November 28, 2014

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

Dear Dr. Tooks,

Thank you to you and the members of the Commission for the opportunity to comment on the Commission on Dental Accreditation's (CODA) Accreditation Standards for Dental Therapy Education Programs. In my November 26, 2013 letter to the Commission, on behalf of The Sullivan Alliance to Transform the Health Professions, I commented in detail on the Commission's work with these developing accreditation standards.

I am impressed with the headway that CODA has made. I recognize how critical your review and scope are to the expansion of access to oral health professions training and dental care delivery for our nation. Areas of the current draft standards available for review now include new language, or have removed language, regarding the:

- Inclusion of dental therapists as members of the oral healthcare team (P. 22, Lines 2-4).

- Removal of the restrictive supervision requirements (P. 25, Line 5-8), which would have limited dental therapists' ability to expand access to care to underserved populations.

- Removal of the restrictive requirement in Standard 2-1 requiring that all dental therapy programs result in a baccalaureate degree. By removing the requirement, colleges and universities will have the flexibility to develop evidence-based programs aimed at producing culturally competent, community-based providers. *This is a key concern for The Sullivan Alliance.*

- Updating of 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). By removing the requirement that only dentists can serve as program directors, colleges and universities have proper flexibility to hire qualified program

directors to meet the unique needs of their program, their students and the communities they serve.

- 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 populations (P. 15, Line 37-43).

These policies are appropriate and important for meeting the needs of communities across the nation. Including them in the final draft of the standards will strengthen the standards in important ways.

My comments below focus on areas of remaining concern identified in my previous response to CODA accreditation standards development for Dental Therapy Education Programs.

1. **The proposed standards that require dental therapy programs to be three years in length.**

The current lack of access to healthcare and health education – because of location, race and ethnicity and/or social circumstance – negatively impacts individual lives and our nation's future economic and social success in dramatic and unnecessary ways.

The lack of minorities within the health professions is considered one of the major contributors to health disparities. Lack of minority health professionals is acute in the dental profession. Currently only 7% of our nation's dentists are underrepresented minorities. The Sullivan Alliance is eager to ensure that dental therapy education will be accessible to students from underserved communities and will prepare dental therapists to practice in their home communities or other underserved areas. An unnecessarily long training period will diminish the accessibility of the training program to individuals from underserved communities and in turn reduce access to critically needed care.

One proven successful method for bringing care to those in most need is found in the two-year Dental Therapist training model. There are over 50 countries that utilize dental therapists and most have done so with dental therapists educated in two-year programs. The evidence, captured in multiple articles, studies and papers, overwhelmingly shows that dental therapists educated in a two-year program without prerequisites provide safe, competent and appropriate care.

If the committee has not yet had an opportunity to review the U.S. model – the Alaska DHAT Education Model as well as the American Association of Public Health Dentistry (AAPHD) Dental Therapist curriculum published in the Journal of Public Health Dentistry in 2011 – I once again recommend these models be examined.

After further Committee review of the available findings regarding the quality of training and care delivery of dental therapists trained in a program with a two year curriculum, I urge the amendment of Standard 2-1 to state that "*The curriculum must include at least two academic years.*"

2. Scope of Practice for Dental Therapists: Standard 2-20

As outlined in my November 26, 2013 letter to the Committee, exclusion of "diagnosis and treatment planning within the scope of practice guidelines is a significant weakness in the draft".
While the scope of dental therapy enumerated in section (2-20) is appropriate, it is incomplete. The list does not include diagnosis, treatment planning, and complete scope as it relates to extractions within the dental therapy scope of practice.

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 which includes diagnosis and treatment planning enables them to work under the general supervision of dentists. This precedent has met the needs of the underserved in this country and in other parts of the globe and should continue to be the model as the Commission develops U.S. standards.

Allowing dental therapists to practice with the full scope of evidence-based practice of dental therapy allows them to reach underserved populations that the current dental team is unable to reach. The urgency of need within these communities must be addressed.

The Alliance respectfully requests 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.

3. Adoption of Dental Therapy Standards

This final issue is not one I addressed last year. It is, however a critical item to be considered by the Commission. It concerns CODA adoption of national dental therapy education standards. Adoption of standards would help streamline education programs and help establish dental therapy programs based on national standards, thereby avoiding the inconsistency or redundancy of individual state dental boards engaging in the work of accrediting individual state education programs.

Today, there are three dental therapy programs training dental therapists in the United States: two in Minnesota, and one in Alaska. Last year's passage of legislation in Maine will result in additional training programs launched within the next two years.

Each of the programs 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.

A lack of national standards and a national accrediting process slows the growth of a health professions career track (Dental Therapy) which is already having a profoundly positive impact on access to care. It confuses and complicates the system for DTs and dentists alike. It limits individual and community access to quality dental care which can be provided by a consistently well trained dental team.

The Commission has an opportunity to adopt well considered national evidence-based standards that have the potential of increasing quality care to thousands of people in need. I urge the Commission's review and recommendation of national standards.

Again, thank you for your work in developing draft standards and for the opportunity to provide comments to the Commission on Dental Accreditation's work to date.

I look forward to the Commission's continued development of standards for those 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,

Louis W. Sullivan, MD
Chair and CEO