



Virginia  
Health Catalyst

# **ORAL HEALTH WORKFORCE GAP ASSESSMENT**

**DECEMBER 2023**

*"It's very stressful for us as dental providers because we see the need [and] we want to help in any way that we can. It breaks our hearts when we have to say we're at capacity. We have a waitlist of almost 2,500 patients for preventive services and almost 870 for [dental] appointments. It's been overwhelming."*

**Dr. Janna Laverdiere, DMD**  
**Dental Director & AEGD Residency Program Director**  
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# EXECUTIVE SUMMARY



Oral health is essential to overall health. Poor oral health is linked to many diseases, including diabetes, heart disease, and cancer.<sup>1</sup> Untreated tooth decay can cause pain, infection, and even death.<sup>2</sup> Alarming, it is the most common chronic disease among children.<sup>3</sup> This is despite the fact that poor oral health is largely preventable with low-cost interventions.

Unfortunately, many Virginians cannot access oral health care and services to prevent, diagnose, or treat oral health issues. Cost is the most common barrier, especially for individuals with low incomes and working-age adults.<sup>4</sup> Recent coverage expansions, including Virginia's adoption of a comprehensive Medicaid dental benefit for adults, have eased but not eliminated this barrier.

In fact, these coverage expansions further highlighted two significant barriers to accessing oral health care:

- 1. There are not enough oral health professionals in many areas of the Commonwealth.**
- 2. There are not enough oral health professionals who serve uninsured, underinsured, or Medicaid-insured Virginians.**

These barriers harm all Virginians, but they harm some more than others. Virginians who have low incomes, belong to historically marginalized communities or live in rural areas suffer the most. Take Falls Church City and Buchanan County as an example. Falls Church City is one of Virginia's wealthiest localities, located in Northern Virginia.<sup>5</sup> Buchanan County is one of Virginia's poorest, located in Southwest Virginia.<sup>6</sup> In 2017, 92% of Falls Church City adult residents reported visiting an oral health professional within the previous year.<sup>7</sup> Only 37% of Buchanan County adult residents reported a visit.<sup>8</sup> Falls Church City is ranked the healthiest locality in Virginia.<sup>9</sup> Buchanan County is ranked near the bottom.<sup>10</sup> Understanding these inequities is necessary for solving them.

## STRATEGIES TO IMPROVE ACCESS

To address these inequities and ensure the oral health workforce meets the needs of all Virginians, members of Virginia Health Catalyst's Future of Public Oral Health Taskforce and corresponding workforce committee convened over a dozen oral health researchers, clinicians, educators, policymakers, and advocates to synthesize existing workforce data and develop recommendations and a path forward. The results are detailed in this report. In short, the members of the taskforce recommend that Virginia:

- Build an accessible, affordable, and equitable **career highway** for current and future oral health professionals.
- **Value** oral health professionals at every stage of their careers.
- **Incentivize** oral health professionals to practice in shortage areas and to serve uninsured, underinsured, or Medicaid-insured patients.
- Deploy the oral health workforce more **equitably and efficiently**, with a focus on public health and prevention.
- Collect and distribute oral health workforce **data** that are comprehensive, accessible, and actionable.

Virginia Health Catalyst's mission is to ensure that all Virginians have equitable access to comprehensive health care that includes oral health. A robust, resilient healthcare workforce is necessary to achieve that goal. It is our hope that this report sheds light on these important challenges and offers our partners and policymakers an actionable framework for solving them.

# KEY FINDINGS

## VIRGINIA'S ORAL HEALTH WORKFORCE FAST FACTS

- There were 7,607 licensed **dentists** in Virginia in 2022.<sup>11</sup>
  - 58% of Virginia's dentists identify as male. 42% identify as female.<sup>12</sup>
  - 59% of Virginia's dentists identify as White; 6% identify as Black; 23% identify as Asian; 6% identify as Hispanic; and 6% identify as another race or as two or more races.<sup>13</sup>
  - There were an estimated 4,307 FTE dentists in Virginia in 2022. 2,000 hours per year of work equals one FTE.<sup>14</sup>
- There were 6,390 licensed **dental hygienists** in Virginia in 2022.<sup>15</sup>
  - 2% of Virginia's dental hygienists identify as male. 98% identify as female.<sup>16</sup>
  - 76% of Virginia's dental hygienists identify as White; 6% identify as Black; 8% identify as Asian; 6% identify as Hispanic; and 4% identify as another race or two or more races.<sup>17</sup>
  - There were an estimated 3,426 FTE dental hygienists in Virginia in 2022. 2,000 hours per year of work equals one FTE.<sup>18</sup>
- There are 49 registered **dental assistants IIs** (DAIIs) practicing in Virginia.<sup>19</sup>
- Only 9% of dentists and 6% of dental hygienists practice in safety net settings, such as free and charitable clinics, federally qualified health centers (FQHCs), FQHC look-alikes, rural health centers (RHCs), and a small number of nonprofit clinics that provide care to uninsured, underinsured, or Medicaid-insured patients.<sup>20, 21</sup>

## ACCESS CHALLENGES

- Only 27% of practicing dentists treat Virginians enrolled in Medicaid or Family Access to Medical Insurance Security (FAMIS), public insurance programs for people who have low incomes or disabilities.<sup>22</sup>
- Thirteen Virginia localities have fewer than one FTE dentist, including eight localities that have no FTE dentists.<sup>23</sup>
- Nine Virginia localities have fewer than one FTE dental hygienist, including five localities that have no FTE dental hygienists.<sup>24</sup>
- 103 of Virginia's 133 localities are designated either a dental geographic Health Professional Shortage Area (HPSA) or are home to a dental population or facility HPSA.<sup>25</sup>

