

June 2020

Dental Therapy Advocacy: Community Engagement Guide

Authored by Kasey Wilson, *Dental Access Project*

Dental Therapy Advocacy: Community Engagement Guide

Introduction

Dental therapy benefits many different groups, which is why it attracts such a wide range of support from various sectors – Tribal governments, community groups and nonprofits, consumer advocates, labor unions, hospitals, community health centers, dental insurance companies, dental hygiene associations, educational institutions, free-market think tanks, dentists, and others. These groups have a variety of social, economic, and ideological reasons for supporting dental therapy, but they all come together to advocate for this evidence-based policy.

Done well, dental therapy programs help address a fundamental issue for communities that have had to overcome significant barriers to access to basic oral health care: Trust. A clean policy, based on evidence and informed by the [trailblazing dental therapy education program](#) in Alaska, ensures educational opportunities and jobs are accessible to communities where needs are the greatest. Building a dental workforce of local providers who are culturally and linguistically tied to the communities where they live and work is changing communities' relationship with oral health care from the inside out.

To pass effective policy and ensure local communities are able to create a culturally and linguistically representative workforce, the needs and voices of directly-impacted communities must be at the decision-making table throughout the process.

Working with communities (not for them) is crucial for advancing dental therapy as an informed, community-centered oral health policy and program. Investing in community engagement strategies offers opportunities to build campaigns that can lead to more sustainable movements and more equitable policy change. In the sections below, we offer:

- General information about the benefits of community engagement;
- Policy provisions that may require specific attentiveness around community engagement;
- Guidelines and suggestions for incorporating community engagement into dental therapy advocacy and campaign work.

In this guide, we focus primarily on engagement with marginalized communities: Those whose needs, preferences, voices, and expertise have been de-centered (i.e., pushed to the margins) in policy conversations and who generally experience the most barriers to accessing dental care.

Based on national statistics, the groups who generally experience the greatest barriers to accessing dental care and the highest disease burden include Black and Latinx people, low-income communities¹, American Indian and Alaska Native Tribal communities², and people with disabilities³. While research is burgeoning, evidence suggests that members of LGBTQ+ communities, especially transgender individuals, face discrimination and barriers to accessing dental care as well⁴. There may also be other marginalized communities when considering the historical, cultural, political, and geographical factors in your state or community. Campaign leaders should take the time to understand the communities in their area.

Benefits of Community Engagement

In addition to centering the voices of those most affected, community engagement strategies can offer other benefits to campaigns and contribute to successful advocacy efforts. Campaigns grounded in community engagement can:

- **Help center (or re-center) campaign goals of improving access to dental care:** Working with marginalized communities and ensuring their skillsets, experiences, and stated needs drive the work can focus your campaign around the goal of improving access to dental care. Lengthy and detailed debates about practice settings and dental procedures, which often arise in dental therapy campaigns, can sometimes distract from this central goal.
- **Build power:** Investing in community engagement can strengthen your coalition with skills that community groups often have that advocates, funders or policy organizations may not, including grassroots organizing, [power analysis](#), and [base-building](#). It can also offer a diversity of skills and perspectives even in areas where advocates are often strong, like policy analysis and communications.
- **Maintain momentum:** Community engagement can strengthen your campaign with a robust and active grassroots base that will continue to put pressure on key decision-makers throughout the campaign. As the work shifts into implementation, community engagement can also help you avoid a lull after legislation is passed, as community groups push for an efficient rulemaking process that maintains the integrity and legislative intent of the policy.

Protecting Community-Centered Policy Elements

Support for dental therapy crosses many sectors and political affiliations, including dentists and dental hygienists. In fact, community-focused public health dentists helped design the provider to meet the unique needs of areas with the largest dental provider shortages. The same dentist-educators who train dental students also train dental therapists. Unfortunately, the well-funded dental lobby and, in some cases, dental hygiene lobbies across the country are putting professional interests over community needs by opposing dental therapy programs outright or working to remove important elements of the

policy. This de-centering of community needs results in dental therapy programs that are less effective or pathways to the profession that are exclusive. Community involvement throughout the design of policy and political negotiations is necessary to protect provisions for addressing oral health equity and keeping jobs in local communities. Below, we outline a few of these areas; however, campaign leaders and policymakers need to consult with community groups in their state or jurisdiction to determine if there are additional areas for consideration.

Understanding Education Requirements

One common problematic trend in dental therapy policy is legislatures adding unnecessary education or training requirements that are in direct conflict with the evidence⁵. These include requiring additional years of education beyond what experts recommend, mandating specific degree requirements or dual degrees, and/or requiring educational prerequisites. This results in local educational institutions and community groups being cut out of the profession, affecting the diversity and distribution of the providers.

