

Strategic Management and Entrepreneurial Action in U.S. Dental Care: Addressing Geographic Gaps in Oral Health Coverage through Differentiated State-Level Solutions

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Abstract: Access to oral health care remains critically uneven across the United States. As of the first quarter of fiscal year 2026, the Health Resources and Services Administration (HRSA) had designated 7,443 Dental Health Professional Shortage Areas (HPSAs), covering more than 63.7 million people and reflecting only 32.93% of estimated dental workforce need met nationally. This article examines the geographic distribution of dental care shortages across the fifty U.S. states and the District of Columbia, identifies the jurisdictions with the least coverage relative to documented need, and proposes differentiated, entrepreneurially driven strategic management solutions for each. Rather than a single national remedy, the analysis argues that effective interventions must be calibrated to local structural conditions, population density, workforce supply, payer mix, and infrastructure, and organized through venture-based models such as dental service organization (DSO) satellite expansion, mobile clinic fleets, teledentistry networks, mid-level workforce programs (dental therapists and dental health aide therapists), and community health center partnerships. The discussion situates these entrepreneurial responses within a strategic management framework and considers their broader importance to United States health policy objectives. The article closes with study limitations and suggestions for future research.

Key Word: dental health professional shortage areas; strategic management; dental entrepreneurship; oral health policy; teledentistry; dental therapy; access to care.

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I. Introduction

Oral health is a well-established determinant of general health, yet millions of residents of the United States live in areas where dental care is structurally scarce. Unlike shortages in primary medical care, dental workforce gaps have historically received less policy attention despite comparable, and in several states more severe, deficits. The Health Resources and Services Administration (HRSA) formally tracks this gap through the Dental Health Professional Shortage Area (HPSA) designation, which quantifies both the number of underserved geographic areas, population groups, and facilities, and the number of additional practitioners that would be required to eliminate the shortage¹.

As of December 31, 2025, HRSA recorded 7,443 dental HPSA designations nationwide, affecting an estimated 63,700,964 people, with only 32.93% of dental care need met and 10,744 additional practitioners required to close the gap¹. These figures are not evenly distributed: some states approach adequate coverage while others report less than one-fifth of documented need met. This unevenness suggests that a uniform, one-size-fits-all federal response is unlikely to be effective, and that state- and region-specific strategic management approaches, many of them entrepreneurial in nature, are needed to translate available workforce, technology, and capital into functioning access points.

This article pursues three objectives. First, it maps the national distribution of dental care shortage using the most recent HRSA quarterly designation data. Second, it identifies the states and the federal district with the lowest proportion of need met and analyzes the structural drivers specific to each. Third, it proposes distinct, entrepreneurially grounded strategic management solutions calibrated to each jurisdiction's particular constraints, rather than a single generic recommendation, and situates these ventures within the broader framework used by U.S. authorities to evaluate endeavors of substantial merit and national importance.

II. Literature Review

Rural and underserved-area dental access research consistently identifies workforce maldistribution as the central constraint. The Center for Health Care Strategies reports that, as of April 2026, 67% of all dental HPSAs were located in rural areas, yet only 14% of practicing dentists worked in rural settings, with more than 98% of dental specialists concentrated in urban areas². The rural dental workforce also skews older than its urban counterpart, compounding retirement-driven attrition².

Several categories of intervention recur across the literature. Workforce-expansion models introduce mid-level providers, dental therapists (DTs) and dental health aide therapists (DHATs), who practice under dentist supervision and can be trained and deployed more rapidly and at lower cost than dentists^{3,4}. Evidence from Minnesota indicates that counties with any dental therapist presence experienced a statistically significant reduction in emergency-department visits for non-traumatic dental conditions⁵. Technology-enabled models, principally teledentistry, extend the reach of a limited supply of dentists through virtual triage, remote diagnosis support, and hygienist-led community service delivery, exemplified by California's Virtual Dental Home model^{2,6}. Mobility-based models, including mobile dental units and school-based health center dental services, bring the point of care to the population rather than the reverse, a strategy multiple states have proposed expanding through the CMS Rural Health Transformation Program⁷. Finally, facility- and pipeline-based models, community health center dental residencies, loan repayment partnerships, and bridge programs recruiting students from underserved communities, address long-term supply rather than short-term access^{8,9}.

