Oregon
Tina Kotek, Governor

Board of Dentistry
1500 SW 1st Ave, Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202
www.oregon.gov/dentistry

MEETING NOTICE

DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE MEETING (DAWSAC)

Oregon Board of Dentistry

ZOOM MEETING INFORMATION (not an in person meeting)
https://us02web.zoom.us/j/81994601039?pwd=W9pv9aT3m1XbENGMDK0PQZ3eP5xFeS.1
Dial-In Phone #: 1-253-215-8782 • Meeting ID: 819 9460 1039 • Passcode: 262877

February 17, 2026
5 pm – 6:30 pm

Committee Members:
Co-Chair, Terrence Clark, DMD
Co-Chair, Ginny Jorgensen
Amberena Fairlee, DMD - ODA Rep.
Laura Vanderwerf, RDH - ODHA Rep.
Kari Hiatt - ODAA Rep.
Kari Kuntzelman, RDH, DT – DT Rep
Lynn Murray
Carmen Mons
Cassie Gilbert
Megan Barron
Alexandria Case
Jessica Andrews
Alyssa Kobylinsky
Amanda Nash

AGENDA
Call to Order: Dr. Terrence Clark, Chair

- Public Meeting Notice
  - Governing bodies subject to Public Meetings Law – **Attachment #1**
- Review & Approve Minutes of December 9, 2025, DAWSAC Meeting
  - Meeting Minutes – **Attachment #2**
- Review HB 3223 and information regarding the formation of this Committee – **Attachment #3**

  The Statute has been updated incorporating HB 3223 into statute.
  ORS 679.330 Advisory committee on dental assistant workforce shortage. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide advice to the board on a quarterly basis on how to address the dental assistant workforce shortage in this state.
- Oral Preventive Assistant Information – **Attachment #4**

This meeting is being held remotely via Zoom. A request for accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.

    - Information Submitted to August Board Meeting – **Attachment #5**
    - University of Washington Center for Health Workforce Studies, *Development and Implementation of the Indian Health Service Expanded Function Dental Assistant-1 (EFDA-1) Occupation* – **Attachment #6**
    - Missouri Oral Preventive Assistant EFDA Pilot Project report – **Attachment #7**

- Dental Assistant Surveys
    - 2019 Survey Sent to Dentists Re: Dental Assistants - **Attachment #8**
    - 2026 DRAFT Survey Questions for Future Survey - **Attachment #9**

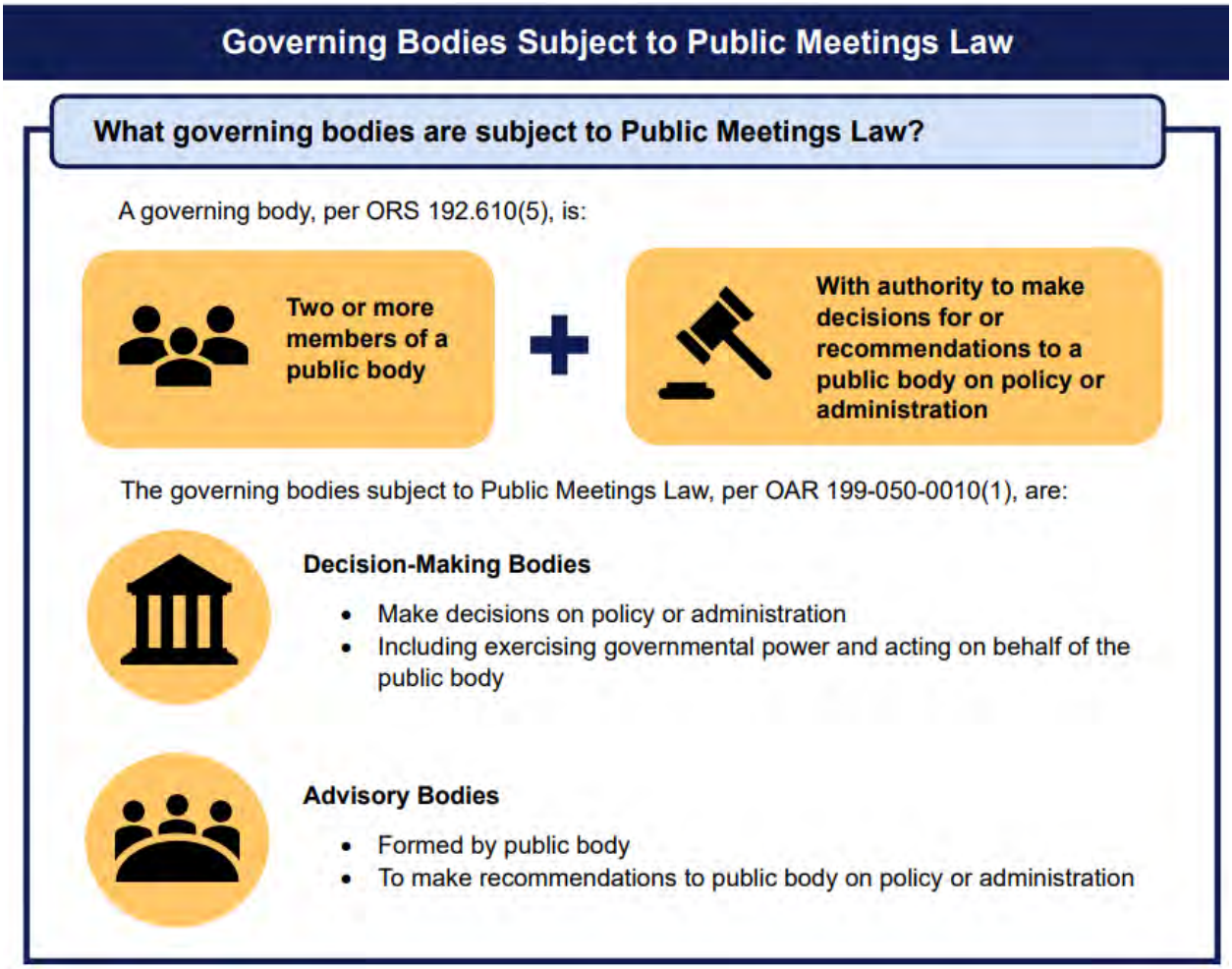
- 2024 Dental Assistant Wage Information - **Attachment #10**

Open Comment – this may be limited by the Chair and the meeting may end before 6:30 p.m. if all agenda topics have been covered by the committee.

The date for the next DAWSAC Meeting will be set by the Co-Chairs and shared with all as soon as it is finalized.

Adjourn

This Committee is subject to Public Meetings Law



DRAFT

OREGON BOARD OF DENTISTRY
DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE MEETING MINUTES (DAWSAC)
December 9, 2025

MEMBERS PRESENT: Terrence Clark, DMD, Co-Chair
Ginny Jorgensen, Co-Chair
Amberena Fairlee, DMD – ODA Rep.
Kari Hiatt – ODAA Rep.
Lynn Murray
Carmen Mons
Alexandria Case
Jessica Andrews
Amanda Nash
Cassie Gilbert
Alyssa Kobylinsky

STAFF PRESENT: Kathleen McNeal, Licensing Manager

VISITORS PRESENT:
VIA TELECONFERENCE* Mary Harrison, ODAA; Lisa Rowley, ODHA; Brett Hamilton; ODA

*This list is not exhaustive, as it was not possible to verify all participants at the teleconference.

Call to Order: The meeting was called to order by Chair Dr. Terrence Clark at 5:00 p.m. via Zoom.

Self-Introductions of Committee Members
Chair Clark welcomed everyone to the meeting and had the DAWSAC Members introduce themselves and share information about their current positions in the dental field.

Dr. Clark announced that the Committee had a quorum.

Public Meeting Notice
Dr. Clark announced that the Committee is subject to Public Meetings Law.

Approval of September 23, 2025 Minutes
Ms. Nash moved and Ms. Andrews seconded that the Committee approve the minutes from the September 23, 2025 DAWSAC Committee Meeting as amended. The motion passed with TC, GJ, AF, KH, LM, CM, AC, JA, CS, AK and AN voting Aye.

DAWSAC Packet Introduced
A copy of HB 3223 was attached for informational purposes.

OBD Letter to the Governor
Dr. Clark directed the Committee's attention to a copy of an OBD Letter to the Governor asking for Board discretion to hold DAWSAC Meetings as needed, not each quarter. The OBD had not heard back from the Governor's office regarding the status of the request.

Attachment #2

Arizona Oral Preventive Assistants Article
The Committee reviewed and discussed information from Arizona that created an "Oral Preventive Assistant" which allowed dental assistants to perform scaling. Dr. Fairlee reported that at the ODA House of Delegates meeting, over 85% of the dentists in attendance wanted a scaling assistant in Oregon. She also stated that the article was an opinion-piece without any data or statistics and that it was important to rely on scientific articles. Committee members discussed scaling and various issues such as proper wages, and education.

Dr. Fairlee moved and Ms. Kobylinsky seconded for the Board to reconsider allowing dental assistants to perform scaling. GJ, KH, LM, CM, AN, JA voted nay. AF, TC, AK, and AC voted aye. The motion died.

The committee discussed getting more information and presenting it to the Board regarding dental assistants performing scaling.

DAWSAC Requests to the Board as of December 2025

Committee members discussed the requests to the Board as provided in the document. The proposed rule changes allowing dental assistants to scale has been moved to the Rules Oversight committee by the Board for further discussion. This committee discussed gathering more information regarding the issue to provide to the Rules Oversight Committee.

The request for a dental assistant registry was discussed and more information would be provided at a later date.

The 2019 dental assistant questionnaire was discussed and Ms. Robinson will provide the survey questions to discuss at the next regularly scheduled meeting.

Open Comment
Ms. Harrison commended the progress in the field of dental assistant since the formation of DAWSAC.

Committee members discussed the workforce shortage issues and the next steps necessary to address these as a committee.

ADJOURNMENT
The meeting was adjourned at 6:30 p.m. Chair Clark stated that the next DAWSAC meeting will be scheduled at a later date.

At the August 25, 2023 Board Meeting the Oregon Board of Dentistry (OBD) established a new standing Advisory Committee named the "Dental Assistant Workforce Shortage Advisory Committee (DAWSAC)" per ORS 679.280, to review, discuss and make recommendations to the Board on addressing workforce shortages in accordance with HB 3223 (2023).

The section of HB 3223 relevant to this is included for reference:

SECTION 5. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide advice to the board on a quarterly basis on how to address the dental assistant workforce shortage in this state.

(2)(a) In appointing members to the advisory committee, the board shall prioritize diversity of geographic representation, background, culture and experience.

(b) A majority of the members appointed to the committee must have experience working as dental assistants.

SECTION 6. This 2023 Act takes effect on the 91st day after the date on which the 2023 regular session of the Eighty-second Legislative Assembly adjourns sine die.

This advisory committee will meet no less than four times per calendar year once established, and generally be scheduled concurrently with regular OBD Board Meetings. The OBD President will designate two Co-Chairs of the Committee whom will be OBD Board Members. Preference will be given to Board Members who have past experience working as a dental assistant.

The advisory committee shall include five representatives from the Oregon dental assistant community who are currently or have worked as an Oregon dental assistant. The OBD President will select the members, and utilize the legislative criteria, if more than five people volunteer to serve on this advisory committee.

The advisory committee will also include one representative from each of the professional associations: The Oregon Dental Association, The Oregon Dental Hygienists' Association and the Oregon Dental Assistants Association and eventually one from the Oregon Dental Therapy Association (should that be established).

The Advisory Committee members will bring relevant topics and agenda items to the meetings, be meaningfully engaged on the relevant issues, offer solutions and assist in gathering speakers, data and information.

The inaugural DAWSAC meeting is tentatively scheduled for October 27, 2023.

Hi Haley,

Per DAWSAC's request for information regarding the Oral Preventive Assistant, I have attached a few documents to be included in the DAWSAC meeting materials:

- Meeting materials that were submitted for the Board of Dentistry meeting in August
- A new report from the University of Washington Center for Health Workforce Studies, *Development and Implementation of the Indian Health Service Expanded Function Dental Assistant-1 (EFDA-1) Occupation*
- Missouri Oral Preventive Assistant EFDA Pilot Project report

Thanks,

Brett

Brett Hamilton, MBA, MPA
Director of Government and Regulatory Affairs, Oregon Dental Association
503-740-0820 (cell)

oregon dental ASSOCIATION

Dear Members of the Oregon Board of Dentistry,

The Oregon Dental Association (ODA) respectfully urges the Board to postpone rulemaking on the proposed revisions to OAR 818-042-0040 and instead assign staff to conduct a thorough analysis of the potential impacts of scaling dental assistants in Oregon.

It's important to note that postponing rulemaking will not change what is currently happening in Oregon—dental assistants will continue to be unable to scale unless there is further proactive legislative and rulemaking action, which the Oregon Dental Association is not considering at this time.

The proposed rule revision could create unintended barriers to future exploration and thoughtful discussion of expanding the scope of practice for dental assistants. ODA appreciates the Board's past commitment to deliberation and inclusive evaluation, as seen in its consideration of dental therapy, dental assistants administering local anesthesia, and more recently, dental hygienists performing Botox injections. We ask for the same measured approach in evaluating the scaling dental assistant model.

At a time when workforce shortages are severely limiting access to dental care across the state and disrupting daily practice operations, it is essential that we remain open to innovative strategies already proven effective in other states. The dental care team should be empowered to work to the fullest extent of their training and licensure to address these urgent challenges.

ODA has conducted preliminary assessments by reviewing other states and agencies currently using scaling dental assistants and has not identified patient safety concerns with coronal scaling performed by trained dental assistants on healthy patients with reversible gingivitis. Moreover, according to the Board, there have been no consumer complaints regarding dental assistants operating outside their scope in this area. In contrast, currently allowed procedures by other members of the dental team, such as local anesthesia and Botox injections present greater risk of irreversible harm when not properly administered.

It is important to re-state that ODA is not currently seeking legislation to introduce scaling dental assistants. The association had only begun reviewing the American Legislative Exchange Council (ALEC) Dental Access Model, which includes Oral Preventive Assistants, before the recent opposition to this proposal prompted us to clarify our position. Any future implementation would require legislative approval and is not presently being pursued.

ODA believes the Board can help ensure a thoughtful path forward by slowing down the rulemaking process and allowing time for comprehensive analysis. We are committed to working collaboratively with the Board to identify patient-centered, innovative solutions to Oregon's dental workforce challenges.

Thank you for your continued leadership and commitment to improving oral health outcomes for all Oregonians.

Sincerely,

Caroline Zeller, DDS, MPH
President, Oregon Dental Association

oregon dental ASSOCIATION

Briefing: Scaling Dental Assistants

The current workforce shortages are negatively impacting access to dental care for Oregonians across the state and impacting dental practice operations. As part of that work to expand access to care it is critical that every member of the dental care team utilize their full scope of practice and skills. At the same time, the ODA is exploring ideas, tools and practices already being used in other states that provide new, innovative strategies to do more within the existing workforce.

The purpose of the document is to present information regarding trained dental assistants, known as a Scaling Dental Assistant, to perform supragingival scaling on healthy patients under direct supervision and assess if Scaling Dental Assistants will improve access to care.

Scaling Dental Assistant Overview

Access to preventive dental care is a growing concern in many parts of the U.S., especially in rural and underserved areas. As oral diseases persist and the dental workforce is stretched thin, policymakers are exploring ways to improve care delivery models. One solution gaining attention is the authorization of Scaling Dental Assistants—dental assistants trained to perform supragingival scaling under strict supervision.

The premise is that allowing trained dental assistants to perform supragingival scaling on healthy patients under direct supervision will improve access to care and increase practice efficiency while maintaining high standards of care.

Dental Access Model Act

On July 26, 2024, the American Legislative Exchange Council (ALEC) Health and Human Services Task Force approved a model ADA introduced called the ALEC Dental Access Model, which includes Oral Preventive Assistants (Scaling Dental Assistants) as an opportunity to address workforce challenges. The model was created to support the expansion of access to dental care, especially in rural areas, by more efficiently utilizing existing members of the dental team. Specifically, the Oral Preventive Assistants will be able to provide supragingival scaling and polishing after meeting training and certification. Certification of Oral Preventive Assistants (OPA)

(1) The scope of practice for an oral preventive assistant shall be limited to taking and recording periodontal probe readings, documenting areas of periodontal concern, and supragingival scaling and polishing. Oral preventive assistants shall be further limited to practicing on periodontally healthy patients or patients with reversible gingivitis. For the first five (5) years after certification of the OPA position in the state, oral preventive assistants shall be limited to practicing in federally designated Health Provider Shortage Areas (HPSAs) or in counties with a population of less than 100,000.

Pilot Project

ODA is tracking activities to address the workforce shortage such as the OPA EFDA Pilot Project in Missouri. The Missouri Office of Dental Health (ODH) asked the Missouri Dental Board (MDB) has a pilot project to address the urgent workforce challenges and provide increased access to care. The project will examine the use of an Oral Preventive Assistant (OPA) Expanded Function Dental Assistant (EFDA) (herein referred to as OPA) to deliver preventive care, including supragingival scaling on healthy patients with a focus on improving access to care, especially in rural areas and in Medicaid clinics where it's been very difficult to recruit hygienists. There are currently sixteen (16) OPAs delivering care in seven (7) clinical sites. The pilot is planned to be completed by the end of October 2025 with final reporting by the end of the year.

The results of the pilot project will be reported to all major stakeholders, including the Missouri Dental Board and the Missouri Department of Health and Senior Services through the Office of Dental Health at the end of October. More information about his project can be found https://www.modental.org/member-resources/advocacy-pac/opa-pilot.

Current Scaling Assistants Scope of Practices

The current scope of practice of dental assistants from all states can be reviewed on the https://www.danb.org/state-requirements, website. Specifically, below is information from states and agencies that are currently utilizing Scaling Dental Assistants:

- In 2025, Arizona passed a law allowing dental assistants to perform supragingival scaling and polishing on periodontally healthy patients or those with mild gingivitis. https://adanews.ada.org/ada-news/2025/april/arizona-oral-preventive-assistants-bill-becomes-law/
- In 2023, Illinois Dental Assistant Qualified in Expanded Functions Requirements | DANB began allowing dental assistants to offer coronal scaling above the gum line on patients aged 17 or younger who are Medicaid recipients, uninsured, or from households earning up to 300% of the federal poverty level
    - Scope of Practice, page 4
- In 1998, Kansas Dental Assistant Requirements | DANB passed a law allowing dental assistants to perform coronal scaling on patients aged 12–17 who are Medicaid recipients, uninsured, or from households earning up to 300% of the federal poverty level
    - Scope of Practice, page 3
- In 1971, the U.S. military began utilizing dental assistants to perform scaling procedures, particularly in preventive care settings.
    - Scope of Practice: In the U.S. military, dental assistants, particularly those in the Army's 68E Dental Specialist role, are trained to perform a range of preventive and assistive dental procedures, including scaling.

- In 1961, the Indian Health Service was one of the first governmental agencies or organizations that adopted the model of expanded function dental assistants (EFDAs) to used to provide basic periodontal services. IHS Periodontal Treatment Initiative EFDA Fact Sheet and Maximizing the Dental Workforce in Your Practice see pg. 39)

Supportive Arguments for Dental Scaling Assistants

- Improved Access to Care: may expand the number of providers who can deliver basic preventive services, reducing wait times and travel burdens for patients.
- Practice Efficiency: prospect of allowing dentists and hygienists to focus on higher-level care by delegating routine scaling to trained assistants.
- Cost-Effective: may lower operational costs and expand care in Medicaid or underserved populations.
- Workforce Development: opportunity for career growth opportunities for dental assistants, aiding recruitment and retention in the dental workforce.

Missouri Dental ASSOCIATION | ADA
3340 American Avenue
Jefferson City, MO 65109
T 573.634.3436 • F 573.635.0764
modental.org

Briefing: Post Pandemic Oral Healthcare Workforce in Missouri

BACKGROUND & PROBLEMS

Like all healthcare sectors, the oral healthcare workforce has diminished, and the COVID-19 pandemic exacerbated the decline. The Missouri Office of Dental Health statewide survey of oral healthcare workers and the most recent re-licensure data provided by the Missouri Dental Board (January 2023) indicated an exit of between 1% and 10% of the oral healthcare workforce: 1% administrative staff, 6% dentists, 8% dental hygienists, and 10% dental assistants. The survey also indicated that 20% of the workforce is considering retirement in the next 5 years due to age or job stress. *A summary page from the Office of Dental Health Workforce Survey Report is attached.*

The result is significantly understaffed clinics that are operating at 60%-80% of their capacity. The workforce shortages have more severely impacted rural clinics and clinics that serve the eligible Medicaid population with wait times for appointments in many Federally Qualified Health Centers of weeks or even months long. The Office of Dental Health used license and permit data to determine where providers are located and where they are needed. *Provider distribution maps by county are attached.* The main take-aways are:

- All but a few metropolitan counties have significant oral healthcare workforce shortages. Rural areas are the most severely impacted.
- There is a shortage of dentists and dental hygienists in rural Missouri: 44% of clinics that had an opening for a dental hygienist were unable to fill that opening.
- In 1995 Missouri developed the Expanded Function Dental Assistants (EFDAs) provider category to increase the productive capacity of dental clinics and address access to care issues. EFDAs (dental assistants with additional approved training) can help dentists with many functions including fillings, crowns, dentures and orthodontics. This program has been very successful, increasing productive capacity of clinics by 15%-25% with no complaints about quality of care. However, there is no EFDA provider category to assist dentists and hygienists with periodontal care.
- Currently the Missouri Dental Board has issued the following number of licenses and permits to oral healthcare providers with Missouri addresses: 2,486 dentist licenses, 3,410 dental hygienist licenses, and 7,084 EFDA permits.
- If you refer to the provider distributions maps you will see that EFDAs are distributed more evenly throughout the state, especially in rural areas where hygienists are scarce.

SOLUTIONS

- Missouri needs an Oral Preventive Assistant (OPA), an EFDA with further training, to assist dentists and hygienists in delivery of periodontal care to improve access to care especially for rural clinics and those that serve Medicaid eligible patients.
    - This new category of OPA-EFDA would have a greater scope than current EFDAs, yet a more limited scope than a hygienist and of course a dentist.
    - The OPA-EFDA would be authorized to treat children and adults who are healthy or just have gingivitis that is reversible with a good cleaning and good home hygiene.
    - The OPA-EFDA would be additionally trained to record gum measurement information so dentists could diagnose and triage patients, and then delegate to the OPA-EFDA to remove above-the-gumline tartar, polish teeth and apply fluoride.
    - The OPA-EFDA would operate under the direct supervision of a dentist or hygienist and would free more highly trained providers to treat more serious problems that might require additional skill.
- Last year, a law was enacted to allow pilot projects to explore new ideas to expand access to oral health care delivery. A 12-month pilot program can be designed to train and use OPA-EFDA in 5 to 10 clinics located in areas of the lowest ratios of hygienists per capita. The provisions of the pilot program statute require evaluation metrics to be used and reported back to the Office of Dental Health and the Dental Board for review.
- Missouri needs to allow communities to invest in OPA-EFDA training. It has proven to be the most cost-effective way to leverage the existing dental workforce and increase productive capacity and access. One EFDA can increase productive capacity of a dentist or hygienist by 15%-25%. It costs $5,000-$10,000 to educate an EFDA, $30,000-$60,000 to educate a hygienist, and $350,000-$500,000 to educate a dentist.
- One of the key reasons the EFDA program has been so successful is that the training programs have been made available regionally and do not require rural students to relocate to metropolitan areas for training and certification.
    - The Office of Dental Health provider maps clearly show that few hygienists who train in St. Louis, Kansas City, Springfield, Joplin or Sedalia return to rural Missouri. Currently EFDA training programs are provided through dental assisting education programs and associations, such as the Missouri Dental Association and Missouri Primary Care Association.
    - OPA-EFDA training programs, would be no different and could be made more accessible, especially to rural Missouri, at a modest cost by making online curriculums available to vo-tech educational centers to convey the didactic portions of the curriculum.
    - FQHCs and regional clinics could be utilized for clinical practicums where students could refine competencies in clinical skills under the direct supervision and mentoring of dentists and hygienists, just as they do in dental assisting and dental hygiene schools, without the need for the student to relocate for training.

DANB
Dental Assisting National Board

Kansas

Allowable and Prohibited Duties for Dental Assistants

At-a-glance information includes a dental assisting career ladder and job titles, radiography requirements, education and exam requirements, delegable functions and supervision levels, and prohibited functions.

These data are presented for informational purposes only and are not intended as a legal opinion regarding dental practice in any state. DANB confers with each state's dental board annually or when changes occur regarding the accuracy and currency of this information. To verify, or if you have any questions, please contact your state's dental board.

INSIDE:

- State requirements and functions chart
- Appendix A: information about numbering system
- Appendix B: information about supervision levels for dental assistants

Attachment #5

KANSAS

State-approved 7/16/2024

State Job Titles

State Career Ladder

There are two recognized levels of dental assistants in Kansas. See the following pages for details about requirements and allowed functions for each level. Numbers for each level are provided for internal reference and do not correspond to specific state designations.

2 Dental Assistant *with expanded duties training*

1 Dental Assistant

State Radiography Requirements

State Radiography Requirements

There are no radiography requirements for dental assistants in Kansas.

All dental assistants may legally operate dental x-ray equipment and perform dental radiographic procedures under the supervision of a licensed dentist.

