ADA American Dental Association®
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Chicago, Illinois 60611

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ADA REFERENCE COMMITTEE WRITTEN TESTIMONY

This form must be completed in full and sent to the appropriate Reference Committee email address to be processed.

rca@ada.org – Reference Committee A (Business, Membership and Administrative Matters)
rcb@ada.org – Reference Committee B (Dental Benefits, Practice, Science, Health and Related Matters)
rcc@ada.org – Reference Committee C (Dental Education and Related Matters)
rcd@ada.org – Reference Committee D (Legislative, Governance and Related Matters)

To be considered by the reference committee, testimony must be received no later than 5:00 pm Eastern Time on **Monday, October 20.**

All fields are required

Resolution Number: 330

Reference Committee (A,B,C,D): B

☒ Pro Testimony

☐ Con Testimony

Submitted By: Dr. JoAnn Gurenlian, American Dental Hygienists' Association (ADHA) Director of Education, Research, and Advocacy

Date Submitted: 10/17/2025

Affiliation

District: N/A

Organization: American Dental Hygienists' Association (ADHA)

In accordance with the ADA Disclosure Policy, at the appropriate time anyone present at this meeting is obligated to disclose any personal, professional or business relationship that they or their immediate family may have with a company, professional organization or individual doing business with the ADA, when such company, professional organization or person is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.

☒ I have read the disclosure policy

☐ I have read the disclosure policy and would like to disclose the following:

Written Testimony: PRO Resolution 330, a policy stating that the ADA encourages all pregnant women to receive regular dental examinations and necessary dental treatment throughout all

stages of pregnancy. The policy further recommends that dental coverage for pregnant women be extended for one year postpartum and included in all dental benefit programs to improve maternal oral health and promote "Age One" dental visits for very young children. This resolution aligns with ADHA's commitment to advancing equitable access to preventive care and promoting evidence-based practices that support maternal and infant/child health. ADHA applauds the ADA for recognizing the importance of comprehensive oral health services during this critical life stage.

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☒ Pro Testimony

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Submitted By: Dr. JoAnn Gurenlian, American Dental Hygienists' Association (ADHA) Director of Education, Research, and Advocacy

Date Submitted: 10/17/2025

Affiliation

District: N/A

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Written Testimony: PRO Resolution 331, a policy stating that the ADA supports federal advocacy efforts to increase funding for women's oral health research, ensure that women are adequately

represented as research subjects in dental clinical trials, and promote the dissemination of research findings on women's oral health issues as appropriate. ADHA affirms that this resolution is a meaningful step toward closing research gaps. We believe this policy will strengthen clinical care, public health initiatives, and professional education.

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Resolution Number: 324

Reference Committee (A,B,C,D): B

☐ Pro Testimony

☒ Con Testimony

Submitted By: Dr. JoAnn Gurenlian, American Dental Hygienists' Association (ADHA) Director of Education, Research, and Advocacy

Date Submitted: 10/17/2025

Affiliation

District: N/A

Organization: American Dental Hygienists' Association (ADHA)

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Written Testimony: CON Resolution 324 outlines the functions and structure of dental teams. ADHA's concern lies within Section E, lines 6–8, which state that "dental hygiene licensure and

practice must require graduation from a CODA-accredited dental hygiene program, or successful completion of an equivalent program that ensures clinical competency as approved by the state licensing board." ADHA strongly disagrees. CODA-accredited programs are the nationally recognized standard for dental hygiene education, providing the rigor, consistency, and accountability necessary to ensure safe patient care. Allowing undefined "equivalent" programs introduces variability, undermines professional standards, and erodes public trust in the dental workforce.

Additionally, Section E, lines 9–13 state that "the ADA supports the use of multiple entry pathways to the dental assisting career... and believes that licensure of dental assistants would create an unnecessary barrier to entry to the profession." However, licensure is a critical mechanism for ensuring that dental assistants are properly trained, qualified, and accountable. Their clinical responsibilities directly impact patient safety, and recognized licensure helps uphold professional standards across the entire dental team.

Finally, Section E, lines 17–20, states that "the ADA may support pilot programs that do not jeopardize the patient's oral health, as based on a valid assessment demonstrating that the program is necessary to fulfill an unmet need and the program does not allow a nondentist to diagnose, treatment plan, or perform irreversible or surgical procedures." While ADHA supports pilot programs designed to address unmet oral health needs, Oral Prevention Assistant (OPA) pilot programs fail to meet the fundamental standards of credible medical studies, resulting in unreliable and potentially unsafe outcomes. These programs often lack valid assessments demonstrating improved health outcomes and present clear risks to patient safety. Therefore, the ADA should not support OPA pilot programs.

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Resolution Number: 325

Reference Committee (A,B,C,D): B

☐ Pro Testimony

☒ Con Testimony

Submitted By: Dr. JoAnn Gurenlian, American Dental Hygienists' Association (ADHA) Director of Education, Research, and Advocacy

Date Submitted: 10/17/2025

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Written Testimony: CON Resolution 325 is a glossary of Workforce Terms. ADHA appreciates the intent to clarify terminology within the dental workforce. However, we must express serious concern regarding the implications of Resolution 325 as currently drafted.

In lines 41–46 on page 3060 and lines 1–2 on page 3061, the document defines a dental hygienist as "an individual who has completed an accredited dental hygiene education program or successful completion of an equivalent program that ensures clinical competency and has been licensed by a state board of dental examiners to provide preventive and therapeutic care services under the supervision of a dentist. Functions that may be legally delegated to the dental hygienist vary based on the educational preparation of the dental hygienist and state dental practice acts and regulations, but always include, at a minimum, scaling and polishing the teeth. To avoid misleading the public, no occupational title other than dental hygienist should be used to describe this allied team member." This is an outdated and limited characterization of the dental hygiene profession. ADHA defines a dental hygienist as "a primary care oral health professional who has graduated from an accredited dental hygiene program in an institution of higher education, licensed in dental hygiene to provide education, assessment, research, administrative, diagnostic, preventive, and therapeutic services that support overall health through the promotion of optimal oral health. This includes assessment, diagnosis, planning, implementation, evaluation, and documentation." ADHA urges the ADA to accurately reflect the modern role and scope of a practicing dental hygienist as an independent, licensed healthcare provider within the dental profession.

Lastly, on page 3062, lines 3–9, the document defines an Oral Preventive Assistant (OPA) as "an expanded function dental assistant who has undergone approved academic and clinical training and demonstrated proficiency in the functions prescribed by their practice act. The OPA works under the direct supervision of a dentist and provides preventive care to healthy child and adult patients that have routine care or gingivitis. The scope of an OPA is prescribed in state practice acts, but is generally limited to: measuring periodontal pockets, removing supragingival calculus, application of fluoride and silver diamine fluoride, and provision of oral hygiene instructions." ADHA asserts that satisfactory OPA training must be conducted through an approved CODA-accredited program, not an unspecified "approved" academic and clinical training program. Furthermore, while the policy allows OPAs to provide preventive care to healthy patients with routine care, OPAs should not be treating patients with any disease, including gingivitis. The OPA scope of practice should not overlap with the duties of a dental hygienist; they should not be probing, measuring periodontal pockets, or removing calculus. Their responsibilities should be limited to applying fluoride, silver diamine fluoride, and providing oral hygiene instructions. No alternative occupational title should be used for this allied team member, and the educational preparation of an OPA is not equivalent to that of a dental hygienist; therefore, OPAs should not perform the assessment or therapeutic functions reserved for licensed dental hygienists.