Teledentistry models led by dental hygienists in underserved communities: a literature review

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PRACTICAL IMPLICATIONS OF THIS RESEARCH

- Dental hygiene-led teledentistry models are a feasible and scalable means of improving access to oral care in rural and underserved communities.
- These models support early detection, prevention, and continuity of care, and they are highly efficient when paired with structural training, appropriate technology, and a supportive policy framework.
- Further research is needed to assess patient outcomes, provider experience, and long-term sustainability of the dental hygiene-led teledentistry program.

ABSTRACT

Objective: This thematic literature review explores current teledentistry models led by dental hygienists in rural, underserved areas. Its primary aim is to critically evaluate the impact of these models on access to care, clinical and economic outcomes, and workforce development. This review provides valuable insights for health care professionals, policymakers, and researchers interested in oral health care and telehealth. **Methods**: A structured literature search was conducted in the following databases: Ovid/MEDLINE, CINAHL, and Dentistry & Oral Sciences (EBSCOhost). The search terms were organized into 3 conceptual categories: population, intervention, and provider. Only peer-reviewed articles on teledentistry-based care delivered by dental hygienists or comparable providers, such as dental therapists, in underserved or rural settings were included. **Results**: Ten studies met the inclusion criteria for review: all explored the implementation of teledentistry models in underserved communities. These studies used a variety of qualitative, descriptive, and mixed-method designs. The literature highlighted effective service delivery models, economic advantages, positive patient and provider outcomes, and policy limitations. **Discussion**: Five key themes emerged: service delivery models and access to care, economic and clinical efficiency, regulatory and policy environments, workforce development and training, and systemic barriers to program sustainability. **Conclusion**: Teledentistry initiatives led by trained dental hygienists are a cost-effective and scalable means of improving access to care for underserved rural or Indigenous populations. Expanding these models across rural and urban regions and integrating this implementation into policy reform, workforce investment, and mainstream dental and dental hygiene education should be considered an urgent priority.

RÉSUMÉ

Objectif : Cette analyse documentaire thématique explore les modèles actuels de télémédecine dirigés par des hygiénistes dentaires dans les régions rurales mal desservies. Son objectif principal est d'évaluer de façon critique l'incidence de ces modèles sur l'accès aux soins, les résultats cliniques et économiques, et le développement de la main-d'œuvre. Cette analyse fournit des renseignements précieux aux professionnels de la santé, aux décideurs et aux chercheurs qui s'intéressent aux soins de santé buccodentaire et à la télésanté. **Méthodes** : Une recherche documentaire structurée a été effectuée dans les bases de données suivantes : Ovid/MEDLINE, CINAHL et Dentistry & Oral Sciences (EBSCOhost). Les termes de recherche ont été organisés en 3 catégories conceptuelles : population, intervention et fournisseur. Seuls les articles évalués par les pairs sur les soins de télémédecine offerts par des hygiénistes dentaires ou des fournisseurs comparables, comme les thérapeutes dentaires, œuvrant dans des milieux mal desservis ou ruraux, ont été inclus. **Résultats** : Dix études répondaient aux critères d'inclusion à analyser; toutes portaient sur la mise en œuvre de modèles de télémédecine dans les communautés mal desservies. Ces études ont été menées au moyen de différentes conceptions qualitatives, descriptives et de méthodes mixtes. La documentation a mis en lumière des modèles efficaces de prestation de services, des avantages économiques, des résultats positifs pour les patients et les fournisseurs et les limites de certaines politiques. **Discussion** : Il en émerge 5 thèmes clés : les modèles de prestation de services et l'accès aux soins, l'efficacité économique et clinique, les environnements réglementaires et stratégiques, le perfectionnement et la formation de la main-d'œuvre, et les obstacles systémiques à la viabilité des programmes. **Conclusion** : Les initiatives de télémédecine dirigées par des hygiénistes dentaires formés constituent un moyen économique et évolutif d'améliorer l'accès aux soins pour les populations en milieu rural ou les communautés autochtones mal desservies. L'élargissement de ces modèles dans les régions rurales et urbaines et l'intégration de cette mise en œuvre à la réforme des politiques, à l'investissement de la main-d'œuvre et à la formation générale sur les soins dentaires et l'hygiène dentaire devraient être considérés comme des priorités urgentes.