Prohibited Duties

Functions NOT Permitted by Dental Assistants in Kansas

The following functions are not permitted by any level of dental assistant:

- Any and all removal of or addition to the hard or soft tissue of the oral cavity
- Any and all diagnosis of or prescription for treatment for disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, or adjacent structure
- Any and all correction of malformation of teeth or of the jaws
- Any and all administration of general or local anesthesia of any nature in connection with a dental operation
- A prophylaxis (except coronal polishing and scaling as defined in “Allowable Functions”; see next page)

KS KANSAS

State-approved 7/16/2024

1 Dental Assistant

Requirements

Education, Training and Credential Requirements

A dental assistant in Kansas may perform basic supportive dental procedures specified by the state dental practice act (see below) under the supervision of a licensed dentist.

There are no education or training requirements for this level of dental assisting.

Allowable

Allowable Functions

DANB's Note on Allowable Dental Assisting Functions
In the state of Kansas, all dental assistants may:

- Expose, process, and evaluate dental radiographs under the supervision of a licensed dentist
- Perform infection control and occupational safety procedures
- Perform other duties not specified by this state's dental practice act.

At this time, DANB cannot list all allowable dental assisting functions for each state because some states' dental practice acts outline very specific allowable functions, while others outline only prohibited functions and some contain minimal or no regulation of dental assisting duties.

2 Dental Assistant *with expanded duties training*

Requirements

Education, Training and Credential Requirements

To perform expanded functions under the direct supervision of a licensed dentist in the state of Kansas, a dental assistant must become qualified as follows:

Coronal polishing: The dental assistant must undergo appropriate training by a licensed dentist.

Coronal scaling: The dental assistant must successfully complete a Kansas Board-approved course of instruction. The supervising dentist must verify proof of completion of required training and must report to the Kansas Board the name and practice location of each dental assistant who is performing coronal scaling by April 3, 2016 or within 30 days of the dental assistant first performing coronal scaling, whichever is later.

Assisting in the administration and monitoring of nitrous oxide and/or oxygen: The dental assistant must:

I. Be certified in CPR

AND

II. Successfully complete a Kansas Board-approved course of instruction which includes 16 hours of instruction at a CODA-accredited teaching program which includes both didactic and clinical instruction in:
   i. Theory of pain control
   ii. Anatomy
   iii. Medical History
   iv. Pharmacology
   v. Emergencies and complications

Allowable

Allowable Functions

Functions with numbers correspond to functions included in a 2002-2005 study of dental assisting core competencies. See page 11 for more information.

Under Direct Supervision*

9. Coronal polishing procedures
20. Coronal scaling (not including subgingival scaling)
59. Assisting in the administration and monitoring of nitrous oxide and/or oxygen (Note: The dental assistant must be certified in CPR and have passed a Board-approved course.)

***Direct Supervision**: The dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and, before dismissal of the patient, evaluates the performance.

Attachment #5

Appendix A: Numbering System for Dental Assisting Functions

The following list of 70 dental assisting tasks was developed by the ADAA/DANB Alliance as part of a study of dental assisting core competencies conducted between 2002 and 2005. These selected tasks were determined to be representative of a broad range of dental assisting core competencies.

The numbered functions listed in the preceding state charts correspond to functions that were included in the DANB/ADAA core competencies study and use language directly from the state's dental practice act. The numbers are provided to facilitate comparison between and among states. Functions listed with bullets in the preceding charts are part of the state's practice act but are not specific matches to the functions that were included in the 2002-2005 study.

1. Perform mouth mirror inspection of the oral cavity
2. Chart existing restorations or conditions
3. Phone in prescriptions at the direction of the dentist
4. Receive and prepare patients for treatment, including seating, positioning chair and placing napkin
5. Complete laboratory authorization forms
6. Place and remove retraction cord
7. Perform routine maintenance of dental equipment
8. Monitor and respond to post- surgical bleeding
9. Perform coronal polishing procedures
10. Apply effective communication techniques with a variety of patients
11. Transfer dental instruments
12. Place amalgam for condensation by the dentist
13. Remove sutures
14. Dry canals
15. Tie in arch wires
16. Demonstrate knowledge of ethics/ jurisprudence/patient confidentiality
17. Identify features of rotary instruments
18. Apply topical fluoride
19. Select and manipulate gypsums and waxes
20. Perform supragingival scaling
21. Mix dental materials
22. Expose radiographs
23. Evaluate radiographs for diagnostic quality
24. Provide patient preventive education and oral hygiene instruction
25. Perform sterilization and disinfection procedures
26. Provide pre- and post-operative instructions
27. Place and remove dental dam
28. Pour, trim and evaluate the quality of diagnostic casts
29. Size and place orthodontic bands and brackets
30. Using the concepts of four- handed dentistry, assist with basic restorative procedures, including prosthodontics and restorative dentistry
31. Identify intraoral anatomy
32. Demonstrate understanding of the OSHA Hazard Communication Standard
33. Place, cure and finish composite resin restorations
34. Place liners and bases
35. Place periodontal dressings
36. Demonstrate understanding of the OSHA Bloodborne Pathogens Standard
37. Take and record vital signs
38. Monitor vital signs
39. Clean and polish removable appliances and prostheses
40. Apply pit and fissure sealants
41. Prepare procedural trays/ armamentaria setups
42. Place orthodontic separators
43. Size and fit stainless steel crowns
44. Take preliminary impressions
45. Place and remove matrix bands
46. Take final impressions
47. Fabricate and place temporary crowns
48. Maintain field of operation during dental procedures through the use of retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.
49. Perform vitality tests
50. Place temporary fillings
51. Carve amalgams
52. Process dental radiographs
53. Mount and label dental radiographs
54. Remove temporary crowns and cements
55. Remove temporary fillings
56. Apply topical anesthetic to the injection site
57. Demonstrate understanding of the Centers for Disease Control and Prevention Guidelines
58. Using the concepts of four-handed dentistry, assist with basic intraoral surgical procedures, including extractions, periodontics, endodontics and implants
59. Monitor nitrous oxide/oxygen analgesia
60. Maintain emergency kit
61. Remove permanent cement from supragingival surfaces
62. Remove periodontal dressings
63. Place post-extraction dressings
64. Fabricate custom trays, to include impression and bleaching trays, and athletic mouthguards
65. Recognize basic medical emergencies
66. Recognize basic dental emergencies
67. Respond to basic medical emergencies
68. Respond to basic dental emergencies
69. Remove post-extraction dressings
70. Place stainless steel crown

Appendix B: Levels of Supervision

An important consideration in the discussion of the delegation of tasks to dental assistants is that of supervision of dental assistants by their dentist-employers. The American Dental Association (ADA) has identified five levels of supervision for allied dental personnel, including dental assistants, which it defines in its "Comprehensive Policy Statement on Allied Dental Personnel," (2010: 505) which is part of its *Current Policies,* last updated in 2020. Note that "allied dental personnel" refers to dental assistants, dental hygienists and dental laboratory technicians.

The five levels of supervision defined by the ADA are as follows:

Personal supervision. A type of supervision in which the dentist is personally operating on a patient and authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.

Direct supervision. A type of supervision in which a dentist is in the dental office or treatment facility, personally diagnoses and treatment plans the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and evaluates their performance before dismissal of the patient.

Indirect supervision. A type of supervision in which a dentist is in the dental office or treatment facility, has personally diagnosed and treatment planned the condition to be treated, authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and will evaluate the performance of the allied dental personnel.

General supervision. A type of supervision in which a dentist is not required to be in the dental office or treatment facility when procedures are provided, but has personally diagnosed and treatment planned the condition to be treated, has personally authorized the procedures, and will evaluate the performance of the allied dental personnel.

Public Health Supervision. A type of supervision in which a licensed dental hygienist may provide dental hygiene services, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings, as designated by state law, and with general oversight of such programs by a licensed dentist designated by the state.

Furthermore, the ADA's "Comprehensive Policy Statement on Allied Dental Personnel" stipulates that intraoral expanded functions should be performed by allied dental personnel "under the supervision of a dentist."

Because the study of dental assisting core competencies undertaken by the ADAA/DANB Alliance did not address the question of supervision, the ADAA/DANB Alliance has not made any recommendations as to the levels of supervision that should be necessary for the delegation of the tasks included in the study to dental assistants. However, the ADAA/DANB Alliance believes it is important to call attention to the fact that while the ADA has defined supervision levels in the aforementioned policy statement, which governs the ADA's own activities and the activities of its members, these definitions have not been uniformly adopted by the dental boards of every U.S. state or district.

For the purposes of the attached charts, if a state's dental practice act specifically defines levels of supervision, the state-specific definition is noted in the template.

DANB
Dental Assisting National Board

Illinois

Allowable and Prohibited Duties for Dental Assistants

At-a-glance information includes a dental assisting career ladder and job titles, radiography requirements, education and exam requirements, delegable functions and supervision levels, and prohibited functions.

These data are presented for informational purposes only and are not intended as a legal opinion regarding dental practice in any state. DANB confers with each state's dental board annually or when changes occur regarding the accuracy and currency of this information. To verify, or if you have any questions, please contact your state's dental board.

INSIDE:

- State requirements and functions chart
- Appendix A: information about numbering system
- Appendix B: information about supervision levels for dental assistants

Attachment #5

ILLINOIS

State-approved 7/16/2024

State Job Titles

State Career Ladder

There are three recognized levels of dental assistants in Illinois. See the following pages for details about requirements and allowed functions for each level. Numbers for each level are provided for internal reference and do not correspond to specific state designations.

3. Expanded Function Dental Assistant (EFDA)
2. Dental Assistant *qualified in expanded functions*
1. Dental Assistant

State Radiography Requirements

State Radiography Requirements

There are no radiography requirements for dental assistants in Illinois.

All dental assistants may legally operate dental x-ray equipment and perform dental radiographic procedures.

Prohibited Duties

Functions NOT Permitted by Dental Assistants in Illinois

Functions with numbers correspond to functions included in a 2002-2005 study of dental assisting core competencies. See page 11 for more information.

The following functions are not permitted by any level of dental assistant:

20. Removal of calculus from teeth
20. Performing supragingival or subgingival scaling
34. Applying cavity bases
46. Taking of material or digital scans for final impressions for the fabricating of prosthetic appliances, crowns, bridges, inlays, onlays or other restorative or replacement dentistry
49. Performing pulp vitality tests

- Diagnosis of or prescription for treatment of disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws, or adjacent structures
- Removal of, restoration of or addition to the hard or soft tissues of the oral cavity except for the placing, carving, and finishing of amalgam restorations and placing, packing, and finishing composite restorations by dental assistants who have had additional formal education and certification as outlined in statute
- Any and all correction of malformation of teeth or of the jaws
- Administration of anesthetics except for monitoring of nitrous oxide, minimal sedation, moderate sedation, deep sedation and general anesthesia after completion of an approved training program
- The operative procedure of dental hygiene consisting of oral prophylactic procedures except for coronal polishing or pit and fissure sealants, as specified
- Making denture adjustments
- Permanently cementing permanent crowns or bridges
- Permanently re-cementing permanent crowns or bridges that have come loose
- Placement of any chemotherapeutic agent for the management of periodontal disease
- Cementing bands and/or bonding brackets
- Air polishing
- Inter-oral use of a high-speed hand piece
- Use of a laser to remove tissue
- Placement or removal of implant prosthetic components and prostheses, including but not limited to the placement or removal of healing abutments, implant supported provisionals, components used in final impression procedures, and final prostheses, which include abutment, crowns, fixed and fixed detachable prostheses and fixed detachable prostheses during recare appointments.

ILLINOIS

IL

State-approved 7/16/2024

1 Dental Assistant

Requirements

Education, Training and Credential Requirements

A dental assistant in Illinois may perform basic supportive dental procedures specified by the state dental practice act (see below) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.

Allowable

Allowable Functions

Functions with numbers correspond to functions included in a 2002-2005 study of dental assisting core competencies. See page 11 for more information.

Under Supervision*

- Any authorized or prescribed services or procedures for which the dental assistant is considered competent by the supervising dentist as a result of on-the-job training
- After being authorized by a dentist, remove loose, broken, or irritating orthodontic appliances on a patient of record for the purpose of eliminating pain or discomfort

DANB's Note on Allowable Dental Assisting Functions

In the state of Illinois, all dental assistants may:

- Expose, process and evaluate dental radiographs
- Perform infection control and occupational safety procedures
- Perform other duties not specified by this state's dental practice act

At this time, DANB cannot list all allowable dental assisting functions for each state because some states' dental practice acts outline very specific allowable functions, while others outline only prohibited functions and some contain minimal or no regulation of dental assisting duties.

***Supervision**: A dentist must authorize the procedure, remain in the dental facility while the procedure is performed, and approve the work performed by the dental assistant before dismissal of the patient. The dentist does not need to be present at all times in the treatment room.

ILLINOIS

IL

State-approved 7/16/2024

2 Dental Assistant *qualified in expanded functions*

Coronal Scaling and Intracoronal Temporization | *Restorative (Amalgams, Composites and Interim Restorations)* | *Coronal Polishing, Sealants, Monitor Nitrous, Monitor Sedation*

Requirements

Education, Training and Credential Requirements

To perform expanded functions under the supervision of a licensed dentist in Illinois, a dental assistant must meet state requirements for each of the desired expanded functions, as outlined below.

To qualify to perform **coronal scaling** and intracoronal temporization of a tooth** under the direct supervision of a dentist, a dental assistant must:

I. Have at least 2,000 hours of direct clinical patient care experience

AND

II. Complete an approved coronal polishing course prior to taking coronal scaling course

AND

III. Complete a structured training program in coronal scaling and intracoronal temporization of a tooth provided by an educational institution (such as a dental school, dental hygiene or dental assisting program), an approved CE provider, or a statewide dental or dental hygienist association approved by the Department, that includes:
- minimum 32 hours of didactic and clinical manikin or human subject instruction in specified content
- an outcome assessment exam that demonstrates competency
- completion of 6 full-mouth scaling procedures, observed and approved by supervising dentist (if training not from a CODA-accredited dental assisting program)
- issuance of a certificate of completion (kept on file at the dental office)

To **place, carve and finish amalgam restorations; place, pack and finish composite restorations;** and **place interim restorations** under the direct supervision of a dentist, a dental assistant must:

I. Pass approved coronal polishing course and approved dental sealants course (prior to taking restorative training program)

AND

II. a. Successfully complete a structured training program meeting the requirements outlined in statute provided by an educational institution accredited by CODA **OR**
b. Have at least 4,000 hours of clinical patient care experience and successfully complete a structured training program meeting the requirements outlined in statute provided by a statewide dental association approved by the Illinois Department of Financial and Professional Regulation (IDFPR)

AND

III. Maintain on file at the dental office the certificate of completion of the required training program, which must be made available to IDFPR upon request

To perform c**oronal polishing, place pit and fissure sealants, monitor patients under nitrous oxide,** or **monitor patients under sedation**, a dental assistant must:

I. Be at least 18 years of age

AND

II. a. Complete 1,000 hours of clinical dental assisting experience **OR**
b. Complete a CODA-accredited dental assisting program **OR**
c. Hold a current national DANB Certified Dental Assistant (CDA) certification

AND

III. a. Complete approved course addressing the expanded function in question, subject to specific didactic and clinical requirements **OR**
b. Provide proof of completion of an approved dental assisting program that contained the expanded function in the curriculum

Note: For nitrous, sedation, and anesthesia monitoring, dental assistants must maintain basic life support certification intended for healthcare providers (BLS) that includes evaluation of hands-on skills and a written exam.

Allowable

Allowable Functions

Functions with numbers correspond to functions included in a 2002-2005 study of dental assisting core competencies. See page 11 for more information.

Under Supervision"

20. Perform coronal scaling (using hand instruments) above the gum line, supragingivally, on the clinical crown of the tooth only on patients 17 years of age or younger who have an absence of periodontal disease and who are not medically compromised or individuals with special needs**
- Perform intracoronal temporization of a tooth (using hand instruments)

** *Coronal scaling shall only be utilized on patients who are eligible for Medicaid or who are uninsured and whose household income is not greater than 300% of the federal poverty level*

Under Direct Supervision*

12, 51. Placing, carving, and finishing amalgam restorations
33. Place, pack, and finish composite restorations
50. Place interim restorations

Under Supervision"

9. Coronal polishing
40. Application of pit and fissure sealants
59. Monitor the patient while nitrous oxide is being administered
- Monitor a patient under minimal sedation, moderate sedation, deep sedation or general anesthesia
- All duties designated to Dental Assistants, under the same level of required supervision

***Supervision**: A dentist must authorize the procedure, remain in the dental facility while the procedure is performed, and approve the work performed by the dental assistant before dismissal of the patient. The dentist does not need to be present at all times in the treatment room.

Attachment #5

3 Expanded Function Dental Assistant

Requirements

Education, Training and Credential Requirements

To perform specified expanded functions in Illinois and hold oneself out as an Expanded Function Dental Assistant, a dental assistant must complete required training in each of the allowed expanded functions. To qualify, a dental assistant must:

I. a. Complete training in the expanded functions from an approved continuing education sponsor **OR**
   b. Complete training in the expanded functions from a dental assistant training program accredited by the Commission on Dental Accreditation **OR**
   c. Complete a training course approved by the Illinois Department of Financial and Professional Regulation
   AND

II. Complete and maintain Basic Life Support certification, proof of which must be kept on file with the supervising dentist

Note: The Illinois General Assembly passed a law in the 2017 legislative session authorizing the creation of an Expanded Function Dental Assistant who may perform the functions listed below. The Illinois General Assembly further amended the law in 2018. The Illinois Department of Financial and Professional Regulation (IDFPR) is in the process of developing rules to implement this new law.

Allowable

Allowable Functions

Functions with numbers correspond to functions included in a 2002-2005 study of dental assisting core competencies. See page 11 for more information.

Under Supervision*

9, 40. Coronal polish and pit and fissure sealants**
46. Take material or digital scans for final impressions‡
12, 33, 51. Place, carve, and finish amalgam restorations and place, carve, and finish composite restorations**
20. Perform coronal scaling (using hand instruments)**
49. Perform pulp vitality test‡
59. Start the flow of oxygen and monitoring of nitrous oxide-oxygen analgesia‡
- Perform intracoronal temporization of a tooth (using hand instruments)

*** As allowed pursuant to requirements summarized on the previous page*

‡ After completing a training program that includes either didactic objectives or clinical skills and functions that demonstrate competency

***Supervision**: A dentist must authorize the procedure, remain in the dental facility while the procedure is performed, and approve the work performed by the dental assistant before dismissal of the patient. The dentist does not need to be present at all times in the treatment room.

Appendix A: Numbering System for Dental Assisting Functions

The following list of 70 dental assisting tasks was developed by the ADAA/DANB Alliance as part of a study of dental assisting core competencies conducted between 2002 and 2005. These selected tasks were determined to be representative of a broad range of dental assisting core competencies.

The numbered functions listed in the preceding state charts correspond to functions that were included in the DANB/ADAA core competencies study and use language directly from the state's dental practice act. The numbers are provided to facilitate comparison between and among states. Functions listed with bullets in the preceding charts are part of the state's practice act but are not specific matches to the functions that were included in the 2002-2005 study.

1. Perform mouth mirror inspection of the oral cavity
2. Chart existing restorations or conditions
3. Phone in prescriptions at the direction of the dentist
4. Receive and prepare patients for treatment, including seating, positioning chair and placing napkin
5. Complete laboratory authorization forms
6. Place and remove retraction cord
7. Perform routine maintenance of dental equipment
8. Monitor and respond to post- surgical bleeding
9. Perform coronal polishing procedures
10. Apply effective communication techniques with a variety of patients
11. Transfer dental instruments
12. Place amalgam for condensation by the dentist
13. Remove sutures
14. Dry canals
15. Tie in arch wires
16. Demonstrate knowledge of ethics/ jurisprudence/patient confidentiality
17. Identify features of rotary instruments
18. Apply topical fluoride
19. Select and manipulate gypsums and waxes
20. Perform supragingival scaling
21. Mix dental materials
22. Expose radiographs
23. Evaluate radiographs for diagnostic quality
24. Provide patient preventive education and oral hygiene instruction
25. Perform sterilization and disinfection procedures
26. Provide pre- and post-operative instructions
27. Place and remove dental dam
28. Pour, trim and evaluate the quality of diagnostic casts
29. Size and place orthodontic bands and brackets
30. Using the concepts of four- handed dentistry, assist with basic restorative procedures, including prosthodontics and restorative dentistry
31. Identify intraoral anatomy
32. Demonstrate understanding of the OSHA Hazard Communication Standard
33. Place, cure and finish composite resin restorations
34. Place liners and bases
35. Place periodontal dressings
36. Demonstrate understanding of the OSHA Bloodborne Pathogens Standard
37. Take and record vital signs
38. Monitor vital signs
39. Clean and polish removable appliances and prostheses
40. Apply pit and fissure sealants
41. Prepare procedural trays/ armamentaria setups
42. Place orthodontic separators
43. Size and fit stainless steel crowns
44. Take preliminary impressions
45. Place and remove matrix bands
46. Take final impressions
47. Fabricate and place temporary crowns
48. Maintain field of operation during dental procedures through the use of retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.
49. Perform vitality tests
50. Place temporary fillings
51. Carve amalgams
52. Process dental radiographs
53. Mount and label dental radiographs
54. Remove temporary crowns and cements
55. Remove temporary fillings
56. Apply topical anesthetic to the injection site
57. Demonstrate understanding of the Centers for Disease Control and Prevention Guidelines
58. Using the concepts of four-handed dentistry, assist with basic intraoral surgical procedures, including extractions, periodontics, endodontics and implants
59. Monitor nitrous oxide/oxygen analgesia
60. Maintain emergency kit
61. Remove permanent cement from supragingival surfaces
62. Remove periodontal dressings
63. Place post-extraction dressings
64. Fabricate custom trays, to include impression and bleaching trays, and athletic mouthguards
65. Recognize basic medical emergencies
66. Recognize basic dental emergencies
67. Respond to basic medical emergencies
68. Respond to basic dental emergencies
69. Remove post-extraction dressings
70. Place stainless steel crown

Appendix B: Levels of Supervision

An important consideration in the discussion of the delegation of tasks to dental assistants is that of supervision of dental assistants by their dentist-employers. The American Dental Association (ADA) has identified five levels of supervision for allied dental personnel, including dental assistants, which it defines in its "Comprehensive Policy Statement on Allied Dental Personnel," (2010: 505) which is part of its *Current Policies,* last updated in 2020. Note that "allied dental personnel" refers to dental assistants, dental hygienists and dental laboratory technicians.

The five levels of supervision defined by the ADA are as follows:

Personal supervision. A type of supervision in which the dentist is personally operating on a patient and authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.

Direct supervision. A type of supervision in which a dentist is in the dental office or treatment facility, personally diagnoses and treatment plans the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and evaluates their performance before dismissal of the patient.

Indirect supervision. A type of supervision in which a dentist is in the dental office or treatment facility, has personally diagnosed and treatment planned the condition to be treated, authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and will evaluate the performance of the allied dental personnel.

General supervision. A type of supervision in which a dentist is not required to be in the dental office or treatment facility when procedures are provided, but has personally diagnosed and treatment planned the condition to be treated, has personally authorized the procedures, and will evaluate the performance of the allied dental personnel.

Public Health Supervision. A type of supervision in which a licensed dental hygienist may provide dental hygiene services, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings, as designated by state law, and with general oversight of such programs by a licensed dentist designated by the state.

Furthermore, the ADA's "Comprehensive Policy Statement on Allied Dental Personnel" stipulates that intraoral expanded functions should be performed by allied dental personnel "under the supervision of a dentist."

Because the study of dental assisting core competencies undertaken by the ADAA/DANB Alliance did not address the question of supervision, the ADAA/DANB Alliance has not made any recommendations as to the levels of supervision that should be necessary for the delegation of the tasks included in the study to dental assistants. However, the ADAA/DANB Alliance believes it is important to call attention to the fact that while the ADA has defined supervision levels in the aforementioned policy statement, which governs the ADA's own activities and the activities of its members, these definitions have not been uniformly adopted by the dental boards of every U.S. state or district.

For the purposes of the attached charts, if a state's dental practice act specifically defines levels of supervision, the state-specific definition is noted in the template.

ARMY WRITER

Thanks for your contributions!

We need more examples. Examples can be contributed by using the form below.

MOS 68E
Dental Specialist
Duty Descriptions

Dental Assistant

Assists dentists during oral surgery, restorative treatments, and preventive care procedures; prepares patients for examinations by arranging instruments and materials; operates dental X-ray equipment to take intra- and extra-oral radiographs; sterilizes instruments and maintains the cleanliness of dental equipment and operatories; manages patient records, schedules appointments, and orders dental supplies; trains or supervises junior enlisted personnel; sets up portable dental operatories.

68E40 Dental SRP NCO

Supervises activities of dental team in a dental facility; provides technical guidance; determines personnel requirements and establishes work priorities; organizes work schedules and duty assignments; instructs subordinates in work techniques and procedures; evaluates personnel performance, counsels personnel, and prepares evaluation reports; prepares administrative, technical, patient, and manpower reports.

68E20 Oral Surgery Assistant

Serves as an oral and maxillofacial surgery assistant for the 214th Surgical Detachment; assists the surgeon with all chairside procedures including operatory setup, anesthesia administration, and cleanup; prepares and sterilizes surgical instruments, materials, and equipment in accordance with infection control and biohazard protocols; provides patients with information on oral health care, treatment plans, and postoperative outcomes; supervises the daily maintenance, readiness, and accountability of medical equipment valued in excess of $57,000.

68EX2 Preventive Dentistry Specialist

As Preventive Dentistry Specialist, examines patients' teeth and gums, recording the presence of diseases or abnormalities; removes soft and hard deposits from teeth; teaches patients how to practice good oral hygiene; provides preventive dental care; removes calculus, stains, and plaque from teeth; takes and develops dental x-rays; applies cavity-preventive agents such as fluorides and pit and fissure sealants.