## TROUBLING HEALTH OUTCOMES

- One-third of Virginians did not visit a dentist in 2022.<sup>26</sup>
  - This includes 28% of White, non-Hispanic Virginians, 38% of non-Hispanic Black Virginians, and 40% of Hispanic Virginians and American Indian or Alaskan Native Virginians.
  - 50% of Virginians whose household income is below \$35,000 per year did not visit a dentist in 2022. Thirty percent of Virginians whose household income is above \$35,000 per year did not visit a dentist in 2022.<sup>27</sup>
- 38% of Virginians had a permanent tooth extracted in 2022.<sup>28</sup>
  - Black, non-Hispanic Virginians were more likely than other racial and ethnic groups to have had an extraction.
  - Virginians with the lowest incomes were more than twice as likely to have had an extraction than Virginians with the highest incomes.<sup>29</sup>

# BACKGROUND

Virginia's oral health professionals help keep us healthy and thriving. This report focuses on dentists, dental hygienists, dental assistant IIs (DAIIs), and dental assistant IIs (DAIIs). Other essential team members include but are not limited to medical coders, front desk staff, and dental lab technicians. These professionals are outside the scope of this report.

## DENTISTS

Dentists are licensed professionals who supervise the other members of the oral health care team. According to Virginia's Health Workforce Development Authority, dentists: Examine, treat and maintain the teeth, gums and other hard and soft tissues of the mouth and surrounding structures. They instruct patients about good oral health practices in order to prevent gum disease and tooth loss. [They] also treat patients who have diseases, injuries or malformations of the teeth, gums and mouth.<sup>30</sup>

The number of FTE dentists grew 11% between 2012 and 2022.<sup>31,32</sup> However, there is cause for concern. While there are more licensed dentists in Virginia now than there were five years ago, there are fewer FTEs.<sup>33,34</sup> This implies that dentists are working fewer hours, though it is unclear why.

## DENTAL HYGIENISTS

Dental hygienists are licensed professionals who provide essential preventive care and disease management to patients under a dentist's supervision. They "provide education and clinical services to promote optimal health [and] provide treatment to help prevent gum disease, tooth decay and other oral health problems."<sup>35</sup>

Virginia's dental hygienist workforce has grown even more rapidly than the dental workforce, with the number of FTEs growing by 27% between 2012 and 2022.<sup>36,37</sup> While the workforce seems sturdy, the COVID-19 pandemic showed that there may be cracks in the foundation. Several media outlets and studies reported an exodus of dental hygienists during the pandemic.<sup>38</sup> State data show a slight decline and rebound. However, there is still anecdotal evidence that dentists are struggling to recruit hygienists.<sup>39</sup>

## DENTAL ASSISTANT IS & DENTAL ASSISTANT IIS

Dentists and dental hygienists are supported by DAIs and DAIIs. DAIs take patients' medical histories, take and develop radiographs, and teach patients how to brush and floss properly, among other tasks.<sup>40</sup> DAIs are unlicensed and are not required to register with Virginia's Board of Dentistry. They can – but are not required – to be certified by an accredited credentialing organization.

DAIIs, also known as enhanced functions dental assistants, can do the tasks of a DAI and more, such as performing pulp capping procedures, packing and carving amalgam restorations, taking final impressions, and other tasks under a dentist's or a dental hygienist's supervision.<sup>41</sup> Only certified DAIs and dental hygienists can train to become a DAI.

## ORAL HEALTH PROFESSIONAL PRACTICE SETTINGS

Most dentists and dental hygienists in Virginia work in solo practices.<sup>42,43</sup> Some work in group practices, either independently or as part of a Dental Service Organization (DSO) – an entity that manages the administrative and business side of a dental practice.<sup>44</sup> There is a growing trend for dentists to practice in DSOs because they handle the administrative burdens of running a practice and tend to offer attractive salaries and benefits.<sup>45</sup>

9% of dentists and 6% of dental hygienists practice in oral health safety net settings.<sup>46,47</sup> These settings include free and charitable clinics, federally qualified health centers (FQHCs), FQHC look-alikes, rural health centers (RHCs), and a small number of nonprofit clinics that provide care to uninsured, underinsured, or Medicaid-insured patients.

Finally, oral health professionals increasingly deliver care in Virginia's public schools as part of school-based oral health programs, which are often associated with a brick-and-mortar safety net clinic. These programs allow oral health professionals to easily reach children, encourage prevention, and schedule care for caries and other oral diseases.

# THE CHALLENGE

Too many Virginians cannot access oral health care. This includes many Virginians who can afford it. Why? **First, there are not enough oral health professionals in many areas of the Commonwealth. Second, most oral health professionals do not serve uninsured, underinsured, or Medicaid-insured Virginians.** This section shares data from multiple sources to prove these claims.

## ***THERE ARE TOO FEW ORAL HEALTH PROFESSIONALS IN MANY AREAS OF THE COMMONWEALTH***

There is no perfect way to measure a health workforce shortage. Yet it is clear that many Virginians are suffering from a shortage no matter how it's measured.

Health Professional Shortage Areas (HPSAs) are the most widely used method for measuring health workforce shortages. The federal government makes these designations based on a complicated methodology that considers the ratio of health care providers to a certain population, the percentage of that population living below the Federal Poverty Level, and the travel time to a health care provider.<sup>48, 49</sup> Geographic areas, specific populations, and medical facilities can all be designated a HPSA.<sup>50</sup> The federal government recognizes primary care, dental care, and mental health care HPSAs.

