The California Oral Health Workforce

Deficits and Opportunities

by Miranda Davis, DDS, MPH, and
Elizabeth Mertz, PhD, MA
March 2026

Overview

This issue brief describes California's current oral health care workforce configuration and explores its capacity to serve the state's population, particularly Medi-Cal (i.e., Medicaid) enrollees, describes the oral health care services that are most provided to Medi-Cal enrollees, and examines a workforce policy opportunity—the authorization of dental therapists—a proven solution to improve oral health care access. A companion issue brief addresses the current state of oral health access in California.

The Oral Health Workforce Problem

California has long struggled to find effective measures to address challenges in access to oral health care services for a significant portion of the state's population, specifically individuals enrolled in Medi-Cal, California's Medicaid program. The state's many investments over the past several decades have had minimal impact on changing the overall situation.[1] In a 2021 report, the University of California, Los Angeles (UCLA) Center for Health Policy Research noted that California's oral health workforce, in its current configuration and scope, is unable to meet California's oral health care needs.[2] Despite having a wide range of licenses and certifications and a robust dentist workforce, the critical gaps that remain are the same ones

that the Surgeon General noted over two decades ago—a lack of workforce diversity, a lack of capacity to address the population's restorative care needs, and a lack of flexibility to adapt the workforce in a large variety of geographic, cultural, and care delivery settings.[3]

California's Oral Health Workforce

California licenses four types of oral health care providers: dentists (DDS/DMDs), oral surgeons (DDS/DMDs + MDs), registered dental hygienists (RDHs), and registered dental assistants (RDAs). Additional certifications for advanced training, including registered dental hygienists in alternative practice (RDHAPs) and registered dental assistants in extended functions (RDAEFs), as well as other roles, are also conferred by the state. These provider types, along with dental auxiliary roles, are summarized in the table below. Dental technicians, who fabricate dental items, are not required to be licensed and are increasingly rare in the oral health workforce.[3]

Table 1. California's oral health workforce

Health care role	Scope of practice	Degree/training/requirements
Dental Community Health Worker (CHW)	Oral health education and navigation, care coordination, and case management. *Medi-Cal billing for dental-focused services provided by CHWs was approved in 2024, but there is no data on uptake.*	Lived experience plus: • training pathway or • experience pathway *Note: CHWs have long been part of the health workforce in California.*
Dental Assistant (DA)	Chairside dental assisting, x-rays, photos; topical agents, tooth polishing, and other procedures as directed and supervised by the dentist.	No specific training requirement to begin working, specific courses required within one year of employment, and additional courses required to be allowed to perform specific procedures.
Orthodontic Assistant **Dental Sedation Assistant**	Add-on certifications for DAs.	• 12 months work experience as a DA • Board approved program, • Written exam

Health care role	Scope of practice	• Degree/training/requirements
Registered Dental Assistant (RDA)	DA procedures plus sealants, temporary fillings, bleaching agents, temporary crowns, and other procedures as directed and supervised by the dentist.	• Dental board-approved program, work experience, or combination • Written exam
RDA in Extended Functions (RDAEF)	RDA procedures plus oral health assessments, placing fillings (after the tooth is prepared by a dentist), and other procedures as directed and supervised by the dentist.	• Dental board-approved program • Written exam
Registered Dental Hygienist (RDH)	RDA scope plus local anesthesia, nitrous oxide, prophylaxis, scaling, curettage, root planning, oral health screenings.	• Associate's, bachelor's, or master's degree from a dental hygiene board-approved program • Written and clinical exams
RDH in Extended Functions (RDHEF)	RDAEF scope plus RDH scope. *Note: this role is being phased out.*	• RDH plus additional training. *Note: this role is being phased out.*
RDH in Alternative Practice (RDHAP)	A specified portion of the RDH scope of practice. RDHAPs have authorization to practice and bill independently, providing RDH services in homes, schools, residential facilities, and underserved areas.	• RDH plus additional education/training from one of three programs in California; bachelor's degree • Documentation of dentist relationship
Dentist	Providing all services covered by Medi-Cal dental benefits.	• Doctorate degree from an accredited program • Written and clinical exams
Specialist Dentist	Dentists with additional training in one or more 11 dental specialty areas of practice. Only oral surgeons are additionally licensed as medical doctors (MDs). Unlike in medicine, other dental specialists are not required to be board-certified, although many are.	• Doctorate degree from an approved dental program • Additional specialist education/training