The literature also converges on a key strategic management insight: no single model resolves shortage on its own. The National Academy for State Health Policy and the Center for Health Care Strategies both emphasize that workforce expansion, technology, and geographic-access strategies are complementary rather than substitutable, and that state-level program design must reflect local rurality, broadband infrastructure, Medicaid participation, and regulatory scope-of-practice constraints^{10,2}. This complementarity, and its dependence on local context, is the analytical basis for the differentiated, state-by-state approach adopted in this article.

III. Methodology

This article adopts a descriptive, policy-analytic design combining secondary quantitative data with a narrative synthesis of applied dental-access literature. Quantitative data on dental HPSA designations, percentage of need met, and practitioners needed by state were drawn from HRSA's Designated HPSA Quarterly Summary for the first quarter of fiscal year 2026 (data as of December 31, 2025), as compiled and tabulated by Becker's Dental Review¹¹, cross-referenced against HRSA's own quarterly report¹ and the Federal Register notice of designated shortage areas¹². Supplementary national and state-level figures were drawn from the Kaiser Family Foundation's State Health Facts dental HPSA indicator¹³.

Jurisdictions for in-depth analysis were selected using the percentage of dental care need met as the primary ranking criterion, prioritizing the six lowest-ranked jurisdictions nationally while ensuring representation across rural, urban, and mixed-density contexts: the District of Columbia (2.9%), Delaware (4.4%), Kentucky (10.4%), New York (16.2%), Georgia (17.8%), and Florida (18.7%, selected in place of the marginally lower

North Carolina at 23% owing to its comparatively larger absolute practitioner deficit of 1,271). For each jurisdiction, structural drivers of shortage were identified from applied health-policy sources (state workforce transformation plans, rural health toolkits, and dental-policy publications), and a distinct entrepreneurial strategic management solution was formulated by matching intervention type, workforce, technology, mobility, or facility-based, to the jurisdiction's documented constraints. No original primary data collection, human-subjects research, or clinical intervention was conducted; the analysis is limited to publicly available secondary sources current through August 2026.

IV. National Landscape Of Dental Care Shortage In The United States

Table 1 presents HRSA-designated dental HPSA data for all fifty states and the District of Columbia as of the first quarter of fiscal year 2026, ordered alphabetically, with the six jurisdictions selected for in-depth analysis highlighted. Nationally, dental HPSA designations totaled 7,443, comprising 567 geographic-area designations, 2,130 population-group designations, and 4,746 facility designations, with a national percentage of need met of 32.93% and 10,744 additional practitioners required to eliminate all designations¹. Sixty-three percent of primary-care-equivalent shortage designations nationally are rural, and dental shortages mirror this rural concentration closely².

State	Total Designations	Percent of Need Met	Practitioners Needed
Alabama	92	24.3%	139
Alaska	333	33.8%	60
Arizona	229	34.7%	381
Arkansas	138	33.4%	107
California	565	36%	475
Colorado	116	57.8%	92
Connecticut	42	32.8%	98
Delaware	12	4.4%	104
Florida	283	18.7%	1,271
Georgia	186	17.8%	402
Hawaii	33	36.5%	39
Idaho	98	37.5%	70
Illinois	248	28.3%	383
Indiana	133	27.8%	207
Iowa	148	27.3%	107
Kansas	133	29.5%	49
Kentucky	226	10.4%	219
Louisiana	176	45.8%	260
Maine	84	27.9%	42
Maryland	42	43%	229
Massachusetts	56	62.1%	20
Michigan	268	30.1%	278
Minnesota	198	43.8%	133
Mississippi	151	40.1%	212
Missouri	329	20.9%	324
Montana	115	45.9%	32
Nebraska	114	49.7%	13
Nevada	66	26.2%	156
New Hampshire	21	21.6%	7
New Jersey	39	50.8%	32