Keywords: dental hygienists; health services accessibility; oral health; teledentistry; underserved populations
CDHA Research Agenda category: access to care and unmet needs

CDHA/CJDH STUDENT WRITING COMPETITION

Our annual writing competition, proudly sponsored by PHILIPS Sonicare, encourages students in a diploma, baccalaureate or degree-completion program to develop a love for writing and research and to recognize the possibilities that such endeavours offer for personal and professional growth. The editorial board of the *Canadian Journal of Dental Hygiene* is delighted to publish the winning literature review entry from its 2024–2025 competition, which ably addresses the Canadian Dental Hygienists Association's *Dental Hygiene Research Agenda* category of "access to care and unmet needs."

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INTRODUCTION

Access to equitable oral health care remains a significant challenge in rural and underserved communities.[1] Contributing factors include limited availability of health care providers, geographic isolation, low socioeconomic status, and transportation barriers.[1] Teledentistry, the remote provision of limited oral care services through digital communication technologies, has emerged as a promising model to address these disparities.[2] Unlike mobile clinics, teledentistry delivers a measure of oral health care through virtual consultations, image sharing, and remote diagnosis or triage, rather than onsite services.[3]

Dental hygienists have increasingly been recognized for their ability to lead teledentistry-based interventions.[4,5] Their role in conducting remote screenings, providing oral health education, and collecting diagnostic data is central to the success of many teledentistry programs. In some models, such as those involving Indigenous dental assistants in Australia, preventive services such as fluoride application were delivered in person within a telehealth-supported framework.[1]

This literature review examines the current landscape of dental hygiene–led teledentistry initiatives in rural and underserved settings. It is structured around key themes: access and equity, clinical and economic outcomes, and implementation and workforce development. Through critical analysis of peer-reviewed studies published between 2010 and 2024, this review highlights current models' benefits, limitations, and research gaps. It offers recommendations for future policy and program development.

"Teledentistry models" in this review refer to the various configurations through which oral health care is delivered remotely, including synchronous (real-time video consultations), asynchronous (store-and-forward transmission of diagnostic data), remote patient monitoring, and mobile screening programs.[2] The specific structure of each model varies by setting and provider type, but they share the common goal of increasing access to preventive and diagnostic oral care for underserved populations.[2,3]

"Telehealth" refers to the use of digital communication technologies to deliver remote health care services across disciplines.[2,3] In this context, teledentistry represents a dental-specific application of telehealth, encompassing tools such as asynchronous diagnosis, virtual triage, mobile screenings, and image-based consultations.[2,3]

METHODS

A structured literature search was conducted in 3 electronic databases: Ovid/MEDLINE, CINAHL, and Dentistry & Oral Sciences (EBSCOhost). The search strategy was developed with a health sciences librarian and organized around 3 conceptual categories: population, intervention, and provider. Search terms included combinations such as "rural," "remote site," "underserved," and "nonurban" (population); "teledentistry," "telehealth," "eHealth," and "digital dental care" (intervention); and "dental hygienists," "oral health aides," and "dental assistants" (provider). Boolean operators (AND/OR) were used to combine terms within and across categories. Filters were applied to limit results to peer-reviewed articles published in English between 2010 and 2024. Only studies with full-text access were included to ensure comprehensive analysis and quality appraisal.