According to this measure, **103 of Virginia's 133 localities are designated either a dental professional HPSA or are home to a population or facility dental HPSA.**<sup>51</sup>

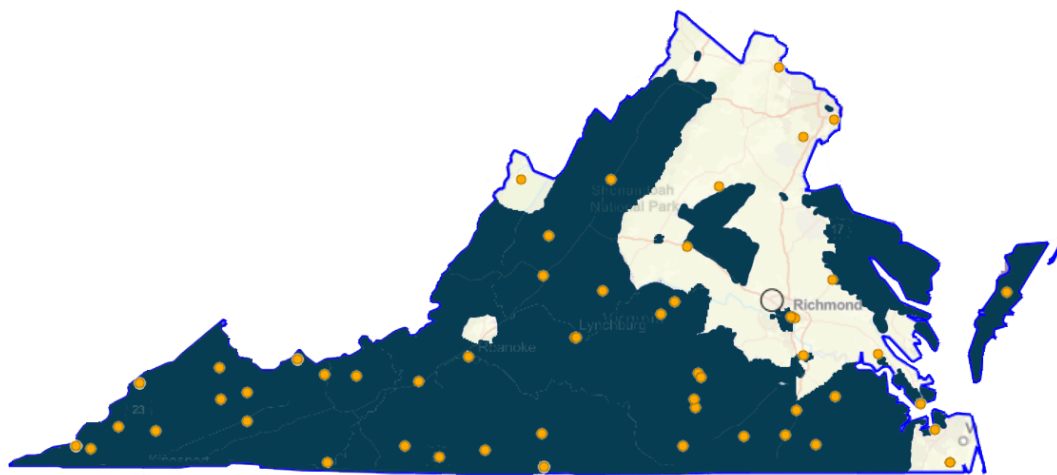


Figure 1: Map of Virginia's Dental Health Professional Shortage Areas.<sup>52</sup>

Another way to measure Virginia's oral health workforce shortage is to analyze data collected by the Virginia Healthcare Workforce Data Center (HWDC). The HWDC administers voluntary surveys to healthcare professionals when they renew their licenses.<sup>53</sup> The response rate for these surveys typically exceeds 75% and often reaches 90%, making them a useful tool for better understanding key characteristics of licensed health professions, including dentists and dental hygienists.<sup>54</sup>

These surveys reinforce what the federal data show: there are not enough dentists and dental hygienists to meet the needs of many communities throughout the Commonwealth. There is roughly only one full-time dentist per 5,000 Virginians in many localities<sup>55</sup> In contrast, there are roughly three full-time dentists per 5,000 Virginians in Northern Virginia; hardly a surplus, but a significant improvement.<sup>56</sup>

Imagine one dentist serving 5,000 patients in a community. The federal government recognizes this ratio as a shortage. The ratio is even smaller – one dentist for every 4,000 individuals – for communities with unusually high needs. It is also important to note that these standards represent the bare minimum. Two or three dentists or dental hygienists per 5,000 individuals may be enough to avoid the shortage designation, but it may not be enough to meet the needs of the community.

Dental hygienists are also unevenly distributed throughout the Commonwealth. There are approximately 1.5 full-time dental hygienists per 5,000 Virginians in Eastern Virginia, Central Virginia, and Southside Virginia.<sup>58</sup> In contrast, there are roughly 2.4 full-time dental hygienists per 5,000 Virginians in West Central Virginia and the Hampton roads region.<sup>59</sup>

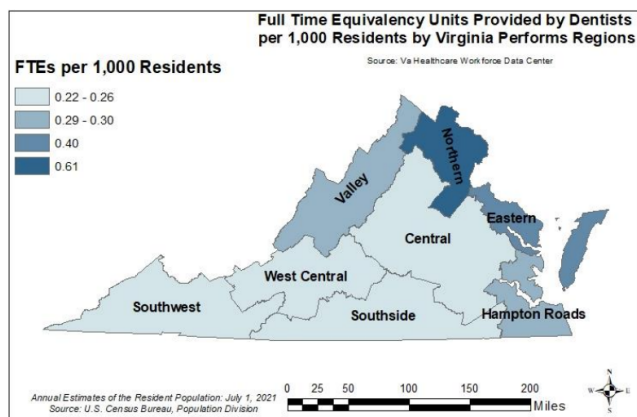


Figure 2: Virginia Healthcare Workforce Data Center Map of FTE Dentists Per 1,000 Residents by Virginia Performs Regions.<sup>57</sup>

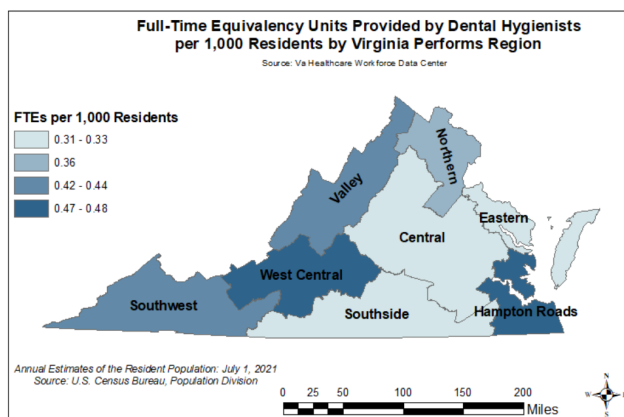


Figure 3: Virginia Healthcare Workforce Data Center Map of FTE Dental Hygienists Per 1,000 Residents by Virginia Performs Regions.<sup>60</sup>

The previous maps show large swaths of Virginia that do not have enough dentists, dental hygienists, or both. However, even regions that appear to have enough oral health professionals have communities that struggle to access care. In reality, many localities, including several in Virginia's more prosperous regions, do not have enough oral health professionals to meet their needs.

