Expanding the Oral Health Workforce to Promote Overall Health: Minnesota Deploys Community Health Workers and Dental Therapists to Advance Equity

By Carrie Hanlon and Rebecca Cooper

Oral health access and quality varies across populations, with disparities related to income, age, sex, race, ethnicity, and medical status persisting despite its value to general health.[1] Minnesota is working to increase access and advance oral health equity through the adoption of emerging health professionals, including community health workers (CHWs) and dental therapists (DTs) and advanced dental therapists (ADTs).[2]

Eight states and tribal organizations in five states allow DTs to provide preventive and restorative dental care.[3] Forty-seven states and Washington, DC have programs designed to integrate CHWs into evolving health care systems, but only a few state programs allow CHWs to play a role in expanding oral health.[4]

Minnesota initiated an expansion of its oral health workforce because more than half of its counties are considered Dental Health Professional Shortage Areas (DHSPAs),[5] which poses a major barrier for rural and under-resourced residents to receive oral health care. Recent data from a Minnesota Department of Health (MDH) survey indicates that the overall dentist to population ratio is one dentist for every 1,641 Minnesotans.[6] This ratio increases for rural residents, with:

- One dentist per 2,153 micropolitan or large rural city residents;
- One dentist per 2,272 small town or small rural city residents; and
- One dentist per 3,938 rural or geographically isolated residents.

Minnesota's 2013-2018 Oral Health Plan details strategies to expand the oral health workforce to reduce these disparities. The following explores how Minnesota's programs and policies are using CHWs and DTs/ADTs to address oral health needs.

Community Health Workers

The Minnesota Department of Human Services (DHS) defines CHWs as community-based workers who provide diagnosis-related patient education, health promotion, advocacy, and disease management for a range of health issues, including oral health. States have embraced the CHW model as a mechanism to engage more vulnerable populations in care.[7] CHWs can work in homes, schools, and in community-based organizations. To help build trust and relationships, CHWs typically come from the communities in which they serve. By providing culturally competent, high-quality access to services and increasing the health knowledge of the individuals they serve, CHWs can help reduce health disparities.[8]

The Minnesota legislature established the Healthcare Education-Industry Partnership (HEIP) in 1998 to address health disparities. In the early 2000s, HEIP worked with the Minnesota Community Health

Worker Project, a group of 21 health care industry, university, and non-profit organizations, to develop a sustainable CHW profession. Through this work group, in 2005, Minnesota became the first state to implement a for-credit, transferrable-credit CHW certificate program through its state college system and private higher education institutions.

More than 650 CHWs been trained through Minnesota's certificate program to date, and about 70 percent are racial and ethnic minorities.[9] The three largest racial and ethnic minority populations Minnesota's CHWs work with are Latino, Somali/East African, and Hmong populations. Medicaid does not directly reimburse CHW for oral health services, so CHWs work under the supervision of eligible providers, such as dentists or physicians, to provide oral health services.[10] Minnesota's Medicaid program covers care coordination and patient education services related to oral health and dental care from a CHW if the CHW received a certificate from the licensed CHW certificate program, or has at least five years of supervised experience with an enrolled dentist, physician, or other eligible provider.[11]

The state was awarded a three-year, $45 million State Innovation Model (SIM) grant in 2013 to expand and improve accountable care models in the state.[12] In Maplewood, a community dental clinic expanded to four clinics across the state using CHW interns. In Mankato, a federally qualified health center used SIM funds to integrate CHWs into a mobile dental unit serving rural areas, which led to a large increase in service utilization. For more information about how CHWs resources are used across the country, explore NASHP's interactive map of *State Community Health Worker Models*.

Dental Therapists and Advanced Dental Therapists

In 2009, Minnesota's legislature authorized the licensing of DTs and ADTs with the requirement that they primarily serve low-income, and under/uninsured patients.[13]

- **DTs** are licensed oral health practitioners and members of an oral health care team who provide evaluative, preventive, restorative, and minor surgical dental care within their scope of practice.[14] DTs are mid–level practitioners licensed by the Board of Dentistry, and work under the supervision of a dentist.
- **ADTs** provide the same services that a DT does, plus oral evaluation and assessment, treatment plan formulation, and non–surgical extraction of certain diseased teeth. ADTs are certified by the Board of Dentistry and can practice under the supervision of a licensed dentist, but the dentist does not need to be on-site during procedures and does not need to see the patient prior to them receiving care from an ADT.

Research shows that DTs improve underserved patients' access to oral health care, including Medicaid enrollees, partly due to reduced waiting times and travel distances.[15] Minnesota has two dental therapy programs that accept and train 10 students per year. In 2018, 92 dental therapists, including ADTs, were licensed to practice in Minnesota.[16]

To ensure Minnesota has appropriate dental workforce coverage for rural areas, Minnesota's Office of Rural Health and Primary Care implemented a state loan forgiveness program. The program is offered to final-year DTs and ADTs as well as licensed DTs and ADTs who plan to practice in a designated rural area for at least three years. These DTs and ADTs are eligible for $10,000 in annual loan repayments.

Next Steps and Reflections

Ensuring access to oral health care requires sufficient provider participation and provider reimbursement. The Minnesota Rural Health Advisory Committee's[17] *Oral Landscape for Rural Residents* report[18] highlighted reimbursement rate challenges specifically for pediatric dental services. As a result, MDH pledged to work with DHS and legislators to promote a reimbursement system that covers the cost of providing oral health services and encourages providers to accept patients participating in public programs. MDH also plans to share workforce data with legislators to:

- Highlight programs that succeed in expanding the workforce in rural Minnesota;
- Facilitate work with stakeholders and within provider communities to encourage practices in order to extend the reach of the existing workforce to meet oral health needs.[19]

State officials across agencies recognize the importance of oral health for overall health and work collaboratively to expand the oral health workforce to ensure access for vulnerable populations and advance equity.

Notes

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[17] The workgroup represented a variety of oral health perspectives and roles, including oral health professionals, dental professional associations, oral health educators, safety-net providers, and other oral health stakeholders.
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[19] Ibid.