State of Washington

Dental Therapy Task Force

Final Report on Recommendations

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by: Center for Dialog & Resolution

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Acronyms:

- ASA: American Standards Association
- CDR: Center for Dialog & Resolution (also known as PCCDR)
- CHAP: Community Health Aide Program
- CODA: Commission on Dental Accreditation
- CPE: Continuing Professional Education
- DDS: Doctor Dental Surgery
- DEH: Department of Environmental Health
- DHAT: Dental Health Aide Therapists
- DOH: Department of Health
- DPP#100: Dental Pilot Project #100 (Oregon State)
- DPP: Dental Pilot Project
- DQAC Dental Quality Assurance Commission
- DT: Dental Therapist
- FQHC: Federally Qualified Health Care
- HB: House Bill
- NPAIHB: Northwest Portland Area Indian Health Board
- OHA: Oregon Health Authority
- PCCDR: Pierce County Center for Dispute Resolution
- PNW: Pacific North West
- RCW: Revised Code of Washington
- RDH: Registered Dental Hygienist
- SB: Senate Bill
- U.S.C.: United States Code
- WAC: Washington Administrative Code
- WDG: Willamette Dental Group
- WSDA: Washington State Dental Association

Task Force

Members	Role as defined in statute
Marcy Bowers	Organizations that represent individuals or underserved communities
Dr. Miranda Davis	Organizations that represent individuals or underserved communities
Dr. Stephan Blandford	Organizations that represent individuals or underserved communities
Dr. Lyle McClellan	Dental Quality Assurance Commission
Beatrice Gandara	University of Washington School of Dentistry
Bracken Killpack	Washington State Dental Association
Colleen Gaylord, RDH	Washington State Dental Hygienists' Association
Rochelle Ferry	Dental Therapist (Port Gamble S'Klallam Tribe)
Dr. Rachael Hogan	Supervising Dentist (Swinomish Tribe)
Dayna Steringer	Dental Only Integrated Delivery System
Dr. Sarah Hill	Urban Indian Health Clinic
Bob Marsalli	Federally Qualified Health Center or the Washington Association for Community Health (representing all WA FQHCs)
Dr. Darren Greeno	Dental therapy education program
Unfilled Seat*	Washington tribe that currently employs dental therapists
Demas Nesterenko	Home Care Labor Union (Labor union representing care providers)
Rep. Jessica Bateman	House Democratic Caucus
Rep. Michelle Caldier	House Republican Caucus
Sen. Emily Randall	Senate Democratic Caucus
Sen. Ann Rivers	Senate Republican Caucus

*Due to wildfires and related issues this seat was not filled.

Introduction

The 18-member task force accepted the challenge of learning from the current practice of dental therapy on tribal lands. Dental therapy as a profession was developed to meet the essential oral health needs of communities who experience limited access to consistent, culturally appropriate, and quality professional dental care. Dental therapists are recruited from within tribal communities and practice in those communities, where they develop trusting relationships with community members, and by extending the dental team allow each member of the team (dental hygienist, dental therapist, dentist, oral surgeon, etc.) to work to the highest level of their scope of practice and increase efficiency and accessibility. The question the task force was asked to explore was *can this experience on tribal lands be scaled up to provide dental care in other underserved communities in Washington state?* The task force did not reach consensus on this question. Some task force members support statewide dental therapy while some propose other ways to make dental care more accessible in the state. This report describes the work of the task force and their recommendations to the legislature, along with the data, resources and experience that inform their recommendations.

Task Force Mandate

Washington State Legislation creates Dental Therapy Task Force on April 25, 2021 Section 222 (DOH) Section 17. "Pierce county center for dispute resolution (PCCDR) to convene a task force, staffed by the PCCDR, to review and make recommendations on bringing the current practice of dental therapy on tribal lands to a statewide scale, and on the practice, supervision, and practice settings needed to maximize the effectiveness of dental therapy."

Task Force Process

Task force defined
…brings diverse perspectives and expertise to understand an issue, explore options for addressing the issue and make recommendations related to the issue.

The Dental Therapy Task Force had five months to deliver a set of recommendations to the Legislature about how to scale dental therapy statewide after a review of tribal experience of the practice of dental therapy. The Center for Dialog & Resolution (CDR, also known as PCCDR) facilitation guidance was informed by the Department of Health, legislative counsel, tribal dental programs, and stakeholders to support the process of convening, and designing a process to produce well thought out recommendations.

The key design challenges for the task force included limited time, full engagement online, public meeting guidance, polarized positions of many stakeholders, and the large scope of the project: to learn from tribal experience and to be creative in recommending ways to scale up statewide to ensure safety and effectiveness.

Convene: Stakeholders from the institutions named in the legislation reached out to the CDR facilitation team to identify individuals to fill the required task force positions. As impartial facilitators, we accepted each organization's delegate and the names put forth by other stakeholders for all but one of the seats. We understand many of the existing task force members and other stakeholders continued to reach out to fill the remaining seat: "the Washington tribe that currently employs dental therapists." The summer fires and subsequent upheaval did not allow for any of those invited to fill this seat to join this task force. The task force consisted of 18 passionate and engaged members.

Decision-making: In an effort to maximize productive dialog that would lead to solid recommendations to the legislature, we did not set a goal of consensus or voting on any given recommendation. The goal instead was to have each member present their proposed recommendation(s) about the practice of dental therapy, share their source documents and then create the space for dialog about the strengths or limitations of their recommendation(s) for statewide scale up of the practice of dental therapy. We promoted productive disagreements based on data and experience, rather than positional debates that could have lasted years without resolution.

This process developed a series of recommendations with well-reasoned statements of support or opposition. In addition, we share with the legislature the series of key resource documents the task force members used to develop their recommendations.

Work plan & meeting schedule: Finding common time to meet for 18 busy professionals was a serious challenge. Our initial design plan included monthly task force meetings open to the public for review of current dental therapy practices and exploration of recommendations. In addition, we created a schedule that included the option for monthly small group work sessions. As facilitators, we initially assumed that given the polarization of positions on dental therapy, it might be easier to develop recommendations in multiple small groups (either like-minded or drastically different perspectives). Our assumptions included holding the virtual space for these small group conversations, yet not actively facilitating.

We designed the meeting schedule to include five public task force meetings and four small work group meetings. The public meetings proposed topics were:

July:	Getting to know the task force, interaction agreements, proposed task force work plan & timeline (July Task Force Meeting Slides 2021-07-26)
August:	Review of dental therapy on tribal lands
September:	Review of dental therapy on non-tribal lands *(task force members instead chose to learn from one another and not invite additional outside speakers)*
October:	Discussion about recommendations to the legislature
November:	Discussion about recommendations and finalizing recommendations

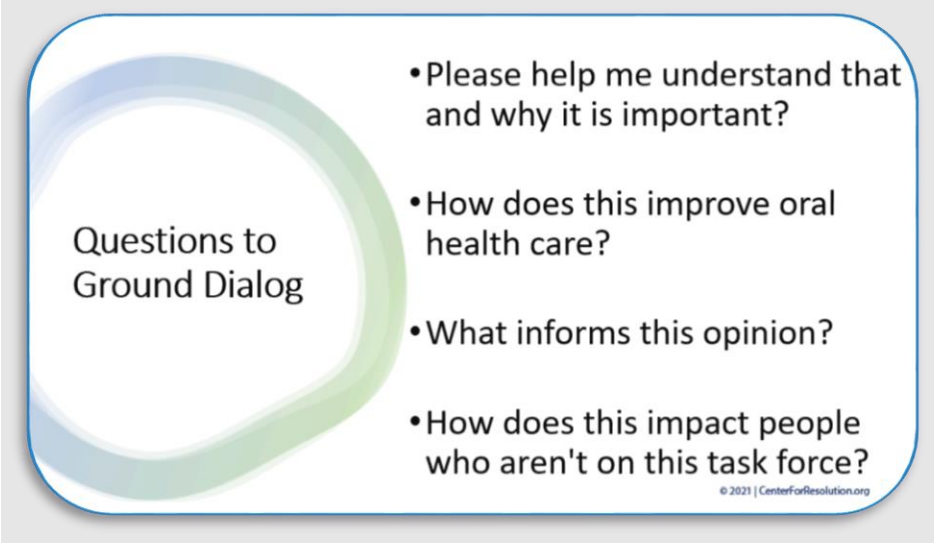
CDR facilitated the public meetings, posted the proposed agendas on our website, and invited members of the public to provide comments to the task force through a Public Input Form.

For the informal small group sessions, task force members adjusted the design for all to work together instead of forming smaller groups. This shifted the facilitation team to supporting open and productive group dialog. Task force members worked on the language of their recommendations outside of meeting times.

Task Force Engagement: Given the online environment for the meetings of this task force (all meetings were held on Zoom), the facilitators explored creative ways for task force members to get to know one another, to develop trust in online interactions and develop expectations that would allow all to disagree with respect. Every task force member filled out a survey, which was summarized in a "Getting to Know Each Other" document (to save meeting time). Task force members also shared what they needed from others to feel brave enough to speak up; in particular if they disagreed with someone in the virtual meeting space. These Task Force Interaction Agreements were reviewed at each task force meeting.

Task Force Interaction Agreements:	
Commit to the task force work:	• Respect that all care about dental access • Be open minded • Give each other benefit of the doubt • Practice patience and creativity • Learn from other experiences
Positive & productive communication:	• Be open to asking and answering questions • Check assumptions at the door • Speak with goal of collaboration • Listen and process other points of view • Step up/step back
Take time to think:	• Come prepared • Fully share on Zoom

The professional diversity represented on the task force, as well as the requirement to learn from tribal experience and bring to a statewide scale required attention to inclusion, respect for diverse cultural representations, and definitions of oral health, quality, risk, and data. As facilitators, we did not expect the task force to reach agreements, yet needed to find respectful and inclusive ways to understand disagreements. The Racial and Social Justice Initiatives in our state inspired our "Questions to Ground Dialog," which were reviewed at each meeting of the task force.



There were moments when task force members felt a lack of respect from others, yet for the most part the goal of producing well-reasoned recommendations created powerful graciousness among the task force. At the end of the process, each member was able to highlight what they learned from the process and express their gratitude for learning from one another.

What Task Force Members Learned About Dental Therapy:

Dental therapy is much more complicated than I thought: licensure, practice, discipline, supervision, etc.
How complex it is and how it deserves a complex solution
Dental therapy is an advocacy position – outreach and improving lives in a social, as well as medical, way
There is a real desire to improve access to oral health care
Tribal experience with dental care
Complexities of language
Support from various and different viewpoints
Why people don't agree with dental therapy
More about corporate dentistry
How important cultural aspects of dental therapy are
Dental therapy in Alaska
More about dental procedures, settings, licensure and related details
What dental therapy actually looks like in practice

What Task Force Members Appreciated about One Other:

Sharing their experience with dental therapy "on the ground"
Willingness to engage in conversation
Explanations about how the legislature works
Keeping us grounded in the bigger issues we need to resolve
Calling things out in a nice way
The professionalism of the task force
Keeping us focused
Hard work, getting things done
Organization
Calm support, kind presence

Resource Documents: Our process design included sharing resource documents that would eventually inform different proposals. We asked all task force members to share their resource documents via a Google Drive. Our original design requested every task force member to rate each resource document and whether they trusted it. Given the large number of documents and short amount of time, this proved to be unmanageable. In this final report, we share the resource documents, without any ratings. You will find many of the recommendations are informed by these resource documents that are in this reports Bibliography.

Review of Current Dental Therapy Practice on Tribal Lands

The August 2021 public meeting of the task force and the September small group meeting of the task force were dedicated to reviewing the practice of dental therapy on tribal lands. On August 23rd, the task force heard presentations from:

Presenter	Topic
Swinomish Tribe, Washington Brian Cladoosby, Past Chairman Rachael Hogan, Swinomish Dental Director (task force member)	Tribal Government Decision to Engage in Dental Therapy; Dental Therapy Licensing Board
Alaska Native Tribal Health Consortium Mary Williard, Clinical Site Director, Alaska Dental Therapy Educational Program; Sarah Shoffstall-Cone, Interim Director of Oral Health Promotion	Dental Therapist Education & Supervision

Northwest Portland Area Indian Health Board Miranda Davis, Project Director of the Native Dental Therapy Initiative (task force member)	Dental Therapy Supervision and Current Practices
University of Washington Donald Chi, Professor of Oral Health Sciences	Research on Dental Therapy programs

Task force members asked questions during the meeting and were invited to submit additional questions to presenters following the meeting. Close to 60 questions were submitted.

The entire September 15th small group meeting of the task force was dedicated to answering the questions task force members had submitted. Two presenters attended the small group meeting to answer questions in person, one answering in absentia for a third presenter. Other presenters answered questions in writing. All but a handful of questions were answered; those unanswered were due to no data being available.

During the remainder of the task force public and small group meetings, there were regular discussions about the practice of dental therapy on tribal lands. Task force members with dental therapy experience on tribal lands provided additional information and continued to answer all questions posed. In addition, the task force considered and discussed the National Model Act for Licensing or Certification of Dental Therapists, which is grounded in dental therapy experience nationwide, and was informed by tribal experience with dental therapy in Oregon, Washington and Alaska.

Guidance for recommendations for scaling up dental therapy in WA

The task force explored a list of topics that guided them in discussing the practice of dental therapy and making recommendations to the legislature. This conversation centered on the learned experience of tribal communities with dental therapy. Topics were drawn from Senate Bill 5142 (Dental Therapy bill in the 2021 legislative session), the National Model Act for Licensing or Certification of Dental Therapists, and other lived experiences of task force members.

"Task Force Topics for Exploration of Statewide Scale Up"

SB 5142 -Sections Discussed	Topics from National Model Act (agreed to by task force)	Additional Topics
S-3 License required S-4 Licensing prerequisites S-5 Procedures performed by dental therapists S-6 Supervision S-7 Not prohibited S-8 Practice settings	▪ Licensing Agency ▪ Education Requirement ▪ Examination or Competency Assessment ▪ Supervision ▪ Clinical Training ▪ Reciprocity	▪ Encounter fees for all Medicaid patients similar to tribal amount. ▪ Encounter fees for home visits and community prevention programs.

S-9 Discipline S-10 Limited license S-11 Exceptions S-12 Dental Quality Assurance Commission S-29 Pilot project	▪ Scope of Practice ▪ Limitations on Practice Settings ▪ Continuing Education ▪ Dental Hygiene ▪ Health Insurance	▪ Requirement for school applicants to come from communities in need. ▪ Requirement to return to those communities to serve. ▪ SC /RP (root planning) and subgingival scaling without consultation of the hygiene board. ▪ System of checks and balances similar to tribes. This level of local oversight reduced malpractice claims and complaints.