Sources: Medi-Cal Dental Community Health Workers, Dental Board of California – Table of Permitted Duties, Dental Hygiene Board of California – Table of Permitted Duties, How to Become an Orthodontic Assistant Permit Holder, How to Become a Dental Sedation Assistant Permit Holder, Dental Sedation Assistant or Orthodontic Assistant Permit Holder, How to Become a Registered Dental Assistant in Extended Functions, Dental Hygiene Board of California – Information for Applicants to Become Licensed

The Supply and Distribution of the Oral Health Workforce

While California has considerably more dentists per population than other states, the geographic distribution of those dentists does not match the need for care. People needing care tend to be lower income and often reside in rural communities; dentists tend to live and work in urban areas with fewer low-income residents.[2,4] At the close of 2025, there were 565 federally designated Dental Health Professional Shortage Areas (DHPSAs) in California, most of which were facility designations (n=455), usually federally qualified health centers (FQHCs) that serve Medi-Cal patients. Additionally, there were 97 population designations, indicating regional shortages of Medi-Cal providers. Almost 3 million people (about the population of Mississippi) live in DHPSAs in California, with only 36.1% of the need being met.[5] The remaining geographic shortages are in rural and remote areas of the state.

Racial concordance between patients and providers has been found to be an impactful factor in health outcomes. For example, greater representation of Black primary care providers is associated with better population health outcomes for Black individuals.[6] And when Black patients are exposed to a greater availability of Black providers, they both use more preventive care and have better health outcomes.[7] Minoritized dentists provide a disproportionate share of care for patients who share the same race and ethnicity as them.[8] Yet, California's dentists lack the same racial/ethnic diversity as the state's population, and there has been very little progress in diversifying the oral health care workforce since we documented it in the early 2000s.[4] According to the California Department of Health Care Access and Information (HCAI), as of December 2024, 45.1% of California's population is Hispanic and Black, while only 9.9% of California's dentists are Hispanic and Black.[10]

The dental assisting and hygiene workforce is slightly more diverse than the dentist workforce, and is predominantly female (over 93% for both occupations).[10] RDAs are 50.1% Hispanic, 27.9% white, 14.5% Asian, 2.4% Black, 2.3% multiracial, 1.4% other race, 0.8% Pacific Islander, and 0.5% American Indian. RDHs are 51.1% white, 21.0% Hispanic, 20.2% Asian, 3.4% multiracial, 2.0% other race, 1.3% Black, 0.7% Pacific Islander, and 0.3% American Indian. However, there has been an ongoing shortage of these providers since the COVID-19 pandemic. This has led to calls from dentists to make access to RDA/DA training easier and to

expand RDA/DA's scope of practice to provide greater flexibility in their deployment in clinical care settings. At the same time, hygienists have pushed back on this effort as potentially harmful scope-of-practice creep, even though the hygiene profession similarly desires expanded scope of practice and is also suffering from severe shortages.[7,18] The reality is that California simply does not have the right types of providers, in the right places, with the right system to support access for California's increasingly diverse population. This is most acute for the state's Medi-Cal population.

Dental Workforce Participation in Medi-Cal

The vast majority of California's dentists do not participate in Medi-Cal in a meaningful way (defined here as providing >100 patient visits annually). The most recent estimates presented by Healthforce Center researchers to the Health Workforce Education and Training Council (HWET), an advisory body to the state of California, showed that while approximately 40% of dentists are enrolled as Medi-Cal providers, only 25% submitted a claim in 2019, and only 15% saw more than 100 adult patients that year.[11] This is consistent with a prior study by the UCLA Center for Health Policy Research, which reported that only 19% of practicing dentists had participated in Medi-Cal in a meaningful way, and only 11% had provided >1,000 visits to Medi-Cal patients annually.[2]

The RDHAP profession is the only other billable dental provider in the Medi-Cal program.[13] RDHAPs provide access to preventive care for populations that often lack dental care, such as residents in long-term care settings.[11] Established in 1997 as an *independent* dental hygiene authority after conducting one of the state's health workforce pilot projects (discussed later in this brief), this provider type is unique to California; the license is not recognized or transferable to any other state.[19] RDHAPs must have a documented agreement with a dentist for "referral, consultation, and emergency services."[13] This agreement does not *require* the dentist to accept referrals from Medi-Cal if the dentist is not enrolled in Medi-Cal, limiting the ability of RDHAP patients to get restorative care or dental extractions if they need it, which they often do.[15] Finally, there are relatively few RDHAPs; they comprise less than 1% of California's total licensed oral health providers and do not tend to practice full-time (average hours per week reported = 26).[14] In 2019, there were 770 licensed RDHAPs out of 83,602 total licensed

oral health providers. With California's three RDHAP education programs, this number is only projected to grow to 851 by 2027.[16]

