

Oral Health 101

An Overview of Dentistry and Oral Health
for Health Department Staff

Module 3 The OH Workforce, Work/ Dental Care Settings and Dental Financing



I am pleased to welcome you to Module 3 of ASTDD's Oral Health 101 learning series.

Learning Objectives

1. Discuss the roles of state boards of dentistry/dental hygiene.
2. Describe the basic scopes of practice of dentists and dental hygienists and what state-specific factors affect scopes of practice.
3. List and define the ADA recognized dental specialties.
4. Describe some new/expanded categories of oral health team members.
5. List several settings where oral health professionals work.
5. Explain differences in public vs private payment options and insurance coverage for dental care.

These are the learning objectives for this module.

State Dental/Dental Hygiene Boards

- Enforce the state practice act
- Regulate professionals on the dental team:
 - Licensure of dentists, dental hygienists and any other dental professionals in the state
 - Oversight of the profession -- professional discipline, making/enforcement of rules and regulations



State dental/dental hygiene boards (or in some states the board of dental examiners) are critical to the regulation of the dental related professions in the state. Each state has its own laws and regulations, often called “dental practice acts” that define scopes of practice and dictate how each classification of dental professional will practice in the state. Every state oral health program should know their state’s practice act to ensure that all their oral health programs comply with state law. Dental/dental hygiene boards are a group of appointed individuals, usually dental professionals and a public member, charged with enforcement of the laws. Common duties include professional licensure, making rules and regulations, and disciplining individuals who are in violation of the practice act.

The next section discusses the most common types of dental professionals and their scopes of practice, but again, these vary from state to state.

Oral Health Workforce: Dentists

- DDS or DMD
- Scope of Practice - *Evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body.*



The traditional “head” of the dental team is the dentist. A dentist must have completed a postgraduate dental school program (usually four years) and received a DDS (doctor of dental surgery) or DMD (doctor of dental medicine) degree, which are equivalent. After receiving the degree, dentists must take a licensing exam to practice. Each state sets its own standards for licensing, so a dentist who wants to practice in multiple states may be subject to different requirements. Some states have collaborated to participate in regional testing exams that states will accept for licensure.

A licensed dentist can perform all tasks that are within the state’s dental practice act. They are also responsible to supervise any dental staff they hire, including dental assistants and dental hygienists.

Dental Specialties

- [Dental public health](#)
- [Endodontics](#)
- [Oral and maxillofacial pathology](#)
- [Oral and maxillofacial radiology](#)
- [Oral and maxillofacial surgery](#)
- [Orthodontics and dentofacial orthopedics](#)
- [Periodontics](#) (also periodontology)
- [Pediatric dentistry](#)
- [Prosthodontics](#)

A general practice dentist is skilled in many types of dental procedures, including restorations such as fillings, bridges and crowns, preventive care, and oral surgery and may treat any age group. Advanced education is available through residencies in general practice, oral medicine, orofacial pain, etc. About 80% of the dentists today work in general practice. Some dentists choose to limit their practice to one clinical area and become specialists. To specialize, a dentist must complete another training program and/or residency in their selected specialty. Once they pass a board exam, they are eligible to refer to themselves as a board certified specialist – for example, endodontist, periodontist, oral surgeon, prosthodontist. In the [United States](#) and [Canada](#), there are nine recognized dental specialties.

Dental Public Health (DPH) is a non-clinical specialty that focuses on the prevention and control of oral diseases and the promotion of oral health at the population or community level. Dental public health involves the assessment of key oral health needs, reviewing key scientific literature to select evidence-based strategies to improve the oral health of populations and to apply other dental research. Many state and federal government agencies and dental schools employ dental public health specialists as dental directors, policy analysts, researchers or other roles. Some dental public health specialists also further specialize as epidemiologists. Oral epidemiologists study and analyze oral diseases by collecting, analyzing and reporting data.

Endodontics is a specialty that deals with the etiology, diagnosis, prevention and treatment of diseases and injuries of the dental pulp and tissues surrounding the pulp. The most common procedure that endodontists perform for diseased pulp tissue is root canal therapy.

