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American Legislative Exchange Council
Board of Directors
Alexandria, VA

RE: ALEC Model Policy on Dental Therapy

Dear Members of the ALEC Board of Directors,

As America's leading advocate for oral health, the American Dental Association is committed to advancing access to quality oral health care for all. This includes workforce innovations that allow for dentists to delegate procedures to appropriately educated and trained practitioners, thereby increasing access to care. However, central to this belief is the conviction that in the best interests of the public, only dentists, equipped with comprehensive education and training, are the qualified professionals to diagnose dental disease, identify oral pathology such as oral cancer, perform surgical and irreversible procedures and supervise procedures by allied dental team members.

On July 26, 2024, the ALEC Health and Human Services Task force approved, by a vote of 10-9, a model legislation on dental therapy that falls short of meaningfully increasing access to care in an appropriate, timely, and economically feasible way. Therefore, the ADA opposes adoption of this model and asks that you not support its final approval.

The dentist is ultimately responsible, ethically and legally, for patient care as acknowledged by the proposed model legislation -- "*A supervising dentist shall accept responsibility for all services performed by a dental therapist pursuant to a collaborative management agreement*." The weight of this responsibility requires that the dentist be the healthcare provider that performs examinations/evaluations; diagnoses; treatment planning; and surgical/ irreversible procedures; prescribes work authorizations; prescribes drugs and other medications; and administers enteral, parenteral or inhalational sedation, or general anesthesia.

Although the model proposed by the taskforce places the "responsibility of all services performed by a dental therapist" on the dentist, it allows the therapist to:

- Conduct an oral evaluation and assessment of dental disease and formulation of an individualized treatment plan.
- Evaluate radiographic images.
- Administer nitrous oxide.
- Perform services such as suture placement, pulpotomy on primary teeth, tooth reimplantation and stabilization, etc.
- Perform a nonsurgical extraction of periodontally diseased permanent teeth with tooth mobility.
- Directly supervise a dental hygienist and authorize them to perform procedures as well as supervise unlicensed individuals who are allowed to perform "remediable" procedures in accordance with a treatment plan approved by the therapist.

We note that "oral evaluation" as defined by the Code on Dental Procedures and Nomenclature (CDT Code) includes a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues including an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may require interpretation of information acquired through additional diagnostic procedures. The purpose of these activities is to reach a fully informed diagnosis and individualized treatment plan for each patient. Given this definition, this model allows a dental

therapist to diagnose dental disease. The training and education required to perform services as a dental therapist does not prepare individuals to diagnose dental disease, identify oral pathology such as oral cancer and determine an individualized treatment plan.

The primary purpose of dentists delegating functions to allied dental personnel is to increase the capacity of the profession to provide patient care while retaining full responsibility for the quality of care. When delegating, the degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the medical and dental history of the patient, as determined with evaluation and examination. In this context, the proposed model allows a dental therapist to perform services under "general supervision" defined as "the *dentist is not present in the dental office or other practice setting or on the premises at the time tasks or procedures are being performed by the dental therapist, but that the tasks or procedures performed by the dental therapist are being performed with the prior knowledge and consent of the dentist*". "Prior knowledge and consent" alone, in our view, is insufficient to support diagnosis, treatment and supervision of other allied personnel. The dentist is the qualified professional to diagnose dental disease, and written standing orders are not a substitute for obtaining a diagnosis.

The ADA believes that the development of any new member of the dental team be based upon determination of need, a CODA-accredited dental school or advanced dental education program, and a scope of practice that ensures the protection of the public's oral health. Failure to specify that dental therapists must graduate from a program accredited by the Commission on Dental Accreditation (CODA), the only body in the United States tasked with evaluating dental education programs, which includes dental therapy; and failure to assure that the patient first become a patient of record examined by the dentist raise significant concerns for the ADA. The ADA believes that any patient to be treated by a dental therapist as authorized by this model legislation must first become a patient of record of a dentist. A patient of record is defined as one who:

a. has been examined by the dentist;
b. has had a medical and dental history completed and evaluated by the dentist; and
c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.

