

January 2026

Moving Oral Health Workforce Reform into Practice *Advancing the Barriers to Bridges Agenda*





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Executive Summary

In 2025, the Schuyler Center's *Barriers to Bridges* report documented how workforce shortages, limited provider participation in Medicaid, and persistent inequities affect access to oral health care across New York State. The report identified a critical finding: New York already has many necessary policy tools in place. The challenge lies in translating those tools into consistent, day-to-day practice.

The recommendations presented here reflect a set of strategies that are ready now, grounded in evidence, informed by providers and communities, and feasible within the current policy environment. Following an April 2025 statewide convening, more than 100 providers, consumers, advocates, policymakers, researchers, and community leaders participated in four workgroups focused on translating policy into practice. The workgroups addressed Teledentistry; Early Childhood Oral Health; Access for People with Intellectual and Developmental Disabilities; and Care Capacity. Each of these issue areas represents high need, existing or achievable policy authority, and clear potential to expand access through oral health workforce improvements.

Teledentistry can be deployed immediately using existing providers and infrastructure. *Early Childhood* prevention offers the highest return on investment and greatest opportunity to reduce future workforce demand. The *Intellectual and Developmental Disabilities (I/DD)* section addresses some of the deepest and most persistent access barriers in the system. *Care Capacity* outlines the workforce reforms required to sustain and scale these approaches. *Cross-cutting* recommendations align Medicaid policy, prevention infrastructure, and implementation supports to ensure reforms translate into routine practice statewide.

Recommendations

Teledentistry

- Establish the Teledentistry Practice and Innovation Center
- Establish a Comprehensive State Framework for Teledentistry Standards and Billing

Early Childhood Oral Health

- Build an Early Childhood Oral Health Training Pathway Across State and Community Systems
- Implement Medical-Dental Integration Pilots With Embedded Evaluation
- Strengthen and Govern the Oral Health Otter Hub to Support Early Childhood Programs

Access for People with Intellectual and Developmental Disabilities

- Make Existing Medicaid Reimbursement Pathways Work in Practice
- Establish a New York State I/DD Dental Passport and Provider Support Program
- Develop a Statewide Training Pathway on I/DD Oral Health Care From Education to Practice

Care Capacity

- Authorize Dental Therapy in New York to Expand Access to Routine Treatment
- Vigorously Implement the 2025 Collaborative Practice Dental Hygiene Law
- Expand and Sustain Community-Based Oral Health Workforce Roles

Cross-Cutting System Actions

- Authorize parent or caregiver application of fluoride varnish
- Authorize medical assistants to apply fluoride varnish
- Embed oral health into non-dental systems
- Establish a State-Led Oral Health Integration Initiative
- Align Medicaid policy to support prevention at scale
 - Create a comprehensive preventive services bundle for children
 - Reimburse medical providers for caries risk assessment
 - Extend medical reimbursement for preventive services during pregnancy
 - Add fluoride varnish coverage for pregnant adults in dental settings

The Path Forward

Most of these recommendations can be implemented without legislative action. Many require only coordination, clear guidance, and modest starter funding. The exception is dental therapy authorization, which requires legislation and represents the only strategy that adds new treatment capacity to address persistent workforce shortages.

Waiting is not a strategy. The longer New York delays implementation, the wider access gaps will become. For people navigating pain, missed work or school, and worsening health, delay carries real consequences. These recommendations focus on what can be done now, building on existing authority, infrastructure, and evidence while laying groundwork for longer-term reform.

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Introduction

In 2025, the Schuyler Center's Oral Health Workforce Project released *Barriers to Bridges*, a comprehensive assessment documenting how workforce shortages, limited provider participation in Medicaid, and persistent inequities affect oral health care across New York State. The report identified five statewide levers for transformation and called for a shift from episodic, office-based treatment toward prevention-focused, community-embedded delivery models supported by a flexible, well-aligned workforce. A



central finding was that New York already has many necessary policy tools in place. The challenge lies in translating those tools into consistent, day-to-day practice. *(For readers unfamiliar with Barriers to Bridges, Appendix B provides a summary of the report's key findings and recommendations.)*

This report identifies concrete action for improvement. Following the April 30, 2025 statewide convening, four workgroups convened to identify concrete steps that could be taken over a two-year implementation horizon. More than 100 providers, consumers, advocates, policymakers, researchers, and community leaders participated in developing the recommendations presented here. The workgroups focused on areas where needs are high, policy authority already exists or is within reach, and there is clear potential to expand access through better use of the oral health workforce.

The recommendations that follow are sequenced to reflect implementation readiness. *Teledentistry* represents an immediately deployable strategy using existing providers and infrastructure. *Early Childhood* highlights prevention as offering the highest return on investment and the greatest opportunity to reduce future demand on the workforce. The section on people with *Intellectual and Developmental Disabilities* addresses some of the deepest and most persistent access barriers in the oral health system. *Care Capacity* outlines the workforce reforms required to sustain and scale the approaches described throughout the report. The report concludes with *cross-cutting* recommendations that align Medicaid policy, prevention infrastructure, and implementation supports to ensure these reforms translate into routine practice statewide.

Why Oral Health Access Requires System Change

Background

The mouth is connected to the rest of the body in ways that profoundly affect overall health and wellbeing. Oral health influences our ability to eat, speak, and engage in daily life, and is increasingly linked to chronic conditions such as heart disease, diabetes, pregnancy complications, and obesity. Yet despite these connections, oral health care in New York continues to operate largely apart from the broader health care system. Most people receive dental care outside medical settings, rely on separate insurance coverage, and experience little coordination between dental and medical providers.

The National Institutes of Health has identified oral health as one of the areas of health care delivery where “striking disparities exist.” In New York, low-income individuals, Black and brown communities, rural residents, people with disabilities, immigrants and refugees, older adults, and people enrolled in Medicaid face disproportionate barriers to oral health care and experience higher rates of oral disease.

Recent data underscore the scope of the challenge. A 2024 consumer survey found that 43 percent of New Yorkers face major barriers to accessing dental care.¹ Access varies sharply by race, ethnicity, and income, with lower rates of consistent care among Black and Latino residents and those with lower incomes. Cost, lack of insurance, transportation barriers, and difficulty finding dentists who accept Medicaid remain the most frequently cited obstacles.

While oral health needs span the life course, from early childhood through older adulthood, access challenges share common roots. Preventive care remains underutilized, particularly among young children and Medicaid-enrolled populations. Individuals with intellectual and developmental disabilities face persistent difficulty finding providers trained and willing to meet their needs. Pregnant individuals experience increased oral health risk but often do not receive timely care. Over time, these gaps contribute to avoidable pain, missed school and work, emergency department use, and higher health care costs.

Despite these access challenges, New York does not lack dental professionals overall. The state has a higher dentist-to-population ratio than the national average and a substantial education and training infrastructure. The core challenge is not the number of providers, but where and how they practice. The Oral Health Needs Assessment for New York found that more than 5 million New Yorkers live in Dental Health Professional Shortage Areas, with the highest levels of unmet need concentrated in rural regions, parts of upstate New York, and high-poverty urban communities. In these areas, provider shortages are compounded by low Medicaid participation among providers, further limiting access to routine and preventive care.

New York's oral health crisis is not primarily a lack of policy authority, but an implementation challenge.

Together, these factors point to a central conclusion: New York's oral health crisis is not primarily a lack of policy authority, but an implementation challenge. Over the past decade, the state has enacted important reforms, including expanded preventive benefits, telehealth authority, and new scope-of-practice options. Yet these policy changes have not consistently translated into routine practice. Providers and systems often lack clear guidance, aligned reimbursement, structured training, and coordinated support to fully use existing authorities.

From Barriers to Bridges to Implementation

In 2025, the *Barriers to Bridges* (B2B) report, developed through the Schuyler Center's Oral Health Workforce Project, provided a comprehensive assessment of New York's oral health workforce and access landscape. The report documented a system under strain, marked by workforce shortages, few dental providers participating in Medicaid, and persistent inequities affecting children, older adults, rural residents, and individuals with intellectual and developmental disabilities. B2B identified five statewide levers for transformation: expanding community-based prevention; integrating oral health across medical, early childhood, disability, and community systems; advancing team-based workforce flexibility; aligning Medicaid payment with preventive and community-based care; and strengthening data, evaluation, and accountability.

A central finding of B2B was that New York already has many of the necessary policy tools in place. The challenge lies in translating those tools into consistent, day-to-day practice. The report called for a shift away from episodic, office-based treatment toward prevention-focused, community-embedded delivery models supported by a flexible, well-aligned workforce.

Following the release of *Barriers to Bridges*, the Schuyler Center’s Oral Health Workforce Project moved into an implementation phase with the launch of the April 30, 2025 *Turning Vision into Action* convening. This convening brought together state agency partners, providers, advocates, educators, and community leaders to identify priority areas where B2B recommendations could be translated into concrete, feasible steps over a two-year implementation horizon.

Four workgroups emerged from this next phase of work: Teledentistry, Early Childhood, Intellectual and Developmental Disabilities (I/DD), and Expanding Care Capacity. Each workgroup focused on an area where needs are high, policy authority already exists or is within reach, and there is clear potential to expand access through better use of the oral health workforce. These workgroups were charged with advancing solutions that can be tested, refined, and scaled.

This report advances the Barriers to Bridges agenda by identifying actionable implementation recommendations.

A Roadmap from Vision to Implementation

This report presents the workgroup recommendations sequenced beginning with those that can be implemented immediately, followed by those that may require more time to lay the groundwork for implementation, i.e., by effectuating regulatory or statutory or other systems change. The roadmap begins with Teledentistry, an immediately deployable strategy that expands access using existing providers and infrastructure. It then turns to Early Childhood, where prevention offers a high return on investment and the greatest opportunity to reduce future demand on the dental workforce.

The I/DD section centers equity by addressing some of the deepest and most persistent access barriers in the oral health system. It highlights the need for training, coordination, and billing clarity to ensure that people with intellectual and developmental disabilities can access routine, community-based care rather than relying on a limited number of specialty providers.