Task force members were invited to work together or alone on their recommendations. Each recommendation was shared with the full task force via Google Drive. Task force members reviewed and discussed each proposal before it was finalized by its initial author.

The CDR facilitation team provided task force members with a template for making recommendations to the legislature:

✓ Topic(s) addressed by recommendation
✓ Recommendation
✓ What informs this recommendation (tribal, research, lived experience, best practices, etc. - provide links to relevant documents)?
✓ Strengths and future implications of this recommendation?
✓ Challenges and potential unintended consequences of this recommendation?

Task Force Recommendations

As a result of the meetings and rich discussions among task force members, six recommendations have been submitted for consideration by the legislature. Task force members were invited to review each recommendation and indicate their support or opposition.

Overview of task force recommendations and task force support or opposition

Recommendations	Task Force Members		
	Support	Don't Support	Neutral
Recommendation A: Create a Washington State Dental Hygiene/Dental Therapy Board to Address Licensure, Examination and Discipline	11	3	3
Recommendation B: Oppose and/or Modify SB 5142	2	11	4
Recommendation C: Modifications to SB 5142	14	2	1
Recommendation D: Additions to Any Dental Therapy Legislation	2	10	5
Recommendation E: Adopt the National Model Act for Licensing or Certification of Dental Therapists	13	2	2
Recommendation F: Create a Pathway for Hygiene Licensure for Dental Therapists	2	10	5

Recommendation A: Create a Washington State Dental Hygiene/Dental Therapy Board to Address Licensure, Examination and Discipline, Proposed by C. Gaylord

Topic(s) addressed by Recommendation
Regulation by Department of Health, licensure, examination, discipline

Recommendation
Consider the following changes to SB 5142:

Add new Section:
(1) The Washington state board of dental therapy and dental hygiene is created. The board shall consist of ten members appointed by the secretary as follows:

(a) Four members of the board must be practicing dental hygienists licensed under this chapter;
(b) Four members of the board must be practicing dental therapists licensed under this chapter;
(c) two public members appointed by the secretary

(2) Members shall be appointed to serve for terms of three years from October 1 of the year in which they are appointed. Terms of the members shall be staggered. Each member shall hold office for the term of his or her

appointment and until his or her successor is appointed and qualified. The terms of the initial members shall be staggered, with the members appointed under subsection (1)(a) of this section serving their current terms on the Dental Hygiene Examining committee; the members appointed under subsection (1)(b) and (c) of this section serving one-year, two-year, and three-year terms initially. Vacancies shall be filled in the same manner as the original appointments are made. Appointments to fill vacancies shall be for the remainder of the unexpired term of the vacant position.

(3) Any member of the committee may be removed by the secretary for neglect of duty, misconduct, malfeasance, or misfeasance in office, after being given a written statement of the charges against him or her and sufficient opportunity to be heard thereon. Members of the committee shall be compensated in accordance with RCW **43.03.240** and shall be reimbursed for travel expenses in accordance with RCW **43.03.050** and **43.03.060**.

Duties of board:

The board shall:
(1) Determine the qualifications of persons applying for licensure under this chapter;
(2) Prescribe, administer, and determine the requirements for examinations under this chapter and establish a passing grade for licensure under this chapter;
(3) Adopt rules under chapter **34.05** RCW to carry out the provisions of this chapter;

Section 2. (definitions)
"board" means the board of dental therapy and dental hygiene as established in this legislation

Section 4. (licensing)
(c) change authority to "board"
2 (a) (b) (c) (d) change to "board"
3 change to "board"

Add new section:
Licensure by endorsement.
An applicant holding a valid license and currently engaged in practice in another state may be granted a license without examination required by this chapter, on the payment of any required fees, if the board determines that the other state's licensing standards are substantively equivalent to the standards in this state: PROVIDED, That the secretary may require the applicant to: (1) File with the secretary documentation certifying the applicant is licensed to practice in another state; and (2) provide information as the secretary deems necessary pertaining to the conditions and criteria of the uniform disciplinary act, chapter **18.130** RCW and to demonstrate to the secretary a knowledge of Washington law pertaining to the practice of dental therapy.

Section 9. (discipline)
The Uniform Disciplinary Act, chapter **18.130** RCW, shall govern the issuance and denial of licenses, unauthorized practice, and the discipline of persons licensed under this chapter. The board shall be the disciplinary authority under this chapter.

Section 10. (limited license)
Delete (ii)
Delete 5

What informs this Recommendation?

Lived experience - I have many years experience working as a member of the Dental Hygiene Examining Committee, state and regional licensing boards examiner, member of multiple regional testing agencies, and the national examining organization. I have been involved in writing rules (WACs) implementing state laws as a member of the committee and as a stakeholder for both DHEC and the Dental Quality Assurance Commission. I feel the administration of rules by the DOH will be more easily facilitated by combining the governance of these two professions together.
Relevant documents for dental professions within Washington state:
RCW 18.29 WAC 246-815 Dental Hygienist
RCW 18.32 WAC 246-817 Dentist
RCW 18.30 WAC 246-812 Denturist

Strengths and future implications of this Recommendation?

The shared scopes of practice are much more similar between dental therapy and dental hygiene than between dental therapy and dentistry. The practice and supervision requirements are similar. Licensing examinations can easily be regulated as dental hygiene exams are currently - the same rules should apply for licensing through regional licensing agencies. Dentists will be supervising both professions no matter where the rule-making authority lies. The scope of practice will not be affected. These are well educated, licensed professionals who are capable of regulating their own professions. Dental therapy will be much better represented with increased professional authority on this board as compared to the commission.

Challenges and potential unintended consequences of this Recommendation?

Licensure compacts in the future will affect dental hygiene and dental therapy somewhat differently as dental therapy is a new profession with more variation in curriculum and state practice laws. Dentistry has a more uniform scope of practice nationally than any other licensed dental profession.

Task Force Member Input on Recommendation A

Task Force Member	Support/ Don't Support/ Neutral	Strengths/ Support	Challenges/ Don't support	Neutral
M. Bowers	Support	Board of dental hygiene and therapy would be better aligned to provide regulatory oversight with professions with a more similar scope than that of dentistry. This would also help ensure preventive oral health care is highlighted in regulation.		

M. Davis	Support	Oversight by peers is an effective means of quality assurance for professionals. Dentists are trusted to oversee and regulate other dentists. Dental hygienists do the same for other hygienists. Given that dental therapists and dental hygienists are professionals in the dental field whose scope and role have many similarities, a combined Board for the two professions makes sense.		
S. Blandford	Support	Representing Children's Alliance, WE SUPPORT this and other proposals to expand access to dental therapy on the grounds that it is good for children and families across the state who desperately need expanded access to resolve basic oral health needs. This proposal also recognizes that expanded dental therapy access is a workforce issue, as it would offer licensure to a significant number of community residents, and would encourage entry into the profession by people of color providers who live in the communities where they work.		
L. McClellan	Don't Support		Doesn't make sense to have hygiene and dental therapy commission/board. Therapists should be included in DQAC and dentists and the commission should write rules and review complaints.	
B. Gandara	Support	I support this proposal but with a modification of adding at least one dentist to the combined dental hygiene, dental therapist board, as there are procedures that therapists perform that a dentist performs that hygienists do not. Also, dentist participation is important because of the unique supervisory role of the dentist with therapists. I learned from Colleen that there are collaborative meetings between the Dental Hygiene Board, Denturists Committee and DQAC, which would be very important to continue with dental therapists on the team.		

B. Killpack	Don't Support		Completely opposed to a separate dental therapy board.	
C. Gaylord	Support	Dental therapy is a separate licensed profession related to dental hygiene, dentistry, and denturism. Each of these are specific and separate professions. Because there is a great deal of shared scope of practice, there is common sense in shared regulatory processes between dental therapy and dental hygiene. This will better align and simplify regulatory oversight by the department of health. Licensure examinations can easily be regulated as dental hygiene exams are now. Practice and supervision requirements are similar. The scopes of practice are similar. The educational requirements of the Commission on Dental Accreditation are similar. The utilization of the Uniform Disciplinary Act will ensure that disciplinary concerns will be treated equally with all other licensed health care professionals. The addition of a licensed dentist to the board could enhance disciplinary decisions. Creation of this board will ensure that preventive oral health care is highlighted in regulation.		
R. Ferry	Support	This proposal allows practicing dental therapists the ability to practice in another state without having to go through the process of recertification.		
R. Hogan	Support	Board of dental hygiene and therapy to better align regulatory oversight with professions with a more similar scope than that of dentistry (the entire dental hygiene scope of practice is included in dental therapy). Ensures preventive oral health care is highlighted in regulation.		
D. Steringer	Neutral			WDG is neutral.
S. Hill	Support	Dental therapists and hygienists would be aligned as mid-level dental providers. This allows dental therapists to be better represented.		
B. Marsalli	Support	Recommendation that oversight board be composed of dental hygienists and dental therapists rather than dentists since the DHAT scope of practice is more aligned with that of hygienists.		

D. Greeno	Neutral			Aligns dental therapy and hygiene regulation.
D. Nesterenko	Support	Access to dental care and health equity.		
J. Bateman	Support	It increases equitable access to oral healthcare.		
M. Caldier	Don't Support		Danger to public due to the procedures listed, minimal supervision, lack of hands-on training for surgical procedures (needs parody with existing health care professionals already performing those procedures), and makeup of oversight board.	
E. Randall	Neutral			Smart addition of establishing a separate board for dental therapy and dental hygiene, unsure if necessary. Reciprocity licensing may be a good option to address access to care.
A. Rivers	No Response			

Recommendation B - Oppose and/or Modify SB 5142, Proposed by B. Killpack

Topic(s) addressed by Recommendation

Washington State Dental Association (WSDA) Recommendation: Amendments to Senate Bill 5142

Recommendation

WSDA Opposes Senate Bill 5142

The WSDA opposes any recommendation to authorize those with less training than a licensed dentist to perform irreversible, surgical procedures. Yet, for over a decade, proponents of the dental therapy model have introduced legislation that would allow just that. And while WSDA has continually raised concerns with the inclusion of irreversible procedures in a dental therapist's scope of practice, to date, there has been no recognition, nor consideration of these concerns by proponents, and no meaningful modifications have been made.

The current legislation, Senate Bill 5142, not only contains several irreversible procedures, it also proposes to authorize the performance of these procedures by a dental therapist without a dentist being onsite or even having first examined and diagnosed the patient. WSDA remains opposed to the current iteration of dental therapy legislation.

Proposed Amendments to Senate Bill 5142

Should the Legislature decide to pass a dental therapy bill, WSDA believes the Legislature, at a minimum, should consider adopting the enclosed amendments (Modified Version of SB 5142 by B. Killpack 2021) in order to increase safeguards and protect patient safety. Many of WSDA's proposed amendments to Senate Bill 5142 are either the same or similar in nature to models from other states. For ease of reference, WSDA has included a list of such amendments below.

1. Strike off-site supervision, making it required that a dental therapist practices under either the close or general supervision of a dentist. *Several states require the dental therapist to work under close or general supervision, meaning the dentist has examined and diagnosed the patient and provided instructions regarding treatment before any procedures are performed by other dental professionals.*
2. Amend licensure requirement of completing preceptorship of at least 400 hours to 2,000 hours and add language that clarifies this requirement is following the completion of a CODA accredited dental therapy program. *Maine*
3. Strike the requirement that a dental therapist pass an examination by the Dental Hygiene Committee and replace it with a requirement to pass a written and clinical exam approved by the Western Regional Examining Board. *Nevada includes that a licensee must complete a clinical exam approved by the Nevada Board of Dental Examiners and the American Board of Dental Examiners or a clinical exam administered by WREB.*
4. Amend language to give the Commission authority to establish by rule the procedures in Sec. 5. *Dental therapists fall under the purview of the Dental Board or Commission in most states.*
5. Add language that requires a dental therapist to complete 21 hours of continuing education annually. *Connecticut, Maine, Michigan, Nevada & Arizona all include CE requirements for dental therapists.*

6. Strike pulpotomies on primary teeth. *Maine, Arizona, Michigan, New Mexico, Nevada, & Connecticut do not allow dental therapists to perform this procedure.*
7. Strike suture placement and removal. *New Mexico does not allow this procedure to be performed by dental therapists. Minnesota, Vermont & Connecticut include only the removal of sutures.*
8. Strike atraumatic restorative therapy. *Maine, Vermont, Arizona, Michigan, Nevada & Connecticut do not include this provision.*
9. Add language that states a dental therapist may not diagnose and must work off an existing treatment plan formulated by a Washington state licensed dentist who has performed an in-person examination of the patient. *Several states require the dental therapist to work under close or general supervision, meaning the dentist has examined and diagnosed the patient and provided instructions regarding treatment before any procedures are performed by other dental professionals.*
10. Amend the number of dental assistants a dental therapist can supervise from 4 to 2. *Vermont*
11. Add language that requires the practice plan agreement between a dentist and dental therapist to be updated at least annually. *Michigan-3 years*
12. Add language that states that a dental therapist may not bill independently for services to any individual or third-party payer. *Arizona*
13. Add language that requires a dentist to review a dental therapist's charts daily. *Nevada- requires review every 30 days*
14. Amend the number of dental therapists a dentist can supervise from 5 to 2. *Vermont*

What Informs this Recommendation?

This recommendation is informed by research, unanswered questions from employers of dental therapists, and findings from Oregon's dental therapy pilot project. Referenced and supporting documents: The dental therapist movement in the United States: A critique of current trends, Oral Health Program Site Visit 04-09-18, Oregon Dental Association Letter to Oregon Health Authority 2018-05-04, Oregon Dental Association Letter to Oregon Health Authority 2018-05-04.

Lack of Available Data on the Practice of Dental Therapy on Tribal Lands

Over the past few months, WSDA has asked members of the task force as well as presenters to the task force for more information regarding the practice of dental therapy on tribal lands as the task force has been convened "to review and make recommendations on bringing the current practice of dental therapy on tribal lands to a statewide scale, and on the practice, supervision, and practice settings needed to maximize the effectiveness of dental therapy."

However, many of WSDA's questions were not addressed. In fact, the task force was told that the questions raised by WSDA could only be answered through research that would costs "millions of dollars" and that the entities that employ the dental therapists are unwilling to share this data. The questions raised by WSDA could easily be addressed through the current functionality of practice management software used in dental offices that employ dental therapists. Employers of dental therapist are electing not to share data about the current practice of dental therapy on tribal lands.

