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Dr. Sherin Tooks, EdD, MS
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611

Dear Dr. Tooks and members of the Commission on Dental Accreditation:

Thank you for the opportunity to comment on the Commission on Dental Accreditation's (CODA) Draft Standards for Dental Therapy Education Programs.

Community Catalyst is a national advocacy organization that has been giving consumers a voice in the health care system for more than a decade. We provide leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high-quality, affordable health care for everyone. Time and again, consumer advocates and community members have documented the fact that people cannot find affordable dental care in their community. As a result, we are working with state and local partners to increase access to care by adding an evidence-based new provider, a dental therapist, to the dental team.

Oral health is essential to overall health. Yet, according to the American Dental Association, 181 million Americans went without a dental visit in 2010[1]. Given that cost and availability of providers in underserved communities are major barriers to care and that dental therapists have increased access to care in underserved communities, we appreciate CODA's work to develop minimum standards for dental therapy training program.

For over 90 years dental therapists have been utilized to extend routine and preventive care to underserved populations. Today, dental therapists provide care in more than 50 countries and there are over 1100 studies [2]documenting that dental therapists - trained primarily in two year programs - provide safe, quality care and expand access to dental care for underserved populations.

As CODA continues its process of developing draft standards for a new mid-level dental provider training program in the United States, it is important to develop evidence based standards, which lead to dental therapy training programs and ultimately graduates that are positioned to meet the unmet needs in this country by providing culturally competent, cost-effective, routine and preventive care in their community.

With that in mind, we thank CODA for its extensive work and for including the following policies in the most recent draft standards. These policies are appropriate and critical to meeting

[1] http://www.ada.org/en/press-room/news-releases/2013-archive/may/americas-dentists-launch-nationwide-campaign-to-address-us-dental-crisis
[2] http://www.wkkf.org/news/Articles/2012/04/Nash-report-is-evidence-that-dental-therapists-expand-access.aspx

the needs of our communities. We urge you to keep the following policies in the final draft of the standards:

- Including dental therapists as members of the oral healthcare team (P. 22, Lines 2-4).
- Removal of the onerous and restrictive supervision requirements which would have limited dental therapists' ability to expand access to care to underserved populations (P. 25, Line 5-8).
- Removing the restrictive requirement in Standard 2-1 that required that all dental therapy programs result in a baccalaureate degree. This allows colleges and universities to have the flexibility to develop evidence-based programs aimed at producing culturally competent, community-based providers.
- Updating Standard 3-2 to recognize that the program director of dental therapy programs could be health and dental professionals other than a licensed dentist (DDS/DMD). This gives colleges and universities proper flexibility to hire qualified program directors that will meet the unique needs of their program, their students, and the communities they serve.
- Including recognition of advanced standing for dental professionals who enter dental therapy programs. By recognizing advanced standing, dental professionals will have the opportunity to build on their existing dental education and expertise, which will create a pathway to opportunities for dental professionals and help produce more providers to meet the needs of our underserved population (P. 15, Line 37-43).

We urge CODA to retain all of those provisions in the final draft of the standards highlighted above. However, we remain concerned by CODA's proposed standards related to the length of training and scope of practice of dental therapists. As currently drafted, the standards would hamper the ability to train providers to meet the severe unmet oral health needs in the country.

Length of Training for Dental Therapists: Standard 2-1

As noted above, it is critical to look to evidence and experience of dental therapists in developing draft standards for dental therapy education programs. Unfortunately, draft **Standard 2-1** requires a minimum of three years of training for dental therapists, which is not consistent with the experience of dental therapists being trained in two years in Alaska and internationally.

Since 2007, the Alaska Native Tribal Health Consortium (ANTHC) in partnership with the University of Washington has trained six graduating classes of dental therapists[3]. Students are trained in two years. Prior to launching the joint DENTEX program, three classes of Alaska Natives were trained in a two-year New Zealand program. In total, there are 25 Alaska dental therapists providing routine and preventive care to 40,000 previously underserved Alaska Natives.

The ANTHC program should serve as a model for national standards due to its extraordinary success in expanding access to care, the success of their graduates in providing technically competent care and the success in recruiting and retaining providers from a diverse community.

In addition to expanding access to care, two-year trained Alaska dental therapists have been studied more than any other dental provider in the country. In the most comprehensive quality study in the field of dentistry, RTI International found that [4]the dental therapists who graduated from the Alaska program provide safe, competent care. Key findings from the evaluation indicate that dental therapists are:

[3] http://depts.washington.edu/dentexak/who-we-are/history/

[4] http://depts.washington.edu/dentexak/wordpress/wp-content/uploads/2012/10/2010RTI-Report.pdf?

- Technically competent to perform the procedures within their scope of work, and are doing so safely and appropriately,
- Consistently working under the general supervision of dentists,
- Successfully treating cavities and helping to relieve pain for people who often had to wait months or travel hours to seek treatment,
- Meeting or exceeding patient satisfaction, and
- Well-accepted in tribal villages.

