusion

Over the course of the next 10-20 years, by all estimations and projections, Florida's population will continue to explode. Currently the state's population grows by more than 1,000 residents every day. In the context of this growth alone, Florida policymakers will face serious and substantive decisions regarding access to and delivery of health care services. Our collective goal must be to expand the supply of those delivering care, and patients' access to those practitioners.

Dental care should be among the top priorities. Research and countless anecdotal examples prove that regular and consistent dental care improves long-term health and lowers risk for cardiovascular disease, dementia, respiratory infections, and diabetes complications, among many other conditions. Poorer, largely rural populations in Florida are far more likely to be at risk due to access challenges, and policymakers can in fact make a profound difference in this area.

The single most impactful way that policymakers can improve the overall trajectory of dental care in Florida is to embrace the innovation present through allowing dental therapists to practice their services. Such a policy innovation would increase the number of qualified providers, improve the capacity of dentists currently practicing in the state, and encourage the development of new highly skilled health care workers. On the patient side, more Floridians would have the ability to receive quality dental care at lower costs, adults and children from poorer and rural communities would be far likelier to seek care before more difficult health challenges arise, and we would model for other states what a practical, market-based health policy reform can accomplish.

References

1. Dentist Profile Snapshot by State 2016, XLSX, Chicago: American Dental Association, November 2017, <<http://www.ada.org/en/science-research/health-policy-institute/data-center/supply-and-profile-of-dentists>>.
2. First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary, PDF, Rockville: Health Resources and Services Administration, January 1, 2018, p. 8, <https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry&rs:Format=PDF>.
3. David A. Nash et al., A Review of the Global Literature on Dental Therapists, W.K. Kellogg Foundation, W.K. Kellogg Foundation, April 2012, p. 351, <<https://www.wkcf.org/resource-directory/resource/2012/04/nash-dental-therapist-literature-review>>.
4. Scott Wetterhall et al., Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska, W.K. Kellogg Foundation, W.K. Kellogg Foundation, October 2010, p. ES.3, <<https://www.wkcf.org/resource-directory/resource/2010/10/alaska-dental-therapist-program-rti-evaluation-report>>.
5. Early Impacts of Dental Therapists in Minnesota, PDF, Minnesota Department of Health and Minnesota Board of Dentistry, February 2014, p. 1, <<http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegrpt.pdf>>.
6. Donald L. Chi et al., Dental Utilization for Communities Served by Dental Therapists in Alaska's Yukon Kuskokwim Delta: Findings from an Observational Quantitative Study, School of Dentistry, University of Washington (Seattle, WA: University of Washington, 2017), p. 2, <<http://faculty.washington.edu/dchi/files/DHATFinalReport.pdf>>.
7. "American Dental Association Statement on Accrediting Dental Therapy Education Programs," American Dental Association, February 12, 2015, <<http://www.ada.org/en/press-room/news-releases/2015-archive/february/statement-on-coda-therapist-standards>>.
8. Mary Jordan, "The unexpected political power of dentists," The Washington Post, July 1, 2017, <https://www.washingtonpost.com/politics/the-unexpected-political-power-of-dentists/2017/07/01/ee946d56-54f3-11e7-a204-ad706461fa4f_story.html?utm_term=.564c5e66e844>.
9. Dentist Profile Snapshot by State 2016.
10. "HPSA Find," HRSA Data Warehouse, <<https://datawarehouse.hrsa.gov/tools/analyzers/HpsaFind.aspx>>.
11. Bradley Munson and Marko Vujicic, Supply of Dentists in the United States is Likely to Grow, publication, Health Policy Institute, American Dental Association, October 2014, p. 6, <http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_1.pdf>.
12. Nash et al., p. 2.
13. Wetterhall et al., p. 2.1-2.5.
14. "ADTEP Certification & Scope of Practice," Alaska Native Tribal Health Consortium, <<https://anthc.org/alaska-dental-therapy-education-programs/adtep-certification-scope-of-practice/>>.
15. "Dental Therapy," University of Minnesota School of Dentistry, <<https://www.dentistry.umn.edu/degrees-programs/dental-therapy>>.
16. Minnesota Statutes, Chapter 150A.106, Section 150A.106, <<https://www.revisor.mn.gov/statutes/?id=150A.106>>.
17. "About Us," Commission on Dental Accreditation, <<http://www.ada.org/en/coda/accreditation/about-us>>.
18. Accreditation Standards for Dental Therapy Education Programs, PDF, Chicago: Commission on Dental Accreditation, February 6, 2015, p. 8, <<http://www.ada.org/~media/CODA/Files/dt.pdf>>.
19. Sarah Shoffstall-Cone and Mary Williard, "Alaska Dental Health Aide Program," International Journal of Circumpolar Health 72, no. 1 (August 5, 2013): p. 1, <doi:10.3402/ijch.v72i0.21198>.
20. Wetterhall et al., p. ES.3.
21. Ibid., p. 4.1.
22. "Alaska Dental Therapy Educational Programs," Alaska Native Tribal Health Consortium, <<https://anthc.org/alaska-dental-therapy-education-programs/>>.
23. Chi et al., p. 2.
24. Early Impacts of Dental Therapists in Minnesota, p. 1.
25. Ibid.
26. Ibid., p. 2.
27. Ibid.
28. Ibid.
29. Anna Martin, Grand Marais Family Dentistry: Dental Therapist Case Study, PDF, Saint Paul: Amherst H. Wilder Foundation, May 2017, p. 3-6, <<http://www.wilder.org/Wilder-Research/Publications/Studies/Delta%20Dental%20of%20Minnesota/Grand%20Marais%20Family%20Dentistry%20-%20Dental%20Therapist%20Case%20Study.pdf>>.
30. Ibid., p. 4.
31. Ibid., p. 3.
32. Ibid., p. 5.
33. Ibid., p. 6.
34. Anna Martin, Midwest Dental: Dental Therapist Case Study, PDF, Saint Paul: Amherst H. Wilder Foundation, May 2017, p. 2-5, <<http://www.wilder.org/Wilder-Research/Publications/Studies/Delta%20Dental%20of%20Minnesota/Midwest%20Dental%20-%20Dental%20Therapist%20Case%20Study.pdf>>.