California's Oral Health Disproportionately Relies on Dentists

In California, most oral health care services sought and needed by Medi-Cal enrollees must be provided by a dentist; current law does not allow dental assistants or hygienists to perform almost any diagnostic or restorative procedures. Of eligible Medi-Cal children ages 0-20 who utilized dental services in 2024, 47% received preventive services (e.g., cleanings, fluoride varnish, sealants) and 23% received treatment services (e.g., fillings, extractions). Of the top ~28.3 million procedure codes billed for Medi-Cal enrollees ages 0-20, ~16.1 million were diagnostic (e.g., examinations, x-rays) and ~3 million were treatment-related.

Of eligible Medi-Cal adults ages 21+ who utilized dental services in 2024, 15.2% received preventive services and 17.3% received treatment services. Of the top ~13.1 million procedure codes billed for Medi-Cal enrollees ages 21+, ~7.3 million were diagnostic, ~2.5 million were preventive, and ~3.3 million were treatment.[16] Table 2 and Figure 1 provide the numbers and percentages of procedures provided to Medi-Cal patients in 2024 across diagnostic, preventive, and treatment services.

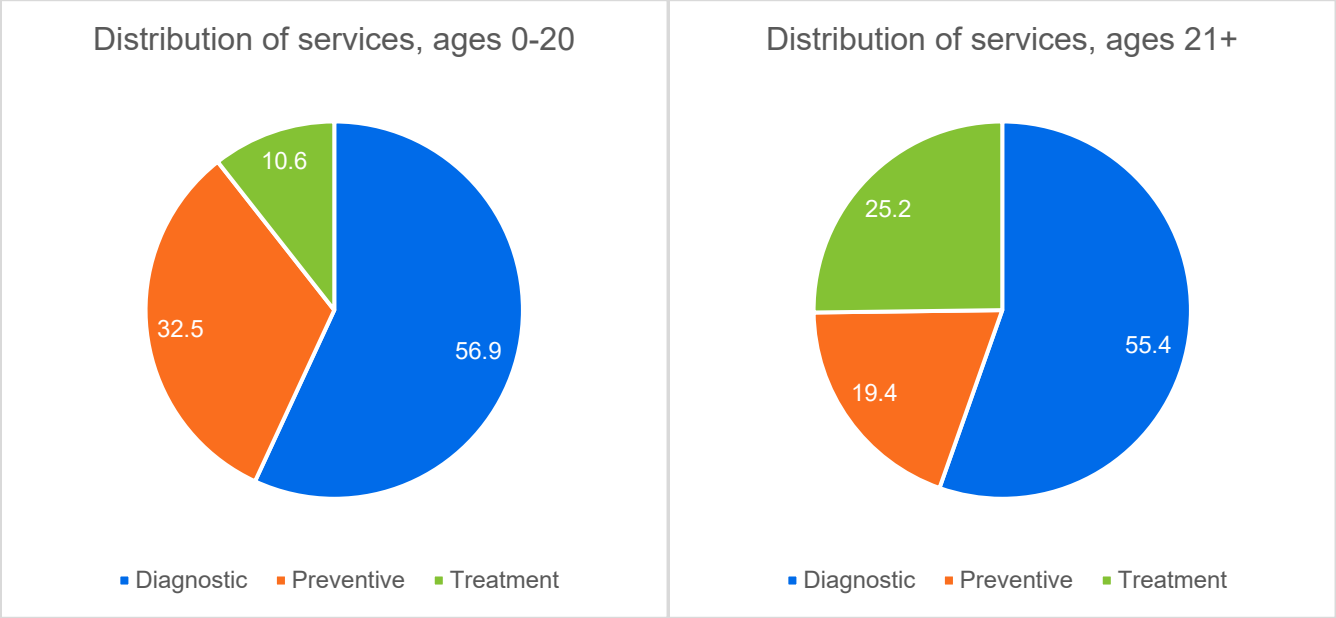
Table 2. Count of oral health care procedures billed to Medi-Cal in 2024

