



**TESTIMONY BEFORE THE NORTH DAKOTA LEGISLATIVE  
ASSEMBLY  
INTERIM HEALTH SERVICES COMMITTEE  
WEDNESDAY, APRIL 13, 2016  
Louis W. Sullivan, M.D.**

Chairman Lee, Vice Chairman Fehr, and members of the Health Services Committee, I want to thank you for the opportunity to testify today regarding access to oral health care and the associated dental health workforce issues. I recognize the scope of your committee is broad and therefore, your focus on these critical areas of health is most necessary and appreciated.

Oral health is an integral part of overall health. Dental caries is the most common chronic disease in children and adults in the U.S.

Dental caries is largely, if not entirely, preventable. Yet in 2011, there were over 850,000 visits to all nations' emergency rooms for preventable dental conditions.<sup>i</sup> Poor oral health increases risk for diabetes, heart disease and poor birth outcomes. It can affect a child's ability to eat, sleep and learn. A recent study by the University of Southern California showed that teens with poor oral health were four times more likely to have a low grade point average.<sup>ii</sup> Other studies show bad teeth prevent otherwise qualified candidate from getting jobs or promotions.

In 2000, the U.S. Surgeon General's report, *Oral Health in America*, called attention to oral health in relation to overall health and well-being.<sup>iii</sup> Current oral health disparities data indicates millions of Americans – adults and children – lack access to routine dental care and preventive services.

This lack of access is widening. Over the past 20 years, the number of dental Health Professional Shortage Areas in the country has grown six-fold – from nearly 800 in 1993 to more than 4,900 in 2014.<sup>iv,v</sup>



As you might expect, dental caries disproportionately impacts low income and rural populations in the U. S. More than 47 million people in the U.S. live in places where it is difficult to access dental care.<sup>vi</sup>

In our nation, more than 14.5 million low-income children received no dental care in 2011.<sup>vii</sup>

Low income adults are almost twice as likely as higher –income adults to have gone without a dental check up in the prior year.<sup>viii</sup>

More than 70 million Americans receiving water from community water systems have no access to fluoridation, which is known to significantly reduce tooth decay.<sup>ix</sup>

More than one fourth of adults in the U.S. aged 65 and over have lost all their teeth.<sup>x</sup>

About 130 million Americans (43 percent of the population) have no dental coverage whatsoever.<sup>xi</sup>

In North Dakota, the numbers closely reflect national trends. Only 67 percent of North Dakotan adults, 18 and older, reported having been to the dentist in the past year.

According to a 2014 report by the University of North Dakota Center for Rural Health, data pointed to three primary oral health needs for the state:

- 1) enhance oral health literacy and prevention programs across the state,
- 2) improve dental coverage, and
- 3) increase access to dental care through adequate dental workforce distribution.

North Dakota has one of the highest Medicaid reimbursement rates nationwide (62 percent in 2013). Nonetheless, only 8 percent of the dental practices billing Medicaid in 2013 provided care to a majority (52 percent) of the Medicaid enrollees accessing dental services. Improving Medicaid reimbursement rates is one avenue to increasing access to care, but other options are also important to pursue.



Certainly the country needs more dentists. North Dakota ranks 26<sup>th</sup> among states when considering the gap between available oral health professionals and community need. The dentist to population ratio is approximately 54 per 100,000 in North Dakota.<sup>xii</sup> As of 2013, 67 percent of all the licensed North Dakota dentists worked in the four largest counties: Burleigh, Cass, Grand Forks, and Ward. Furthermore, 12 counties had no dentist, 9 had 1 dentist, and 9 counties had 2 dentists.

Of course, training new dental providers takes time – and money. We hope new dentists will want to practice in areas of need. However, dentists joining the National Health Service Corps have, on average, \$142,000 in student loan debt - this is more than 10 percent greater debt than the average for physicians.<sup>xiii</sup> While we can hope and expect these new dentists to bring passion for their profession and a responsibility to care for their fellow citizens, what is their financial incentive to locate traditional practices in dental professional shortage areas?

The reality is, if we are to meet the oral health needs of our citizens, we must consider new models of care.

One proven model is that of the Dental Therapist. Similar to nurse practitioners and physician assistants in medicine, dental therapists are professionally trained, midlevel dental providers who can help people get the dental care they need. They support the work of a dentist and can work in different locations, often using telehealth technology, while under a dentist's supervision.

You will hear shortly from a senior representative of Commission on Dental Accreditation (CODA). In 2015, by adopting and implementing standards for dental therapy education, the Commission on Dental Accreditation (CODA) ensured that the quality and scope of educational training for Dental Therapists will be consistent from one state to another. This significant decision by the CODA guarantees patients --and dentists-- the same level of confidence in the qualifications and standards of training for a dental therapist as they have for a dentist.

When dentists are in short supply, dental therapists—*who actually receive as much, or more clinical training hours than dentists do on a specific number of routine and preventive procedures*—can expand the reach of dentists and provide vital dental services, oral health education and prevention, offering continuity of care for underserved communities.



Dental therapists are trained (in the case of Minnesota, side by side with dental students) to provide a limited scope of routine dental services, including:

- Preventive care such as patient instruction, oral health outreach and oral screenings
- Dental exams, x-rays and fluoride treatments
- Cleanings and placement of sealants
- Fillings
- Simple extractions

These mid-level dental providers have been in place in other countries – Canada, the UK, Australia and New Zealand for up to 90 years. In fact in New Zealand, a school-based delivery system using dental therapists has been in place since 1921.