The following maps show the number of dentists and dental hygienists per 5,000 residents in every Virginia locality. The darker the shading, the fewer dentists and dental hygienists per resident. The maps illustrate that there are localities scattered across the Commonwealth that have one or fewer dentists or dental hygienists. There are a handful of localities that do not have a single dentist or hygienist.

#### DENTISTS FTEs PER 5,000 RESIDENTS

- 0 Dentists Per 5,000 Residents
- <1 Dentist Per 5,000 Residents
- 1-3 Dentists Per 5,000 Residents
- >3 Dentists Per 5,000 Residents

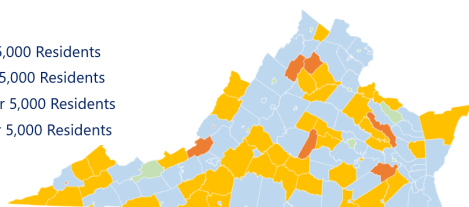


Figure 4: Dentist FTEs Per 5,000 Residents by Virginia Locality.<sup>61</sup>

#### DENTAL HYGIENIST FTEs PER 5,000 RESIDENTS

- 0 Dental Hygienists Per 5,000 Residents
- <1 Dental Hygienist Per 5,000 Residents
- 1-3 Dental Hygienists Per 5,000 Residents
- >3 Dental Hygienists Per 5,000 Residents

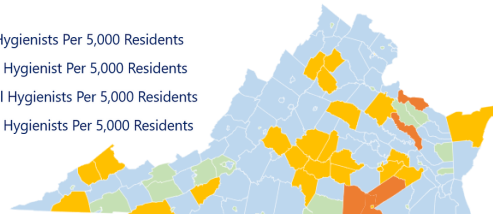


Figure 5: Dental Hygienist FTEs Per 5,000 Residents by Virginia Locality.<sup>62</sup>

The data show that there are many localities that do not have enough oral health professionals to meet the communities' needs. However, residents may drive over county or city lines to seek care. Thus, measuring the number of providers per capita in each locality may overstate the number of people who cannot access care.

The American Dental Association Health Policy Institute developed a methodology to measure access to oral health care that focuses on the time it takes to reach a provider instead of the number of providers per resident in a particular locality. According to this methodology, 18% of Virginians – roughly 1.5 million people – either do not live within 15 minutes of a dentist or live in areas with only one dentist within a 15-minute travel time for every 5,000 people.<sup>63</sup>



Crucially, this data does not consider whether the dentist is accepting new patients or if he or she accepts a particular insurance plan. It doesn't consider if the dentist has appointments outside the normal workday or if the patient has access to stable means of transportation. These and other social determinants of health must be considered when interpreting the data. No matter the methodology, the result is the same. There are not enough oral health professionals in many areas of the Commonwealth.

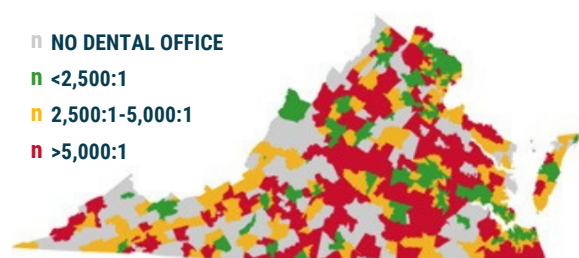


Figure 6: Population Per Dentist Within a 15-Minute Travel Time.<sup>64</sup>

## MOST ORAL HEALTH PROFESSIONALS DO NOT SERVE UNINSURED, UNDERINSURED, OR MEDICAID-INSURED VIRGINIANS

Over 2 million Virginian children and adults are insured through Medicaid, Virginia's public insurance program for individuals who have low incomes or disabilities.<sup>65, 66</sup> Medicaid members tend to have more complex health and social needs than privately insured Virginians. Medicaid is also a major source of insurance for non-Hispanic Black and Hispanic Virginians.

### ONLY 27% OF VIRGINIA'S DENTISTS TREATED MEDICAID MEMBERS IN 2022.

Virginia's Medicaid program has a dental benefit for adults and children. It is comprehensive, and it is free for eligible members. Still, Medicaid members struggle to access oral health care because most dentists do not accept Medicaid insurance. Only 27% of Virginia's dentists treated Medicaid members in 2022.<sup>67</sup> Moreover, only 12% of dentists treated at least 100 Medicaid patients.<sup>68</sup> A separate analysis found that the "percentage of licensed dentists in Virginia treating any Medicaid patients [was] next to last among 41 states..."<sup>69</sup> Virginia policymakers recently increased the Medicaid payment rate to incentivize dentists to treat Medicaid members. It is too soon to tell if this policy change will have a significant effect.