Care Capacity follows as the structural foundation that supports all other strategies. This section outlines the workforce reforms required to sustain and scale the approaches described throughout the report, including team-based care models, expanded scopes of practice, and new provider roles needed to meet demand.

The report concludes with cross-cutting recommendations that align Medicaid policy, prevention infrastructure, and implementation supports to ensure these reforms translate into routine practice statewide.

One foundational insight from *Barriers to Bridges* continues to shape this work: progress in oral health depends on adequate public infrastructure to support policy implementation. While this phase of work is focused on identifying actionable workforce strategies rather than agency structure, the recommendations that follow assume sufficient state capacity to administer programs, align Medicaid policy, support cross-system coordination, and monitor implementation. Without these investments, even strong workforce reforms risk delayed or uneven impact.

Taken together, this roadmap reflects a clear throughline: expanding access requires coordinated action across delivery models, prevention systems, workforce capacity, and payment policy. No single reform is sufficient on its own. Each section builds on the last, creating a cohesive strategy to move New York’s oral health system from policy aspiration to action.

RECOMMENDATIONS

Recommendations Regarding Teledentistry



The recommendations below advise using teledentistry to increase access, efficiency, and reach. Teledentistry represents one of New York’s strongest, immediate opportunities to extend the reach of the oral health workforce, particularly in rural regions, school-based programs, long-term care facilities, and other high-need settings. The *Barriers to Bridges* report identified teledentistry as a promising strategy to expand access without requiring major capital investments or long training pipelines. While New York already has a favorable legal and regulatory framework for teledentistry, adoption has lagged due to confusing billing and documentation requirements, inconsistent understanding of supervision standards, and limited technical assistance for providers, especially in small or rural practices.

New York continues to face workforce shortages, low Medicaid participation among dental providers, and persistent challenges connecting underserved populations to care. Teledentistry offers a rare opportunity to address all three challenges simultaneously. It allows dentists to extend their reach beyond traditional practice settings, supports hygienist-led care, reduces unnecessary in-person visits, and enables timely screening, triage, and treatment planning. With appropriate implementation support, teledentistry can rapidly increase access to preventive and diagnostic services for populations that routinely face barriers to in-person care.

To seize this opportunity, the Teledentistry Workgroup focused on identifying practical, high-impact steps to move teledentistry from authorization to routine practice. The group proceeded in three phases: an environmental scan and policy review, barrier identification, and solution design. Across meetings, participants consistently emphasized that while the regulatory framework is permissive, implementation remains the primary challenge. Providers understand that teledentistry is allowed; they need clear guidance and support to integrate.

The Workgroup examined models from other states and reviewed national telehealth learning collaboratives. Experiences from these efforts reinforced that successful uptake requires a combination of clear operational guidance, aligned reimbursement, and structured opportunities for providers to learn from peers and test workflows. Based on this analysis, the Workgroup identified three core pillars for statewide adoption: training and technical support, structured learning collaboratives, and formalized statewide standards.



The policy barriers to teledentistry are largely gone. The challenge now is implementation; helping providers understand how to use it, bill for it, and integrate it into everyday practice.

—Courtney Chinn, DDS, MPH
Clinical Associate Professor, NYU Dentistry

Teledentistry Recommendation 1:

Establish the Teledentistry Practice and Innovation Center (TPIC)

To move teledentistry from policy authorization to routine practice, New York should establish a **Teledentistry Practice and Innovation Center (TPIC)** as a statewide backbone implementation entity. TPIC would serve as the coordinating hub for implementation, training, technical assistance, and quality improvement, ensuring that teledentistry is deployed consistently, equitably, and at scale across New York State.

TPIC would support providers, systems, and community partners in navigating the practical challenges of teledentistry adoption, including clinical workflows, staffing models, technology selection, compliance, and reimbursement. While New York has made important progress in authorizing teledentistry, many providers—particularly safety-net clinics, schools, long-term care facilities, and programs serving people with disabilities—lack the operational capacity to implement teledentistry without structured support.

Teledentistry is one of the few workforce strategies that can be deployed immediately without expanding licensure or increasing provider supply. TPIC helps ensure that this potential is realized by giving providers the infrastructure they need to use teledentistry effectively. In doing so, TPIC directly advances the *Barriers to Bridges* goal of maximizing the existing workforce while new workforce pathways are developed.

Core Functions of TPIC:

Practice implementation and technical assistance

TPIC would provide hands-on assistance to dental and non-dental settings seeking to adopt teledentistry, including workflow design, staffing models, consent processes, documentation standards, and integration with electronic health records. This support would help reduce start-up costs and shorten the time from policy change to routine service delivery.

Workforce training and capacity building

TPIC would develop and disseminate standardized training for dentists, dental hygienists, dental assistants, and community-based partners on teledentistry delivery. This includes onboarding new graduates, upskilling the existing workforce, and supporting expanded team-based models that maximize limited provider capacity, a core goal of the *Barriers to Bridges* initiative.

Medicaid and payer alignment support

TPIC would serve as a centralized source of guidance on Medicaid billing, coding, documentation, and compliance for teledentistry services. By clarifying reimbursement pathways and reducing administrative burden, TPIC would help increase provider participation and ensure that authorized services reliably translate into reimbursed care.

Learning collaborative and innovation hub

TPIC would convene a statewide learning collaborative to share best practices, troubleshoot challenges, and elevate successful models across settings such as schools, early childhood programs, long-term care facilities, and programs serving individuals with intellectual and developmental disabilities. This function allows teledentistry to continuously evolve in response to workforce shortages and community needs.

Data, evaluation, and continuous improvement

TPIC would collect and analyze implementation data to assess access, utilization, equity, and workforce impact. These insights would inform ongoing policy refinement and provide funders and policymakers with clear evidence of return on investment.

Together, education, technical assistance, and learning collaboratives position the TPIC as a foundational driver of statewide readiness and implementation capacity. By supporting providers at every stage of adoption and turning on-the-ground learning into shared standards, the Center would help establish a consistent, high-quality teledentistry infrastructure capable of expanding access and strengthening New York's oral health workforce.

Teledentistry Recommendation 2: Establish a Comprehensive Framework for Teledentistry Standards and Billing

New York State should establish a comprehensive, coordinated framework for teledentistry standards and billing to provide clear, consistent guidance for providers across settings. While teledentistry is authorized and reimbursable under Medicaid, providers continue to report uncertainty about supervision requirements, documentation expectations, image-capture standards, and billing pathways. This lack of clarity has slowed adoption and created uneven practice across the state.



The New York State Department of Health, in coordination with New York State Medicaid and the State Education Department, should jointly lead this effort. Together, these agencies should establish a Teledentistry Standards Task Force and develop a Medicaid Teledentistry Coding and Documentation Toolkit to translate existing authority into operational guidance that supports compliant, high-quality care.

NYS Department of Health, NYS Medicaid, and NYS Education Department joint responsibility:

Medicaid Teledentistry Coding and Documentation Toolkit

A foundational step in strengthening teledentistry implementation is the creation of a Medicaid Teledentistry Coding and Documentation Toolkit. This practical resource should clearly outline allowable billing codes, required documentation elements, consent processes, data and reporting expectations, and clinical thresholds for both synchronous and asynchronous care.

Providers consistently report confusion about billing and compliance. A statewide toolkit would reduce variability and administrative burden by establishing clear expectations. The toolkit should include annotated billing examples, sample image-capture protocols, and model chart notes to illustrate what compliant, high-quality teledentistry practice looks like in real-world settings. To maximize impact, the toolkit should be fully integrated into the education, technical assistance, and learning collaborative activities of the Teledentistry Practice and Innovation Center.

Teledentistry Standards Task Force

Beyond billing guidance, providers need clear, state-sanctioned standards that define the clinical and regulatory parameters of teledentistry. To address this need, New York should establish a Teledentistry Standards Task Force, modeled on successful state-led efforts such as the Perinatal Oral Health Guidelines Committee.

The Task Force should include representatives from the Department of Health, State Education Department, Medicaid, dentists, dental hygienists, school health experts, long-term care leaders, early childhood specialists, and telehealth compliance experts. Its charge should be to develop formal guidance that can evolve alongside technology and practice.

As part of its work, the Task Force should review national and cross-state models, with particular attention to states that have achieved more mature teledentistry implementation. This review should inform the development of New York–specific standards addressing key issues such as image-capture modalities and quality thresholds, supervision requirements for synchronous and asynchronous care, consent processes for different populations, clinical decision-making parameters, and privacy and data security protections.

Implementation Timeline and Translation to Practice:

To maintain momentum, the state should establish a clear process, timeline, and set of deliverables for this work. The Department of Health and State Education Department should jointly convene the Task Force and charge it with producing draft guidance within six to nine months. An early step should be identifying the specific questions that must be resolved to support statewide implementation, such as what constitutes a diagnostic-quality image, which services may be delivered asynchronously, and how supervision requirements align with Collaborative Practice Dental Hygiene.

Once developed, standards and billing guidance should be operationalized through provider education, technical assistance, and learning collaboratives supported by the Teledentistry Practice and Innovation Center. This approach ensures that guidance does not remain theoretical but is translated into routine practice and sustained system change.

Together, these recommendations establish the infrastructure and guidance needed for effective teledentistry implementation; the following section outlines the respective roles of government and philanthropy in launching, sustaining, and scaling this work.

Teledentistry: Implementation Roles and Path to Sustainability

Although the long-term home for this work should be within state government, philanthropy is well positioned to catalyze early progress by supporting the launch of the TPIC. Philanthropic investment can fund initial infrastructure for training, technical assistance, and learning collaboratives, generating proof of concept, and producing models, guidance, and data that state agencies can later adopt and sustain.