68EN5 Dental Laboratory Technician

Performs procedures in fabrication and repair of removable and fixed dental prosthodontic appliances based on consultation requests; fabricates fixed and removable precision appliances; fabricates simple and complex orthodontic, pedodontic, periodontic and surgical appliances; assists in fabricating maxillofacial appliances; manages the operational maintenance of laboratory equipment; orders and receives supplies.

Squad Leader

Serves as squad leader for the Area Support Platoon on an MTOE, Dental Company (Area Support), supervising three Soldiers; trains new Soldiers to operate dental equipment; provides counseling and mentorship to Soldiers on career progression; takes interest in health, welfare and morale of Soldiers; supports the commander's intent on all policies and guidelines for the unit maintenance program; conduct inventories to identify shortages and deficiencies of $350,000 worth of dental equipment and vehicles to ensure 100% readiness to accomplish the unit mission.

68E20 Dental Specialist

Supervises the set up of field dental clinic; assists in four-handed dentistry including exams, endodontics, oral surgery, extractions, and restorative procedures; performs instrument sterilization; exposes dental radiographs, performs charting; manages patients records; seats patients; schedules appointments.

68E20 Dental Specialist

Serves as a Dental Specialist in a brigade support battalion medical company in the 1st Brigade Combat Team, 101st Airborne Division (Air Assault); provides Echelon II combat dental health support for Forward Operating Base Fenty consisting of 3,500 Soldiers, coalition forces, Afghan National Army, and civilian contractors; directly responsible for the health, welfare, morale, and combat readiness of two Soldiers; supervised the daily maintenance, readiness, and accountability of medical equipment valued in excess of $900,000.

MOS 68E - Dental Specialist

Major Duties. The dental specialist assists the dental officer in prevention, examination, and treatment of diseases of teeth and oral region, or assists with the management of dental treatment facilities. Duties for MOS 68E at each level of skill are:

MOSC 68E10. Patient care. Receives and seats patients; prepares dental operatory, selects and arranges instruments, measures and records temperature, blood pressure and pulse, and assists dentist during patient exams; provides oral hygiene instructions; assists with administration of anesthesia and in placement and removal of sutures; prepares restorative and impression materials; performs Cardiopulmonary Resuscitation and operates resuscitative equipment; manages infection control and disposes of contaminated waste and dental radiography materials; loads and unloads radiographic film cassettes; protects self and patient from excessive ionizing radiation exposure; exposes bite-wing periapical, occlusal film, and panoramic radiographic film; schedules appointments, retrieves, files, and maintains dental records; receives, stores, packs, unpacks and safeguards dental supplies and equipment; performs preventive maintenance on dental equipment; sets up, maintains, disassembles and packs dental field equipment shelters.

MOSC 68E20. Supervises dental teams, sections, or small fixed or mobile dental facilities; assists dental officers in prevention, examination, and treatment of diseases of teeth and oral region; assists and advises subordinate personnel on supply economy procedures; supervises the packing, unpacking, loading, setting up, and storage of dental unit field equipment and shelters; assists in presentation of training programs; prepares the site for field dental treatment facilities; assists with technical and administrative management of dental treatment facilities under the supervision of a Dental NCO.

MOSC 68E30. Supervises activities of dental teams, sections, or clinics in small or medium sized fixed or mobile dental facilities; provides technical guidance; ensures comfort, safety, and cleanliness of dental

facilities; determines personnel requirements; establishes work priorities; organizes work schedules and assigns duties; instructs subordinates in work techniques and procedures; evaluates personnel performance; counsels personnel and prepares evaluation reports; supervises movements and establishment of field dental units; prepares unit CBRN plans and supervises procedures; prepares administrative, technical, patient, and manpower reports; establishes and monitors stock level of supplies and equipment; requisitions and maintains dental supplies and equipment.

MOSC 68E40. Supervise activities of dental teams, large fixed or mobile dental facilities or dental clinic commands; assists with the planning, execution, and oversight of missions within multifunctional medical battalions; prepares periodic and special reports concerning personnel, patients, dental care and treatment operations; supervises and plans training in general military and MOS specific subjects; coordinates administrative activities and prepares dental treatment facility SOPs; revises topography of selected operational site and advises on the location of field treatment and sanitation facilities; prepares operational orders and fragmentation orders in support of medical missions; ensures compliance with infection control protocols; manages dental readiness of supported units; coordinates the deployment, establishment, disestablishment, and redeployment of mobile dental facilities; plans, develops, and supervises loading plans for dental field organizations; performs staff, budget, and advisory duties.

MOSC 68E50. Serves as senior enlisted advisor of fixed dental activity, deployable dental company, or area dental laboratory or as staff NCO at a medical battalion or brigade; supervises general administrative functions and coordinates personnel assignments; evaluates training programs and requirements; assists the Commander in the administrative and technical supervision of subordinate dental facilities; assists in the planning, development, and management of the command budget programs; coordinates and supervises unit preventive maintenance and supply programs; assists with the planning, execution, and oversight of missions within a medical brigade or medical command; assists with the coordination, reception, staging, and integration of deployed units; assists with deployment, reintegration, reconstitution, and retraining; assists in the development of operational plans and tactical SOPs; provides technical assistance in planning and staffing of facilities.

Use this form to contribute examples.

MOS:

Duty Title:

Duty Description:

Submit

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IHS Periodontal Treatment Initiative
EFDA Fact Sheet

History and Need of Expanded Function Dental Assistants

Traditionally, periodontal services have been provided by a licensed dentist and/or a licensed or registered dental hygienist. However, the Indian Health Service was one of the first governmental agencies or organizations that adopted the model of expanded function dental assistants (EFDAs). Starting in 1961, the IHS initially used EFDAs in providing basic restorative services to augment the services provided by dentists, and over the past several decades, EFDAs have increasingly been used to provide basic periodontal services to American Indian/Alaska Native (AI/AN) patients to augment the care provided by dentists and dental hygienists.

Access to oral health care is not evenly distributed in the United States or in Indian Country. While urban areas and larger IHS or tribal dental programs often employ one or more dental hygienists to provide preventive care and periodontal therapy to AI/ANs, many smaller programs located in more isolated areas do not have that luxury. While the IHS does employ over 400 dental hygienists as of 2015, more than two thirds of these hygienists are located in the largest (in terms of AI/AN population served) IHS-funded dental clinics. The last oral health status survey (2014) showed that 17% of AI/AN adults over the age of 35 suffer from severe periodontal disease (with pockets $\geq$ 5.5 mm) compared to a prevalence of just 10% for the U.S. overall, and an evaluation of data from the National Health and Nutrition Examination Survey (NHANES) in 2014 showed that prevalence of periodontal disease may even be higher, especially among those older than 35, minority populations, those at or below the federal poverty level, those with less formal education, and current smokers. With a low access to dental care in the IHS (around 25%), not enough dental hygienists in underserved areas, and many patients with some of the social and economic contributing factors leading to periodontal disease, **expanded function dental assistants ("Perio EFDAs") are a great option to help meet the periodontal needs of AI/ANs.**

"Perio EFDAs" undergo an intensive hands-on curriculum through formal IHS continuing dental education to provide basic periodontal therapy to AI/AN patients. This fact sheet will detail that curriculum and provide IHS, tribal, and urban dental programs with information on how your program, too, can benefit from trained Perio EFDAs providing quality periodontal care for your patients.

Overall Health begins with Periodontal Health!

EFDA Fact Sheet—continued

Perio EFDA Training

Periodontal Expanded Functions—Basic

Most dental assistants who are Perio EFDAs have been trained to provide basic periodontal services. The IHS offers a one-week basic course to develop or improve skills in ultrasonic scaling. Learning objectives for this course include:

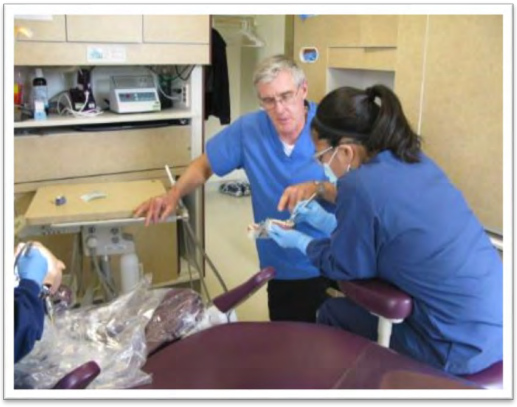
1. Relate Community Periodontal Index (CPI) scores to a need for periodontal treatment.
2. Detect disease, supra- and sub-gingival calculus.
3. Accurately code for periodontal and hygiene procedures with IHS/ADA coding.
4. Remove visible calculus through ultrasonic scaling of teeth.
5. Recommend effective toothpastes, mouthrinses and oral hygiene aids to patients.
6. Motivate patients to improve plaque removal and periodontal health.
7. Identify those at risk for periodontal breakdown.

This course, which includes online, didactic and clinical components, includes a lab with ultrasonic instrumentation on a typodont with simulated calculus. Those enrolled will also clean each other's teeth for a ½ day before seeing patients for at least 1 ½ days. Following the training, students must satisfactorily complete 20 patient cleanings at their home dental clinic within 6 months after course completion, evaluated by a preceptor, before receiving a course completion certificate by the IHS Division of Oral Health.

Periodontal Expanded Functions—Advanced

The advanced course is also a one-week course offered by the IHS for EFDAs who have previously taken the basic course. In addition to the learning objectives from the basic course, students also learn the following in this course:

1. Use universal scalers efficiently and atraumatically.
2. Sharpen scalers correctly and efficiently.



Like the basic course, students must complete 20 patient cleanings at their home dental clinic, documented through training progress records evaluated by a preceptor, before receiving a course completion certificate by the IHS Division of Oral Health.

Starting in FY 2016, new courses will be provided for interested dental assistants in multiple areas of the IHS. **Please check the IHS DOH CDE site for offerings.**

Overall Health begins with Periodontal Health!

EFDA Fact Sheet—continued

How can Perio EFDAs be utilized in our programs?

How are Perio EFDAs being used now?

Many IHS, Tribal, and Urban dental programs across the country currently utilize Perio EFDAs. In a recent survey of chief dentists and program managers, 98.5% of trained Perio EFDAs are being used routinely in that capacity.

How can a Perio EFDA be used in your facility?

Even in programs with dental hygienists, Perio EFDAs can serve a vital role. While dental hygienists can focus on treating the patients with periodontal disease, the Perio EFDAs can provide services such as routine preventive prophlaxis cleanings, periodontal maintenance (working with the hygienist), oral hygiene instructions, and other preventive services (fluoride applications, sealants, dietary counseling, etc.). By using the EFDA in this way, it maximizes efficiency for both the assistant and the dental hygienist.

For programs without a dental hygienist, or with too few dental hygienists, the EFDA can provide basic scaling using ultrasonic and sonic scalers, or, if they have completed the advanced course and have demonstrated competency, they can remove visible calculus through hand scaling. By using the Perio EFDA in this way, it ensures that patients are receiving at least basic periodontal services in your facility. Perio EFDAs work under the supervision of a dentist or hygienist, and the dentist or hygienist provides a "check in" and "check out" on each patient treated by a Perio EFDA.

How much could a Perio EFDA save our clinic?

If your program is unable to hire a dental hygienist due to costs, the annual salary of a federal GS-5 Civil Service or equivalent tribal hire EFDA is approximately only 40-50% that of a dental hygienist. In addition, considering the costs of referring patients out of your program to specialists for basic periodontal care, the costs of an EFDA to take care of the basic periodontal needs of your patients is minimal.

Perio EFDAs are a cost effective resource that will help your dental program provide quality basic periodontal services to the AI/AN population you serve.

Overall Health begins with Periodontal Health!

Development and Implementation of the Indian Health Service Expanded Function Dental Assistant-1 (EFDA-1) Occupation

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Natalia V. Oster, PhD, MPH; Grace A. Guenther, MPA; Paula M. Kett, PhD, MPH, RN; Samantha W. Pollack, MHS; Susan M. Skillman, MS
University of Washington Center for Health Workforce Studies

KEY FINDINGS

The Expanded Function Dental Assistant-1 (EFDA-1), also called the perio EFDA, is an expanded role for dental assistants working in Indian Health Service (IHS) facilities following completion of an IHS-directed training program. Based on key informant interviews and literature reviews, this report describes the perio EFDA role, insights about its implementation, and comparative details in Washington's dental workforce and related career pathways. Following are major study findings:

- Employing perio EFDAs helped to increase patient access to routine preventive services and allowed dentists, dental hygienists, and dental therapists (where employed) to deliver more services at the top of their scope of practice.
- Clinic motivations to employ perio EFDAs included mitigating dental hygienist shortages, reducing costs and increasing clinic efficiency, and providing staff development opportunities for dental assistants.
- Increasing the number of perio EFDA training opportunities will require identifying additional host IHS dental clinics, and addressing the ongoing shortage of qualified course instructors.
- The success of perio EFDA training often depends on identifying motivated dental assistants interested in higher pay, professional growth, and a desire to contribute more meaningfully to tribal and community oral health needs.
- Potential additional training settings for perio EFDAs include co-locating with dentist or dental assistant education and training programs.
- In general, dentists were supportive of incorporating perio EFDAs into their practices, while some dental hygienists were more hesitant when it caused their workloads to be disproportionately comprised of the most complex cases.
- Dentists and other clinic staff may benefit from training on how to work effectively with perio EFDAs, although such training is not available at present.
- Curriculum and course plan revisions are reportedly underway in some locations to help address reported concerns with perio EFDA student confidence.
- Demand for dental hygienists and dental assistants in Washington remains high. In addition to expanding education programs, exploring the use of additional dental workforce roles may help address the state's workforce gaps.

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Attachment #6

Development and Implementation of the Indian Health Service Expanded Function Dental Assistant-1 (EFDA-1) Occupation

INTRODUCTION

Project Background and Objectives

This study by the University of Washington Center for Health Workforce Studies (UW CHWS), with funding from the Washington State Dental Association (WSDA), aims to describe the Expanded Function Dental Assistant-1 (EFDA-1) occupation model within the Indian Health Service (IHS), U.S. Department of Health and Human Services. This report outlines the history, implementation, training, and scope of practice associated with the EFDA-1 role, and shares insights from IHS sites where the model has been adopted. Our report draws on a literature review and key informant interviews to describe the IHS EFDA-1 role and experiences with implementation. In IHS literature and throughout our key informant interviews, EFDA-1s are commonly referred to as "perio EFDAs."[1,2] Given this, we have adopted the perio EFDA nomenclature for consistency and clarity throughout the report. To provide context regarding how the perio EFDA role compares with currently licensed oral health occupations in the state, this report also summarizes prior UW CHWS studies describing the occupations, and supply and demand trends, among Washington's dental workforce.

Approach

Literature review. To better understand the role of perio EFDAs within the IHS, we reviewed current literature, technical documentation, and a variety of online resources, including IHS Continuing Dental Education course materials, perio EFDA program fact sheets, scope of practice guidelines, and historical reports which outline the development of the perio EFDA model.

Key informant interviews. We identified potential key informants with knowledge of, and/or experience with, the IHS EFDA roles from our reviews of relevant documents and websites and recommendations from knowledgeable individuals. After attempting to contact and invite approximately 50 candidates, we conducted interviews with 10 key informants with experience in developing, administering, or practicing in settings that utilize the perio EFDA role. Interviewees represented a range of roles, including current and former IHS or IHS-affiliated dental clinic directors, practicing perio EFDAs, dental educators, and IHS administrators.

We developed a semi-structured interview guide with open-ended questions exploring interviewees' professional background, current role, and experience with perio EFDAs in the IHS. The guide examined interviewees' understanding of dental workforce models involving perio EFDAs, including the rationale for the role, the gaps it aimed to fill, its evolution, and challenges and facilitators in implementation. Conversations further addressed where the perio EFDA model has been implemented, how its functions vary across clinical settings, how it differs from other IHS dental assistant models, and measurable outcomes such as cost savings, improved access to care, and success in filling vacancies.

We conducted interviews with a range of clinics serving tribal communities. While some clinics provide care exclusively to tribal members, others extend services to non-tribal patients under specific conditions.

Interviews were conducted via Zoom by at least two research team members and lasted 45 to 60 minutes. After conducting the interviews, we analyzed the responses to identify patterns and recurring themes.

Relevant prior UW CHWS studies. UW CHWS recently conducted several research studies describing Washington's oral health workforce. Through the Washington Oral Health Workforce Tracking Program (WOHW) we examined the supply of and demand for dental occupations in the state by analyzing available secondary data and conducting workforce surveys.[3] Relevant comparative information from those analyses is summarized in this report.

PERIO EFDAS IN THE INDIAN HEALTH SERVICE (IHS)

History of EFDAs in the IHS

The IHS has developed dental workforce strategies aimed at improving access to oral health care for American Indian and Alaska Native (AI/AN) communities in the U.S.[2,4] The EFDA role, introduced in 1961, was the first alternative dental workforce model developed by the IHS, created to support dentists and dental hygienists by expanding the training and role of dental assistants to enable them to provide basic periodontal care and prophylactic services.[1,4] The perio EFDA role has evolved over time and is now broadly integrated within IHS tribal programs. Perio EFDAs work in all IHS settings but are commonly found in rural areas and other settings with limited access to dental care.[1]

Larger IHS tribal dental programs and IHS dental clinics in urban areas typically can employ dental hygienists to deliver preventive and periodontal services. However, many smaller and remote clinics may be limited in their ability to employ dental hygienists.[1,5] In 2015, IHS employed over 400 dental hygienists, with more than two-thirds serving in the highest-volume IHS-funded dental clinics.[1] Perio EFDAs are used to help extend a clinic's preventive care capacity, particularly in clinics with less access to dental hygienists. Perio EFDAs perform routine cleanings and other basic preventive procedures, which helps to reduce the workload of dental hygienists and expand patient access to dental services.

IHS Perio EFDA Scope of Practice

The IHS outlines the scope of services that perio EFDAs may provide, which include:[2]

- relating the community periodontal index, a periodontal screening performed by a dentist or dental hygienist, to assess the need for periodontal therapy;
- detecting diseased tissue and the presence of supra- and sub-gingival calculus;
- performing an ultrasonic scaling of teeth using ultrasonic equipment (such as a Cavitron), to remove all visible plaque and calculus;
- providing oral hygiene education to patients, including recommending toothpastes, mouth rinses, and other oral hygiene aids; and
- identifying patients at risk for further periodontal breakdown and ensuring those patients receive follow-up care from a dentist or dental hygienist.

Perio EFDAs' scope of practice does not include diagnosing periodontal disease, hand scaling and root planing, or any type of periodontal surgery.[2] For patients with periodontitis, a periodontal workup must be done by the dentist or dental hygienist before the perio EFDA does a debridement using an ultrasonic scaler. Finally, a perio EFDA can provide services under the indirect supervision of a dentist or dental hygienist (they must physically be in the facility) and they may not provide services under general supervision (i.e., when no dentist or dental hygienist is in the facility).[2]

IHS Perio EFDA Education and Training

Between 2012 and 2017 (the most recent data available), the IHS trained 251 dental assistants to become perio EFDAs through 37 different courses.[2] Training of perio EFDAs involves completing online prerequisites, a formal one-week in-person training, and further clinical training at the perio EFDA's home clinic. Specifically, basic perio EFDA training includes the following components and steps:[1,2,4]

- **Complete online prerequisites**: To become a perio EFDA, dental assistants complete two online modules on oral hygiene instruction and antimicrobials and must successfully pass the associated tests before attending the in-person class.
- **Supervisor nomination**: Enrollment in the in-person class requires a nomination from the dental assistant's supervisor.
- **Complete a one-week in-person class** (see **Box 1** for detailed objectives). This includes:
    - Seminars in periodontics, dental hygiene, and ultrasonic instrumentation
    - Typodont exercises
    - Structured progression to supervised practice on peers and clinic patients
- **Fulfill clinical requirements**: Within six months of completing the in-person class, trainees must successfully complete 20 ultrasonic cleanings under the observation of a licensed dentist at their home clinic. Each cleaning is evaluated using IHS grading criteria, with emphasis on the effective removal of both visible and potentially subgingival calculus.
- **Submit paperwork**: After successfully passing the 20 home-clinic cleanings, the supervising dentist submits the required paperwork to the IHS training administrator via email and copies the course instructor. After these steps, the dental assistant may be designated as a perio EFDA.

Box 1. Perio EFDA Course Learning Objectives

The learning objectives for the one-week perio EFDA course include:[1]

1. Relate Community Periodontal Index (CPI) scores to a need for periodontal treatment.
2. Detect disease, supra- and sub-gingival calculus.
3. Accurately code for periodontal and hygiene procedures with IHS/American Dental Association coding.
4. Remove visible calculus through ultrasonic scaling of teeth.
5. Recommend effective toothpastes, mouth rinses and oral hygiene aids to patients.
6. Motivate patients to improve plaque removal and periodontal health.
7. Identify patients at risk for periodontal breakdown.

Earlier references indicated IHS provided training for both "basic" and "advanced" level perio EFDA roles, with advanced perio EFDA certification allowing the EFDA to use hand instruments to remove visible plaque and calculus.[1] However, no recent courses have been offered for advanced perio EFDA training, with course descriptions of perio EFDAs now indicating that hand scaling is no longer a part of the periodontal EFDA curriculum.

"Restorative EFDA" is an additional EFDA role for which IHS training is currently available.[6] While not a focus of this report, restorative EFDAs are dental assistants trained in the placement and finishing of composite, glass ionomer, and amalgam restorative materials in IHS, tribal, and IHS-funded urban dental programs.[7] Recent IHS course descriptions indicate the curriculum was revised in October 2024 to replace the previous restorative EFDA courses of restorative basic, advanced, and composite-only.

Interview Findings: Perio EFDA Training

Findings from interviews with key informants and written documentation describing and commenting on the IHS perio EFDA training process and outcomes are described below.

Availability of training opportunities. Interviewees were generally positive about the training perio EFDAs receive, though several noted that EFDA courses are first-come, first-served, and securing a spot can be challenging. After identifying a dental assistant who is interested in EFDA training, a clinic director noted, "you have to know what you're looking for [in terms of identifying a class], then grab a training slot." A waitlist for the IHS perio EFDA training course is available, but demand often exceeds capacity, making access to training highly competitive.

Clinic perspectives on hosting perio EFDA training. A clinic director who plans to host an EFDA training class explained in an interview that the clinic will need to commit significant resources to meet class needs, which they are willing to do in order to take advantage of the training resource. The clinic will allocate time and space and will reduce patient appointments in order to host an in-person 32-hour course led by an instructor sent by IHS. The interviewee cited that the current shortage of qualified teachers can be a barrier to offering these courses. In-person classes typically accommodate six to eight dental assistants. Host sites usually occupy up to two-thirds of the training slots, which is an incentive to host, while other clinics provide the remaining students.

Selection of dental assistants for perio EFDA training. Several clinic directors noted that the success of perio EFDA training often depends on the personality and motivation of the dental assistant receiving the training. One dentist emphasized that trainees must be self-motivated and proactive, seeking out opportunities to grow professionally. Because access to EFDA training is limited, several clinic directors indicated they directly select candidates to recommend for training, while others stated they request applications from dental assistants in their clinic and choose participants based on those submissions.

One clinic director described his process for identifying dental assistants to recommend for perio EFDA training:

> *[As is the case for] any healthcare person, you have some that are better than others… and because they're working under your license, you make determinations about who is going to provide those services. So there were some [EFDAs] that probably did not quite meet the quality, and then…patients need to be re-treated, or, you know, the dentist needs to come in and provide additional follow-up… You do your due diligence as dental director, you had to be very careful working with the clinic manager [to determine] who is going to be provided that training.*

Recertification of perio EFDAs. Several interviewees noted that each perio EFDA is expected to complete five dental cleanings annually, including hygiene and calculus removal, under dentist supervision. Paperwork and recertification are tracked internally at the clinic level, with no submissions to IHS. While recertification is encouraged, it is not mandated or monitored. Of note, the high turnover in IHS dental clinics can lead to requirements being overlooked if new staff are unfamiliar with EFDA roles. Several interviewees noted that clearer guidance is needed to ensure that training and recertification take place.

Motivations for dental assistants to pursue perio EFDA training. Interviewees said dental assistants are motivated to pursue perio EFDA training for both personal and community service reasons. For many, the opportunity to earn a higher salary is an incentive. Perio EFDA programs were designed to meet the needs of tribal communities, often located in rural communities where dental hygienist shortages are common. In these settings, perio EFDAs help fill gaps in preventive care. An interviewee who provides perio EFDA training noted that students often express gratitude for the chance to expand their skills and contribute more meaningfully to their communities. One interviewee observed that while perio EFDAs receive rewards for their work, they often do not receive commensurate recognition or financial compensation for their contributions to clinic service, which is typically attributed to the dentists.

Perspectives on where to train perio EFDAs. Interviewees offered mixed suggestions about the most appropriate settings for perio EFDA training. One suggested that if in-clinic training were not used, integrating perio EFDA training into dental schools could be effective because it could provide dentists with experience working with perio EFDAs. The interviewee also suggested adding EFDA training to dental assistant training programs could be effective, but suggested integration with dental hygiene education would likely not be as successful because of some negative perceptions of the EFDA role among dental hygienists. Another instructor suggested that a dedicated EFDA training school and simulation area would be ideal but emphasized that IHS clinics already function well as training locations. Because tribal students can train within their own clinics or other tribal clinics, the interviewee said the current training experience is relevant for these students because it creates a training environment that mirrors the realities of their clinical practice.

Preparing dental teams to work with perio EFDAs. IHS and tribal clinic leaders are generally aware of perio EFDA roles because they must sponsor the dental assistants to attend perio EFDA training, which typically involves paying for their travel and related expenses. However, several interviewees noted that dentists and other clinic staff may also need training to learn how to work effectively with perio EFDAs. Structured training for clinic dentists and staff to clarify perio EFDAs' scope, training, and implementation is not currently offered. Several interviewees suggested that options such as in-person or video training in best practices for employing perio EFDAs in clinic teams could be useful.

