Alternate Practice Models: Future Trends for Oral Health Care

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Your Experience in Dental Settings

Objectives

1. Describe different models for alternate dental hygiene practice.
2. Compare the scope of practice differences among the major models.
3. Analyze how state practice acts influence access to care and the development of these models.
4. Evaluate which 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.

Purpose of Alternate Practice Models

- Expand access to preventive oral health care
- Reach underserved and high-need populations
- Address shortages of traditional dental providers
- Deliver care in non-traditional and community-based settings

Overview of Major Models

- Registered Dental Hygienist in Alternative Practice (RDHAP)
- Advanced Dental Therapist (ADT)
- Dental Health Aide Therapist (DHAT)
- Collaborative practice
- Unsupervised or direct access

Registered Dental Hygienist in Alternative Practice (RDHAP)

California (1998)

Supervision	Procedures	Settings
Independent Practice	Preventive care	Homebound and long-term care facilities

Can treat patients for 18 months without dentist involvement.

Advanced Dental Therapist (ADT)

Minnesota (2009)

Supervision	Procedures	Settings
Collaborative management	Preventive, restorative, limited surgical	Low-income, uninsured, and shortage areas

*Dentist sets standing orders; **not required** to see the patient first or be on site.*

Dental Health Aide Therapist (DHAT)

Alaska (2005)

Supervision	Procedures	Settings
Direct or General	Preventive care and basic restorative	Rural and tribal communities

Certain procedures require dentist consultation and may only be done in emergencies.

Collaborative Practice

New Mexico (1999)

Supervision	Procedures	Settings
Written collaborative agreement	Preventive care	Public health and school programs

Dentist sets standing orders; hygienist delivers care independently.

Direct Access/Unsupervised Models

Supervision	Procedures	Settings
No prior authorization	Preventive care	Schools, public health, community programs

Permitted in 43 states.

https://www.adha.org/wp-content/uploads/2025/02/ADHA-Direct-Access-Chart-02-2025.pdf

State Practice Acts

State laws that define what dental hygienists can and cannot do.

- Supervision requirements
- Scope of practice
- Approved practice settings
- Determine whether alternate practice models can exist

How Supervision Levels Affect Access

Supervision levels determine how independently hygienists can practice and how far care can reach into the community.

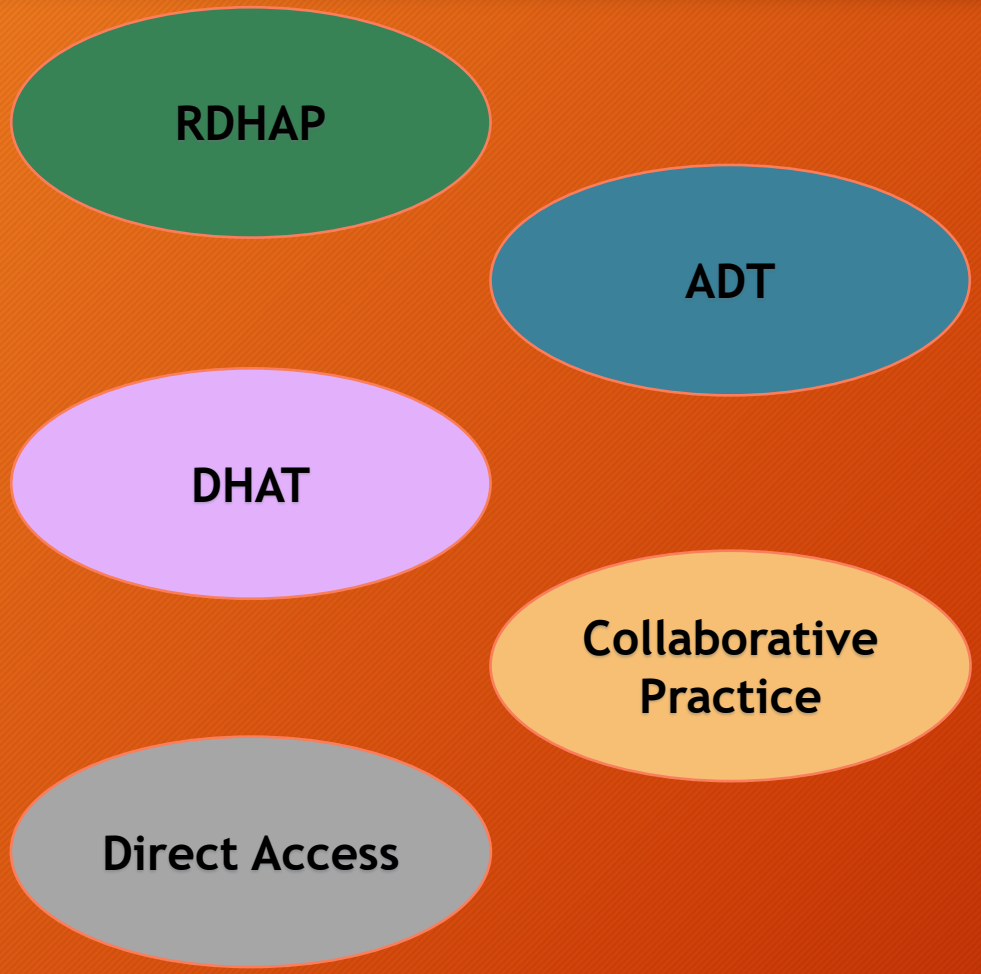
Independent	Collaborative	General Supervision	Direct Supervision	No Direct Access
Full autonomy; Greatest flexibility and reach	Moderate autonomy; Strong community access	Dentist authorizes care but does not need to be present	Dentist must be present; Limits outreach	Hygienist cannot initiate care independently

Montana Limited Access Permit (LAP)

- Supervision
  - Public health supervision
  - Dentist not required on site
- Procedures
  - Preventive care
- Settings
  - Schools
  - Long-term care
  - Community sites
- Eligibility requirements
  - 2,400 hours in last 3 years
  - OR 3,000 career hours (min. 350 hours in last 2 yrs.)

Best Practice Models for Specific Populations

Matching Models to Access Barriers



- High unmet restorative needs
- Delayed access to preventive care
- Limited access for children
- Geographic isolation
- Mobility and transportation limitations

Advocacy for Alternate Practice Models

- Use evidence to support changes in
  - Laws
  - Regulations
  - Policies
- Communicate with stakeholders
- Promote models that improve access to preventive care
- Stay within the ethical and professional scope of the profession

Communication Strategies

- Messaging should be
  - Clear
  - Respectful
  - Fact-based
- Focus on
  - Patient outcomes
  - Cost effectiveness
  - Public health impact
- Tailor messages to audience
  - Use layman’s terms

Summary

1) Alternate practice models **expand access** to preventive oral health care
2) Each model differs in **scope, supervision, and setting**
3) State practice acts **determine** what hygienists can do
4) Matching models to barriers helps **identify** the best fit for community needs
5) Hygienists use evidence to **advocate** for improved access