2015 SENATE HUMAN SERVICES

SB 2197

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2197
1/20/2015
22182

☐ Subcommittee
☐ Conference Committee

Donald Mueller Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill to provide an appropriation to the state department of health to expand a dental sealant program for elementary aged students and for a dental case management pilot project.

Minutes:

Attach #1: Testimony by Cheryl Underhill
Attach #2: Testimony by Marcia Olson
Attach #3: Testimony by Brent Holman, DDS
Attach #4: Pediatric Oral Health - The use of Case Management to Improve Dental Health in High Risk Populations

Chairman Judy Lee opened the hearing on SB 2197. All senators were present.

Definition Acronyms: HRSA = Health Resources and Services Administration)

Senator Bekkedahl (District 1), dentist, introduced it to the committee. I am the prime sponsor of SB 2197. It is an appropriation of some monies to do two things: (1) to expand the dental sealant program, $150,000 to expand that program (2) and $50,000 would go to a case management pilot project for high risk students to find a provider, access dental services and navigate some of the insurance hurdles that they find to get care. What we are attempting to do here is to try and move another one of the barriers to care that we've seen for children that are most susceptible to these issues.

Senator Warner asked a technical question. My understanding dental care is an infection. Is that right? Senator Bekkedahl replied yes. Senator Warner replied it is a bacterial infection. When you put a sealant over it, do you need to somehow sterilize and have killed the infection or do you seal the infection inside?

Senator Bekkedahl answered yes, that is correct. What happens is when decay starts but doesn't penetrate the upper layer which is called the enamel, into the lower layers which is then more susceptible to damage. You do a process called enamel-plasty which you put a small bit in a dental drill which we call hand pieces, and we go in and remove the decayed portion of the enamel, then put on the sealant. Once you get down to hard enamel structure, so you never leave that carious material in the bacteria in that place when you

seal over it. If you do, you run the risk of the decay further penetrating and causing a problem later.

Senator Warner asked does a person who applied the sealant have to have technical training and how deep to go, technique, what kind of qualifications are that would be relative to getting rid of that infection rather than just simple paint brush and painting on the sealant?

Senator Bekkedahl replied that he does that care himself, and he also does the sealant. But the hygienists are licensed to do the sealant. I still do that because I want to be there for the removal of that tissue. To me it is still a surgical procedure and I would like to be doing that. But that is just my personal preference.

Cheryl Underhill, Executive Director of North Dakota Oral Health Coalition, testified IN FAVOR of SB 2197. (Attach #1) (5:50-8:36)

Senator Warner asked about the geographical boundaries of the pilot project. What community does it serve or does it go once over lightly the entire state?

Cheryl Underhill referred to Dr. Holman that will provide further testimony that would answer those questions.

Senator Dever asked just to put the $150,000, into perspective, how much are we spending now?

Cheryl Underhill referred further testimony by future person to provide that information for you.

Marcia Olson, Executive Director of Bridging the Dental Gap in Bismarck, testified IN FAVOR of SB 2197 (Attach #2) (10:48-16:34). In reply to Senator Warner's question, the public health hygienists and those who come out from the Ronald McDonald Care Mobile, into the school based project do not do any drilling to remove any cavities; they only place the sealant on teeth that does not have cavities that are visibly identifiable.

V. Chairman Oley Larsen when you are doing the Ronald McDonald and going to the schools with free and reduced lunch, what kind of data are you collecting from these students? Are you gathering data that their parents have the new Medicaid expansion or medical insurance for free?

Marcia Olson indicated they do collect information self-reported income and also self-reported about they have any coverage with any health plan. There is always miss-reporting, and this takes staff some time trying to contact parents to find out if there some insurance. Sometimes we track this down by contacting the Medicaid office. Regarding the expanded program, it is still filtering down, so only have a few, mostly in-based around Bismarck/Mandan.

V. Chairman Oley Larsen asked if they contact the insurance department and gather the list of the agents that are qualified to enroll people on the Medicaid expansion and the

marketplace and have them team with those people to gather that information that they would be willing to do?

Marcia Olson indicated they do not because not enough staff, but that is why they have requested the case manager program. We want to see if that would help to eliminate up front, some of those issues and help them get signed up for some of those programs and also get them placed in a dental home.

Senator Axness asked what the level of funding from the federal government that was reinstated? Do you know what that number is?

Marcia Olson indicated the total amount covering the sealant project is $310,457 dollars. Of that, Ronald McDonald Care Mobile will receive $ 94,000. NDSU has $16,000 to be paid for evaluation studies that is required of most of the federal grants that we've had to find out if we're doing what we say were doing; Health Department about $200,000 to service those 1900-2000 kids.

Senator Dever asked in my understanding that children who go to the dentist receive these services. Is this to target those who are not going to the dentist?

Marcia Olson indicated yes. Primarily, the idea is to service in schools that have the most free and reduce lunch and for the most part, those are the students that do not go and get these services taken care. There will probably be some that get covered that probably could and there is no charge to them. But, there is no way to necessarily filter out every single person.