RESULTS

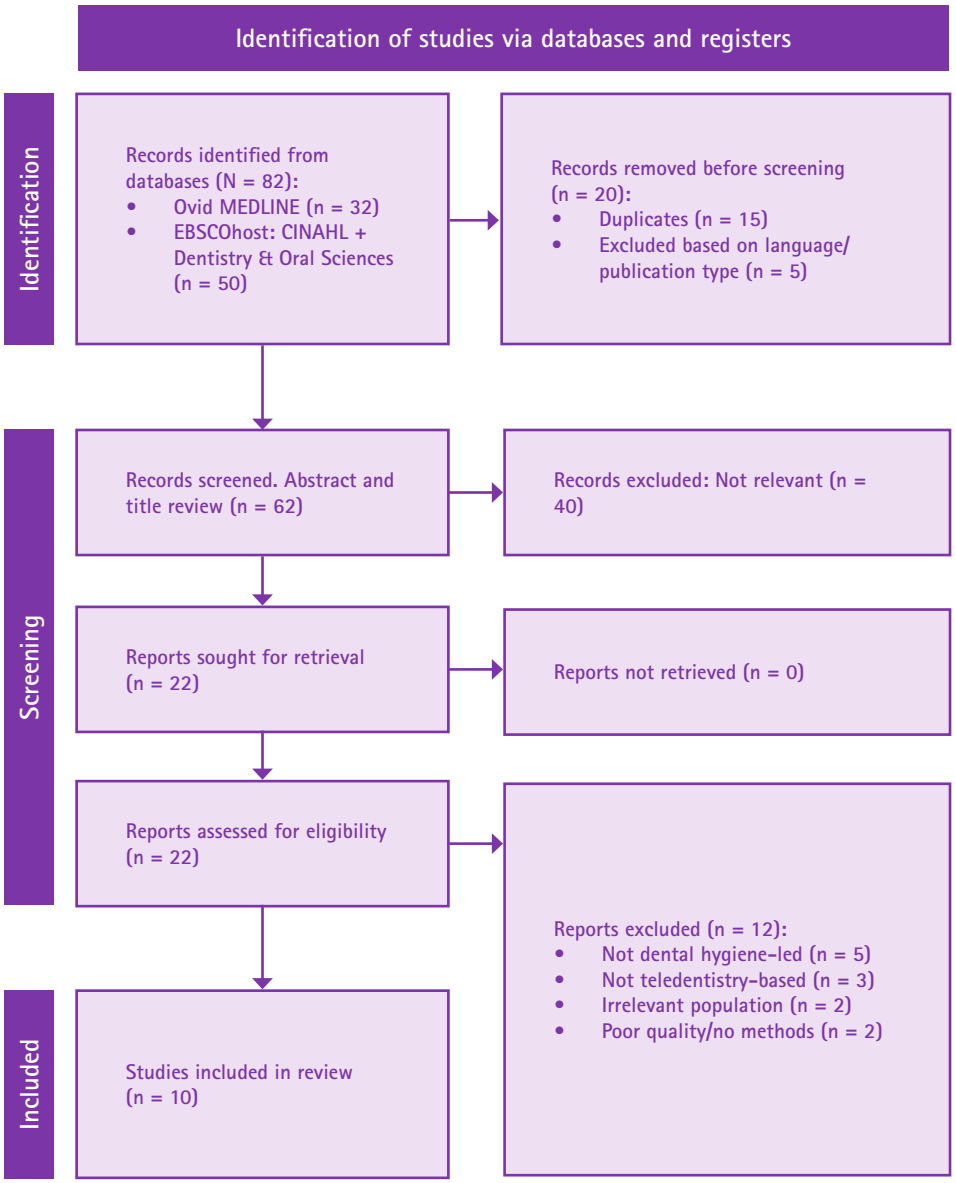
The literature search retrieved 82 records, 20 of which were removed prior to screening because they were duplicates, they were not written in English or they were not peer-reviewed articles. The titles and abstracts of the remaining 62 articles were screened by the author for relevance. Studies were included for full-text review if they described teledentistry-based interventions delivered by dental hygienists or comparable dental therapists, focused on rural, remote or underserved populations, and employed qualitative, descriptive or mixed-methods designs.

A total of 22 articles met the criteria for full-text review. Of these, 12 were excluded for the following reasons: not dental hygiene–led (5 studies), not focused on teledentistry (3 studies), irrelevant populations (2 studies), and poor quality or lack of methods (2 studies). Initially, studies prior to 2018 were excluded. However, 3 relevant pre-2018 articles were retained to capture foundational models and ensure conceptual continuity. Although this was not a systematic review, all included studies were appraised using the CASP (Critical Appraisal Skills Programme) checklist to assess methodological quality, relevance to the research question, and peer-reviewed status, to ensure a baseline level of quality. This resulted in the identification of 10 peer-reviewed studies that met all inclusion criteria for final review. The study selection process is illustrated in Figure 1.

The study designs of the 10 selected articles included qualitative, mixed-methods, case study, observational, and descriptive cross-sectional methodologies. Geographically, 6 studies were conducted in the United States, 3 in Australia, and 1 in Malaysia. These studies encompassed school-based and community care models, some of which integrated remote supervision through store-and-forward or synchronous teledentistry platforms. Most interventions were dental hygiene–led and involved screening, preventive care or remote service delivery through teledentistry. Significant findings highlighted improvements in access, potential cost savings, and challenges such as provider scope limitations and technical readiness. Table 1 summarizes key characteristics of the 10 studies included in this review: study design, population focus, type of intervention, provider involvement, and main findings.

