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Comprehensive Evaluation of the Missouri OPA-EFDA Pilot Project

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Table of Contents

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Introduction

The Missouri Dental Hygienists' Association (MDHA) undertook a detailed review of the OPA-EFDA Pilot Project to determine whether the program demonstrated clinical safety, measurable treatment outcomes, increased clinic capacity, or improved access to care. Legislators and regulatory agencies rely heavily on the integrity of research presented to them, particularly when it involves modifications to scope of practice, public funds, or patient safety. Therefore, this report structures its findings in a clear, accessible, and evidence-grounded format, emphasizing the importance of methodological rigor and transparent reporting.

Executive Summary

The Missouri Oral Preventive Assistant-Expanded Functions Dental Assistant (OPA-EFDA) Pilot Project was designed to assess whether Expanded Function Dental Assistants could safely improve access to oral healthcare, increase clinic capacity, and allow more efficient use of dentist and dental hygienist time. This evaluation finds that the pilot did not meet the fundamental standards required of evidence used for legislative or regulatory decision-making. Significant flaws in study design, the absence of Institutional Review Board (IRB) oversight, inconsistent data collection, and reliance on non-clinical metrics undermine the validity of the reported findings and limit their usefulness for policymaking purposes.

This evaluation determined that none of the pilot's three stated objectives were achieved. The project failed to demonstrate valid clinical outcomes, measurable improvements in access to care, or meaningful expansion of clinic capacity attributable to OPA-EFDAs. Re-evaluation rates of less than one percent and the lack of standardized clinical outcome measures prevent any reliable assessment of safety or effectiveness. Given these limitations, the pilot does not provide a sound evidentiary basis for creating a new provider category. Policymakers are better served by focusing on proven, licensed workforce solutions that already meet established standards for patient safety, accountability, and effectiveness.

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OPA-EFDA Pilot Project: Design Considerations

Key Findings

- Bias manifested across project design, clinic and participant selection, data collection, measurement, and conclusions.[1-2]
- Lack of required safeguards used when research is utilized for human-subjects—particularly IRB oversight—compromised the reliability, validity, and ethical grounding of the study.[3-4]
- The project did not adhere to universally recognized standards for research or program evaluation.[5]
- The design had weaknesses that affected the reliability of subsequent data interpretations.
- Supragingival scaling (scaling above the gumline) alone is not the standard of care to prevent and control gum disease.
  - The standard of care is to remove all plaque and deposits from the teeth at one appointment, as it is almost impossible to just scale teeth above the gumline and stop instrumentation under the gumline. Research has shown that supragingival scaling alone can actually harm a patient, leading to periodontal abscesses and worsened oral health outcomes through insufficient care.[6]
- Probing is difficult even for experienced practitioners. This is responsibility reserved exclusively for licensed dentists and dental hygienists who have completed extensive education and training.

Workforce Claims, Clinic Selection Bias, and Conflicts of Interest

- Claims of "significant" hygienist workforce shortages in participating clinic locations were presented without definition or evidence.
- Potential impact of permanent OPA-EFDA position upon dental assistant workforce shortages was not presented.
- OPA-EFDAs already had full-time responsibilities and were only involved in 2.4% of the appointments in their clinics.
- Eligibility restrictions for Medicaid-participating clinics lacked transparency regarding application availability and criteria. Request for Applications (RFA) or the detailed eligibility screening questions were not disclosed.

- Conflicts of interest occurred where Missouri Dental Board (MDB) or Missouri Dental Association (MDA) officers supervised OPA-EFDAs within their own clinics.

Absence of IRB Oversight

- No IRB protocol number or documentation was included.[7-8]
- Without IRB oversight, required CITI Program training for investigators working with human-subjects was also absent.[9]
- Required IRB approval for protocol modifications was not obtained.
- The project was not registered with ClinicalTrials.gov, limiting transparency.[10]
- Lack of IRB review allowed methodological deviations to occur without necessary oversight or justification.

Human Subjects Selection Bias

- Pilot expanded beyond its statutory authority by including all patients rather than Medicaid or underserved populations.[11]
- Unclear whether patients were new or existing, emergency or comprehensive, or whether full periodontal evaluations occurred.

Data Collection & Measurement Bias

- No standardized clinical indicators, such as probing depths, bleeding points, plaque indices, or x-rays were used to determine disease status and change during re-evaluation.
- Patient satisfaction surveys were incorrectly treated as indicators of clinical improvement (treatment outcomes).[12-13]
- Lack of clarity in application of the 2017 World Workshop periodontal classification to include identification of intact or reduced periodontium; stable periodontium; non-periodontitis patients; and successfully treated stable periodontitis patients. [Chappell, Table 1, p. 80][14]
- No accounting for local or systemic risk factors influencing oral disease progression, i.e., plaque/biofilm retention, oral dryness, tobacco use, recreational substance use, metabolic conditions.