The following are examples of WSDA questions that remain unanswered:

- Within Northwest Portland Area Indian Health Board (NPAIHB), Swinomish Dental, and Alaska Native Tribal Health Consortium (ANTHC) affiliated clinics, what are the most frequently performed procedures by dental therapists for pediatric and adult patients? What percentage is preventive? What percentage is restorative? What percentage is diagnostic?
- Within NPAIHB, Swinomish Dental, and ANTHC affiliated clinics, what percentage of services provided by dental therapists are also provided by dental hygienists or dental assistants?
- Within NPAIHB, Swinomish Dental, and ANTHC affiliated clinics, how often does a dental therapist perform extractions per month on average?
- Within NPAIHB, Swinomish Dental, and ANTHC affiliated clinics, how often does a dental therapist perform pulpotomies (similar to a root canal) on primary teeth per month on average?
- Within NPAIHB, Swinomish Dental, and ANTHC affiliated clinics, how often does a dental therapist perform atraumatic restorative therapy per month on average?
- Within NPAIHB, Swinomish Dental, and ANTHC affiliated clinics, how often does a dental therapist perform cavity preparation per month on average?
- Within NPAIHB, Swinomish Dental, and ANTHC affiliated clinics, how many stainless-steel crowns are placed each month on primary teeth by a dental therapist per month on average?

At times, conflicting antidotal information was provided on the frequency with which surgical procedures were performed by dental therapists. On some occasions, the task force was informed that the work of dental therapists is much more similar to that of dental hygienists than to procedures performed by dentists. In addition, a sample schedule of a dental therapist showed work that can already be performed by existing auxiliary staff.

On the other hand, dental therapists in Oregon are being asked to perform surgical extractions, including extractions of teeth without structure above the gum line that is beyond the scope of the “simple” extractions that proponents of dental therapists have historically argued be included in the dental therapist scope of practice.

The absence of data about the procedures performed by dental therapists in tribal settings makes providing recommendations as outlined in the proviso illogical.

Proposed Dental Therapy Scope Beyond International Dental Therapy Scope

Published in the Journal of Public Health Dentistry in 2017 *The Dental Therapist Movement in the United States: A Critique of Current Trends*, is authored by renowned proponents of the dental therapy model, who highlight several distinctions and shortcomings of the proposed model in Washington and other states. The authors note that dental therapists in other countries are focused on providing care to children in government-run, school-based clinics.

The authors' conclusion is a cogent summary of their concerns:

The only programs of documented, evidence-based effectiveness involving dental therapists in improving public health have been those in which therapists treat children; practice in the public sector; and are distinctive members of the oral health workforce with credentials not including those of a dental hygienist. Dental therapists treating adults raise significant issues regarding the complexity of adult care, the inefficiencies of treating adults, the safety of treating adults, and the ethical failure to prioritize the care of children. Dental therapists practicing in the public sector in school- based programs help ensure access to essentially all children, and also reduces the cost of care for children. Requiring that dental therapists also be credentialed as dental hygienists simply expands the scope of practice of hygienists; it does not numerically increase the oral health workforce.

Additionally, it potentially diminishes the time available for dental hygienists to care for adults with periodontal disease.

Proponents of dental therapy have been unwilling or unable to share data demonstrating the safety and efficacy of the scope of practice proposed in Senate Bill 5142. During one presentation made to the task force, a proponent cited an article entitled *Dental Therapists: Evidence of Technical Competence* and stated that this article provides evidence that dental therapists can perform all of the "limited set of procedures" that fall within a dental therapist's scope of practice. However, when asked to provide specific references to literature that demonstrates that dental therapists can perform the full scope of procedures proposed in Senate Bill 5142 (including pulpotomies, tooth reimplantations, extractions of permanent teeth) the presenter was unable cite any applicable data.

The proponent also conceded that several articles cited in the aforementioned article clearly indicated that the data state that "no specific conclusions reported with regard to technical competence" and therefore these studies cannot be used to demonstrate that dental therapists are "clinically competent."

The task force heard a presentation from Dr. Donald Chi regarding his study *Dental Utilization for Communities Served by Dental Therapists in Alaska's Yukon Kuskokwim Delta*. Proponents argue that this data proves that access to dental therapists results in fewer extractions among adults in children wherever dental therapist are able to practice. Dr. Chi acknowledged that his data does not demonstrate this conclusion drawn by proponents. Instead, Dr. Chi's data shows that remote villages without access to dental providers on a regular basis have improved oral health outcomes when dental providers are able to provide routine care. The same conclusions would have been found if dentists or dental hygienists had been utilized – the scope of dental therapists specifically did not impact the results.

Oregon's Dental Pilot Project #100

As mentioned previously, WSDA continues to raise concerns with the inclusion of surgical, irreversible procedures in a dental therapist's scope. Proponents have failed to address these concerns or even discuss patient safety issues that have occurred as was the case with the Oregon Dental Pilot Project #100 (Project 100).

Project 100 is a pilot that educates and employs dental therapists to serve American Indian/Alaska Native patients. The project was approved by the Oregon Health Authority (OHA) in February 2016 and has been extended to operate through May 2022.

In examining public documents from Project 100, it was brought to our attention that during the project there, in fact, have been instances of patient harm, including misdiagnosed cavities, failed surgical extractions requiring the intervention of a dentist, subjecting an elderly patient to painful and unnecessary anesthetic delivery, and putting a child at serious risk when analgesics were delivered without adequate patient weights being recorded.

There were also several instances of dental therapists practicing outside of their scope of practice, such as performing or attempting extractions and providing services to patients under the use of nitrous oxide, despite lacking the appropriate training to do so. In addition, several concerns were raised around incomplete and inaccurate record keeping as well as a lack of informed consent from patients, even though state rule requires the project to obtain written informed consent for each patient.

On multiple occasions, those observing Project 100 who had patient safety concerns attempted to engage OHA in dialogue. OHA repeatedly did not respond to those raising concerns in any meaningful way. In addition, OHA repeatedly did not include concerns raised by observers in its public reports on Project 100.

After one observer publicly shared concerns about Project 100 and OHA review, OHA publicly reprimanded this observer. These actions taken collectively have had a chilling effect on individuals sharing patient safety concerns with Project 100. WSDA is initiating a public records request to obtain more information.

Strengths and Future Implications of this Recommendation?

As mentioned previously, WSDA remains opposed to the dental therapy model. If a statewide dental therapy model were to pass in Washington state, WSDA believes our proposed amendments would help to increase patient safety through increased oversight and safeguards.

Challenges and Potential Unintended Consequences of this Recommendation?

The current proposed model of dental therapy in Senate Bill 5142 presents several challenges and potential unintended consequences. However, many of the amendments WSDA has proposed could potentially help to mitigate consequences such as patient safety concerns, lack of oversight, dental therapists practicing outside of their scope, and non-existent savings to patients.

Task Force Member Input on Recommendation B

Task Force Member	Support/ Don't Support/ Neutral	Strengths/Support	Challenges/ Don't Support	Neutral
M. Bowers	Don't Support		The information presented in the introduction to this proposal is sometimes out of context and often plain wrong. This is disrespectful most of all to the Native dental therapists working in Washington and Oregon who are safely and successfully bringing care to their communities. Furthermore, this proposal puts up barriers to dental therapists ever being able to practice, which defeats the purpose of working to provide access to oral health care.	
M. Davis	Don't Support		This proposal misleads and mischaracterizes in nearly every sentence. The introduction first notes that the proposal is informed by "unanswered questions." Then it references six questions for which the WSDA did not receive answers. It does not provide the context that the WSDA submitted a list of 59 questions to employers of dental therapists. Myself, Dr. Mary Williard, and Dr. Rachael Hogan, spent a great deal of time and effort answering these questions. Answers were given both in writing and during task force meetings and discussion was offered around each question, along with providing extensive and detailed information about the practice of dental therapy on tribal lands. The list of six questions bulleted in the introduction to this proposal were the only ones not answered and that was because the clinics have not compiled that data – in fact, I'm not aware of any clinic or private office that compiles the data requested in these questions unless specifically funded to do so in the context of research. More importantly, data to answer those six bulleted questions is not necessary to understand whether the practice of Dental Therapy is safe, effective, and improving the health of communities. In fact, plenty of evidence already exists that does indeed show Dental Therapy to be safe, effective, and improving the health of communities. The introduction goes on to state that "dental therapists in Oregon are being asked to perform surgical extractions…." This is a blatantly false statement. For reference, please see the Standard Operating Procedures for Oregon Dental Pilot Project #100 regarding the list of procedures that	

			dental therapists are allowed to perform in Oregon. Dental therapists in Oregon are allowed to perform simple extractions (not surgical extractions). The WSDA is well aware that there is a difference between surgical extractions and simple extractions. For further documentation regarding extraction procedures performed by dental therapists in Oregon, please refer to the many Oregon Health Program Site Visit reports that can be found both on the Oregon Health Authority's website describing Dental Pilot Project #100, as well as in the references section of this report. Additionally, for very specific information about extractions performed by a dental therapist in Oregon in 2018, please read communication between Northwest Portland Area Indian Health Board (NPAIHB) and the Oregon Health Authority (OHA), dated May 11, 2018. This letter is a publicly available document and can also be found in the resources section of this report. To summarize: OHA in February 2018 cited three extraction procedures about which they mistakenly assumed the dental therapist had worked outside their scope. The Northwest Portland Area Indian Health Board (NPAIHB) and the Oregon Health Authority (OHA) letter from May 2018 explains that, in fact, the dental therapist was working under the direct supervision of a dentist during the preceptorship (training) phase, and the dentist allowed the dental therapist to begin the extraction procedure to gauge whether the procedure was within the dental therapist scope of a simple extraction. When the team together learned that two of the extractions were indeed surgical rather than simple, the dentist took over and the extraction was completed by the dentist. The third procedure described in question was indeed a simple extraction. Dental therapists in Oregon have never been asked to complete a surgical extraction. This dynamic of working under direct supervision with the safeguard of a more advanced provider available to take over, while gauging skill level, is the very intent of the preceptorship phase under which the dental therapist in Oregon was working. The dentist explained that the dental therapist was doing exactly as they were directed by their supervisor, and that those procedures that do not fall as obviously into the category of a simple extraction would not have been attempted by a dental therapist if the dentist had not been right	

			there supervising. Dental therapists are well trained to know their limited scope of practice and to remain safely within that scope; the preceptorship phase of training under direct supervision of a dentist serves to further clarify the limits of that scope. The introduction to this proposal later states, "proponents of dental therapy have been unwilling or unable to share data demonstrating the safety and efficacy of the scope of practice proposed in SB 5142." This too is false. There is abundant data to demonstrate safety and efficacy: from over 15 years of practice in Alaska, over 10 years in Minnesota, and 5 years of a highly scrutinized pilot project in Oregon. All these states utilize a scope identical or similar to that proposed in SB 5142 and all show an incredibly strong record of safety and efficacy. Multiple sources of evidence from these states can be found in the resources section of this report. The introduction to this proposal then takes a giant and dishonest liberty in interpreting information given by researcher Donald Chi. WSDA states, "The same conclusions would have been found if dentists or dental hygienists had been utilized–the scope of dental therapists specifically did not impact the results." Dr. Chi never said this statement or anything aligning to this statement and it is misleading of WSDA to write this. Dr. Chi's research published in 2017, Dental Utilization for Communities Served by Dental Therapists in Alaska's Yukon Kuskokwim Delta: Findings from an Observational Quantitative Study, examined ten years of data in Alaska and has in fact found that, in Alaska, the more days a dental therapist a community has received services from a dental therapist, the better the oral health of that community. Next there is a section in this proposal's introduction about Oregon's Dental Pilot Project #100 (DPP#100). DPP#100 was discussed to some extent in my response to one blatantly false WSDA statement already. I will provide much more information about the cited concerns related to DPP#100 below. I will preface this information with the reminder that DPP#100 has been actively underway for over five years, with multiple dental therapists working in two clinics. The project has shown a strong record of safety and has culminated in Oregon passing legislation authorizing dental therapists to practice statewide (Oregon House Bill 2528) in 2021 with	

			bipartisan support. The Oregon Dental Association did not oppose HB2528. This proposal's introduction states that "during the project there, in fact, have been instances of patient harm…" – a statement that is verifiably false. I will discuss the "examples" given in detail. However, for a summary, please see the site visit reports (available on OHA website and also in the resources section of this report). There has never been an instance of patient harm by a dental therapist in DPP#100. To verify this, please see all site visit reports available on the OHA website and in the resources section of this report. Very specifically, in the Oral Health Program Site Visit report from 02-26-18 - the one visit WSDA shares concerns about - the first bullet under Summary of Findings states: "there were no instances of patient harm that were revealed during the site visit." OHA has conducted several site visits throughout the duration of DPP#100 and has not found an instance of patient harm. Now I will describe each of the concerns about DPP#100 noted by WSDA in this proposal to show why the language used in the proposal introduction is misleading and false: - "misdiagnosed cavities" – many dentists do not agree with other dentists about when to call a demineralized area of a tooth a "cavity." Research directing diagnosis and treatment of "cavities" continues to advance. It is therefore inevitable that not all dentists on the OHA advisory committee for DPP#100 will agree with each other or with the dental therapists on which lesions should be considered "cavities." This is why second opinions can be valuable, as it is not uncommon to have one practitioner diagnose many more "cavities" than another. - "failed surgical extractions" – this was discussed fairly thoroughly above. There has never been a "failed surgical extraction" by a dental therapist in DPP#100. There were two procedures when a dentist was directly supervising a dental therapist during an extraction procedure and when it became evident that the extraction was too complex for the dental therapist to perform, the dentist completed the extraction. All	

