National Network for Oral Health Access

User's Guide for Implementation of On-the-Job Dental Assistant Training Programs in Community Health Centers

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Contents

Executive Summary

Across the country, the community health center (CHC) oral health workforce has experienced severe disruptions due to the COVID-19 pandemic. Most acutely, CHCs report a dental assistant (DA) shortage, an issue that precedes the COVID-19 pandemic, but has been exacerbated by the pandemic's effects. Full Time Equivalent (FTE) dental personnel statistics have not recovered to pre-pandemic numbers. This limits current CHC teams in providing the access to oral health that they once provided and produces stress for those staff remaining in the clinic. Among all dental team member types, the biggest impact on CHCs has been, and continues to be, the loss of dental assistants.[1]

In response to the DA shortage, NNOHA conducted a dental assistant needs assessment in 2021 while the pandemic was still at its height. The needs assessment evaluated the DA workforce climate in CHCs and included job satisfaction, salary trends, reasons for leaving DA positions, and training background of DAs. The needs assessment revealed that 74% of dental leaders across the country reported a dental assistant shortage in their clinic and that in response, some CHCs implemented innovative strategies to recruit and retain DAs, including developing their own in-house DA training programs.

DA training programs are designed to address local DA shortages by widening the CHC's application pool, streamlining onboarding procedures for DA hires, and creating a supportive, environment that welcomes DAs to the community health center world. However, creating an in-house DA training program can be an extensive undertaking, including in-depth research, capital expenses, and time. Therefore, in 2022 as a follow-up to the needs assessment, NNOHA conducted interviews with CHCs that sustainably operate their own DA training programs to identify implementation steps and gather promising practices.

Before developing a new DA training program of their own, CHCs should determine what the need is for DAs in their community and within the CHC, and determine if developing an in-house dental assisting training program is the appropriate response. Each clinic has its own capacity to plan, implement and support an in-house DA training program. The factors that CHCs should consider in assessing their readiness to plan and implement an in-house training program include, but are not limited to, state requirements to become a dental assistant, the CHC's policies and protocols regarding dental assisting, its ability to have flexible staffing, and its ability to sustain the dental program while ramping up the training program. The health center must also analyze its physical, financial, operational, and workforce capacity to implement and execute an in-house dental assisting training program.

Planning requires consideration of the frequency, length, scope, and size of the training program, including whether the organization will use and adapt an existing curriculum or create its own content. Having a competency plan to measure and evaluate dental assistant trainees'

[1] NNOHA Community Health Center Workforce Survey: Analysis of 2021 Results. https://drive.google.com/file/d/1TCoHh6chKFN2HujdJYAWuo_lJVyQSE5H/view?usp=sharing.

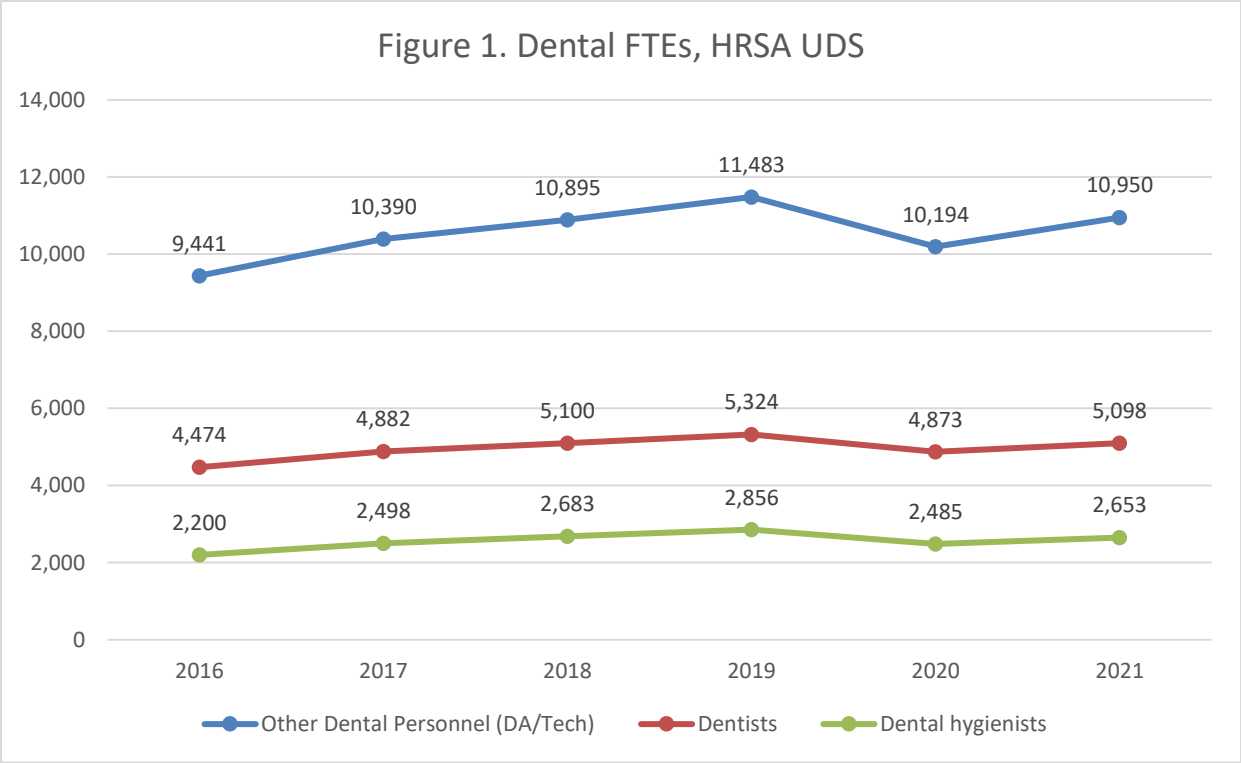
knowledge and skills is also essential. CHCs must be ready to develop new policies and protocols to support, monitor and evaluate the program, including a plan for trainee retention.