The specialty **oral and maxillofacial pathology** is concerned with diagnosis and study of the causes and effects of diseases of the oral and maxillofacial region.

Oral and maxillofacial radiology is concerned with the production and interpretation of images and data (diagnostic imaging) used for diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region..

Orthodontics deals primarily with the diagnosis, prevention and correction of malocclusion and abnormalities of the teeth and jaws.

Periodontics includes the prevention, diagnosis and treatment of diseases of the tissues supporting and surrounding the teeth.

Pediatric dentistry is a specialty dedicated to treating children, especially those with special needs.

Prosthodontics deals with restoring function, comfort, appearance and health of the mouth when teeth have been lost or severely compromised. Common treatments include dentures, implants, crowns and bridges.

General practice dentists and specialists work together; for example a general dentist will refer a more complicated case to a specialist, who will assess and manage the specialty problem and refer the patient back to the generalist for his/her regular dental needs.

Oral Health Workforce: Registered Dental Hygienists (RDH)

- Scope of practice: *Science and practice of recognition, prevention and treatment of oral diseases and conditions as an integral component of total health.*
- State to state variations:
 - Supervision by dentist
 - Scope of work
 - Categories of licensure



A registered dental hygienist typically works for a dentist, and focuses on the prevention of oral disease. Their practice is determined by state law, both in the type of procedures they may perform and the amount of supervision they require. Typically dental hygienists clean teeth by removing plaque and calculus, and provide patient education. They also conduct risk assessments, take radiographs, place sealants and apply fluoride.

Some states allow hygienists to do much more including administering dental anesthesia, placing temporary fillings and using a rotary handpiece to smooth rough teeth and fillings.

In most cases, dental hygienists are supervised by dentists, but state law defines how much supervision is required. Some states require a dentist to be present while the hygienist is working. This is direct supervision. Other states are more liberal, allowing hygienists to work without the presence of a dentist, although a dentist must direct the patient's care. This is indirect supervision. In a few states, a hygienist is able to work independently without a dentist's direct or indirect supervision.

Most dental hygienists hold an associate's degree or a certificate, with four-year bachelor's degree or six-year master's degree programs being slightly less common. Like dentists, dental hygienists are licensed by the state board that sets the requirements for licensure. Some states have established separate dental hygiene state boards to regulate the profession.

Most dental hygienists work in private practice, but they also practice in other settings such as local and state public health programs. Dental hygienists staff many types of positions in state oral health programs, including as dental directors, program managers, health educators, sealant or fluoridation coordinators, and data coordinators. Some states have created special approvals, certifications or licensure for dental hygienists to work in alternative practice settings such as schools, WIC centers, medical practices, Head Start Centers, long-term care facilities, etc. as "public health dental hygienists" or other designations. For example, in California dental hygienists take extra coursework to be Registered Dental Hygienists in Alternative Practice (RDHAP).

Other Members of the Oral Health Workforce

- Dental Therapists
- Dental Assistants
- Community Dental Health Coordinators (ADA)
- Denturists



In addition to the dentist and dental hygienist professions, some states license or otherwise regulate other types of professionals that can provide oral health services.

Dental therapists are mid-level dental providers that provide preventive and some restorative and surgical procedures. Dental therapists were created to increase access to care for underserved populations; one of the first mid-level practitioners created was the Dental Health Aide Therapist (DHAT) for Alaskan Native Tribal or Indian Health Service clinics in Alaska. DHATs are high school graduates who have two years of specialized training in dental therapy.

Since the creation of the DHAT in Alaska, other states that were struggling with oral health disparities and access to professional dental care created their own new dental workforce models, and the term “dental therapy” is used for several new and proposed dental professionals and training programs. For example, some models start with a degree in dental hygiene and then add additional training in restorative and surgical procedures. Others are similar to the DHAT program and educate high school or college graduates to be therapists. Some states propose a mixture of both. As of 2017, only about 8 states allow the practice of dental therapy; many public health dental advocates continue to promote this concept, and some national foundations have supported advocacy efforts to amend state practice acts to allow dental therapists.