			patients of dental therapists in DPP#100 have received safe and effective care. - "subjecting an elderly patient to painful and unnecessary anesthetic delivery" – I am not familiar with language describing such an event in any report related to DPP#100 - "putting a child at serious risk when analgesics were delivered without adequate patient weights being recorded" – most dentists do not record patient weights for routine procedures requiring a modest amount of local anesthetic. During the early years of DPP#100, dental therapists were not required to record patients' weights, and these were the times referenced here. The requirement to record patient weights was added in later years of the project as an extra precaution, even though it is a precaution most dentists do not take. Dental therapists in DPP#100 have never put a child at risk. - "providing services to patients under the use of nitrous oxide" – Dental therapists in DPP#100 provided services to patients using nitrous oxide only when they were working under the direct supervision of a dentist who holds a nitrous oxide permit and the dentist was administering the nitrous oxide. Again, the dentist was in the room, administering the nitrous oxide, and directly supervising. Given that even dental assistants may provide services to a patient using nitrous oxide when under the direct supervision of a dentist who holds a nitrous oxide permit, the supervising dentists in the project had deemed this scenario to be safe and allowed. OHA recognized that the concerns cited related to nitrous oxide had been the result of a lack of communication. After OHA raised concerns about the above topics in February 2018, the project sponsors and clinics responded and a stipulated agreement was reached to improve communication and ensure compliance. Any deficiencies and misunderstandings identified by OHA in the first months of the pilot project were quickly and successfully remediated. The follow-up site visit report states: "DHAT trainees are operating under their approved scope of practice. The project is in full compliance with their approved amended	

			application." All site visit reports for the remainder of the project have made similar statements. I very much hope that if you are interested in learning more details about DPP#100, you read the letters and site visit reports available in the resources section of this report and on the OHA website. It is a closely monitored project with multiple levels of oversight in which dental therapists have been working for years under close scrutiny. The project evaluated several measurable outcomes and has ultimately found dental therapy to be a safe and effective profession in Oregon. DPP#100 data can be found in the Oregon Tribes Dental Health Aide Therapist Pilot Project fact sheet which describes findings. Opponents and critics of the pilot project sat on the pilot's formal OHA Advisory Committee, reviewed DHAT charts, attended site visits, and made recommendations on approval and modifications to the pilot. Ultimately the pilot project led Oregon to pass legislation authorizing dental therapists statewide with bipartisan support and without opposition from the Oregon Dental Association. Finally, the proposal given here in the form of a redlined version of SB 5142 is not in alignment with the abundant evidence surrounding the topic of dental therapy, nor the recommendations of experts in the field. For recommendations from a group of experts from around the nation, please see the National Model Act for Licensing or Certification of Dental Therapists which I have submitted as a proposed policy.	
S. Blandford	Don't Support		Representing Children's Alliance, WE DON'T SUPPORT this proposal, finding it too weak to address our core issues of expansion of access and workforce improvements in underserved communities.	
L. McClellan	Neutral			Some of the requirements go beyond what is reasonable for this provider but could work. It can be used as a reference for legislation.
B. Gandara	Don't Support		Regarding scope of practice: I disagree with the limitations of the scope of practice in this proposal. I made comments below why I think dental therapists	

			should be allowed to perform procedures that the attached bill does not allow. I think cavity preparation and pulpotomies of primary teeth by dental therapists should be permitted, as this is an aspect of preventive care that those without access do not get. Ultimately, the lack of access can result in serious infections in primary teeth and early primary tooth loss. A pulpotomy is a dental procedure in primary (baby) teeth in which the pulp in the crown portion of the tooth with a deep cavity is removed and the live tissue in the root canals is left intact. Pulpotomies are not the same as root canal therapy which requires precision removal of pulpal tissue of the entire tooth with specialized instruments and replacement with filling material. The dental therapists were never intended to perform root canal therapy. Regarding adults, increased access via dental therapists to early restorative care to treat caries in permanent teeth will prevent pulpal disease and tooth loss. This is particularly important since currently there are few opportunities to get endodontic care or crowns or dental prostheses to replace lost teeth. Regarding atraumatic restorative care (ART) by therapists, careful attention should be placed in training for clinical decision making of when to use this or not, rather than just banning it. Regarding tooth reimplantation and stabilization, the sooner the avulsed tooth is reimplanted, the better chance of success of retention of the tooth. Therefore, this should be permitted for therapists, particularly in remote areas as they may be a hour or more away from a DDS. In cases of gingival trauma that can accompany a displaced tooth, one or two sutures may be needed. Therefore, the ability to suture should be permitted. I think talking the case over with the supervising dentist, whether on the premises or off site, should be done with arrangements for follow-up of the patient with the therapist and the supervising dentist. I do not think surgical extractions by the dental therapist should be permitted nor has that been proposed by Dr. Hogan or Dr. Davis in their proposals. But sometimes simple, non-surgical extraction sites of one or more loose teeth can be improved by strategic placement of a suture or two, another reason to allow therapists to place sutures. I think dental therapists should be allowed to formulate treatment plans independently for patients who don't have chronic disease and are not complicated medically. If a	

			patient has chronic disease such as diabetes or immunologic problems, or chronic orofacial pain, or mucosal conditions, the treatment plan should be reviewed with a dentist either on site or off site with use of intra-oral photos or videos if possible. A possible model of determining how complicated a patient is regarding physical status and medical history, is the use of ASA ratings. (https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system). Patients who are at ASA of 2-3 or above would require dentist approval of treatment plans. The exact schedule of reviews of treatment plans for medically complex cases by the supervising dentist can be determined by the practice setting but daily would be ideal, or at least weekly. Dental Therapists supervision of auxiliaries I think that the number of auxiliaries that a dental therapist may supervise depends on what the auxiliaries function is. If they are chairside expanded function auxiliaries (versus front desk or sterilization area support), the limit should be two or three depending on the experience of the therapist. I think the more auxiliaries you have, the more supervisory training you need. The supervising dentist is also responsible for overseeing the use of auxiliaries by the dental therapist. Regarding reimbursement for services.	
B. Killpack	Support	See background of Proposal B.		
C. Gaylord	Don't Support		I disagree with many statements made in this proposal. I spent many hours seriously reviewing the documents provided to the Task Force. I attended all meetings of the Task Force and listened to all discussions. The introduction to Proposal B states that questions were unanswered or not addressed. Of the tribal presenters that we had, each had specific expertise in dental therapy education or practice. I find the complaint of "lack of available data" was unfair as the presenters were asked to provide information outside their area of expertise. All questions were answered diligently and honestly. Asking for specific percentages of specific procedures across four different dental professions seemed beyond reasonable expectations. The concentration on the Oregon Pilot Project was time-consuming and unhelpful. Quoting study conclusions regarding therapists dually-licensed as dental hygienists is unhelpful as that model is not being considered. Regarding WSDA's opposition to Senate Bill 5142 – 1) "less training than a dentist" – under	

			CODA accreditation a therapist should have the equivalent training for any given procedure; 2) “no recognition, nor consideration…no meaningful modifications” – in the past 10 years that I have personally worked on this legislation, there have been significant changes each biennium which have never been recognized by WSDA; 3) “without a dentist being onsite” – all therapists work under the supervision of a dentist. The list of proposed amendments to Senate Bill 5142 have included the most restrictive language in the nation.	
R. Ferry	Don’t Support		The proposal is not supportive of dental therapy.	
R. Hogan	Don’t Support		The introduction to this proposal intentionally misstates and misdirects information about my efforts as a Supervising Dentist on Tribal Lands to provide answers in task force meeting conversations, offer educational presentations, submit resource documents and data to support the work we have been successfully doing in the PNW for the past 5 years. The language in the proposal was disrespectful, most of all, to the Native dental therapists working in Washington and Oregon who are safely and successfully bringing care to their communities. I urge legislators to question everything presented here, and instead take a closer look at the relevant studies, reports and data submitted as part of the larger report. Significant amount of time was dedicated to answering the 59 additional/follow-up questions (22 specific to Swinomish practice or licensing) and all but 6 questions were answered. Those not answered were due to data not being collected in an adequate manner to correctly represent future predictions of productivity for a dental team. Current data collected measured/prioritized safety, access to care, quality of care, and patient satisfaction… all which was equal or above data from States or countries with a much longer presence of DTs and all of which showed improved oral health access and patient satisfaction. Factors ranging from operatory space (Swinomish Dental clinic expansion from 5 to 10 chairs in April 2019) and preceptorship (6mo-1yr of Direct Supervision not allowing optimized efficiency) and Covid-19 (significantly impacting patient care delivery for the last 2 years) interfere with accuracy of impact of DTs in the last 4 years at Swinomish and hence questions were not answered. Encouraged to defer to other	

			mature programs that have long standing research performed and are shared among the resource list. As an advisory committee member to the Oregon Dental Pilot Project #100 I am aware that multiple comments in the intro are false…. -There was no instance of patient harm. -DTs are not asked to perform surgical extractions or to work outside their scope in any manner. All communication surrounding the 2018 site visit were submitted to the resource documents and show that any issues were resolved. I have every confidence that the Oregon DTs are practicing above standards and patients are safe and receiving the highest quality of care. Concerns raised in this proposal were out of context and addressed in the pilot to the fact that DTs are now authorized statewide in Oregon. Scope of practice should include all of CODA standards for DTs, especially diagnosis, otherwise will not see significant optimization of dental team performance. All providers should be able to work at the top of their scope for the most efficient dental delivery model. It is disheartening to me to see the work of this task force so mischaracterized. I took many days out of my clinical and administrative (and personal) schedule to participate with due diligence on this task force, and did so to the best of my ability. I provided honest answers and used best evidence to support proposals as they were discussed. It was refreshing to see many faces of those not usually represented on oral health issues recognized at the table and though it was called out numerous times that the dental profession should have more specialists represented, it was an anomaly to see the patient population represented more adequately than it has been in the past (there is still a way to go in that regard). There were at least 5 dentists present at most meetings (always the majority). With oral health among the greatest unmet needs of our State and I applaud the composition of membership set forth in the proviso.	
D. Steringer	Neutral			WDG is neutral.
S. Hill	Don't Support		This proposal would effectively neuter dental therapists, making their care more difficult to access for underserved communities.	

B. Marsalli	Neutral			Proposal is premised upon opposition to the profession. While the desire for patient safety is laudable in and of itself, many of the proposed changes appear to be punitive, administratively burdensome, and costly for practices to maintain. No reasons provided why differing states adopt certain restrictions or requirements. The requirement for 21 hours of continuing professional education is good and should be reduced to 15 to match CPE hours for dental hygienists.
D. Greeno	Neutral			The proposal appears to purposefully mischaracterize current dental therapy practice and the work of the task force.
D. Nesterenko	Don't Support		The premise being a misrepresentation of what was discussed at the task force meetings.	
J. Bateman	Don't Support		It lacks focus on increasing access to oral healthcare.	

M. Caldier	Support	Preserves safety to the public with irreversible procedures.		
E. Randall	Don't Support		Washington State should pursue legislation that genuinely aims for expanding dental care access. The proposed amendments are too constraining.	
A. Rivers	No Response			

Recommendation C - Support for and Additions to SB 5142, Proposed by R. Hogan Additions to SB 5142 in red.

Proposal	What informs proposal	Strengths/ Challenges
Education/Exams:		
(1) The department shall issue a license to practice as a dental therapistto any applicant who: (a) Pays any applicable fees established by the secretary under 28RCW 43.70.110 and 43.70.250;29 (b) Successfully completes a dental therapist program that is accredited or has received initial accreditation by theAmerican dental association's commission on dental accreditation, or (c) Successfully completes a dental therapist program that is not CODA-accredited and proof of at least 400hour preceptorship under close supervision (d) Passes an examination approved bythe committee; (e) Submits, on forms provided by thesecretary, the applicant's name, address, and other applicable information as determined by the secretary; and (2)(a) The secretary shall establish thedate and location of the examination. Applicants who meet the education requirements for licensure must be scheduled for the next examination following the filing of the application. The secretary shall establish by rule the examination application deadline. (b) The examination must contain subjects appropriate to the scope of practice and questions on laws in thestate of Washington regulating dentaltherapy practice. (c) The committee shall establish by rule the requirements for a reexamination if the applicant has failedthe examination. (d) The committee may approve an examination prepared or	Preceptorships are not required for any other dental provider under Washington state law so eliminating it from previous proposals brings this proposal into better alignment withexisting statute (RCW 18.32.040, RCW 18.29.021). CODA Current Accreditation Standards ensures programs are competency-based, and so using CODA as the standard for education programs eliminates the need for additional clinical hours beyond what a therapist would get in their education program. The practice plan requires a dentist sign offon every procedure, so this is an additional observation of dental therapist competency.	**Strengths:** Consistency with licensure requirements forother dental professionalsin WA. Removing preceptorship requirement takes away unnecessary burden on supervising dentist, resulting in better availability and care for patients. Relies on accredited education program and exam to determine competency. Relies on experts from Commission on Dental Accreditation to determine adequacy of education programs. **Challenges:** Dental therapists from MN and from AK pre-CODA accreditation would likely have already completed a

administeredby a private testing agency or association of licensing authorities. (3) The secretary in consultation withthe committee must establish by rulethe procedures to implement this section.	While the Community Health Aide Program (CHAP) Alaska Standards and Procedures (upon which the Swinomish Dental Therapy License is based) requires a 400-hour preceptorship. This is being revised in the new Portland Area CHAP Standards whichallows for those clinical hours to be completed in the education program. In order to maximize workforce in first five years, allow dental therapists trained at education programs created before the establishment of the CODA standards to getlicensed with a 400 hour preceptorship.	lengthy preceptorship would have burden of another preceptorship.
Scope:		
(1) Subject to the limitations in this section, a licensed dental therapist mayprovide the following services and procedures under the supervision of a licensed dentist and to the extent the supervising dentist authorizes the service or procedure to be provided by the dental therapist: (a) Oral health instruction and diseaseprevention education, including nutritional counseling and dietary analysis; (b) Comprehensive charting of the oralcavity; (c) Making and reading radiographs; (d) Mechanical polishing; (e) (e)prophylaxis (f) Periodontal scaling and root planning (g) Application of topical preventive or prophylactic agents, including fluoride and pit and fissure sealants; (h) Pulp vitality testing; (i) Application of desensitizingmedication or	This scope aligns with the CODA Accreditation Standards for Dental Hygiene Education Programs and recommendations of the National Model Act,and curriculum and competencies at existing dental therapy programs. It is the curriculum that has been submittedby Skagit Valley College for CODA review. This scope closely aligns with the AK and WA Tribal DHAT scope of practice.	**Strengths:** Dental therapists should be allowed to provide services to the extent they have been educated. The direct impact of limiting scopeis to take away needed care to those who may desperately need it.

