Course: DENT 205 Professional Issues/Ethics in Dental II

Topic: Alternate Practice Models: Future Trends for Oral Health Care

Audience: Adult Learners (Senior Level Dental Hygiene Students)

Time: 50 minutes total

- Anticipatory set= 5 minutes
- Lesson content= 40 minutes
- Summary= 5 minutes

Materials: Computer, Projector, PowerPoint slides, Microsoft Teams, Stable internet connection, Microphone, Webcam

Instructional Objectives:

Upon completion of the lecture, the student should be able to:

1. Describe different models for alternate dental hygiene practice.
2. Compare the scope of practice differences among the major alternate dental hygiene practice models.
3. Analyze how state practice acts influence access to care and the development of alternative practice models.
4. Evaluate which alternate practice model is the best match for the access-to-care needs of a chosen population.
5. Advocate for evidence-based policy changes that support expanded access to preventive oral health services.

References:

American Dental Hygienists' Association. (2025, September 22). *Dental hygiene practice act overview: Permitted functions and supervision levels by state*. https://www.adha.org/wp-content/uploads/2026/01/Practice-Act-9.22.25_Update.pdf

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California Dental Hygienists' Association. (2023, October). *What is an RDHAP?* https://cdha.org/Portals/CDHA/Eblasts/What%20is%20an%20RDHAP%20(Revised%20Updated)%20(1).pdf

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Lenaker, D. (2017). The dental health aide therapist program in Alaska: An example for the 21st century. *American Journal of Public Health, 107*(Suppl 1), S24–S25. https://doi.org/10.2105/AJPH.2017.303831

Minnesota Department of Health. (2024, February 12). *Dental Therapist (DT) and Advanced Dental Therapists (ADT)*. https://www.health.state.mn.us/facilities/ruralhealth/emerging/dt/index.html

New Mexico Dental Hygienists' Association. (n.d.). *About collaborative practice*. https://www.nmdha.org/legislative/collaborative_practice

LESSON CONTENT	NOTES – MEDIA – Q/A
I. ANTICIPATORY SET A. Introduction Alternate dental hygiene practice models were developed to expand preventive oral health services beyond traditional clinical settings. Today's lecture introduces these models and examines how they function across different states and populations. B. Gain Attention/Motivate Imagine living in a community where the nearest dentist is over 100 miles away. No public transportation, no nearby clinics, and no dentist for hours. Consider who provides preventive oral health care in that situation. C. Activate Prior Knowledge Before we look at alternate practice models, think about the settings where you've seen dental hygienists provide care. What roles or limitations have you noticed in those environments? Those experiences help you understand why some communities need different models of care. D. Establish Rationale By attending today's lecture, you will learn why alternate dental hygiene practice models matter for improving access to preventive oral health care. Understanding the impact of state laws and workforce design helps you see how these models expand services to communities that have historically been underserved. E. Present Instructional Objectives After today's lecture, you should be able to: 1. Describe different models for alternate dental hygiene practice. 2. Compare the scope of practice differences among the major alternate dental hygiene practice models. 3. Analyze how state practice acts influence access to care and the development of alternative practice models.	PP Slide #1: Title slide: Alternate Practice Models: Future Trends for Oral Health Care PP Slide #2: Picture of empty rural highway Note: Emphasize that this scenario is common in rural and tribal regions to frame the need for alternate models. Q: Why do you think traditional dental office models haven't been enough to meet the needs of all communities? A: Answers will vary, but the students will learn that the traditional office model works for some populations, but it doesn't reach people who face geographic, financial, or logistical barriers to care. PP Slide #3: Your experience in dental settings PP Slide #4: Objectives

4. Evaluate which alternate practice model is the best match for the access-to-care needs of a chosen population. 5. Advocate for evidence-based policy changes that support expanded access to preventive oral health services.	

LESSON CONTENT	NOTES – MEDIA – Q/A
I. Alternante Practice Models: A. Purpose 1. Increase access to care 2. Reach underserved populations 3. Address shortages 4. Deliver care in non-traditional settings B. Major models 1. Registered Dental Hygienist in Alternative Practice (RDHAP) a. Independent practice model b. California 1998 c. Preventive care d. Settings i. Dental Health Professional Shortage Areas ii. Residences of the homebound iii. Nursing homes iv. Hospitals v. Residential care facilities vi. Public health settings 2. Advanced Dental Therapist (ADT) a. Mid-level provider model b. Minnesota 2009 c. Collaborative management i. Preventive ii. Restorative iii. Limited surgical procedures d. Settings i. Dental Health Professional Shortage Area ii. Uninsured and underserved iii. Low-income 3. Dental Health Aide Therapist (DHAT) a. Community-based provider model b. Alaska 2005 c. Prevention and basic restorative care d. Settings i. Tribal ii. Rural 4. Collaborative practice a. New Mexico 1999 b. Written agreement with dentist	PP Slide #5: Purpose of alternate practice models Note: Highlight that these models vary by state and were developed at different times in response to local workforce shortages and community needs. PP Slide #6: Overview of major models PP Slide #7: RDHAP Q: Based on what we've discussed, why do you think California created the RDHAP model? A: This model was created to increase access to preventive oral health care for people who could not realistically receive care in traditional dental offices. PP Slide #8: ADT PP Slide #9: DHAT PP Slide #10: Collaborative practice