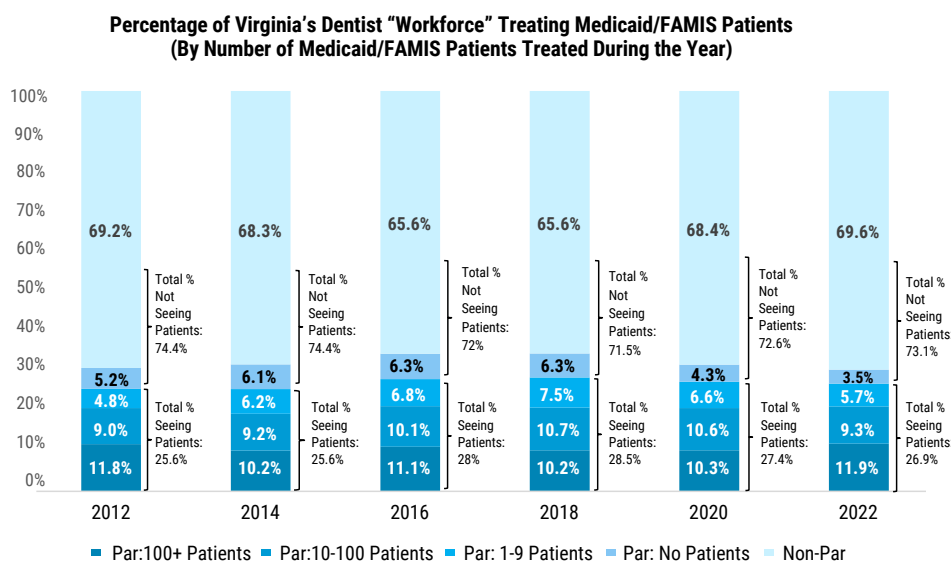


Figure 7: Percentage of Virginia's Dentist "Workforce" Treating Medicaid/FAMIS Patients (By Number of Medicaid/FAMIS Patients Treated During the Year).<sup>70</sup>

These data paint a clear picture. Virginians who have the highest need for care have the hardest time accessing it. 50% of Virginians whose household income is below \$35,000 per year did not visit a dentist in 2022. 38% of non-Hispanic Black Virginians and 40% of Hispanic Virginians and American Indian or Alaskan Native Virginians did not visit a dentist in 2022.<sup>71</sup>

# THE OPPORTUNITY

Although Virginia faces serious obstacles to building an oral health workforce that meets the needs of all Virginians, there is reason for optimism. Several states have invested in their oral health workforces and made reforms to ensure that care is equitable, effective, and efficient. Virginia can be the next state to act.

This section introduces a framework for thinking about these obstacles and identifying action steps to resolve them. The framework has three goals:

- Ensure access to oral health care regardless of race, income, or location;
- Ensure all Virginians who want to can plan, start, or advance an oral health career;
- Ensure all oral health professionals are valued and able to practice effectively and efficiently.



The framework recommends five strategies to achieve these goals:

- Build an accessible, affordable, and equitable **career highway** for current and future oral health professionals.
- **Value** oral health professionals at every stage of their careers.
- **Incentivize** oral health professionals to practice in shortage areas and to serve uninsured, underinsured, or Medicaid-insured patients.
- Deploy the oral health workforce more **equitably and efficiently**, with a focus on public health and prevention.
- Collect and distribute oral health workforce **data** that are comprehensive, accessible, and actionable.



## ***BUILD AN ACCESSIBLE, AFFORDABLE, AND EQUITABLE CAREER HIGHWAY FOR CURRENT AND FUTURE ORAL HEALTH PROFESSIONALS***



There are insufficient training opportunities for Virginia's current and future oral health professionals. There is only one dental school in Virginia. There are six dental hygiene programs, but only two are located in the western part of the state. There are only two community college DAII programs – one at Germanna Community College and a Germanna satellite program at Mountain Empire Community College.

Moreover, these training opportunities are often hard to find and have confusing prerequisites. One dentist remarked that he had looked into DAII certification for the assistants in his practice, but it was unclear to him what education they would need and if there were nearby programs. Unfortunately, this appears to be the norm, not the exception. The solution is to build an accessible, affordable, and equitable career highway for current and future oral health professionals.

The first on-ramp should begin in elementary school, where students should be exposed to oral health careers just as they are other health professions. This could be through career days, bring your parent to work days, and health science or science, technology, engineering, and mathematics (STEM) days. The second on-ramp should be in middle- and high-school, where students can begin basic training toward an oral health career. Virginia's dental career and technical education programs provide excellent opportunities to do this.

These dental career and educational training programs should directly connect graduating students with dental clinics, including federally qualified health clinics, free clinics, and private solo or group practices in the area. These students can begin their careers as DAIs while completing the necessary training to enroll in a DAII program. The clinics, in turn, should be in contact with the DAII programs, keeping them abreast of when employees are nearing their certification.

Virginia's community colleges offer the next on-ramp. The Virginia Community College System (VCCS) boasts 23 community colleges and 40 locations that are equitably spread across the Commonwealth.<sup>72</sup> Students can earn health professional degrees and certificates more quickly and affordably than most four-year institutions. They are engines that power Virginia's healthcare workforce.

As mentioned above, only Germanna Community College operates a DAII program. There is a tremendous opportunity to replicate these programs at community colleges in Virginia's shortage areas by leveraging remote learning and partnerships. Germanna did this by partnering with Mountain Empire Community College (MECC) in Wise County, Virginia, to launch Southwest Virginia's first DAII program. The students complete their didactic training via remote learning taught at Germanna and complete their clinical training at the MECC campus. MECC welcomed its first cohort of DAII students in the Fall of 2022, and clinical training began in the Spring of 2023. This partnership doubled the number of DAIs that graduate in Virginia each year.