resin; (j) Fabrication of athletic mouth guards; (k) Placement of temporary restorations; (l) Fabrication of soft occlusal guards; (m) Tissue conditioning and soft reline; (n) Atraumatic restorative therapy andinterim restorative therapy; (o) Dressing changes; (p) Tooth reimplantation; (q) Administration of local anesthetic; (r) Administration of nitrous oxide; (s) Emergency palliative treatment ofdental pain; (t) The placement and removal of space maintainers; (u) Cavity preparation; (v) Restoration of primary andpermanent teeth; (w) Fabrication and placement oftemporary crowns; (x) Preparation and placement ofpreformed crowns; (y) Pulpotomies on primary teeth; (z) Indirect and direct pulp capping onprimary and permanent teeth; (aa) Stabilization of reimplanted teeth; (bb) Extractions of primary teeth; (cc) Suture placement and removal; (dd) Brush biopsies; (ee) Minor adjustments and repairs onremovable prostheses; (ff) Recementing of permanent crowns; (gg) Oral evaluation and assessment of dental disease and the formulation of anindividualized treatment plan; (hh) identification of oral and systemicconditions requiring evaluation and/ortreatment by dentists, physicians or other healthcare providers, and management of referrals (ii) The supervision of expanded function dental auxiliaries and dental assistants. However, a dental therapist may supervise no more than a total of four expanded function dental auxiliaries and dental assistants at any one time in any one	In AK, communities with dental therapists with this scope of practice have improved oral health outcomes in both children and adults. Dental Utilization for Communities Served by Dental Therapists in Alaska's Yukon Kuskokwim Delta: Findings from an Observational Quantitative Study. Conclusions from Safety Net Care and Midlevel Dental Practitioners: A Case Study of the Portion of Care That Might Be Performed Under Various Setting and Scope-of-Practice Assumptions find that variations of this scope been shown to have the potential to alleviate much of the burden on the dental safety net because much of the need among vulnerable populations falls wellwithin their scope of practice. *Overall, 48% to 66% of all procedures couldhave been performed by a midlevel dental practitioner. Nearly half of all visits, and roughly a third of all patients, could have been entirely cared for by a practitioner trained in prophylaxis and with evaluation capabilities. Such practitioners could handle roughly 80% of the visits at the community- based clinic and more than half of the visits at the hospital-based clinic.*	

practice setting. A dental therapist may not supervise an expanded function dental auxiliary or dental assistant with respect to tasks that the dental therapist is not authorized to perform; (jj) Nonsurgical extractions of periodontally diseased permanent teethwith tooth mobility of plus 3 to plus 4 if the teeth are not unerupted, are not impacted, are not fractured, and do notneed to be sectioned for removal; (kk) Other related services and functions for which the dental therapist has been education and training and to the extent authorized by the supervisingDentist.; and (ll) The dispensation and oral administration of drugs pursuant tosubsection (2) of this section. (2)(a) A dental therapist may dispense and orally administer the following drugswithin the parameters of the practice plan contract established in section 6 ofthis act: Nonnarcotic analgesics, anti- inflammatories, preventive agents, and antibiotics. (b) The authority to dispense and orallyadminister drugs extends only to the drugs identified in this subsection and may be further limited by the practice plan contract. (c) The authority to dispense includes the authority to dispense sample drugs within the categories established in this subsection if the dispensing is permittedunder the practice plan contract. (d) A dental therapist may not dispenseor administer narcotic drugs as definedin chapter 69.50 RCW. (e) A dental therapist does not have theauthority to prescribe drugs. (3) A dental therapist may only provideservices and procedures in which theyhave been educated. (4) A dental therapist may not provide any service or procedure that is not bothauthorized by this section and been authorized by the supervising dentist via inclusion in the dental therapist's practice plan contract.		
Supervision:		
(1) A dental therapist may onlypractice dental therapy under the supervision ofa dentist licensed under chapter 18.32 RCW and pursuant to a written practice plan contract with the supervising dentist. A dental therapist may not practice independently. In circumstances authorized by the supervising dentist in the written	The practice of dental therapy in the United States, whether authorized by state or tribal license or federal certification is universally under the	**Strengths:** This is a very detailed set of requirements for dental supervision oversight that leavesvery little discretion to dentists ordental therapists.

practice plan contract, a dental therapist may provide services without the prior examination or diagnosis of a dentist and without the dentist being personally on site when services are provided. The contract must, at a minimum, contain the following elements: (a) The level of supervision requiredand circumstances when the prior knowledge and consent of the supervising dentist is required; (b) Practice settings where servicesand procedures may be provided; (c) Any limitations on the services orprocedures the dental therapist mayprovide; (d) Age and procedure-specific practice protocols, including case selection criteria, assessment guidelines, and imaging frequency; (e) Procedures for creating andmaintaining dental records for 1patients treated by the dental therapist; (f) A plan to manage medical emergencies in each practice settingwhere the dental therapist provides care; (g) A quality assurance plan for monitoring care provided by the 5dental therapist or, including patientcare review, referral follow-up, and aquality assurance chart review; (h) Protocols for administering and dispensing medications, including the specific circumstances under which themedications may be dispensed and administered; (i) Criteria relating to the provision of care to patients with 11specific medicalconditions or complex medical histories, including requirements for consultation prior to the initiation of care; and (j) Specific written protocols governing situations where the dental therapist encounters a patient requiring treatment that exceeds the dental therapist's scope of practice or capabilities and protocols for referral ofpatients requiring evaluation and treatment by dentists, denturists, physicians, advanced registered nursepractitioners, or other health care providers. (2) The dental therapist shall acceptresponsibility for all services and procedures provided by the dental therapist or any auxiliary dental providers the dental therapist is supervising pursuant to the practiceplan contract. (3) A supervising dentist who knowingly permits a dental therapist toprovide a service or procedure that is not authorized in the practice plan contract, or any dental therapist who provides a service or procedure that is not authorized in the practice plan contract, commits	supervision of a licensed dentist, with a detailed practice plan (National Model Act pg. 42). There is no evidence from states and Tribes utilizing dental therapists that this policy doesnot provide an abundance of oversight and accountability.	Along with thenewly added requirement to submit practice plans to DOH, it greater aligns with the requirements of the Tribal licenses currently used in Washington.

unprofessional conduct for purposes of chapter2818.130 RCW. (4) A dentist who enters into a writtenpractice plan contract with a dental therapist shall: (a) Directly provide or arrange for another dentist, denturist, or specialistto provide any necessary advanced procedures or services needed by the patient or any treatment that exceeds the dental therapist's scope of practiceor capabilities; (b) Ensure that he or she or anotherdentist is available to the dental therapist for timely communication during treatment if needed. (5) A dental therapist shall perform only those services authorized by the supervising dentist and written practiceplan contract and shall maintain an appropriate level of contact with thesupervising dentist. (6) Practice plan contracts must besigned and maintained by both thesupervising dentist and the dental therapist at a minimum of every 2years. (8) A dental therapist shall submit a signed copy of the practice plan with licensure renewal to the Department ofHealth. If the practice plan is revised inbetween annual submissions, a signed copy of the revised practice plan must be submitted as soon as practicable after the revision is made. (7) A supervising dentist may supervise no more than a total of fivedental therapists at any one time.		
Tribal Sovereignty:		
Nothing prohibits or affects: (1) The practice of dental therapy by an individual otherwise licensed underthis title and performing services withinhis or her scope of practice; (2) The practice of dental therapy in the discharge of official duties on behalf of the United States government, including, but not limited to, the armed forces, coast guard, public health service, veterans' bureau,or bureau of Indian affairs; (3) The practice of dental therapypursuant to an education programdescribed in section 4 of this act; (4) The practice of dental therapy under the supervision of a dentist necessary to meet the clinical experience or preceptorship requirements of section 4 of this act; or (5) The practice of federally certified dental health aide therapists or triballylicensed dental therapists practicing inclinics	Any statewide dental therapy licensing bill must be consistent and not conflict with existing state law including: Chapter RCW 70.350 Dental Health Aide Therapists, **RCW 18.32.030** Exemptions from Chapter.	**Strengths:** This policy allows for expansionof dental therapy statewide without interfering with existing Tribal licenses and Federal certification of dental therapists.

operated by an Indian health service, Indian health service direct, tribal 638, or an urban Indian health program system of care, as those terms are defined in the Indian healthcare improvement act, Title 25 USC Sec. 1603(12), (25) and (29).		
PracticeSettings:		
(1) A dental therapist may practiceonly in the following settings: (a) Federally qualified health centers,federally qualified health center look-alikes, or nonprofit clinics; (b) School-based health clinics; (c) Long-term care facilities; (d) Correctional institutions; (e) Hospitals; (f) Clinics operated by accredited schools of dentistry, dental therapy, ordental hygiene; and (g) Clinics operated by an Indian healthservice, Indian health service direct, tribal 638, or an urban Indian health program system of care, as those terms are defined in the Indian health care improvement act, Title 25 U.S.C. Sec. 1603(12), (25) and (29).2 (h) Practice settings in which the dental therapist's patient base is atleast 35% Medicaid, low income oruninsured (i) Clinics that serve an area designated by the federal Health Resources and Services Administration as Dental Professional Shortage Areas. (2) A dental therapist may not work inany other setting that is not listed in this section.	All of the practice settings in this policy are directed to deliver care to those who have thegreatest barriers to care, and highest diseaseburden. Until a robust dental therapy workforce is established, this ensures the policy is targeted to help resolve lack of oral health care in these settings. Almost all states that have dental therapylicensing laws have some practice setting limitations (National Model Act for Licensing or Certification of Dental Therapists pg. 42).	**Strengths:** Offers a broad range of settings while focusing workforce where itis most needed. **Challenges:** Enforcement of practice settingsmay be burdensome to regulators. Limits private practice use of dental therapy, which may limit ability to increase % of Medicaidpatient base.
Portability:		
(1) The department shall issue a limited license to any applicant who, asdetermined by the secretary: (a) Holds a valid license, certification,or recertification in another state, Canadian province, or has been certified or licensed by a federal or tribal governing board in the previous two years, that allows a substantially equivalent, but not the entire scope ofpractice in section 5 of this act; (b) Is currently engaged in active practice in another state, Canadianprovince, or tribe (c) Files with the secretary documentation certifying that theapplicant:	Allows portability of licensed/certified dental therapists from other state and tribal jurisdictions, consistent with RCW 18.29.190: Initial limited license.	**Strengths:** Allows a pathway for more rapiddevelopment of Washington workforce while also holding outof state practitioners to the standards established by statuteand rule in WA.

(i) Has graduated from a dental therapy school accredited by the commission on dental accreditation orhas graduated from a dental therapy education program that the dental hygiene examining committee determines is substantially equivalentto an accredited education program; (ii) Has successfully completed the national dental therapy examination, or until such time that that exam is developed, the national dental hygieneexamination; and (iii) Is licensed or certified to practice inanother state or Canadian province, orhas been certified or licensed by a federal or tribal governing board in the previous two years; (d) Provides such information as the secretary deems necessary pertaining to the conditions and criteria of the uniform disciplinary act, chapter 18.130RCW;33 (e) Demonstrates to the secretary knowledge of Washington state lawpertaining to the practice of dental therapy; and (f) Pays any required fees. (2) A person practicing with a limited license granted under this section hasthe authority to perform only those dental therapy procedures in section 5of this act that he or she was licensedor certified to practice in their previousstate, tribe, or Canadian province. (3) Upon demonstration of competencyin all procedures in section 5 of this act, the limited license holder may apply for licensure as a dental therapistunder section 4 of this act.		

Task Force Member Input on Recommendation C

Task Force Member	Support/ Don't Support/ Neutral	Strengths/ Support	Challenges/ Don't support	Neutral
M. Bowers	Support	This proposal combines the lived experience of those providing safe and effective care in Tribal communities employing dental therapists with conversations we had at the task force meetings and learnings from other policy proposals by task force members. It also offers the most specific evidence in every section to inform a common-sense policy proposal worthy of consideration.		
M. Davis	Support	The assignment for this Task Force was to examine what works well for Tribal communities utilizing dental therapy in Washington State and to consider how it can be expanded statewide. This proposal does just this: it was submitted by Dr. Rachael Hogan who has supervised more dental therapists and for more time than any other dentist in Washington. Dr. Hogan		

		has worked and continues to work closely with several dental therapists and her clinic provides excellent care. This proposal was discussed piece by piece at length during task force meetings and the version presented here is the result of those discussions. It includes what we know is working well in Tribal communities AND also includes pieces proposed by multiple members of the task force.		
S. Blandford	Support	Representing Children's Alliance, WE SUPPORT this and other proposals to expand access to dental therapy on the grounds that it is good for children and families across the state who desperately need expanded access to resolve basic oral health needs. This proposal also recognizes that expanded dental therapy access is a workforce issue, as it would offer licensure to a significant number of community residents, and would encourage entry into the profession by people of color providers who live in the communities where they work.		
L. McClellan	Support	This proposal is the closest to what the legislature had tasked us with, and has some safeguards added that were brought forth by the task force.		
B. Gandara	Support	I had just a few concerns at first but I believe they are addressed in the National Model Act document, which I support. One concern is the use of nitrous oxide by dental therapists. I think the use of nitrous oxide sedation by dental therapists should be supervised by direct and/or indirect supervision by dentists after the same training required for hygienists and dentists. I don't think general supervision is adequate for remote area use of nitrous oxide sedation. Anything that can impact a patient's oxygenation requires special training and experience and patient evaluation and monitoring. I believe a dentist with training in use of nitrous oxide sedation should be on site to supervise dental therapists' use of nitrous oxide sedation. Unless there is specific training for the therapist and adequate time of observation by the dentist of the therapist in the role of supervisor, I think the number of 4 expanded function dental auxiliaries and dental assistants that a dental therapist can supervise at a given time may be too high. I don't have any literature to cite for this concern, other than if the dentist is allowed to supervise 5 therapists, there is a multiplicative effect if each therapist is supervising their own auxiliaries. Supervision is an important skillset and should be assessed carefully as we expand the dental team. I support the provision in this proposal that care to patients with specific medical conditions or complex medical histories require special consultation with the supervising dentist prior to initiation of care. This promotes a fuller incorporation of the patient's medical conditions in diagnosis and management of the patient's oral health that a dentist's training can provide.		