The DENTEX Program's has trained and retained dental therapists who are diverse and provide culturally competent care in rural and underserved communities. In fact, according to the ANTHC:

- 78% of dental therapists practice in their village of origin or region of origin.
- 88% of dental therapists are Alaska Natives.
- 81% retention rate over the course of ten years.

The success of Alaska's two year program should not be overlooked or amended by adding a third year of training. Instead, the Alaska program, which graduates and retains a higher percentage of diverse providers, should be a model for CODA to follow.

Requiring additional training could negatively impact the ability of training programs to recruit and train culturally competent providers. Rather than add additional training that provides no tangible benefit in terms of quality of provider, we urge CODA to utilize standards that mirror the success of the program in Alaska.

When deciding on length of training, we ask the Commission to utilize the work of the American Association of Public Health Dentistry (AAPHD)[5], which convened a panel of dental educators who engaged in a thorough 14-month program that reviewed the Alaska program as well as international dental therapy programs. As a result of the work, the panel outlined the principle competencies and curriculum to educate dental therapists. The panel's findings were published in a special edition of the Journal of Public Health Dentistry and detail the framework for a two-year dental therapy curriculum that culminates with an Associate's degree.

As follow-up to the AAPHD panel, Community Catalyst convened a panel of academic and program experts comprising representatives from all three of the existing U.S. educational programs for dental therapists, as well as experts in dental therapy practice in the U.S. and Canada and educational standards experts. The panel researched accreditation models, standards and competencies for existing health professions to address critical issues such as curricula, faculty credentials, basic program length, and the level of financial support and type of setting needed to offer quality education programs. The panel recommended[6]:

- Dental therapists should be trained to practice under the supervision of a dentist and to work collaboratively as part of a dental care team.
- Dental therapy curricula must include at least two calendar years of full-time instruction or its equivalent at the post-secondary level, and graduates must receive an Associate's degree. If a student is to be jointly trained in dental therapy and dental hygiene, the curriculum must include at least three years of full-time instruction or its equivalent.
- Graduates from dental therapy programs must be able to competently provide care within a scope of practice that includes assessing patients' oral health needs, providing preventive care and treatment for basic oral health problems and recognizing and

[5] http://www.aaphd.org/aaphd-publishes-proposed-curriculum-guidelines

[6] http://www.communitycatalyst.org/doc-store/publications/dental-therapy-education-standards.pdf?

managing complications, while adhering to all recognized community and professional standards.

- Dental therapy education program leaders must be qualified to administer the program, but do not need to be dentists. However, if a program is not dentist-led it must employ a dental director—a licensed dentist who is continually involved in the program.

We respectfully ask CODA to review the evidence from the Alaska DHAT Educational Program, other well-established international models of dental therapy education, the findings of the AAPHD panel, and the results of the Community Catalyst panel that explored dental therapy education standards before adopting a requirement of three years of training. These established programs and the evidence-based work of the AAPHD panel demonstrate that a dental therapy program should consist of two academic years of training and therefore, **we urge CODA to amend Standard 2-1 to read, "*The curriculum must include at least two academic years.*".**

Scope of Practice for Dental Therapists: Standard 2-20

It is disappointing that the CODA draft standards included an incomplete scope of practice for dental therapists in its most recent draft standards. While the scope of dental therapy detailed in section (2-20) is appropriate, it is incomplete because it does not include diagnosis, treatment planning, or complete scope as it relates to extractions.

By excluding diagnosis and treatment planning in the scope of practice of dental therapists the Commission is ignoring the evidence-based practice of dental therapy, which includes diagnosis and treatment planning. Allowing dental therapists to practice with their full scope allows them to reach underserved populations that the current dental team is unable to reach. Requiring that diagnosis and treatment planning be done by dentists and/or failing to include diagnosis and treatment planning in a dental therapist's scope of practice significantly limits where and how a dental therapist practices. Dental therapists' scope has included diagnosis and treatment planning and enables them to work under the general supervision of dentists. This precedent has met the needs of the underserved and should continue to be the model for standards.

Similarly, evidence and experience shows that dental therapists' scope of practice should include extractions of primary teeth and limited extractions of permanent teeth. Dental therapists are effective because they can provide routine and preventive care and we should not limit their scope as part of the CODA process.

In Alaska and Minnesota dental therapists are able to extract primary teeth and are able to extract permanent teeth with limitations. In both states, being able to provide routine care is critical to building trust with patients and also extremely safe.

In fact, Dr. Edwin Allgair, who oversaw 8 dental therapists as former dental director and DHAT supervisor at the YKHC clinic in Bethel, remarked in a July 2012 presentation that "We established that extractions are an important service for DHATs to gain trust of the patients who historically seek episodic urgent care. As of 7/25/12, just my 8 DHATs together have performed 2,798 extractions since 2004. I cannot recall more than perhaps 5 of those that required the patient to travel in to Bethel to complete the procedure with a dentist."

Additionally, Children's Dental Services, the first employer of dental therapists in Minnesota, reported that "extractions of primary teeth are a very important part of the scope. Many emergency appointments result in infected teeth being extracted. This is often the only possible treatment to address infection, takes kids out of extreme pain and can quite literally save lives."