In addition to those who provide direct clinical services to patients, dental offices typically employ dental assistants who support the licensed staff and provide other valuable services. Dental assistants can attend an educational program to receive certificates or associate programs or receive “on the job” training. Dental assistants help dentists and hygienists with clinical procedures, take radiographs and interact with patients on initial intake information and follow-up instructions. Some assistants also manage the business side of the office by filing insurance claims, maintaining records, scheduling appointments and managing schedules, doing lab work and managing infection control/sterilization procedures. Some states regulate dental assistants by requiring them to have dental radiology certification and infection control courses, but other states do not. Some states allow assistants to do expanded functions (EFDAs) such as filling teeth, making temporary restorations, etc. Most dental assistants work in private practices or community health centers, but also provide services in school-based sealant programs, mobile clinics and other community-based programs. Often they function as the gatekeeper into the practice.

The American Dental Association promotes the “Community Dental Health Coordinator” model where CDHCs provide basic preventive services but primarily serve as community oral health educators and patient navigators.

A few states allow for denturists, a type of provider who can make and adjust dentures. Dentist supervision of denturists varies by state.

Work Settings

- Private practice: solo or group practice
- Tribal and other community-based clinics, including community health centers, hospital clinics or operating rooms
- Mobile vans, portable equipment, teledentistry
- Federal, state, and local government agencies
- Universities and colleges: health professions education programs or research
- Dental insurance companies
- National non-profit associations



Most dental teams work in private practices in the U.S., either owned by an individual dentist or in a group practice. About 57% work in solo practice and 44% in group practices that can range from two or more dentists working together using a dental management corporation, or hundreds of dentists employed by a nationwide chain of dental centers. The profession seems to be in transition with large multi-site group practices becoming more prevalent.

For people with no dental insurance or limited benefits and limited income, finding and receiving dental care can be very challenging. This is where the “dental safety-net” comes into play. Community-based programs can occur in several settings and receive funding from diverse sources. Community health center and tribal clinics can be stand alone dental programs or integrated into general health services. Federally qualified health centers (FQHCs) receive funding from the federal government through grants from the Bureau of Primary Health Care. Some programs are sponsored by non-profit agencies that must engage in fundraising to sustain their programs. A few hospitals, especially children’s hospitals, provide outpatient and inpatient dental services.

While most clinics are “fixed buildings” where patients come to the site for care,

other services may be provided via mobile vans that contain dental operatories or via portable equipment that is set up inside a community building such as a Head Start center, school or senior center, long-term care facility or a person's home. These models are used to improve access to care for populations that experience obstacles to seeking care. Recent improvements in teledentistry and changing supervision requirements allow dental hygienists to practice in these "off site" or public health settings, and also allow general dentists to seek specialty consultation without the patient having to travel to the specialist's office. Teledentistry allows provision of dental care, advice, or treatment through the medium of information technology, rather than through direct personal contact with each patient.

Oral health programs are scattered throughout federal agencies and usually fall under other health programs such as Maternal and Child Health, Chronic Disease, Health Professions, Health Services, etc. Some provide funding for clinical or health promotion programs through block grants or individual grants to agencies, while others focus on oral health surveillance, policy development or research. The National Institute for Dental and Craniofacial Research hires researchers to administer grant programs and to perform several types of research. State and local government oral health programs are usually located in health departments, but other programs in government may also address oral health such as departments of aging, corrections, developmental services, and health care financing. State oral health programs focus primarily on prevention, health promotion, oral health surveillance, monitoring laws and regulations, and providing technical assistance to local or community-based programs. Dental professionals also work as employees or consultants to provide oversight, work with dental providers, and analyze data for state Medicaid/CHIP programs. Many local (city or county) health departments do not have a dedicated oral health program; those that do often focus primarily on clinical services. It is important for oral health program staff to understand where all of these entities are in their governmental structure to ensure coordination of policies and programs and to avoid conflicting or duplicative efforts.