B. Killpack	Don't Support		See background of Proposal B.	
C. Gaylord	Support	I support the provisions of this proposal. I like the specific evidence offered for all sections. The scope of practice should be as broad as the education received by the therapist. Dentists are allowed to constantly update their scope of practiced based on current educational scope taught in dental schools. The requirements for supervision are very detailed and appropriate to protect the public. The submission of the practice plan agreement is appropriate. Practice setting limitations make sense in targeting the populations that need the care the most, but...the therapist should be safe to practice in any setting with the provisions in this proposal. Is the question safety of the public, access to care, or the most needed settings right now? Portability of licensure while upholding standards is becoming an important issue in all healthcare professions. The limited license provision matches current dental hygiene licensure.		
R. Ferry	Support	The proposal has been written by someone with a great amount of knowledge and experience with the field of dental therapy.		
R. Hogan	Support	This is my proposal, which combines the lived experience of those providing safe and effective care in Tribal communities employing dental therapists with conversations and policy proposals by other task force members. It also offers the most specific evidence in every section to inform a common-sense policy proposal worthy of consideration. Native communities carry the greatest oral health disparities and Dental Therapy was a native solution to a problem never solved by the traditional dental delivery care system. It has been implemented at Swinomish for 4+ years as modeled by Alaska and in all regards monumentally successful. As we look to innate solutions in meeting populations where they are lacking resources (both tangible and intangible) and include diversity, equity, and inclusion into the equations of providing holistic, culturally responsive health care, there is no better example than what has been shared of the dental practice at Swinomish. We are a patient centered clinic, guided by the community we serve bringing the expertise, experience, and evidence-based knowledge to comprehensive, integrated oral health care that prioritizes prevention. Other communities with barriers to access due to cultural or financial or educational or unknown should know that Dental Therapists are an incredible solution towards addressing that difficult problem.		
D. Steringer	Support	WDG supports Proposal C as it combines the lived experience of those providing safe and effective care in Tribal communities employing dental therapists with the conversations and policy proposals by other task force members. It also offers the most		

		specific evidence in every section to inform a common-sense policy proposal worthy of consideration.		
S. Hill	Support	Dr. Hogan's recommendations allow for a pathway for dental therapists from new, non-CODA accredited institutions which is invaluable as dental therapy grows. Additionally, the practice agreement revision assures that dental therapists and their dentists not only continue to work together with their practice plan, but also keep it in writing, giving everyone a similar standard to work towards.		
B. Marsalli	Support	Recommendations are made by a practicing dentist with the Swinomish Tribe who actively supervises DHATs.		
D. Greeno	Neutral			Proposal is aligned with current research and CODA standards.
D. Nesterenko	Support	Access to dental care and health equity.		
J. Bateman	Support	It increases equitable access to oral healthcare.		
M. Caldier	Don't Support		Danger to public due to the procedures listed, minimal supervision, lack of hands-on training for surgical procedures (needs parody with existing health care professionals already performing those procedures), and makeup of oversight board.	
E. Randall	Support	This proposal is informed by existing standards practiced through WA Tribal DHAT and builds upon SB 5142 by expanding		

		pathways for licensure (allows dental therapy programs that are not CODA-accredited).		
A. Rivers	No Response			

Recommendation D - Additions to Any Dental Therapy Legislation, Proposed by M. Caldier

Topic(s) addressed by Recommendation

Additions to Any Dental Therapy legislation

Recommendation

As the appointed State Representative for the House Republican Caucus, we do not support allowing a dental provider with only two years of training to not only perform the entire hygienist's scope of practice, but also irreversible procedures like fillings, extractions and pulpotomies with minimal dentist supervision.

The following concepts should be added to any dental therapist legislation:

1. Budget language that raises the per member per month (PMPM) spend for Medicaid dental (both children and adults) for fee for service and FQHC encounters fees up to being on par with the tribal encounter PMPM spend.
2. Increasing reimbursement for oral health education and limited preventive care in patient's homes.
3. Dental therapist supporters have said that dental therapists are different because they will come from underserved communities. To ensure this happens, dental therapists should be required to come from and return to an underserved community for a certain period of time in order to obtain licensure. DQAC will define "underserved communities" in rule.
4. State funding of $xxx per year for loan repayment or scholarships for dentists, hygienists and dental therapists that come from and return to underserved communities as defined by DQAC in rule.

What informs this Recommendation?

My lived experience as a mobile dentist who provided care in nursing homes informs this recommendation.

The House Republican Caucus has a history of supporting adequate training for surgical procedures, especially when caring for our most vulnerable populations.

The House Republican Caucus does, however, support finally investing in the dental Medicaid program, and utilizing the per member per month allocation for tribes to expand to all Washingtonians eligible for Medicaid. In addition, we should also make investments in preventative services that if there was a dental therapist, that would be an ideal role for this type of minimally trained provider.

Our state's dental safety net has problems. No dental provider (dentist, dental therapist, or something else) is able to provide quality care for everyone unless significant improvements are made. Only by everyone working together will we be able to get these reforms passed.

Strengths and future implications of this Recommendation?

If enacted, this Recommendation will go a long way to provide everyone with access to high quality dental care. These concepts are included as amendments to dental therapist legislation to ensure that all advocacy groups that support dental therapists will also support these actual solutions.

Challenges and potential unintended consequences of this Recommendation?

The majority party has not made covering the true cost of dental safety a priority.

Task Force Member Input on Recommendation D

Task Force Member	Support/ Don't Support/ Neutral	Strengths/ Support	Challenges/ Don't support	Neutral
M. Bowers	Don't Support		The purpose of the task force was to explore expanding dental therapy from tribal lands to statewide. While the Medicaid increases in this proposal could have merit – and are issues my organization has historically supported – it is out of the scope and intent of the task force.	
M. Davis	Don't Support		The purpose of the task force was to explore expanding dental therapy from tribal lands to statewide. While there are many reasons to consider increasing Medicaid reimbursement, this was not the assignment for this task force. Dental therapy policy can result in impressive outcomes all while remaining budget-neutral.	
S. Blandford	Don't Support		Representing Children's Alliance, we DON'T SUPPORT this proposal, finding it too weak to address our core issues of expansion of access and workforce improvements in underserved communities.	
L. McClellan	Don't Support		If they are trained in a CODA accredited school then they should be proficient in all the tasks performed. We are not in as qualified a position as CODA to say therapists are competent or not.	
B. Gandara	Don't Support		Though I do not support most of Dr. Caldier's items on her proposal, I think that aspects of the proposal, such as increased reimbursement by Medicaid, are very good. That would certainly help with access to care issues. However, I don't think approval of dental therapists in Washington State should hinge on whether Medicaid reimbursement can be increased, since it is a separate issue. Since less than 30% of Medicaid-eligible clients utilize dental services presently,	

			there needs to be more efforts in helping individuals access professional care by reaching out with oral health education, oral health care navigation and facilitation, which is within the scope of dental therapists. I also support increasing reimbursement for oral health education and limited preventive care ("limited" needs to be defined) in non-office settings such as patient's homes, nursing homes, schools (bringing it to where the patient is), as well as remote areas, which would support dental therapists' work in these areas so it is prioritized and sustainable. But it is a separate issue than the goal of our Task Force. Again, I don't think approval of dental therapists in Washington State should hinge on whether Medicaid reimbursement can be increased. I don't think it can be required dental therapists to come from and return to the communities they are from unless the community sponsors their education costs and plans are made for payback. But I think that they should be eligible for loan repayment programs as Dr. Caldier suggested. The lower cost and time for dental therapist training makes becoming a dental professional more attainable for someone from an underserved community and provides upward mobility for pursuing further education. Close community ties are both what keeps providers in communities and also what draws providers away (in the case of dentists who stay only for only a few years, leaving clinics with shortages or high turnover of dentists).	
B. Killpack	Support	Addressing the underlying systemic barriers to equitable dental care.		
C. Gaylord	Neutral			This proposal is outside the scope of the Dental Therapy Task Force. I disagree with some statements – This is not "only two years of training" – CODA requires three years, which can be accelerated, as can dental

				and dental hygiene education. “Minimally trained” is offensive. Underserved communities do not need to be defined by DQAC – there are underserved people everywhere. I agree with the following concepts – Increasing reimbursement for education and preventative care within patient’s homes. Investing in the dental Medicaid program.
R. Ferry	Don’t Support		This proposal does not support dental therapy.	
R. Hogan	Don’t Support		The purpose of the task force was to explore expanding dental therapy from only tribal lands to statewide. While the Medicaid increases in this proposal could have merit, it is out of the scope of the intent of the task force. Proposals (like those previously mentioned) are budget neutral making them more likely to succeed. Attaching monetary means is unnecessary and makes DT even more contentious. I continually support more funding for oral health as well as oral health integrated into overall health, but that is for another task force.	
D. Steringer	Neutral			WDG is neutral.
S. Hill	Neutral			In contrast to the introduction of this proposal, I fully support the implementation of DHATs with their current educational system. That said, I support Rep. Caldier's proposals to add the following to any dental therapist legislation (1) budget language increasing PMPM spend for Medicaid, (2) increasing reimbursement for oral health education and limited preventive care, (3) state funding of $xxx

				per year for loan repayment. These additions would improve oral health for underserved communities.
B. Marsalli	Don't Support		The assertion "No dental provider (dentist, dental therapist, or something else) is able to provide quality care for everyone unless significant improvements are made" is false. Today across the state of Washington, community health centers provide high quality and affordable access to oral healthcare for all, regardless of the ability to pay.	
D. Greeno	Neutral			The proposal mischaracterizes the training of dental therapists.
D. Nesterenko	Don't Support		Being outside of the scope of the task force.	
J. Bateman	Don't Support		I support increasing Medicaid reimbursements, however that was not the directive for the task force.	
M. Caldier	Support	True solutions to access problem.		
E. Randall	Neutral			I appreciate Rep Caldier's attempts to find common ground, but am unsure the degree this proposal could constrain dental therapy, or the ways it may block this legislation's pathway by including budget language re: Medicaid dental spend. There is a proposal for including state funding for loan repayment/scholarship for dental care professionals-- perhaps that proposal should be pursued as a separate piece of legislation.
A. Rivers	No Response			

Recommendation E - Adopt the National Model Act for Licensing or Certification of Dental Therapists, Proposed by M. Davis

Topic(s) addressed by Recommendation

Recommendation

I am submitting the National Model Act (NMA) as a proposed policy to be considered to guide authorization of Dental Therapy in Washington State.

What informs this proposal:

The National Model Act was developed in 2018-2019 by a nationwide panel of experts, including dentists, dental specialists, dental therapists, dental educators, public health professionals, health care administrators, and legal consultants.

As stated on page 4 of the introduction to the National Model Act:

The Model Program is based on the following three primary sources of information on emerging standards and best practices in dental therapy licensing:

1. The research evidence on DT programs in the areas of oral health access, quality, safety, patient satisfaction, and financial/business impact on dental practices.
2. The laws, policies and lessons learned in the states and tribal communities that have DT licensing or certification programs.
3. The expertise of researchers, educators, practitioners, employers and regulators who have direct experience with the profession.

Model program policies were developed and endorsed by a multi-disciplinary review panel of individuals with extensive expertise with dental therapy programs. The consortium identified individuals to serve on the review panel based on the following criteria:

- All panel members have existing, direct professional experience with and knowledge of dental therapists, dental health aide therapists, and similar oral health professionals;
- Panel membership is multi-disciplinary, representing educators, researchers, licensing agencies, employers, supervising dentists, and dental therapists;
- The panel has a range of expertise with different types of dental practices, practice models, geographic areas, and patient populations served; and
- The panel includes individuals with expertise in improving access, oral health, and health equity for underserved, low-income and historically underrepresented population

The biographies of the consortium of experts comprising the panel that created the NMA can be found on page 28 of the document. The written sources informing the creation of the NMA can be found in its bibliography on page 35 of the document.

Strengths and Future Implications:

The guiding principles of the National Model Act are based on the **policy goals** and legislative intent expressed by the policymakers and stakeholders who were responsible for establishing DT programs or are seeking to establish new programs.

Effective: the program is effective in achieving the following policy goals:

- Increase access to oral health services for underserved populations
- Improve oral health of underserved populations
- Improve health equity and achieve greater diversity of the oral health workforce
- Provide for safe, high quality oral health services
- Control the cost of health care services
- Control the cost of oral health education and reduce barriers to entry to the profession, especially for people from underserved populations

Evidence-based: the program is supported by research and documented facts on the experience and outcomes of DT programs.

Flexible: the program allows for effective DT practice in a wide range of geographic locations, types of dental practices, sites of service including mobile or community-based, and populations served.

Facilitates Growth of the Profession: the national standards facilitate the growth of the DT profession nationwide through greater uniformity of standards for education, scope of practice, supervision, reciprocity, and other professional licensing requirements, while preserving an appropriate amount of flexibility for states and tribal governments to adapt to their unique circumstances, priorities and policies.

Consensus-based: the national standards represent the consensus of experts with direct expertise and knowledge with all aspects of the DT/DHAT profession including education, licensing, service delivery, access, quality, equity, and clinical practice.

Challenges and Potential Unintended Consequences:

Perhaps the most significant challenge to those wishing to create policies to authorize Dental Therapy is an abundance of misinformation shared by those who are opposed. For this reason, looking to the abundance of existing evidence and research is important.

Another challenge in the creation of Dental Therapy policy is the variation in existing policy between states that have already passed legislation to authorize its practice. For this reason, looking to a document like the NMA that has already been created by experts who have considered the challenges and consequences of existing policies can be very helpful to decide which policies will have the greatest outcomes.

Finally, the unintended consequences of *not* moving forward with statewide dental therapy legislation are serious. Our current system of oral health care delivery is not working for many thousands to millions of

people in Washington State, and health disparities remain vast. While the solutions to these problems must be multifactorial, the evidence shows us that the practice of dental therapy results in improved outcomes for populations where it has been authorized and implemented.