Most importantly, engaging key stakeholders, leaders, trainees, and the entire dental team is a key component of successful DA training programs. Successful in-house DA training programs need health center administrations ready to provide resources for the training program and have key team member support, including substantial buy-in from existing dental assistants in the CHC. Ongoing communication and engagement within the clinic and dental team is critical, as is selecting and equipping trainers with the resources they need to teach trainees.

For many health centers, developing an in-house dental assistant training program will be a viable option for building employment capacity within the community and for the health center dental program and increasing access to care. This User's Guide for Implementation of On-the-Job Dental Assistant Training Programs in Community Health Centers can be a useful resource in determining a health center's level of readiness to engage in planning and implementing an in-house program, and a guide to planning considerations in developing a program.

Background

The impact of the COVID-19 pandemic on the health center workforce spans across all departments and staffing categories. HRSA's Uniform Data System (UDS) shows that dental personnel, including dental assistants and dental technicians, decreased by 11 percent during the pandemic, experiencing the sharpest decline of the CHC oral health workforce (Figure 1). The number of dental personnel still has not returned to pre-pandemic numbers. This affects the current CHC team members who remain, as evidenced by NNOHA's latest *Community Health Center Workforce Survey*, where 46% of DAs reported their greatest challenge while working during COVID-19 was burnout from team shortages. In fact, across all dental team member types, the biggest impact felt from COVID-19 is the loss of DAs.[2]