Chairman Judy Lee indicated that people who receive free lunch might also receive expanded or regular Medicaid. There is a certain percentage of students in a school that all the students in the school get this service because some might be insured and there are others who may have dental services either or the ability to pay, or insurance that covers it. So, I certainly support the program, but that is a bit of a struggle for me.

Marcia Olson replied that she can understand and appreciates that. We do request info from each of the people that are coming to get our services, if they have seen a dentist or have a dental home where they have been to in the last two years, then we do not address that, while we turn them down, but if they have not been to anybody in the past 2 years then we will see them. (ended 22:00)

Dr. Brent L Holman, DDS, testified IN FAVOR of SB 2197. (Attach #3) (22:50-26:03)
Attach #4 included. In reference to Senator Warner's question, the literature does say if you can visually identify no decay, that if you have the intact sealant, the decay will not progress. That is the academic status. In reference to what Senator Lee said, he also has heartburn about the idea that we want to make sure this is for high risk children that do not have a dental home and my understanding is those are questions that you try to ascertain that fact and that would be an important goal of what you're doing when you're looking at families and getting their consent before you do this as well.

Senator Warner hygienists were making small talk and she determined that he lived in the county and then she opened his mouth and asked if you lived south or west of Minot? We live southwest of Minot. How could you know that by looking at my teeth? The hygienists replied that because the area south and west of Minot has natural fluoride in the waters and the areas north and east do not. Are those kinds of geographical determinants, urban, rural, fluoridated water, non-fluoridated are they relevant to making determinations as to where these projects would geographical area these projects should be centered in?

Dr. Holman answered the current study is about low income school federal subsidized school lunch programs being the criteria. But it is correct that it could be geographical, and again the target is high-risk kids. From a technical stand point when a kid screened, and it's part of the sealant program that is in place, the idea would be as an example, this is not to be determined yet, but if you see 4 cavities and some etchings on the teeth that have high acid content and matches up with some diet history that you have, that might be the risk assessment tool we have, but we're not sure yet. But if it is, that would link you up to a potential group of children that you fan estimate based on what the studies say. If we're hoping based on this, were thinking we can handle 100 and would provide enough data to determine the criteria. Want to learn from this, 100 children, and children would not have gone to the dentist and gotten treatment completed. That is the whole point of this and also to develop criteria for how do you evaluate whether that savings is worth talking to Medicaid about this being pay for that service which is case management which before has not been covered. You start out with some designation and gets' you closest to the population of low income which for us in dentistry has most of the dental disease. That is pretty much shown in the literature. 80% of the dental disease is in 20% of the population and that is predominantly in low income individuals.

Senator Dever asked is this $150,000 is to supplement other moneys already now included in the proposed budget in the Department of Health? How much is that?

Dr. Holman indicated yes, the $150,000 is an add on to the funding already there for the sealant part, and the $50,000 is our estimate of what it would take to add that additional component most of which would be the technical assistance consultant that would figure out how to develop our evidence in our data tracking.

Senator Dever asked what they have in their department.

Dr. Holman referred to Department of Health who will be able to tell us that.

Chairman Judy Lee if more dentists saw more Medicaid patients, why do we need case management because they just get the services and find out if they need services. What I see, is a way to have another layer of administration here but not providing more services to the kids who need it. So help me understand why this is better?

Dr. Holman responded that there are many different reasons why folks don't go to the dentist. Having the availability of dentists is one, cost of the services, but there are other factors there as well. What we're trying to do is figure out; we know those folks are out there that don't access the dentist for whatever reason. We can find out more about that population and more importantly find out a way to institutionalize out-reach and the private

dental practice which is the whole goal here. To develop a reimbursement system that saves Medicaid money and it would seem to be a good public health investment to say how can we get to those folks that don't go, in this case children?

Chairman Judy Lee indicated that we have Medicaid funds that aren't used because they can't find a dentist who will see them. So even if we have the funding, the barrier is finding someone who will see them, not telling that they need to be seen. The young invincible didn't want to go to the dentist because their teeth didn't hurt. These are children, but they aren't going to the doctor either. This is a complicated problem. It is a separate question. There was testimony in earlier sessions with resistance on the part of the dentists to Ronald McDonald Care Mobile? You've worked all that out and say you are collaborating on this or do you still have some resistance to that service?

Dr. Holman answered the other question. I don't think there is any doubt that case management isn't the solution, it is one of a lot of a potential solution. An effective solution is to do as many things as you can, as Medicaid participation by dentists a problem, no question it is. Again there are multiple reasons for that. I think we always have differences in anecdotal information versus what we can gain by Medicaid data, but I can tell you our practice in Fargo will see Medicaid children in a day or two, and all the pediatric dentists there do that the same. We can see a child with major problems in the hospital in a week. That is probably true and we are documenting that around the state. But the answer is it is not one thing. You try to work on all of that. We try to work on getting people to understand that it would be good if you have openings in your schedule and you feel its fits your business model you need to be seeing Medicaid patients. We can do better at that. There is no question about that. But, there isn't any one silver bullet. Case management is something we're trying to learn from; it's not seen as the solution and it may not turn out to be that it works real well but it makes sense based on data that we have nationally that outreach is the key to getting those folks that will not go to the dentist for whatever reason. When we did the mission at Standing Rock, the folks at Standing Rock they knew the kids that had major decay problems and where they lived. They knew that they needed to get their on the two days that we had 20 pediatric dentists there, and on the last day we were thinking about leaving and they said we know these folks are down the road 3 miles and we've even offered to go and pick them up, but we cannot get the kid here. So, you know there are other things there, a list of things that are documented. But you try to do all that you can. I don't disagree with you, Medicaid participation is a problem and that is something you try to improve.