There are currently about 66 dental schools and 335 dental hygiene programs in the U.S. Most have clinics where students provide care to patients under faculty supervision. Faculty positions usually involve clinical or didactic instruction and some type of research for those in tenure track positions. Some dental schools hire dental professionals with additional advanced degrees as research scientists.

Major dental insurance companies hire dental professionals to develop policies, provide training, review claims and perform health services research.

There are numerous national non-profit associations such as the ASTDD, the Children's Dental Health Project, Oral Health America, etc. that focus on policy and

advocacy initiatives, educational campaigns, technical assistance and training, and development of other resources. Many of these hire experienced oral health professionals as employees or independent contractors to provide their services, administer the organization, and collaborate with other groups.

Dental Financing: Medicaid/CHIP

- Federal and state government funded
- Each state has a different program
- Federal law requires:
 - Coverage for income eligible children, pregnant women and people with disabilities
 - Children’s coverage includes dental coverage
 - States can choose to cover more people such as adults or pregnant women and expand benefits for dental services
- Barriers to receiving care



In addition to regulating dental providers, state government also influences the oral health of its citizens by financing dental treatment through its Medicaid program. Medicaid is an assistance program that provides health coverage for people of all ages with low-income, pregnant women and people with disabilities; as of July 2017, more than 69 million people in the U.S. were enrolled. Medicaid is financed through the Centers for Medicare and Medicaid Services (CMS), and is a shared federal/state program with federal match ranging from 50-73% of a state’s total covered expenditures depending on that state’s average per capita income. Federal law requires states to cover certain “mandatory eligible” populations and provide them with a minimal set of benefits. Dental coverage for children is a required component of all state Medicaid programs.

States can choose to cover more populations and provide more benefits than are federally required. For example, uninsured adults are not mandatorily eligible, and dental coverage is optional for all adult recipients. The Affordable Care Act encouraged states to expand their Medicaid programs to include low-income, uninsured adults, or at least pregnant women, but not all states have done so.

Medicaid is often confused with Medicare, which is a federal insurance program that provides health coverage primarily for people older than age 65, regardless of income. It also covers younger disabled people and dialysis patients. Both programs are administered by CMS. Medicare provides no routine dental benefits. Given the oral health needs of seniors, state oral health programs are working with their advocacy partners to promote inclusion of dental benefits under Medicare.

One in three children in the United States is enrolled in the state’s Medicaid or Children’s Health Insurance Program (CHIP) programs. States can design their CHIP program in one of three ways: 1) a separate CHIP program under which a state receives federal funding; 2) a Medicaid expansion program in which a state receives federal funding to expand Medicaid eligibility to optional targeted low-income children; and 3) a combination CHIP, under which a state receives federal funding to implement both a Medicaid expansion and a separate CHIP program. CHIP is designed for uninsured families whose income is too high to be eligible for their state’s Medicaid program. Like Medicaid, CHIP is administered by the states, and is jointly funded by the federal government and states. However, the federal matching rate for state CHIP programs is typically about 15 percentage points higher than the Medicaid matching rate for that state. State Medicaid/CHIP programs and state oral health programs are natural partners in oral disease prevention because both are working to improve the oral health of children in low-income families that may not regularly access dental care.

Federal law provides guidance on the type of health benefits that all children on Medicaid must receive. These mandatory benefits are outlined in what is known as EPSDT, the Early and Periodic Screening, Diagnostic and Treatment program. All states have an EPSDT program. Components of EPSDT include required immunizations, laboratory tests, physical exams and health education. EPSDT includes a dental component, so all children on Medicaid receive a full dental benefit that includes both preventive and restorative treatment. Medicaid law requires states to develop their own periodicity schedule (a schedule of the content and frequency of recommended screenings, assessments and treatments) after consultation with dental groups involved in child health care, or they may adopt a nationally recognized dental periodicity schedule. Thirty-four states currently use the periodicity schedule developed by the American Academy of Pediatric Dentistry, which recommends that children be seen by a dentist following the eruption of the first tooth, but not later than 12 months of age.