Data Analysis & Reporting Concerns

- Data emphasized anecdotal or non-clinical metrics.
- Selective reporting appeared to favor desired outcomes.
- Lack of standardized measurement tools prevented meaningful data interpretation.
- Conclusions presented were not supported by the underlying data.

Section Summary

These design and oversight deficiencies collectively undermine the integrity of the OPA-EFDA Pilot Project. Without adherence to established research and ethical standards, the findings cannot be considered reliable or suitable for policymaking.

Evaluation of Pilot Project Objectives

The Missouri OPA-EFDA Pilot Project established three primary objectives to be evaluated through the deployment of 16 newly trained OPA-EFDAs across seven clinic locations. Each objective, along with the pilot's reported findings, is reviewed below.

Objective 1

Assess the treatment outcomes of OPA-EFDAs for healthy and gingivitis patients from both clinical and patient perspectives.

Assessing treatment outcomes is essential for accountability, transparency, and evidence-based policymaking. Meaningful evaluation requires the use of valid clinical indicators that demonstrate safety, effectiveness, and health improvement.

Key Issues Identified

- Patient satisfaction was used as a proxy for clinical outcomes. Patient satisfaction does not equate to clinical quality, safety, or health improvement and is not a valid measure of treatment effectiveness.[12-13]
- Only two new duties—supragingival scaling and periodontal probing—were evaluated. All other procedures assessed are tasks already performed by dental assistants (placement of sealants, fluoride application, etc.).
- No standardized clinical outcome measures were reported, such as plaque indices, probing depths, bleeding scores, or attachment levels. The term "improvement" was not defined.
- The report indicates that the threshold for classifying patients as having "gingivitis" was raised from 10% bleeding points to 30% bleeding points.
  - This change potentially allowed billing under CDT code D4346 ("scaling in presence of generalized moderate or severe gingival inflammation").
  - Use of this code raises concerns regarding inappropriate or fraudulent billing.
  - D4346 is a periodontal disease code and would require scaling below the gingival margin, which OPA-EFDAs are not legally authorized to perform.
- Supervisors reportedly spent only 10–15 minutes twice per day evaluating OPA-EFDAs, an insufficient amount of time to meaningfully assess competency or quality of care, rendering performance scores unreliable indicators of clinical competency.

- The study does not describe calibration of clinical supervisors, making it impossible to determine how performance ratings were assigned and whether evaluations were consistent across sites.
- Re-evaluation rates for 2024 and 2025 were:
  - 2024: 12 of 959 (1.25%) patients treated by dentists and hygienists
  - 2025: 10 of 1,626 (0.6%) patients treated by OPA-EFDAs
    These sample sizes for the re-evaluation rates were too small to be statistically meaningful or clinically valid.

Conclusion – Objective 1

Objective 1 was not met. The pilot failed to demonstrate valid clinical outcomes, safety, or effectiveness of OPA-EFDAs as a new provider type.

Objective 2

Determine whether OPA-EFDAs increased clinic capacity and access to care, as measured by total services, attended appointments, exams delivered, and new patients.

Key Issues Identified

- Only two new services—probing and supragingival scaling—were relevant to measuring increased capacity, and minimal clinical time was allocated to these services.
- Only 10 patients treated by OPA-EFDAs were re-evaluated for health outcomes, representing less than 1% of the patient population. Comprehensive evaluation should have been conducted for all patients receiving care.
- The requirement for direct supervision significantly reduces efficiency, as dentists or hygienists must examine each patient and complete care that OPA-EFDAs are not authorized to provide.
- The need for dentists or hygienists to interrupt schedules to complete subgingival care undermines workflow efficiency and is operationally impractical.
- Reassigning a dental assistant to the role of an OPA-EFDA exacerbates the shortage of dental assistants and reduces the feasibility of expanding and sustaining that role.
- According to the report's own conclusions, pilot data did not demonstrate a significant increase in clinic capacity or access to care.
- High patient satisfaction ratings were again used as indicators of success, despite a lack of relevance to capacity or clinical effectiveness.
- Overall reporting of findings overstated impact and did not align with the underlying data.

Conclusion – Objective 2

Objective 2 was not met. The pilot failed to demonstrate increased access to care or expand clinic capacity attributable to OPA-EFDAs.