Chairman Judy Lee indicated that they appreciate what has been done in those special programs too. There have been some really good things done with the reservation and some other things. My question about whether or not you have resolved the differences that you might have had at one time, organizationally, with the Ronald McDonald house?

Dr. Holman indicated he is new to this, and has no issue with the Ronald McDonald house. Anything you can do to find ways to go out and meet the need is what we should be doing. There are differences in philosophies about how to do that obviously, but I don't think the goals are any different between the dental profession and everybody else. I certainly at this point would recommend or say to you that we fully support the care mobile and other things that try to get outreach. Outreach is very important, that is what this program is all about.

Chairman Judy Lee I know that the Blues used to pass through dental insurance, and now that has ceased, and so those funds have now been directed to the Dakota Medical Foundation and I believe there is a board which includes if not all the majority will probably be dentists in determining in what that money will be used for. My understanding is that it is supposed to be used for access. I sent a message to find out what the money was and its $6.3m dollars. So, why wouldn't you be looking at that fund to really expand this project on case management rather than state funds?

Dr. Holman Again I cannot speak for that group, but I can tell you that certainly fits among many other things that will be talked about that fits the mission of the foundation. The practical answer is it's an endowment, so we don't have any money $6.3 M to spend until it is earned 5%, so that could be a year or two depending on the market. I have no doubt that would be a ready source for that and I think this is part of because we need to start getting data about how this works, looking for any source. It's a partnership whether it's state money or grant funding. Grant funding is obviously is where we actually thought we were going to have through DentaQuest, in the summer time and that didn't pan out to be the case. So we're looking for other ways to find out more information about it. I agree with you that fits perfectly and I have no doubt that will be one of the things that is considered.

Rod St. Aubyn, representing North Dakota Dental Hygienist Association, testified IN FAVOR (no written testimony) (38:38-40:36) In terms of the North Dakota Hygienist Association we are very much in support of the dental sealant program. **V. Chairman Oley Larsen** asked about some of the insurances and some of that. I think it is important, in my previous life, in Blue Cross Blue Shield, one of the thinks with the ACA, the Affordable Care Act in determining the essential health benefits, it is good to remind everyone that every health plan must include the list of essential health services, which includes toward the bottom of the list, preventative pediatric dental and vision services for children. Theoretically, everyone should be on insurance or Medicaid or the expanded Medicaid. In reality we do know there are a lot of people that are still currently uninsured. Many of those probably could either receive significant subsidies or be recipients of the extended Medicaid, or Healthy Steps. I am hopeful that we can actually expand some of the dental sealant program for children just because of the access to health insurance services.

V. Chairman Oley Larsen if we kill this bill, do you think this will this force people to go and access that insurance that is free to everybody? Is that an essential benefit that is for everybody?

Rod St Aubyn responded that he has his doubts that this will happen. This is an outreach to get to the children. Part of the problem is the children aren't reaching out to the dentists or to the dental hygienists. We are supportive of the dental sealant program for sure.

OPPOSITON TO SB 2197
No testimony opposing SB 2197

NEUTRAL TO SB 2197

Chairman Judy Lee asked if someone from the North Dakota Department of Health could respond to an earlier question about the money that we had and lost and it's back again. If you could just give us a little short report on it, that would be very helpful.

Kim Mertz, Director for the Division of Family Health in North Dakota Department of Health (42:19-44:55) No formal testimony. She responded as far as the information on our federal funds, Marsha provided good information. What happened is we do have grant from Federal Government for oral health. Currently, the total grant funding for that is $427,000. But as Marcia pointed out $310,000 is specifically earmarked for sealant program. The rest of that money were using and were doing long term care projects. The elder population also has an incredible need for oral health services as well. So what happened is we had this funding for several years and we were able at one point we were in over 50 schools, serving about 2,000 children. What happened is then the grant cycles for these funds are only three years. So, then the 3 years came and we wrote another grant and unfortunately we weren't funded. As Marcia pointed out what happened at that time, then we had to lay off all of our four public health hygienists. We did use some existing Maternal and Child Health Funds that we had and were only able to provide services in two schools. So we went from serving plus schools down to two schools. Those two schools we selected were really the highest need schools. The next year we got a notification from HERSA that we were reinstated and the funding again which was terrific. What happens with that is now currently were in our first year of our grant cycle, and will have two more years left, so those funds will go through 2017. What happens with the federal funds is that it's great when the money is there. We try very hard to have a very sustainability plan and so unfortunately what happens though when the funding goes away sometimes so does the program. What happened when we lost that funding and we went from the 50 schools to the 2 schools is really what happens to that is that it's really a disruption in services. All of a sudden serving 2000 kids, then we get down and serve less 100 children. We really know that it's really disruptive. I believe the point in bureau health coalition and the other supporters of this bill is really to insure that if federal funding goes away a base program will always be able to be maintained. To answer your question, Senator Dever this money is not in the Governor's budget.