	Diagnostic	Preventive	Treatment	Total
Ages 0-20	16,106,730	9,199,510	2,996,543	28,302,783
Ages 21+	7,251,492	2,540,650	3,291,207	13,083,349
Total	23,358,222	11,740,160	6,287,750	41,386,132
Source: *Medi-Cal Dental Services Division Statewide Fact Sheet*				

Examining the services used by Medi-Cal patients allows consideration of the types of providers who can deliver the necessary services. Under the current workforce policy, a dentist is the only provider allowed to perform diagnoses and complete nearly all the treatment services needed, including routine care. A small number of diagnostic and treatment procedures, such as oral assessments and deep/complex cleanings, can be done by dental

hygienists and RDHAPs. The result is a workforce configuration that is heavily and disproportionately reliant upon dentists.

Figure 1. Percent of oral health care procedures billed to Medi-Cal in 2024



Dentists' inability to delegate the diagnosis and treatment for routine procedures to additional members of the dental team results in long waiting lists to receive care from the relatively few dentists who participate in Medi-Cal.[18] This limitation also does not allow people to choose from any variety of provider types when seeking oral health care or benefit from different arrangements of team-based care.

Evidence-Based Practices and Policies

While there have been many efforts to attract dentists to Medi-Cal, such as simplifying the provider enrollment system, reducing administrative burdens such as treatment authorization requests, providing outreach and assistance to dentists to enroll, resourcing training and performance based incentives, and increasing reimbursement rates, these initiatives have not resulted in a significant change in the number of dentists who see patients enrolled in Medi-Cal

nor the number of Medi-Cal patients dentists treat.[12] In part, that is because providers know these initiatives are subject to wide variations in the state funding environment, given that adult coverage is optional in Medicaid, and Medicare does not cover routine dental benefits. For example, Proposition 56 tobacco tax revenue funded dental fee enhancements and a relatively successful loan repayment program (CalHealthCares),[20] but the latter is now paused, and the former is now proposed for a claw back to close the state budget gap.[21] Policy to ensure adequate payment for dental care is critical, but incremental improvements, such as raising rates in Medicaid programs, are likely not enough to solve ongoing disparities.[22] Research from Healthforce Center at the University of California, San Francisco suggests that the greatest potential for meaningful improvements in oral health access lies in policy changes and investments in the oral health workforce that address long-standing structural barriers.

California's Health Care Workforce Investments

While the oral health care workforce presents unique challenges, the reality in California is that there are shortages and maldistribution across much of the health care workforce, including primary care, behavioral health, nursing, and long-term care workers, to name a few.[23,24] To remedy these issues, the state of California, through a series of workforce-focused initiatives and legislation (AB 133, 2021), reorganized health workforce policy and planning under the Department of Health Care Access and Information (HCAI) and launched the HWET framework and council, along with targeted grant programs and a centralized data infrastructure.[25–27] Innovative approaches to health workforce policy and programming have a long history in California. For example, the Health Workforce Pilot Projects Program was established in 1970 to facilitate novel investments in expanding the health workforce. The dental field has taken advantage of this more than once to expand scopes of practice, most notably the introduction of the RDHAP.[28]

The contemporary approach by the state reflects a deliberate philosophy: *to address persistent workforce shortages, geographic maldistribution, and lack of diversity while also advancing economic mobility and community development*. California has prioritized expanding training pathways for frontline health workers—including community health workers, behavioral health providers, nurses, and allied health professionals—particularly roles that do not require four

years of postgraduate training.[29] By investing in shorter-term, community-based, and earn-and-learn models, the state aims to build a workforce that reflects the populations served, increases access in underserved regions, and creates sustainable career ladders that both strengthen the health system and provide economic opportunity.

The Children and Youth Behavioral Health Initiative is an example, with over $4 billion dedicated to expanding the behavioral health workforce to address growing need and demand for these services.[30] Within this initiative, the state is increasingly recognizing the importance of non-doctorate roles such as certified wellness coaches[31] – building on longstanding efforts to expand community health workers/representatives/promotores in expanding access to primary care while providing more accessible career options.[32] Medicine has long used nurse practitioners and physician assistants/associates to address routine health care needs. Expanding the health care team has improved access to care, increased efficiency, and supported patient-centered models of care with positive effects on health outcomes and social determinants of health.[33]

The oral health workforce is notably absent from these efforts, despite longstanding workforce deficits and widespread unmet oral health care needs. However, these investments in accessible health careers, addressing shortages and lack of diversity, have a parallel in new oral health care workforce roles. A shift toward workforce redesign offers an opportunity to address both access to care and pathways into health professions for individuals from underserved communities.