While philanthropy can accelerate early development, only government can provide the long-term stability, scale, and policy integration needed for teledentistry to become a reliable component of the oral health system.

| Policymakers: Ensuring Scale, Stability, and Alignment | Philanthropy: Catalyzing Early Implementation and Learning |
|--|--|
| Establish long-term ownership of teledentistry implementation within state government to ensure sustainability, scale, and integration with Medicaid policy. | Fund the initial launch of the Teledentistry Practice and Innovation Center, including staffing, infrastructure, and start-up costs. |
| Convene and lead the Teledentistry Standards Task Force to issue clear, statewide clinical and regulatory guidance. | Support development of training materials, technical assistance tools, and early learning collaboratives. |
| Align Medicaid billing, documentation, and supervision guidance to reduce provider confusion and administrative burden. | Underwrite pilot learning collaboratives that allow providers to test and refine teledentistry workflows in real-world settings. |
| Integrate teledentistry standards and guidance into state agency communications, provider education, and oversight activities. | Support evaluation and documentation of early models to generate proof of concept and inform public adoption. |
| Sustain and scale effective teledentistry models through Medicaid policy, guidance, and potential rate or incentive alignment. | De-risk innovation early implementation while public systems establish permanent structures. |

Together, these complementary roles allow New York to move quickly while building the durable public infrastructure needed for long-term, equitable teledentistry implementation.

Translating to Practice

Teledentistry provides a powerful way to extend the reach of New York’s oral health workforce, improve efficiency, and expand access for populations that routinely face barriers to in-person care. With enabling legislation and Medicaid reimbursement already in place, the state is well positioned to move from authorization to widespread adoption.

By pairing a statewide implementation center with clear standards, billing guidance, and structured opportunities for shared learning, New York can ensure that teledentistry is used consistently, safely, and effectively across settings. These investments would allow existing providers to serve more patients, reduce unnecessary in-person visits, and strengthen prevention, triage, and care coordination—particularly in rural and high-need communities.

Teledentistry demonstrates how targeted implementation support can unlock the full potential of existing policy tools and workforce capacity.

While technology-enabled care is essential for reaching underserved communities, workgroup participants consistently emphasized that long-term improvements in access depend on strengthening prevention early in life. Expanding teledentistry can help close immediate gaps, but reducing future demand on the oral health workforce requires intervening before disease takes hold.

Recommendations Regarding Oral Health and Early Childhood Systems

The following section focuses on Early Childhood and highlights how integrating oral health into the systems that serve young children and families—pediatric care, early learning, home visiting, and community-based supports—offers the greatest opportunity to improve equity, reduce avoidable disease, and build a more sustainable oral health system over time.

The recommendations below reflect the Early Childhood Workgroup’s prioritized strategies for strengthening prevention, workforce readiness, and system integration. Dental disease in young children is often described as a “hidden epidemic.” Early tooth decay is not always visible until pain interferes with eating, sleeping, or learning, and its impacts are concentrated among children living in poverty. While most children will not experience severe dental disease, children from low-income families, Black and Latino families, immigrant families, and rural communities face significantly higher rates of untreated decay.² These disparities reflect the same social and economic conditions that drive inequities across health outcomes more broadly.

At the same time, dental disease in early childhood is largely preventable. Evidence consistently shows that early prevention can dramatically reduce decay and lower long-term treatment costs, yet utilization of preventive services among children under five remains low.³ These gaps point not to a lack of effective interventions, but to challenges in delivery, workforce readiness, and integration across the systems that serve young children and families.



If we wait until children reach a dental office to prevent disease, we have already missed the opportunity. The systems that see families first—child care, pediatricians, home visiting—are where prevention has to start.

—Lindsay Wright, RDH, Community Coalition Coordinator, Erie County Department of Health

The *Barriers to Bridges* report identified early childhood as one of the highest-return opportunities for improving oral health equity in New York. It called for embedding oral health into early childhood systems and equipping non-dental professionals—including pediatric providers, community health workers, and early childhood educators—with standardized training and tools. This approach reflects the reality that keeping young children’s teeth healthy depends on the many programs and providers families already trust, including WIC, home visiting, Early Intervention, Head Start, child care, and pediatric primary care, particularly given ongoing shortages of dentists who serve young children enrolled in Medicaid.



The Early Childhood Workgroup was convened to translate this vision into action. Meeting between April and October 2025, the Workgroup brought together clinicians, early childhood providers, community health workers, advocates, educators, and state agency representatives. Discussions focused on practical strategies to move prevention upstream by integrating oral health into existing early childhood systems, strengthening workforce training, and expanding access to preventive services for children from birth through age five.

Throughout the process, participants emphasized the importance of engaging the systems where families already interact with trusted providers. These include WIC, Head Start, home visiting programs, pediatric and obstetric care, and child care. The Workgroup developed a practical roadmap that combines workforce training, family-centered education, and policy alignment to expand preventive reach. Rather than creating new programs, the recommendations prioritize alignment, standardization, and ease of implementation within existing infrastructure.

Early Childhood Recommendation 1: Build an Early Childhood Oral Health Training Pathway

New York State should establish a coordinated early childhood oral health training pathway led by the Office of Children and Families (OCFS) using Aspire as the primary platform for delivery. The pathway should integrate standardized oral health content across Head Start, Aspire-supported early childhood programs, Healthy Families, and community health worker training programs. This approach ensures that professionals who regularly interact with families during pregnancy and the first years of life receive consistent, evidence-based oral health training.

Training should consist of short, practical modules tailored to different roles, including early childhood educators, home visitors, community health workers, and family support staff. Content should focus on prevention, anticipatory guidance, oral health risk awareness, and referral pathways, while reinforcing how oral health supports broader child development and family wellbeing. Embedding this content into Aspire and existing professional development requirements minimizes administrative burden and supports statewide consistency.

OCFS should serve as the lead agency for implementation, in partnership with the New York State Department of Health and community-based intermediaries. A 12- to 18-month pilot period should assess training uptake, workforce confidence, and integration into routine practice. Findings should inform refinement and statewide scale.

Early Childhood Recommendation 2: Advance Medical–Dental Integration in Early Childhood Care

Medical–dental integration offers a practical opportunity to embed oral health prevention into obstetric and pediatric care, where families already receive consistent services. Strategic, time-limited pilots can help New York test and refine models that strengthen prevention, improve care coordination, and expand access for young children and pregnant people, without requiring immediate statewide expansion.

New York State should support pilots that integrate oral health screening, education, and referral into prenatal, postpartum, and well-child visits. Pilot sponsors could include local health departments, federally qualified health centers, and large pediatric and obstetric practices serving high volumes of Medicaid-enrolled families. Community health centers should be prioritized given their experience delivering integrated, team-based care.

Each pilot should include embedded evaluation and data collection to assess feasibility, utilization, provider experience, and referral completion. Results should be used to inform future Medicaid policy, reimbursement decisions, and guidance for broader implementation.

Early Childhood Recommendation 3: Strengthen Early Childhood Oral Health Resource Infrastructure

Oral Health Otter is a provider-facing resource designed to help early childhood programs, including Head Start, integrate oral health into everyday practice. The hub offers accurate, ready-to-use information and materials that providers can confidently share with families, reducing the time required to identify trustworthy oral health resources.

New York State should formalize governance and long-term stewardship of Oral Health Otter within the Council on Children and Families (CCF). CCF should oversee content review, updates, multilingual access, and alignment with state policy and clinical guidance to ensure accuracy and consistency.

Oral Health Otter was developed in response to provider feedback requesting a trusted, time-saving resource that could be easily integrated into existing programming. Intentional diffusion through early childhood networks, including Head Start, home visiting programs, community health workers, child care providers, and community health centers—will be essential. Tracking provider use and distribution through these systems can help assess reach and inform ongoing improvement.

Early Childhood: Implementation Roles and Path to Sustainability

Strengthening oral health prevention in early childhood requires coordinated leadership across state systems and partnership with philanthropy. Policymakers play a critical role in setting clear expectations for integration by defining pilot scope and evaluation metrics, clarifying allowable activities and Medicaid billing pathways, and supporting data sharing across early childhood, health, and community-based systems. State leadership is essential to ensure that successful models are aligned with policy, embedded in routine practice, and positioned for statewide scale.

Philanthropy can accelerate early implementation by providing start-up funding for pilot sites, underwriting evaluation and shared learning, and supporting peer exchanges that help providers refine and replicate effective approaches. By funding early-stage innovation and dissemination, philanthropy can help reduce risk, build the evidence base, and speed the transition from pilot activity to durable system change.

| <p>Policymakers: Enabling System Alignment</p> | <p>Philanthropy: Catalyzing Innovation and Learning</p> |
|---|--|
| <p>Define pilot scope and expectations by establishing clear goals, eligible sponsor types, and core evaluation metrics to ensure consistency across sites.</p> | <p>Provide start-up capital to support early implementation at local health departments, federally qualified health centers, and large pediatric and obstetric practices, reducing financial risk for participating sites.</p> |
| <p>Clarify policy and reimbursement parameters by issuing guidance on allowable activities, documentation requirements, and Medicaid billing pathways that support integration.</p> | <p>Underwrite evaluation and data analysis to support embedded learning and synthesis of findings across pilot sites.</p> |
| <p>Support data sharing and alignment by facilitating data use agreements and shared metrics while ensuring privacy and compliance.</p> | <p>Convene peer learning by funding learning exchanges that allow pilot participants to troubleshoot challenges and share emerging practices.</p> |
| <p>Use pilot findings to inform scale by applying results to guide future policy decisions and system-wide adoption of effective models.</p> | <p>Accelerate dissemination by supporting communication and replication of successful approaches across regions and provider types.</p> |

Translating to Practice

Integrating oral health into early childhood systems offers one of the most effective and equitable strategies for improving long-term oral health outcomes in New York. By strengthening prevention early in life and equipping the non-dental workforce with the training and tools to support families, the state can reduce avoidable disease and future demand on the dental workforce.

The Early Childhood Workgroup’s recommendations focus on implementation rather than invention. They build on existing systems that families already trust and emphasize alignment, standardization, and ease of use. Together, these strategies demonstrate how prevention-focused investments can improve access, advance equity, and create a more sustainable oral health system over time.

Recommendations to Improve Oral Health Access for People with Intellectual and Developmental Disabilities

This section focuses on improving oral health access for people with intellectual and developmental disabilities by strengthening provider preparation, clarifying reimbursement pathways, and creating tools that support communication and care coordination. These strategies build on the same implementation-focused approach advanced throughout this report, ensuring that existing policy authority translates into accessible, person-centered care.

The following recommendations reflect the I/DD Workgroup’s prioritized strategies for expanding access, strengthening provider capacity, and translating existing policy tools into routine practice.