Chairman Judy Lee asked Kim Mertz if they had some money in the Governor's budget is that correct or is just a federal grant?

Kim Mertz replied it is just a Federal Grant that we have. There is no other additional money for this program.

Senator Howard Anderson, Jr. asked Kim if she could explain to them how the case management program would actually work and answer Senator Warner's question about the scope, is it physically limited or does it cover the whole state. How do you envision it working within your department?

Kim Mertz replied (45:23-47:48) $50,000 is not very much to do case management for a biennium and so really what we would be doing is we would be looking at a very small school so a small pilot project. Case management is complicated as it takes an incredible amount of time and energy to work with families. It's not just trying to get families into the dentist. It's really trying to get them to navigate the system. That is kind of what case

management is about. It's working with the families to certainly educate them but also what case managers do is help them overcome the barriers. Navigating different systems is very difficult. First of all if is they don't have insurance, can we hook them up to insurance. A lot of families know that is out there but it's difficult for them to actually figure out how to navigate, get on line, fill out the paperwork, do all of that stuff. Case management can help with that. In addition to that, there are things, like transportation, where there is really one of the greatest needs that we hear about all the time. Families have a lot of trouble with transportation. How can we help them with that? Geographic barriers, maybe they are 60 miles from the closest dentist. Also, working with dental offices is the other thing; but being that liaison in between to actually help the family kind of link to that dental office. So case management is complicated and it takes a lot of time. I see this as being again a pilot in a small school to see what we can really do. Hopefully with that data we can show that the children really will have increased access. The whole point of this is to link children to a dental home. Our sealant program in the schools is not taking the place of a dentist. It is not taking the place of a dental home. We are not only there putting sealants on kids' teeth and putting fluoride varnish in but, we're there to educate not only the children but we send information home to the parents as well. We ask them to follow up with your dental home. If you don't have a dental home and you need dental care, they can contact us and we will help them. Now a case manager at a school could do that at a much better level than what just our hygienists and our oral health staff at the state can do.

Senator Warner replied that it strikes me as it might be useful to use this as a module that you plugged into an interaction with the family on some other projects. It might not be medically related. It seems like it is a stand-alone project of $50,000 doesn't go very far. But if you could piggy-back on to something else, would that be useful?

Kim Mertz replied certainly. I would agree that $50,000 is a very small amount of money especially when you're talking about a biennium. Whenever were doing any type of project where pilot work implementing a full program we are always looking on ways that we can piggy-back or collaborate with projects that are already existing to really make sure that we really leverage our resources. So while we haven't done any work on that, that would be something that we could look into.

Senator Howard Anderson, Jr. One of the options that V. Chairman Oley Larsen talked about is federal government is spending a huge amount of resources to facilitate this, partnering with one of those facilitators to help them through this - is that an option?

Ms. Mertz indicated yes, we do have navigators in the state, link people to insurance and that would be a very good suggestion.

V. Chairman Oley Larsen asked about the role that the IEP team and school counselors play in this other part? I have been on these IEP teams in my education hat, and if there was a problem that comes up that team meets together and we get the answers done. So, are you going to be part of this IEP team and counselor team as well then?

Ms. Mertz indicated that currently they do not have input into the IEP or the IHP. I don't know how many of those Individual Education Plans or Individual Healthcare Plans or 504's in school actually include oral health in them as they need that a child has. Oral Health is

an incredible need as you know. If there would be a case manager pilot program in a small school, that case manager may be very effective to be part of that team. Currently right now we are not linked to that.

Chairman Judy Lee There is other areas of need with intellectual disabilities or other disabilities. What about refugees? The catch 22 is that the Family Health Care center in Fargo provides dental check-ups when they come. Up until recently, they could provide services. Now under Medicaid expansion, refugee Medicaid program can no longer cover services if these individuals qualify for expanded Medicaid. Our expanded Medicaid, right or wrong does not include adult dental services. So the folks that are coming in, the top 2 countries from which refugees are coming into the Fargo area right or into Cass County are Nepal and Bhutan. There is not reimbursement, and there used to be done. I think it would be smart if that Refugee and Medicaid program would cover the services that are not provided under expanded Medicaid. But right not we got nothing. So we've got several hundred people who are coming in, many of whom have extraordinary services. You might also be surprised to know that the Spanish speaking refugees and immigrants are # 5 in the list of countries from whom our folks come, 3 is Somalia. We love the fact that there is great diversity that is added to our community and they have added to the work force in ways that we would have had a very hard time replacing if they weren't there. But there are challenges to schools, health care, and our schools and communities have responded in quite remarkable way. But we still have folks that we cannot serve because of the Medicaid refugee program. There has to be a way to reinstate those services, not limited to children.