Finally, Virginia's Area Health Education Centers (AHEC) program offers another on-ramp to the oral health career highway. The AHEC program leverages community partnerships to develop local and regional workforce pathway programs that connect community members – often young people – with health workforce training and job opportunities. These programs include but are not limited to health workforce recruitment, identification of career opportunities, assistance for displaced or unemployed adults with finding health careers and connecting students with internships and preceptorships.<sup>73</sup> AHECs are located throughout Virginia.<sup>74</sup>

Virginia's AHEC program is funded entirely through grants from the Health Resources and Services Administration. The General Assembly used to support the program with additional state dollars, but it eliminated this contribution during the Great Recession. Supplementing the federal investment with state dollars could significantly strengthen AHEC programs throughout the Commonwealth.

## VALUE ORAL HEALTH PROFESSIONALS AT EVERY STAGE OF THEIR CAREERS



The oral health career highway only works if employers, educators, and policymakers value oral health professionals at every stage of their career. If the highway is a straight road with multiple on-ramps, employers, educators, and policymakers are the roadside assistance, ensuring that everyone can get onto the highway and keeping the road free of obstacles.

Student loan debt is a big obstacle on the highway. On average, oral health professionals earn enough over the course of their careers to offset the student loan debt they accumulate during training. However, the significant debt they carry – particularly early in their careers – incentivizes them to work in practices that can immediately help them pay down their loans. These practices tend to be located in affluent communities.

Graduating dentists are also increasingly likely to work at established practices or DSOs instead of starting or joining practices where there is unmet need. One student interviewee explained that they did not have sufficient training in business or practice management. They also noted that it would be difficult to secure and pay off a loan to start a practice given their existing student loan debt. They concluded, “this just worsens the disparities because we’re all more likely to go to established practices in more established areas.”

### ONLY 6% OF VIRGINIA’S DENTISTS IDENTIFY AS BLACK DESPITE 19% OF VIRGINIA’S OVERALL POPULATION IDENTIFYING AS BLACK

Student loan debt also helps explain why individuals from historically marginalized communities are so underrepresented in the oral health workforce. For instance, Black dentists graduate with an average of \$315,000 in educational debt, over \$25,000 more than other racial/ethnic groups.<sup>75</sup> This likely contributes to the underrepresentation of Black dentists in Virginia. Only 6% of Virginia’s dentists identify as Black despite 19% of Virginia’s overall population identifying as Black.<sup>76</sup>

Policymakers should act to reduce oral health professionals’ debt, perhaps in return for the professional practicing in a shortage area or committing to serve Medicaid patients. The next subsection explores this possibility in more detail.

Employers also play an essential role. The most straightforward way for employers to value oral health professionals is to offer competitive salaries and benefits that reflect the education and skills the professional has mastered. Many DAIs do not seek certification because the costs of certification outweigh the benefits. This has a cascading effect on the workforce because DAIs must be certified to enroll in a DAI training program. Dental clinics should consider covering the costs for a DAI to become certified. They should also consider offering higher salaries to certified DAIs in recognition of their additional training.

Compensation is just one way to value oral health professionals. Providing a positive work environment and prioritizing professionals’ mental health is crucial to preventing anxiety, depression, and burnout. Dental clinics and supervising dentists should encourage their teams to set healthy workplace boundaries, consider offering additional paid time off or mental health days, and provide mentor/mentee opportunities for new employees.

These initiatives cost money, so it is imperative that health insurance payors also value oral health professionals and prioritize their mental health and overall well-being. Private and public reimbursement rates should reflect the total effort that goes into treating patients. Moreover, payors should make it as easy as possible for dentists to be reimbursed for their work.

One dental stakeholder commented that they would rather offer patients highly discounted prices rather than enroll in Medicaid because of perceived administrative hurdles associated with the program. It is unclear if Medicaid is especially burdensome compared to private insurance, but one thing is certain: overburdening oral health professionals with administrative work leads to anxiety and burnout. Worse, it takes time away from what oral health professionals do best: treating patients.

Finally, policymakers must recognize that some providers may need additional support, especially those who serve a disproportionate share of patients with complex medical or social needs, intellectual or developmental disabilities, or low incomes. Policies should reflect the additional effort – both physical and mental – that oral health professionals put in to treat these patients. This could mean increasing reimbursement for federally qualified health centers and other safety net clinics, increasing hospital reimbursement for the resources needed to treat patients in the operating room, or directly incentivizing oral health professionals via scholarship support or loan repayment. This leads to the next strategy.





## INCENTIVIZE ORAL HEALTH PROFESSIONALS TO PRACTICE IN SHORTAGE AREAS AND TO SERVE UNINSURED, UNDERINSURED, OR MEDICAID-INSURED PATIENTS



Virginia needs more oral health professionals, particularly in rural areas. That said, having more oral health professionals does not solve Virginia's access issues if they do not serve the uninsured, underinsured, or Medicaid-insured. Dentists who grew up in poorer communities are more likely to treat patients who have lower incomes. Dentists who identify with a historically marginalized community are more likely to serve patients from that community. Dentists who grew up in rural areas are more likely to serve patients who live in rural areas.<sup>77</sup>