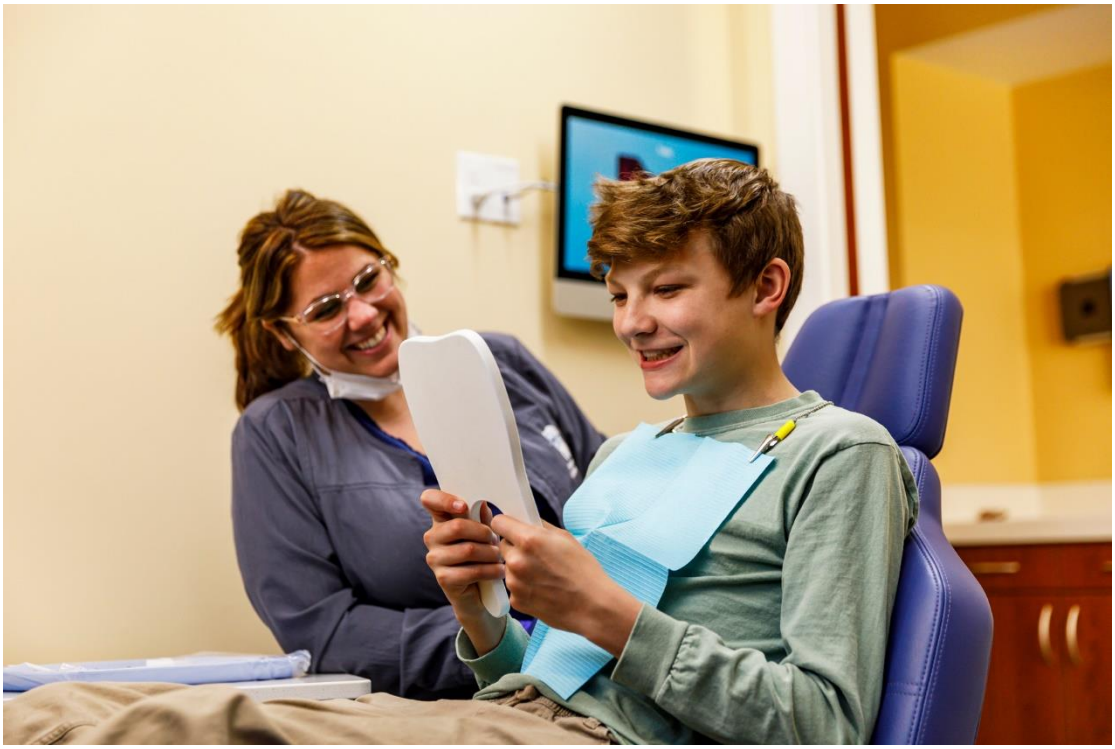


In response to the DA shortage, NNOHA conducted a dental assistant needs assessment in 2021. The *Dental Assistant Needs Assessment* evaluated the DA workforce climate in CHCs including job satisfaction, salary trends, reasons for leaving DA positions, and training background of DAs. In the Assessment, 74% of dental leaders across the country reported a dental assistant shortage in their clinic.[3] As a response, 22% of CHCs reporting have implemented an innovative strategy to recruit and retain DAs: in-house, on-the-job DA training

[2] NNOHA Community Health Center Workforce Survey: Analysis of 2021 Results. https://drive.google.com/file/d/1TCoHh6chKFN2HujdJYAWuo_IJVyQSE5H/view?usp=sharing.
[3] 2021 NNOHA Dental Assistant Needs Assessment. https://drive.google.com/file/d/1-wJaozKkkOHOp0tudIF6lo5Q4wNER0bD/view?usp=share_link

programs. Because trainees who participate in on-the-job training programs are more likely to be community members or existing team members, the training program also establishes a community-based economic resource and strengthens ties between the CHC and its service area, providing opportunities for economic advancement and health equity for the communities that CHCs serve.

As a follow-up to the *Dental Assistant Needs Assessment*, NNOHA conducted interviews with CHCs that sustainably operate their in-house dental assistant training programs. Based on the results of those interviews, this publication provides guidance to CHCs with interest in developing their own DA training programs. In addition, this publication reviews planning considerations for on-the-job dental assistant training programs and gathers promising practices from the interviewed organizations to assist in planning the implementation of an in-house DA training program to recruit and retain DAs and increase access to dental care.



Planning Considerations for On-the-Job Dental Assistant Training Programs

I. Evaluate the need for an in-house training program

NNOHA recommends two or more full-time dental assistants per one full-time dentist for optimal oral health care delivery,[4] a DA to dentist ratio that reflects HRSA's UDS pre-pandemic dental workforce data. Therefore, most CHCs express concern about their insufficient dentist to DA ratio to their administrators, highlighting its impact on clinic capacity and team burnout. CHCs demonstrate the need for an in-house training program pointing to a paucity of local DA schools and other training options, resulting in a limited supply of qualified DAs in their service area. Furthermore, many CHCs report that new DA hires from other training programs need additional training regardless, so formalizing onboard training specific to the health center dental program is more efficient than the existing hiring and onboarding process.

> *"You have to have an invested administration that really can see the future and see that our future really looked grim ..."*
> *– Dental Operations Manager*

Another aspect of evaluating program need is knowledge of the requirements for entry-level dental assisting in the clinic's home state. Most states do allow on-the-job training of entry-level dental assistants, but each state has variations in the minimum requirements for becoming a dental assistant, and understanding how the planned program will address the requirements is important.

II. Engage key stakeholders

The key stakeholders who participate in the implementation or approval of a DA training program include executives, particularly the Chief Executive Officer (CEO) and Human Resources director as well as the dental director and/or dental program manager, as these individuals can assist with initiation or management of the program. The CHC's board may also be a key stakeholder. Additionally, the existing DAs at the CHC will likely take on the role of the trainers or have their own productivity and workflows altered by the training program. Therefore, it is critical to get buy-in from the existing DAs.

> *"…we got together with our leads [dental assistants], number one: to make sure this is something they were going to be able to support."*
> *– Administrative Site Director*

For CHCs in partnerships with outside organizations (i.e., a local community college), the partnering organization's administration also

[4] NNOHA Operations Manual for Health Center Oral Health Programs: Chapter 5 - Workforce and Staffing, 2020. https://drive.google.com/file/d/1p-iClXI9qFLSiClXk0RSr7r9paZr-Kdx/view?usp=drivesdk.

needs to have buy-in to engage with the CHC in planning and allocating resources and time to the new program. For CHCs looking to provide DA trainees participating in the in-house program with state or regional certifications and licenses, regional certifying boards may require approval or certification of the in-house training program. Lastly, interdepartmental support (IT, Medical, Communications/Marketing, and/or Legal) can facilitate implementation by assisting with marketing, creating and reviewing curriculum, or in providing some aspects of the DA training.