Ms. Mertz confirmed. Intellectual disability or other health care needs, a huge population that is underserved, and very few specialty dentists in the state will see them. This is a multi-prong approach that we have to do to address this issue. It is not a simple thing. By us, being in the schools with the school based dental sealant program, and providing fluoride varnish it is one approach of many that have to be taken. Even though a child does have health insurance that doesn't assure them that their parents are going to take them to the dentist. Just by the fact of having insurance, your chances are better but we know that some of those of kids don't get their either.

Senator Judy Lee Closed Hearing on SB 2197.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2197
1/20/2015
22232

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

"Click here to type reason for introduction of bill/resolution"

Minutes: "Click to enter attachment information."

These minutes are from committee work on January 20, 2015.

Senator Howard Anderson, Jr. indicated that when he looked at the $50,000, and we asked questions about that, he was surprised that the $50,000 for case management would need to be applied to one small school.

Senator Warner stated he was concerned about the same part of the bill. It would work better for more comprehensive view of client needs where it may be more appropriate for a social worker to do this function, or as a component of some other point of access.

Chairman Judy Lee indicated that we are talking about screenings of preschoolers who are preparing for kindergarten. Chairman Judy Lee provided input on integrated services, and doesn't expect them to be dental experts, but this could provide opportunities and not sure the case management project in once school does it. (2:30)

Senator Howard Anderson, Jr. indicated maybe the department will use facilitators from school rather than from the department. Senator Howard Anderson, Jr. didn't think we have to put anything extra in the bill.

Chairman Judy Lee asked if Senator Howard Anderson, Jr. is asking for an amendment that deletes that portion of the appropriation. **Senator Howard Anderson, Jr.** said no, but **Senator Warner** would be open to this.

Chairman Judy Lee discussed that if we were to leave in the $150,000, and we removed the $50,000, which is deleting on line 8, beginning with "and", all of line 9 and line 10, and on line 11, "through management." Chairman Judy Lee asked the wish of the committee.

Senator Dever shared the concerns of the other members, but $50,000 isn't a lot of money. Perhaps it should be left in.

Chairman Judy Lee indicated we could let the appropriations committee remove it if they want.

Senator Dever indicated that the $50,000 could be added to the $150,000 and further expand. The bill states "to expand" as if we already have it as a state program, but we previously have not provided funding for this program.

Chairman Judy Lee indicated that the Department of Health really counted on the federal grant. Previously, our committee was frustrated that the Department of Health didn't tell us that this was threatened. Then when we found out it wasn't there, and the Department didn't know and didn't suspect that there would be a curtailing of those funds, it becomes messy, especially when the feds fund it for three years and then drop it for one year, and then they bring it back in for three.

V. Chairman Oley Larsen stated his issue is that we are going to pile on yet another person to navigate Medicaid or health insurance options. In school systems, children have IEP's right when they hit kindergarten if they need them. If that kid didn't have proper hygiene, medical, housing, more learning, it was known. V. Chairman Oley Larsen worked with a school in New Town, an agent would come in and would help enroll people into Obamacare and get free health insurance and free dental insurance. People are not utilizing this. Now we want to add another case manager to help utilize that again and add another thing when we have 253 agents that are willing to come into any location and meet with these people and educate them and enroll them. The navigators should be formulating this and schools should be working with these families to get the free agents to counsel them and enroll them and get the job done. So I am opposed to giving them any more money to increase more people to do what isn't being done that free people will do.

Chairman Judy Lee stated that we've had our challenges over the years with getting CHIP enrollment, that is on the schools, free and reduced lunch applications, who to contact to have CHIP enrollment information, and it's been a struggle, particularly with the reservations because they feel the treaties require the feds to provide the medical services, but if they would sign up for CHIP, those dollars would be freed up for other issues.

V. Chairman Oley Larsen again reiterated the job of the navigators today. These folks are there to provide that information.

Chairman Judy Lee can the schools give a list of the navigators or insurance providers?

V. Chairman Oley Larsen answered absolutely. The problem is they feel its more work than what it's worth. That's their job. They are the liaison to get these services.

Senator Dever withdrew his previous comments. You can take a horse to water but you can't make them drink. I understand that one of the biggest problems that dentists have with Medicaid patients is they make appointments and don't show up.

Chairman Judy Lee stated that she is sympathetic to that. But at the Family Health Care Center, they have unscheduled time, first come, first served. Considering it is free or sliding scale fees, she doesn't find that to be awful. If there is too many people to serve in that stretch of time, and they were open 4:00 to 7:00, it was into the early to mid-evening, so folks after work could come. The persons who might be there and who would not perhaps be served at the end of the day, they would be given an appointment time certain for the next time they could come so they didn't have to keep coming. If they were from out of town, they were served then regardless. The clinic in West Fargo didn't have appointments, and so anyone who came to the clinic was first come first serve. Those situations where people don't keep appointments and the thing to do is, then have a block of time where they'll see Medicaid or uninsured patients - first come first serve.

V. Chairman Oley Larsen made a motion to AMEND SB 2197 to remove the $50,000 for the dental case management, and continue to leave the appropriation in for the sealant program. The motion was seconded by **Senator Dever**.

Discussion:
Senator Warner indicated that the wording for $200,000 will also need to be fixed.

Roll Call Vote
6 Yes, 0 No, 0 Absent.