Thematic analysis was conducted to synthesize findings into 3 domains: access and equity, clinical and economic outcomes, and implementation and workforce development. These domains were then organized into 5 key themes: 1)

Figure 1. PRISMA flow diagram depicting the identification, screening, eligibility, and inclusion process for studies included in this literature review



service delivery models and access to care; 2) economic and clinical efficiency; 3) regulatory and policy environments; 4) workforce development and training; and 5) systemic barriers to program sustainability. Each domain captures a specific aspect of dental hygiene-led teledentistry, while the themes illustrate the nuanced challenges and opportunities within those areas. Together, they offer a structured lens through which to analyze and discuss the implementation and sustainability of teledentistry models for rural and underserved populations.

DISCUSSION

Five key themes were identified within the 3 domains through thematic analysis of the included studies. The following discussion explores each of these themes in depth, highlighting how dental hygiene-led teledentistry models address challenges in access, cost-effectiveness, workforce development, and sustainability.

Service delivery models and access to care

Service delivery models in teledentistry refer to how care is structured and delivered to populations that lack regular access to traditional oral health care services. In rural communities, these models are often designed to overcome barriers such as geographic isolation, provider shortage, and costs.[1,5,6,7] Teledentistry initiatives aim to extend the reach of dental hygienists through remote screening, asynchronous consultation, and mobile-supported care. The studies reviewed highlight various approaches to improving access, specifically through school-based and community-integrated programs.[1,6,7]

Table 1. Summary of studies included in the thematic literature review

Authors, year	Country	Study design	Population	Intervention	Provider type	Key findings
Skinner et al. (2020)[1]	Australia	Observational	Indigenous school programs	Fluoride varnish application	Dental assistants	Indigenous dental assistants safely applied varnish in rural schools
McLeod et al. (2021)[4]	USA	Survey	Dental hygiene students	Curriculum integration for teledentistry	Dental hygienists	Students support integration; barriers include the scope of practice and reimbursement
Capocelli et al. (2019)[5]	USA	Theoretical model	Dental hygienists in rural Virginia	Remote supervision model	Dental hygienists	Proposes a phased model with training and billing reforms
Simmer-Beck et al. (2011)[6]	USA	Descriptive	School-based programs	Dental hygienist-led screening and fluoride	Dental hygienists	Only 11% follow-up rate; highlights the need for systemic referral support
Ward et al. (2022)[7]	USA	Mixed-methods	Rural school children	Dental hygienist-led screening and remote triage	Dental hygienists	99% completion; 50% had untreated caries
Estai et al. (2018)[8]	Australia	Cost analysis	2.7 million school-aged children	Teledentistry screening model	Dental hygienists	AUS$85 M cost savings; major savings from labour and travel
Estai et al. (2016)[9]	Australia	Literature review	Rural underserved populations	Role of mid-level dental providers (MLDPs)	Dental hygienists and dental therapists	MLDPs reduce the burden on dentists and improve preventive care
Schwarz et al. (2025)[10]	USA	Policy commentary	Rural workforce strategy	Policy and education integration	Dental hygienists and policy makers	Workforce gaps addressed via education and legislative models
Daniel and Kumar (2017)[11]	USA	Experimental	Pediatric patients	Image-based caries diagnosis	Dental hygienists versus dentists	Dental hygienists achieved comparable diagnostic accuracy to dentists
Khokhar et al. (2022)[12]	Malaysia	Cross-sectional	Dental professionals	Provider awareness of teledentistry	Mixed providers	Found gaps in confidence and technical readiness

Teledentistry initiatives were primarily aimed at populations with limited access to traditional oral health services; they were set up in rural schools, Indigenous communities, and underserved urban settings.[1,5,6-9] Programs in Virginia, rural American states, and remote Australian regions reported high completion rates of teledental appointments and strong community acceptance. In Australia, Indigenous dental assistants applied fluoride varnish in schools using a structured training model that included clinical instruction, supervised practice, and standardized protocols to ensure safety and consistency in care delivery.[1] In the United States, school-based teledentistry programs led by dental hygienists significantly expanded access to care in underserved communities.[6] One study reported that 99% of virtual dental hygiene visits were completed, and 50% of screened students had untreated caries.[7] These results underscore the effectiveness of task-sharing models and the critical role of dental hygienists in extending workforce capacity to improve access. Moreover, when Indigenous providers deliver services within their own communities, it not only enhances trust and patient engagement but also supports culturally safe care and long-term sustainability.[1] This approach addresses both geographic and social barriers by aligning service delivery with local needs, values, and existing relationships, which is something especially vital in rural and Indigenous settings where historical mistrust or systemic neglect has limited health care utilization.[1]