III. Select program implementation leaders

Implementation leaders are typically dental directors or dental office managers, but they can also be any team member who has the passion and ambition to develop the DA training program. Therefore, some CHCs create a new role for an educator to serve as the leader. Furthermore, implementation leaders typically have a background in dental assisting, teaching/adult education, and/or program management. CHCs largely attribute the success of their in-house DA training programs to an implementation leader who "loves to teach" or "loves dental assisting."

> *"I volunteered, because it was my thought and idea, and I'm the one who wrote the curriculum, and the competencies that we were going to be using, the resources that we were going to bring into play, so I had the full go ahead from operations and our CEO to just go ahead and take charge of the program." – Dental Program Manager*

IV. Develop a budget

When developing budgets for their in-house dental assistant programs, CHCs develop an initial budget which includes one-time startup costs and an operating budget of ongoing costs to continue the program. CHCs report initial start-up costs ranging from $2,000 to $169,000, therefore, a CHC's DA training program can vary substantially in cost depending on the length, scope, and size of the program. Purchasing training materials and using extra clinical equipment and supplies can affect the cost of the DA training program as well. In general, CHCs may use funds for:

- Teaching materials (curriculum, textbooks)
- Dental training simulators and models (manikins, typodonts)
- Trainee personal protective equipment
- Extra clinical equipment/supplies for practicing skills (radiograph sensors, blood pressure cuffs, dental instruments, clinic materials)
- General school supplies (binders, flashcards)

In addition to equipment costs, depending on the training program, salaries or personnel costs can increase the budget. CHCs typically bring on two to six trainees per training cycle, often depending on positions available in the clinic, as some programs hire trainees as employees and pay them an entry-level DA wage during their training. CHCs can also assign a portion of the

salaries of the implementation leader and/or trainers, usually an existing employee of the health center, to the DA training program budget.

CHCs also allocate funds for certification classes, such as radiography, infection control, American Medical Technologists (AMT) or Dental Assistant National Board (DANB) certifications, or any local certifications that an individual state requires for DAs.

The organization-wide or dental department budget typically serves as the primary funding source for the in-house dental assistant training program. Some CHCs seek out local or state grants or solicit donations for supplies and instruments. Some CHCs develop programs that require the trainees to pay a fee for some aspect of the training program (i.e., application fee, scrubs, books, and/or certifications).

V. Select trainers

The number and backgrounds of CHC DA program trainers may vary, largely depending on the level of interest and capacity of team members. Trainers may include one or two team members, or involve the entire dental team. CHCs reported to NNOHA that most trainers do not have formal training in teaching DAs, but do have informal DA training experience. Some trainers also have a background in adult education. During some CHC training programs, trainers may receive additional certifications or continuing education (CE) on radiology, infection control, and/or adult education.

> *"…make it as much of a team effort as possible…divide the workload a little bit…pick your people who are passionate about education and training, and who are excited to train dental assistants, be a part of that process." – Dentist*

Moreover, CHCs stress the importance of understanding the role existing team members want to play in the training program. Some team members may want to help train new DAs, which helps build clinic morale, but CHCs should note that some team members may prefer not to take on additional responsibility in training. As such, CHCs may choose to hire a trainer specifically for the in-house program.

VI. Create trainee requirements and recruitment strategies

In-house DA training programs typically have one or more of the following requirements for their trainees:

- Age 18 years old or older
- High school diploma/GED
- Eligible to work in U.S.
- Mission/community service driven motivation
- Demonstrates ambition and aptitude
- Has basic understanding of DA responsibilities

Recruitment methods for trainees include *internal* recruitment of existing team members (i.e. front desk or medical team) who express interest in dental assisting. *External* recruitment can entail posting advertisements digitally (social media, job boards) and in the community (i.e. posting notices in grocery stores or train stations), but also through the CHC's current patient base, by recruiting patients who express interest and aptitude.

> *"[The dental assisting training program is] capturing people in the community that might have thought about being a dental assistant or are just excited about the opportunity to get that training."*
> *– Lead Dental Assistant*

VII. Design program schedule and curriculum

A training program cycle may run anywhere from one week in length to two years, but most program cycles for the CHCs that NNOHA interviewed are four to six weeks. Often, the time between onboarding as a trainee and working independently as a DA may vary depending on the CHC's capacity and needs.

As for the course content and schedule, some programs teach didactic course content first, then have trainees move on to clinical experiences in the second part of the program while other programs run didactic and clinic activities simultaneously, either alternating by days/weeks or running both activities in the day. Terminology and basic anatomy may be taught didactically through books, videos, and online resources, through simulating patient care in a clinic (clinical labs) and shadowing other DAs with live patient care.

CHCs employ various training methods for different clinical components:

Infection prevention and control (IPC)

IPC is one of the highest and earliest priorities in CHC DA training programs. IPC training occurs via labs, shadowing DAs and/or sterilization technicians, watching videos, reading books, and/or taking online trainings. Many programs must follow state or regional policies and procedures that dictate where, when, and how DAs train in IPC.