Objective 3

Evaluate whether incorporating OPA-EFDAs allows dentists and hygienists to reallocate time toward patients with more serious or urgent periodontal needs.

Key Issues Identified

- Evidence of increased capacity was anecdotal rather than data-driven.
- The report explicitly states that pilot data did *not* demonstrate a significant increase in access to periodontal care.
- Deployment of OPA-EFDAs was limited to less than 4% of appointments, preventing a meaningful evaluation of this objective.

Conclusion – Objective 3

Objective 3 was not met. There is no evidence that OPA-EFDAs improved access to care for patients with greater periodontal needs.

Summary for Legislators

- None of the three objectives of the OPA-EFDA Pilot Project were achieved.
- The study failed to demonstrate safety, effectiveness, improved access, or meaningful clinical outcomes.
- Re-evaluation and outcome measurement rates were insufficient (<1%) to support evidence-based conclusions.
- OPA-EFDAs did not perform clinically substantive duties at a level that justifies recognition as a new provider type.
- Missouri already licenses dental hygienists who possess the education, ethical training, and clinical competence to safely deliver preventive and therapeutic oral healthcare.
- MDHA recommends rejecting authorization of OPA-EFDAs and instead focusing on proven strategies to retain, expand and fully utilize the existing dental hygiene workforce.

Solutions to Address Healthcare Shortages

The Missouri Dental Hygienists' Association (MDHA) recognizes the urgent need to strengthen Missouri's clinical dental hygiene workforce, particularly in rural and underserved areas. While workforce challenges persist, current data and evidence point to practical, high-impact solutions that can improve access to oral healthcare statewide.

Current Workforce Landscape

- Missouri has more active and residing dental hygienists than dentists, according to the Missouri Division of Professional Registration (Oct. 11, 2025). https://mopro.mo.gov/license/s/license-downloads[15]
- Workforce attrition has been more significant among dental assistants than dental hygienists according to the Missouri Department of Health and Senior Services. Missouri Oral Healthcare Report on Workforce. Missouri Office of Dental Health. February, 2023.[16]
- Despite these figures, access gaps remain, especially in rural communities, due to distribution, scope-of-practice limitations, and retention challenges.

MDHA-Supported Solutions

1. **Strengthen and Expand Education Pathways**
   - Support existing dental hygiene programs, which have successfully increased enrollment and launched rural satellite programs to improve access to care.
   - Provide funding to continue to expand dental hygiene programs and increase class capacity.
2. **Allow Dental Hygienists to Practice to the Full Extent of Their Education**
   - Enable full scope of practice.
   - Reduce unnecessary supervision requirements.
   - Allow direct access to patients.
   - Expand public health and community-based practice opportunities.

3. **Improve Workforce Retention using evidence-based retention strategies, including:**
   - Positive and respectful workplace culture
   - Ergonomic protections
   - Reasonable patient scheduling
   - Appropriate equipment and instruments
   - Proper infection control standards
   - Fair and competitive compensation
   - Flexible scheduling options
   - Job-sharing and part-time opportunities
   - Mutual respect among all members of the dental team

4. **Support Workforce Pipeline**
   - Support the ADHA Hygienist Inspired Chairside Recruitment Program, which recruits individuals into the dental hygiene profession into areas of need.

5. **Expand Financial Incentives**
   - Include dental hygienists in loan forgiveness and repayment programs.
   - Support scholarships and incentive programs that encourage practice in areas of greatest need.

6. **Promote Regulatory Modernization**
   - Support licensure portability to improve workforce mobility.
   - Allow for the practice of dental therapy in Missouri.
   - Support self-regulation of the dental hygiene profession.

Conclusion

The Missouri OPA-EFDA Pilot Project does not provide a reliable evidentiary basis for legislative or regulatory action. Significant deficiencies in design, oversight, data collection, and outcome measurement prevent meaningful evaluation of patient safety, clinical effectiveness, or workforce impact. The absence of institutional review board oversight, lack of standardized clinical indicators, and extremely low re-evaluation rates undermine the credibility of the findings and limit their relevance for policymaking.

Across all three stated objectives, the pilot failed to demonstrate improved treatment outcomes, increased access to care, or meaningful expansion of clinic capacity attributable to OPA-EFDAs. Where benefits were asserted, they were based largely on non-clinical or anecdotal measures rather than validated data. For policymakers charged with protecting patient safety and ensuring accountability, this pilot does not meet the standards required to justify creation of a new provider category. Missouri already licenses dental hygienists with established education, clinical training, and accountability, and strengthening this proven workforce represents a more evidence-based approach to improving access to oral healthcare.

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