People with intellectual and developmental disabilities experience some of the most persistent barriers to oral health care in New York State. Although the need for preventive and routine dental care is often greater for this population, families report long wait times, difficulty finding providers with appropriate training, and challenges



navigating Medicaid benefits and Office for People with Developmental Disabilities (OPWDD) supports. Providers consistently express a desire to care for people with I/DD, but many feel underprepared, under-resourced, and uncertain about how to adapt care environments or secure reimbursement for the additional time and supports required.

The *Barriers to Bridges* report documented that these challenges occur across the full continuum of care, from locating a provider, to receiving services, to navigating follow-up and transitions from pediatric to adult care. The report found that Medicaid reimbursement structures do not adequately account for the added complexity of I/DD dental care. Building on this finding, implementation-phase discussions identified underutilization of existing Medicaid reimbursement codes, including RE81 and RE95, intended to support this population. These codes remain difficult for many providers to use consistently, limiting their impact on access.



Families are doing everything right, but the system still makes access feel impossible. Providers want to help, but without training, tools, and workable reimbursement, good intentions don't translate into care.

—Trina Rose Cutugno, BCPA

The I/DD Workgroup was convened to translate this analysis into practical action. The group began from a shared premise that the primary barrier is not a lack of commitment among providers or families, but a lack of coordination, training, and supportive infrastructure. Providers are often left to navigate clinical adaptations, regulatory requirements, and reimbursement rules on their own, while families face a fragmented and difficult-to-navigate system.

Meeting between April and October 2025, the Workgroup brought together clinicians, caregivers, disability advocates, educators, community organizations, and state agency representatives. Discussions focused on achievable strategies to strengthen provider capacity, improve patient and caregiver experience, and reduce reliance on a small number of specialty providers. These recommendations advance the *Barriers to Bridges* vision by expanding the effective capacity of New York's existing oral health workforce and aligning policy with day-to-day care delivery.

By strengthening provider preparation, clarifying billing pathways, and creating tools that support communication and care coordination, New York can move from policy permission to accessible, person-centered care for people with intellectual and developmental disabilities.

I/DD Recommendation 1:

Make Existing Medicaid Reimbursement Pathways Functional

New York State should take deliberate action to ensure effective and consistent use of existing Medicaid billing codes RE81 and RE95 so they function as intended to support oral health care for people with intellectual and developmental disabilities. Although these codes are designed to recognize the additional time, coordination, and complexity often required, they remain underutilized due to limited awareness, inconsistent guidance, and administrative uncertainty about appropriate use.

The New York State Department of Health, in coordination with OPWDD, Medicaid Managed Care plans, and professional associations, should lead a statewide education and implementation effort. This effort should include short, practical education modules and quick-reference billing guides that clearly explain when and how RE81 and RE95 may be used, required documentation, and examples of successful claims. These materials should be embedded into continuing education, teledentistry training pathways, and learning collaboratives to ensure consistent messaging statewide.

To ensure accountability and sustained uptake, New York should track and publicly report RE81 and RE95 claim submission and approval rates during an initial 12-month implementation period. These data should be used to identify plan-level or regional barriers, refine guidance, and address persistent denials. Fully activating these existing Medicaid tools represents a low-cost opportunity to expand effective workforce capacity and improve access without requiring new legislation.

I/DD Recommendation 2:

Establish an I/DD Dental Passport and Provider Support Program

New York State should develop and implement a standardized I/DD Dental Care Passport to improve communication, preparedness, and access to care for people with intellectual and developmental disabilities. Modeled on the Kansas Dental Passport, this tool would capture essential information such as communication preferences, sensory sensitivities, behavioral supports, and prior dental experiences, helping providers tailor care and minimize disruptions in care.⁴

To be effective, the passport should be paired with provider education and technical assistance focused on I/DD-responsive care. This should include short, practical training modules for clinical and front-office staff, guidance on workflow integration, and access to shared-care tools and sensory supports. The passport should be available in both digital and printable formats, supported by QR codes and multilingual versions, to ensure usability across practice settings.

The Department of Health, in partnership with OPWDD, academic institutions, disability advocates, and professional organizations, should lead implementation, beginning with a 12- to 18-month pilot in regions with high unmet need. Evaluation should assess provider uptake, patient experience, appointment completion, and impacts on sedation use and care coordination, with findings informing statewide rollout and Medicaid alignment.

I/DD Recommendation 3:

Build a Statewide I/DD Oral Health Training Pathway

New York State should establish a coordinated training pathway that prepares the oral health workforce to serve people with intellectual and developmental disabilities across the professional lifecycle, from pre-licensure education through continuing education and practice-based support. This recommendation directly advances the *Barriers to Bridges* finding that workforce shortages are driven as much by preparation and support as by provider supply.

Core I/DD competencies, including communication strategies, sensory-informed care, behavior supports, care planning, and coordination with medical and social service providers, should be embedded in dental and dental hygiene education. Post-licensure, accessible continuing education should be offered through synchronous and asynchronous formats.



The Teledentistry Practice and Innovation Center should serve as a central hub for this work by housing a curated training library, supporting virtual case consultation, and convening learning collaboratives that allow providers to apply I/DD-specific skills in real-world settings. The pathway should be closely linked to reimbursement education, including guidance on RE81 and RE95 billing and care models that reduce reliance on sedation and hospital-based dentistry.

I/DD: Implementation Roles and Path to Sustainability

This section outlines complementary roles in implementing and sustaining the recommendations above.

Improving oral health access for people with intellectual and developmental disabilities requires coordinated leadership by state agencies and partnership with philanthropy. Policymakers play a critical role in clarifying reimbursement pathways, embedding I/DD-responsive care into workforce training, and ensuring accountability so existing Medicaid tools function as intended. State leadership is essential to align policy with day-to-day care delivery and support providers in serving this population.

Philanthropy can accelerate progress by funding early implementation of training, technical assistance, and shared-care tools, including the I/DD Dental Care Passport. By underwriting evaluation and peer learning, philanthropic partners can help demonstrate what works, reduce risk for providers, and speed the transition from pilot efforts to durable, statewide practice.

| Policymakers: Turning Policy into Practice | Philanthropy: Accelerating Adoption and Impact |
|--|--|
| Issue standardized, statewide guidance on the use of RE81 and RE95, including documentation examples and clinical scenarios. | Fund development of provider-friendly education modules, billing guides, and implementation tools. |
| Embed RE81/RE95 education into continuing education, teledentistry pathways, and learning collaboratives. | Underwrite peer learning, office hours, and technical assistance that help providers troubleshoot billing and workflow challenges. |
| Track and report RE81/RE95 claim submission and approval rates to identify barriers and ensure accountability. | Support data collection and evaluation to demonstrate impact and inform Medicaid refinement. |
| Align reimbursement with workforce goals to support extended visits and care coordination. | Fund early implementation of the dental care passport and provider support models to de-risk adoption. |

Translating to Practice

Improving oral health access for people with intellectual and developmental disabilities requires more than coverage or isolated clinical expertise. It depends on a workforce that is prepared, supported, and equipped to deliver care in community-based settings, and on policies that function reliably in day-to-day practice.

The I/DD Workgroup’s recommendations focus on translating existing authority into usable tools—through training, reimbursement clarity, and care coordination supports that expand the effective capacity of New York’s oral health workforce. By reducing reliance on a small number of specialty providers and strengthening the ability of general practices to serve people with I/DD, New York can make meaningful progress toward equitable access.

The persistent access barriers faced by people with intellectual and developmental disabilities reflect a broader challenge across New York’s oral health system: demand exceeds the capacity of the current workforce, particularly in high-need communities. Even when prevention and integration strategies are in place, access will remain limited if the workforce is not structured to meet population needs.

Recommendations to Strengthen the Workforce and Expand Access

This section on Care Capacity focuses on the structural workforce reforms required to sustain and scale the strategies outlined throughout this report. By modernizing who can deliver care and how care teams function, New York can build the foundation needed to improve access for all populations, now and into the future.

It is time to modernize the oral health workforce to meet New Yorkers' needs. The *Barriers to Bridges* report identified workforce shortages as one of the most significant structural barriers to oral health access in New York State. While innovations in care delivery, prevention, and integration can improve how services are provided, they cannot fully succeed without sufficient workforce capacity to meet demand. Across regions and populations, New Yorkers continue to face long wait times for appointments, limited access to routine treatment, and shortages of providers willing and able to serve Medicaid-enrolled patients, rural communities, older adults, and people with disabilities.⁵



We can improve how care is delivered, but if we don't change who is allowed to deliver care, access will remain limited. Workforce reform is the foundation everything else depends on.

—Anthony J. Mendicino, Jr., DDS
Chief Dental Officer, Finger Lakes Community Health

These challenges are not simply the result of where care is delivered, but of who is authorized to deliver care and under what conditions. Existing workforce structures have not kept pace with population needs, leaving dentists responsible for services that could safely be delivered by other trained providers, and underutilizing non-dentist roles that could expand access and efficiency. As a result, even well-designed delivery innovations risk falling short without parallel action to modernize the workforce.

Positioned as the capstone of this report, this section focuses on the structural workforce reforms required to support and sustain the strategies outlined in the Teledentistry, Early Childhood, and I/DD sections. These recommendations are intended to expand who can provide care, strengthen team-based models, and ensure that New York's oral health workforce is equipped to meet current and future demand.

The Care Capacity Workgroup was convened to examine how New York could expand oral health workforce capacity in both the near and long term. Over multiple months, the Workgroup brought together a diverse group of stakeholders, including dentists, dental hygienists, community health workers, educators, health system leaders, advocates, and state agency representatives. Participants reflected a wide range of practice settings and perspectives, including community health centers, private practices, academic institutions, and community-based organizations from both urban and rural regions.

Workgroup discussions were grounded in findings from the *Barriers to Bridges* report, the Oral Health Needs Assessment, and related workforce analyses. Members reviewed data on workforce shortages and access gaps, examined national models and evidence from other states, and discussed the practical realities of care delivery in New York. Throughout the process, participants weighed feasibility, impact, and implementation considerations, particularly how workforce reforms could improve access for populations with the highest unmet need.