Senator Warner made a motion that the Senate Human Services Committee give a "DO PASS" pass recommendation for SB 2197 as amended and re-refer to appropriations. The motion was seconded by **V. Chairman Oley Larsen**.

No discussion.

Roll Call Vote
6 Yes, 0 No, 0 Absent.

V. Chairman Oley Larsen will carry the bill.

15.0684.01001
Title.02000

Adopted by the Human Services Committee

January 20, 2015

TD
1/20/15

PROPOSED AMENDMENTS TO SENATE BILL NO. 2197

Page 1, line 2, remove "and for a dental case management pilot"

Page 1, line 3, remove "project"

Page 1, line 6, replace "200,000" with "150,000"

Page 1, line 7, remove "of which $150,000 is"

Page 1, line 8, remove "and $50,000"

Page 1, remove lines 9 and 10

Page 1, line 11, remove "options, and gather data to demonstrate the efficacy of dental case management"

Renumber accordingly

Date: 01/20 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2194

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0684.01001 Title .02000

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Larsen Seconded By Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 01/20 2015
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2197

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0684.01001 Title.02000

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Warner Seconded By Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Larsen

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2197: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2197 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "and for a dental case management pilot"

Page 1, line 3, remove "project"

Page 1, line 6, replace "200,000" with "150,000"

Page 1, line 7, remove "of which $150,000 is"

Page 1, line 8, remove "and $50,000"

Page 1, remove lines 9 and 10

Page 1, line 11, remove "options, and gather data to demonstrate the efficacy of dental case management"

Renumber accordingly

2015 SENATE APPROPRIATIONS

SB 2197

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2197
1/27/2015
Job # 22617

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Erin Liebelt for Alicia Delzer

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation to the state department of health (DOH) to expand a dental sealant program for elementary aged students.

Minutes: Testimony Attached #1- 3

Chairman Holmberg: Called the committee to order on Tuesday, January 27, 2015 at 11:00 am in regards to SB 2197. All committee members were present. Lori Laschkewitsch, OMB and Sheila M. Sandness, Legislative Council, were also present.

Senator Brad Bekkedahl, District 1, Williston, and Prime Sponsor of the Bill: Testified as to what the Bill does. I am a dentist by profession, so this is an issue I have great understanding of. He explained the procedure that is done in the sealant program. It was established through a federal grand process in the past through the department of health and they have established dental hygienists that actually go into the school districts and apply this sealant that prevents the decay. It is targeted to low and moderate income children. There are qualifications that the school has to have for the amount of low and moderate income children in their school to qualify to even have the sealant program in their school. The federal program comes and goes, it was dropped from its funding appropriation and the department of health had to lay off all of the four staff people that apply these sealants in these program areas. We were serving about 2,000 children a year, if it were approved this $150,000 would continue the baseline operation of this program. The federal money which has most recently restored will supplement than and give us the bonus of servicing even more children. (:47-3.54)

Senator Carlisle: Was this vetted in the Governor's budget with the Department of Health or is this outright new money? You made a comment about somebody approving it, what did I miss?

Senator Bekkedahl: Yes, this was a bill that was approved out of Human Services Committee to come with appropriations of only a $150,000 for your review. It went through the floor at the Senate. This was not in the governor's budget, it is new money.

Senator Sorvaag: The federal government is funding part of it, how many children are going to be treated by what they did?

Senator Bekkedahl: They are serving about 2000 children per year with the current federal funding. This would service an equal 2000 number of children. With the federal funding it offers the opportunity to serve 4000 children and the case load is much higher than that.

Vice Chairman Bowman: Is it to purchase the sealant or is it for someone to do the procedure?

Senator Bekkedahl: The bulk of the funding is to maintain the staffing for the program and the rest for the sealant.

Senator Robinson: What's the amount of the federal funding?

Senator Bekkedahl: I do not know. We have somebody here that can answer that question.

Senator Wanzek: Is what I hear you say is this can save a lot of dental costs down the road for these children and how long will it work?

Senator Bekkedahl: You're exactly right and they have information that was provided in testimony in Human Services. The biggest savings is I am not treating a six year old child with a huge tooth ache.

Senator Gary Lee: With this program, are these children covered with Medicaid or is this a supplement to those particular services provided by Medicaid?

Senator Bekkedahl: Many of them would already qualify for the Medicaid services. This is one of the attempts that North Dakota Dental Association made to remove more barriers through the oral health coalition. One of the barriers we see is children not getting to the dentist. This program was to bring the care to the child in the school, I served in a clinic for 10 years, the biggest barrier was getting the kids for treatment, and transportation is a big issue. The case management part which you don't see in here which had a $50,000 appropriation was to put someone in place that would take those children that we see have neglected care and place them into a system where we get them to care. That was removed at the request of human services committee.

Senator Gary Lee: In terms of Medicaid, are any of these children being paid for under Medicaid coverage or you're saying it's too difficult a program for them to access because of transportation and things like that?

Senator Bekkedahl: This is a way to get to those children that are not being served for whatever reason and this is the way to get to those children. We do it already with the head start program but we are missing children and this is an attempt to get the service that saves all of us in the long run.