State	Total Designations	Percent of Need Met	Practitioners Needed
New Mexico	104	21.4%	165
New York	163	16.2%	588
North Carolina	209	23%	657
North Dakota	70	40.4%	14
Ohio	184	39.6%	411
Oklahoma	187	41.6%	175
Oregon	144	40.8%	162
Pennsylvania	153	40%	268
Rhode Island	15	38%	33
South Carolina	96	47.9%	227
South Dakota	100	26.7%	47
Tennessee	162	30.8%	396
Texas	275	29.9%	362
Utah	60	49.6%	23
Vermont	13	77.6%	0
Virginia	178	53%	296
Washington	204	58%	219
Washington, D.C.	10	2.9%	22
West Virginia	123	22.6%	140
Wisconsin	165	29.3%	205
Wyoming	30	31.5%	11

Table no 1: Dental Health Professional Shortage Area (HPSA) Designations By U.S. State, First Quarter Of Fiscal Year 2026

The data reveal that shortage severity, measured by percentage of need met, does not correlate simply with the raw number of designations or with population size. California records the highest absolute number of designations (565) but a relatively moderate 36% of need met, whereas Delaware, with only 12 designations, meets just 4.4% of need, indicating that a small number of severely under-resourced designations can leave a jurisdiction's population almost entirely without adequate access. This distinction is central to the strategic-management argument advanced in Section VI: raw designation counts alone are a poor guide to intervention design, and effective planning requires disaggregating designation volume, need-met percentage, and absolute practitioner deficit.

V. State-Level Analysis And Differentiated Entrepreneurial Solutions

This section analyzes the six jurisdictions with the most severe documented dental coverage gaps and proposes, for each, an entrepreneurial venture model calibrated to its specific structural profile. The models draw on documented strategies from comparable jurisdictions but are adapted rather than replicated, consistent with the literature's emphasis on context-specific design¹⁰.

V.1 District of Columbia (2.9% of need met; facility-concentrated urban shortage)

The District of Columbia records the lowest percentage of dental need met of any U.S. jurisdiction despite its small size and dense urban population, indicating that its ten designations are almost entirely facility-based rather than geographic, that is, specific safety-net clinics and institutions lack adequate dental staffing even where dentists practice nearby in the metropolitan area¹¹. This pattern is characteristic of urban HPSA facilities such as community health centers, correctional facilities, and public housing clinics that struggle to retain providers because of low Medicaid reimbursement².

Proposed solution, Urban Safety-Net Dental Hub: an entrepreneurial venture structured as a nonprofit-affiliated dental service organization (DSO) that contracts directly with existing Federally Qualified Health Centers (FQHCs) and designated facilities to embed salaried, equity-compensated dentist and hygienist teams, financed through blended Medicaid managed-care contracts and value-based payment arrangements. A

teledentistry triage layer, following the tele-consultation model documented as the fastest-growing teledentistry application segment¹⁴, would allow a smaller core clinical staff to prioritize same-day urgent cases across multiple facility sites, addressing the facility-specific, rather than geographic, nature of the District's shortage.

V.2 Delaware (4.4% of need met; small-state facility shortage with high per-designation deficit)

Delaware presents an unusual profile: only 12 total designations, yet these translate into 104 practitioners needed and just 4.4% of need met, the second-lowest rate nationally. This suggests concentrated, high-intensity shortages in a small number of facilities or population groups rather than broad geographic dispersion¹¹.

Proposed solution, Hub-and-Spoke Satellite Network: a single well-capitalized flagship clinic (the hub), located centrally within New Castle, Kent, or Sussex County, supported by two or three lower-overhead satellite operatories staffed on a rotating basis and by dental hygienists practicing under Delaware's direct-access provisions. This mirrors the allied-health-professional workforce model documented in the Rural Oral Health Toolkit¹⁵, scaled to Delaware's compact geography, allowing a single entrepreneurial dental practice to service the entire state's shortage footprint without requiring the recruitment of dentists to each underserved facility individually.

