POSITION STATEMENT
Dental Access Model Act

The American Dental Hygienists' Association (ADHA®) opposes the adoption of the Dental Access Model Act, crafted by the American Dental Association (ADA) and supported by the American Legislative Exchange Council (ALEC).

This proposed model advocates for dental assistants to perform scaling — a critical, preventive and therapeutic procedure that falls within the scope of dental hygiene practice that requires specialized education and clinical training.

The Dental Access Model Act is based on a recently initiated pilot program supported by the Missouri Dental Association and legislation enacted in Wisconsin. The Act and its adoption are controversial because there are no available data or reported outcomes of the pilot program demonstrating safety, appropriateness, or efficacy of allowing dental assistants to perform scaling procedures. Prematurely expanding this model without supporting evidence endangers patient safety, compromises quality of care, and undermines the established standards of dental hygiene practice. Further, the minimal training of an oral preventive assistant is not comparable to the extensive didactic and clinical education required for dental hygienists to competently perform these services.

While the new model Act may increase productivity, it primarily increases profits for private fee-for-service dental practices, rather than making dental care more accessible to all those in need, including the underserved. This model demonstrates dentists' prioritization of self-interest rather than the interest of the public.

Dental hygienists provide high quality preventive and therapeutic oral health care, which involves far more procedures than scaling. Their expertise encompasses thorough general and oral health assessments, including oral pathology screenings, periodontal staging and grading, performing breathing and airway assessment, identifying caries, providing preventive care, performing complete scaling therapy for patients with gingivitis, carrying out scaling and debridement for those with periodontitis, facilitating behavior, assisting with tobacco cessation and nutritional counseling and offering evidence-based individualized recommendations for self-care. When dentists authorize inadequately trained personnel to perform scaling, the public should be advised that they are at risk of receiving substandard care.

In addition, the ADA incorrectly assumes that there are many healthy patients that need only limited care. In fact, most Americans suffer from either gingivitis or periodontitis, making comprehensive dental hygiene care essential. Scaling alone, without other preventive and therapeutic services, poses risks including long-term implications for oral and overall health. Even seemingly healthy individuals require the comprehensive preventive care provided in a visit with a dental hygienist, which goes far beyond what a scaling assistant can offer.

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It is contradictory that while the ADA claims their model will solve dental workforce shortages, they are creating another group that also requires supervision. Further, the ADA opposed ALEC's endorsement of dental therapists – proven licensed providers who have safely delivered quality care to underserved populations for over 15 years in the United States. Dental therapy will increase access to care and is not tied to a private fee-for-service model.

Another concern with adopting this model is ADA's failure to engage ADHA in discussion during its development and continuing to disregard existing workforce shortage data that suggests straightforward solutions. Additionally, ALEC neglected to perform due diligence by failing to obtain testimony from ADHA and other key stakeholders before endorsing this Act. The adoption of this Act requires further study while simultaneously acknowledging dental therapy legislation that ALEC supported in the past.

For these reasons, the ADHA firmly opposes the adoption of the Dental Access Model Act and urges stakeholders to pursue evidence-based solutions that prioritize patient safety and improved access to oral healthcare.

The ADHA encourages individuals and state groups to express their opposition to the Dental Access Model Act by contacting their state legislators, members of the ALEC Board of Directors, or ALEC's CEO Lisa Nelson at lisanelson@alec.org.

To learn more about ADHA's positions on workforce shortages and dental hygiene education, and the policy related to scaling visit adha.org/positions.