Furthermore, the stipulation around informed consent within this model states the following: "*Any dentist or dental therapist who treats a patient shall inform the patient about the availability of reasonable alternate modes of treatment and about the benefits and risks of these treatments. The reasonable dentist standard is the standard for informing a patient under this section. The reasonable dentist standard requires disclosure only of information that a reasonable dentist would know and disclose under the circumstances."* This inappropriately places the burden on the dental therapist to be able to explain treatment plans and alternatives to patients to the same level as a dentist who has much more expansive education and qualifications, all while the dentist takes full responsibility for the actions of the dental therapist.

In addition to our concerns expressed above, we maintain that there appears to be little appetite for dental therapy in states that have adopted authorizing legislation. Advocates have long asserted that dental therapy would address dental workforce shortages, particularly in rural areas and other areas with underserved populations. This has not come to fruition. Despite fourteen states having passed some form of dental therapy legislation, most of these states do not have a single therapist practicing or even licensed years after passage of their legislation.

While pilot projects exist on tribal lands in Oregon, Washington, and Idaho, the vast majority of dental therapists continue to practice in Minnesota. A report from 2019 indicated that about 73 percent of dental therapists in Minnesota work in a metropolitan area[i], and 139 total dental therapists had active licenses in Minnesota as of April 2024[ii]. The state of Minnesota provides detailed healthcare workforce data[iii], including work status, average hours worked, time spent providing patient care, and other metrics, for dentists, dental hygienists, and dental assistants. However, it does not track such data for dental therapists. This lack of transparency makes it virtually impossible for policymakers to determine whether dental therapists are making a measurable impact in improving access in rural and underserved areas as intended.

Furthermore, dental therapy education programs exist only in three states – Minnesota, Alaska, and Washington – while dental schools and dental hygiene and dental assisting programs operate in virtually every state in the nation. Earlier this year a dental therapy education program at Metropolitan State University was suspended.

We find, as well, that state investment in these programs tends to have a poor return. In Vermont, over $2.6 million in private, state, and federal funds have been spent on a still non-existent program intended for Vermont Technical College (VTC). A 2023 state audit[iv] identified several critical issues, including the potential misuse of funds as well as an inability of VTC to satisfy the conditions necessary for CODA accreditation. At best, VTC will be unable to enroll any students until 2027, even if all underlying concerns were fixed immediately.

We acknowledge that the long-running debate over dental therapy has resulted in good faith efforts by the model's author to improve upon initial proposals and address concerns in the dental community. However, underlying policy issues lead us to conclude that dental therapy is not a viable dental workforce innovation for state policymakers to pursue.

The ADA believes a better and faster approach to address dental workforce shortages is to create state legislation and funding initiatives for existing dental education programs to address the current shortage of hygienists, dental assistants, and expanded function dental assistants who function efficiently in the current dental team model. The ADA encourages states to adopt policies incentivizing dentists and dental hygienists to work in rural and health provider shortage areas serving publicly insured patients by reducing their student loan burden as a quick, cost-effective pathway to help reduce the numbers of underserved populations while simultaneously delivering high-quality care. Community Dental Health Coordinators (CDHCs) who work closely with families to find appropriate care should also be supported within state health policies.

We appreciate both your commitment to improving oral health and your diligent review of model legislation before you determine your final position this December. We would welcome the opportunity to meet with you to discuss and develop innovative approaches and best practices we have identified that achieve the goal of improving access to care that are economically viable, expedient, and provide adequate protection of the public's health.

As such, we respectfully request that you do not support the dental therapy model legislation recently passed by the Health and Human Services Task Force.

On behalf of the 159,000 members of the American Dental Association, thank you for considering our request. Please contact Jim Schulz, Senior Vice President of Government Affairs, for more information at schulzJ@ada.org.

Sincerely,

Linda J. Edgar, D.D.S., M.Ed.
President

Raymond A. Cohlmia, D.D.S.
Executive Director

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[i] https://www.health.state.mn.us/data/workforce/oral/docs/2019dt.pdf

[ii] https://mn.gov/boards/dentistry/consumers/active-licenses/index.jsp

[iii] https://www.health.state.mn.us/data/workforce/hcwdash/index.html?url_var=workstatuspatientcare#NaN

[iv] https://auditor.vermont.gov/sites/auditor/files/documents/Dental%20Therapy%20Final%209-22-23.pdf