An Overdue Workforce Solution

California's current oral health delivery model relies heavily on dentists to provide the vast majority of services, limiting the system's ability to address widespread unmet need. A more effective and sustainable approach is to modernize the dental team by authorizing dental therapists to expand capacity, improve efficiency, and maintain high standards of care.

Dental therapists are licensed oral health professionals who practice as part of a dentist-led, team-based care model. They are trained to deliver many of the most commonly needed

services, including preventive care, diagnosis of dental caries, basic restorative treatments, and certain nonsurgical extractions. This model is well established internationally and has been successfully implemented in the United States for more than two decades, beginning in Alaska and now authorized in 14 states.[34,35] Accreditation standards for dental therapy education have been implemented, ensuring educational quality and consistency, and enabling license portability among states.[36]

A robust body of evidence demonstrates that dental therapists provide safe, high-quality diagnostic, restorative, and preventive care, while expanding access for underserved populations.[34,37] Importantly, supervision requirements can be structured to allow for general (offsite) supervision, enabling dental therapists to practice in community-based settings without requiring a dentist's physical presence. This flexibility supports care delivery in high-need locations such as rural and underserved areas, including schools, mobile clinics, long-term care facilities, and patients' homes.[38,39]

Authorizing dental therapy also presents an opportunity to improve provider diversity and better align the workforce with the populations most in need of care. Compared to doctorate-level training pathways, allied health professions typically have fewer financial, geographic, and logistical barriers to entry.[40] As a result, these providers are more likely to come from underserved communities, practice in Health Professional Shortage Areas (HPSAs), and serve Medicaid populations.[24]

Emerging evidence from states that have implemented dental therapy shows that integrating these providers enables clinics to serve more patients and improve oral health outcomes, while also providing a sustainable economic opportunity for high school graduates seeking a health career.[37,39] At a time when California faces ongoing constraints in Medi-Cal and public health funding, and when job opportunities for recent graduates continue to be challenging, policies that increase system efficiency, promote sustainable economic well-being, and maintain or improve quality are especially critical. Authorizing dental therapists offers a practical, evidence-based strategy to strengthen the state's oral health system and expand access to care.

Conclusion

Despite statewide efforts to expand access to oral health care in California, significant gaps persist—particularly for low-income populations and communities of color. The burden of oral disease continues to fall disproportionately on socioeconomically disadvantaged groups, rural residents, older adults, people with disabilities, and other historically underserved populations.[27]

Dental therapy has emerged as a proven, evidence-based policy solution to address these disparities. Fourteen states—including all of California's neighboring states—have authorized dental therapists, demonstrating improved access to care and positive health outcomes.

Although California's oral health workforce laws appear broad, they remain overly restrictive in practice. Current regulations concentrate diagnostic authority and most treatment responsibilities within a single provider type: dentists. This structure limits the system's capacity to meet population needs and contributes to ongoing access challenges. Authorizing dental therapy offers a practical pathway to improve access, reduce disparities, and strengthen the state's oral health system.

Find more research and evidence from Healthforce Center on the policy landscape for Medi-Cal dental services and access to dental care.

Acknowledgements

The evidence synthesized in this report was supported by a grant from The California Wellness Foundation, and this publication was made possible through a grant from The California Endowment.

About Us

Healthforce Center's Policy Advisory is a trusted partner to California state, regional, and national leaders, providing expert guidance and community-informed

research that accelerates cross-sector health workforce policy solutions.

References

1. Kottek A, Mertz E. Policies and Initiatives Impacting Medi-Cal Dental Care: 2014 - 2023. Published online 2024. https://healthforce.ucsf.edu/file/91999-06asnapshotofcaliforniaslocalpublichealthdepartmentspdf

2. Pourat N, Ortega-Verdugo P, Ditter M. *The Challenge of Meeting the Dental Care Needs of Low-Income California Adults With the Current Dental Workforce*. UCLA Center for Health Policy Research; 2021. https://healthpolicy.ucla.edu/sites/default/files/2023-04/dental-care-needs-low-income-ca-adults-policybrief-jun2021.pdf

3. Dental Technician. California Dental Certifications. Accessed March 16, 2026. https://dentalcertifications.com/dental-technician/