The U.S. post-secondary educational system provides several levels of accountability to ensure the dental workforce is properly trained and ready for licensure. The United States Department of Education recognizes the [Commission on Dental Accreditation](#) (CODA) as the national accrediting body for postsecondary dental education. CODA oversees the standards for all dental educational programs including dentistry, dental hygiene, dental assisting, and dental therapy. In addition to these national standards, colleges, and universities often include another layer of requirements, resulting in additional prerequisites (courses students must take before entering a degree program) or credit requirements (courses required prior to receiving a degree).

⁵The measure for “necessary” should be patient safety as demonstrated by evidence. Dental therapists are proven to safely execute their limited scope after three academic years (or equivalent) of education. In this regard, “unnecessary” reference policy language that diminishes accessibility to the profession and/or access to care without, in turn, improving the safety of the provider.

Legislatively mandating education requirements beyond these existing two layers has a cascading effect that can make dental therapy education programs longer and more costly, limiting accessibility to this profession, especially for low-income and other marginalized communities.

- **What’s important:** Legislatively mandating specific degree requirements increases educational costs for students and future employers and prevents some educational institutions, which otherwise meet the national accreditation standards, from offering dental therapy programs. This can result in less affordable, less equitable education programs and reduced competition.
- **Recommendation:** Protect opportunities for job and economic investment in marginalized, underemployed, and rural communities. Support [national standards](#) for licensing and educating dental therapists to promote national consistency, maximize market opportunity and advance oral health equity.

Understanding Scope of Practice/Authorized Procedures

Dental therapists first joined U.S. dental teams in 2004 as a strategy to improve access to care in communities with severe dental provider shortages. Communities that have long gone without adequate access to dental care usually need more restorative care than communities with regular access. Certain procedures in a dental therapist's scope (e.g., filling cavities, pulpotomies, "simple" extractions) may rarely be needed in affluent communities that are well-served by the current dental care system but are routinely needed in communities that have been historically marginalized and continue to be underserved by the current system.

Dental therapists receive targeted and extensive training in their limited scope and therefore are experts in these procedures. Dental therapists work under the supervision of a dentist and the ability to perform their full scope is vital to their effectiveness in meeting community needs. The dental lobby regularly comes to the table in support of dental therapists providing preventive care but utilizes scare tactics to remove vital services from the provider's scope. Keep this in mind when considering policy on the scope of procedures dental therapists are authorized to perform.

- **What's important:** Dental therapists have been safely delivering both preventive and restorative care in remote regions of Alaska for over 15 years and rural Minnesota for over a decade. The dental therapy scope of practice for these two states is [almost identical](#). The intensive education and existing licensing/certification structures ensure providers are ready for practice. In addition, supervising dentists retain control and can limit a dental therapist's scope and dictate supervision levels through standing orders/practice plans.
- **Recommendation:** Protect policy that will allow communities access to the full range of the preventive and restorative procedures dental therapists are trained to provide. Assessments of current providers and local Medicaid reimbursement data can help ensure vital services are included in the scope of practice. Use the scope of procedures in the [CODA dental therapy accreditation standards](#) as a floor and consider the slightly broader scope in the [national standards](#). Consult with community members regularly to ensure you understand which procedures are most important for and needed in local communities.

Understanding Levels of Supervision

Supervision levels are defined in state statutes and can vary from state to state and provider to provider. Generally, there are three levels of supervision dental therapists can practice under:

- 1) General (or off-site) supervision allows a dental therapist to practice when their supervising dentist is not physically present and has not first examined a patient.
- 2) Indirect supervision allows a dental therapist to practice when their supervising dentist is not present in the same room where care is being provided but requires the dentist to be on site.
- 3) Direct supervision restricts a dental therapist to practice only with their supervising dentist in the same room where care is being provided.

Dental therapists have safely performed their full scope of practice under general supervision for over 15 years. In the U.S., supervising dentists remain accessible to dental therapists and the providers regularly communicate as outlined in their supervision agreements (standing orders/practice plan agreements). General supervision allows dental therapists to extend care into settings and communities where their supervising dentist is not present, maximizing the reach of the dental team into community-based settings outside of traditional dental clinics or offices (e.g., senior centers, schools, emergency rooms, and/or satellite clinics). Conversely, direct supervision creates inefficiency by requiring two highly trained practitioners (a dental therapist and their supervising dentist) to be present while care is provided for one patient.

- **What's important:** Dental therapists safely perform preventive and restorative care under general supervision in both Alaska and Minnesota. General supervision frees up a dentist to perform more complex procedures for which they are uniquely trained and allows dental therapists to practice in community-based settings.
- **Recommendation:** Protect policy that authorizes dental therapists to practice under general supervision for their full scope of practice. Support national standards, which recommend general supervision as the base and allow supervising dentists to determine the specific services each dental therapist provides and the associated levels of supervision.

First and foremost, **keeping communities central to policy decisions** is integral for authentic community engagement. This means not only including marginalized communities, but following the lead of community members, keeping their stated needs central in making policy decisions and guiding negotiations, and building relationships throughout and beyond the campaign.