V.3 Kentucky (10.4% of need met; Appalachian rural workforce shortage)

Kentucky reports 226 designations and a 10.4% need-met rate, the lowest among the fifty states, reflecting the well-documented Appalachian rural access crisis: low dentist-to-population ratios, provider aging, and limited local training infrastructure¹⁶. Rural areas nationally average 4.7 dentists per 10,000 residents compared with 7.8 in urban areas¹⁶.

Proposed solution, Dental Therapist-Led Rural Practice Network: an entrepreneurial venture built around the dental therapist/dental health aide therapist workforce model already licensed or under consideration in several states, in which a supervising dentist establishes a network of therapist-staffed satellite sites across Appalachian counties, connected by tele-mentoring for case consultation. Evidence from Minnesota shows that counties with dental therapist presence saw a statistically significant reduction in preventable emergency-department visits⁵, supporting the clinical and economic viability of this workforce-substitution model. The venture would be financed in part through loan-repayment partnerships modeled on Iowa's Fulfilling Iowa's Need for Dentists (FIND) program, which pairs practice commitments in underserved communities with dental-education debt relief⁹.

V.4 New York (16.2% of need met; large population with urban-rural access mismatch)

New York records 163 designations, a comparatively low count relative to its population, but only 16.2% of need is met and 588 additional practitioners are required, the third-largest absolute deficit of any state. Broadband limitations in significant portions of the state constrain remote-care delivery even as urban boroughs face separate access barriers tied to cost and insurance acceptance¹⁷.

Proposed solution, Statewide Teledentistry-Plus-School Network: a venture combining a licensed teledentistry platform for virtual exams, triage, and orthodontic monitoring, the segment identified as generating the highest teledentistry market share in 2026¹⁴, with an in-person hygienist-staffed service line delivered through school-based health centers, following the New York State issue-brief recommendation that virtual and in-person components be paired rather than deployed independently to offset broadband gaps¹⁷. Because New York already reimburses teledentistry under certain Medicaid provisions, the venture's revenue model can rely on a blended cash-pay, commercial, and Medicaid reimbursement structure rather than the uncertain reimbursement environment reported in states without teledentistry mandates¹⁸.

V.5 Georgia (17.8% of need met; rural south with the largest number of designations among the six)

Georgia reports 186 designations and 402 practitioners needed, with only 17.8% of need met, reflecting a predominantly rural, geographically dispersed shortage pattern typical of the U.S. South¹¹.

Proposed solution, Mobile Dental Fleet as a Scalable Social Enterprise: a venture centered on a fleet of mobile dental units rotating across a defined circuit of rural counties on a fixed weekly or monthly schedule, integrated with medical-dental collaboration protocols similar to Ohio's MORE Care model, in which primary care visits trigger oral-health screening, fluoride varnish application, and referral². Multiple states have proposed funding mobile and portable dental units through the CMS Rural Health Transformation Program⁷, indicating an available capital-blending pathway for this model. Structured as a for-profit or hybrid social enterprise contracting with county health departments, the mobile fleet allows a single entrepreneurial operator to reach dispersed rural populations without the fixed cost of constructing permanent clinics in each underserved county.

V.6 Florida (18.7% of need met; largest absolute practitioner deficit nationally)

Florida records 283 designations and the single largest practitioner deficit of any state, 1,271 additional dentists needed, despite a percentage of need met (18.7%) that places it just outside the five lowest-ranked jurisdictions. Its scale of absolute deficit, combined with a large population of veterans and individuals with autism spectrum disorder and other special health care needs who face documented additional barriers to routine dental care, makes it a distinct case requiring a scale-oriented rather than purely geographic solution.

