Policy on Workforce Issues and Delivery of Oral Health Care Services in a Dental Home

Latest Revision

2025

How to Cite: American Academy of Pediatric Dentistry. Policy on workforce issues and delivery of oral health care services in a dental home. *The Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2026:66-71.

Purpose

The American Academy of Pediatric Dentistry (**AAPD**) advocates optimal oral health and health care services for all children, including those with special health care needs. Strategies for improving access to dental care, the most prevalent unmet health care need for disadvantaged US children, and increasing utilization of available services should include, but not be limited to, workforce considerations. This policy will address workforce issues with an emphasis on the benefits of oral health care services delivered within a dentist-directed dental home.

Methods

In 2008, the AAPD created a Task Force on Workforce Issues which was charged, in part, with investigating the problem of access to oral health care services by children in the US and analyzing the different auxiliary delivery systems available. The task force's findings and recommendations were summarized in a report[1] presented to the AAPD's Board of Trustees in 2009. That report served as the original basis for this policy developed by the Council on Clinical Affairs, adopted in 2011,[2] and last revised in 2019.[3] This revision included an electronic search with PubMed/MEDLINE using the terms: (*evidence based dentistry* [**Majr**] OR *dental care for children* [Majr] OR *pediatric dentistry* [Majr]) AND (*pediatric dentistry workforce* [**Tiab**] OR *oral health care access* [Tiab] OR *oral health disparities* [Tiab] OR *dental therapy model* [Tiab] OR *expanded function dental assistant** [Tiab] OR *expanded function dental auxiliar** [Tiab] OR *dental care delivery* [Tiab] OR *dental workforce* [Tiab] OR *oral health inequal** [Tiab] OR *dental care access* [Tiab] OR *dental therap** [Tiab]); fields: all; limits: within the last 10 years, English. Forty-one articles were identified in this search. Additionally, reports and policies of the American Dental Education Association, American Academy of Pediatrics, and the American Dental Association were reviewed. Expert opinions and best current practices were relied upon when clinical evidence was not available.

* *Used in the PubMed/MEDLINE search to identify all terms that begin with this truncated base.*

Background

Access to oral health care for children is an important concern that has received considerable attention since publication of *Oral Health in America: A Report of the Surgeon General*[4] in 2000. The report identified "profound and consequential disparities in the oral health of our citizens" and that dental disease "restricts activities in school, work, and home, and often significantly diminishes the quality of life."[4] It concluded that for certain large groups of disadvantaged children there is a silent epidemic of dental disease.[4] This report identified dental caries as the most common chronic disease of children in the US, noting that 80% of tooth decay is found in 20% to 25% of children, large portions of whom live in poverty or low-income households and lack access to an ongoing source of quality dental care.[4] A follow up report by the National Institute of Health in 2021 found that—despite seeing a decrease in the prevalence of caries in permanent teeth from 25% to 18% in school-aged children—some minority racial groups and those affected by poverty saw less improvement.[5] In addition, this report noted approximately 1 in 5 children has special health care needs stemming from physical or developmental disabilities or orofacial conditions that can make it more challenging to receive routine oral health care.[5]

The mission of the AAPD is "to advance optimal oral health for all children by delivering outstanding service that meets and exceeds the needs and expectations of our members, partners, and stakeholders."[6] The AAPD has long focused its efforts on addressing the disparities between children who are at risk of having high rates of dental caries and the millions of US children who enjoy access to quality oral health care and unprecedented levels of oral health. The AAPD's advocacy activities take place within the broader health care community and with the public at local, regional, and national levels.

Access to care considerations are more complex than a simple shortage or maldistribution of dentists. Many children experiencing high rates of dental caries are enrolled in Medicaid or are recipients of their state's Children's Health Insurance Program (CHIP). Health care professionals often elect to not

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **Majr:** Medical subject heading major topic. **Tiab:** Title and abstract.

participate as providers in these programs due to low reimbursement rates and the frequency of failed appointments by patients whose treatment is publicly funded.[7,8] Despite these barriers, pediatric dentists report the highest percentage of patients insured through public assistance among all dentists.[9] Additionally, Medicaid-enrolled children living in areas with more pediatric dentists are more likely to utilize preventive dental care.[10] The increased presence of underrepresented populations among health care professionals is important for building trust between providers and marginalized families.[5,11,12] The AAPD's legislative priorities align with aims to increase professional diversity and health equity through the support of provider training programs, recommended Medicaid reform, and expansion of the dental workforce.[13]

Inequities in oral health can result from underutilization of services. Lack of health literacy, limited English proficiency, and cultural and societal barriers can lead to difficulties in utilizing available services. Financial circumstances, as well as geographical and transportational considerations, also can impede access to care. Eliminating such barriers will require a collaborative, multifaceted approach,[14,15] including support for dentists in health care professional shortage areas.[16] Systematic policy and environmental changes that improve living conditions and alleviate poverty are needed to directly address the social determinants of health.[17] All the while, stakeholders in children's oral health care must promote education and primary prevention so disease levels and the need for therapeutic services decrease.

