The mission of ADEA is to develop an inclusive, future-ready oral health workforce prepared to improve the health of all people and communities through leadership, education and collaboration.

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The Hon. Ty Masterson and the ALEC Board of Directors
American Legislative Exchange Council
National Chair
2733 Crystal Drive, Suite 1000
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Dear Sen. Masterson and Members of the ALEC Board of Directors:

On behalf of oral health educators and the patients their graduates care for, I write to express the American Dental Education Association's (ADEA's) concerns with the recently proposed Dental Access Model Act.

As The Voice of Dental Education, ADEA is the sole national organization representing academic oral health education. Our members include all 77 U.S. dental schools, more than 800 allied (e.g., dental hygiene, dental therapy, dental assisting) and advanced dental education programs, more than 50 corporations and approximately 15,000 individuals.

Concerns About Oral Preventive Assistants

ADEA applauds efforts to increase oral health care access for those in need of care; however, we question the effectiveness of the proposed model legislation in achieving that goal and fear that the scope of practice envisioned for the new oral health professional, Oral Preventive Assistants (OPA), puts patients at risk.

Under this model legislation, the scope of practice for an OPA includes taking and recording periodontal probe readings, documenting areas of periodontal concern, and performing supragingival (above the gum line) scaling and polishing on periodontally healthy patients or patients with reversible gingivitis. In all states, these duties are typically assigned to licensed dental hygienists who, along with licensed dentists and in some states dental therapists, are the only trained professionals permitted to engage in these dentistry practices. To learn these skills, licensed dental hygienists complete at least two years of coursework from a program accredited by the Commission of Dental Accreditation (CODA), pass a licensing exam and complete clinical rotations. This two-year period allows for repetitive practice, evaluation and guidance that creates competent dental hygienists upon graduation. One brief course provided to an OPA does not allow for obtainment and repeated demonstration of skill competency and creates a risk for patients who could be treated by an OPA, as well as malpractice exposure for the practicing dentist.

Additionally, while two states, Kansas and Illinois, allow supragingival scaling, only one state pilot program, in Missouri, permits OPAs to take and record periodontal probe readings and document areas of periodontal concern. These are diagnosing activities that assist a dentist with identifying periodontal problems. Missouri's pilot program is very limited and lacks data to show that this practice is safe. ADEA is concerned that the reduced training and lack of experience of OPAs could lead to missed

diagnoses of periodontal issues in patients that see OPAs. Missing these problems is likely to negate the preventive purpose of scaling and will likely lead to an increase in oral health problems among patients.

Probing is also a technique-sensitive procedure that requires the insertion of an instrument under the gums, and if done incorrectly it can cause trauma to the gums. ADEA is concerned that the lack of training, repetition and guidance received by OPAs in conducting this procedure will cause harm to patients.

OPAs are also being put forth as potential providers of basic preventive services to rural patients who are periodontally healthy, especially in health care shortage areas. Patients in these locations are almost never "periodontally healthy" due to previous lack of access to care.[1] These patients are not appropriate for care by an OPA, given OPAs' limited education and ability to treat or even recognize or document oral health concerns. It is important to note that the term "periodontally healthy" is misleading in that patients most always have one or more locations of periodontal disease, even though the rest of the oral tissue is healthy. Furthermore, supragingival scaling separately or alone has shown no clinical significance unless followed by subgingival scaling.[2] If the intent is to provide therapeutic care to improve oral health, supragingival scaling alone is not the solution.

The *Journal of Clinical Periodontology* has published clinical practice guidelines that state the best treatment for periodontal health is both supra- and subgingival scaling[3]. Because OPAs would be limited to scaling above the gums, and are unlikely to work with patients who are "periodontally healthy", it is likely they will only partially remove a calcium deposit as some of the deposit will sit below the gum line. Supragingival scaling, with the retention of residual calculus/tarter subgingivally, can result in the development of periodontal abscesses.[4] Leaving subgingival calculus/tarter, while only scaling supragingivally, is considered patient neglect. While allowing OPAs to conduct periodontal probe readings and documentation is intended to help prevent this from happening, the OPAs' lack of training will increase the likelihood of problems below the gum going undetected and developing into bigger problems.