> *"They do HIPAA training, bloodborne pathogens, infection control, and other health center compliance trainings before they ever step foot in an operatory." – Dental Operations Manager*

Radiology

Radiology training occurs via practicing in labs with manikins, shadowing DAs as they take radiographs, and watching videos. Requirements for radiology training is largely state dependent, as some CHCs need to follow state policies and procedures that dictate where and when DAs should receive radiology training.

Procedures

Methods of training on dental procedures are the most variable, as dental procedures can be learned through videos, books, and shadowing, and practicing in labs and/or assisting a live

patient with a trainer present.

Electronic dental record (EDR) training
Training learners on using the EDR occurs mostly through shadowing and labs. Some CHCs dedicate a non-dental team member who performs clinic-wide electronic health records training, and thus, serves as the designated trainer for the EDR part of the program.

Patient management
Patient management is taught largely through shadowing other DAs with patients, which entails discussing the case with the trainee before seating the patient and after discharging the patient. Clinics may also supplement shadowing with videos about patient management and customer service.

IX. Establish the training setting(s)

The location of didactic training can take place in a variety of settings, including the clinic (during clinic hours and/or during non-clinic hours), a non-clinical location (classroom), or at home (self-study).

Some CHCs that NNOHA interviewed found it helpful to have multiple sites or extra operatories that can be solely used for teaching, although other CHCs run their entire training program (didactic and clinical) concurrently with patient care. Having a flexible, wide range of hours to use facilities also helps with efficient training. If training within in the clinic is not possible, community centers, high schools, or community colleges can serve as locations for didactic training and even basic labs and simulations.

Common learning-space challenges include having operatories that are not set up similarly to the one where the new dental assistant will be working, or operatories that are too small for effective training. Also, requiring trainers or trainees to travel too far or too often to multiple sites can be burdensome.

X. Develop competency assessments

Competency assessments throughout the training program may be administered as checklists/sign off sheets, quizzes, exams, or one final exam. Some training programs use quizzes or exams solely for the didactic training portion. CHCs often require trainees to perform procedures in the presence of the trainer. The trainer then signs off on a competency checklist. CHCs may also create a checklist (see NNOHA's CHC Developed DA Training Materials) specifically for the program or use the CHCs' existing DA competency checklist. Similarly, CHCs may embed the training program into their regular clinic competency procedures, where trainees are assessed as a DA in 30-60-90-day or annual review.

Some clinics require their trainees to challenge regional or national certifying exams, such as American Medical Technologists or Dental Assistant National Board exams, to assess their competency in dental assisting. For clinics that do not use any written or documented competencies, they provide trainees feedback after each procedure until they demonstrate the ability to work independently. In fact, most programs dictate the ability of a DA to work competently on their own as the end of the training process.

> *"[Trainees] work one on one, side by side with a coach in their clinic…the coach really gets the day-to-day tasks and delegation on how to do those things and then they have a skills log booklet that they fill out…, if they do [procedures] specifically themselves, their coach signs off on it, dates it by the end of the program." – Dental Assistant Training Program Specialist*

XI. Develop program evaluation

Program evaluations track program improvement, program impact, and trainee competency. Common program evaluations include satisfaction surveys from the trainees and trainers, as well as documenting the recruitment rate (trainees hired/total trainees) and retention rate (trainees remaining in organization/total trainees). Program evaluation can also include the clinic competency assessments. For clinics that receive a restricted grant for the DA training program, the grantmaking organization may require more information, such as demographic information, to be collected during the program.

> *"We do a follow up with our doctors and our assistants on a regular basis. We check in on them to see how the assistants are doing. And, again, it's not just those technical competencies, but the behavioral part of it. How are they interacting with the staff? How are they interacting with the patient? Our metrics are more of a one-on-one, face-to-face interaction, with not only the staff who has been involved with the training, but also meeting with the person who is the trainee, as to how they feel the training is going."*
> *– Dental Program Manager*

Lastly, ongoing communication and feedback between the program leaders, trainers, trainees, and supervisors is a key part of program evaluation and improvement. Most programs report that aspects of their in-house DA training program have changed from the originally implemented plan, suggesting these CHCs continually re-evaluate and refine the program.

XII. Develop trainee retention strategy

Of the clinics NNOHA interviewed, 73% report that the implementation of their in-house DA training program is very effective in addressing recruitment challenges, as it widens their applicant pool. If DA trainee retention is a high priority for the CHC's training program, some

clinics establish employment contract clauses (if permittable in their area and if the trainee is also hired as part of the program) requiring trainees to work with the organization for a certain length of time after the training program. Some CHCs require trainees to pay a fee for some aspect of the program to establish a level of accountability and commitment.