Studies from Alaska and Minnesota, where dental health aide therapists and dental therapists deliver preventive and basic restorative services within remote and Indigenous communities, highlighted the feasibility of integrating expanded-scope providers into teledentistry models.[7,9,10] Their roles support teledentistry by enabling in-person components of care such as fluoride application, education, and triage, while coordinating remotely with supervising dentists. This approach reduces the need for onsite specialists and improves continuity of care.

Economic and clinical efficiency

The economic and clinical viability of teledentistry is a central consideration in its adoption, particularly in publicly funded or resource-limited settings. Efficient care delivery,

cost saving, and comparable clinical outcomes are among the key benefits that support the integration of dental hygiene-led models into service delivery.[7,8] As the literature demonstrates, these models reduce the cost associated with travel, workforce burden, and infrastructure, while not impacting the diagnostic accuracy and quality of patient outcomes. This section explores how dental hygiene-led teledentistry contributes to improved cost-effectiveness, streamlined service delivery, and optimized use of health care resources.

One Australian cost-analysis study comparing school-based teledentistry with conventional chairside delivery estimated annual savings of up to 85 million Australian dollars.[8] The model, applied to 2.7 million school-aged children, attributed the majority of savings to reduced labour, travel, and accommodation expenses, and increased efficiency through centralized data management and asynchronous image transmission. These findings suggest that large-scale implementation of dental hygiene-led teledentistry could result in substantial cost savings in other publicly funded systems as well. In the North American context, where rural and Indigenous populations face similar geographic and access barriers, adopting such models could improve service equity while alleviating pressure on the oral health workforce and infrastructure.

Another study revealed that dental hygienists have diagnostic accuracy that is comparable to that of dentists when identifying dental caries using photographic data.[11] The rapid expansion of teledentistry during the COVID-19 pandemic further validated its cost-effectiveness and clinical relevance, particularly in triage, follow-up, and continuity of care.[2] However, global variability in provider awareness and confidence has been reported, with notable gaps in technical readiness.[12]

Regulatory and policy environments

Successfully bringing teledentistry into everyday care takes more than just technology and clinical capacity; it also relies on clear policies and supportive regulations. Whether dental hygienists are allowed to provide care remotely often depends on how their role is defined, whether services are reimbursed, and whether licensing allows them to work across regions. Without these pieces in place, even the most promising teledentistry models cannot reach the communities that need them most.[13-15]

Two studies emphasized the impact of legislation and supervision requirements on the feasibility of dental hygiene-led teledentistry.[4,11] One study found that dental hygiene students in North Carolina supported integrating teledentistry into curricula but were constrained by restricted scopes of practice and lack of Medicaid reimbursement.[4] Another study proposed a phased implementation model combining remote supervision, training, and reimbursement strategies to address regulatory barriers for dental hygienists.[5] These findings illustrate variability in policy environments and the need for coordinated advocacy to support expansion.

Policy frameworks mentioned across the literature included national oral health strategies and state-level legislative reforms.[7,10] In Australia, the National Oral Health Plan and jurisdictional workforce initiatives supported expanded roles for mid-level providers.[9] In the United States, pilot programs under Medicaid waivers and alternative payment models enabled dental hygienists to offer teledentistry under general or remote supervision.[11,16] However, inconsistent licensing, supervision mandates, and billing limitations hinder widespread adoption.

Workforce development and training

The success of teledentistry hinges not only on access to technology but also on a well-prepared and confident oral health workforce. For dental hygienists to take on expanded roles in virtual care, they require targeted training, mentorship, and support systems that align with evolving scopes of practice. Studies have shown that structured training programs and early exposure to teledentistry in education can enhance provider readiness, build confidence, and ultimately improve care delivery in rural and underserved areas.