The need for additional perio EFDA training. Several interviewees suggested that additional perio EFDA training, beyond the five-day course, may benefit the EFDAs, clinics, and patients. One trainer noted that some perio EFDAs leave the current five day course feeling inadequately prepared because the training compresses too much information into too little time, with too few opportunities for practice. To address this, one interviewee shared that an expanded IHS program is being developed in some locations. The proposed course, still in early planning, may include one week of in person instruction followed by 16 weeks of hands-on training at the trainee's home clinic, focused on instrumentation, moisture control, and other core skills. Course enrollees would be required to have at least one year of dental assisting experience. The 16 week hybrid model perio EFDA course would combine didactic learning through a learning management system with interactive workbooks and applied dental exercises.

Interview Findings: Perio EFDAs in IHS Clinics

We found that clinics are motivated to integrate perio EFDAs into their teams for several reasons, including to reduce costs, increase clinical efficiency, expand patient access to care, address dental hygienist shortages, and support staff development.

Costs and clinic efficiency. According to IHS, EFDAs represent a cost-effective workforce model because they can help a clinic provide high quality basic periodontal services and reduce referrals at salaries that are approximately 40–50% lower than those of dental hygienists in IHS dental programs.[1] Perio EFDAs may further reduce costs by improving clinical efficiency.[1] During the interviews for this study, a former IHS dental clinic director emphasized this point, noting that "Efficiency was the main driver for having EFDAs." He explained that patients with advanced periodontal disease require visits every few months and "Perio EFDAs helped alleviate some of the backlog with the more basic disease states of patients."

Patient access to care. Perio EFDAs may help clinics better meet patient needs by increasing staffing flexibility and expanding scheduling options. One IHS clinic director noted that "Access to EFDAs allow patients to get their cleaning at the same time as ortho [orthodontic appointments], rather than scheduling a second, additional cleaning appointment."

Several current and former IHS dental clinic directors noted that perio EFDAs often work with children because pediatric cleanings fall within their scope of practice, as children's cleanings are usually less complex and rarely involve periodontal disease. In clinics where perio EFDAs' work is primarily focused on pediatric patients, they may also manage uncomplicated adult cases when appropriate, improving the dental team's ability to treat more patients.

Team reactions to the introduction of the EFDA model. According to our interviewees, while dentists are typically supportive of incorporating perio EFDAs into their practices, dental hygienists have varied reactions to the introduction of perio EFDAs. Some noted that dental hygienists supported the model, particularly given the ongoing shortage of hygienists. The IHS dental clinic communities were described as tight-knit, with staff working together to support one another. Others acknowledged that while some dental hygienists may not support the EFDA model, those in public health settings tended to recognize its necessity. Some interviewees expressed concern that when perio EFDAs are employed, dental hygienists might lose access to the "easier" cases. Perio EFDAs often take on more routine pediatric cases, allowing dental hygienists to focus on patients, typically adults, with greater treatment needs. While focusing on complex patients allows dental hygienists to spend more time practicing at the top of their license, it can also make their work more challenging because IHS clinic populations often include patients with complicated dental needs and health histories.

Effect on dental hygienist shortages. According to the IHS, the most recent available data (2017) indicated that 409 dental hygienists were employed across IHS and tribal dental programs.[5] This equates to roughly one hygienist per 3,978 IHS users.[5] By comparison, IHS recommends at least one full-time equivalent dental hygienist per 3,200 users.[5,8] Public health standards suggest one hygienist per 1,300 visits, or about one per 2,684 users.[5,9] Based on these benchmarks, the IHS currently operates at 67–80% of the recommended hygienist capacity.[5] Furthermore, IHS notes that "a vast majority of smaller dental programs (which comprise most of the IHS) employ only part-time, intermittent dental hygienists," a factor not reflected in the above staffing ratios.[5]

In responding to this workforce gap, a 2017 IHS Division of Oral Health report states "…training periodontal expanded function dental assistants helps fill that void, where these staff can provide routine preventive services such as dental sealants, fluoride applications, and prophylactic cleanings as well as provide periodontal services including oral health education, gross debridements (general ultrasonic cleanings), and isolated scaling of visible calculus supra- and subgingivally."[5]

During this study's interviews, several clinic directors highlighted the role of perio EFDAs in alleviating the effects of ongoing dental hygienist shortages. Clinics described delegating basic teeth cleaning to perio EFDAs, especially when not all patients require a dental hygienist's expertise. One clinic director explained, "Sometimes hygienists' schedules are blocked for an hour to see a patient with only two teeth" whereas this is a task that could be undertaken by a perio EFDA.

Other interviewees described additional ways in which perio EFDAs support hygienists. A clinic director said: "Before I [the dentist] get in to do the exam, the EFDA removes the supragingival calculus so I can see the teeth better to do my examination. Then, we have them see the hygienist. And that makes the hygienist's job easier, because then they're focused more on the subgingival aspects of the periodontal disease, and I'm sure they appreciate having less work to do when they see that patient."

Another IHS dental clinic director, whose clinic had previously employed perio EFDAs and was interested in working with them again said:

> *The difference between a hygienist and expanded functions assistant [perio EFDA] is the [dental hygienists'] ability to do deeper scaling in root planing in particular, and so it'd be nice to have our hygienists basically take care of… the more advanced cases, and [have the perio EFDA focus on] folks that just need routine cleanings, maybe don't have a lot of calculus, just going through and making sure things are okay, kind of minor things. It'd be nice to have an assistant to help out with that. We're in a situation where we have one hygienist between myself and another dental therapist… You want at least a couple of hygienists taking care of the recall and periodontal needs for your patients…so we're a little bit inverted as far as that ratio goes, and the way that looks like for our patients is that it's really hard to get in with our hygienist. Like, she's not really able to meet the needs of the community. [Working with an EFDA] would take some of the load off of her [the dental hygienist] for the easy stuff to get her working more at the top of her license.*

Impact on staff development. Several IHS dental clinic directors noted that a key motivation in training and integrating perio EFDAs is to provide staff development opportunities. One clinic director explained that his goal is to enable the full dental team to practice at the top of their scope. When dental assistants express interest in EFDA training, he said as a manager he views this as an opportunity to promote upward mobility. Investing in this pathway, he noted, "helps with morale and helps retain your more skilled assistants."

Another IHS dental director whose clinic currently employs several perio EFDAs noted, "We're always trying to help train up people. And tribal members really love tribal members giving health services to them." Later in the same interview, a perio EFDA interviewee added that investing in upskilling dental assistants is both practical and necessary, "because it's hard to find a hygienist who can work in these small rural communities."

Prior Assessments of the Perio EFDA Provider Model

Prior evaluations of the IHS perio EFDA model indicate that dental programs with perio EFDAs on staff demonstrate greater utilization of procedures within the perio EFDA scope of practice, including dental sealants, topical fluoride applications, prophylaxis cleanings, and periodontal gross debridements, compared to dental programs without perio EFDAs.[2,5] Dental programs employing perio EFDAs also generally provided more dental services, as measured by total services and services per patient visit, although results varied by site.[2] Additionally, in dental programs with perio EFDAs, hygienists and dentists performed more advanced periodontal procedures, likely because perio EFDAs were able to handle more basic tasks. However, little or no improvement was observed in the proportion of children aged 2–15 receiving sealants, children ages 1–15 receiving at least one topical fluoride application, or in overall patient visits, relative value units, and services per patient.[2]

DENTAL WORKFORCE IN WASHINGTON STATE

Who Currently Provides Dental Care in Washington

Perio EFDAs are not currently licensed by Washington State and as a result are not authorized to work outside of tribal and IHS settings. Of the oral health occupations licensed in Washington State, only dental assistants, expanded function dental auxiliaries (also called EFDAs, although a different occupation than expanded function dental assistants), dental hygienists, dental therapists, and dentists perform periodontal duties. **Table 1** compares the scope of practice associated with dental occupations in Washington and perio EFDAs. The following summary of the supply, demand and career pathways of oral health occupations in Washington, largely drawn from findings of the UW CHWS' Washington Oral Health Workforce (WOHW) Tracking Program,[3] provides context for understanding how the scope and role of perio EFDAs compare with the state's currently licensed dental workforce.

Dental assistants in Washington can perform tasks including coronal polishing, applying topical varnishes and sealants, removal of sutures and periodontal dressings, and primary prevention (e.g., oral hygiene instruction, applying topical fluorides). Expanded functional dental auxiliaries (as licensed by Washington), in addition to the duties of a dental assistant, can place interim restorations (under supervision).[10] Dental hygienists have an expanded periodontal scope of practice in Washington that allows them to perform scaling and root planing, remove of stains and deposits from teeth, apply topical preventive and prophylactic agents, polish and smooth restorations, and apply topical anesthetics and microbials. Perio EFDAs have been added to **Table 1** for comparison with dental occupations currently licensed to provide care in Washington.

Table 1. Scope of practice associated with Washington State licensure for dentists, dental therapists, dental hygienists, expanded function dental auxiliaries, and dental assistants compared with Indian Health Service (IHS) expanded function dental assistants (perio EFDAs)

	Procedures	Dentists	Dental Therapists	Dental Hygienists	Expanded Function Dental Auxiliaries	Dental Assistants	IHS Perio EFDAs
Diagnostic	Taking medical and dental history	•	•	•	•	•	•
	Dental screening and assessment	•	•	•	•	•	•
	Dental charting and oral inspection	•	•	•	•	•	•
	Vital signs	•	•	•	•	•	•
	Assess for sealants	•	•	•	•		
Clinical support	X-rays	•	•	•	•	•	•
Primary prevention	Oral hygiene instruction	•	•	•	•	•	•
	Dietary counseling	•	•	•	•	•	•
	Topical fluorides	•	•	•	•	•	•
	Dental sealants	•	•	•	•	•	•
Removal of deposits from teeth	Coronal polishing	•	•	•	•	•	•
	Dental prophylaxis (scaling)	•	•	•			•
	Nonsurgical therapeutic periodontal procedures	•	•	•			•
Preventive anti-microbial therapy	Apply antimicrobials	•	•	•			•
Cavity treatment	Placement of temporary restorations	•	•	•	•	•	
	Pack and carve restorations (amalgam or resin)	•	•	•	•		
	Extractions	•	•				
	Prefabricated crowns	•	•				
	Pulpotomy	•					
	Pulp capping	•	•				
	Root canal therapy	•					
Other services	Impressions for models and guards	•	•	•	•	•	•
	Impressions for crowns	•			•		•
	Other oral surgery	•					
	Placement of orthodontic appliances	•					
	Orthodontic adjustment	•					
	Check for loose bands, wires	•		•	•	•	
	Periodontal dressings	•	•	•	•	•	
	Other periodontal surgery	•					

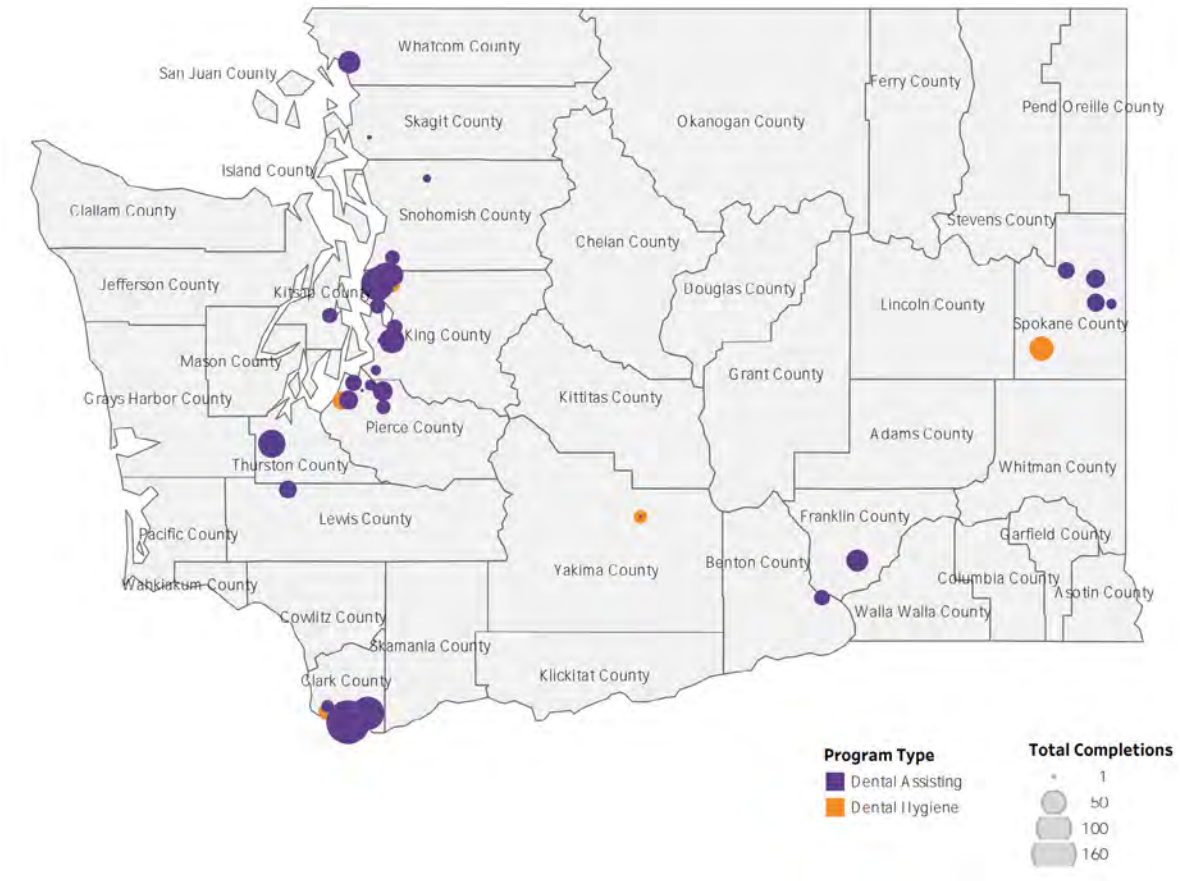
Dental Assistant and Dental Hygienist Education in Washington State

Dental assistant. There are multiple routes to become a dental assistant in Washington state, including community and technical colleges, private career school programs, apprenticeship programs, career/technical education (CTE) programs, and on-the-job training. Programs at community and technical colleges range from certificates (nine or more months to complete) to associate's degrees. Private career school dental assistant programs range from four weeks to one year. In Washington, there are two dental assistant apprenticeship programs and seven CTE programs, and during the 2023-2024 academic year, there were 27 programs at private career schools and 17 at community and technical colleges.[11]

Dental hygienist. Dental hygiene training in Washington state is achieved through either an associates degree or bachelor's degree program. During the 2023-2024 academic year, there were nine dental hygiene programs with at least one completion in Washington state (**Figure 1**). Six of Washington's nine programs conferred bachelor's degrees (about 67%), compared with an estimated 15% of dental hygiene programs nationally in 2024-2025 that conferred bachelor's degrees.[12,13]

Figure 1 shows the locations of dental assisting and dental hygiene education and training programs in Washington that receive federal funding, and does not include apprenticeships and on-the-job training programs.

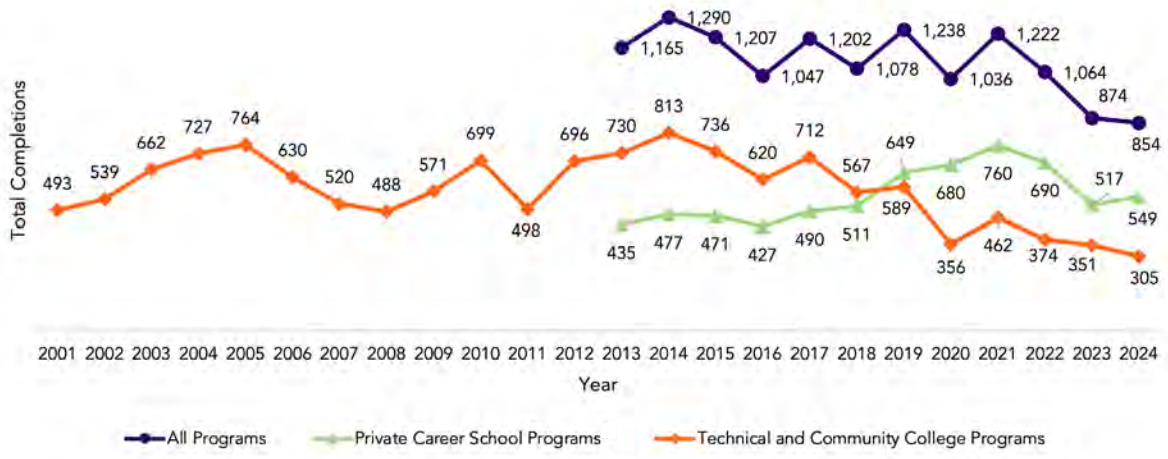
Figure 1. Locations of Dental Assisting and Dental Hygiene Education and Training Programs in Washington, 2024



Source: Data on institution counts and degree completions by oral health occupation are from the U.S. Department of Education's national database, Integrated Postsecondary Education Data System (IPEDS). IPEDS may not capture completions from programs that do not receive federal funding, or individuals who may have entered the profession through on-the-job training or apprenticeship arrangements.

Dental assisting program completions have decreased over time in Washington, from a high of 1,290 in 2014 to 1,222 in 2021 and further to 854 in 2024 (**Figure 2**). Due to a lack of relevant data, however, these numbers do not include individuals who completed on-the-job training or apprenticeship to become a dental assistant.

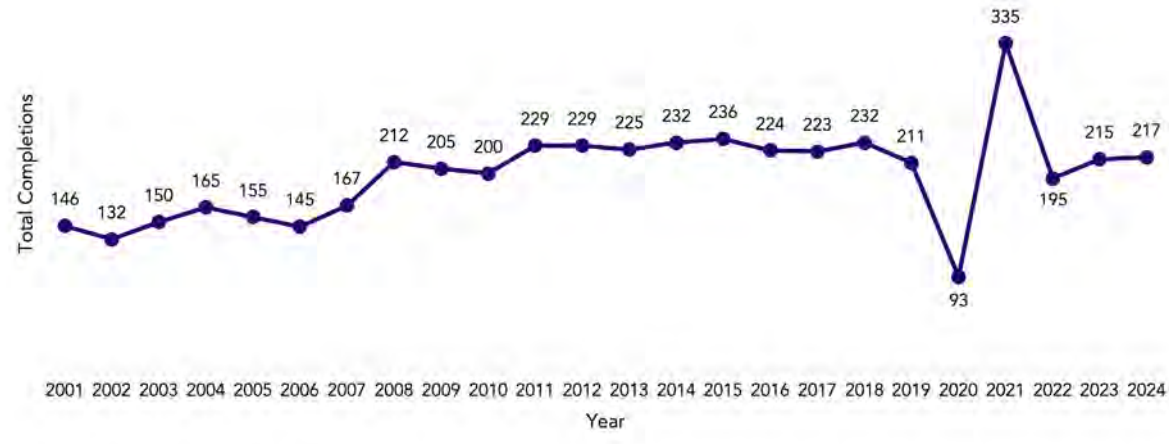
Figure 2. Dental Assisting Program Completions in Washington State, 2001-2024



Source: Data on institution counts and degree completions by oral health occupation are from the U.S. Department of Education's national database, Integrated Postsecondary Education Data System (IPEDS). IPEDS may not capture completions from programs that do not receive federal funding, or individuals who may have entered the profession through on-the-job training or apprenticeship arrangements. Completion counts for "private career school programs" are from data compiled by the Washington Workforce Training and Education Coordinating Board from the Web-based Data and Reporting System (WBDRS), are only available for analysis beginning in 2013.

Dental hygiene program completions have slowly been increasing since 2001 from 146 to 217 in 2024 (**Figure 3**).

Figure 3. Dental Hygiene Program Completions in Washington State, 2001-2024



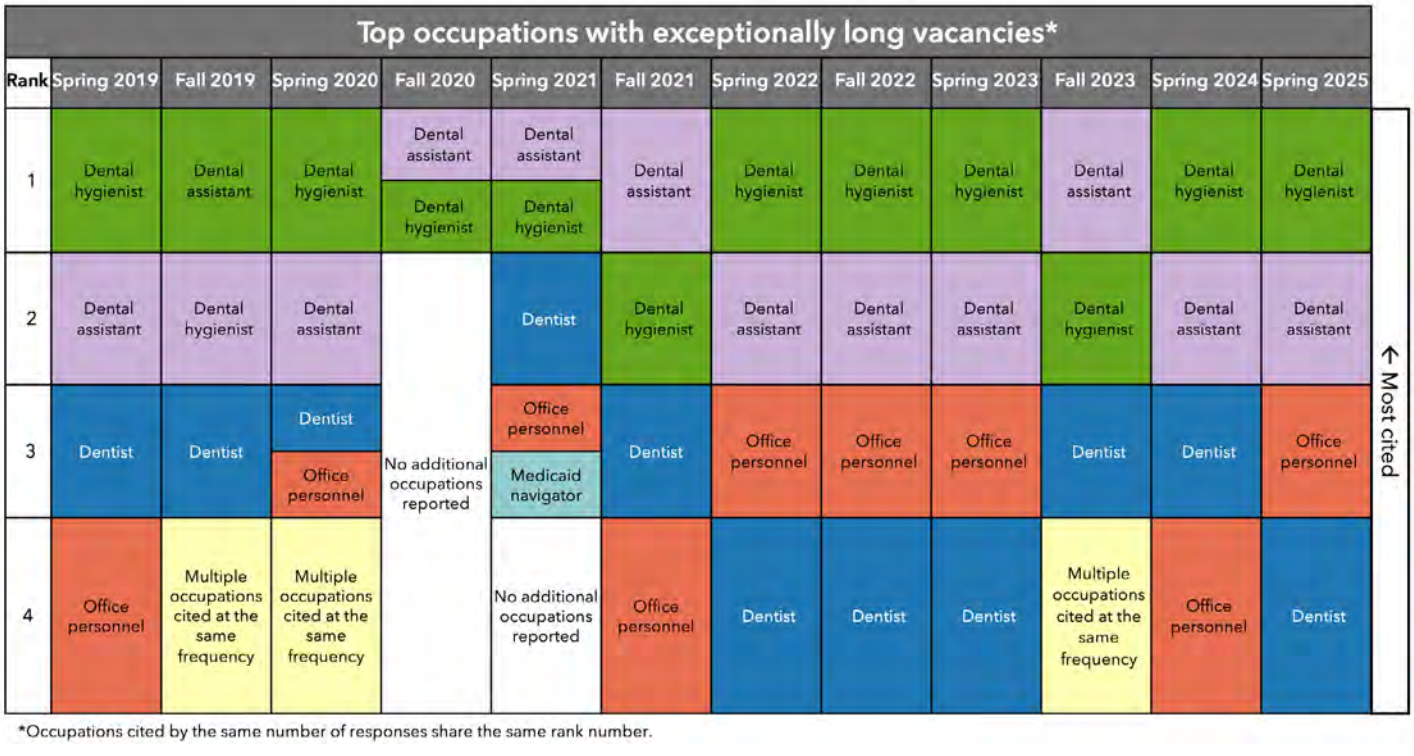
Source: Data on institution counts and degree completions by oral health occupation are from the U.S. Department of Education's national database, Integrated Postsecondary Education Data System (IPEDS). IPEDS may not capture completions from programs that do not receive federal funding.

Demand for Dental Assistants and Dental Hygienists

Nationally, the U.S. Health Resources and Services Administration's National Center for Health Workforce Analysis (NCHWA) has projected less than 1% growth in dental hygienist supply between 2022 and 2037, compared with a 6% increase in demand, resulting in a national shortfall across this time period of more than 11,000 dental hygienists.[14] Comparable national projections from NCHWA are not available for dental assistants, but the U.S. Bureau of Labor Statistics projects a 6% growth in employment of dental assistants from 2024 to 2034, faster than the average for other occupations.[15]

Between 2022 and 2024, the number of dental assistants in Washington increased by 3.6% (from 16,250 to 16,831 with in-state addresses) and dental hygienists increased by 2.3% (from 6,004 to 6,143 with in-state addresses).[16] In spite of this growth, the supply of the two occupations has not kept up with demand in the state, as indicated by responses since 2016 to the Washington State Health Workforce Sentinel Network. Employer respondents to Sentinel Network surveys have consistently cited exceptionally long vacancies and need for dental assistants and hygienists in dental offices and clinics, and in community health centers (including Federally Qualified Health Centers and clinics providing care for free or on a sliding scale) in Washington state (**Figure 4**).[17,18]

Figure 4. Occupations with Exceptionally Long Vacancies from Sentinel Network Respondents, 2019-2025[18]



*Occupations cited by the same number of responses share the same rank number.

Sentinel Network respondents reported a shortage of both dental assistants and hygienists across Washington state, noting that education programs are not keeping up with the growing demand for these occupations. According to respondents, this shortage was exacerbated by the COVID-19 pandemic, during which many dental hygienists retired, leaving positions that have been difficult to fill. In addition, some respondents commented that wages for dental assistants and hygienists have not kept pace with the rising demand for dental health workers.

FINDINGS SUMMARY AND CONCLUSIONS

The Expanded Function Dental Assistant-1 (EFDA-1), also called the perio EFDA, is an expanded role for dental assistants working in Indian Health Service (IHS) facilities following completion of an IHS-directed training program. Perio EFDAs' scope of practice expands on dental assistants' scope to include ultrasonic scaling, among other tasks, under the indirect supervision of a dentist or dental hygienist. This report describes the history of the perio EFDA role, shares insights about its implementation from IHS administrators and sites where the model has been adopted, and provides a summary of Washington's dental workforce and related career pathways.