> *"We're training these people in a federally qualified health center setting, hoping that they all go work at federally qualified health centers." – Dental Director*

Regardless of whether CHCs with in-house DA training programs exceeded their training goals, or if the organization experienced attrition, CHCs' reported their appreciation for the role they played in training community members to be skilled, competent DAs and increasing access to care for the whole community.

Readiness Assessment

The following is a checklist to assist CHCs in determining if an in-house DA training program is an appropriate strategy for their organization.

The Need

Creating an in-house DA training program can be a significant undertaking, including capital expenses and existing staff time. Before starting the process of developing a DA training program, CHCs should determine if there is demonstrable need for DAs in their community and within the CHC by asking the following questions:

1. Will an in-house, on-the-job DA training program meet our workforce needs and objectives?

First, determine if housing a DA training program meets the organization's workforce needs and goals in a timely and efficient manner. Some clinics note that developing a strong relationship with a local DA training program and serving as an extramural rotation site is an efficient strategy in establishing a pathway for DAs to their CHC. CHCs may also consider partnering with existing high school or job corps training programs to establish CHC DA pathways. (See NNOHA's Academic Partnership White Paper). Some CHCs may find other recruitment and retention strategies (such as establishing career ladders or increasing salaries/benefits) more appropriate for their organization's immediate needs.

2. What are the local/state regulations in our state?

CHCs should research regulations for a DA training program; every state has its own policies, and protocols regarding DA, IPC, radiology, employment, and education programs.

Tip: *The Dental Assisting National Board website provides DA requirements by state, along with state dental board practice acts and reports of recent state dental assisting legislative and regulatory changes. CHCs can also contact their state's constituent of the American Dental Assistants Association to get more information about training and state board requirements.*

Capital and Operating Expenses

As with most new CHC programs, a DA training program costs money. CHCs must consider how they will fund and sustain the program.

3. Have sources of funding and capital expenditures been identified?

CHC DA training programs can vary substantially in cost depending on the length, scope, and size of each program. CHCs need to establish a program budget and identify funding sources. Often, the CHC's dental department or the CHC funds the training programs, but grantmaking organizations, primary care associations, local dental organizations and local dentists may also serve as potential resources.

CHC Operations

It is important that CHCs determine how the DA training program will operate efficiently alongside regular clinical operations. This includes dental program capacity, leadership buy-in, and training program design.

4. Does the organization have the capacity to house a DA training program?

Health centers vary in their capacity to support an in-house DA training program. Some CHCs have the capacity to host the entire program in their clinic, while other CHCs may need to partner with an outside organization. The CHC may experience lost revenue due to reduced patient volumes during the start of the training project; therefore, it is important that the CHC plans for this and remains flexible. A CHC should be able to sustain itself while ramping up the training program. Therefore, CHCs need to consider physical (square footage, operatories, sites), financial (initial drop in productivity and revenue, fixed training program costs), operational (flexible hours and available resources), and workforce (willing and supportive team) capacity to determine the organization's overall capacity to implement and sustain an in-house dental assisting training program.

Tip*: Any clinic considering an in-house DA training program needs to have a supportive culture for trainees. Consider whether the organization has the morale, time, and resources to commit to investing in education for its team, including entry-level and existing allied team members.*

5. Is there buy-in from key stakeholders, including a prospective DA training program leader?
CHCs must have buy-in from the organization's administration and dental team if they are considering implementing their own DA training program. Successful in-house DA training programs have CHC leadership that is ready to provide resources for the training program and supportive team members, including substantial buy-in from existing DAs in the CHC.

> ***Tip:*** *CHCs must identify the individual(s) who love teaching, adult education, and/or dental assisting and has time in their schedule to devote to designing and implementing the program.*

Program Design

CHCs need to consider the frequency, length, scope, and size of the training program, including whether the organization will use and adapt an existing curriculum or create its own content. Having a competency plan to measure and evaluate dental assistant trainees' knowledge and skills is also strongly recommended. CHCs must be ready to develop new policies and protocols to support, monitor, and evaluate the program.

6. Is there a recruitment strategy?
CHCs considering implementing their own DA training program must consider whether the organization will recruit internally or externally, and then identify the requirements for potential trainees. Will trainees need to have previous work experience? Will trainees need to have a high school diploma/GED? Will trainees need to be bilingual? The dental and executive teams should discuss what trainee requirements will best serve the organization's workforce needs. In addition, CHCs should consider how they will promote the opportunity internally and externally.