While participants expressed strong support for delivery innovations, prevention strategies, and care integration approaches addressed in other sections of this report, there was broad consensus that these efforts will not achieve their full potential without structural workforce reform. Through sustained dialogue and shared problem-solving, the Workgroup coalesced around a set of priority

recommendations that reflect strong alignment across professional disciplines and community perspectives. These recommendations represent areas of broad agreement and are intended to provide a clear, actionable path forward for expanding oral health care capacity statewide.

Workforce Recommendation 1: Authorize Dental Therapy in New York

New York currently lacks a mid-level oral health provider authorized to deliver routine restorative services, leaving dentists as the sole providers for many treatments that could be safely delegated. This constraint has contributed to treatment backlogs, inefficiencies in care delivery, and persistent access gaps, particularly in community health centers and other safety-net settings. The absence of dental therapy has become increasingly consequential as workforce shortages deepen, and demand continues to grow.

Dental therapy addresses this gap by adding a new category of providers trained to deliver routine preventive and restorative care as part of a dental team. In states that authorize dental therapy, evidence shows improved access, shorter wait times, and more efficient use of dentists' time.⁶ For New York, dental therapy represents the most direct and impactful strategy for expanding treatment capacity, especially in high-need communities.

Dental therapy is the only recommendation that adds net new treatment capacity and directly addresses persistent shortages that cannot be resolved through scope expansion or efficiency gains alone.

- ▶ New York must enact legislation authorizing dental therapy with a clearly defined scope of practice, supervision framework, and eligible practice settings.
- ▶ State funding should support the establishment of in-state dental therapy education programs, prioritizing institutions prepared to launch early and serve high-need regions.
- ▶ Education pathways should be designed to integrate dental therapists into existing dental teams in community health centers, schools, long-term care facilities, mobile programs, and rural practices.
- ▶ Medicaid must explicitly recognize dental therapists as reimbursable providers for authorized services.
- ▶ Reimbursement structures should support team-based care models that allow dentists to focus on complex care while dental therapists deliver routine services.

Workforce Recommendation 2: Implement the 2025 Collaborative Practice Dental Hygiene Law

New York's 2025 collaborative practice dental hygiene law created new opportunities to expand preventive care, particularly in community-based settings. However, experience from other scope-of-practice reforms shows that authorization alone does not guarantee impact. Without intentional implementation, provider education, and supportive reimbursement, new authority can remain underutilized.

- ▶ Dental hygienists are already embedded in schools, long-term care facilities, primary care sites, and community organizations across New York. Fully activating their collaborative practice authority is one of the fastest ways to increase preventive capacity, reduce unmet need, and reach populations that face barriers to traditional dental care.

- ▶ New York State should finalize and implement regulations that reflect the law’s intent and enable broad, flexible use of collaborative practice authority, with priority given to populations with the highest unmet need. Regulations should avoid unnecessary administrative requirements that delay adoption or limit practice settings.
- ▶ Public funding should support dental hygiene schools to develop and deliver RDH–CP coursework, including curriculum design, faculty time, and coordination with clinical partners.
- ▶ Professional associations and academic institutions should lead coordinated outreach to ensure hygienists statewide understand the credential and pathways to participation.
- ▶ Medicaid reimbursement must support services delivered by RDH–CPs in authorized community-based settings.
- ▶ Administrative barriers to billing and participation should be minimized, particularly for small and rural practices.



Workforce Recommendation 3: Expand and Sustain Community-Based Oral Health Workforce Roles

Even when providers are available, many patients struggle to access and complete oral health care due to non-clinical barriers. Transportation challenges, limited health literacy, appointment coordination, and follow-up needs all contribute to missed care opportunities. Community health workers (CHWs) and community dental health coordinators (CDHCs) are well-positioned to address these gaps.

New York has invested significantly in CHW infrastructure across health and social care systems, but oral health integration has been inconsistent. Formalizing and sustaining oral health roles for CHWs and CDHCs would strengthen prevention, navigation, and continuity while allowing dentists and hygienists to focus on clinical care.

- ▶ New York should establish standardized oral health training for CHWs and CDHCs that builds on existing certification and workforce development frameworks. State agencies should support a statewide intermediary to coordinate training, technical assistance, and quality improvement. Potential hosts include local health departments, rural health associations, CHW networks, and federally qualified health centers.
- ▶ The curriculum should build from existing, free models, such as the Smiles for Life medical–dental curriculum. The program should be free to trainees and provide certificates upon completion.
- ▶ Training should be adaptable across regions and settings, including community health centers, schools, and social service organizations.
- ▶ Oral health content should be embedded within existing CHW training and continuing education structures to ensure sustainability.
- ▶ Medicaid reimbursement pathways must be clarified and expanded to support oral health-related services delivered by CHWs and CDHCs.
- ▶ Sustainable financing is essential to allow these roles to be embedded in care teams.

Workforce: Implementation Roles and Path to Sustainability

While authorizing dental therapy requires legislative action, the following implementation roles focus on Recommendations 2 and 3, where authority already exists and progress depends on effective rollout, workforce uptake, and sustainable financing.

Philanthropy can play a critical role in accelerating implementation of workforce reforms where authority already exists, particularly collaborative practice dental hygiene and community-based oral health workforce roles such as community health workers and community dental health coordinators. By supporting professional organizations and community partners to develop training, materials, and technical assistance, philanthropy can help translate new and existing authority into routine practice. In addition to dentists and dental hygienists, effective uptake requires informing health care, early childhood, and community-based settings about these expanded workforce roles and how they can be deployed to meet local needs. Rapid adoption is essential for realizing the full potential of these reforms, and philanthropic partners are uniquely positioned to move quickly, respond to emerging needs, and fund early implementation activities that public systems often cannot—strengthening and speeding the transition from policy to practice.



Implementation Roles for Collaborative Practice and Community-Based Workforce Models

| <p style="text-align: center;">Policymakers: Enabling Broad and Effective Implementation</p> | <p style="text-align: center;">Philanthropy: Accelerating Adoption and Uptake</p> |
|---|---|
| <p>Ensure regulations reflect legislative intent. Regulations should support broad, flexible implementation of the collaborative practice dental hygiene law, with a focus on serving populations with the highest unmet need. Overly restrictive rules risk delaying adoption and limiting the law’s impact.</p> | <p>Fund early implementation activities. Philanthropy can support professional organizations and partners to develop training materials, technical assistance, and implementation supports that speed adoption while public systems are still ramping up.</p> |
| <p>Avoid unnecessary administrative barriers. Regulatory and oversight requirements should be streamlined to encourage participation by hygienists, employers, and community-based settings, particularly in underserved areas.</p> | <p>Support statewide training development. Philanthropic funding can help dental hygiene schools and partners cover curriculum design, faculty time, and coordination with clinical sites, costs that many institutions cannot absorb on their own.</p> |
| <p>Invest in workforce training capacity. Public funding should be provided to dental hygiene schools and community-based partners to develop and deliver the coursework required for the RDH-CP credential and oral health-focused CHW/CDHC training, ensuring training is accessible and consistent statewide.</p> | <p>Underwrite coordinated outreach and promotion. Philanthropy can fund proactive, statewide communication efforts so hygienists and community-based workforce partners understand the new credential, how to obtain it, and where collaborative practice can be deployed.</p> |
| <p>Promote cross-sector awareness. State agencies can help ensure that appropriate health care and community settings understand the new authority and how collaborative practice hygienists and community-based oral health workforce role can expand access to care.</p> | <p>Leverage trusted messengers. Philanthropic support can enable professional organizations CHW networks, and academic institutions and community-based organization to lead education and outreach using consistent messaging.</p> |
| <p>Monitor implementation and impact. Policymakers should track uptake of the RDH-CP credential and service delivery patterns to identify gaps and inform ongoing refinement.</p> | <p>De-risk innovation. By funding early adoption, technical assistance, and learning opportunities, philanthropy can help demonstrate what works and inform future public investment.</p> |
| <p>Align Medicaid reimbursement for community-based oral health workforce roles. State agencies should clarify and expand Medicaid reimbursement pathways for CHWs and CDHCs to support oral health education, care coordination, navigation, and follow-up delivered as part of oral health teams.</p> | <p>Support pilot financing and evaluation. Philanthropy can fund pilot payment models, evaluation, and learning to demonstrate the impact of CHW/CDHC oral health roles and inform long-term Medicaid alignment.</p> |

Translating to Practice

The Care Capacity recommendations reflect a shared understanding that New York’s oral health access challenges cannot be solved without structural workforce reform. While prevention, integration, and delivery innovations improve how care is provided, they depend on a workforce that is authorized, trained, and supported to meet demand. Without expanding who can deliver care and how care teams’ function, access gaps will persist regardless of other system improvements.

Authorizing dental therapy adds new treatment capacity where shortages are most severe. Fully implementing collaborative practice dental hygiene accelerates prevention and expands reach. Strengthening community-based workforce roles improves navigation, continuity, and patient experience. Together, these reforms create the conditions necessary for a more efficient, equitable oral health system.

As the capstone of this report, the Care Capacity recommendations focus on strengthening and stabilizing the existing oral health workforce. These strategies address immediate pressures facing providers, including staffing shortages, burnout, and uneven participation in Medicaid. Together, they establish the workforce foundation needed to support expanded models of care across settings and populations.

Recommendations Regarding System Alignment

The cross-cutting recommendations that follow focus on aligning policy, payment, and practice to deliver prevention at scale. They identify the shared infrastructure, training, and Medicaid alignment needed to translate policy changes into routine practice. By addressing these system-wide enablers, the recommendations aim to ensure that workforce reforms result in measurable, equitable improvements in access to oral health care across New York State.

Across all four workgroups, participants emphasized that prevention cannot be confined to dental clinics alone, particularly when Medicaid already covers many preventive oral health services that remain underutilized in practice. To meaningfully reduce oral health disparities and alleviate pressure on a constrained workforce, preventive services must be delivered through the systems where people already receive care and support, including medical settings, early childhood programs, services for people with intellectual and developmental disabilities, and community-based organizations.