Proposed solution, Multi-Site DSO with Population-Specific Clinical Tracks: an entrepreneurial dental service organization designed for rapid, replicable clinic expansion across designated Florida HPSA counties, incorporating dedicated clinical tracks for veterans and for patients with autism spectrum disorder or other special needs, populations for whom targeted, sensory-adapted, and appointment-flexible care models have been shown to reduce avoidable emergency care utilization. The DSO structure allows standardized clinical protocols, shared administrative and revenue-cycle infrastructure, and staged capital deployment across sites, matching the scale of Florida's absolute practitioner shortfall more efficiently than a single-clinic model.

VI. Strategic Management Framework For Entrepreneurial Action In Dental Care Access

Across the six jurisdictions analyzed, four recurring venture archetypes emerge: (1) workforce-substitution models (dental therapists, dental health aide therapists, and hygienist direct-access practice), which reduce cost-per-encounter and can be deployed faster than expanding the dentist supply; (2) technology-enabled models (teledentistry triage, remote monitoring, and virtual dental homes), which extend the effective reach of a fixed clinical workforce; (3) mobility-based models (mobile units, portable equipment, school-based delivery), which relocate the point of care to the population rather than requiring population migration toward fixed clinics; and (4) scale-and-integration models (multi-site DSOs, medical-dental integration, and population-specific clinical tracks), which apply standardized management infrastructure to reach a large absolute deficit efficiently.

Strategic management theory suggests that the choice among these archetypes should be driven by a jurisdiction's specific constraint profile rather than by the archetype's general popularity. Where the binding constraint is workforce supply (as in Kentucky), a workforce-substitution venture is indicated; where the binding constraint is facility-specific institutional understaffing amid an otherwise adequate regional workforce (as in the District of Columbia and Delaware), a hub-and-spoke or embedded-staffing venture is more efficient; where the binding constraint is a combination of geographic dispersion and infrastructure (as in New York and Georgia), technology-mobility hybrid models are indicated; and where the binding constraint is sheer absolute scale of deficit (as in Florida), standardized multi-site expansion is required. This diagnostic-first approach, matching venture design to the specific, evidenced constraint rather than applying a uniform national template, constitutes the core strategic management contribution of this analysis and is consistent with the broader health-policy literature's finding that workforce, technology, and access strategies are complementary rather than mutually substitutable^{10,2}.

Each archetype also carries distinct capital and reimbursement requirements. Workforce-substitution ventures require up-front investment in licensure navigation and supervisory infrastructure but carry lower recurring labor cost per encounter. Technology-enabled ventures face the most volatile revenue environment, since teledentistry reimbursement varies sharply by state and payer, and industry analysis cautions that direct-to-consumer, cash-pay teledentistry has not scaled reliably as a stand-alone revenue model¹⁸; technology should therefore be deployed as a force multiplier within a broader clinical operation rather than as an independent venture. Mobility-based ventures require durable capital equipment but comparatively low fixed real-estate cost, and are increasingly eligible for blended public funding through state rural health transformation awards⁷. Scale ventures require the greatest up-front capital but achieve the lowest marginal cost per additional site once administrative infrastructure is established.

VII. Considerations Of National Importance

The persistence of dental care shortages affecting more than 63.7 million people, combined with documented downstream consequences, including preventable emergency department utilization for non-traumatic dental conditions⁵, establishes that closing these gaps carries substantial merit and national importance rather than being a matter of purely local or private concern. This is the threshold standard that U.S. adjudicative authorities apply, in other contexts, to endeavors considered to warrant national-interest treatment: under *Matter of Dhanasar*, an endeavor of substantial merit and national importance is one whose value can be evaluated independently of whether it is already being pursued by others, and may be shown through, among other things, its potential to broadly enhance societal welfare or cultural or artistic enrichment, or its impact on a matter that a government entity has recognized as a priority^{19,20}.