Based on the need of millions of Americans to access routine and preventive care and the success of dental therapists in providing access to quality care, **we respectfully request that the Commission add diagnosis, treatment planning, primary extractions and extractions of**

permanent teeth that are not impacted and that do not need sectioning or an incision for removal to the list of areas of competency required for oral health care provision in the scope of dental therapy in Standard 2-20.

Adoption of Dental Therapy Standards

In closing, we urge CODA to adopt dental therapy education standards in order to streamline education programs, avoid multiple dental boards from wading into accrediting education programs in their state, and help establish a dental therapy program based on national standards.

As the Commission considers adopting national standards, it is critical to understand there is a significant need for better access to routine and preventive dental care and that dental therapists are able to provide care to underserved, vulnerable populations.

As noted above, 181 million Americans went without a dental visit in 2010 according to the American Dental Association. Finding a dentist is problematic for low-income and rural populations. According to the Health Services and Resource Administration more than 45 million Americans live in dental health professional shortage areas (DHPSAs) across the country and a minimum of 7,100 new dental providers are needed to meet the existing dental care needs of underserved Americans. For low-income children enrolled in Medicaid, 52% did not receive dental care in 2011[7].

A 2013 Community Catalyst report, *Economic Viability of Dental Therapists*[8], assessed dental therapists in practice in both Alaska and Minnesota between August 2011 and December 2012. The report highlighted that in both states, in a variety of settings, dental therapists provide cost-effective, routine and preventive dental care to traditionally underserved Medicaid, rural, and tribal populations highlighted above that are struggling to get care. The report also showed:

- The majority of services dental therapists provided were preventive (diagnosis, fluoride varnish, cleanings, etc.) and routine (restorations).
- Dental therapists are cost effective – for every dollar in revenue they generate it costs less than $0.30 to employ them.
- Dental therapists primarily treat children, low-income adults, Native Americans and those who would not otherwise have access to dental care. Seventy-eight percent of dental therapists' patients in Minnesota were publicly insured and the majority were under 21. In Alaska, 66 percent of patients served by dental therapists were under 21.

In February 2014, the Minnesota Department of Health released a comprehensive report on the practice of dental therapists in Minnesota. The report highlights that the early use of dental therapists is extremely positive from the perspective of the employers of dental therapists. Dental practices employing dental therapists are reporting increased ability to see Medicaid patients, an increase in the number of patients they are able to see, an increase in communication among the dental team, dentists performing more complicated procedures and

[7] This figure counts children age 1 to 18 eligible for Medicaid's early and Periodic Screening, Diagnostic and Treatment Benefit. See: US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Form CMS-416 (National) Fiscal Year: 2011," Annual EPSDT Participation Report, April 1, 2013. Analysis by the Pew Charitable Trusts.

[8] http://www.communitycatalyst.org/doc-store/publications/economic-viability-dental-therapists.pdf,

delegating routine care, and a cost benefit to the practices to help them deal with low Medicaid rates[9].

The January, 2013 edition of the Journal of the American Dental Association (JADA) reported that dental teams with mid-level providers were more successful at providing services to populations with untreated decay than dental teams without mid-level providers (dentists alone[10]).

Dental therapists are making a significant impact in expanding access to care for underserved populations. The need for dental therapists is only growing as more Americans go without dental care. Yet, there is no national accrediting process for the profession.

Already, there are three dental therapy programs training dental therapists in the United States: two in Minnesota, and one in Alaska. With passage of legislation in Maine there will be additional training programs launched within the next two years. Each program is graduating competent providers. In Minnesota the two programs have produced 42 graduates and it is anticipated that by 2016 there will be 71 graduates. In Alaska, 25 dental therapists are practicing and have increased access to care for over 40,000 Alaska Natives. Additionally, the ANTHC studied the economic impact that dental therapists are having a positive economic impact on Alaska Native communities and are generating $9.3 million in annual activity.

Dental therapists in both Alaska and Minnesota are making good salaries that range from $60,000-$90,000 annually. Given the need for better access to care for underserved populations, the economic viability of employing dental therapists, and the good salaries, there will surely be a demand among employers to hire dental therapists as well as a number of well-qualified students interested in pursuing the good paying job of dental therapist.

Similarly, over 15 states are currently exploring emerging workforce models to address their dental needs., Rather than continue to progress on a state by state basis that requires state dental boards to certify and/or accredit educational programs in each respective state, we urge CODA to adopt standards and implement a national accrediting process for dental therapy education programs

Again, we thank the CODA for its work in developing draft standards and for the opportunity to provide feedback on draft dental therapy education standards. We look forward to working with the Commission to further develop standards for the profession's graduates who will be an integral part of the dental team and will play a critical role in extending care to currently underserved communities throughout the country.

Sincerely,

David Jordan
Dental Access Project Director
Community Catalyst

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[9] http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf.

[10] http://jada.ada.org/content/144/1/75.full#sec-16