The *Barriers to Bridges* report identified prevention and integration as essential strategies for improving access and controlling costs, particularly for populations with the highest unmet need. Subsequent workgroup discussions reinforced that New York already has many of the necessary tools in place, including Medicaid coverage for key preventive services and a broad network of trusted providers. However, these tools are deployed unevenly due to fragmented reimbursement policies, inconsistent guidance, and limited implementation support across systems.

The state already covers many preventive services, but coverage alone does not create access. Without expanding delivery authority and aligning Medicaid policy, prevention will continue to fall short of the communities it is meant to serve.

To move from isolated successes to statewide impact, New York must invest in a shared preventive infrastructure that aligns Medicaid policy, delivery systems, and workforce roles. The recommendations in this section focus on translating existing coverage into routine practice by expanding who can deliver prevention, clarifying reimbursement pathways, and embedding oral health into non-dental systems.

System Alignment Recommendation 1: Expand Fluoride Varnish Access Across Settings

Fluoride varnish is a low-cost, evidence-based preventive service that significantly reduces tooth decay in young children and other high-risk populations. Medicaid already covers fluoride varnish for children, yet utilization remains low statewide. One major reason is that delivery is largely tied to dental settings, even though many children and families experience persistent barriers to accessing dental care.

Expanding who can deliver fluoride varnish and where it can be provided would reduce pressure on the dental workforce and help ensure prevention reaches families regardless of dental provider availability. To do so, New York should pursue multiple, complementary pathways to expand access.

Authorize parents or caregivers to apply fluoride varnish under provider guidance

Allowing parents or caregivers to apply fluoride varnish following in-person or telehealth instruction from a licensed provider would extend prevention to families facing persistent access barriers. This approach maintains clinical oversight while enabling preventive care to occur in the home. Authorizing this model will require statutory change but builds on existing Medicaid coverage.



Authorize medical assistants to apply fluoride varnish in medical settings

Authorizing trained medical assistants to apply fluoride varnish under appropriate supervision would significantly expand preventive capacity in high-volume pediatric and primary care settings. Medical assistants are already embedded in these settings and routinely support preventive services. This change would require statutory action and aligned Medicaid guidance, but could be implemented quickly once authorized.

Together, these approaches would increase preventive reach, reduce reliance on visits for basic prevention, and help ensure children receive timely oral health protection even when dental appointments are delayed or unavailable.

System Alignment Recommendation 2: Embed Oral Health into Non-Dental Systems

Across the Early Childhood, I/DD, and Teledentistry workgroups, participants emphasized that improving access requires meeting people where they already receive services. For young children, families, and people with intellectual and developmental disabilities, non-dental systems such as early childhood programs, primary care, and disability services are often the most consistent points of contact. These systems are therefore critical partners in prevention, early identification, and care coordination.

New York should expand oral health screening, education, prevention, referral, and teledental consultation within early childhood programs, medical settings, I/DD services, and community-based organizations. Teledentistry can play a key role in supporting this integration by connecting non-dental providers to dental expertise for assessment and referral in settings without on-site dental capacity.

To move beyond isolated pilots, the state must provide clear leadership, shared expectations, and implementation support across agencies and systems.

Establish a State-Led Oral Health Integration Initiative

To address implementation barriers identified across all four workgroups, New York State should establish a time-limited, cross-agency Oral Health Integration Initiative charged with moving oral health integration from pilot activity to routine practice.

Key components of Oral Health Integration Initiative to move oral health integration from pilot to practice:

Convene a cross-agency integration workgroup.

The Department of Health should convene a formal workgroup including OCFS, OPWDD, Medicaid, Early Intervention, public health programs, and other relevant state agencies. This group should build directly from the findings of the Early Childhood, I/DD, and Teledentistry workgroups.

Conduct a focused crosswalk of systems and authority.

The workgroup should complete a focused, structured crosswalk to identify:

- where oral health activities can be embedded into existing programs and workflows
- what authority already exists and where statutory or regulatory change is needed
- where Medicaid billing and guidance require clarification or alignment

The goal should be actionable recommendations rather than a descriptive inventory.

Issue unified guidance and expectations for integration.

Based on the crosswalk, DOH should issue clear guidance defining expected or encouraged oral health activities within specific systems, how programs can access training and teledental support, and how integration aligns with prevention and equity goals.

Pair expectations with incentives and implementation support.

Guidance should be paired with targeted incentives such as grants, rate enhancements, technical assistance, or priority consideration in competitive funding. Incentives should reward embedding oral health into routine practice rather than creating stand-alone initiatives.

System Alignment Recommendation 3:

Align Medicaid Policy, Payment, and Guidance to Scale Prevention

Across all four workgroups, Medicaid policy misalignment emerged as a persistent barrier to delivering preventive oral health services consistently and at scale. While New York Medicaid covers several key preventive benefits, limits on coverage for non-dental providers has constrained uptake.

Recent policy analysis reviewed through this initiative indicates that New York is falling behind peer states in reimbursing preventive oral health services, particularly when delivered by medical and other non-dental providers.⁷ Several states have moved deliberately to treat prevention as a core access strategy, aligning Medicaid policy to support risk-based care, medical–dental integration, and comprehensive prevention packages.⁸ These models demonstrate that prevention can be scaled without increasing demand on the dental workforce.

New York should pursue the following priority Medicaid actions:

Create a comprehensive preventive services bundle for children.

New York should establish a Medicaid preventive services bundle for children from birth through age 21 that reimburses dental providers for caries risk assessment, oral hygiene instruction, nutritional counseling, and oral health case management. States such as Montana, Connecticut, and Texas reimburse these services individually, and Montana’s Access to Baby and Child Dentistry (ABCD) program provides a bundled preventive payment for high-risk young children.⁹ Alternative payment models such as bundled payments offer incentives that support prevention, minimally invasive care, and integration of services, contrasting with traditional fee-for-service incentives that reward procedure volume.¹⁰

Reimburse medical providers for caries risk assessment.

New York should add Medicaid reimbursement for caries risk assessment by medical providers, drawing on models used in states such as Connecticut and Texas. Risk assessment enables targeted prevention rather than a one-size-fits-all approach, supports appropriate use of fluoride varnish, and can be integrated into existing well-child visit workflows.

Extend medical reimbursement for preventive services during pregnancy.

New York should reimburse medical providers for fluoride varnish application and caries risk assessment during pregnancy and through 12 months postpartum. Several states have aligned medical and dental benefits to strengthen maternal oral health integration.¹¹ New York already extends dental coverage during this period, and aligning medical reimbursement would leverage existing prenatal visits while positioning the state as a national leader in maternal oral health integration.

Add fluoride varnish coverage for pregnant adults in dental settings.

New York should expand Medicaid dental benefits to include fluoride varnish for pregnant adults over age 21. New York already reimburses for silver diamine fluoride for pregnant adults, indicating that the billing infrastructure is in place to support this addition. Expanding fluoride varnish coverage would strengthen prevention during a high-risk period and further align policy with evidence-based practice.

Aligning Medicaid benefits, billing codes, and administrative guidance to support prevention would reduce provider confusion, encourage broader participation, and allow preventive services to be delivered wherever people receive care. Without these updates, New York risks continuing to lag behind peer states in deploying prevention as a core access and workforce strategy, limiting the impact of the reforms outlined throughout this report.

Conclusion: Advancing the Barriers to Bridges Agenda

New York's oral health access challenges are well documented. What has been missing is not analysis, but action. The recommendations in this report are intentionally practical and actionable. Many require only modest starter funding, clear ownership, and a commitment to move from policy to implementation. None depend on a single transformative solution or expanding the workforce in ways that may take years to materialize.

Across all four workgroups, a consistent message emerged: waiting is not a strategy. The longer the state delays action in pursuit of a comprehensive or perfect fix, the more access gaps will widen. Workforce shortages will deepen, provider burnout will accelerate, and preventable oral health problems will escalate children, older adults, people with disabilities, and communities already facing the greatest barriers to care. For real people navigating pain, missed work or school, and worsening health, delay carries real and immediate consequences.

The recommendations outlined in this report focus on what can be done **now**. Many build on existing authority, infrastructure, and evidence. They require coordination, implementation support, and accountability far more than new policy frameworks. With targeted investment and clear leadership, these strategies can begin improving access in the near term while laying the groundwork for longer-term reform.

Some reforms require legislative action. Authorizing dental therapy is the clearest example. It is also the only recommendation in this report that adds a new category of clinical provider capable of delivering routine restorative treatment. Dental therapists are not a temporary fix; they are a proven and reliable component of dental teams in states that have adopted the model.¹² Enacting dental therapy legislation is essential to expanding treatment capacity in high-need communities and cannot be replaced by efficiency gains or scope adjustments alone.

Importantly, the recommendations presented here do not represent the full universe of changes needed to achieve oral health equity in New York. Rather, they reflect a set of strategies that are ready now, grounded in evidence, informed by providers and communities, and feasible within the current policy environment. Acting on these recommendations does not preclude future reforms; it builds momentum, stabilizes the workforce, and delivers immediate benefit while more complex solutions continue to be developed.

Barriers to Bridges, released in 2025, opened with a clear premise: meaningful progress in oral health requires a strong public infrastructure to support it. That premise remains central. While this report focuses on workforce-level solutions, the success of these recommendations depends on sufficient state capacity to implement, oversee, and sustain them.

Policy change alone is not enough. The success of New York's oral health workforce reforms depends on sustained investment in state capacity to implement them.

Many of the strategies outlined here, including Medicaid policy alignment, teledentistry implementation, workforce training pathways, and cross-system coordination, require active state leadership and administrative capacity. Without sustained investment in staffing, data systems, and interagency coordination, even well-designed reforms risk slow or uneven adoption. Advancing oral health equity in New York will require pairing policy change with targeted, sustainable public investment needed to carry that policy into practice. A key component of that infrastructure should include an independent, statewide oral health coalition of diverse constituencies that can identify service gaps, support policy development and translate policy into projects.

Barriers to Bridges identified 54 actionable recommendations to redesign New York's oral health workforce and expand access to care. Some of those recommendations require significant resources, legislative action, or long-term system change. This implementation phase was designed to move from vision to action by advancing a focused set of strategies that could be developed now, tested, and brought to scale.