Senator O'Connell: If you had enough money to serve everyone you possibly could see, how many could you serve?

Senator Bekkedahl: We would like to get to all of them but I don't know that number. This again, this puts us into a position to start identifying some of that.

Senator Heckaman: When you go into a school are you identifying the whole school as eligible?

Senator Bekkedahl: As I understand, I believe most of the schools identified are through the school lunch program, it is my understanding that all the children get looked at that point.

Representative Kathy Hawken, District 46: Testified in favor. I am an advocate to get some money for major issues for children that need dental care. This is a preventive piece; many of these children do not have that opportunity to get to the dentist. This is an extremely positive thing for not a lot of money. I am sorry about the case management piece was removed. It can save the state of North Dakota money but more importantly it helps the children have a healthy life. I hope you will see your way clear to fund it.

Vice Chairman Bowman: We had a mobile dental unit that goes out to help the families.

Marsha Olson, Executive Director of Bridging the Dental Gap in Bismarck: Testified in favor of SB 2197 and provided Written Testimony Attached # 1, explained the sealant program and the benefit of such a program. The purpose of SB 2197 is to provide funds to expand care to approximately another 2000 children. You asked what the current funding was for the existing project that was funded by the Health Resource Service Administration; the total amount allowed is $310,457. Of that $16,000 is to be used by NDSU as an evaluation tool, and they are to report back to HRSA on how we have done and whether or not it is a good program to continue with. The Ronald McDonald Care Mobile, the contract with them is about $94,292 and the care mobile will expand sealants to the schools they are going to service already based on their program. We will hire more hygienists that will be connected to the care mobile program. You need to know that with the care mobile not all kids want to come in and have the care done but if was just the hygiene cleaning and placements of sealants they are much more open to those types of services done. The bottom line would be that $200,000 would be what is left to run the North Dakota Health Departments Dental Sealant Project. (15:34-23:28))

Chairman Holmberg: You mentioned schools, is your program school specific or school districts specific?

Marsha Olson: School specific.

Senator Sorvaag: When they do the sealant, it is not an exam but I presume they identify further problems they can hopefully refer from there?

Marsha Olson: There is a report that is filled out, that says they were able to seal a number of teeth and also would put that they saw decay on a number of teeth if that was

the case. They send home a note to the parent recommending the child go to a dentist for further dental care. Senator Gary Lee's question regarding Medicaid, about 40% is Medicaid and the rest is non Medicaid but that does not mean that some of them would not qualify for Medicaid it is just the appropriate people have not contacted them to be able to get them signed up. The care mobile program can bill Medicaid but the state cannot. It's all kids in the school are eligible to be seen. The care mobile requests, if a child has seen a dentist in the last two years, they would not see them because they think they have a dental home. And they would try to see the other children.

Senator Heckaman: Said she had two questions. The first one is there still funding for fluoride rinse? The second question, has there been any coordination with the sealant program with Indian Health Service Dental?

Marsha Olson: Yes there is funding for the fluoride rinse but not sure how the other is coordinated. Indian Health Service sites are a lot of where we go with the care mobile and for the state program. (26:30-27:10)

Cheryl Underhill, Director of ND Oral Health Coalition: Testified in favor of SB 2197 and provided Written Testimony Attached # 3. She gave background on the coalition. (27:51-29:13)

Senator Heckaman: On your handout here you say3rd graders is that the year you are focusing on?

Cheryl Underhill: Yes I also wanted to mention on the handout the taxpayer's savings estimate is very conservative.

Senator Heckaman: On the head start programs that you service do they compensate you then?

Cheryl Underhill: I will allow our department of health representative to get into that.

Senator Mathern: What is the coalition position regarding the case management?

Cheryl Underhill: We support the case management proposal.

Senator Mathern: Why is that not in the Bill?

Cheryl Underhill: That was removed but she does not know why.

Dr. Brent, Director of the ND Dental Association: Testified in favor of SB 2197 and provided Testimony Attached # 3. Questions asked about fluoride treatment. (30:59-33.18)

Chairman Holmberg: Any other questions?

Senator Carlisle: Question for Lori Laschkewitsch where in the vetting process in the department of health did this fall or how was it presented if it was?

Lori Laschkewitsch, OMB: It was not included as an optional request in the health department's budget it was a legislative initiative.

Chairman Holmberg: If no one else wishes to testify. We will close the hearing on 2197.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

2197
2/12/2015
Job # 23770

☒ Subcommittee
☐ Conference Committee

Committee Clerk Signature: mmonson for Alice Delzer

Explanation or reason for introduction of bill/resolution:

A Subcommittee for DHS dental sealant.

Minutes:

Senator Kilzer called the subcommittee together on Thursday, February 12, 2015 in the Senate Conference Room in regards to SB 2197. We do want to put it in perspective with other programs.

Present: Senator Kilzer, Senator Erbele, Senator Mathern and Lori Laschkewitsch, OMB and Michael Johnson, Legislative Council.

Senator Kilzer: Why isn't it in the Health Department? Marcia can you give us a little history?