> ***Tip:*** *If the CHC will recruit trainees outside of the organization, consider presenting to local high schools or community centers. Existing dental team members can share what it is like to work in the dental field, opportunities for advancement, and advertise the DA training program.*

7. Have sources for curriculum and training materials been identified?
No one size fits all for a CHC DA training program, and there are many options for training curriculums. There are national online training curriculums or some CHCs may prefer to develop their curriculum completely on their own. NNOHA has collected examples of DA training curriculums available to adapt, from several organizations including CHCs (see NNOHA's CHC Developed DA Training Materials). The curriculum should align with state regulatory guidelines (see Step 2 in this Readiness Assessment). Sources of curriculum are vast (books, videos, national dental certifying board exam materials), therefore, programs will need to determine

whether the program will rely heavily on formal textbooks/materials or on the expertise of an experienced team member. Additionally, CHCs can partner with a local DA school to support the curriculum.

8. How will trainees be compensated?
Most trainees are hired immediately upon acceptance into the training program and are paid an entry-level DA wage by the organization during the training program. CHCs that do not hire DA trainees immediately will need to decide if, and how, trainees will be compensated.

9. How will the program be evaluated?
Programs should be evaluated to improve and track the program's impact. Therefore, consider what information the CHC needs to collect or measure (i.e. trainee details, program details, clinic productivity). Will program evaluations include satisfaction surveys from trainees, team members, and/or patients? In NNOHA's research, CHCs suggest, especially for the first cycle of trainees, that communication should be frequent and ongoing to allow adjustments to the program.

> ***Tip:*** *Designing a DA training program will take longer than expected; develop a realistic timeline and set SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) goals.*

10. What is the program's dental assistant retention strategy?
The finding from the 2021 NNOHA Workforce Survey indicated that 57% of dental assistants who planned to leave their CHCs in five years also reported a need to increase their income. In 2021, the median hourly wage was $18.00 for CHC dental assistants, while DANB, which includes private practice dental assistants, reported the 2021 median hourly wage as $19.80. In addition, over 58% of dental assistants noted that the number of vacation and sick days and continuing education reimbursement were "inadequate."[5] In fact, dental assistants received over $1,000 less per year for CE compared to dental hygienists and dentists in 2021. Therefore, to improve recruitment and retention of dental assistants, it is recommended that community health centers provide competitive salaries and benefits, including continuing education benefits.

[5] NNOHA Community Health Center Workforce Survey: Analysis of 2021 Results. https://drive.google.com/file/d/1TCoHh6chKFN2HujdJYAWuo_lJVyQSE5H/view?usp=sharing.

Additional Recommendations

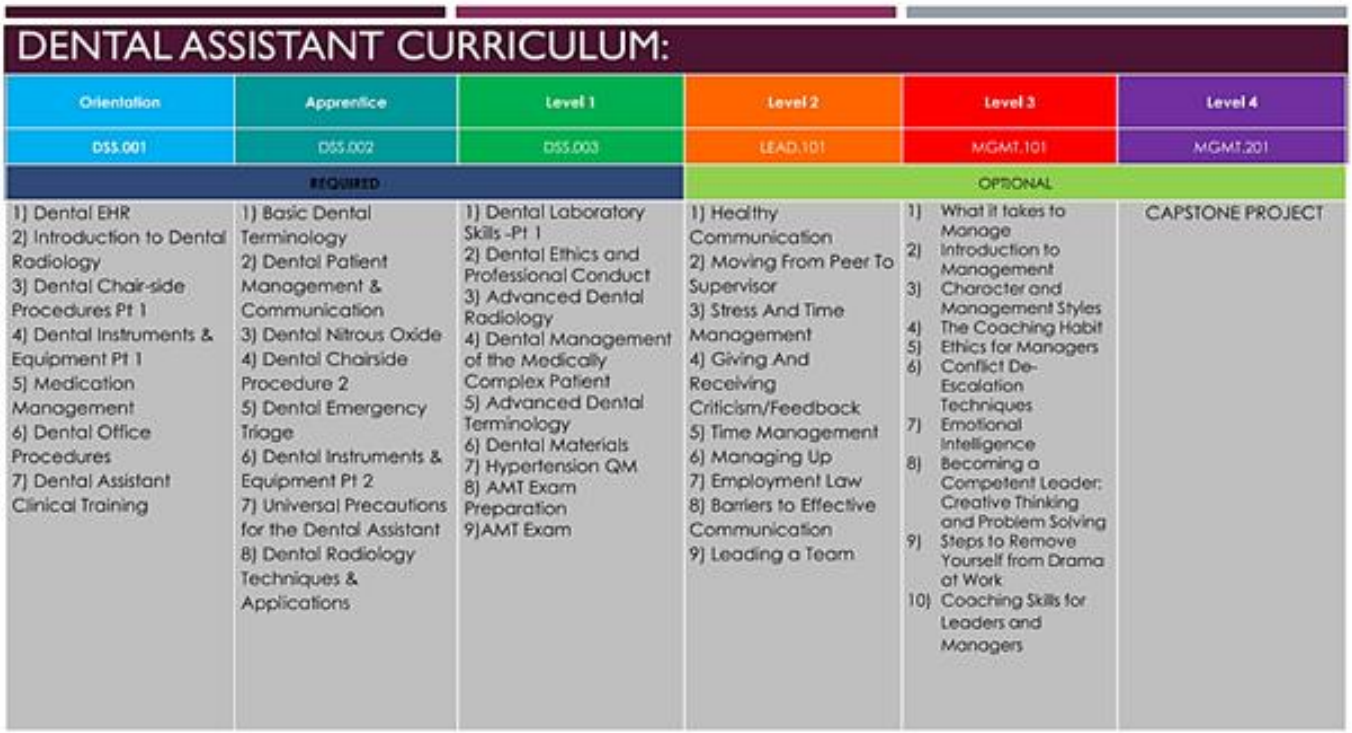
Establish Career Ladders for Career Development

