Dear Members of the Health Committee,

I submit this testimony today on behalf of the National Coalition of Dentists for Health Equity (NCDHE). NCDHE is a national organization of highly respected dentists from the fields of dental education, research, public health and clinical practice who are committed to social justice and racial equity in oral health. Our members include 6 former dental school deans, 2 former Chief Dental Officers of the United States Public Health Service, 2 past presidents of the American Public Health Association and the Project Director and Executive Editor of the U.S. Surgeon General's report on oral health among numerous other very distinguished oral health professionals. We have been referred to as the People's Dental Association as we have no interest other than that of the public good.

While we do not take a position on the merits of any specific pieces of legislation, we do offer our perspective on the science and evidence that may either support or contest concepts for the provision of oral care in the interest of improving equity and quality. Workforce is one of our areas of special interest and thus the reason for this testimony. For too long health policy has either omitted oral health or relegated it to a position of secondary importance when, in fact, poor oral health has been associated with adverse pregnancy outcomes, diabetes, cardiovascular disease and so on. As former Surgeon General C. Everett Koop stated,"You're not healthy without good oral health". Yet, for too long the color of one's skin, income, age, education, where a person lives, whether they have a disability or transportation or child care have determined whether or not they have equitable opportunity to attain oral health. These factors have been highlighted by the recent COVID pandemic, which has resulted in decreased dental utilization, which, in turn, has created a backlog of needs as well as increased costs for care. These factors have even further exacerbated the plight of the underserved.

Although data shows us that issues of equity remain in medical care, many advances have been made. Nurse Practitioners and physician assistants have taken medical care beyond the walls of the physician office. They have increased the reach of physicians while controlling costs. Dental therapists offer the same opportunity for oral care but have faced unfounded opposition from the profession. Dental programs such as Mission of Mercy (MOM) and other volunteer programs, while based on the best intentions of dentists and others, are a bandaid approach that does not provide a dental home, continuity of care or a true and dependable system of care. Numerous studies that have evaluated the quality of care provided by dental therapists have all demonstrated that for their limited scope of service, the quality has been at least equal to that provided by dentists. In 2015, the Commission on Dental Accreditation (CODA), the body designated by the US Department of Education to establish and monitor standards for dental schools and dental hygiene programs, established standards for dental therapy programs. Dental therapists are licensed by the same Board that licenses dentists and hygienists.

NCDHE calls to the attention of the committee the "Model Act for Licensing or Certification of Dental Therapists", developed by a multi disciplinary group of experts who brought knowledge of health care, equity, dental therapy education and direct experience working with dental therapists. Having reviewed HB2528, it appears that the language in the bill closely follows the standards established by CODA and the guidance provided in the Model Act. We believe that the evidence demonstrates that legislation that incorporates the principles of these two documents will assure a quality model for improving access to oral care. We wish you the best in your deliberations and offer our consul should you wish.