Overall, the study found:

- Key informants, in general, indicated that training and employing perio EFDAs helped to increase patient access to routine preventive services and allowed dentists, dental hygienists, and dental therapists (where employed) to deliver more services at the top of their scope of practice.
- The literature and interview findings indicate that dental hygienist shortages, prevalent in tribal and IHS clinics, may be mitigated to some extent by employing perio EFDAs.
- Cost reduction and increased clinic efficiency were cited as the primary reasons for clinics to support training and employment of perio EFDAs.
- Clinic informants also reported that training and integrating perio EFDAs into their practice provided staff development opportunities for dental assistants, which supports workforce retention.
- Previous evaluations of IHS alternative dental models, including perio EFDAs, found that clinics employing these models increased the number of services provided, including greater use of services per patient.
- Training courses for perio EFDAs were generally viewed positively by tribal and IHS dental clinic leaders, although availability is limited and waitlists are common. Post-training recertification of perio EFDAs is not enforced by IHS, leading some interviewees to recommend clearer guidance and oversight of recertification.
- Interviewees reported that securing a perio EFDA training spot can be challenging. Increasing the number of training opportunities will require identifying additional IHS dental clinics with the capacity to host trainings and address the ongoing shortage of qualified course instructors.
- The success of perio EFDA training, according to interviewees, often depends on identifying candidate dental assistants who are self-motivated and eager for professional growth.
- Motivations for dental assistants to pursue perio EFDA certification include the potential for higher pay, professional growth, and a desire to contribute more meaningfully to tribal and community oral health needs.
- Interviewees suggested a range of potential training settings for perio EFDAs, including continuing the current in-clinic approach or co-occurring with dentist or dental assistant education and training.
- While dentists are typically supportive of incorporating perio EFDAs into their practices, dental hygienists expressed more mixed reactions to their introduction; supporting perio EFDA use when it allows a clinic to care for their clients more efficiently, and hesitating when employing perio EFDAs shifts a perceived disproportionate share of the most complex cases to the dental hygienist.
- Several interviewees noted that dentists and other clinic staff may benefit from training on how to work effectively with perio EFDAs, although such training is not available at present.

- Because the current IHS training is very compressed, some interviewees suggested additional perio EFDA training may be beneficial to increase students' confidence in their preparation. Revisions to the curriculum and course plan are currently being developed in some locations.

Given the high demand for dental hygienists and dental assistants in Washington state, exploring the use of the perio EFDA model outside of the IHS system, or otherwise adopting perio EFDA roles, may help address dental access gaps. Our study findings suggest, however, that additional study may be needed to determine the feasibility of adding perio EFDAs to Washington's general oral health workforce, including assessing the acceptability of the role among the public and the dental workforce, and identifying options for delivering the necessary training for both perio EFDAs and their supervisors. In addition, ongoing data collection and analysis to track the state's dental workforce and access to oral health care are needed to inform ongoing policy and practice decisions.

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Authors

Natalia V. Oster, PhD, MPH, Research Scientist, Center for Health Workforce Studies, University of Washington
Grace A. Guenther, MPA, Research Scientist, Center for Health Workforce Studies, University of Washington
Paula M. Kett, PhD, MPH, RN, Deputy Director, Center for Health Workforce Studies, University of Washington
Samantha W. Pollack, MHS, Research Scientist, Center for Health Workforce Studies, University of Washington
Susan M. Skillman, MS, Senior Deputy Director, Center for Health Workforce Studies, University of Washington

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University of Washington • School of Medicine
Box 354982 • Seattle WA 98195-4982
phone: (206) 685-0402 • fax: (206) 616-4768
https://familymedicine.uw.edu/chws/

Missouri Oral Preventive Assistant EFDA Pilot Project

FINAL ANALYSIS & REPORT

JANUARY 2026

Guy Deyton, DDS — Principal Investigator
Christine Spinka, PhD — Data Scientist
Clark Oelrichs — Senior Research Specialist

Attachment #7

Contents

Introduction

Pursuant to the provisions of section 332.325, RSMo (Medically underserved populations, Pilot Project), the Missouri Dental Board collaborated with the Office of Dental Health (ODH) within the Missouri Department of Health and Senior Services (DHSS) to create a Pilot Project designed to train and deploy a new oral healthcare worker, an **Oral Preventive Expanded Function Dental Assistant (OPA-EFDA)** to address oral healthcare workforce shortages. As detailed in Section 1 of this report, the workforce shortages were most acute in rural Missouri and in clinics serving Medicaid-eligible patients and had resulted in long waits for appointments and access to care issues.

The OPA-EFDA Pilot Project has three objectives:

1. Assess the treatment outcomes of this new worker, an OPA-EFDA, for healthy and gingivitis patients from a clinical and patient perspective.
2. Determine if OPA-EFDAs can increase clinic capacity and access to care as measured by total services, attended appointments, exams delivered and new patients.
3. Evaluate if incorporating OPA-EFDAs in the dental workforce can enhance access to care for patients with more serious or urgent periodontal needs by allowing hygienists and dentists to reallocate time previously spent on periodontally healthy patients to those with more pressing periodontal requirements.

Executive Summary

- **OPA-EFDAs proposed scope of practice:** Is to assist dental hygienists and dentists in the triage of new patients and the care of healthy and gingivitis patients to create more appointment opportunities, improve access and reduce appointment wait times, especially in rural areas and in clinics that serve Medicaid-eligible patients.
- **OPA-EFDAs are well trained:** During the Pilot Project clinical study, OPAs were supervised and observed delivering care in 1,626 patient visits in 7 clinics. Clinical supervisors were required to evaluate OPA-EFDA performance on 8 scales that mirrored the educational objectives of the OPA-EFDA training curriculum. The average rating for global clinical performance of OPAs by clinical supervisors was 9.6 out of 10, which is interpreted as 'Excellent, strongly exceeds expectations'. A detailed account of OPA-EFDAs performance reviews is available in Section 6: *OPA-EFDA Evaluation of Performance by Clinical Supervisors*.
- **OPA-EFDA patient ratings of care were excellent**: A total of 1,011 patients evaluated the care they received from OPA-EFDAs immediately after treatment. The average patient evaluation score was 9.8 out of 10, which is interpreted as 'Excellent, strongly exceeds expectations.' That compares favorably with a 9.7 average patient evaluation score from

695 patients for care by doctors and hygienists. Further details on the patient evaluation protocol are in Section 5 of this report, and a full account of 290 patient comments are available in the addendum.

- **OPA-EFDA treatment outcomes for healthy and gingivitis patients met or exceeded expectations as evaluated by patients and their supervising dentists**. Details regarding OPA-EFDAs performance are in Section 5 (Patient Evaluation), Section 6 (Performance Evaluations by Clinical Supervisors), and Section 8 (Clinical Outcomes Treating Gingivitis Patients).
- **OPA-EFDAs caused no adverse incidents or complaints**: There were no reported adverse incidents, patient injuries or patient complaints during the 8-month OPA-EFDA Pilot Project study. However, one participant did request a private conversation with the project supervisor without specifying a reason. That call was to thank the state of Missouri for developing the project.[13] Details of that call can be found in Section 7: *In Their Own Words*. Details on the federally certified Institutional Review Board's (IRB)-approved process of defining and reporting adverse incidents are contained in the addendum.
- **OPAs impact on clinic capacity:** The Pilot Project study data did NOT demonstrate a significant increase in clinic capacity or improved access for more serious periodontal patients because the OPA-EFDA Pilot Project design artificially limited the deployment of OPA-EFDAs.
    - Simply put, because this is a Pilot Project, OPA-EFDA applications were limited to existing employees of participating clinics.
    - Those employees already had full-time clinical responsibilities. After their OPA-EFDA training, they only practiced as OPA-EFDAs in segments of time they could be spared from other duties.
    - Across all participating clinics, OPA-EFDAs were only involved in 2.4% of the appointments in their clinics during the study, a small fraction of what they would be involved with as a full-time OPA-EFDAs.
    - A review of dental literature estimates that OPA-EFDAs, assisting hygienists and dentists in treating healthy and gingivitis patients, would be eligible to be involved in between 21%-33% of all clinic appointments [5,6,7,8].
    - Three clinics in the study with the highest deployment levels of OPA-EFDAs averaged a 7.3% deployment rate of the total clinic appointments. Those clinics demonstrated capacity gains and offer a glimpse of the OPA-EFDAs potential contribution to clinic capacity and access improvement. Refer to Sections 10 and 11, for OPA-EFDA impact on clinic capacity and access.

- **A previous study done by Johns Hopkins University for the Indian Health Service demonstrated that periodontal EFDA's increase services delivered by 12.1% and access by 25%.**[9] More details are available in Section 16*: Analyzing and Assimilating Previous Similar Studies*.
- **The Pilot Project solicited feedback from patients, OPA-EFDAs and clinic supervisors regarding OPA-EFDA care. Representative examples are below:**
    - **Patient: "**I enjoyed my visit today. The level of knowledge and professionalism was wonderful. Will Recommend!"
    - **OPA-EFDA**: "Even though it's been a long and sometimes overwhelming journey, it's clear how necessary this role is especially when patients are waiting so long just for basic cleanings. This feels truly groundbreaking for our state, and I'm proud to have been part of something that can make such a meaningful impact."
    - **Clinical Supervisor**: "The OPA-EFDA position has provided care to a significant number of patients who would have had to wait 12 months or longer otherwise … I fully intend to continue to use OPA-EFDA's as a major access to care for the benefit of my patients."

    While we recognize this is a lengthy report, we encourage you to read Section 7: *OPA-EFDA Evaluation – In Their Own Words*, as we believe these firsthand perspectives are essential to provide the real story behind the pilot's success and offer compelling anecdotal evidence of how the OPA-EFDA contributes to safe, effective patient care and improved access. A complete catalog of all patient comments received is available in the addendum.
- This study was approved by an Institutional Review Board certified by the U.S. Department of Health and Human Services Office for Human Research Protections. Refer to ***OPA-EFDA Pilot Project IRB Review and Study Bias Control*** in the addendum for a discussion of implemented IRB recommendations.

Conclusions

Based on the results of the OPA-EFDA Pilot Project study:

- There is a need to address long-standing oral healthcare workforce shortages in specific geographical areas and specific clinical settings in most states. In Missouri, those areas are rural clinics and clinics serving Medicaid-eligible patients.
- OPA-EFDAs are well trained and rated highly by both clinical supervisors and patients.

- OPA-EFDAs practicing in their proposed scope under the direct supervision of dentists and hygienists are a safe addition to the oral healthcare workforce.
- OPA-EFDAs will create more available appointments in dental clinics and significantly improve access to care based on the conclusions of the higher deploying clinics in this study and the Indian Health Service Study on periodontal EFDAs.
- Missouri and other states and territories should consider amending their dental practice acts to allow OPA-EFDAs to contribute to the care of patients under the supervision of dentists and hygienists to help address the prevalent oral healthcare workforce shortages.
- The curriculum developed to train OPA-EFDAs is well constructed with adequate testing and quality assurance and should be considered for approval in Missouri for training OPA-EFDAs and serve as a model for other states and territories.

Report Sections

1. **Reasons for this Pilot Project:** Details the current oral healthcare workforce shortage and resulting access problems in rural areas and Medicaid clinics.
2. **OPA-EFDA Project Design:** Discusses the study design, vetted and approved by Governor Mike Parson, the Missouri Dental Board (MDB) and a federally certified Institutional Review Board (IRB).
3. **OPA-EFDA Curriculum and Training:** Explains curriculum based on the Indian Health Service curriculum for a similar worker that has been successfully deployed since 1977 and has resulted in a 12.5% increase in clinical services.
4. **OPA-EFDA Clinical Study Overview:** Discusses the three objectives of the study.
5. **OPA-EFDA Evaluation of Care by Patients:** Reviews the process of collecting patient evaluations approved by the IRB and the outcomes of the patient evaluations.
6. **OPA-EFDA Evaluation of Performance by Clinical Supervisors:** Discusses performance evaluation of OPA-EFDAs by clinical supervisors to assess adequacy of the OPA-EFDA curriculum and resulting competency of the OPA-EFDAs as observed by their supervisors.
7. **OPA-EFDA Evaluation – In Their Own Words:** Provides direct quotes from patients, OPA-EFDAs, Clinic Supervisors.
8. **Assessment of OPA-EFDA Clinical Outcomes Treating Gingivitis Patients:** Summarizes evaluation of OPA-EFDA care of gingivitis patients, as compared to treatment outcomes for gingivitis patients treated by doctors and hygienists.
9. **Definitions for Clinic Capacity and New Patient Characteristics:** Definitions to further understand assessments in Sections 10 and 11.
10. **Assessment of OPA-EFDA Impact on Clinic Capacity with High Deployment:** Includes case studies of 3 clinics with higher deployment rates (4%-9%), with complete data reports as prescribed by the study protocol. The data demonstrates the promise OPA-EFDAs, including summary analysis and comments from participating clinics.
11. **Assessment of OPA-EFDA Impact on Clinic Capacity with Low-Deployment:** Includes case studies of 4 clinics with lower deployment rates (< 4%), with complete data reports as prescribed by the study protocol. Even when data points trended positively for clinics in this group, analysis could not definitively associate the positive trend with OPA-EFDA contributions.
12. **New Patient Characteristics of Participating Clinics:** Describes the new patient profile for the clinics participating in the OPA-EFDA Pilot Project.

13. **Selection and Characteristics of Participating Clinics:** Describes evaluation criteria to intentionally select a wide range of clinics for the OPA-EFDA Pilot Project.
14. **Obstacles, Solutions, and Limitations of the OPA-EFDA study:** Discusses the three major obstacles in the execution of this Pilot Project.
15. **Confounding Factors and Statistical Analysis:** Discusses confounding factors and secondary outcomes of this study..
16. **Analyzing and Assimilating Similar Studies:** Reviews the findings of the Johns Hopkins University Study of the IHS Perio EFDA-1 with the OPA-EFDA study to draw conclusions.
17. **Study Limitations:** Discusses the three study limitations and how they were addressed.
18. **Conclusions:** Provides summary of oval study conclusions.
19. **References:** Provides summary of citations in this report.
20. **Addendum:** Contains relevant reference documents for this report.

Section 1: Reasons for this Pilot Project

Like all healthcare sectors, the oral healthcare workforce has diminished, and the COVID-19 pandemic exacerbated the decline. The Missouri Office of Dental Health statewide survey of oral healthcare workers and the most recent re-licensure data provided by the Missouri Dental Board indicated an exit of between 1% and 10% of the oral healthcare workforce: 1% administrative staff, 6% dentists, 8% dental hygienists and 10% dental assistants. The survey also indicated that 20% of the workforce is considering retirement in the next 5 years due to age or job stress. *A summary page from Office of Dental Health Workforce Survey Report is included in Addendum for reference*.

The result is significantly understaffed clinics that are operating at 60%-80% of their capacity. The workforce shortages have more severely impacted rural clinics and clinics that serve the Medicaid-eligible population, with wait times for appointments in many Federally Qualified Health Centers of weeks or even months long. The Office of Dental Health used license and permit data to determine where providers are located and where they are needed. *Provider distribution maps by county are included in Addendum for reference*.

The main takeaways are:

- All but a few metropolitan counties have significant oral healthcare workforce shortages. Rural areas are the most severely impacted.
- There is a shortage of dentists and dental hygienists in rural Missouri: 44% of clinics that had an opening for a dental hygienist were unable to fill that opening.
- In 1995 Missouri developed the Expanded Function Dental Assistants (EFDAs) provider category to increase the productive capacity of dental clinics and address access to care issues. EFDAs (dental assistants with additional approved training and permitting) can help dentists with many functions including fillings, crowns, dentures and orthodontics. This program has been extremely successful, increasing productive capacity of clinics by 15%-25% with little or no complaints about quality of care. However, there is no EFDA provider category to assist dentists and hygienists with periodontal care.
- The absence of a periodontal EFDA in areas of workforce shortages severely limit a clinic's ability to intake new patients and maintain existing patients at check-ups because both require periodontal data collection and evaluation.
- Currently the Missouri Dental Board has issued the following number of licenses and permits to oral healthcare providers with Missouri addresses: 2,647 dentist licenses, 3,705 dental hygienist licenses and 7,399 EFDA permits.
- If you refer to the provider distributions maps you will see that EFDAs are distributed more evenly throughout the state, especially in rural areas where hygienists are scarce.

- One logical solution to acute workforce shortages is to create an EFDA to assist dentists and hygienists with periodontal care. This provider role was developed by the U.S. Indian Health Service (IHS) in 1977. More than 1,200 Perio-1 EFDAs have been successfully trained by IHS and deployed in workforce shortage areas where IHS found it difficult to recruit an adequate number of hygienists. A study by Johns Hopkins University comparing IHS clinics using Perio-1 EFDAs with IHS clinics without Perio-1 EFDAs demonstrated Perio-1 EFDAs increased access to dental care by 25% and total services by 12.1%.[9]

Section 2: OPA-EFDA Project Design

One Purpose, Three Phases, Three Objectives

One Purpose: The OPA-EFDA Pilot Project design is focused on addressing one central problem: Poor access to dental care caused by long-standing workforce shortages for patients attending rural clinics and clinics serving Medicaid-eligible patients.

A proposed solution in Missouri is to adopt a program that has been used widely and successfully by the U.S. Indian Health Service: Training and deploying Periodontal Expanded Function Dental Assistants (OPA-EFDA) to help dentists and hygienists see and treat more patients.

Three Phases: The project has 3 phases.

1. **Learning phase**: Consisting of didactic coursework and clinical instruction in a simulated clinical training facility. This phase was executed January 3 – September 27, 2024.
2. **Practice phase**: A closely supervised clinical practicum with structured mentoring. This phase was executed January 3 – February 20,2025.
3. **Clinical study phase:** When OPA-EFDAs deliver care to patients and are evaluated by their supervising clinicians and by patients. This phase was executed March 3 – October 28, 2025.

Three Objectives: The clinical study has 3 objectives.

1. Assess the treatment outcomes of OPA-EFDA from a clinical and patient perspective.
2. Determine if OPA-EFDAs can increase clinic capacity and access to care.
3. Determine if OPA-EFDAs increase access to care for patients with more serious periodontal problems.

This Pilot Project plan was submitted and approved by the Missouri Dental Board, the office of Governor Mike Parson, and then an Institutional Review Board duly registered with the federal Office for Human Research Protections (OHRP). Details follow in Sections 3 through 12.

Section 3: OPA-EFDA Curriculum and Training

January 3 – September 27, 2024

The OPA-EFDA curriculum was conceptually based on the skill set of the Indian Health Service Periodontal EFDA-1 program. It was developed by a committee drawing on 30 years of experience in delivering expanded function dental assisting education in Missouri's extremely successful EFDA program. The OPA-EFDA curriculum was approved by the Missouri Dental Board before instruction began. The following is a synopsis of the curriculum/training program:

1. **Prework (18 hours):**
   The OPA-EFDA candidate completed online didactic training consisting of 11 learning modules prior to the clinical session. Modules use written didactic material, illustrations, photographs, and videos. Intra-module quizzes were strategically placed to ensure comprehension and required satisfactory completion to progress to the next module. Passage of a final exam was required to proceed to the hands-on clinical sessions.

   Modules Include:
   - Introduction: Course Overview (including Infection Control and Positioning)
   - Module 1: Anatomy, Physiology and Morphology
   - Module 2: Periodontal Etiology and Classification
   - Module 3: Armamentarium Identification and Implementation
   - Module 4: Instrument Maintenance and Sterilization
   - Module 5: Oral Hygiene Instructions
   - Module 6: Infection Control and Patient Positioning
   - Module 7: Patient Assessment and Data Collection
   - Module 8: Periodontal Probing – Principles and Techniques
   - Module 9: Supragingival Scaling – Principles and Techniques
   - Module 10: Coronal Polishing – Principles and Techniques
   - Module 11: Placement of Glass Ionomer Sealants, Fluoride Varnish and Silver Diamine Fluoride

2. **Simulated Clinical Lab**
   Hands-On Clinical Sessions (32 hours total, across 4, 8-hour sessions). The OPA-EFDA candidates attended in-person, hands-on clinical training sessions with dentists and/or hygienist trainers. Clinical sessions included lectures and skill development training in simulated dental operatories. Hands-on training and skills performance were completed first on typodonts and then on assistant partners.

3. **Competency Exam**

   OPA-EFDA candidates were required to pass a written exam and a hands-on competency skill test to receive a certificate of course completion from the Missouri Dental Association, an EFDA course provider approved by the Missouri Dental Board. A certificate of satisfactory course completion was a pre-requisite to matriculate to the Clinical Practicum Phase.

4. **OPA-EFDA Clinical Practicum**
   Time Frame: January 3 – February 28, 2025

   The purpose of a clinical practicum is to enable a newly trained OPA-EFDA to gain experience in treating patients and developing their skills in a closely supervised environment. The OPA-EFDA Pilot Project required highly structured evaluation and mentoring (E&M) sessions to be conducted and documented by supervising clinicians. Supervising clinicians were required to block their schedules at least twice a day for a minimum of 10-15 minutes each time to facilitate direct observation of OPA-EFDA performing specific tasks. The clinical supervisors were required to complete an evaluation form that mirrors the task execution skill subset as taught in phase 1. Specific grading criteria are outlined in each form. Specific written recommendations for improvement were required to be annotated for each E&M session. Documentation of passing evaluations on 49 E&M sessions, according to the following schedule, was required for OPA-EFDAs to be eligible to matriculate to the clinical study portion of the project:

   - Periodontal Probing (20)*
   - Supragingival Scaling (20)*
   - Coronal Polishing (3)**
   - Application of Fluoride Varnish/SDF (3)**
   - Application of Glass Ionomer Sealants (3)**

   *Mirrors mentoring requirements of the Indian Health Service Curriculum for Perio EFDA 1 (their version of OPA-EFDA).

   **Represents skills currently within the scope of dental assistants. Three required E&M sessions were included to clearly establish skill set standards for these functions.

Section 4: OPA-EFDA Clinical Study Overview

March 3 – October 28, 2025

Objective 1: Determine if treatment outcomes of OPA-EFDAs for healthy and gingivitis patients meet expectations from a clinical and patient perspective.

Metrics Used:

- Patient Evaluation of OPA-EFDA Care
    - Outcome: Refer to Section 5 for a comprehensive discussion.
- Supervising Clinician's Performance Evaluation of OPA-EFDA Care
    - Outcome: Refer to Section 6 for a comprehensive discussion.
- Assessment of OPA-EFDA Clinical Outcomes Treating Gingivitis Patients
    - Outcome: Refer to Section 8 for a comprehensive discussion.

Objective 2: Determine if OPA-EFDAs can increase clinic capacity and access to care.

Metrics Used:

- Compare clinic capacity data points March-October 2025 (with OPA-EFDA) to same period in 2024 (without OPA-EFDA).
    - Total services value in dollars
    - Number of attended appointments
    - Number of exams delivered
    - Number of new patients

Outcome: Refer to two case study discussions (Sections 10 and 11) for analysis and discussion.

Objective 3: Determine if OPA-EFDAs access to care for patients with more serious periodontal problems.

Metrics Used:

- Compare the aggregate total of the following periodontal service March-October 2025 (with OPA-EFDA) to same period in 2024 (without OPA-EFDA).
    - Number of gross debridement appointments
    - Number of scaling in the presence of gingivitis appointments
    - Number of scaling and root planing appointments
    - Number of periodontal surgery appointments
    - Number of periodontal maintenance appointments
    - Number of periodontal referrals

Outcome: Refer to two case study discussions (Sections 9 and 10) for analysis and discussion.

Section 5: OPA-EFDA Evaluation of Care by Patients

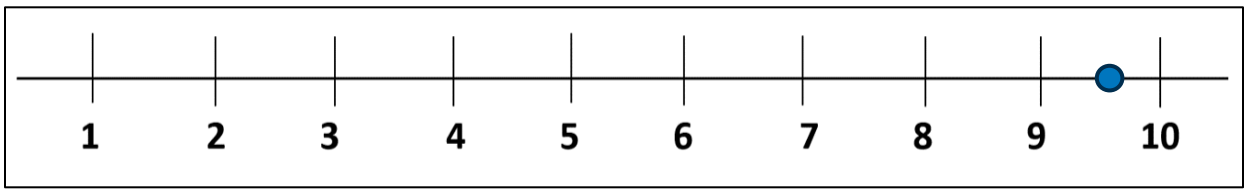
Patient evaluation of OPA-EFDA care of healthy and gingivitis patients was one of the primary endpoints of the study. The patient evaluation of OPA-EFDA care was compared to patient evaluation of care by doctors and hygienists. Both sets of patients were given a Likert Scale (from 1 to 10) patient evaluation instrument at the end of care appointments. Copies of the instruments are

identical, except for the reference to the caregiver, and are contained in the appendix to this report. To minimize bias, protocol was as follows:

- Patients were told in advance that part of the study included them providing a confidential evaluation of the care they received.
    - In 2024, healthy and gingivitis patients consenting to participate in the study were treated by either doctors or hygienists.
    - In 2025, healthy and gingivitis patients consenting to participate in the study were treated by OPA-EFDAs if they were available.
- Immediately after patients received care, they were asked to evaluate their level of satisfaction for the care using a tablet that displayed a Likert Scale (from 1 to 10). They were instructed that 1 was a very low level of satisfaction and 10 was a very high level of satisfaction. They were instructed on how to select their score and record it on the tablet, but not to select it until the staff person left the room.
- Due to published studies indicating that a positive bias may occur if subjects believe their reviews may be read by the service providers, tablets using REDCap data management software were used to collect patient survey data. This enabled patients to submit the review confidentially, with the screen reverting to the homepage after submission. Patients were advised of this in advance.
- It should be noted that two of the eight clinics had difficulty incorporating tablets into their digital environment in the first two months of data collection of the control group (care delivered by doctors and hygienists). In those clinics, paper forms were used initially for two months, and patients were advised to fold the forms and pass them to the receptionist as they exited. This may have increased the risk of positive bias in the collection of reviews of care by doctors and hygienists in those clinics before the technical issues with tablets were resolved. In simpler terms, in two clinics, patient reviews of doctor and hygienist care for the first two months may have been slightly skewed toward a higher, more positive, score.