This work is not an endpoint. Rather, it is a critical step in building momentum and demonstrating what is possible when policy, practice, and partnership align. Continued progress will depend on others—including state leaders, advocates, providers, and funders—stepping forward to advance additional recommendations and carry this work into its next phase.

New York has the opportunity to move decisively. The tools exist. The workforce is ready. What is required now is leadership and action—by the state and its partners—to begin implementing solutions that work today and build a stronger, more equitable oral health system for the future.



There is no single solution to solve New York's oral health access crisis. The time to take action is now and scale up proven solutions we already have. Every untreated cavity, infection, or missed preventive visit escalates into ER visits, lost workdays, and higher healthcare spending.

—Melissa Wendland, Director, Strategic Initiatives, Common Ground Health.

This work is not an endpoint, but a catalyst for continued action.

Appendix A

Recommendation-Level Policy and Implementation Summary

| Workgroup / Strategy Area | Recommendation | Type of Reform | Primary Actor(s) | Legislative Action Required |
|---|--|--|-----------------------------|-----------------------------|
| Teledentistry | Establish the Teledentistry Practice and Innovation Center (TPIC) | Workforce infrastructure | NYS DOH, partners | No |
| Teledentistry | Establish a Comprehensive State Framework for Teledentistry Standards and Billing | Medicaid implementation / guidance | NYS DOH, Medicaid | No |
| Early Childhood Oral Health | Build an Early Childhood Oral Health Training Pathway Across State and Community Systems | Workforce training | NYS DOH, OCFS, partners | No |
| Early Childhood Oral Health | Implement Medical–Dental Integration Pilots with Embedded Evaluation | Systems integration | NYS DOH, Medicaid, partners | No |
| Early Childhood Oral Health | Strengthen and Govern the Oral Health Otter Hub to Support Early Childhood Programs | Workforce infrastructure / stewardship | NYS DOH, partners | No |
| Access for People with I/DD | Make Existing Medicaid Reimbursement Pathways Work in Practice | Medicaid policy + implementation | NYS DOH, Medicaid | No |
| Access for People with I/DD | Establish a New York State I/DD Dental Passport and Provider Support Program | Workforce infrastructure / care coordination tools | NYS DOH, OPWDD, partners | No |
| Access for People with I/DD | Develop a Statewide Training Pathway on I/DD Oral Health Care from Education to Practice | Workforce training | NYS DOH, academic partners | No |
| Care Capacity | Authorize Dental Therapy in New York to Expand Access to Routine Treatment | Statutory access reform | Legislature | Yes |
| Care Capacity | Vigorously Implement the 2025 Collaborative Practice Dental Hygiene Law | Implementation / regulatory | NYS DOH, SED, partners | No |
| Care Capacity | Expand and Sustain Community-Based Oral Health Workforce Roles | Workforce infrastructure / program investment | NYS DOH, partners | No |
| Cross-Cutting Statutory Access Reforms | Fluoride Varnish Parent Application | Statutory access reform | Legislature | Yes |
| Cross-Cutting Statutory Access Reforms | Fluoride Varnish Application by Medical Assistants | Statutory access reform | Legislature | Yes |
| Cross-Cutting Medicaid Policy and Implementation Reforms | Embed Oral Health into Non-Dental Systems | Systems integration | NYS DOH, sister agencies | No |
| Cross-Cutting Medicaid Policy and Implementation Reforms | Establish a State-Led Oral Health Integration Initiative | Implementation leadership | NYS DOH (multi-agency) | No |

| Workgroup / Strategy Area | Recommendation | Type of Reform | Primary Actor(s) | Legislative Action Required |
|---|---|-----------------------|-------------------------|------------------------------------|
| Cross-Cutting Medicaid Policy and Implementation Reforms | Align Medicaid Policy to Support Prevention at Scale | Medicaid policy | NYS DOH, Medicaid | No |
| Cross-Cutting Medicaid Policy and Implementation Reforms | Create a comprehensive preventive services bundle for children | Medicaid policy | NYS DOH, Medicaid | No |
| Cross-Cutting Medicaid Policy and Implementation Reforms | Reimburse medical providers for caries risk assessment | Medicaid policy | NYS DOH, Medicaid | No |
| Cross-Cutting Medicaid Policy and Implementation Reforms | Extend medical reimbursement for preventive services during pregnancy | Medicaid policy | NYS DOH, Medicaid | No |
| Cross-Cutting Medicaid Policy and Implementation Reforms | Add fluoride varnish coverage for pregnant adults in dental settings | Medicaid policy | NYS DOH, Medicaid | No |

Appendix B



From Barriers to Bridges: Redesigning New York’s Oral Health Workforce for Equity and Access

Executive Summary

Oral health is a vital component of overall health, yet many New Yorkers—particularly people with low-income, Black and brown New Yorkers, rural residents, and people with disabilities—face significant disparities in access to care. Recognizing this pressing issue, the Schuyler Center for Analysis and Advocacy launched the Future Oral Health Workforce Project in 2024. This initiative synthesized insights from statewide studies, expert consultations, and community convenings to develop comprehensive recommendations for building a more equitable and effective oral health system. This report highlights the critical challenges in oral health care and offers actionable solutions to improve access and address the state’s persistent workforce shortages.

Access to quality oral health care is essential for overall wellbeing, yet millions of individuals in New York face barriers to receiving basic dental services. A robust and well-distributed oral health workforce is critical to breaking these barriers, as it directly impacts the availability, affordability, and accessibility of care, particularly for underserved populations. The general understanding of which providers constitute the oral health workforce should include many health care and non-clinical providers who assist with oral health education, preventive services, and referrals to dental care and connecting services, like case management.

Strengthening this workforce is not just about improving individual health outcomes—it is a fundamental step toward reducing disparities, addressing social determinants of health, and ensuring equitable access to care for all.

Recommendations

Enhance New York State’s Oral Health Infrastructure:

Build Capacity at State Agencies to Deliver Oral Health Programs

Recommendations for NYS Department of Health:

- *Establish an Oral Health Office within the NYS Department of Health.* Invest state resources to build a knowledgeable team capable of directing statewide oral health programs, collecting and analyzing data, and monitoring program effectiveness.
- *Create a cross-agency oral health workgroup and an oral health stakeholder group to be convened on a regular basis.* The groups would be tasked, at a minimum, with developing a data agenda, reviewing needs assessments and program outcomes, and considering workforce needs.
- *Re-establish the Oral Health Technical Assistance Center (TAC).* The TAC should facilitate data collection, connect regional programs to resources, share best practices, and pilot innovative initiatives. It could also provide technical assistance to Medicaid dental providers.
- *Develop a new State Oral Health Plan.* Partner with State agencies, advocacy organizations, and community stakeholders to create a new, comprehensive State Oral Health Plan. This plan should address workforce challenges and propose innovative workforce models to meet the state’s oral health needs.

- *Ensure that oral health is recognized in health planning documents.* Connections should be made so oral health becomes a component of all health policy development, such as the NYS Master Plan for Aging, chronic disease plans, and other comprehensive strategies to improve population health.

Improve Data Collection, Analysis, and Research Collaborations to Inform Oral Health Policy

Recommendations for NYS Department of Health:

- *Fully fund the health workforce data collection law.* This data will be invaluable for understanding workforce distribution, identifying areas of need, and planning for future workforce development.
- *Invest in the development of comprehensive oral health data and make it available to the public.* This data should include Medicaid claims data, which can offer valuable insights into service utilization and outcomes and should be used to inform the development of targeted programs and policies. Regular data updates and improved data integration across health systems will support evidence-based decision-making.
- *Encourage dentists to submit electronic health data to the Statewide Health Information Network for New York (SHIN-NY).* Once connected, they can access and exchange electronic health information with other health entities in their region, including hospitals, clinics, nursing homes, home care agencies, payers, ambulatory practices, behavioral health providers, laboratories, pharmacies, and EMS agencies, among others.
- *Engage in research and collaboration on best practices.* Engage with other state and national partners to research and identify best practices for improving the oral health of underserved populations, including people with special health care needs, children in early childhood, and those in rural areas. Stakeholders should collaborate on opportunities to replicate successful programs and identify effective financing mechanisms for these efforts.

Expand Workforce Capacity:

Expand the Scope of Practice for Dental Providers

- *Broaden the settings in which dental hygienists can practice under a collaborative agreement, extending beyond the current restrictions to Article 28 facilities.* Potential new settings include schools, long-term care facilities, group homes for individuals with intellectual and developmental disabilities, veterans' facilities, temporary housing facilities, prisons, drug treatment centers, voluntary foster care agencies, domestic violence shelters, and homebound residents who are unable to visit traditional health care settings. This would bring New York in line with the practice in most other states.
- *Revise the requirements for collaborative practice agreements to allow dental hygienists to perform all services designated under general supervision without the need for prior evaluation by a dentist or medical professional.* These services could be performed without supervision in authorized settings.
- *Expand the scope of practice for dental hygienists to include more services they are educated and trained to provide.* This should encompass minor adjustments to removable appliances, temporary recementing of crowns, and emergency palliative treatments for dental pain, such as smoothing sharp edges on broken teeth or restorations.

Expand the Role of Medical Providers

Recommendation for NYS Medicaid:

- *Implement Medicaid reimbursement for oral health preventive services such as education, risk assessment, and case management.* While New York allows medical providers to bill for fluoride varnish application, there is currently no separate reimbursement for oral health education, risk assessments, or case management. These essential components of care

require staff time and materials and should be reimbursed to support comprehensive preventive services.

Recommendations for Policymakers:

- *Allow dental hygienists to be supervised by physicians for services that fall within the medical scope of practice by amending both the dental hygiene and physician scope of practice laws to accommodate this arrangement.* This would facilitate greater medical-dental integration by eliminating the need for a separate supervisory arrangement with a dentist for dental hygienists working in medical settings. Services could include the application of fluoride varnish and silver diamine fluoride and conducting risk assessments.
- *Authorize medical assistants to apply fluoride varnish.* Allowing medical assistants to apply fluoride varnish under the supervision of medical or dental providers would help broaden access to this critical preventive service in medical offices, schools, and clinics, particularly in underserved areas.
- *Allow parents to apply fluoride varnish when under the supervision of a provider authorized to provide the service.* This change would allow parents to apply fluoride varnish on a telehealth visit with the dental or medical provider. This would be a particular benefit to children in rural areas where transportation is difficult.