Applied to the ventures proposed in Section V, several features align with that framework's evaluative logic without altering its legal or immigration-specific character: the endeavors address a federally documented shortage (HRSA-designated HPSAs), operate across jurisdictions that federal and state governments have already

identified as transformation priorities through programs such as the CMS Rural Health Transformation Program⁷, and are structured to produce measurable, broadly distributed public health benefit rather than narrowly private gain. The Dhanasar framework further specifies that a petitioner's or entrepreneur's positioning to advance an endeavor may be shown through a specific, credible plan for future activities, past record of success in related or similar efforts, and the interest of relevant government or quasi-government entities in the endeavor¹⁹, criteria that the jurisdiction-specific, evidence-matched venture designs proposed in Section V are intended to satisfy at the level of strategic and clinical planning. The framework's final consideration, whether, on balance, advancing the endeavor benefits the United States more than would be achieved through conventional channels alone, is directly analogous to the health-workforce policy question this article addresses: whether entrepreneurial, venture-based delivery models can close access gaps more effectively than incremental expansion of the existing delivery system.

This alignment is presented here as a policy-analytic observation about how entrepreneurial dental-access ventures relate to established criteria for evaluating endeavors of national consequence, and should not be read as an assessment of any individual case or petition.

VIII. Limitations Of The Study

This article has several limitations. First, the analysis relies on HRSA HPSA designation data, which, while authoritative, is updated quarterly and subject to revision as areas are added, withdrawn, or reclassified; figures cited reflect the first quarter of fiscal year 2026 and may not capture subsequent changes. Second, the percentage-of-need-met metric aggregates geographic, population-group, and facility designations, which have different underlying causes and may mask within-state heterogeneity, for example, a state with a moderate statewide percentage may still contain severely underserved counties. Third, the proposed entrepreneurial solutions are conceptual strategic management models derived from documented analogous programs in other jurisdictions; they have not been operationally piloted or financially modeled in the specific jurisdictions discussed here, and actual feasibility would depend on state-specific licensure, scope-of-practice, and Medicaid reimbursement rules not exhaustively analyzed in this article. Fourth, the selection of six jurisdictions for in-depth analysis, while methodologically justified, necessarily excludes other severely underserved states (e.g., North Carolina, Alabama, West Virginia) that merit comparable attention in future work.

IX. Suggestions For Future Studies

Future research should pursue financial feasibility modeling for each proposed venture archetype, including capital requirements, break-even timelines, and payer-mix sensitivity analysis under real state Medicaid reimbursement schedules. Comparative outcome studies tracking emergency-department utilization, treatment completion rates, and cost per patient served before and after entrepreneurial venture implementation would strengthen the evidentiary basis for archetype selection. Further work should also examine regulatory pathways, dental therapist scope-of-practice legislation, teledentistry reimbursement mandates, and direct-access provisions for hygienists, on a state-by-state basis, given their direct bearing on which venture archetypes are legally viable in a given jurisdiction. Finally, extending the state-level analysis in this article to the full set of jurisdictions below the national average percentage of need met would provide a more complete strategic map for entrepreneurial dental-access investment nationally.

X. Conclusion

Dental care access in the United States remains structurally uneven, with 7,443 HRSA-designated shortage areas and only 32.93% of estimated need met nationally as of the most recent quarterly data. This unevenness is not uniform in character: the District of Columbia and Delaware exhibit facility-concentrated shortages amid otherwise denser populations, Kentucky reflects a classic Appalachian rural workforce deficit, New York and Georgia combine geographic dispersion with infrastructure constraints, and Florida presents the largest absolute practitioner deficit in the country. Because these constraint profiles differ, effective entrepreneurial responses must differ as well, a conclusion this article has operationalized by proposing six distinct venture models, each matched to its jurisdiction's documented structural drivers, and organized under a broader strategic management framework that treats workforce, technology, mobility, and scale as complementary rather than competing tools. Closing these gaps constitutes a matter of substantial merit and national importance, and entrepreneurial, evidence-matched venture design offers a viable pathway to doing so more rapidly than incremental expansion of the existing delivery system alone.

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