The results of the patient evaluation of care surveys are as follows:

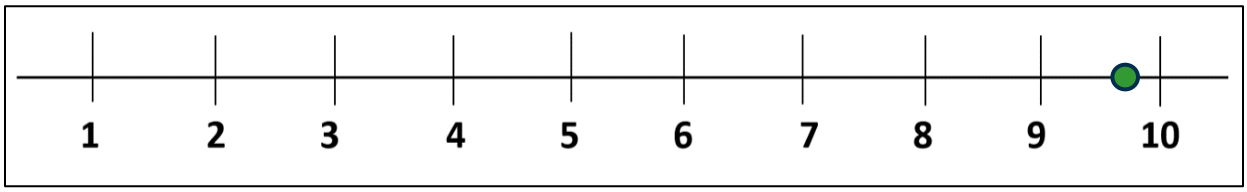
Healthy and Gingivitis Patient Evaluation of Care Provided by <u>Doctors and Hygienists</u>



N= 708

Mean Score: 9.7/10

Healthy and Gingivitis Patient Evaluation of Care Provided by OPA-EFDAs



N= 1,010
Mean Score: 9.8/10

Discussion: A total of 1,718 patients with healthy gums and those with gingivitis rated the care they received in the participating clinics very highly for doctors and hygienists, as well as for OPA-EFDAs. In fact, 1,010 patients rated OPA-EFDA care slightly higher, at 9.8 out of 10, versus a 9.7 out of 10 rating for doctors' and hygienists' care by 708 patients. These are exceedingly lofty ratings, ranking in the "Excellent, strongly exceeds expectations" descriptive category.

Score	Interpretation	Description
10	**Outstanding / Exceptional**	Far exceeds expectations; rare, top-tier performance; role model level.
9	**Excellent**	Strongly exceeds expectations; high-quality and consistent performance.

Refer to the article "Using Likert Scale Evaluations in Performance Assessments and Customer Satisfaction Surveys" in the Addendum for details regarding the use and analysis of Likert evaluations.[1,2,3,4,9]

Section 6: OPA-EFDA Evaluation of Performance by Clinical Supervisors

Performance evaluation of OPA-EFDAs by clinical supervisors was a secondary endpoint of the OPA-EFDA study, intended to assess the adequacy of the OPA-EFDA curriculum in preparing OPA-EFDAs to deliver care and the resulting competency of the OPA-EFDAs as observed by their supervisors in their daily practice.

The study protocol instructed supervisors to evaluate OPA-EFDAs twice during the study: once at approximately the midpoint and once at the conclusion. The evaluation instrument requires supervisors to assess the OPA-EFDAs' performance on eight specific criteria that align with the educational objectives of the OPA-EFDA curriculum, using a Likert Scale with opportunities for comments. The final assessment instrument was distributed to clinical supervisors on October 21, 2025, and returns were requested by October 29, 2025. The instructions were to complete the evaluation candidly. If there were more than one supervisor, the supervisors could collaborate. To

ensure the anonymity of individual OPA-EFDAs, supervisors were instructed to code the evaluation using a number, rather than the OPA's name, before communicating the results. *A copy of the performance review instrument is contained in the Appendix.*

The following is an aggregate summary of the OPA-EFDAs' performance evaluations submitted by their clinical supervisors:

Category: <u>Asepsis Technique and Infection Control</u>

N=15
Mean Score: 9.9/10

Category: <u>Dental Charting & Diagnostic Imaging</u>

N=15
Mean Score: 9.3/10

Category: <u>Periodontal Probing</u>

N=15
Mean Score: 8.9/10

Category: Supragingival Scaling

N=15

Mean Score: 9.3/10

Category: Coronal Polishing

N=15

Mean Score: 10/10

Category: Placement of Sealants & Fluoride

N=15

Mean Score: 9.6/10

Category: Delivery of Oral Hygiene Instructions

N=15

Mean Score: 9.7/10

Category: Global Performance Assessment

N=15

Mean Score: 9.6/10

Discussion: OPA-EFDAs final performance rankings as evaluated by their clinical supervisors ranged between 8 (Exceeds expectations) and 10 (top tier performance) with an average ranking of 9.67 ("Excellent, strongly exceeds expectations"). It is clear their clinical supervisors were very satisfied with their performance.

Score	Interpretation	Description
10	**Outstanding / Exceptional**	Far exceeds expectations; rare, top-tier performance; role model level.
9	**Excellent**	Strongly exceeds expectations; high-quality and consistent performance.
8	**Very Good**	Exceeds expectations; above average; reliable and commendable.

Refer to the article "Using Likert Scale Evaluations in Performance Assessments and Customer Satisfaction Surveys" in the Addendum for details regarding the use and analysis of Likert evaluations.[1,2,3,4,9]

Sampling of Supervisor's comments:

- **Asepsis & Infection Control:** "____ uses standard precautions on all patients. She maintains her equipment using an intricate disinfection/sterilization process with multiple indicators that are tracked and logged. She practices excellent hand hygiene before and after patient care. She wears all appropriate PPEs. She cleans her rooms prior to seating patients and uses all appropriate barriers.
- **Periodontal Probing:** "____ charts accurately and thoroughly. She is always + 1/-1 to my perio charting and very accurate. She records bleeding as necessary with minimal discomfort to the patient."

- **Supragingival Scaling:** "____ is very precise when removing deposits above the gum. She uses the appropriate angulation and instruments when scaling. She knows how to position herself to get appropriate access. She is able to identify fine deposits and understands how to utilize the air/water syringe to reveal spots of calculus that need to be removed."
- **Supragingival Scaling:** "Excellent instrumentation skills. Provides thorough removal of deposits while maintaining patient comfort and efficient time management."
- **Oral Hygiene Instruction**: "Provides clear, engaging education customized to each patient's age and understanding. Reinforces positive behaviors and preventive habits effectively."
- **General Comment**: "____ has been instrumental in increasing access for our patients. She is able to create rapport. Many of the patients she has seen [as an OPA] had very acute needs due to [poor] appointment availability and they were able to get in sooner.
- **General Comment:** "Overall, with the OPA we have been able to see more patients. We have received excellent feedback from the patients."

Section 7: OPA-EFDA Evaluation – In Their Own Words

This section includes direct quotes from patients, OPA-EFDAs and Clinic Supervisors (dentists and hygienists) who participated in the Pilot Project. While the section is lengthy, we believe these firsthand perspectives are essential — they provide the real story behind the pilot's success and offer compelling anecdotal evidence of how the OPA-EFDA contributes to safe, effective patient care and improved access. Patients had the opportunity to submit comments when they filled out their evaluations for treatment.

The evaluations and comments were input on a tablet and sent to the online servers at the State Department of Health, where it was stored until this report was written. The ODH data analyst provided the comments, which are verbatim in this section and in the patient comment section in the addendum. The only exception is patient PB's contribution: that is a reconstructive transcription of a telephone call done immediately afterward. You'll see why.

Patient: "Wonderful! My son has autism; you did great with him. He didn't get upset at all. Thank you so much."

Patient: "I used to come every 3 months and that stopped with the short staffing with hygienists. It was once or twice a year. Now I get to go back to my routine cleaning every 3 months with ____. She is the best!!"

PB (Patient): At the conclusion of her appointment with [KR], an OPA-EFDA, after PB had confidentially evaluated her care, PB told KR she wanted the head of the project to call her and said,

"Give them my phone number." KR obliged, but worried, because everything seemed to go so well. Per the project's adverse event protocol, PB's request was forwarded to Dr. Guy Deyton, the primary investigator, who promptly called PB and asked how he could help. PB responded:

> "I just wanted to talk to the head of this state project to tell you 'thank you!' Thank you and whoever else is involved for starting this project so I don't have to wait so long to have my dental appointments. It got to the point where I was only getting in every year to year-and-a-half because the office I go to lost their hygienist. I've been twice to [KR] and she's great, and I've got another appointment. I just thought somebody ought to know." (Used with PB's permission.)

If you want to read more patient comments, all 290 received are in the ***OPA-EFDA Patient Comments*** in the addendum.

SP (OPA-EFDA): "I think being part of this study has been really important because it highlights just how much our state needs Oral Preventative Assistants … Even though it's been a long and sometimes overwhelming journey, it's clear how necessary this role is especially when patients are waiting so long just for basic cleanings. Having OPAs also helps free up the hygienist's schedule, allowing care to be delivered more efficiently overall. This feels truly groundbreaking for our state, and I'm proud to have been part of something that can make such a meaningful impact."

KH (OPA-EFDA): "I want to express my deepest gratitude for the opportunity to complete Missouri's Oral Preventive Assistant Pilot Program. This experience has been truly transformative for me — not only as a dental assistant, but as someone who cares deeply about the health and dignity of every patient who sits in our chair. Through this program, I have gained skills and knowledge that have strengthened my confidence and expanded my ability to serve. More importantly, it has reaffirmed why I chose this profession in the first place: to make a real difference in people's lives. Being able to provide preventive care, comfort, and education to patients — many of whom have gone far too long without help — has been an incredibly meaningful part of my journey. I am excited and honored to carry this training forward. I am committed to using everything I've learned to support our dentists, uplift our community, and help ensure that every Missourian has access to compassionate, preventive oral care. This program has opened the door to serving patients in a deeper and more impactful way, and I am truly thankful for that opportunity. Thank you for believing in this initiative, and for believing in the dental assistants who step forward to grow, learn, and serve. With sincere appreciation, KH"

OPA-EFDA (Clinic 2): "Being an OPA has only caused positive outcomes for our dental office and that we would love to utilize it even more than we already are. Being an OPA has expanded my abilities and education to provide to our patients on top of all of my other EFDA licenses I am able to do in the office. This has helped gain insight as well to what our hygienists see on the daily and has made it easier to have our hygienists see the cleanings that need their detailed attention compared to a patient who has stayed consistent with their cleanings that I can easily give my full attention to. I

only hope to further use my OPA license to continue getting more patients seen and get everyone back on a 6-month schedule rather than being overdo for cleanings. OPA has been a major benefit for our rural office, and I only see it continuing to soar."

Clinic 5 Supervisor: "As a practicing general dentist in St. Louis, I feel the OPA-EFDA pilot program has been an enormous success in our office. For over two years we have employed only one hygienist as opposed to our usual three due to labor shortage. The OPA-EFDA position has provided care to a significant number of patients who would have had to wait 12 months or longer otherwise. Most importantly, we were able to guarantee our veterans and active military members that they would be seen within a week when needed. I fully intend to continue to use OPA-EFDA's as a major access to care for the benefit of my patients. Without this position, patients will continue to face barriers to seek care and suffer as a result. I see OPA-EFDA's as the best immediate solution to a longer-term problem and look forward to utilizing it for my patients."

Clinic 1 Staff (Joint Statement): "Having an OPA-EFDA in our clinic has made a significant impact on patient access and experience. It allows our clinic to increase availability for patients who need immediate care, most notably those who are losing access to their Medicaid benefits. By integrating this role into our team, we are able to reduce wait times, open up more chair time for providers, and ultimately help more patients receive care when they need it most. What's been especially meaningful is the patient feedback. Many patients who have had negative experiences in the past with dental care have shared how positive, comfortable and respected they've felt with our OPA-EFDA. This role not only expands capacity but helps to build trust and improve overall patient satisfaction."

Clinic 6 Supervisor: "Our office was chosen to participate in the pilot program of the OPA-EFDA. We began with obstacles, but soon found our 2 dental assistants who were ready to help move the hygiene workforce forward in Missouri. Both of our assistants are more than needed in their respective jobs as an office manager and a lead dental assistant. We knew we would have to make adjustments in our clinic workflow. We have been searching to hire a RDH for over 3 years with very little success plus our current RDH already has a 5-6 month waiting list. We want to continue delivering high quality care to our patients and also decrease their wait time. The OPA-EFDA pilot program has decreased our RDH wait time by having our OPA-EFDAs see perio type I patients (lower maintenance/minimum scaling/low health risk) daily to open times for our RDH to tend to their more difficult needs. Our OPA EFDAs have also increased their probing and supra-gingival skills since this pilot program began and their working relationship with our RDH has greatly improved. Our RDH continues to praise this pilot program because she is able to treat our patients that require more of her time and maintenance. We have also been allowed to re-assign many of our younger, healthier adult patients to the OPA EFDAs for treatment. Having an OPA-EFDA has kept our office from allowing patients to fall behind on routine periodontal maintenance and prioritize S & RP much sooner. Would I hire an OPA-EFDA full-time at our practice? Absolutely! The information above is just

a few points on how this has positively impacted our office and allowed us to maintain adequate oral health care to all patients in our practice and help serve more in our area."

Clinic 7 Supervisor: First, I would like to say that each of my OPA's took extreme pride in being able to participate in the study and took the position very seriously. Their clinical skills were exceptional including accuracy of pocket depths, removal of supragingival calculus, and explaining to patients the importance of preventative care. While there is truth in numbers, I would like to share my personal observations from the study. Patient satisfaction was excellent from the skillsets completed by the OPA. The utilization of the OPA in my office, even as a study, showed increased efficiencies to patient visits including more access to care of my non-OPA patients. This efficiency is even with the extra paperwork involved for patients being part of this study. While I continue to look for help having more hygienists in my office, the OPA has helped keep my healthy patients healthy while continuing to treat my entire patient population. While the OPA is helpful, it is not a substitute for a hygienist in the office. I could have 10+ OPAs in my office and I would still be looking for another hygienist. I firmly believe the inclusion of the OPA in statute would benefit Missourians oral health.

Clinic 4 Supervisor: *This final "comment" is a longer, but valuable commentary on the OPA-EFDA, with a structured analysis for ease of reading*.

> **Case Study – Why We Need OPAs:** In 2025, the clinic recorded a 7% increase in examinations delivered and a 1.4% increase in attended appointments compared to the same period in 2024, after adjusting for scheduling and staffing differences. Despite these gains, several key service areas declined:
>
> - Total Clinic Services: −19%
> - New Patients: −7.5%
> - Periodontal Services: −38%
>
> **Drivers of Declining Service Volume:** Clinic leadership attributed these declines primarily to the ongoing shortage of full-time hygienists. Over the past two years, the clinic has been unable to hire a single additional full-time hygienist, leaving the clinic with 35,000+ active patients, 4 full-time doctors, and only 1 full-time hygienist. The unreliable availability of temporary hygienists further limited capacity, requiring doctors to redirect significant time toward providing hygiene services rather than focusing on procedures within the middle and upper ranges of their clinical scope. This shift also resulted in more patients receiving limited, problem-focused care instead of comprehensive care. The clinic attempted to compensate for the hygiene shortage by hiring an additional doctor, which increased doctor days but further reduced the relative availability of hygiene days. As a result, the majority of operations have shifted toward doctor-provided care, and the hygiene department is now largely surviving through the support of Oral Preventive Assistants (OPAs).

Role and Challenges of OPAs: The clinic participated in the OPA pilot with three OPAs, one of whom was lost during the study due to a health issue. None of these OPAs were full-time; they volunteered because they recognized the high need. Given their competing responsibilities, OPAs estimate that they were able to function in the OPA role for only 10% of their total clinic time. To stabilize the workforce, the clinic intends to hire OPAs at scale once fully approved — specifically, two OPAs for every hygienist and one to two OPAs for each doctor. With 16 existing operatories and 18 more opening in January 2026, staffing plans for six doctors and one hygienist call for the hiring of 10 OPAs. Currently, 6-8 full-time hygienist positions remain unfilled, underscoring the depth of the workforce shortage.

Strategic Considerations and Future Direction: The clinic strongly believes in the long-term value of OPAs and plans to pair OPAs with every doctor and hygienist to better serve patients. Doctor-assigned OPAs would focus on providing care to healthy and gingivitis new patients, since all new patients see a doctor first in the clinic, and to existing patients who are past due on doctor's treatment schedule. Hygiene-assigned OPAs would work in tandem with hygienists as a team to increase the capacity of each hygienist and allow hygienist to focus on patients with poor or deteriorating periodontal status. The clinic also notes that competition from suburban areas has accelerated the loss of hygienists from the city, resulting in an even more limited hygiene workforce for the underserved population compared to the broader regional market.

Conclusion: Despite growth in examinations and appointment attendance, the clinic's decreasing hygiene capacity — and the resulting shift toward doctor-centric care — has significantly constrained comprehensive service delivery. Expanding the OPA workforce is viewed as a critical strategy to restore balance, improve access and support both doctors and hygienists in meeting the needs of the clinic's large and diverse patient population.

Section 8: Assessment of OPA-EFDA Clinical Outcomes Treating Gingivitis Patients

Evaluation of OPA-EFDA care of gingivitis patients, as compared to treatment outcomes for gingivitis patients treated by doctors and hygienists, was one of the secondary endpoints of the study.

For any non-dental lay readers of this report, the following definition of gingivitis may be helpful:

Gingivitis is a reversible inflammation of the gums with usual symptoms of redness, swelling, and tendency to bleed easily when eating, toothbrushing, or when gum pockets are measured. It is different than more serious gum infections in that there has been no damage to underlying support of teeth and gingivitis is reversible with a good cleaning and improved home hygiene.[10, 11]

The protocol for developing the comparison was as follows:

- New patients seen in each participating clinic between March and October 2024 and the same period in 2025 were periodontally diagnosed as healthy, gingivitis or periodontitis, using the 2018 American Academy of Periodontologists/European Federation of Periodontology (AAP/EFP) diagnostic protocols.
- To avoid any hint of diagnostic controversy and to make re-evaluation outcomes very clear and easy to assess, we raised the inclusion criteria for treating gingivitis patients in this study to ≥ 30% bleeding points.
- Patients with a diagnosis of gingivitis were provided education about their diagnosis and offered gingivitis therapy consisting of scaling in the presence of gingivitis (that may or may not have been preceded by a general debridement depending on their accumulated plaque), oral hygiene education and a re-evaluation appointment 2-4 weeks after active treatment.
- If patients consenting to participate in the Pilot Project accepted treatment in March – October of 2024, the treatment was provided by either hygienists or dentists (control group). If patients consenting to participate in the Pilot Project accepted treatment in March – October of 2025, treatment was provided by OPA-EFDAs if available (interventional group).
- Re-evaluation used 2018 AAP/EFP diagnostic protocol: health (< 10% bleeding points), localized inflammation (10%-29% bleeding points), or generalized inflammation (≥ 30% bleeding points).
- On re-evaluation, patients with generalized inflammation were deemed NOT to have improved, and healthy patients or those with localized inflammation were deemed to have improved.
- In 2024, there were 30 patients who accepted gingivitis therapy and were treated and re-evaluated either by dentists or hygienists. Upon re-evaluation, 93% were improved.
- In 2025, there were 33 patients who accepted gingivitis therapy and were treated by OPA-EFDAs and re-evaluated by dentists. Upon re-evaluation, 76% were improved.

- All patients who were not improved after gingivitis treatment, in both the control and intervention groups, were assessed by the supervising dentist or hygienist to have poor home oral hygiene.
- Primary investigator's notes:
    - A 70%-90% success rate for localized gingivitis therapy is consistent with published reports in peer-reviewed journals with a reduced rate of success for generalized gingivitis.[17,18]
    - This study only treated generalized gingivitis patients.
    - Several studies cite the quality of patient's oral hygiene subsequent to gingivitis therapy as a significant factor in improvement after therapy.[19,20,21]
    - This gingivitis treatment study did not account for the natural tendency for positive bias when a provider evaluates outcomes of care they personally delivered. Hygienists and dentists re-evaluated their own treatment outcomes. Dentists generally evaluated treatment outcomes of OPA-EFDA care. Two studies indicate the overestimation of treatment effects due to bias can be as much as 29%-36%.[22, 23]

Conclusion: OPA-EFDAs treatment outcomes for gingivitis patients falls within expected clinical standards as described in studies published in peer-reviewed journals.

One important limitation to this study was the inclusion criteria for participating clinics, which required the clinics to accept Medicaid-eligible patients and have at least 20% of their patient population be comprised of Medicaid-eligible patients. Because gingivitis therapy is not a covered benefit for Medicaid patients in Missouri other than pregnant or 1-year post-partum mothers, there was a financial disincentive for patients to accept treatment. Treatment acceptance was poor in that population.

Section 9: Definitions for Clinic Capacity and New Patient Characteristics

To make the clinic assessment summaries more readable (in Sections 10 and 11), an editorial decision was made to provide definitions for these charts in a section rather than replicating them below each clinical chart. The definitions are as follows:

New Patient Characteristics

1. **Health**: absence of inflammation; probing depths (PD) ≤4 mm; bleeding on probing (BOP) ≤10% of sites; no clinical attachment loss (CAL) or Bone Loss (BL).[10]
2. **Gingivitis**: inflammation of the gingiva characterized by erythema, edema, or other visible signs of inflammation; PD ≤4 mm; BOP ≥10% of sites; no CAL or BL.[10]

3. **Periodontitis**: an inflammatory disease of the periodontal attachment apparatus resulting in CAL of two or more non-adjacent teeth not caused by trauma, caries, malpositioned teeth, endodontic lesions, or root fractures.[12]
4. **Adult**: Age ≥ 13 (Missouri Medicaid Definition)
5. **Child**: Age < 13 (Missouri Medicaid Definition)
6. **No Periodontal Dx for NP Problem-Oriented Examinations**: Patients that enter the clinic seeking a diagnosis and emergency or palliative care receive a problem-oriented examination and do not receive a full periodontal exam or a definitive periodontal diagnosis. Therefore, the number of patients with a periodontal diagnosis may not match the number of new patients each month or in cumulative analysis.

Clinic Capacity

1. **Clinic Workdays**: 1 full clinic day = at least 8 hours of patient access for treatment. Increments of less than 8 hours are reported as fractional days.
2. **Doctor Workdays**: 1 full doctor day = at least 8 hours of doctor-patient time availability. 3 doctors working 1 full day = 3 doctor days. Increments of less than 8 hours are reported as fractional days.
3. **Hygiene Workdays**: 1 full hygiene day = at least 8 hours of hygienist-patient time availability. 3 hygienists working 1 full day = 3 hygiene days. Increments of less than 8 hours are reported as fractional days
4. **Total Periodontal Services**: the aggregate number of the following periodontal services performed in each clinic is used in this study to determine the clinic's actual capacity to serve patients with periodontal diagnoses more serious than health: gross debridement, scaling in the presence of gingivitis, scaling and root planing, periodontal surgery, periodontal maintenance, and periodontal referrals.
5. **Expected 2025 Production**: To account for confounding variations of clinic schedules, doctor schedules, and hygienist schedules between 2024 and 2025, Expected 2025 Production calculations were used to compare with actual production to assess the impact of OPA-EFDAs. Expected productivity is calculated by multiplying the 2024 average productivity in each capacity category against the actual days worked in 2025. This calculation was applied for total clinic production, doctor production, hygiene production, number of new patients, number of examinations delivered, and number of periodontal services delivered.

Section 10: Assessment of OPA-EFDA Impact on Capacity in Clinics with Higher Deployment

Case Studies of 3 Clinics with Higher Deployment Rates (4%-9%)

Three with the highest OPA-EFDA deployment rates (4%-9% of total clinic appointments) illustrate the promise OPA-EFDAs. Clinics 2, 5 and 7 averaged a 7.3% deployment rate as a percentage of total appointments. Each demonstrated clinic capacity gains and has a unique story to tell. The next three pages contain all the required clinic capacity data and analysis as it relates to the impact of OPA-EFDAs.

Clinic 7 Description: The majority of patients in this **rural practice** (1 full-time doctor, 2 part-time doctors, 1 hygienist, 4 OPA-EFDA, 9 dental assistants) are Medicaid-eligible. The clinic director states it has been very difficult to recruit hygienists to this rural, predominantly Medicaid clinic. General anesthesia (GA) services have been statistically removed from analysis because OPA-EFDAs cannot contribute to GA procedures.

Clinic Capacity Data

Data Category	√March		√April		√May		√June		√July		August		√September		√October		Cumulative Totals	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024**
Total Clinic Production ($) [1,2]	471000	502596	451999	542891	384169	455700	437885	382893	549449	415553	488061	522714	444050	482573	501,815	484,573	$ 3,728,428	$ 3,789,493
Total Clinic Production (Appts)	807	772	773	846	777	721	719	504	873	390	837	849	790	775	785	765	6361	5622
Total New Patients	142	131	129	139	116	102	142	112	161	106	150	134	104	114	113	92	1057	930
Total Examinations	435	374	308	373	328	354	507	360	555	484	509	566	314	377	408	326	3364	3214
Clinic Workdays	19	18	22	20	22	21	18	17	20	20	21	21	18	19	20	20	160	156
Doctor Workdays	27	31	32	29	26	30	25	20	32	20	29	27	20	25	26	28	217	210
Hygienist Workdays [3]	9	0	9	0	9	0	9	0	11	0	9	0	10	0	5	0	71	0
Total Periodntal Services	35155	35213	31525	33629	28605	27570	33000	23730	41905	32235	34360	36640	31322	27694	40067	34535	275939	251246
Doctor Production [1,2]	450575	502596	434027	542891	366719	455700	420505	382893	524989	415553	469210	522714	426649	482573	484233	484573	3576907	3789493
Hygiene Production	20425	0	17972	0	17450	0	17380	0	24460	0	18851	0	17401	0	17582	0	151521	0
General Anesthsia Revenues [1,2]	79650	107280	86361	82440	24845	117025	46440	144670	66965	74400	100632	87020	54125	85325	65155	86725	$ 524,173	$ 784,885
Total Clinic Production - GA Revenue [2]	391350	395316	365638	460451	359324	338675	391445	238223	482484	341153	387429	435694	389925	397248	436850	397848	$ 3,204,445	$ 3,004,608
Doctor Prod-GA Revenue [2]	370925	395316	347666	460451	341874	338675	374065	238223	458024	341153	368578	435694	372524	397248	419078	397848	$ 3,052,734	$ 3,004,608

Analysis: In March-October 2025, this multi-practitioner, 4 OPA-EFDA, rural clinic serving predominantly Medicaid-eligible patients experienced:

- 10.3% increase in attended appointments.
- 10.8% increase in new patients.
- 7.1% increase in periodontal services delivered.
- 2.1% increase in examinations when compared to the same period in 2024, after adjusting for scheduling and staffing differences.