Recommendations for NYS Department of Health:

- *Promote medical-dental integration by replicating successful programs from other states and piloting initiatives that address barriers and develop best practices.* New York should prioritize adopting successful early childhood oral health programs from other states given the proven benefits in improving health and dental outcomes.¹³ Other models could focus on pregnant women, children and adults with special health care needs, and older adults.
- *Support and promote interdisciplinary training programs at educational institutions.* These programs can equip dental and medical providers to collaborate and promote more holistic health care delivery.

Expand the Role of Non-Medical Providers

Recommendations for NYS Department of Health:

- *Develop a plan for the delivery of consistent oral health messages in training programs for non-clinical providers working in a variety of settings.* The integration of training and resources should be provided across all state agencies. This could be facilitated by a cross-agency coordination council or a Technical Assistance Center.
- *Ensure that oral health education and toothbrushing curriculum is available and resourced at all Head Start and early care settings.*
- *Expand the [Oral Health Otter webpage](#) to include other providers.* The Oral Health Otter is a webpage from the NYS Council on Children and Families that provides early care and learning providers easy access to oral health resources. It can be adapted for use with other populations.
- *Establish an oral health education and training program for caregivers and health care professionals assisting children and adults with special health care needs or intellectual and developmental disabilities (I/DD).* Supporting early prevention of oral disease for this population, at risk of higher dental need, will reduce the need for more complex treatment and restorative care. The program can be based on existing curriculums and integrated into existing trainings.

Leverage and Expand Teledentistry

Recommendations for NYS Department of Health:

- **Create a learning community of providers** across the state already engaged in teledental services. Regular discussions and knowledge-sharing sessions among these providers can help establish a body of best practices, identify research needs and findings, and highlight policy changes that would enhance services. This collaborative effort can also uncover opportunities for partnerships and improve the overall effectiveness of teledental care.
- **Provide technical assistance to private dental offices and community health centers in underserved areas** to help them develop or participate in existing teledental programs. This could be facilitated through a renewed **NYS Oral Health Technical Assistance Center**, which can offer guidance on implementing teledentistry and overcoming barriers such as equipment, training, and regulatory challenges.
- **Collaborate with State efforts to expand broadband access** to ensure that private dental offices and community health centers in areas of high dental need have the internet capacity to implement or participate in teledental programs. Expanding broadband access is critical for ensuring the success of teledental services, as reliable internet connectivity is essential for high-quality virtual care.
- **Consider opportunities to train local dental practices on emerging technologies like AI diagnostic tools or digital oral health records.** This new technology can bolster telehealth effectiveness and enhance the efficiency of small practices.

Recommendation for Policymakers:

- **Adopt measures to allow out-of-state dentists to read images and develop treatment plans.** This could include:
 - **Creation of a special-purpose telehealth registry** for out-of-state providers to participate in teledental services.¹⁴
 - **Adoption of the Interstate Compact for Dentistry and Dental Hygiene**, which would allow licensed dentists from participating states to practice in New York, expanding the pool of available professionals for teledental services.

Expand the Use of Community Health Workers and Community Dental Health Coordinators

Recommendations for NYS Department of Health:

- **Develop an oral health curriculum for community health workers (CHWs) training programs.** To promote oral health across all the sites where **CHWs** work, it is crucial that they are trained to understand the importance of oral health, improve **oral health literacy**, and have access to relevant resources. These resources would assist CHWs in making effective connections to care for the individuals they serve. New York could consider adapting one of the many successful curricula currently in use in other states.
- **Ensure that CHW payment systems are aligned with the services they provide.** Explore potential changes or improvements in Medicaid reimbursement structures for CHWs offering oral health-related services.
- **Provide Medicaid reimbursement for community dental health coordinators (CDHCs) working at community health centers.** Medicaid reimbursement should be extended to include CDHCs at community health centers, recognizing their valuable role in reducing health disparities and improving access to oral health services.

Increase the Number of Oral Health Providers:

Recognize Dental Therapy as a Profession in New York

Recommendations for Policymakers:

- **Enact legislation to authorize dental therapy in New York.** There are successful examples of dental therapy laws from states that have already implemented the profession, as well as model laws and proposals that have been introduced in New York.
- **Provide funding to establish a dental therapy training program in New York.** Ensure that the passage of the dental therapy law is accompanied by funding to launch a training program within the state. Many states that have implemented dental therapy have faced challenges due to a lack of available training programs. New York should prioritize the creation of an educational pipeline to train an adequate number of dental therapists to address the growing demand for dental care across the state.
- **Allocate funding to the New York State Education Department to implement dental therapy regulations.** Provide necessary funding to support the establishment and regulation of this profession.

Create Oral Health Education Career Pathways

- *New York State should develop a Dental Professions Career Plan with the following components:*
 - *Data on current resources for dental education, gaps in service delivery, and unmet needs in communities.* Input from stakeholders, including consumers of dental services, should also be part of the assessment. A data plan should be one of the first components of the initial evaluation.
 - *Specific goals to expand the dental workforce, particularly for underserved populations and geographies, including Medicaid beneficiaries.* The plan should align with identified goals and needs, providing details on necessary funding, resource allocation, and any legislative or regulatory changes required to support the workforce.
 - *Partnerships with educational institutions, community organizations, and other stakeholders to ensure the long-term sustainability of the workforce pipeline.*
 - *Funding for local programs, such as Area Health Education Centers and BOCES programs to recruit and train students.*
 - *Partnership with the NYS Department of Labor to develop apprenticeship programs in entry-level dental professions.*

Adopt the Dentist and Dental Hygienist Interstate Compact

Recommendations for Policymakers:

- *Enact legislation for joining the interstate Dentist and Dental Hygienist Compact.*
- *Examine avenues for streamlining licensure for oral health professionals moving to New York.*

Opportunities for Foreign Trained Dentists

Recommendations for NYS Department of Health:

- **Develop a comprehensive plan using models from medical schools.** Design a clear, structured plan based on successful models from medical schools to facilitate the practice of foreign-trained dentists in New York. This plan should outline a pathway for approvals and streamline the process for licensure.
- **Conduct research on foreign-trained dentists' practice patterns.** Conduct research to better understand the practice patterns, locations, and patient populations served by foreign-trained dentists in New York. This data will help develop more effective policies to attract and retain these practitioners, ensuring they are positioned where they are needed most.

Recommendations for Policymakers:

- **Provide alternative paths to licensure for foreign-trained dentists.** Allow foreign-trained dentists to complete either a full-time faculty mentorship at an accredited New York State dental school or a full-time experience as a general practice dental preceptee in a designated dental health shortage area. Set standards for the preceptor and standardize training. These options will help integrate foreign-trained professionals into the workforce while addressing access issues.
- **Provide funding to community health centers (CHCs) to attain accreditation for the Commission on Dental Accreditation's Advanced Education in General Dentistry (AEGD) program.** The accreditation process for training programs, including those designed for foreign-trained dentists, is often complex, lengthy, and expensive. CHCs are uniquely positioned as ideal training environments, offering emerging dentists valuable experience serving medically underserved communities. Moreover, dentists who train and live in these communities often choose to remain, fostering long-term access to care. With sufficient financial support and technical assistance, more CHCs can establish training programs, expanding opportunities for dental education, increasing the number of dentists in New York, and creating a robust workforce pipeline to support CHCs.

Create Incentives for Delivery of Care to Underserved Populations

Financial Incentives for Medicaid Participation

Recommendations for NYS Department of Health and Policymakers:

- **Increase Medicaid Fee-for-Service (FFS) dental rates.** New York should conduct a comprehensive evaluation of Medicaid FFS dental rates to determine an adequate rate increase and develop a plan to enact appropriate increases. A dental add-on payment on top of community health centers' (CHCs) existing rate will help CHCs and enhanced rates will help private dental practices.
- **Consider reimbursement incentives for preventive oral health services.** This could include performance-based payment models for additional preventive oral health services to encourage the provision of preventive care.
- **Evaluate Medicaid managed care rates and their impact on dental access.** Analyze the impact of Medicaid managed care dental reimbursement rates on network adequacy, provider participation and patient access to dental services.
- **Institute supplemental payments for special needs dental programs.** Investigate the potential for supplemental payments beyond the existing D9997 code, such as California's D9920 code, to support dental providers serving individuals with special needs. These payments would help address the additional challenges of providing care, ensuring that providers are compensated appropriately for the extra time and resources required.
- **Defray the financial cost of training new providers in community health centers.** This includes designated state funding for CHC dental residency training programs, technical assistance, the cost of preceptors, and other associated costs.
- **Ensure adequate state funding for service obligated scholarship and loan repayment programs.** Allocate sufficient funding to state-funded programs to enhance the recruitment and retention of oral health professionals in underserved areas.
- **Include dental providers in the Doctors Across NY (DANY) Loan Forgiveness Program.** Expand funding for DANY and include dental professionals or create an analogous program. This initiative would help attract and retain skilled dental providers in underserved areas by offering financial incentives, such as loan repayment assistance, to those who commit to working in these communities.

Reduce Administrative Burden and Provide Technical Assistance to Dental Practices and Community Health Centers

Recommendations for Policymakers:

- *Establish a pilot program that assists private practicing dentists and CHCs with Medicaid enrollment, billing, and coding.* The program should provide technical assistance, streamline the credentialing process and remove all identified barriers. There should also be a public campaign to attract the attention of private practicing dentists to the new opportunity.
- *Consider policies to support small or solo dental practices in underserved areas.* This may include grants, tax incentives, or the potential for shared services to reduce overhead.

Conclusion

Addressing New York’s oral health challenges requires systemic reforms, targeted workforce strategies, and innovative care delivery models. The recommendations in this report provide New York State with a policy roadmap that can reduce disparities, improve health outcomes, and ensure that all residents have access to the oral health services they need. This roadmap also provides a foundation for equitable and sustainable oral health policies that prioritize the needs of underserved populations. Collaboration among government agencies, providers, community organizations, and academic institutions will be critical in achieving these goals.

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