4. Mertz EA, Grumbach K. Identifying Communities with Low Dentist Supply in California. *Journal of Public Health Dentistry*. 2001;61(3):172-177. doi:10.1111/j.1752-7325.2001.tb03386.x

5. Bureau of Health Workforce. *Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2026 Designated HPSA Quarterly Summary*. Health Resources and Services Administration; 2025. data.hrsa.gov>generatehpsaquarterlyreport file:///C:/Users/miran/Downloads/BCD_HPSA_SCR50_Qtr_Smry.pdf

6. Snyder J, Upton R, Hassett T, Lee H, Nouri Z, Dill M. Black Representation in the Primary Care Physician Workforce and Its Association With Population Life Expectancy and Mortality Rates in the US. *JAMA network open*. 2023;6(4). doi:10.1001/jamanetworkopen.2023.6687

7. Frakes M, Gruber J. The Effect of Provider Diversity on Racial Health Disparities: Evidence from the Military. *Rev Econ Stud*. Published online October 1, 2025:rdaf072. doi:10.1093/restud/rdaf072

8. Mertz EA, Wides CD, Kottek AM, Calvo JM, Gates PE. Underrepresented Minority Dentists: Quantifying Their Numbers And Characterizing The Communities They Serve. *Health Aff (Millwood)*. 2016;35(12):2190-2199. doi:10.1377/hlthaff.2016.1122

9. Race & Ethnicity of California's Health Workforce. HCAI. Accessed March 16, 2026. https://hcai.ca.gov/visualizations/race-ethnicity-of-californias-health-workforce/

10. *Health Workforce Research Data Center Annual Report to the Legislature – January 2026*. Department of Health Care Access and Information; 2026. https://hcai.ca.gov/wp-content/uploads/2026/02/Health-Workforce-Research-Data-Center-

Annual-Report-to-the-Legislature-%E2%80%93-January-2026-1.pdf

11. Mertz E. California's Oral Healthcare Workforce. Presented at: The Health Workforce Education and Training Council; September 2023. https://hcai.ca.gov/document/day-2-agenda-item-3-oral-health-workforce-hwet-council-september-2023/

12. Registered Dental Hygienist in Alternative Practice - Allowable Duties and Frequently Asked Questions - Dental Hygiene Board of California. Accessed March 16, 2026. https://www.dhbc.ca.gov/consumers/duties_rdhap.shtml

13. California Legislature. *Business and Professions Code*. 2009. Accessed March 23, 2026. https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=BPC&division=2.&chapter=4.&article=9.

14. Documentation of Registered Dental Hygienist in Alternative Practice (RDHAP) Relationship with Dentist. Published online 2005. https://www.dhbc.ca.gov/formspubs/form_rdhap_ddsrelationship.pdf

15. *Health Workforce Research Data Center Annual Report to the Legislature – April 2025*. Department of Health Care Access and Information; 2025. https://hcai.ca.gov/wp-content/uploads/2025/06/Health-Workforce-Research-Data-Center-Annual-Report-to-the-Legislature-April-2025-2.pdf

16. Health Workforce Research Data Center Annual Report to the Legislature - April 2025.

17. California Department of Health Care Services. Dental Fee-For-Service and Dental Managed Care Performance Fact Sheet. February 2025. Accessed June 22, 2025. https://www.dhcs.ca.gov/services/Documents/MDSD/FFS-DMC-Fact-Sheet-February-2025.pdf

18. Work MC. Medi-Cal's Dental Care Gap: Getting a Tooth Pulled Is Easy — Much Harder To Get an Implant. California Healthline. August 7, 2024. Accessed March 23, 2026. https://californiahealthline.org/news/article/medicaid-dental-care-gap-implants-california/

19. Mertz B, Liang S, Jura M, et al. Assessing the Impact of Policy Incentives on California Dental Provider Participation in Medicaid. In: *2023 Annual Research Meeting*. AcademyHealth; 2023. Accessed June 22, 2025. https://academyhealth.confex.com/academyhealth/2023arm/meetingapp.cgi/Paper/58413

20. Physicians for a Healthy California > Programs > CalHealthCares. Accessed March 23, 2026. https://www.phcdocs.org/programs/calhealthcares

21. Legislative Analyst's Office. The 2025-26 California Spending Plan: Health. Accessed March 18, 2026. https://lao.ca.gov/Publications/Report/5075