-
35. Ibid., p. 2-3.
 36. Ibid., p. 5.
 37. Christina Vracar et al., Oral Health Status of Florida's Older Adult Population 2015-2016, PDF, Tallahassee: Florida Department of Health, 2016, p. 5, <<https://www.astdd.org/www/docs/fl-older-adult-bss-report-2015-2016.pdf>>.
 38. "Aging and Dental Health," American Dental Association, December 14, 2017, <<http://www.ada.org/en/member-center/oral-health-topics/aging-and-dental-health>>.
 39. Lauren Kent, "Where Do the Oldest Americans Live?" Pew Research Center, July 09, 2015, <<http://www.pewresearch.org/fact-tank/2015/07/09/where-do-the-oldest-americans-live/>>.
 40. Vracar et al., p. 5.
 41. Ibid., p. 4.
 42. Ibid.
 43. "Rural health for Florida Introduction," Rural Health Information Hub, June 26, 2016, <<https://www.ruralhealthinfo.org/states/florida>>.
 44. Phillippe Bilger, 2015-2016 Workforce Survey of Dentists, PDF, Tallahassee: Florida Department of Health, January 2017, p. 13-15, <http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/florida-workforce-survey-dentists-2015-2016.pdf>.
 45. "State Fact Sheets: Florida," Economic Research Service, December 14, 2017, <<https://data.ers.usda.gov/reports.aspx?StateFIPS=12&StateName=Florida&ID=17854>>.
 46. Joan Alker and Anne Swerlick, Medicaid in Small Towns and Rural Florida: A Lifeline for Children, Families, and Communities, PDF, Washington, DC: Georgia University Health Policy Institute, June 28, 2017, p. 11, <<https://ccf.georgetown.edu/wp-content/uploads/2017/06/FPN-June-28-webinar-Rural.pdf>>.
 47. Ibid., p. 13.
 48. Ibid., p. 14.
 49. Margaret Langelier and Simona Surdu, Oral Health in Michigan, report, The Center for Health Workforce Studies, State University of New York (Rensselaer, NY: State University of New York, 2015), p. 113, <http://www.chwsny.org/wp-content/uploads/2015/06/Oral_Health_MI_Report_Final_reduced.pdf>.
 50. Scott L. Tomar, Hospital Emergency Department and Hospital Inpatient Admissions in Florida for Non-Traumatic Dental Conditions, 2015 and 2016, working paper, Department of Community Dentistry and Behavioral Science, University of Florida (Gainesville, FL: University of Florida, 2017), p. 5.
 51. Ibid., p. 6.
 52. Ibid., p. 2.
 53. Cesar R. Sabates, "Mid-level Providers: Why Membership in the ADA Matters," Beyond the Bite, October 12, 2017, <<https://blog.floridadental.org/tag/dental-therapist/>>.
 54. J. Timothy Wright, "Do midlevel providers improve the population's oral health?" The Journal of the American Dental Association 144, no. 1 (January 2013): p. 93, <doi:10.14219/jada.archive.2013.0018>.
 55. Jane Koppelman, Kelly Vitzthum, and Lisa Simon, "Expanding Where Dental Therapists Can Practice Could Increase Americans Access To Cost-Efficient Care," Health Affairs 35, no. 12 (December 2016): p. 2201, <doi:10.1377/hlthaff.2016.0844>.
 56. Jud Magrin, "Dentists, UF College Feuding Over Clinics," The Gainesville Sun, September 20, 1997, Vol. 122, No. 79.
 57. Ibid.
 58. Ibid.
 59. Frank A. Catalanotto, "Phone Interview with Dr. Frank Catalanotto," telephone interview by author, December 14, 2017.
 60. Ibid.



✉ The James Madison Institute
The Columns
100 North Duval Street
Tallahassee, FL 32301

☎ 850.386.3131

💻 www.jamesmadison.org

Stay Connected

📘 The James Madison Institute

🐦 @JmsMadisonInst

📺 [youtube.com/user/JamesMadisonInstitut](https://www.youtube.com/user/JamesMadisonInstitut)

📷 [flickr.com/photos/jmsmadisoninst](https://www.flickr.com/photos/jmsmadisoninst)

📌 [pinterest.com/jmsmadisoninst](https://www.pinterest.com/jmsmadisoninst)