It is clear that educators, employers, and policymakers should do more to increase the number of oral health professionals who represent these communities. Building accessible, affordable, and

equitable career highways is an essential strategy. However, relying exclusively on this approach is insufficient because these professionals – while more likely than others to serve communities similar to the ones in which they grew up – are not destined to do so. They, understandably, may move into more affluent or urban areas. They may also prioritize self-pay or privately paying patients if they have debt to pay off. Moreover, it should not disproportionately fall on any one group of oral health professionals to treat the uninsured, underinsured, Medicaid-insured, and high-need populations. All oral health professionals must do their part. That said, simply exhorting dentists to treat patients who have higher needs and lower-paying insurance is neither an effective nor sustainable strategy. Policy must play a role. Virginia, like most states and the federal government, has programs that repay a portion of newly graduated healthcare providers' student loans in return of them serving in shortage areas designated by the Health Resources and Services Administration (HRSA). Virginia's State Loan Repayment Program (VA-SLRP), for instance, offers up to \$140,000 in loan repayment for eligible providers in return for two years of service in an HRSA-designated Health Professional Shortage Area (HPSA).<sup>78</sup>

### VIRGINIA'S STATE LOAN REPAYMENT PROGRAM OFFERS UP TO \$140,000 IN LOAN REPAYMENT FOR ELIGIBLE PROVIDERS IN RETURN FOR TWO YEARS OF SERVICE IN AN HRSA-DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREA

Unfortunately, this program is not living up to its potential for oral health professionals. Few dentists and dental hygienists are currently benefitting from the program. Part of the issue is that these professionals are competing against hundreds of other healthcare providers in different fields for an extremely limited pot of money. This arrangement pits dentists and other healthcare providers against each other.

The program is also administratively burdensome. An interviewee lamented that many safety net clinics struggle to understand how these programs work, much less be able to try to guide a potential employee through them. Another said that the agency that administers these programs needs more staff members to support it. Finally, an interviewee stressed that while the money matters, safety net clinics must do more to showcase the benefits of living in rural areas. This requires additional time and resources.

Policymakers should strengthen loan repayment programs for Virginia's dentists and dental hygienists. The Code of Virginia authorizes – but does not fund – a loan repayment program for dentists as well as conditional scholarships for dentists and dental hygienists.<sup>79, 80, 81</sup> Restoring funding, alongside appropriate reforms to strengthen the programs, would go a long way toward incentivizing newly graduated oral health professionals to practice in areas that need them. Restoring Virginia's dental loan repayment and scholarship programs is just a start. Policymakers should also explore opportunities to increase Medicaid reimbursement rates for dentists and dental clinics that treat a disproportionate share of uninsured, underinsured, or Medicaid-insured patients. Hospitals and physicians have benefited from these arrangements for decades. Dental clinics and dentists should benefit from these policies too.

## DEPLOY THE ORAL HEALTH WORKFORCE MORE EQUITABLY AND EFFICIENTLY, WITH A FOCUS ON PUBLIC HEALTH AND PREVENTION



Virginia's oral health workforce does not seem to be working as equitably or efficiently as it could. Two care models, remote supervision and teledentistry, can allow oral health professionals to practice more efficiently while strengthening access for those who need care the most. In addition, there is a tremendous opportunity to leverage non-dental medical providers and community health workers to prioritize prevention and public health. This section examines each of these opportunities.

### REMOTE SUPERVISION

Under remote supervision, the dental hygienist – not the dentist – conducts an initial oral assessment. After the initial assessment, the hygienist may continue to treat a patient for 90 days, at which point the supervising dentist must examine the patient or refer the patient to another dentist for examination.<sup>82</sup>

The supervising dentist develops a treatment plan for the patient that the dentist and/or hygienist implements.<sup>83</sup> While the supervising dentist must be accessible for consultation, he or she is not physically present when the dental hygienist conducts the initial examination or follow-up treatment.<sup>84</sup> This model allows hygienists to reach more people in shortage areas – particularly in school-based settings.<sup>85</sup>

Remote supervision has the potential to improve access, but stakeholders shared that it is underutilized. One dental stakeholder commented that it is extremely difficult to integrate patients first seen under remote supervision into their practice within 90 days. Another stakeholder noted that limited staff and resources also make it challenging to set up remote supervision programs in school-based settings.

These challenges are solvable, but they will require a concerted effort among dentists, dental hygienists, and other stakeholders. A stakeholder workgroup has already begun working on legislation to raise the 90-day threshold to 180 days. It will also seek guidance from the Board of Dentistry to help demystify the rules and requirements surrounding remote supervision.

### TELEDENTISTRY

Teledentistry is another model that can increase the oral health workforce's efficiency. From Virginia Health Catalyst's Teledentistry toolkit:

Teledentistry is the use of electronic information to provide and support dental care delivery, diagnosis, consultation, treatment, transfer of dental information, and education. This enables clinicians to provide care without patients needing to travel to the dental office. It can reduce dental-related emergency room visits and increase access to oral health services for remote populations. Through teledentistry, patient visits occur over video chat or by electronic messaging after a provider reviews photos of the patient's oral health concerns. [It] is not a specific service, but a means to provide oral health care and education.<sup>86</sup>

Dentists can also use teledentistry in tandem with remote supervision. Under this joint model, a dental hygienist conducts the initial visit. The supervising dentist conducts the follow-up visit via teledentistry, allowing him or her to decide whether or not the patient requires an in-person exam. While teledentistry use has grown dramatically since the pandemic, its full potential is still untapped. Several barriers, including broadband availability, technological literacy, and the cost to install the required technology equipment and software, may be preventing oral health professionals and patients from fully embracing teledentistry.<sup>87</sup> Patients may not know if their insurance covers teledentistry services. For instance, Virginia's Medicaid program covers teledentistry services, but beneficiaries and their dentists may not know that. Greater utilization of teledentistry will improve access to care throughout the Commonwealth, particularly in areas that do not have enough oral health professionals to meet the needs of people who live there.

