

*Comments of the North Dakota State Board of Dental Examiners
Before the Health Services Committee*

Re: Interim Committee Study related 1454 § 1

Weds, July 31, 2013

Presented by Rita Sommers, Executive Director of the NDSBDE

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Good morning Chairman Lee and Members of the Committee. My name is Rita Sommers, I serve as the Executive Director of the NDSBDE. I am here today to provide information regarding mid level providers from the perspective of the dental board.

The mission of State's public boards generally has one theme – to protect the public. The Board of Dentistry regulates the dental health, safety and welfare of the public by licensing qualified individuals and enforcing statutes and administrative rules fairly and consistently. In Minnesota, the state legislature changed laws affecting the scope of practice to permit a formerly unrecognized entity – dental therapists – to perform specific duties related to dentistry, citing significant unmet oral health needs and dental provider shortages as motivation for the new laws. A small number of dental therapists are now employed in Minnesota in a variety of practice settings—private practice, Federally Qualified Community Health Centers, hospitals and non-profit dental service organizations.

Concerns from the BODE's perspective:

- 1) **Public Safety:** Ensuring patient safety is the most important fundamental principle when considering the creation of any new dental worker. Dental Examiners and you as legislatures^{NDS} must work together to ensure that citizens of North Dakota treated by any new or existing dental professional receives safe, effective, quality care. The ND Board of Dental Examiners regulates the practice of dentistry by adopting rules for education, testing and licensure to ensure a minimal level of competency, and require individual practitioners meet professional standards in order to practice. Accreditation of educational programs, and licensure provide the foundation of quality assurance in the delivery of healthcare. Therefore whether a dentist, mid level provider, hygienist or dental assistant, the health care provider must be educated, tested, and licensed under core principles centered on patient safety
- 2) **Scope of practice: Dental Therapist/Advanced Dental Therapist** – The scope of practice is variable because the education they receive is variable. Several models have been created as a result of different admission requirements to three different educational programs that currently exist. Two models exist in MN, the ADT, and DT; both were originally called OHP (oral health practitioners). The American Dental Hygienists' Association designed the ADHP model (Advanced Dental Hygiene Practitioner). Their vision was for the ADHP to be "a master's – level educated, licensed oral healthcare provider designed to leverage the existing dental hygiene workforce for a greater impact on the delivery of oral health care to those in need." Many other models and acronyms

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are on the horizon. Metropolitan State University in MN began to develop their ADT (Advanced Dental Therapist) based on ADHA's approved competencies.

- 3) **Testing/proof of minimal competency:** ND requires successful clinical board and a National Board results for licensure within our state. Currently, the MN dental therapist (DT) is not required to take a National Board. A National Board designed to assure minimal competency of mid-level providers does not currently exist. Of the three dental therapist programs exist in MN acceptance into the Metro program requires a degree in dental hygiene. Therefore these candidates have successfully passed the Dental Hygiene National Board. The Minnesota board of Dental Examiners has developed a written exam and certification process for the ADT. However, the Minnesota Board is not a clinical testing agency or a nationally recognized accrediting body. The Central Regional Dental Testing Service has developed and implemented a clinical examination intended for the dental therapist. The NDSBDE accepts results of this regional clinical board exam for licensure of dentists and would require the same for therapists, should such an entity be introduced into the North Dakota work force.

- 4) **Accreditation:** ND statute requires a degree from an accredited dental school or dental hygiene program for licensure. Accreditation does not yet exist for MN therapist programs. CODA, (Commission on Dental Accreditation) is now evaluating MN therapist programs for accreditation for the MN programs. The anticipated date of completion of this process is not yet available however a "comment period" for stakeholders ends Dec 1, 2013. *While the Commission on Dental Accreditation has directed circulation of the proposed Dental Therapy Education Standards, there will be no implementation date until further documentation has been provided which shows that criteria #2 and #5 of the Principles and Criteria Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation are met. Criteria #2 states: Has the allied dental education area been in operation for a sufficient period of time to establish benchmarks and adequately measure performance? Criteria #5 states: Is there evidence of need and support from the public and professional communities to sustain educational programs in the discipline?* Currently North Dakota requires dental, dental hygiene and dental assisting candidates to show proof of successfully completing a dental program accredited by CODA and a nationally recognized board examination.