During this same period, the total amount of services declined slightly (−.4%). When asked about the increase in new patients and new patient services, the clinic director stated that the combination of a hygienist and OPA-EFDAs significantly increased their capacity to see more new patients. In addition, the OPA-EFDA/hygienist team allowed more time to discuss with/educate patients about more serious periodontal problems. The doctor added that treatment acceptance for gum infections in adult Medicaid patients is relatively low because it is only a covered benefit for expectant and 1-year postpartum mothers.

Data Category	Expd. 2025 Prod	2025 Actual (-) Expected	2025 Actual % Difference
Total Clinic Production ($) [1,2]			
Total Clinic Production (Appts)	5766	595	10.3%
Total New Patients	954	103	10.8%
Total Examinations	3296	68	2.1%
Clinic Workdays			
Doctor Workdays			
Hygienist Workdays [3]			
Total Periodntal Services	257688	18251	7.1%
Doctor Production [1,2]			
Hygiene Production	113139	38383	33.9%
General Anesthsia Revenues [1,2]			
Total Clinic Production - GA Revenue [2]	$ 3,217,900	$ (13,455)	-0.4%
Doctor Prod-GA Revenue [2]	$ 3,104,762	$ (52,028)	-1.7%

Clinic 2 Description: This **small, inner-city practice** (1 full-time doctor, 1 part-time doctor, 1 OPA-EFDA, 1 dental assistant) serves many Medicaid-eligible patients. The clinic lost its only hygienist in April 2025 to a suburban clinic that does not take Medicaid patients. In August 2025, the senior doctor took medical leave for a serious health issue that appears to require a practice transition sale. The second doctor and the OPA-EFDA, fully credentialed in additional EFDA functions, have maintained the practice and cared for the patients since August 2025.

Clinic Capacity Data

Data Category	√March		√April		√May		√June		√July		August		September		October		Cumulative Totals	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024
Total Clinic Production ($)	63499	59669	82547	63297.43	53175	53177.19	71960	46166	70123	69015	62808.78	66418	66287	67695	78189.93	61508	548589.7	486945.6
Total Clinic Production (Appts)	291	242	271	287	227	317	266	231	262	297	275	271	115	263	279	278	1986	2186
Total New Patients	31	39	19	26	9	40	15	30	15	43	16	27	15	26	7	14	127	245
Total Examinations	134	111	111	128	90	118	124	94	126	134	100	115	95	109	99	117	879	926
Clinic Workdays	17	16	18	18	16	17	14	12	18	18	12.5	23	15	16	18	18	128.5	138
Doctor Workdays	17	16	26	23	14.5	27.75	14	18	17	38	12.5	28	15	27	18	19	134	196.75
Hygienist Workdays	15	16	0	12	0	12	0	10	0	7	0	8	0	5	0	10	15	80
Total Periodntal Services	38	41	44	39	30	50	52	36	42	46	31	65	44	49	51	58	332	384
Total Doctor Production [2]	40350	39368	68329	52325.44	45643	43649.83	52872	31915	51983	52390	40704	43381	66286	55666	57366.93	41227.68	423533.9	359923
Total Hygiene Production	8130	11029		10972		9527.36		10451		7004		8386		5670.98		9914	8130	72954.72
Total EFDA Production	10269	7736	8106	3384	3626	3916	11137	2599	11026	9036	13305	13532	13596	4048	20823	9163	91888	53414.08

Analysis: The second doctor (who became full time) and the fully credentialed OPA-EFDA, have maintained the practice and cared for the patients from August – October of 2025.

- In 2025, doctor and hygienist treatment time was reduced by 32% and 81% respectively compared to 2024.
- However, dental services delivered to patients actually increased by 12% due to the hard work and dedication of the second doctor and the OPA-EFDA.
- After adjusting for scheduling and staffing differences between 2025 and 2024, this represents a 112% increase in delivered services over expected production.

Data Category	Expd. 2025 Prod	2025 Actual (-) Expected	2025 Actual %Difference
Total Clinic Production ($)	258811	289779	112.0%
Total Clinic Production (Appts)	2036	-50	-2.4%
Total New Patients	228	-101	-44.3%
Total Examinations	862	17	1.9%
Clinic Workdays			
Doctor Workdays			
Hygienist Workdays			
Total Periodntal Services	358	-26	-7.1%
Total Doctor Production [2]	335146	88388	26.4%
Total Hygiene Production	117184	-109054	-93.1%

- The effort to maintain the practice and support existing patients was made at the expense of new patients and periodontal services, which decreased compared to 2024 (−44.3% and −7.1% respectively), accounting for differences in schedule and staffing levels.
- Most importantly, the patients were cared for, and the practice was maintained while the search for a new dentist to take over was underway.
- The clinic is currently aggressively recruiting a new dentist and hygienist. Given the difficulty Medicaid clinics are experiencing in recruiting hygienists, having a trained OPA in this practice was an important factor in maintaining the clinic's viability and patients' access to care due to the medical disability of the doctor.

Clinic 5 Description: This 1-doctor, 1-hygienist **metropolitan clinic** sees a significant number of Medicaid-eligible patients. They state that they have lost two hygienists in the last 3 years to suburban practices that do not serve Medicaid patients. They were having difficulty keeping up with existing patient recall appointments and were not able to serve deploying military personnel and disabled veterans as the supervising doctor intended.

Clinic Capacity Data

Data Category	√March		√April		√May		√June		√July		August		September		October		Cumulative Totals	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024
Total Clinic Production ($)	87711	94400	97045	91486	84318	94517	78111	71090	68235.29	83129	36114	64051	81669	79350	65936	66246	599140	644269
Total Clinic Production (Appts)	287	355	289	307	224	304	264	269	202	238	151	211	268	214	249	250	1934	2148
Total New Patients	21	34	23	12	22	21	18	26	25	13	15	14	50	10	22	24	196	154
Total Examinations	184	232	185	164	150	175	151	177	134	156	71	111	185	164	145	145	1205	1324
Clinic Workdays	17	16	18	18	16	17	17	16	18	18	12	13	17	16	18	18	133	132
Doctor Workdays	16	16	18	14	16	15	15	16	15	15	7	11	16.5	15.5	13	15	116.5	117.5
Hygienist Workdays	17	23	18	21	16	19	16	16	10	18	10.5	13	17	16	18	18	122.5	144
Total Periodntal Services	30	40	41	39	21	22	25	5	14	44	19	25	38	16	23	24	211	215
Doctor Production	59001	66060	66693	64920	58766	71281	50331	51214	47572	61324	19730	50688	48814	58804	36769	45774	387675	470065
Hygiene Production	28710	28339	30353	26566	25552	23236	27780	19877	20664	21806	16384	13363	32720	20546	29168	20472	211330	174205
Military & VA New Patients Serve	15	0	7	7	10	16	3	0	9	0	9	0	28	0	7	9	88	32

Analysis: In March-October 2025, this 1-doctor, 1-hygienist metropolitan clinic experienced a 26.3% increase in new patients when compared to the same period in 2024, after adjusting for scheduling and staffing differences. This significant increase in new patients resulted from an intentional decision to utilize OPA-EFDAs to provide care to deploying military personnel and disabled veterans, a project that had been previously deferred due to difficulty recruiting hygienists. The total services, periodontal services, examinations and attended appointments declined by 2.5%, 2.6%, 9.7% and 10.6% respectively. When asked about the decline in some aspects of care, staff in this small clinic stated that no additional staff were added during the study, and the work of the study itself reduced their patient care time. The clinic decided to utilize OPA-EFDAs to care for backlog of existing patients needed to be seen for continuing care and extend services to deploying military personnel and disabled veterans.

Data Category	Expd. 2025 Prod	2025 Actual (-) Expected	2025 Actual % Difference
Total Clinic Production ($)	614259	-15120	-2.5%
Total Clinic Production (Appts)	2164	-230	-10.6%
Total New Patients	155	41	26.3%
Total Examinations	1334	-129	-9.7%
Clinic Workdays			
Doctor Workdays			
Hygienist Workdays			
Total Periodntal Services	217	-6	-2.6%
Doctor Production	414868	-27193	-6.6%
Hygiene Production	148195	63135	42.6%

New Patient Data Category		Periodontal Analysis 2024+2025 #	%
New Patient Periodontal Diagnosis		165	
	Health [1]	87	52.7%
	Gingivitis [2]	36	21.8%
	Periodontitis [3]	42	25.5%
Age Group:	Adult [4]	237	86.5%
	Child [5]	3	1.1%

Section 11: Assessment of OPA-EFDA Impact on Capacity in Clinics with Low Deployment

Case Studies of 4 Clinics with Lower Deployment Rates (< 4%)

This section contains the complete data reports as prescribed by the study protocol from 4 clinics with the lowest OPA-EFDA deployment percentage. This group demonstrates some capacity data points increased and some capacity data points decreased. When we discussed this as a group, the following reasons were commonly expressed:

- OPAs are new and it takes a while for people to change old habits.
- It took participating clinics a while to understand that they needed to schedule OPA-EFDAs like hygienists: assigning them an operatory and pre-scheduling patients.
- Participation in the study took a considerable amount of time, taking time away from patient care to perform tasks like explaining the study to patients, obtaining additional consents, documenting patient data in 2 software programs and collecting patient treatment evaluations.

In these clinics, with lower deployment rates, the data analyst was not confident we could ascribe positive trends to OPAs even when capacity data points trended positively.

Clinic 1 Description: In August 2024 this **metropolitan clinic** utilized 7 full-time dentists, 2 full-time hygienists, 1 part-time hygienist and 1 OPA-EFDA. In August 2025 that changed to 6 full-time dentists, 1part-time dentist and 5-full time hygienists.

Clinic Capacity Data

Data Category	√March		√April		√May		√June		√July		August		√September		√October		Cumulative Totals	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024**
Total Clinic Production ($)	702314	522912	767598	599851	703257	569091	611771	520595	736368	661550	684626	759552	573263	646576	710822	816944	5490019	5097071
Total Clinic Production (Appts)	1237	1107	1359	1247	1236	1178	1162	1089	1369	1334	1294	1473	1153	1271	1363	1521	10173	10220
Total New Patients	197	213	228	248	195	233	188	182	204	160	197	258	171	179	204	225	1584	1698
Total Examinations	532	456	595	518	595	453	521	404	534	508	501	570	469	467	532	569	4279	3945
Clinic Workdays	21	21	22	22	21	21	20.5	19.5	22	22	21	22	20	20	23	23	170.5	170.5
Doctor Workdays	98.5	108.5	88	128	90	93	86.5	86.5	103.5	120	96.5	126.5	96.5	99.5	131	109.5	790.5	871.5
Hygienist Workdays*	84	37	77	22	75.5	23	70	21.5	74.5	85	73.5	86	60	66	76	90.5	590.5	431
Total Periodontal Services	144	79	164	55	130	75	160	91	164	129	151	145	136	107	145	155	1194	836
Doctor Production	610487	491151	672724	571739	623685	528737	529904	474534	647046	586923	594569	675454	499697	580586	634343	730793	4812455	4639917
Hygiene Production	91827	31761	94874	28112	79572	40354	81867	46061	89322	74627	90057	84098	73566	65990	76479	86151	677564	457154

Analysis: In March-October 2025, this multi-practitioner metropolitan clinic experienced a 13,5% increase in clinic services, an 8.5% increase in examinations, and a 42.8% increase in periodontal services delivered when compared to the same period in 2024 after adjusting for scheduling and staffing differences. The number of attended appointments, and new patients declined by .5% and 6.7% respectively. When questioned about the changes in capacity indicators, both positive and negative, staff suggested the increase in examinations and periodontal services could have been due to collaboration between the OPA-EFDA and hygienist. They also indicated that the decline in new patients and slight decline in attended appointments could possibly be due to the participation in the study. Tasks like obtaining additional consents, documenting patient data in 2 software programs, and collecting treatment evaluations took time and took time away from patient care. Staff also indicated they focused their OPA-EFDA's efforts first on resolving a backlog of patients needing continuing care. After consulting the data analyst, OPA-EFDAs appeared to help this clinic increase patient access, but because the overall deployment rate was less than 4%, analysts could not confidently attribute the increased capacity solely to OPA-EFDAs.

Data Category	Expd. 2025 Prod	2025 Actual (-) Expected	2025 Actual % Difference
Total Clinic Production ($)	4835001	655018	13.5%
Total Clinic Production (Appts)	10220	-47	-0.5%
Total New Patients	1698	-114	-6.7%
Total Examinations	3945	334	8.5%
Clinic Workdays			
Doctor Workdays			
Hygienist Workdays*			
Total Periodontal Services	836	358	42.8%
Doctor Production	21512342	-16699887	-77.6%
Hygiene Production	626333	51231	8.2%

New Patient Data Category		Periodontal Analysis 2024+2025 #	%
New Patient Periodontal Diagnosis [6]		2101	
	Health [1]	376	17.9%
	Gingivitis [2]	715	34.0%
	Periodontitis [3]	1010	48.1%
Age Group:	Adult [4]	2090	99.5%
	Child [5]	11	0.5%

Clinic 3 Description: This 4-doctor, 6-hygienist, 4 OPA-EFDA, 20-dental assistant **rural clinic** cares for a large Medicaid-eligible population (34% of their patients). They aggressively recruit hygienists but struggle to keep up with re-care.

Clinic Capacity Data

Data Category	√March		√April		√May		√June		√July		August		√September		√October		Cumulative Totals	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024**
Total Clinic Production ($)	740308	744171	839505	782284	686272	720196	710579.03	756207.92	786957	601128	686124	788651	682170	731101	749345	793686	5881260.03	5917425
Total Clinic Production (Appts)	2678	2278	2290	2283	3640	2092	2454	2281	2569	2222	2315	2112	2159	2636	2589	1521	20694	17425
Total New Patients	174	188	187	184	144	149	214	188	174	224	158	216	142	143	184	225	1377	1517
Total Examinations	886	1029	930	1080	888	988	1173	825	1132	937	1081	1145	895	1215	1240	569	8225	7788
Clinic Workdays	19	18.5	20	21	18.5	19.5	19.5	17.5	20.5	19.5	18.5	19.5	19	19	20.5	23	155.5	157.5
Doctor Workdays	76	91	118	98	90	96	94	86	75	70	65	68	64	72	74	109.5	656	690.5
Hygienist Workdays*	130	126	141	136	129	141	132	122	100	87	95	82	87	101	102	90.5	916	885.5
Total Periodntal Services	134	176	162	170	138	160	98	156	102	130	79	141	109	125	64	155	886	1213
Doctor Production	594939	579995	687968	611685	531423	561894	612501	599206	625335	496545	570052	573540	557311	553122	610529	682070	4790058	4658057
Hygiene Production	145369	164176	151537	170599	154849	158302	98077.91	157002	161622	104583	116072	215111	124859	177979	138816	111616	1091202	1259368

Analysis: In March-October 2025, this multi-practitioner rural clinic experienced a 2.7% increase in clinic services, a 20.3% increase in attended appointments and 7% increase in examinations delivered compared to the same period in 2024, after adjusting for scheduling and staffing differences. New patients and periodontal services delivered declined by 8.1% and 26% respectively in 2025 compared to the same period in 2024, after adjusting for differences in scheduling and staffing. When questioned about the decrease in periodontal services, staff suggested that there was a preference to relieve the backlog of re-care appointments for existing patients rather than focusing on new patients. Primary investigator's note: It is quite possible that the increase in attended appointments and exams delivered was a direct result of the addition of 4 OPA-EFDAs because OPAs contributed to 375 patient visits over the 8 months of the clinical study and in this clinic OPAs were focused primarily on serving recall patients. Because 375 visits were less that the 4% (of total visits) minimum threshold, we could not confidently ascribe the capacity increase to OPAs with a high level of confidence.

Data Category	Expd. 2025 Prod	2025 Actual (-) Expected	2025 Actual % Difference
Total Clinic Production ($)	5728068	153192	2.7%
Total Clinic Production (Appts)	17204	3490	20.3%
Total New Patients	1498	-121	-8.1%
Total Examinations	7689	536	7.0%
Clinic Workdays			
Doctor Workdays			
Hygienist Workdays*			
Total Periodntal Services	1198	-312	-26.0%
Doctor Production	4598907	191151	4.2%
Hygiene Production	221154	870048	393.4%

New Patient Data Category		2025 Totals #	2025 Totals %	2024 Totals #	2024 Totals %
tient Periodontal Diagnosis [6]		388		439	
Health [1]		289	84%	362	82.5%
Gingivitis [2]		12	3%	20	4.6%
Periodontitis [3]		43	13%	57	13.0%
Age Group:	Adult [4]	196	59%	278	63.3%
	Child [5]	134	41%	161	36.7%

Clinic 4 Description: This **urban clinic** (4 full-time doctors, 1 full-time hygienist, 3 part-time temporary hygienists, 3 OPA-EFDA, 16 dental assistants) sees 80%-90% Medicaid-eligible patients. They state they have great difficulty recruiting hygienists competing with suburban clinics that do not see Medicaid patients, and their temporary part-time hygienists cannot be scheduled dependably due to a high demand for temporary dental hygienist services.

Clinic Capacity Data

Data Category	March		April		May		June		July		August		September		October		Cumulative Totals	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024**
Total Clinic Production ($)	$1,106,046	$1,071,700	$1,213,395	$1,216,857	$1,167,174	$ 987,322	$1,114,660	$1,044,869	$1,207,878	$1,175,219	$1,024,760	$1,092,766	$ 937,438	$1,202,274	$ 920,059	$1,430,242	$8,691,411	$9,221,248
Total Clinic Production (Appts)	2,682	2,571	2,914	2,798	2,501	2,281	1,756	1,677	1,943	1,849	1,798	1,754	1825	1828	2118	2434	17537	17192
Total New Patients	297	371	338	351	307	288	305	302	363	354	341	388	329	377	403	452	2683	2883
Total Examinations	2,811	3,000	2,916	3,198	2,946	2,535	2959	2749	3,040	3,154	4,746	4982	1825	1475	1643	946	22886	22039
Clinic Workdays	21	21	22	22	21	20	20	19	22	22	21	22	22	21	21	22	170	169
Doctor Workdays	62	51	67	55	66	44	62	47	65	56	62	55	55	56	72	73	511	437
Hygienist Workdays*	26	37	32	33	27	22	62	47	32	23	17	15	16	16	30	30	242	223
Total Periodntal Services	113	114	89	112	81	101	46	173	66	156	227	337	166	357	189	221	977	1571
Doctor Production	$1,049,379	$1,005,153	$1,164,536	$1,153,434	$1,112,866	$930,263	$1,061,706	$964,594	$1,156,991	$1,089,114	$976,219	$1,029,975	$891,885	$1,138,627	$878,663	$1,330,614	$8,292,244	$8,641,773
Hygiene Production	$56,667	$66,547	$48,860	$63,423	$54,308	$56,959	$52,955	$80,275	$50,877	$86,105	$48,541	$64,791	$45,553	$63,647	$41,396	$99,628	$399,157	$581,374

Analysis: This multi-practitioner inner city clinic struggled with implementation of OPA-EFDAs in the first half of the study due to workforce shortage. They aspire to 5-8 hygienists each paired with an OPA-EFDA. In March-October 2025, the clinic experienced a 1.4% increase in clinic services, a 3.2% increase in examination delivered compared to the same period after adjusting for scheduling and staffing differences. Total clinic services, new patients and periodontal services declined by 19%, 7.5%, and 38% respectively. When questioned about the decrease in the latter three services, staff suggested that difficulty in recruiting full-time hygienists and the unreliable availability of temporary hygienists were the primary reasons, resulting in doctors having to provide dental hygiene services rather than procedures in the middle and top of their scope of practice. They also contributed that no OPA-EFDAs in this pilot are full-time: current staff volunteered because they felt the need was great. Because OPA-EFDAs in their clinic have many other responsibilities, they estimate they only operated as OPA-EFDAs 10% of their clinic time. Once OPA-EFDAs are approved, they stated they would hire and train an OPA-EFDA to work with every hygienist. See clinic 4 supervisor's comments in Section 7: '*In Our Own Words*'.

Data Category	Expd. 2025 Prod	2025 Actual (-) Expected	2025 Actual % Difference
Total Clinic Production ($)	10736048	-2044637	-19.0%
Total Clinic Production (Appts)	17294	243	1.4%
Total New Patients	2900	-217	-7.5%
Total Examinations	22169	717	3.2%
Clinic Workdays			
Doctor Workdays			
Hygienist Workdays*			
Total Periodntal Services	1580	-603	-38.2%
Doctor Production	8692908	-400664	-4.6%
Hygiene Production	443200	-44043	-9.9%

Clinic 6 Description: This 3-doctor, 1-hygienist, 2-OPA-EFDA, 2-dental assistant **metropolitan clinic** serves a significant number of Medicaid-eligible patients. They report increasing difficulty recruiting hygienists, competing with clinics that do not serve Medicaid patients. They need help providing continuing care for existing patients and providing new patient appointments.

Clinic Capacity Data

Data Category	√March		√April		√May		√June		√July		August		√September		√October		Cumulative Totals	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024**
Total Clinic Production ($)	259341	234876	261461	229980	187525	233513	190170	160323	215431	217627	196472	208026	211457	186515	229,743	236,808	1751600	1707668
Total Clinic Production (Appts)	670	662	642	666	486	619	518	494	570	610	501	571	516	544	590	614	4493	4780
Total New Patients	45	56	33	42	28	53	62	51	76	74	36	37	19	22	33	37	332	372
Total Examinations	414	373	389	363	300	355	312	330	331	348	290	348	324	301	370	389	2730	2807
Clinic Workdays	17.4	16.5	20	20	20	21	20	19	21	20	17.5	18	21	18	22	22	159	155
Doctor Workdays	50.4	48.5	55	56	43	52	40	33	54	55	46	52	42	46	48	49	378	392
Hygienist Workdays*	17.4	16.5	40	26.5	25	22	29	25	25	23	21	18	23	25	26	27	206	183
Total Periodntal Services	19	30	28	34	20	36	36	25	31	22	36	13	25	12	37	20	232	192
Doctor Production	201983.07	188158.7	193772	182921	132493	191414	124062	128902	173237	182153	153425	179038	159908	148186	203916.23	194819	1342796	1395592
Hygiene Production	57357.85	46717.3	67,689	47059	55,032	42099	66108	31421	42194	35474	43047	28988	51549	38329	25826.7	41,989	408804	312076

Analysis: In March-October 2025, this multi-practitioner metropolitan clinic experienced a 3% increase in clinic services provided, and periodontal services increased by 17.5% compared to the same period in 2024 after adjusting for scheduling and staffing differences. During the OPA study, this clinic focused on reducing the backlog of existing patients who needed re-care appointments. During the study, the number of attended appointments, new patients and examinations declined by 8.6%, 13.2% and 5.4% respectively. Periodontal services delivered declined by 8.1% in 2025 compared to the same period in 2024, after adjusting for differences in scheduling and staffing. When questioned about the decline in some clinic capacity statistics, staff suggested that there was a preference to relieve the backlog of re-care appointments for existing patients rather than focusing on new patients. They also pointed out that the two staff who trained/received OPA-EFDA certification had full-time responsibilities in addition to their efforts to participate in the pilot, which significantly limited their time to practice as OPA-EFDAs. In addition, they stated that the study itself consumed clinic time away from patient care, requiring extra informed consents, formal evaluations from every OPA patient, and inputting data into the specialized software used in the study. The clinic supervisor volunteered that both patients and staff were very happy with OPA-EFDA training and care and would certainly hire one or more FT OPAs when they are approved. See clinic 6 supervisor's comment in Section 7: *In Their Own Words*

Data Category	Expd. 2025 Prod	2025 Actual (-) Expected	2025 Actual % Difference
Total Clinic Production ($)	1700875	50725	3.0%
Total Clinic Production (Appts)	4916	-423	-8.6%
Total New Patients	383	-51	-13.2%
Total Examinations	2887	-157	-5.4%
Clinic Workdays			
Doctor Workdays			
Hygienist Workdays*			
Total Periodntal Services	197	35	17.5%
Doctor Production	1435337	-92540	-6.4%
Hygiene Production	270978	137826	50.9%

New Patient Data Category		Periodontal Analysis 2024+2025 #	%
tient Periodontal Diagnosis [6]		97	
Health [1]		44	45.4%
Gingivitis [2]		35	36.1%
Periodontitis [3]		18	18.6%
Age Group:	Adult [4]	78	80.4%
	Child [5]	19	19.6%

Section 12: New Patient Characteristics of Participating Clinics

The study protocol reviewed and approved by the Institutional Review Board requires the OPA-EFDA Pilot Project to describe the new patient profile for the clinics participating in the Pilot Project. The following is a description of the age and periodontal diagnostic classification of new patients based on reports of 5 of 7 participating clinics. See Section 14: *Obstacles and Solutions During the OPA-EFDA Study.*

- **Age Characteristics of New Patients** in Clinics Participating in the OPA-EFDA Pilot Project:
    - 10.4% are classified as children using the Missouri Medicaid definition of less than 13 years old.
    - 89.6% are classified as-adult using the Missouri Medicaid definition: 13 years or older.