22. Flynn B, Starkel Weninger R, Zaborowski M, Vujicic M. *Barriers to Dental Care Among Adult Medicaid Beneficiaries: A Comprehensive Analysis in Eight States*. ADA Health Policy Institute; 2024. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/barriers_Medicaid_participation_utilization.pdf

23. Healthforce Center at UCSF. *Annual Report: Update on California's Physician Workforce*. Healthforce Center; 2024. https://healthforce.ucsf.edu/document/2024-annual-ret-californias-physician-workforce-final-reviewed-accessibility-checked-pdf

24. Coffman J, Fix M. *Building the Future Behavioral Health Workforce: Needs Assessment*. Healthforce Center; 2023. https://static1.squarespace.com/static/5b1065c375f9ee699734d898/t/63e695d3ce73ca3e44824cf8/1676056025905/CBHDA_Needs_Assessment_FINAL_Report_2-23.pdf

25. Health Workforce. HCAI. Accessed June 22, 2025. https://hcai.ca.gov/data/health-workforce/

26. Health Workforce Data. HCAI. Accessed March 10, 2026. https://hcai.ca.gov/workforce/health-workforce/workforce-data/

27. California Health Workforce Education and Training Council. HCAI. Accessed March 10, 2026. https://hcai.ca.gov/workforce/health-workforce/council/

28. Wides C, Dower C. *A Review of California Office of Statewide Health Planning and Development, Health Workforce Pilot Projects Program 1973-2007*. Center for the Health Professions; 2010. https://healthforce.ucsf.edu/sites/g/files/tkssra14981/files/7._2010-05_A_Review_of_OSHPD_Health_Workforce_Pilot_Projects_Program_1973_to_2007.pdf

29. Workforce for a Healthy California. California Health & Human Services. Accessed March 4, 2026. https://chhs.azurewebsites.us/workforce4healthyca/

30. Children and Youth Behavioral Health Initiative. HCAI. Accessed March 4, 2026. https://hcai.ca.gov/workforce/initiatives/children-and-youth-behavioral-health-initiative/

31. HCAI-WC. Accessed March 23, 2026. https://cawellnesscoach.org/

32. Community Health Workers, Promotores & Representatives. HCAI. Accessed March 23, 2026. https://hcai.ca.gov/workforce/initiatives/community-health-workers-promotores-chw-p/

33. Gkiouleka A, Aquino MRJ, Ojo-Aromokudu O, et al. Allied health professionals: A promising ally in the work against health inequalities- A rapid review. *Public Health in Practice*.

2022;3:100269. doi:10.1016/j.puhip.2022.100269

34. Mertz E, Kottek A, Werts M, Langelier M, Surdu S, Moore J. Dental Therapists in the United States: Health Equity, Advancing. *Medical Care*. 2021;59(Suppl 5):S441-S448. doi:10.1097/MLR.0000000000001608

35. State-by-State Dental Therapist Authorization Overview - OHWRC. OHWRC. Accessed March 4, 2026. https://oralhealthworkforce.org/infographics/authorization-status-of-dental-therapists-by-state/

36. Dental Therapy Programs. Accessed March 25, 2026. https://www.americandentaltherapyassociation.org/dental-therapy-programs

37. Chi DL, Lenaker D, Mancl L, Dunbar M, Babb M. Dental therapists linked to improved dental outcomes for Alaska Native communities in the Yukon-Kuskokwim Delta. *J Public Health Dent*. 2018;78(2):175-182. doi:10.1111/jphd.12263

38. Blue CM, Kaylor MB. Dental therapy practice patterns in Minnesota: a baseline study. *Community Dent Oral Epidemiol*. 2016;44(5):458-466. doi:10.1111/cdoe.12235

39. Elani HW, Mertz E, Kawachi I. Comparison of dental care visits before and after adoption of a policy to expand the dental workforce in Minnesota. *JAMA Health Forum*. 2022;3(3):e220158. doi:10.1001/jamahealthforum.2022.0158

40. Ly DP, Jena AB. Trends in diversity and representativeness of health care workers in the United States, 2000 to 2019. *JAMA Netw Open*. 2021;4(7):e2117086. doi:10.1001/jamanetworkopen.2021.17086

41. Gadgil M, Jackson R, Rosenblatt N, Aleemuddin A, Peck C, Bates J. *Status of Oral Health in California: Oral Disease Burden and Prevention 2017*. California Department of Public Health; 2017. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/Status%20of%20Oral%20Health%20in%20California_FINAL_04.20.2017_ADA.pdf