c. Provides preventive services without dentist present d. Settings i. Schools ii. Public health programs 5. Unsupervised or direct access models a. 43 states b. Hygienist initiates preventive treatment off their own assessment c. Settings i. Public health settings ii. Schools iii. Community programs	PP Slide #11: Unsupervised and direct access models Note: Remind students collaborative practice requires a dentist's written oversight and direct access does not.
II. Scope of Practice: A. Definition 1. Services each model is legally allowed to provide 2. Level of autonomy or supervision required 3. Settings where care can be delivered 4. Populations each model is designed to serve B. Core dimensions 1. Supervision level a. Independent practice b. Collaborative management c. Community-based d. Written collaborative agreements e. Direct access/unsupervised care 2. Scope of procedures a. Preventive only b. Preventive and basic restorative c. Preventive, restorative, and limited surgical 3. Practice settings a. Homes b. Schools c. Long-term care facilities d. Tribal clinics e. Remote villages f. Community clinics g. Public health programs h. Mobile units 4. Populations served a. Rural/remote communities	PP Slide #12: Scope of practice Q: Which practice settings benefit the most from providers who can work without a dentist on site? A: The greatest benefit occurs in settings where patients cannot easily travel to a dental office or where dentists are scarce.

b. Tribal communities c. Geriatrics d. Children e. Low-income f. Individuals with mobility or transportation barriers	
C. State variation 1. No uniformity across United States 2. Broad autonomy vs. restricted practice 3. Legislature shapes differences	PP Slide #13: State variation
III. State Practice Acts: A. Definition 1. State laws that define what dental hygienists can and cannot do 2. Outline a. Supervision levels b. Scope of practice c. Allowable settings 3. Determine if alternate practice models can exist	PP Slide #14: State practice acts
B. How supervision levels affect access 1. Independent practice a. Greatest flexibility b. Expanded reach 2. Collaborative practice a. Moderate autonomy b. Increased community access 3. General supervision a. Dentist not present but must authorize care 4. Direct supervision a. Limits outreach b. Dentist must be present 5. No direct access a. Cannot initiate treatment	PP Slide #15: How supervision levels affect access Note: Supervision levels adopted from ADHA's Practice Act Overview.
D. Why states adopt or reject models 1. Workforce shortages 2. Access issues a. Rural b. Tribal 3. Political climate a. Professional advocacy 4. Dental boards and associations a. Support	PP Slide #17: Why states adopt or reject models Q: Which factors have the biggest influence on whether a state adopts an alternate practice model? A: States adopt alternate practice models when they have significant access problems, supportive political conditions, and a public health system that can sustain the model.

b. Opposition 5. Public health priorities E. Montana's Limited Access Permit (LAP) 1. Supervision level a. Public health supervision b. Dentist not required on site 2. Services a. Preventive care 3. Settings a. Schools b. Long-term care facilities c. Community sites	PP Slide #18: Montana's LAP
IV. Best Practice Models for Specific Populations: A. Identifying access-to-care barriers 1. Geographic isolation 2. Transportation limitations 3. Limited provider availability 4. Delayed access to preventive care 5. Low income 6. Lack of insurance 7. High needs in long-term care facilities 8. Limited access for children 9. Cultural barriers	PP Slide #19: Best practice models for specific populations PP Slide #20: Access-to-care barriers
B. Match barrier to models' strengths 1. RDHAP a. Best when barrier is i. Mobility ii. Transportation 2. ADT a. Best for areas with i. Few dentists ii. High unmet restorative needs 3. DHAT a. Strong for i. Tribal communities ii. Remote communities b. Cultural competence is essential c. Continuity of care is essential 4. Collaborative Practice Hygienist a. Best when preventive services are needed at scale b. Strong in i. Public health programs	PP Slide #21: Matching models to barriers Note: These are the best fits for each model, but some do overlap. Q: Why might a state choose a collaborative practice model over direct access for school-based programs? A: Collaborative practice expands preventive care in schools while preserving a level of dentist involvement that some states view as safer or more politically feasible than full direct access.