- **Periodontal Diagnostic Classification of New Patients** in Clinics Participating in the OPA-EFDA Pilot Project:
    - 47.7% - Healthy
    - 36.6% - Gingivitis
    - 14.7% - Periodontitis

- **Periodontal Classification of OPA-EFDA Patients** in Clinics Participating in the OPA-EFDA Pilot Project:
    - 61.8% - Healthy
    - 38.2% - Gingivitis

Section 13: Selection and Characteristics of Participating Clinics

The selection of the clinics participating in the OPA-EFDA Pilot Project was managed by a selection committee comprised of then current director of the Office of Dental Health, Dr. Jackie Miller, a Past Director of the Missouri Office of Dental Health, Dr. John Dane, and a retired Community Health Professor at UMKC Dental School, Dr. Michael McCunniff. Clinics were invited to apply by the publication of a detailed Request for Applications (RFA). Interested clinics submitted written applications answering detailed eligibility requirement questions. The applications were reviewed by the committee using the evaluation criteria below:

1. **Dental Hygiene Shortage Areas**: Only clinics located in areas with significant dental hygienist workforce shortages were eligible for participation.
2. **Dental Medicaid Clinic**: Only clinics that were currently enrolled in the Dental Medicaid Program and actively serving the Medicaid population were eligible. In a 2022 workforce

survey conducted by the Office of Dental Health, clinics serving Medicaid patients and those in rural areas were most severely impacted by oral healthcare workforce shortages.

3. **Adequate Clinic Site Infrastructure**: The site infrastructure and staffing were evaluated to ensure they were adequately equipped and staffed to collect and report the clinical data associated with the OPA-EFDA clinical study, assessing the impact on access and quality of care.
4. **Geographic and organizational diversity**: The committee attempted to select clinics that represented diverse profiles (rural vs. urban; single doctor vs. multi doctor; with existing hygienists vs. without) to assess how an OPA-EFDA will perform in various settings.
5. **Absence of History of Disciplinary Action**: The names of all applicants who passed the first level of committee review were forwarded to Missouri Dental Board Executive Director, Brain Barnett to ensure there was no history of disciplinary action attached to the licenses of the clinical providers.

After provisional selection, the clinic names and locations were submitted to Governor Mike Parson's office for review and approval.

The following is a roster of clinics participating in the OPA-EFDA Pilot Project:

Participating Clinic	Location	Rural	Metro	Urban	# Drs	# Hygienists	# OPA-EFDA	# Non OPA-EFDA Assistants
Clinic 1(C)	Mid-Missouri		√		9	5	1	20
Clinic 2 (H)	Eastern Inner City			√	1	1	1	1
Clinic 3 (M)	Northwest Missouri	√			7	7	4	13
Clinic 4 (PL)	Eastern Inner City			√	4	1 FT; 3 PT	3	16
Clinic 5 (P)	Eastern Missouri		√		1	1	1	0
Clinic 6 (SV)	Western Missouri		√		3	1	2	2
Clinic 7 (W)	South Central Missouri	√			1FT; 2 PT	1	4	9
Clinic W (E)*	Eastern Missouri		√		4	5	1	4

*Clinic W withdrew after the OPA-EFDA clinical trial began. Their only OPA-EFDA left their employ to work in a dental lab, reportedly for a higher compensation package.

OPA EFDA Candidate Recruitment: This was limited to existing employees of participating clinics because of the nature of a Pilot Project evaluating the role of a proposed healthcare provider. Although ideal to have tested full-time OPA-EFDAs, it would have been unfair to the participating clinics to require adding one or more full-time staff, put the new employee through OPA-EFDA training and employing them for 1 year, with no certainty they would be able to practice as an OPA-

EFDA when the Pilot Project concluded. Therefore, recruitment was limited to existing employee dental assistants who had passed all the pre-requisites established by the Missouri Dental Board to be eligible to take Expanded Function training courses. That was accomplished by publishing a memorandum of understanding (MOU) to eligible employees of participating clinics, detailing their opportunity for an expanded scope of practice, educational commitments, and role in the OPA-EFDA clinical study. All OPA-EFDA candidates signed the OPA-EFDA MOU.

Section 14: Obstacles and Solutions During the OPA-EFDA Study

There have been **three major obstacles** in the execution of this Pilot Project. For each, data analysts were consulted, and we were advised to make notes of the circumstance, and they would consider the implications as the examined the data.

Problem 1: *2-Factor Database Searches*. Some data was much more difficult to obtain than originally envisioned. Specifically, data search of patient's electronic records using two-factor search was not possible with any of the practice management software utilized by participating clinics.

- Examples of planned 2 factor searches
    - New Patients + Age < 13
    - New Patients + Age ≥ 13
    - New Patients + Dx Health
    - New Patients + Dx Gingivitis
    - New Patients + Dx Periodontitis

Problem 1 Solution: Manual Chart Audits. Very time-consuming, but the only alternative.

Problem 2: *Software Platform Switch in Mid Project*. Two clinics switched practice management software at the end of 2024. That resulted in the control group data on one software platform and the interventional group data on a second software platform.

Problem 2 Solution: Heroic diligence and flexibility and persistence on the part of administrators in both clinics allowed them to provide the needed data.

Problem 3: *Medical Leave and Employment Change*. Two OPA-EFDAs and one doctor had medical leaves ranging from 1 month to 3 months. 1 OPA-EFDA left a participating clinic to work in a dental laboratory.

Problem 3 Solution: Pray for health and recovery and consult data analysts. Two individuals recovered and returned to work. One is still managing their situation.

Section 15: Confounding Factors and Statistical Analysis

Ronald Coase, Nobel-winning economist, once defined statistics as the art of torturing numbers until they confess – in strange tongues. This section will alternate between the data analysts explaining in their own language the relationships they found in the pilot project data and an attempt to explain what they said in plain English.

Primary Outcome

Data Analyst: One primary endpoint of this study was to evaluate the outcomes of OPA-EFDA treatment from a patient's perspective compared to patient's evaluation of treatment performed by doctor's and hygienists. The sample mean Likert scores for these groups were 9.69 and 9.77 for the dentist/hygienist group and the OPA group, respectively. The null hypothesis – that mean satisfaction scores for an OPA are lower than those for dentist/hygienist – was assessed using a two-sample t-test with an assumption of equal variance for the two groups.

This null hypothesis was rejected with a p-value of p=0.0021, and strong evidence was found that mean satisfaction scores for the OPAs is as good as that for the dentist/hygienist group. As the assumption of normality is not satisfied for this data, the null hypothesis was also assessed using a permutation test with a total of 10,000 simulated permutations; the test yielded a p-value of p=0.0023, again providing strong evidence that mean satisfaction scores for the OPA group are as good as those for the dentist/hygienist group.

One limitation of this study and associated analysis is the confounding of the group effect with the effect of time (2024 vs 2025). However, because no major changes in care delivery occurred during this period at the practices in this study, it seems reasonable to believe that the effects seen are due to the group and not the changing of the calendar.

Plain English: The data demonstrates that patients regard care provided by OPA-EFDAs to be equivalent, or slightly better, than care provided by doctors and hygienists.

A second primary endpoint of this study was to evaluate the clinical performance of OPA-EFDAs using Likert-style performance evaluations by supervising clinicians and by comparing outcomes for gingivitis therapy by doctors and hygienists (control group) to OPA-EFDA treatment (interventional group).

The performance evaluations of OPAs, like the patient evaluations of care, are very high, indicating clinical supervisors are quite satisfied with OPA-EFDA clinical outcomes. Because there is no comparison group, statistical analysis is not necessary, except to say it would be unlikely that a comparison group of clinicians would obtain aggregate performance ratings that were meaningfully higher than OPA-EFDAs.

The gingivitis therapy outcome comparisons demonstrate that treatment outcomes for OPA-EFDAs are similar to treatment outcomes by doctors and hygienists. 93% of gingivitis patients

treated by doctors and hygienists improved. 76% of patients treated by OPA-EFDAs improved. Of the nearly 200 patients who were diagnosed with gingivitis, only 66 total patients accepted treatment and returned for revaluation gingivitis. This was primarily due to low acceptance rate for gingivitis therapy because it is not a covered benefit. The best reporting method in small to moderate sample sizes is a direct report of outcomes.

Secondary Outcomes and Accounting for Confounding Factors

A secondary outcome of this study was to determine if OPA-EFDAs could contribute to an increased clinic capacity thereby improving access to care. Raw analysis of data indicated that impact of OPA-EFDAs on clinic capacity was related to the deployment of OPA-EFDAs expressed as a percentage of total clinic appointments after confounding factors were accounted. In deployments of less than 4% of total clinic appointments, the impact on clinic capacity was quite variable with some positive and some negative results. In a subset of higher deploying clinics, 4%-9% of total clinic appointments, there was increased evidence of positive impact on clinic capacity after confounding factors were accounted, best described in case study presentations.

Confounding Factors

A confounding factor in a scientific study is a variable that distorts or hides the relationship between two things you are trying to understand, like OPA-EFDAs and increased clinic capacity.

The following data points were used to assess clinic capacity:

- Total monthly clinic services ($)
- Total monthly clinic appointments attended
- Total monthly new patients
- Total monthly patient examinations delivered

After analyzing the moth-to-month differences in 2025 data when compared to 2024 data, the following circumstances were deemed to be confounding factors that needed to be statistically accounted for to gain a clearer picture of the impact of OPA-EFDAs:

- Clinic schedules sometimes varied.
- Staffing of doctors sometimes varied.
- Staffing of hygienists sometimes varied.
- In clinics that offered general anesthesia (GA) services, the month-to-month revenues for those procedures fluctuated widely independent of the presence of OPA-EFDAs. The fluctuations of GA procedures and revenues were considered a confounding factor.

Expected Productivity as a Method to Minimize Confounding Factors: When comparing data for specific months of 2025 compared to the same month of 2024, the following methods were used to account for confounding factors to gain a clearer understanding of the impact of OPA-EFDAs on clinic capacity.

Expected Clinic Capacity: To minimize the risk of mistakenly attributing changes in clinic capacity data points to OPA-EFDA contributions, expected clinic capacity values were computed to reflect differences in the number of scheduled clinic days, doctor days and hygienist days for each month in 2025 compared to 2024. This was accomplished by using the 2024 average productivity data values for each unique clinic to adjust for the differences in scheduling and staffing between individual months in 2025 compared to 2024.

- **Tracked Clinic Data:** The following data was tracked for the months of March through October in 2024 and 2025 for each unique clinic:
    - Total Clinic Services ($)
    - Total Number of Appointments Attended
    - Total Doctor Services Provided ($)
    - Total Hygienist Services Provided ($)
    - Number of New Patients
    - Number of clinic days* of operation per month
    - Number of doctor days** contributed per month
    - Number of hygienist days*** contributed per month

    *Clinic days: 1 full clinic day = at least 8 hours of patient access for treatment. Increments of less than 8 hours are reported as fractional days.

    **Doctor days: 1 full doctor day = at least 8 hours of doctor-patient time availability. 3 doctors working 1 full day = 3 doctor days. Increments of less than 8 hours are reported as fractional days.

    ***Hygiene days: 1 full hygiene day = at least 8 hours of hygienist-patient time availability. 3 hygienists working 1 full day = 3 hygiene days. Increments of less than 8 hours are reported as fractional days.

- **Average Productivity Per Day Data**: To account for changes in clinic schedules, doctor staffing levels, and hygienist staffing levels, average values for the following data points for each unique clinic were derived from their 2024 practice data:
    - Average doctor production/doctor day
    - Average hygienist production/hygiene day
    - Average number of new patients/clinic day
    - Average number of appointments/clinic day
    - Average number of examinations/clinic day

- **Expected Productivity Computation:** Expected productivity values for 2025 were calculated for each unique clinic by multiplying the 2024 average productivity values and the respective clinic days, doctor days, and hygiene days. For example, calculations for the expected monthly productivity data for the month of March 2025 would be:

    - **Expected 2025 March Doctor Production** =
      (March 2025 # of Doctor Days) x (2024 Average Doctor Production / doctor day)

- **Expected 2025 March Hygiene Production** =
  (March 2025 # of Hygiene Days) x 2024 Average Hygiene Production / hygiene day)
- **Expected 2025 March Total Office Production** =
  (March 2025 Expected Doctor Production) + (March 2025 Expected Hygiene Production)
- **Expected 2025 March New Patients** =
  (March 2025 # of Clinic Days) x (2024 Average New Patients / Clinic Day)
- **Expected 2025 March Total Appointments** =
  (March 2025 # of Clinic Days) x (2024 Average Appointments / Clinic Day)
- **Expected 2025 March Examinations** =
  March 2025 # of Clinic Days x 2024 Average Examinations / Clinic Day

- **General Anesthesia Services:** One clinic provided a significant amount of general anesthesia services for patients. GA revenues sometimes accounted for a significant portion of this clinic's monthly revenues: ranging from a low of 5.5% to a high of 38% of total monthly revenues during the study period. Wide fluctuations in GA revenues were observed in both 2024, prior to OPA-EFDAs, and in 2025 when OPA-EFDAs were contributing to care. Assisting in GA requires special training and credentialling beyond OPA-EFDA training and credentialling. Because OPA-EFDAs could not participate in GA procedures and because the fluctuations associated with GA obfuscated OPA-EFDA impact, it was decided to consider this clinic's revenues as a capacity metric after extracting GA revenues for both 2024 and 2025.

- **Actual 2025 Productivity compared with Expected Productivity.** To glean the impact of OPA-EFDAs on clinic capacity the actual 2025 clinic productivity was compared with the expected 2025 clinic productivity once the identified confounding factors were statistically managed.

Plain English: The OPA-EFDA Pilot Project demonstrated anecdotal evidence that deployment of OPA-EFDAs over 4% of total clinic appointments had an increased positive effect on clinic capacity data. The Pilot Project study data, taken as a whole, did NOT demonstrate a significant increase in clinic capacity or improved access for more serious periodontal patients because the OPA-EFDA Pilot Project design artificially limited the deployment of OPA-EFDAs.

Section 16: Analyzing and Assimilating Previous Similar Studies

A review was conducted of the Johns Hopkins University Study of the Indian Health Service (IHS) Perio EFDA-1 published in 2017. The findings of that study were combined with findings of the Missouri OPA-EFDA study to draw conclusions.

The primary findings of the Johns Hopkins/IHS Perio-EFDA-1 study in 12 IHS clinics were:

IHS Clinics utilizing Perio EFDA-1s versus clinics not using Perio EFDA-1s.

- achieved a 12.1% increase in procedures delivered.
- achieved a 25% increased rate of access to dental care.
- increased their preventive dental sealants delivered by 79.7%.
- increased their delivery of preventive fluoride varnish by 66.6%[9]

Missouri's Oral Preventive Assistant EFDA is conceptually modeled after the Indian Health Service Perio-EFDA-1 program. Taken together, the OPA-EFDA Pilot Project and IHS clearly demonstrates:

- There is a long-standing need to address oral healthcare workforce shortages where it is difficult to recruit hygienists. The IHS found it difficult to recruit an adequate number of hygienists in many underserved areas in all of its 12 districts and developed the Periodontal EFDA program in 1977 directed by Dr. Greg Smith, a periodontist.[14, 15] In Missouri, rural clinics and clinics that serve Medicaid-eligible patients have acute workforce shortages and difficulty recruiting hygienists as outlined by the Missouri Office of Dental Health Report on Workforce and the Office of Dental Health Survey of Oral Healthcare providers.[16]
- Periodontal EFDAs trained in the OPA-EFDA Pilot Project and in the IHS system are well trained.
- Both dentists and patients rate Missouri's OPA-EFDA care very highly.
- Periodontal EFDAs are a safe addition to the healthcare workforce. There were no adverse events nor were there any patient complaints in the Missouri study.
- Periodontal EFDAs do add to clinic's productive capacity and increase access to care.

Section 17: Study Limitations

- The OPA-EFDA Pilot Project study's major limitation was that the first cohort of graduates were already full-time employees with full-time responsibilities, which significantly limited their deployment. Fortunately, there is a study of the impact of the full-time IHS Perio EFDA-1s done by Johns Hopkins University for the Indian Health Service that can assist us in envisioning the impact of full time OPAs.
- A second limitation was the unexpected deficiencies of all 4 practice management software platforms employed by the 7 clinics to run 2-factor search and reports. The inability to run and report 2-factor searches led to retrospective manual chart audits to mine the information required by the study. Five of the seven participating clinics were able to 'muster' the task. Two clinics did the lion's share of manual review but didn't have the manpower.to complete the review for characteristics of new patients.

- A third limitation was medical leave involving 3 clinicians. In the case of the compromised lead doctor in Clinic 2, the part-time associate transformed into a full-time doctor, who with the OPA-EFDA assistant performed heroic work maintaining the practice. They also introduced an unknown variable: a different clinical team with unknown historical productive capacity.

Section 18: Conclusions

1. There is a need to address long-standing oral healthcare workforce shortages in specific geographical areas and in specific clinical settings in most every state and territory. In Missouri, those areas are rural clinics and clinics serving Medicaid eligible patients.
2. The Indian Health Service (IHS) and Missouri have developed similar, but slightly different approaches to educating a Periodontal EFDA to attempt to address workforce shortages and improve access to care.
3. Periodontal EFDAs in both systems seem to be well trained, OPA-EFDAs in Missouri's program received extraordinarily high ratings by both doctors and patients.
4. Periodontal EFDAs are a safe addition to the healthcare workforce. There were no adverse events nor were there any patient complaints in the Missouri study that included 1,626 patient visits.
5. Periodontal EFDAs do add to clinic's productive capacity and increase access to care as evidenced by the Indian Health Service study and foreshadowed in the higher deploying clinics in the Missouri study.
6. Missouri and other states and territories should consider adapting their dental practice statutes and rules to allow the addition of periodontal EFDAs to the oral health treatment team.

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Section 20: Addendum

The addendum attached to this report contains the following key documents associated with the OPA-EFDA Pilot Project:

1. OPA-EFDA Patient Comments Regarding Treatment
2. Missouri Office of Dental Health Summary of Workforce Survey of Oral Healthcare Providers
3. Dental Hygienist Shortage Areas by County, Missouri Office of Dental Health
4. Expanded Function Dental Assistant Shortage Areas by County, Missouri Office of Dental Health
5. Dentist Shortage Areas by County, Missouri Office of Dental Health
6. Consent for Control Group Participation in OPA-EFDA Pilot Study (Dr & Hygienist Tx)
7. Consent for Interventional Group Participation in OPA-EFDA Pilot Study (OPA-EFDA Tx)
8. OPA-EFDA Assent Form (Age 7-17)
9. Guidelines for Conducting an Assent Discussion with a Minor
10. Patient-Guardian Treatment Assessment Form for Doctor and Hygienist Care (Control Group)
11. Patient-Guardian Treatment Assessment Form for OPA-EFDA Care (Interventional Group)
12. Supervising Clinician's Final Assessment of OPA-EFDA Performance Form
13. Missouri OPA-EFDA Pilot Project Adverse Incident Protocol
14. Missouri OPA-EFDA Pilot Project Adverse Incident Reporting Form
15. Evaluating the Effectiveness of IHS Periodontal Expanded Function Dental Assistants
16. OPA-EFDA Pilot Project IRB Review and Study Bias Control Recommendations
17. OPA-EFDA Project Report Bibliography
18. Using Likert Scale Evaluations in Performance Assessments and Customer Satisfaction Surveys

1. What type of setting do you primarily practice dentistry?

- ◯ Private Practice - Sole Practitioner
- ◯ Group Practice
- ◯ Public Health (FQHC, County, Corrections, Community etc.)
- ◯ Education
- ◯ Other
- ◯ No longer practicing (Retired, Disabled etc.)

2. How many dental assistants do you employ or work at your primary location?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4+
- ◯ Not Applicable - No longer practicing

3. Which of the following Oregon certifications does your dental assistant(s) hold? (Check all that apply)

- ☐ Expanded Functions - General
- ☐ Expanded Functions - General with Restorative Endorsement
- ☐ Expanded Functions - Orthodontic
- ☐ Expanded Functions - Preventive
- ☐ Anesthesia Assistant
- ☐ None of the above

4. Within your practice do you utilize the Dental Assisting National Board's (DANB) signoff sheet to train your dental assistant(s) to perform EFDA duties to obtain certification in Oregon?

- ◯ Yes
- ◯ No

5. Which expanded function duties do you allow your assistant(s) to perform once certified in Oregon? (Check all that apply)

- [ ] Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains.
- [ ] Remove temporary crowns for final cementation and clean teeth for final cementation.
- [ ] Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth.
- [ ] Place temporary restorative material (i.e., zinc oxide eugenol based material).
- [ ] Place and remove matrix retainers for alloy and composite restorations.
- [ ] Polish amalgam or composite surfaces with a slow speed hand piece.
- [ ] Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instrument.
- [ ] Fabricate temporary crowns, and temporarily cement the temporary crown.
- [ ] Perform all aspects of teeth whitening procedures.
- [ ] All of the above.

6. Which EFDA duties, if any, do you consider obsolete? (Check all that apply)

- [ ] Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains.
- [ ] Remove temporary crowns for final cementation and clean teeth for final cementation.
- [ ] Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth.
- [ ] Place temporary restorative material (i.e., zinc oxide eugenol based material).
- [ ] Place and remove matrix retainers for alloy and composite restorations.
- [ ] Polish amalgam or composite surfaces with a slow speed hand piece.
- [ ] Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments.
- [ ] Fabricate temporary crowns, and temporarily cement the temporary crown.
- [ ] Perform all aspects of teeth whitening procedures.
- [ ] All the above duties should remain as expanded function duties.
- [ ] None of the above duties should remain expanded function duties.

7. What duties would you like to see added to the expanded functions list?

1. What type of setting do you primarily practice dentistry?

- ◯ Private Practice - Sole Practitioner
- ◯ Group Practice (4 or more providers)
- ◯ Public Health (FQHC, County, Corrections, Community etc.)
- ◯ Education
- ◯ Other
- ◯ No longer practicing (Retired, Disabled etc.)

2. How many dental assistants do you employ or work at your primary location?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4+
- ◯ Not Applicable - No longer practicing

3. Which of the following Oregon certifications does your dental assistant(s) hold? (Check all that apply)

- ☐ Expanded Functions - General
- ☐ Expanded Functions - General with Restorative Endorsement
- ☐ Expanded Functions - Orthodontic
- ☐ Expanded Functions - Preventive
- ☐ Expanded Functions - Local Anesthesia
- ☐ Expanded Functions - Anesthesia
- ☐ None of the above

4. Within your practice do you utilize the Dental Assisting National Board's (DANB) signoff sheet to train your dental assistant(s) to perform EFDA duties to obtain certification in Oregon?

- ◯ Yes
- ◯ No

5. Do you think 6 months is enough time to complete the signoff sheet?

- ◯ Yes
- ◯ No

6. Which expanded function duties do you allow your assistant(s) to perform once certified in Oregon? (Check all that apply)

- [ ] Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains.
- [ ] Remove temporary crowns for final cementation and clean teeth for final cementation.
- [ ] Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth.
- [ ] Place temporary restorative material (i.e., zinc oxide eugenol based material).
- [ ] Place and remove matrix retainers for alloy and composite restorations.
- [ ] Polish amalgam or composite surfaces with a slow speed hand piece.
- [ ] Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instrument.
- [ ] Fabricate temporary crowns, and temporarily cement the temporary crown.
- [ ] Perform all aspects of teeth whitening procedures.
- [ ] All of the above.

7. Which EFDA duties, if any, do you consider obsolete? (Check all that apply)

- [ ] Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains.
- [ ] Remove temporary crowns for final cementation and clean teeth for final cementation.
- [ ] Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth.
- [ ] Place temporary restorative material (i.e., zinc oxide eugenol based material).
- [ ] Place and remove matrix retainers for alloy and composite restorations.
- [ ] Polish amalgam or composite surfaces with a slow speed hand piece.
- [ ] Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments.
- [ ] Fabricate temporary crowns, and temporarily cement the temporary crown.
- [ ] Perform all aspects of teeth whitening procedures.
- [ ] All the above duties should remain as expanded function duties.
- [ ] None of the above duties should remain expanded function duties.

8. What duties would you like to see added to the expanded functions list?

9. How much do you pay your dental assistants on average?

10. How long on average does a dental assistant stay employed in your office?

- ◯ <1 year
- ◯ 1-3 years
- ◯ 4-7 years
- ◯ >10 years

11. What do you see as the biggest barriers to retaining dental assistants?

12. What are your ideas to increase the number of dental assistants in the workforce?

Occupation Profiles

Dental Assistants (319091)
Oregon (All Counties)

Median Hourly Wage	2024 Employment	Job Openings per Year	10-Year Growth
$28.54	5,525	813	11.6%

Description

Perform limited clinical duties under the direction of a dentist. Clinical duties may include equipment preparation and sterilization, preparing patients for treatment, assisting the dentist during treatment, and providing patients with instructions for oral healthcare procedures. May perform administrative duties such as scheduling appointments, maintaining medical records, billing, and coding information for insurance purposes.

- Expand All
- Job Openings Listed with the Oregon Employment Department
- Job Openings from Other Websites
- State of Oregon Licenses & Certifications
- Wage Range 2025
- Employment Outlook
- Area Employment Projections
- Industries of Employment
- Educational Requirements
- Knowledge, Skills, Abilities, and Work Activities
- Schools and Training Providers
- Related Occupations