Task Force Member Input on Recommendation E

Task Force Member	Support/ Don't Support/ Neutral	Strengths/ Support	Challenges/ Don't support	Neutral
M. Bowers	Support	This National Model Act is the most comprehensive look at dental therapy legislation across the country and offers a road map for Washington to expand dental therapy statewide.		
M. Davis	Support	The National Model Act should serve as a guide for Washington State. It was written by experts from around the country who used all the available evidence, as well as lessons learned from around the country and world. It is the most comprehensive and evidence-based example policy on Dental Therapy in existence. Many other states developed their policies before the Model Act was available. We are fortunate to have this compilation of best policy, developed by experts, all in one document.		
S. Blandford	Support	Representing Children's Alliance, WE SUPPORT this and other proposals to expand access to dental therapy on the grounds that it is good for children and families across the state who desperately need expanded access to resolve basic oral health needs. This proposal also recognizes that expanded dental therapy access is a workforce issue, as it would offer licensure to a significant number of community residents, and would encourage entry into the profession by people of color providers who live in the communities where they work.		
L. McClellan	Neutral			Proposal is more generic and could apply to all the models of dental therapy and not precisely the tribal model tasked. It could be used as a resource to guide legislation.
B. Gandara	Support	The work and thought that went into putting the National Model Act together is comprehensive and based on experiences of many highly-trained and experienced		

		individuals who, together, understand the larger picture of access to care needs and how to preserve and empower the dental profession while adapting to a new model of care. It also takes into consideration states' individual preferences while laying out a plan for standardizing the basic requirements of a Dental Therapist including training, scope of practice, licensure, practice settings and supervision issues.		
B. Killpack	Don't Support		See background of Proposal B.	
C. Gaylord	Support	Of all the information we received as Task Force members this is the most comprehensive document. It is evidence-based policy written by a most competent multi-disciplinary panel of individuals with extensive expertise. It utilizes documented studies, research, and literature. Comments on each of the section of policies reviewed cover valid and researched concerns providing rationales for policy decisions. This document would be my primary proposal recommendation. Specific recommendations for Washington: Licensing agency – Dental Hygiene and Therapy Board under Department of Health as stated in Proposal A. Education – CODA accreditation, advanced standing in education to allow career pathways for dental hygienists and dental assistants, flexibility to minimize barriers Competency – After years of experience with clinical examinations, I am updating my opinion to the concept of elimination of clinical single-encounter exams. Due to the evolution of competency-based education, I think competency assessment standards are changing for all dental professions and dental therapists should be included in that. Supervision – requirements stated in Proposal C. Include off-site supervision definition in current dental hygiene law. Written Supervision agreement – as stated in Proposal C. Reciprocity – see limited license as stated in Proposal C. Scope of Practice – include all procures within CODA-accredited education. Practice settings – include as many as possible in an effort to provide as much care as possible. Continuing Education – match dentistry requirements.		
R. Ferry	Support	Very well thought out and expresses knowledge of the dental team associated with a DHAT.		
R. Hogan	Support	This National Model Act is the most comprehensive look at dental therapy legislation across the country and offers a road map for Washington to expand dental therapy statewide. This is an excellent policy guide for states considering DT legislation. Reading this information could have sufficed in lieu of a DT task force, in fact I believe that was the charge of the Act: to bring		

		all of the information to one forum with experts from across the national dental, education, and clinical fields. Most of what is being practiced on tribal lands is followed or reiterated here.		
D. Steringer	Support	WDG supports Proposal E as this National Model Act is the most comprehensive look at dental therapy legislation across the country and offers a road map for Washington to expand dental therapy statewide. It also aligns favorably with the current Oregon dental pilot project in which WDG participates, and the recently passed legislation allowing dental therapists to obtain licensure in Oregon.		
S. Hill	Support	The National Model is well vetted and should be considered when Washington State legislates dental therapy.		
B. Marsalli	Support	Comprehensive and evidence-based.		
D. Greeno	Neutral			Proposal provides map for potential expansion.
D. Nesterenko	Support	Access to dental care and health equity.		
J. Bateman	Support	It increases equitable access to oral healthcare.		
M. Caldier	Don't Support		Danger to public due to the procedures listed, minimal supervision, lack of hands-on training for surgical procedures (needs parody with existing health care professionals already performing those procedures), and makeup of oversight board.	

E. Randall	Support	This proposal is largely based off Minnesota's legislation. The scope of practice proposed here is not as robust as the language written in SB 5142.		
A. Rivers	No Response			

Recommendation F - Create a Pathway for Hygiene Licensure for Dental Therapists, Proposed by B. Killpack

Topic(s) addressed by Recommendation

Addressing Washington State's Workforce Challenges

Recommendation

In order to facilitate a more meaningful dialogue around increasing access to dental care, WSDA believes the Task Force should first focus its attention on addressing the glaring workforce shortages in Washington State. Specifically, the Task Force should examine the existing data on the severe shortage of hygienists and consider possible ways to increase the number of trained individuals who could provide desperately needed dental hygiene services.

Washington State's Workforce Needs

Washington state's extreme shortage of dental hygienists is having a negative impact on access to dental care.

- Demand for dental hygienist positions in Washington significantly outweighs the supply.
- For every 1 hygienist seeking a position, there are over 3-4 positions available.
- Statewide, hygienist positions are open an average of 4.2 months before filled.
- With a typical hygienist schedule (10 patients per day, four days per week), each persistent opening translates into 160-200 patients not receiving care each month.
- Safety net clinics report scheduling hygiene appointments up to 90 days out – leading to more missed appointments. Dentists in these clinics aren't fully serving patients, either because of a lack of support staff or because they are instead performing hygiene services.

Creating a Pathway for Hygiene Licensure For Dental Therapists

The current need for hygienists in our state cannot be overstated. If the state is going to consider a new oral health care provider in Washington state, the focus of that provider's scope should be on preventive care, as there is a significant demand for this type of care in both community health center and private health care settings throughout the state.

Accordingly, as a way to help address the severe shortage of dental hygienists, WSDA proposes to create a pathway for dental therapists, who have graduated from a CODA accredited program, to obtain a limited hygiene license in Washington State. Given the hygiene training dental therapists receive, allowing them to provide preventive care would provide immediate relief to countless dental offices in dire need of hygienists.

This recommendation would require the creation of a core hygiene license that would authorize the full range of preventive procedures currently allowed but would not permit the procedures in the state's dental hygiene scope for which dental therapists do not have training. However, if a dental therapist were to receive additional training (or can demonstrate that additional training has already been received), they could perform the full hygiene scope by applying for an endorsement.

What informs this Recommendation?

WSDA strongly encourages the Legislature to review the enclosed results to the 2020 Workforce Survey, created by WSDA and the Washington Dental Hygienists' Association, to better understand the workforce shortages plaguing our state. Should any legislator have questions as to what modifications would need to be made in statute and/or rule to implement the aforementioned policy recommendation, WSDA would be more than willing to walk through next steps and answer any questions.

Strengths and future implications of this Recommendation?

Challenges and potential unintended consequences of this Recommendation?

Task Force Member Input on Recommendation F

Task Force Member	Support/ Don't Support/ Neutral	Strengths/ Support	Challenges/ Don't support	Neutral
M. Bowers	Don't Support		The purpose of the task force was to explore expanding dental therapy from only tribal lands to statewide. This proposal about hygiene workforce shortage is out of the scope and intent of the task force. Furthermore, it fails to demonstrate any evidence as to how it would improve access to care for people with low incomes.	
M. Davis	Don't Support		The purpose of the task force was to explore expanding dental therapy from tribal lands to statewide. This proposal is a distractor: it does not address the purpose of the task force at all. Instead, it suggests giving existing dental therapists a license to practice as hygienists.	
S. Blandford	Don't Support		Representing Children's Alliance, we DON'T SUPPORT this proposal, finding it too weak to address our core issues of expansion of access and workforce improvements in underserved communities.	
L. McClellan	Neutral			This proposal is mostly workforce related and can be used as a reference for legislation.
B. Gandara	Don't Support		It would have been very helpful to know if the practices that responded to the survey served patients with	

			Medicaid coverage. Given that the results of the dental hygiene shortage study presented by Bracken are 75% from independent dental practices and only 6% from community clinics, this study does not provide useful information that can be applied to dental therapists and access to care, which is the common goal of our Task Force. If dental therapists are funneled into independent practices to solve the independent practices' needs for dental hygiene services along the Puget Sound corridor, that does not help with access to care in health care shortage areas or in urban community clinics.	
B. Killpack	Support	Helps address severe dental hygiene shortages in Washington.		
C. Gaylord	Don't Support		This proposal is beyond the intent of the scope of the Task Force. As the only dental hygienist on the Task Force, I am well aware of WSDA's concerns with workforce issues. But this is our new reality in the pandemic worldwide labor market. The only portion of this proposal related to dental therapy is the concept of a limited dental hygiene license for dental therapists. The original proposal for dental therapy allows for the scope of dental hygiene practice – a limited license would not be necessary.	
R. Ferry	Don't Support		The proposal does not concentrate of dental therapy, rather on dental hygiene. Off topic and void.	
R. Hogan	Don't Support		The purpose of the task force was to explore expanding dental therapy from only tribal lands to statewide. This proposal about hygiene workforce shortage is out of the scope of the intent of the task force.	
D. Steringer	Neutral			WDG is neutral.
S. Hill	Don't Support		While we do have a shortage of hygienists, DHATs are trained in addressing other needs as well. Utilizing them for hygiene and preventive only would be a disservice to their training and insufficient to provide what Washington residents need to address oral health inequities.	
B. Marsalli	Neutral			The proposal is laudable yet it does not address the fundamental questions the task force was convened to

				address regarding SB 5142.
D. Greeno	Neutral			Proposal appears to focus on dental hygiene.
D. Nesterenko	Don't Support		The premise being a misrepresentation of what was discussed at the task force meetings.	
J. Bateman	Don't Support		It is outside the scope of the task force.	
M. Caldier	Support	Preserves safety to the public with surgical and irreversible procedures.		
E. Randall	Neutral			While dental hygienists are important to dental care and a dual licensure pathway would have great benefits, this does not do enough to address current needs or accomplish what the task force has set out to do.
A. Rivers	No Response			

Conclusion

Facilitators delight in finding agreement in a group, thrive on productive disagreements that lead to creative responses, and strive to support each person being able to fully express themselves. The work of this task force was difficult from the beginning. Certain members felt they were in the minority and their voice would not be heard. Others felt there were disrespectful attitudes towards people with limited access to dental care and people of different cultures. Others felt there were disrespectful comments made about their professions. The short time frame of the task force made some feel there was a foregone conclusion: dental therapy will be practiced in the State of Washington beyond tribal lands.

As facilitators we did not ask task force members to reach agreement. Our first process design principle was to NOT vote on recommendations to the legislature. The mental model of a traditional legislative task force, and

often of the work of public policy, is to vote and allow the majority to prevail. Our understanding of the mandate for this task force was different:

- to convene experts with diverse positions;
- support them in sharing data, expertise and experience that informs their positions;
- help them learn from one another; and
- encourage them to develop recommendations that speak to the challenges of those opposed.

Not debating "my way or your way," was a difficult habit to break during this task force. We celebrate the powerful recommendations and carefully thought-out responses in support and opposition that were produced.

The tribal experience with dental therapy that was shared, reviewed, and is actively being implemented in our state and beyond had a powerful impact on the task force. The presence of dental therapists, with a scope of work that includes elements of dental hygiene and dentistry, has changed the reality of dental care in tribal communities. Based on task force conversations, efforts to scale up dental therapy in Washington raise issues about overreach of the dental therapy profession, quality assurance, supervision and training. Replicating a tribal community-based model in non-tribal rural and urban settings also poses challenges and raised concerns about cost-cutting approaches to dental care in low-income communities.

The challenge to you as legislators is to weigh the systemic concerns of supervision, quality assurance, professional development and scope of practice against the need to make dental care more available to Washingtonians who do not currently have access to consistent, trustworthy, and quality dental care.

Bibliography: Table of Policy Recommendation Resource Documents

Title of Article & Publishing Source	Referenced in	Published By	Year Published	Authored by	Category
Ensuring All Kids Experience Optimal Oral Health		KIDS COUNT in Washington - State of Washington Kids 2020	2020	Unknown	INFO SHEET
10 Years of Data Show Dental Therapists Boost Productivity and Revenues		Pew Charitable Trusts	2020	Kristen Mizzi Angelone & Allison Corr	ARTICLE
2021 Washington Adult Dental Reimbursement Rates		Washington State Dental Association	2021	Unknown	INFO SHEET
A Coming Surge in Oral Health Treatment Needs: Pandemic-related events appear poised to create a spike in oral disease among adults.		CareQuest Institute for Oral Health	2021	Eric P. Tranby, et. al	REPORT
A review of the Global Literature on Dental Therapists.		National Library of Medicine	2013	David A. Nash, et. al	ARTICLE

A Sample Dental Therapy Curriculum for Community Colleges		Community Catalyst	2017	Community Catalyst	REPORT
Access to Dental Care Dashboard		ARCORA: The Foundation of Delta Dental in Washington	2020	Unknown	DATA REPORTS
Alaska Dental Therapy Education Program		Alaska Native Tribal Health Consortium	2021	Unknown	WEBSITE
American Indian and Alaska Native Access to Oral Health Care: A Potential Solution		Journal of Health Care for the Poor and Underserved	2016	Terrence C. Batliner	ARTICLE
An Advanced Dental Therapist in Long-Term Care: Heather Luebben's Case Study		Apple Tree Dental	2018	Unknown	DATA REPORT
An Advanced Dental Therapist in Rural Minnesota: Jodi Hager's case study.		Apple Tree Dental	2018	Unknown	DATA REPORT
Assessing the Impact of Washington State's Oral Health Access to Care Workforce on Patient		Center for Health Workforce Studies - University of Washington	2017	Davis G. Patterson, PhD, et. al	REPORT
Building Momentum for Dental Therapists		W.K. Kellogg Foundation	2016	Unknown	INFO SHEET
Chapter 70.350 RCW: DENTAL HEALTH AIDE THERAPISTS	Recommendation C	Washington State Legislature		Washington State Legislature	POLICY
Clinical Technical performance of dental therapists in Alaska		The Journal of the American Dental Association	2014	James D. Bader DDS, et. al.	ARTICLE
CODA Accreditation Standards for Dental Hygiene Education Programs	Recommendation C	Commission on Dental Accreditation	2021	Commission on Dental Accreditation	POLICY
CODA Current Accreditation Standards	Recommendation C	Commission on Dental Accreditation	2021	Commission on Dental Accreditation	WEBSITE
Colville Dental Therapists Lead Way for Innovative Dental Care During Pandemic		Wenatchee World	2020	Arielle Cawston	NEWS
Community Health Aide Program Alaska Standards and Procedures	Recommendation C	Community Health Aide Program Alaska	2021	Community Health Aide Program Alaska	WEBSITE
Consumer Survey Focused on Parents' Experiences Accessing Oral Health Services for Their Children.		Oral Health Workforce Research Center	2020	S. Surdu, et. al	REPORT
Dental Data		Washington State Health Care Authority	2019	Unknown	DATA REPORT
Dental Therapist Spotlight: Jason Mecum		W.K. Kellogg Foundation	2021	W.K. Kellogg Foundation	WEBSITE
Dental therapists create a two-tiered system of care		The Seattle Times	2021	Marissa Bender & Harlyn Susarla	NEWS
Dental Therapists in General Dental Practices: An Economic Evaluation		Journal of Dental Education	2012	Tryfon J. Beazoglou, et. al	ARTICLE