## NON-DENTAL MEDICAL PROVIDERS

The previous recommendations have focused on growing the oral health professional workforce. However, health professionals who have traditionally practiced outside the oral health context have an important role to play as well. They are especially important when it comes to prevention. Take fluoride varnish, for example. Fluoride varnish is an easy-to-apply dental treatment that is extremely effective in preventing cavities. Virginia law allows physicians, physician assistants, nurse practitioners, nurses (both RN and LPN), and medical assistants to apply fluoride varnish.<sup>88</sup>

Unfortunately, physicians and other non-oral health professionals have been reluctant to provide this service. They usually have very little time with a patient and just do not have the capacity to do “one more thing.” They may also be unaware that they are allowed to apply fluoride varnish, or they may be uncomfortable applying fluoride varnish as they did not learn how to do it during their medical or nursing training. In addition, Virginia’s Medicaid program only reimburses non-dental medical providers for applying fluoride varnish to children through age three (soon to be increased to age five).

The bigger issue, however, is that medical and dental care remain separate. Medical and dental providers are trained in different schools and practice in different settings. They use different electronic health records and procedure codes. Asking physicians or nurses to do oral health assessments or apply fluoride varnish is like asking them to speak a foreign language, even if they are capable of doing it.

The answer is to integrate medical and dental care. This is a tall task, but it is possible. Several of Virginia’s safety net clinics are leading the way with promising results. Other providers should follow suit, and policymakers should make a concerted effort to promote and incentivize medical-dental integration. Applying fluoride varnish and conducting oral health assessments are good starting points.

## COMMUNITY HEALTH WORKERS

Community Health Workers can also play an indispensable role in promoting oral and overall health. A Community Health Worker (CHW), also known as a Community Dental Health Coordinator (CDHC) in the oral health context, is a “frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.”<sup>89</sup> CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through outreach, community education, informal counseling, social support, and advocacy.

Health-related social needs, broadly referred to as the social determinants of health, prevent people from being healthy even if they have access to clinical care. CHWs are uniquely equipped to identify these needs and help resolve them. They can practice in many different settings, either alongside clinicians or in collaboration with them while being based in the community.

There are roughly 250 certified Community Health Workers practicing in Virginia<sup>90</sup> Many of these CHWs work in grant-funded positions. The federal government invested in building the CHW profession in response to the COVID-19 pandemic. However, most of this investment is in the form of one-time grants set to expire in the next few years. Sustainable funding is needed to continue growing Virginia’s CHW profession. Virginia can do this by authorizing its Medicaid program to pay for CHW services. This is a cost-efficient financing mechanism because CHW services have been shown to promote prevention and avert higher-cost emergency departments and other clinical interventions.<sup>91</sup> Virginia’s Medicaid program should cover these services as soon as possible.





## **COLLECT AND DISTRIBUTE ORAL HEALTH WORKFORCE DATA THAT ARE COMPREHENSIVE, ACCESSIBLE, AND ACTIONABLE**

The systematic collection and distribution of oral health workforce data that are comprehensive, accessible, and actionable are essential. The success of the other four strategies depends on it. Virginia's oral health stakeholders are lucky to have a wealth of high-quality data sources. The Bureau of Labor Statistics, the American Dental Association, the American Dental Association Health Policy Institute, and the Virginia Healthcare Workforce Data Center all collect and make extraordinarily valuable data available. These resources help policymakers and other stakeholders summarize the state of the oral health workforce and its trends.



There is an opportunity to do more. Virginia needs more comprehensive data to tell stakeholders how many cars are on the oral health workforce highway, how many are on the on-ramps and off-ramps, how many are broken down, and why. It needs more localized data to better pinpoint workforce shortages and to invest resources accordingly.

More data are only helpful if they are accessible. Oral health stakeholders, especially educational programs, should share as much pertinent data as is allowed by law that is relevant to keeping oral health students and professionals on the workforce highway. There should be a “one-stop shop” for students, professionals, and educators.

Finally, data must be actionable. Stakeholders, especially policymakers, must be able to use the data to draw conclusions and to change course if necessary. Do certain incentive programs work? If not, why not? How many high school students are participating in dental career educational and technical programs? Where are they? How many go on to pursue oral health careers? The answers to these questions will determine whether these strategies are effective and how they can be improved. More comprehensive, accessible, and actionable data are not a solution in itself to Virginia's oral health access barriers. However, the other strategies can't succeed without it.

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## **CONCLUSION**

Appearances can be deceiving. At first glance, Virginia's oral health workforce looks strong. There are thousands of dentists and dental hygienists providing care to millions of Virginians. However, this façade cracks under closer inspection. Too many Virginians are unable to access oral health. For many, it's because there aren't enough oral health professionals nearby. For others, it's because they cannot find a dentist who accepts Medicaid or treats the uninsured and underinsured. For some, it's both. Solving these challenges will strengthen access for Virginians. It will also make a dent in the racial, class, and geographic inequities that disproportionately harm the people who need the most care.

Tooth decay is preventable. Periodontal disease is preventable. Tooth extractions are preventable. No physician would advise ignoring a mild infection of a limb just to amputate it when the infection worsens. The same standard must apply to oral health. That begins with the recognition that oral health is essential to overall health. It ends with every Virginian – no matter what they look like or where they live – having equitable access to comprehensive health care that includes oral health. Virginia policymakers, oral health professionals, and public oral health advocates have an opportunity – and a responsibility – to solve this problem. Doing so will help ensure healthier futures for all Virginians, no matter who they are or where they live.

It's time to get to work.

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