All AAPD advocacy efforts are based upon the organization's strategic objectives.[6] A major component of the AAPD's advocacy efforts is the development of oral health policies, best practices, and evidence-based clinical practice guidelines[18] that promote access to and delivery of safe, high-quality comprehensive oral health care for all children—including those with special health care needs—within a dental home. A dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivery, in a comprehensive, continuously accessible, coordinated, and family-centered way.[19] Such care takes into consideration the patient's age, developmental status, and psychosocial well-being and is appropriate to the needs of the child and family. This concept of a dental home was detailed in a 2001 AAPD oral health policy[20] and is derived from the American Academy of Pediatrics' model[21,22] of a medical home. The AAPD, American Academy of Pediatrics, American Dental Association, and Academy of General Dentistry support the establishment of a dental home as early as 6 months of age and no later than 12 months of age.[18,22-24] This presents time-critical opportunities to provide education on preventive health practices and reduce a child's risk of preventable dental/oral disease when delivered within the context of an ongoing relationship. Prevention can be customized to an individual child's and/or family's risk factors. Growing evidence supports the effectiveness of early dental visits in reducing dental caries.[25-27] Each child's dental home should include the capacity to refer to other dentists or medical care providers when all medically-necessary care cannot be provided within the dental home. The AAPD strongly believes a dental home is essential for ensuring optimal oral health for all children.[28] Alternatives sites, including mobile dental services and school-based programs, require periodic evaluation to determine their effectiveness in serving as dental homes for those who cannot access care in traditional settings.[16]

Central to the dental home model is dentist-directed care. The dentist performs the examination, diagnoses oral conditions, and establishes a treatment plan that includes preventive services; all services are carried out under the dentist's supervision. The dental home delivery model implies direct supervision of allied dental personnel by the dentist (ie, physical presence during the provision of care). The allied dental personnel (eg, dental hygienist, expanded function dental assistant/auxiliary, dental assistant) work under direct supervision of the dentist to increase productivity and efficiency while preserving quality of care. This model also allows for provision of preventive oral health education and preventive oral health services by allied dental personnel under general supervision (ie, without the presence of the supervising dentist in the treatment facility) following the examination, diagnosis, and treatment plan by the licensed, supervising dentist. Furthermore, the dental team can be expanded to include auxiliaries who go into the community to provide education and coordination of oral health services within the dental home. Utilizing allied personnel to improve oral health literacy could decrease individuals' risk for oral diseases and mitigate a later need for more extensive and expensive therapeutic services.

In addition to promoting optimal oral health for all children through its policies, best practices, and clinical practice guidelines, the AAPD advocates improvements in professional education, access to care, and innovations in workforce models including expanded dental team and incorporation of advances in technology.

The AAPD's Task Force on Workforce Issues reported that several provider models to improve access to care for disadvantaged children have been proposed and, in some cases, implemented following the Surgeon General's report.[1] At the heart of the issue with each nondentist provider (eg, dental therapist, midlevel provider) proposal is ensuring ongoing access to dental care for the underserved. Therefore, practice location and retention of independent nondentist providers are important considerations. When providers are government employees (eg, Indian Health Services, National Health Services Corps), they are assigned to high-need areas. The dental therapist model has been shown to improve utilization of dental care services in Alaska.[29,30] However, the current US proposed models are private practice/nongovernment employee models, providing no assurances that independent providers will locate in underserved areas. Case studies of private practices in Minnesota describe the impact of dental therapists on production. Their findings suggest that geographic access to dental care did not expand as it did with the Alaska initiative or with the international model of dental therapists.[31-33] Moreover, evidence from

several developed countries that have initiated nondentist oral-health care provider programs suggests that, when afforded an opportunity, those practitioners often gravitate toward private practice settings in less-remote areas, thereby diminishing the impact on care for the underserved.[34]

All nondentist provider models that have been proposed and currently exist consist of an abbreviated level of education compared to the educational model of a dentist.[35-38] As of 2025, 3 nondentist provider programs are approved by the Commission on Dental Accreditation (CODA).[39] The prerequisites and training length are different for each. The dental health aid therapist (DHAT) model in Alaska requires a certificate of high school completion and encompasses 3 years of training.[36,40] This is markedly different than the typical training for a dentist. All dentists complete a rigorous set of college-level science courses as prerequisites and then complete typically 4 years of dental-specific academic and clinical training.[35] This specialized education equips the dentist with the biological principles, diagnostic skills, and clinical techniques to distinguish between health and disease and to manage oral conditions while taking into consideration a patient's general health and well-being. The clinical care they provide during their doctoral education is under direct supervision. Those who specialize in pediatric dentistry must spend an additional 2 or more years in a full-time postdoctoral program that provides advanced didactic and clinical experiences.[41] The skills that pediatric dentists develop are applied to the needs of children through their ever-changing stages of dental, physical, and psychosocial development, treating conditions and diseases unique to growing individuals.