Educational readiness is also key; dental hygiene students generally support teledentistry integration, though curriculum development remains inconsistent due to variations in institutional priorities, faculty training, and regulatory guidance.[4] In some programs, teledentistry is introduced only as a theoretical concept, with limited hands-on opportunities or simulation-based learning. Others may not address it at all, leaving graduates underprepared for emerging practice models. This inconsistency reflects a broader gap between education and real-world service delivery, particularly in areas where virtual care is most needed.

Training and educational readiness were frequently identified as both enablers and barriers.[1,6] Programs described in 2 of the studies provided hands-on experience for dental hygiene students and assistants, contributing to improved access and expanded professional pathways.[1,6] Continuing education and training are needed to enhance readiness for teledentistry roles.[16] Innovative models integrating teledentistry into underserved communities, such as school-based screening programs, mobile oral health units, and asynchronous specialist consultations, have been shown to alleviate workforce shortages when paired with educational and financial policy support.[10] These models often rely on dental hygienists or trained auxiliaries to conduct initial assessments, deliver preventive care such as fluoride varnish, and collect diagnostic data, allowing dentists to remotely review cases and focus their efforts where most needed.

Systemic barriers and program sustainability

While teledentistry offers promising solutions for underserved communities, its long-term success depends

on addressing systemic barriers that limit implementation and scale. Inconsistent funding, limited digital infrastructure, workforce shortages, and fragmented health systems can undermine even the most well-designed programs. Additionally, without coordinated policy reform, sustained training efforts, and equitable reimbursement models, these initiatives risk becoming short-term projects rather than lasting solutions. Ensuring program sustainability requires commitment across educational, clinical, and governmental sectors to support continuity and impact. Barriers to sustainability included inconsistent reimbursement, low referral follow-up rates, and a lack of standardized protocols.[7,10] Even in programs with high screening completion rates, the transition to restorative care was not guaranteed.[7] In one study, only 11% of children who were referred following teledental screenings received the necessary follow-up treatment.[6] This illustrates a breakdown between initial assessment and continued care, a gap that undermines the overall effectiveness of teledentistry initiatives.[6] Additional studies have noted that without reliable funding mechanisms and system-wide referral coordination, even well-executed programs struggle to achieve lasting impact.[7,11] These findings underscore the urgent need for integrated referral infrastructure, cross-sector collaboration, and standardized clinical pathways to ensure teledentistry can be sustainably scaled in underserved populations.[6,7,11]

Study limitations

This thematic review provided an analysis of recent dental hygiene-led teledentistry models. However, certain limitations should be noted. First, only peer-reviewed articles were included, which may have overlooked innovative grey literature. Additionally, the diversity in study design limited the ability to compare outcomes directly. Despite these limitations, the review offers a valuable synthesis of current literature and trends.

CONCLUSION

When dental hygienists lead teledentistry, it is more than a technological advancement. It is a practical, scalable solution to the persistent issue of unequal access to oral health care. This review highlights how dental hygienist-led models, such as school-based screenings and fluoride programs in rural communities, and asynchronous diagnostics supported by remote supervision, can make a measurable impact in rural and underserved communities.[1,5,6] The success of these models depends on supportive policy, consistent reimbursement structures, and ongoing investments in training to ensure long-term sustainability.

The findings of this review are particularly relevant in light of the recently launched Canadian Dental Care Plan (CDCP), which aims to improve access to essential oral health services for low- and middle-income Canadians. CDCP includes coverage for preventive, diagnostic, restorative, and periodontal services—many of which can be delivered or supported by dental hygienists through teledentistry.[17] By leveraging dental hygiene–led teledentistry models, particularly in rural and remote communities, CDCP could be implemented more equitably and efficiently. Incorporating these models into CDCP delivery may reduce workforce strain, improve early detection, and enhance continuity of care for underserved populations.

Recommendation for future research

Future research should evaluate long-term clinical outcomes of dental hygiene-led teledentistry programs and economic metrics. Comparative studies between in-person and virtual models in underserved populations would offer valuable evidence on effectiveness and patient–provider satisfaction. There is a need for implementation research that explores how policy, reimbursement models, and interprofessional collaboration can influence the scalability of teledentistry models. Expanding training programs and including teledentistry competencies in dental hygiene curricula should also be studied to assess provider readiness. Finally, future studies should explore integrating these models into national programs such as the Canadian Dental Care Plan to enhance equity through continuity of care.

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CONFLICTS OF INTEREST

The author has declared no conflicts of interest.

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