ii. School-based care 5. Direct Access Hygienist a. Strong for i. School programs ii. Mobile units iii. Community outreach b. When rapid preventive access is needed without prior authorization	
C. Legal considerations 1. Is this model allowed in the state? 2. What supervision level is required? 3. Are there restrictions on settings? 4. Can the provider bill procedures?	PP Slide #22: Legal considerations Note: Emphasize that legal considerations determine whether these models can operate in a given state.
V. Advocacy for Alternate Practice Models: A. Definition 1. Using evidence to support changes in a. Laws b. Regulations c. Policies 2. Communicating with stakeholders 3. Promoting models that improve access to preventive care 4. Staying within the ethical and professional scope of the profession	PP Slide #23: Advocacy for alternate practice models
B. Stakeholders 1. State legislators 2. State dental boards 3. Public health departments 4. Tribal health organizations 5. Professional associations 6. Community coalitions	PP Slide #24: Stakeholders
C. Communication strategies 1. Messaging a. Clear b. Respectful c. Fact-based 2. Focus on patient outcomes 3. Highlight a. Cost effectiveness b. Public health impact 4. Tailor messages to audience a. Layman's terms b. Avoid jargon	PP Slide #25: Communication strategies Q: What makes a message both respectful and persuasive when talking to policymakers? A: A respectful, persuasive message is clear, evidence-based, patient-focused, and tailored to the policymaker's priorities.

D. Evidence to support policy change 1. ADTs demonstrate high clinical quality a. Outperformed dentists on 2024 ADEX 2. DHAT impact in Alaska a. Decrease emergency care b. Increase preventive services 3. RDHAP outcomes in long-term care facilities a. No patient-care lawsuits E. Ethical considerations 1. Must prioritize patient welfare 2. Evidence should be a. Unbiased b. Accurate 3. Must stay within professional scope	PP Slide #26: Evidence to support policy change Note: Each evidence point on the slide includes a hyperlink to the original source. PP Slide #27: Ethical considerations Q: Why is it important to use unbiased and accurate evidence when advocating for alternate practice models? A: Policymakers rely on trustworthy information, and using biased or inaccurate data could harm credibility, mislead decision-makers, or compromise patient welfare.

LESSON CONTENT	NOTES – MEDIA – Q/A
SUMMARY: Let's recap what we covered today. We reviewed the major alternate dental hygiene practice models and how they expand preventive care in underserved communities. We compared their scopes of practice, supervision levels, and practice settings. We examined how state practice acts shape these models, including Montana's LAP hygienists as a local example. We then evaluated which models best address specific access-to-care barriers across different populations. Finally, we discussed how we as dental hygienists can use evidence to advocate for policy changes that improve access to preventive oral health services.	PP Slide #28: Summary Note: Thank the students for their attention and participation. Q: Which model would best address access barriers in your community and why? A: Answers will vary. Provide clarity on any misconceptions.

Test Items

Objective #1: Describe different models for alternate dental hygiene practice.

Test Item #1: Which statement **best** describes an alternate dental hygiene practice model?

A. A model that requires direct supervision from a dentist at all times
B. A practice approach that expands where and how hygienists can provide preventive care
C. A traditional private-practice model focused on restorative procedures
D. A temporary permit allowing hygienists to practice only during emergencies

Objective #2: Compare the scope of practice differences among the major alternate dental hygiene practice models.

Test Item #2: When comparing alternate dental hygiene practice models, which factor most clearly reflects a difference in scope of practice?

A. Requiring additional continuing education hours
B. Allowing the hygienist to initiate care without prior dentist authorization
C. Using the model in private practice or public health settings
D. Requiring a written agreement with a supervising dentist

Objective #3: Analyze how state practice acts influence access to care and the development of alternative practice models.

Test Item #3: Which aspect of a state practice act has the greatest impact on a hygienist's ability to expand access to care?

A. The number of CE hours required for license renewal
B. The fee charged for initial licensure
C. The number of dental board members appointed each term
D. The supervision level under which the hygienist is allowed to practice

Objective #4: Evaluate which alternate practice model is the best match for the access-to-care needs of a chosen population.

Test Item #4: A tribal community in a remote region has limited access to dental providers, long travel distances to the nearest clinic, and a high need for preventive and early-intervention services. The tribal health department wants a model that supports culturally responsive care delivered within the community.

In 3–4 sentences, explain which alternate dental hygiene practice model would best meet the needs of this tribal population and how the model's features address the access-to-care barriers described in the scenario.

Objective #5: Advocate for evidence-based policy changes that support expanded access to preventive oral health services.

Test Item #5: In 3–4 sentences, explain how a dental hygienist can use evidence-based information to advocate for policy changes that expand access to preventive oral health services.

Correct Answer Key:

1. B
2. B
3. D
4. The best model for this tribal community is the Dental Health Aide Therapist (DHAT) model, which was originally designed to serve Alaska Native and American Indian communities. DHATs provide preventive and basic restorative services directly within the community, reducing the need for long travel to distant clinics. Their training emphasizes culturally responsive, community-based care, aligning with the tribe's goals. This model directly addresses the access-to-care barriers described in the scenario.
5. A dental hygienist can advocate for policy changes by presenting unbiased, evidence-based data showing how expanded preventive services improve patient outcomes and reduce access disparities. By communicating clearly and respectfully with stakeholders such as legislators, dental boards, and public health leaders, hygienists can highlight the cost-effectiveness and public health impact of alternate practice models. They can also reference successful models from other states to demonstrate the effectiveness of expanded supervision levels or practice settings. Using accurate evidence and staying within their professional scope strengthens the credibility of their advocacy efforts.