Dental Therapists in the United States		Medical Care	2021	Elizabeth Mertz, PhD, MA, et. al	ARTICLE
Dental Therapists making a difference in Minnesota, a decade of data shows		Badger Institute	2021	Kevyn Burger	WEBSITE
Dental therapists: A global perspective		International Dental Journal	2008	David Nash, et. al	ARTICLE
Dental Therapists: Evidence of Technical Competence		Journal of Dental Research	2013	E. Phillips & H.L. Shaefer	ARTICLE
Dental Therapists' Diverse Skillset Helps Meet the Challenge of Providing Dental Care During a Pandemic		National Partnership for Dental Therapy	2020	National Partnership for Dental Therapy	NEWS
Dental Therapy Education		Northwest Portland Area Indian Health Board	Unknown	Unknown	WEBSITE
Dental Therapy Helps Increase Revenue, Access to Oral Health Care		Pew Charitable Trusts	2017	John Grant & Rebecca Singer Cohen	NEWS
Dental Therapy Implementation: Video 3 of 3		Youtube	2021	Swinomish Dental	VIDEO
Dental Therapy in Minnesota		Minnesota Department of Health/Minnesota Board of Dentistry	2018	Unknown	DATA REPORT
Dental Therapy on the Swinomish Reservation		San Juan Udpdate	2020	Asiah Gonzalez	NEWS
Dental Therapy Seen as Best Practice in Boosting Access to Care		Pew Charitable Trusts	2019	Jane Koppelman a nd Allison Corr	NEWS
Dental therapy timeline		The PEW Charitable Trusts	2020	Unknown	INFO SHEET
Dental Therapy Toolkit: A Resource for Advocates & Partners		W.K. Kellogg Foundation	2020	Unknown	INFO SHEET
Dental Therapy Toolkit: A Resource for Potential Employers		Minnesota Department of Health	2017	Unknown	REPORT
Dental Therapy Works for Washington		Children's Alliance	2019	Unknown	WEBSITE
Dental Therapy: Expanding the dental team to improve access to dental care and diversify the dental workforce		National Coalition of Dentists for Health Equity	2021	Unknown	INFO SHEET
Dental Utilization for Communities Served by Dental Therapists in Alaska's Yukon Kuskokwim Delta: Findings from an Observational Quantitative Study.	Recommendation C, Task Force Member Input on Recommendation B	University of Washington School of Dentistry	2017	Donald Chi, et. al.	REPORT
Despite COVID-19 Challenges Dental Therapy Had a Watershed 2020 and I s Poised to Grow. Midlevel providers have proved crucial to practices and patients during the pandemic.		Pew Charitable Trusts	2021	Kristen Mizzi Angel one	NEWS

Difference in the Decision to Attend College Among African Americans, Hispanics, and Whites		The Journal of Higher Education	2000	Laura Walter Perna	ARTICLE
Diversity, College Costs, and Postsecondary Opportunity: An Examination of the Financial Nexus between College Choice and Persistence for African Americans and Whites		The Journal of Higher Education	2005	Edward P. St. John, et. al	ARTICLE
Economic Viability of Dental Therapists		Community Catalyst	2013	Frances M. Kim, DDS	REPORT
Education Pays 2013: The Benefits of Higher Education for Individuals & Society		College Board	2013	Sandy Baum, et. al	REPORT
Equity and leadership spur dental therapy tipping point		W.K. Kellogg Foundation	2020	W.K Kellogg Foundation	WEBSITE
Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska		Research Triangle Institute International	2010	Sott Wetterhall, et. al.	REPORT
Examining Oral Health Care Utilization and Expenditures for Low-Income Adults		Center for Health Care Strategies, Inc.	2017	Stacey Chazin, et. al	DATA REPORT
Expanding Access to Dental Therapy		American Dental Hygienists' Association	2019	Unknown	INFO SHEET
Expanding the Dental Team: Increasing Access to Care in Public Settings		W.K. Kellogg Foundation	2014	Unknown	REPORT
Expanding the Dental Team: Studies of Two Private Practices		Pew Charitable Trusts	2014	Unknown	REPORT
Experts Develop Model Dental Therapy Legislation		Pew Charitable Trusts	2019	Jane Koppelman	NEWS
Grand Marais Family Dentistry: Dental Therapists Case Study		Wilder Research	2017	Jose Diaz	DATA REPORT
Health Aides of Alaska		Community Health Aide Program Alaska	2021	Unknown	WEBSITE
Health Impact Review of HB 2321: Concerning Mid-Level Dental Professionals		Washington State Board of Health/Governor's Interagency Council on Health Disparities	2014	Sierra Rotakhina	REPORT
Health Policy Institute Infographics		American Dental Association	2021	Unknown	INFO SHEET
How Dental Therapists Can Address the Social and Racial Disparities in Access to Care		American Journal of Public Health	2017	Yee et. al	ARTICLE
How Evidence-based Is US Dental Workforce Policy For Rural Communities?		Oral Health Workforce Research Center	2020	M. Werts, et. al	REPORT

IDAPA 19		Idaho State Board of Dentistry	2019	Idaho State Board of Dentistry	POLICY
Impact of Dental Therapists on Productivity and Finances: II. Federally Qualified Health Centers		Journal of Dental Education	2012	Tryfon J. Beazoglou, et. al	ARTICLE
Improving Dental Care Access in Rural America		Unknown	Unknown	Rebecca Singer Cohen and Julie Stitzel	WEBSITE
Indian Country Leads National Movement to Knock Down Barriers to Oral Health Equity		AJPH Press	2017	Brian (Speepots) Cladoosby	ARTICLE
Influence of Private Practice Employment of Dental Therapists in Saskatchewan on the Future Supply of Dental Therapists in Canada		Journal of Dental Education	2012	Gerry Uswak & Emory Keller-Kurysh	ARTICLE
Innovations in Oral Health and Primary Care Integration: Alignment with the Shared Principles of Primary Care		The Primary Care Collaborative	2021	Unknown	REPORT
Let dental therapists serve all communities statewide		The Seattle Times	2021	Tera Bianchi	NEWS
Main Barriers to Getting Needed Dental Care All Relate to Affordability.		Health Policy Institute, American Dental Association	2019	Niodita Gupta, M.D., M.P.H., Ph.D.; Marko Vujicic, Ph.D.	DATA REPORT
Maximizing Community Voices to Address Health Inequities: How the Law Hinders and Helps		Journal of Law, Medicine & Ethics	2017	Julie Ralston Aoki, et. al.	ARTICLE
Measuring oral health and quality of life		Department of Dental Ecology, School of Dentistry, University of North Carolina	1997	Edited by Gary Slade	ARTICLE
Medical Midlevel and Dental Therapist: A False Comparison		Washington State Dental Association	Unknown	Unknown	INFO SHEET
Midwest Dental: Dental Therapist Case Study		Wilder Research	2017	Brittney Wagner, et. al	DATA REPORT
Minnesota's Dental Therapist Workforce		Minnesota Department of Health/Office of Rural Health & Primary Care	2019	Unknown	REPORT
Modified Version of SB 5142 by B. Killpack 2021	Recommendation B	Bracken Killpack	2021	Bracken Killpack	POLICY
National Model Act for Licensing or Certification of Dental Therapists	Recommendation C, Recommendation E, Task Force Member Input on Recommendation B	National Dental Therapy Standards Consortium	2019	National Dental Therapy Standards Consortium	POLICY

Native Dental Therapy Initiative		Northwest Portland Area Indian Health Board	Unknown	Unknown	WEBSITE
New study finds Alaska dental therapists provide safe, competent, and appropriate care		W.K. Kellogg Foundation	2010	Unknown	WEBSITE
Northwest Portland Area Indian Health Board ODPP#100 Response to NARA findings signed 2018-05-11	Task Force Member Input on Recommendation B	Northwest Portland Area Indian Health Board	2018	Northwest Portland Area Indian Health Board	CORRESPONDENCE
Oral Health Dashboard Shows Health Disparities Examples		ARCORA: The Foundation of Delta Dental in Washington	2020	Unknown	DATA REPORT
Oral Health in Indian Country: Challenges and Solutions		National Indian Health Board	Unknown	Unknown	INFO SHEET
Oral Health Program Site Visit 02-26-18	Task Force Member Input on Recommendation B	Oregon Health Authority	2018	Unknown	DATA REPORT
Oral Health Program Site Visit 03-26-18	Task Force Member Input on Recommendation B	Oregon Health Authority	2018	Unknown	DATA REPORT
Oral Health Program Site Visit 04-09-18	Recommendation B, Task Force Member Input on Recommendation B	Oregon Health Authority	2018	Unknown	DATA REPORT
Oral Health Program Site Visit 05-22-18	Task Force Member Input on Recommendation B	Oregon Health Authority	2018	Unknown	DATA REPORT
Oral Health Program Site Visit 05-22-19	Task Force Member Input on Recommendation B	Oregon Health Authority	2019	Unknown	DATA REPORT
Oral Health Program Site Visit 09-20-18	Task Force Member Input on Recommendation B	Oregon Health Authority	2018	Unknown	DATA REPORT
Oral Health Program Site Visit 11-06-19	Task Force Member Input on Recommendation B	Oregon Health Authority	2019	Unknown	DATA REPORT
Oral Health Status Has Improved for Children, but Some Gaps in Treatment Access Persist		The Pew Charitable Trusts	2020	Jane Koppelman & Allison Corr	NEWS
Oral Health Surveillance Report Conclusion and Comment		Centers for Disease Control & Prevention	2019	Unknown	REPORT

Oregon Dental Association Letter to Oregon Health Authority 2018-05-04	Recommendation B	Oregon Health Authority	2018	Oregon Health Authority	CORRESPONDENCE
Oregon Dental Association Letter to Oregon Health Authority 2018-10-16	Recommendation B	Oregon Health Authority		Oregon Health Authority	CORRESPONDENCE
Oregon House Bill 2528 2021	Task Force Member Input on Recommendation B	Oregon Legislative Assembly	2021	Oregon Legislative Assembly	POLICY
Oregon Tribes Dental Health Aide Therapist Pilot Project.	Task Force Member Input on Recommendation B	Northwest Portland Area Indian Health Board	2021	Unknown	INFO SHEET
Projected Supply of Dentists in the United States, 2020 – 2040		Health Policy Institute, American Dental Association	2021	Bradley Munson, B.A.; Marko Vujicic, Ph.D.	DATA REPORT
Provider and Community Perspectives of Dental Therapists in Alaska's Yukon-Kuskowkim Delta: A qualitative program evaluation		Community Dentistry and Oral Epidemiology	2019	Donald L. Chi, et. al.	ARTICLE
RCW 18.29: Requirements for licensing	Recommendation A	Washington State Legislature	Unknown	Washington State Legislature	POLICY
RCW 18.29.021: Requirements for licensing	Recommendation C	Washington State Legislature	Unknown	Washington State Legislature	POLICY
RCW 18.29.190: Initial limited license	Recommendation C	Washington State Legislature	Unknown	Washington State Legislature	POLICY
RCW 18.30 WAC 246-812 Denturist	Recommendation A	Washington State Legislature	2021	Washington State Legislature	POLICY
RCW 18.32.030: Exemptions from chapter	Recommendation C	Washington State Legislature	Unknown	Washington State Legislature	POLICY
RCW 18.32 WAC 246-817 Dentist	Recommendation A	Washington State Legislature	2021	Washington State Legislature	POLICY
Recent Dental Therapy and Oral Health Workforce Literature in the U.S.		Unknown	2021	Unknown	RESOURCE LIST
Safety Net Care and Midlevel Dental Practitioners: A Case Study of the Portion of Care That Might Be Performed Under Various Setting and Scope-of-Practice Assumptions	Recommendation C	American Journal of Public Health	2015	Elizabeth Phillips, et. al	ARTICLE
Senate Bill 1549		80th Oregon Legislative Assembly - 2020 Regular Session	2020	Unknown	POLICY
Smile Survey 2015-2016		Washington State Department Of Health	2017	Unknown	REPORT
Standard Operating Procedures for Oregon Dental Pilot Project #100	Task Force Member Input on Recommendation B	Unknown	2021	Unknown	POLICY

Supply of Care by Dental Therapists and Emergency Dental Consultations in Alaska Native Communities in the Yukon Kuskokwim delta: a mixed methods evaluation		Community Dental Health Journal	2020	Donald L. Chi, et. al.	ARTICLE
The Capacity of Dental therapists to provide direct restorative care to adults		Australian and New Zealand Journal of Public Health	2009	Hanny Calache, et. al.	ARTICLE
The Contributions of Dental Therapists and Advanced Dental Therapists in the Dental Centers of Apple Tree Dental in Minnesota		Center for Health Workforce Studies	2020	M. Langelier, et. al	REPORT
The dental therapist movement in the United States: A critique of current trends	Recommendation B	Journal of Public Health Dentistry	2017	David Nash, et. al	ARTICLE
The Oral Health of American Indian and Alaska Native Adult Dental Patients: Results of the 2015 IHS Oral Health Survey		US Department of Health and Human Services	2016	Kathy R. Phipps, Dr.P.H. and Timothy L. Ricks, D.M.D., M.P.H.	DATA REPORT
The Oral Health of American Indian and Alaska Native Children Aged 1-5 Years: Results of the 2018-2019 IHS Oral Health Survey		US Department of Health and Human Services	2019	Kathy R. Phipps, DrPH, et. al	DATA REPORT
The Swinomish Dental Therapy Story		Youtube	2021	Swinomish Dental	VIDEO
Training New Dental Health Providers in the U.S.		W.K. Kellogg Foundation	2009	Burton L. Edelstein DDS, MPH	REPORT
Training of Supervising Dentists for DTs: Video 2 of 3		Youtube	2021	Swinomish Dental	VIDEO
Tribal Dental Therapy Law in Washington State		National Indian Health Board	2018	National Indian Health Board	POLICY
Tribal Oral Health Initiative		National Indian Health Board	Unknown	Unknown	WEBSITE
University of Minnesota Dual Degree (BSDH/MDT)		Regents of the University of Minnesota	2021	University of Minnesota School of Dentistry	WEBSITE
What is a Dental Therapist?		Pew Charitable Trusts	2018	Unknown	VIDEO
Why Does Oral Health Matter?		Community Catalyst	Unknown	Unknown	INFO SHEET
WSDA OPPOSES SB 5142 Establishing the Profession of Dental Therapist		Washington State Dental Association	Unknown	Unknown	INFO SHEET
Senate Bill 5142 by 67th Legislature State of Washington	Task Force Member Input on Recommendation C, E & F	Washington State Legislature	2021	Washington State Legislature	POLICY