In this country, Alaska Native Tribes have led the way in establishing the dental therapist model.<sup>xiv</sup> 2014 marked the 10<sup>th</sup> year of practice for the Alaska Dental Health Aide Therapists (DHATs). Today more than 40,000 Alaska Native people living in 81 rural, mostly remote communities across the state, have access to dental care and prevention services as a result of this community driven solution. Alaska Dental Health Aide Therapists (DHATs) are trained in Alaska in a program overseen by The University of Washington school of Medicine according to a proven worldwide model: a two-year (full-time), post-high school competency-based primary care curriculum, incorporating innovative preventive and clinical strategies.

In the lower 48 states, where in many areas of the country the need is just as great as that of Alaska's remote villages, change is coming. Your neighboring state, Minnesota, was the first state beyond Alaska, to establish licensure of dental therapists. Their legislation created two types of dental therapists: Dental Therapist (DT) and Advanced Dental Therapist (ADT). The scopes of practice of these two provider types are very similar; the major difference lies in the level of supervision.

I know you are considering legislation introduced during the 2015 session (SB 2354) which would establish a mid-level dental therapy model to address North Dakota's need for oral health access. Maine, Vermont, Kansas, New Mexico, Washington state and soon others are part of the legislative community seeking solutions by establishing Dental Therapists within their oral health delivery teams. In Maine, the legislature is currently considering a key item in implementing their Dental



Therapist model, requiring “general supervision” by dentists. This is particularly important when considering rural oral health access.

I want to take a moment to address what is, for me, a deep frustration -- The pushback by organized dentistry to establishing Dental Therapists within the oral health professions community. The effort to stop the development of DT models is significant and based, in large part on misinformation and fear. . . not unlike the pushback in medicine in the 1960’s, 70’s and 80’s, when nurse practitioners and physician assistants were introduced into the health system.

Dental therapists are not a threat to dentists or, more importantly, to the quality of care provided to patients.

Dental Therapists should be seen as an asset to a dental practice. They can bring increased revenue into a dental practice and free up dentists to focus on more complex procedures. Dental Therapists work under the supervision of a dentist. DTs are part of a care delivery **team**.

Dental therapists have the potential to significantly improve access to care and transform how dental care is delivered and managed.

I commend the North Dakota Legislative Assembly for exploring opportunities to reduce dental service provider shortages statewide.

Increasing access to care in communities currently without regular dental care is important. It changes lives.

Thank you for your time. If the Committee schedule allows, Chairman Lee, I would be pleased to address any questions you may have related to my prepared statement.



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<sup>i</sup> U.S. Department of Health and Human Services. Agency for Healthcare Research and Quality. *Healthcare Cost and Utilization Project, 2011 National Statistics on Emergency Department Visits*. <http://hcupnet.ahrq.gov/Hcupnet> (Note: Data retrieved using first listed ICD-9-CM diagnosis codes related to diseases of the tooth and pulp/periapical tissues including 521.0-521.9 and 522.0-522.9.)

<sup>ii</sup> University of Southern California. "Poor Oral Health Can Mean Missed School, Lower Grades." Accessed on 9/29/14. <https://dentistry.usc.edu/2012/08/10/poor-oral-health-can-mean-missed-school-lower-grades/>

<sup>iii</sup> US Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. 2000. <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf>.

<sup>iv</sup> American Dental Education Association. "How HRSA's Title VII and Title VIII Health Professions Programs Help Shape the Health Care Workforce." September 2010.

<https://www.aamc.org/advocacy/hpniec/events/catalanottoapresentation.pdf>

<sup>v</sup> U.S. Department of Health and Human Services. Health Resources and Services Administration. "Designated Health Professional Shortage Areas (HPSA) Statistics as of August 29, 2014," pg 3. Accessed on 9/29/14.

[http://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW\\_Reports/BCD\\_HPSA/BCD\\_HPSA\\_SCR50\\_Smry\\_HTML](http://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry_HTML)

<sup>vi</sup> Ibid.

<sup>vii</sup> W.K. Kellogg Foundation. *Oral Health*. Accessed on 9/24/14. <http://www.wkcf.org/what-we-do/healthy-kids/oral-health>

<sup>viii</sup> U.S. Senate. Committee on Health, Education, Labor & Pensions. *Dental Crisis in America: The Need to Expand Access*. February 2012. <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>

<sup>ix</sup> American Academy of Pediatrics. "Fluoride toothpaste should be used when child's first tooth erupts: AAP. AAP News. Vol. 35, No. 9. September 1, 2014. pp. 18

<sup>x</sup> National Institute of Dental and Craniofacial Research. *Tooth Loss in Seniors (Age 65 and Over)*. Accessed on 9/29/14. <http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/ToothLoss/ToothLossSeniors65andOlder.htm>

<sup>xi</sup> National Association of Dental Plans. "Dental Benefits Improve Access to Dental Care." Accessed on 9/29/14. <http://www.nadp.org/docs/default-source/HCR-Documents/nadphcr-dentalbenefitsimproveaccesstocare-3-28-09.pdf>

<sup>xii</sup> United Health Foundation. America's Health Rankings 2015: North Dakota. Retrieved from: <http://cdnfiles.americashealthrankings.org/SiteFiles/StateSummaries/NorthDakota-Health-Summary-2015.pdf>

<sup>xiii</sup> HRSA. *Oral Health Workforce*. Accessed on September 30, 2014.

<http://www.hrsa.gov/publichealth/clinical/oralhealth/workforce.html>

<sup>xiv</sup> "After 10 years, Alaska dental health aides are a big reason to smile." *Alaska Dispatch News*.

<http://www.adn.com/article/20140604/after-10-years-alaska-dental-health-aides-are-big-reason-smile?sp=/99/328//>