Some public health organizations implement dental assistant career ladders, which allow dental assistants opportunities for upward mobility in their organization, including more leadership positions in the clinic and in the administration. Below are two examples of career ladders from the field:

Salud Family Health Centers Career Ladder

Salud Family Health Centers' in-house dental assisting training program also entails a career ladder (see Figure 2). Once hired dental assistants complete the required portion of dental assistant training (Orientation, Apprentice, and Level 1), they have the option of completing additional training (Levels 2, 3, and 4) and applying for management and leadership roles in the health center.

Figure 2. Salud Family Health Centers Dental Assistant Career Ladder Curriculum
Note: Visit NNOHA.org to see a larger view of this career ladder.



Indian Health Services Expanded Function Dental Assistant Training Program (USPHS)

The Indian Health Services (IHS) offers an Expanded Function Dental Assistant (EFDA) training program for its dental assistants. The DAs mostly seek these higher opportunities in expanded functions to provide care to tribal members. The IHS has four levels of Expanded Function Dental Assistant training courses: periodontal, restorative-basic, restorative-advanced, and restorative-composite only, each with their own curriculum. IHS has around 30-40 week-long courses each year offering 36 hours of continuing dental education (CDE) credits. Dental assistants from tribal programs pay to attend one of these courses, so the amount of tuition USPHS receives each year covers the costs of the program. Therefore, the program is self-sustaining in terms of budget. Trainees are not paid in the program, other than their normal home clinic salary.

The trainee starts by taking a 6-9 hour long online prerequisite course. They must pass pre-tests and post-tests to be able to register for the in-person training. The in-person training takes place over a week, combining both didactic and hands-on training. After completing the hands-on training, the trainee returns to their home clinic and must demonstrate competency within a six-month period, under a dental leader's direct supervision. Once the trainee successfully completes the post-course requirements, the Chief Dental Officer certifies them. In total, the program usually lasts six months or less.

Promote Positive Culture and Wellness

Nearly half of DAs in the 2021 NNOHA Workforce Survey reported that their primary reason for working in a community health center was that they wish to practice in a community-based setting, while 43% of dental assistants said that they had a mission to serve the dentally underserved. Although mission-minded individuals are more inclined to work in a CHC, negative workplace cultures can be a deterrent. Therefore, CHCs should demonstrate empathy, promote engagement, address concerns of stress and burnout, and reward and recognize teams to build morale.

Conclusion

CHCs are experiencing dental assistant workforce disruptions that are negatively impacting access to care for populations in need. As a response, CHCs across the country are implementing formal, in-house DA training programs as an innovative approach to addressing local DA workforce shortages and creating economic opportunities for community members. Ultimately, these DA training programs present an opportunity to increase the capacity of dental delivery systems to provide care and reinvest in the whole community, increase access to care, and strengthen the relationship between the dental workforce and populations community health centers serve.

Resources

2021 NNOHA Dental Assistant Needs Assessment. https://drive.google.com/file/d/1-wJaozKkkOHOp0tudIF6lo5Q4wNER0bD/view?usp=share_link

Association for Clinicians of the Underserved's STAR^2 Center – HRSA National Training and Technical Assistance Partner for CHC Workforce
https://chcworkforce.org/

Dental Assisting Curriculum Framework
https://www.dalefoundation.org/courses/catalog/course/dental-assisting-curriculum

Dental Assisting Training Materials
https://www.nnoha.org/pages-1/resources-%7C-workforce-%7C-dental-assistant-training-materials

Dental Infection Prevention and Control Certification
https://www.osap.org/certification

NNOHA Academic Partnership White Paper: Partnering with Academic Institutions and Residency Programs to Develop Service Learning Programs
https://drive.google.com/file/d/1ehCmXzR4bsdd6MqCW3ahkRCZKpvCLvrH/view

NNOHA Community Health Center Workforce Survey: Analysis of 2021 Results.
https://drive.google.com/file/d/1TCoHh6chKFN2HujdJYAWuo_lJVyQSE5H/view?usp=sharing

State Dental Assisting Requirements
https://www.danb.org/state-requirements

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