Finally, the model legislation is not clear on whether OPAs would be permitted to practice under the teledentistry laws outlined in the proposal. ADEA has concerns about the possibility of OPAs being permitted to practice under a teledentistry model if this would be permitted under the bill. Given the lack of training and potential risk to patients, it would not be safe to allow OPAs to work under a teledentistry model without a dentist immediately available to assist with both medical and dental emergencies.

Alternatives

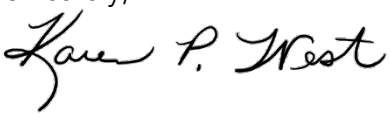
Many states have increased access to oral health providers by allowing dental hygienists to work to the full scope of their education and training. A review found that several studies demonstrated positive impacts on oral health outcomes in states that have increased autonomy of dental hygienists when compared to states that have a more restrictive scope of practice[5]. One study found that autonomous scopes of practice were significantly associated with fewer extractions of permanent teeth.[6] Another found that that 23.8% of all nontraumatic emergency department visits were preventable and restrictive scopes of state dental practice policies were associated with higher numbers of preventable dental emergency department visits.[7]

Conclusion

The proposed model legislation attempts to apply a flawed short-term solution to the existing and growing oral health profession workforce shortage. The solution is not to put insufficiently trained individuals in patient care, but to develop a "future-ready oral health workforce prepared to improve the health of all people and communities."* Allowing OPAs to practice has not proven to be safe or effective for reaching patients in need. To our knowledge, no data have demonstrated the safety of scaling assistants in states where they are permitted to practice. The lack of education and training through a CODA-accredited program, including clinical experience to demonstrate mastery of technique and a record of satisfactory patient outcomes, has the potential to lead to patient safety issues. Other strategies to increase the access to quality oral health care by providing additional financial incentives, as many states now do, to professionals to practice in rural underserved areas, or allowing dental hygienists to work to their full scope of education and training, have been shown to be an effective way to reach patients in need of care and provide them with the high-quality care they deserve.

Thank you for considering our concerns. We are ready to work collaboratively with you and your colleagues to increase access to oral health care. If you have any questions or would like additional information, please contact me or Phil Mauller, ADEA Senior Director for State Relations and Advocacy, at maullerp@adea.org.

Sincerely,



Karen P. West, D.M.D., M.P.H.
President and CEO

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[1] The American Academy of Periodontology defines Periodontal Health as a state free from inflammation and characterized by shallow pockets and the absence of gingival bleeding. There is no evidence of periodontal inflammation, such as bleeding on probing, redness, swelling or pus.

[2] Oliveira LM, de Oliveira CA, Angst PDM, Antoniazzi RP, Zanatta FB. Should supragingival scaling be performed separately prior to subgingival scaling and root planning in nonsurgical periodontal therapy? A systematic review of randomized trials. Int J Dent Hyg. 2024 Feb;22(1):35-44. doi: 10.1111/idh.12731. Epub 2023 Sep 3. PMID: 37661290.

[3] Sanz M, Herrera D, Kebschull M, et al. On behalf of the EFP Workshop Participants and Methodological Consultants. Treatment of stage I–III periodontitis—The EFP S3 level clinical practice guideline. *J Clin Periodontol*. 2020; 47: 4–60. https://doi.org/10.1111/jcpe.13290

[4] The American Academy of Periodontology defines a periodontal abscess as a localized collection of pus in the gingival wall of a periodontal pocket or sulcus. It can cause significant tissue breakdown and is characterized by the following symptoms: bleeding on probing, pain, pus, deepening periodontal pocket and increased tooth mobility.

[5] Gadbury-Amyot CC, Simmer-Beck ML, Lynch A, Rowley LJ. Dental hygiene and direct access to care: Past and present. Int J Dent Hyg. 2023 Nov;21(4):781-788. doi: 10.1111/idh.12772. Epub 2023 Oct 7. PMID: 37804220.

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* ADEA Strategic Framework, 2024-2027, mission statement.

[6] Langelier M, Continelli T, Moore J, et al. Expanded scopes of practice for dental hygienists associated with improved oral health outcomes for adults. Health Aff (Millwood). 2016 Dec; 35(12):2207-15.
[7] Akinlotan MA, Ferdinand AL, Maxey HL, et al. Dental hygienists' scope of practice regulations and preventable non-traumatic dental emergency department visits: A cross-sectional study of 10 U.S. states. Community Dent Oral Epidemiol. 2022 Feb;51:274-82.