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- 5) **Regulating agreements:** The DT and the ADT require a collaborative agreement (a contractual understanding between parties – in regard to therapists, usually with a licensed dentist within the state). What would such a collaborative agreement consist of? How would an agreement be renewed, when? How would the Board regulate such agreements? If the DT and ADT are in remote locations, what if emergency medical services are not readily available in the event of a potentially catastrophic event during treatment by a DT; what if no collaborative dentists are available in remote locations; and what is a reasonable proximity of the collaborating dentist to a DT or ADT? (MN: An advanced dental therapist in accordance with the collaborative management agreement must refer patients to another qualified dental or health care professional to receive any needed services that exceed the scope of practice of the advanced dental therapist. In addition to the collaborative management agreement requirements described in section 150A.105, a collaborative management agreement entered into with an advanced dental therapist must include specific written protocols to govern situations in which the advanced dental therapist encounters a patient who requires treatment that exceeds the authorized scope of practice of the advanced dental therapist. The collaborating dentist must ensure that a dentist is available to the advanced dental therapist for timely consultation during treatment if needed and must either provide or arrange with another dentist or specialist to provide the necessary treatment to any patient who requires more treatment than the advanced dental therapist is authorized to provide.)

- 6) **Licensed workforce:** In listening to legislators testify prior to voting on HB 1454 in the 2013 House/Senate I had to ask myself, what is the legislators' definition of "access"? Each legislator seems to qualify statements with a unique explanation of why an access issue exists. Is it the number of patients who receive care, the ability of patients to get care, the degree to which patients get care or the ease with which they get care? Or is it determined by the cost of care provided to the patient. I have witnessed a great deal of debate over the midlevel provider which focuses exclusively on treating disease that has already occurred. This is essentially increasing the speed at which you are bailing a very leaky boat. Workforce is but a small part of the access factor. Other factors include patient education, availability of transportation, cultural factors, language, understanding the value of care and more.

- 7) **Laws governing location or population where service is provided:** Once a determination has been made that a “*dental manpower shortage area*” exists, or where an “*underserved*” population exists, can laws designate where licensees could work? Is it appropriate or constitutional to relegate therapists to practice within underserved population boundaries? Would this improve access to care? Would we provide incentives for therapists to work in designated areas or with designated sectors of the population (Medicaid for example)? Can anything be learned from the DHAT (Alaska’s dental therapist)? “An essential part of Alaska’s DHAT program is that DHATs are recruited from the rural and frontier areas where they serve. There are two reasons for this. First, locally recruited students are more likely to work and live in these rural and frontier areas on a long-term basis. Most dentists are recruited and trained outside rural and frontier areas, and are less likely to choose to practice in remote areas. Second, because they are from the same culture as their patients, DHATs (dental health aid therapist) can provide more culturally sensitive care and education to patients.¹⁶”
- 8) How many mid level providers are likely to seek out ND licensure once they are educated in MN? Will this number be likely to impact issues related to access in North Dakota? Are the alternative options that might utilize the existing dental infrastructure (dentists, hygienists, dental assistants) in a more effective manner? With these questions in mind, I would inquiry whether public health and the private sector utilize dental hygienists and dental assistants to their full capacity. Can the scope of current licensees be expanded in some way that would provide most of the same services with providers who are residents in rural ND or desire to live in ND. Has the ND State College of Science had an opportunity to address how they may enhance their existing program to meet the needs of the Medicaid population? I propose these questions to demonstrate that there are more aspects to the answer of the access problem. Mid level providers may or may not be one answer however if this is the only solution the Legislators propose then we are back to bailing water from a boat with many holes. The lion’s share of the underserved will remain “underserved”.
- 9) Some stakeholders and now this Legislature have verbalized via HB 1454 the urgency of addressing the issue. The Board maintains that a multi-faceted array of solutions is required to meet the need and ensure public safety. One issue that the NDSBDE cannot address and the Legislature can address is the “financial sustainability of the existing

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network of providers is threatened by low reimbursement rates and the high cost of providing dental care.” (*Oral Health in North Dakota Executive Summary August 2012*)

- 10) Elements of the initial legislation, had it passed, posed potential issues and challenges for the regulatory process, included in testimony from the BODE Feb 2013. The creation of a multi-faceted array of solutions will require a commitment to meeting the needs of the public. Whatever the solution or remedy might come to, it would be evaluated by efficacy and then fiscal responsibility but most importantly safety of the public. Recognizing that the Board of Dental Examiners (BODE) which regulates dentistry and protects the public, I believe it extremely surprising that the bill was not crafted with any consultation from the BODE and that even now the process to evaluate the potential for a new provider seems remiss to not include the entity that can provide a great deal of information and expertise in regulation and safety of the public. I would encourage the committee to take advantage and utilize the BODE in their discussion and consideration of DT’s.

- 11) The Center for Health Workforce Studies at the School of Public Health, University at Albany, with support from the Otto Bremer Foundation and the Pew Center on the States Children's' Dental Campaign performed environmental scan interviews with 48 stakeholders in oral health. The NDSBDE was fortunate to contribute facts outlining the workforce and information related to the workforce such as duties that hygienists and assistants are authorized to provide under various levels of supervision and the potential impact this would have were the licensed professionals utilized to their full potential. As you promulgate information regarding how access to care could increased, safely, efficiently and timely consider the actual functions that a therapist may perform and those of our current statute related to the dental hygienist and then ask yourself, are we utilizing our workforce to their fullest capability?