While most pediatric dental patients can be managed effectively using communicative behavioral guidance techniques, many of the disadvantaged children who exhibit the greatest levels of dental disease require advanced techniques (eg, sedation, general anesthesia).[42,43] Successful behavior guidance enables the oral health team to perform quality treatment safely and efficiently and to nurture a positive dental attitude in the pediatric patient.[44] Accurate diagnosis of behavior and safe and effective implementation of advanced behavior guidance techniques necessitate specialized knowledge and experience.

The specific clinical skills practiced by a nondentist oral-health care provider differ from the comprehensive skills required of a dentist. In general, studies addressing the technical quality of restorative procedures performed by nondentist providers have found that—within the scope of services and circumstances to which their practices are limited—the technical quality is comparable to that produced by dentists.[45,46] No evidence has been shown to suggest that they deliver any expertise comparable to a dentist in the fields of diagnosis, pathology, trauma care, pharmacology, behavioral guidance, treatment plan development, and care of patients with special health care needs. Evaluations which demonstrate comparable levels of technical quality merely indicate that individuals know how to provide certain limited services, not that those providers have the knowledge and experience necessary to determine whether and when various procedures should be performed. Furthermore, dentists are expected to comprehensively manage an individual's oral health care, which may be complicated by concurrent conditions or have implications for overall health. Technical competence cannot be equated with long-term outcomes.

The AAPD continues to work diligently to ensure that the dental home is recognized as the foundation for delivering oral health care of the highest quality to infants, children, and adolescents, including those with special health care needs. The AAPD envisions that many new and varied delivery models will be proposed to meet increasing demands on the infrastructure of existing oral health care services in the US. New Zealand—known for utilizing dental therapists since the 1920's and frequently referenced as a workforce model for consideration in the US—makes dental care available at no cost for children up to 18 years of age[47,48(pxxiii)]; most public primary schools have a dental clinic, and many regions operate mobile clinics.[47] In New Zealand's latest nationwide oral health status survey, 1 in 2 (49.3%) children aged 2-17 years was found to be caries free.[48(p153)] The report indicated 2008 caries rates for 5-year-olds and Year-8 students (12-13 years old) were 43.0% and 49.0% respectively.[48(p22)] These rates help refute a presumption that nondentist providers will overcome disparities.

Technology continues to shape the future of oral health care to the extent that the AAPD has maintained a policy on teledentistry since 2021.[49] This allows the AAPD to advocate for greater acceptance and utilization of electronic communications and technologies to increase access to oral health services and improve quality of care through extension of the dentist-centered oral health care model.

Policy statement

The American Academy of Pediatric Dentistry remains committed in its vision and mission to address the disparities between children who lack access to quality oral health care and those who benefit from such services. The AAPD believes that all infants, children, and adolescents, including those with special health care needs, deserve access to high-quality comprehensive preventive and therapeutic oral health care services provided through a dentist-directed dental home. In the delivery of all dental care, patient safety must be of paramount concern.

The AAPD encourages greater use of an expanded dental workforce including nondentist providers under direct supervision by a dentist to help increase volume of services provided within a dental home, based upon their proven effectiveness and efficiency in a wide range of settings.[46-48,50-53] The AAPD also supports provision of preventive oral health services by a licensed dental hygienist or nondentist provider under general supervision (ie, without the presence of the supervising dentist) following the examination, diagnosis, and treatment plan by the licensed, supervising dentist. Similarly, partnering with other health providers, especially those who most often see children during the first years of life (eg, pediatricians,

family physicians, pediatric nurses), will expand efforts to improve children's oral health.

The AAPD strongly believes in a patient- and family-centered dentist-directed oral health care model. The AAPD will continue its efforts to

- educate families, health care providers, academicians, community leaders, and partnered governmental agencies on the benefits of early establishment of a dental home.
- forge alliances with legislative leaders that will advance the dental home concept and improve funding for delivery of oral health care services and dental education.
- expand public-private partnerships to improve the oral health of children who suffer disproportionately from oral diseases.
- encourage recruitment of qualified students from rural areas and underrepresented minorities into the dental profession.
- partner with other dental and medical organizations to study barriers to care and underutilization of available services.
- support scientific research on safe, efficacious, and sustainable models of delivery of dentist-directed pediatric oral health care that is consistent with the AAPD's oral health policies and clinical practice recommendations.
- embrace advancements in technology and teledentistry to increase access to and improve quality of oral health care services.

Furthermore, the AAPD encourages researchers and policy makers to consult with the AAPD and its state units in the development of pilot programs and policies that have potential for significant impact on the delivery of oral health care services for our nation's children. Evaluation of the duration, content, and outcomes of nondentist provider training programs is needed to inform future recommendations with regard to their scope of practice.

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