Although children on Medicaid may have dental coverage, in many parts of the U.S. they experience difficulties finding a dental office that will care for them. In 2012, less than half of children on Medicaid received any dental service. There are many reasons for this. Dentists often cite Medicaid’s low reimbursement rates as the reason they don’t accept Medicaid children as patients. There are parts of the country that have shortages of dentists and dental specialists.

Dental Insurance

- State Departments of Insurance regulate the insurance in each state
- Dental vs. health insurance: Co-pays, yearly maximums, uncovered services
- Managed care
- ACA



The largest public dental financing programs for children are Medicaid and CHIP; in 2016 about two-thirds of Americans under age 65 reported having private dental insurance. The majority of private dental insurance is provided as a benefit through employers, and coverage varies widely. Insurance is regulated by the state where it is offered, and each state has its own laws and regulations.

Dental insurance is not “insurance” in the usual meaning of the word. Most “health” insurance is based on relative risk and the fact that most illnesses/diseases are unpredictable. There needs to be a mix of high- and low-risk individuals to keep costs reasonable. Instead, because most people need at least preventive dental care on a regular basis, dental insurance is essentially prepaid health care, covering a specified set of benefits regardless of risk. Some dental plans limit the amount they will pay for more expensive treatments such as fillings, root canals, crowns or implants, and there is usually a cap on the maximum annual payment allowed. Usually there are co-payments for both dental and health insurance where the patient pays a portion of the total cost of the visit or service. Specialty care such as orthodontics is often not included in the benefit package or requires additional coverage. Although people with dental insurance commonly receive more dental care than those without, having coverage does not always mean that a patient can afford all the care they need.

Many states use managed care organizations (MCOs) to implement their Medicaid programs. There are many types of MCOs, but many use a Preferred Provider Organization, meaning there is a network of providers that all of the insured choose from; if they go outside of the network and see a different provider, they have to pay more “out of pocket” costs. Another type of MCO is a health maintenance organization (HMO), where the health plan is paid a set amount for every person enrolled in the plan and is required to provide all the care needed for that one set amount. Managed care is typically used to reduce the costs of health care, and is becoming increasingly more common. In many Medicaid programs that use MCOs, the dental benefit is contracted out to administrative service organizations that deal exclusively with dental providers. These companies (e.g., Dentaquest, Scion) often work with state Medicaid programs and dental providers to enroll and treat low-income children.

The Accountable Care Act (“Obamacare”) requires that pediatric dental benefits be offered as one of 10 essential health benefits, either via coverage that is embedded into a medical plan, or in separate stand-alone dental plans. But in most states, enrollees are not required to have pediatric dental coverage if they buy a health plan through the state or federal health care exchange, even if there are children on the policy. Adult dental coverage is not included in the ACA.

Resources

- Career in Dentistry <http://www.ada.org/en/education-careers/careers-in-dentistry>
- Dental Hygiene Practice, <http://www.adha.org/practice-issues>
- Overview of the Dental Safety Net
<http://www.adea.org/dentalsafetynet/>
- Medicaid <https://www.medicaid.gov/medicaid>
- ACA
<https://www.healthaffairs.org/doi/10.1377/hblog20170113.058329/full/>

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Here are some additional resources you may wish to review.

Learning Activities

- Compare scopes of practice for dental professionals in states with liberal practice acts vs those with limited scopes of practice and tighter supervision.
- Visit a few dental workplaces or programs to compare the differences in scopes of services, equipment, personnel and patient populations.
- Interview a variety of dental and medical professionals about their health professions education and describe the differences.
- Contrast dental care financing with what you know about health care financing.

We suggest doing further reading and interviewing various health and dental professionals to compare their educational experiences, work settings, scopes of practice, patient populations, and how patients pay for care.

We also encourage you to review the previously listed other resources.

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We'd like to finish by acknowledging the sources of some of the pictures we have used.

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