Marcia Olson, Executive Director for Bridging the Dental Gap: I did testify in the Human Services policy committee to support this bill. This bill appropriates $150,000 to be added to the Seal North Dakota Program. There's an existing Seal North Dakota Program which happened to get put back into effect in November because originally we were doing it solely on money from the feds and that money was taken away from us.

Senator Kilzer: How much was that?

Marcia: Another $150,000.

Senator Kilzer: So this is making up for it?

Marcia: Actually, no. What this is designed to do is to let us expand the program from that basic service of $150,000 which serves approximately 2000 kids to an additional 2000 kids across the state.

Senator Erbele: You're saying that in November that $150,000 came back?

Marcia: Yes, HRSA (Health Resources Services Administration) had denied the state's request. They originally funded that program. When they denied the grant then we had to let go all of the public health hygienists that were serving the ND schools. We were only able to service with money left over two schools, St. John and Warwick. After that we were not able to go out to any more schools. HRSA came back in September and said they would be interested in funding the grant we originally proposed. We started putting together the budget and they did end up funding us. In November we started going out to several schools and we are trying to catch up with some of the schools that we had to miss. What we want to do is expand the program and serve 4000 kids rather than 2000 kids. We want base funding so if HRSA takes it away again, there will still be some money to continue providing these services to the base numbers of children we are serving with the SEAL ND Program. The SEAL ND program is for the lower income.

Senator Kilzer: There is $150,000 in the health department. Did you ask for another $150,000?

Marcia: No, we did not. This bill is being sponsored by the Oral Health Coalition.

Senator Kilzer: The Health Department budget is over in the other side. Is there a reason why you would bring it to the Senate, why not in the House?

Marcia: We were following the advice that was given to us. This was initiated through the Oral Health Coalition.

Senator Kilzer: Do they have other bills?

Marcia: They have one other bill. That is the dental loan repayment program. There are two different programs and we are trying to consolidate into one so it's not as confusing.

Senator Kilzer: Are there other dental bills by the oral health coalition?

Marcia: There's money that would be in the Health Department's budget that would cover some of the oral health field. I don't know all the pieces. There's also the dental therapist bill and the bill for board of directors.

Senator Kilzer: The Ronald McDonald. How does that fit in?

Marcia: The Ronald McDonald has the care mobile. They do have some funding in the oral health budget in the health dept.

Senator Kilzer: They have had some independent bills. There are none now.

Senator Kilzer: You've had some expansion over the years, right? Or have you have stayed at $150,000

Marcia: They have stayed at 150. This would allow more kids, double it, and more schools.

Senator Kilzer: So this is an expansion type of bill, is that correct?

Marcia: Yes, and then hopefully, in the long run, would provide a base funded by the state rather than being dependent on the feds who may pull their money.

Senator Erbele: Do we put the fed dollars at risk when we help support at the state level? He was told no.

Senator Mathern: This received considerable support during the interim committee. It was more a matter of how to move forward. There was debate about income test or not going to the schools. In that regard, the committee didn't come forward with the bill. But it was widely supported as probably the best thing we could do to prevent cavities in kids. The goal was that eventually each kid would have a dentist. Until that happens at least they could get the sealant on their teeth. It prevents a lot of problems. I would encourage us to take action on this.

Senator Kilzer: It will be in our list of priorities. I thought there was a school free lunch program.

Senator Mathern: The schools that have the highest number of free lunches are the schools on the agenda.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2197
2/17/2015
Job # 24028

☒ Subcommittee
☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation to the state department of health (DOH) to expand a dental sealant program for elementary aged students.

Minutes:

Senator Kilzer, Senator Erbele & Senator Mathern were all present.

Senator Kilzer said that the fiscal note is $150,000 of new dollars plus $150,000 of old dollars.

They all agreed and vote passed.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2197
2/18/2015
Job # 24039

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation to the state department of health to expand a dental sealant program for elementary aged students.

Minutes:

Senator Kilzer said this program would expand the program to two more schools for an additional $150,000. The subcommittee gave it a Do Pass.

Senator Kilzer moved Do Pass.
Senator Mathern seconded.

Senator G. Lee asked how this fits in with the Ronald McDonald Dental Mobile.

Senator Kilzer said they are separate progams. The Ronald McDonald is dental care where they do fillings and extractions. This is application of a sealant. They choose the schools by the percentage of free and reduced meals. At the schools, they see all the kids, but the difference is that they do dental treatment and this is just a sealant progams.

Senator G. Lee: They don't work collaboratively? (Answer - No.)

Senator Mathern: There is an Oral Health Coalition that works together and this bill comes from that coalition. The sealant program works with the Ronald McDonald House. They go to the school where they do the sealants and then they have the Ronald McDonald Mobile coordinated so that when they find out this kid has cavities that are beyond what the sealant can do, they try to get that person seen through the Ronald McDonald service.

A Roll Call vote was taken. Yea: 13 Nay: 0 Absent: 0

The bill goes back to the Human Services Committee and **Senator Larsen** will carry the bill on the floor.

Date: 2-17-15
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2197

Senate Appropriations Committee

☒ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By _____ Seconded By _____

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Heckaman		
Senator Bowman			Senator Mathern	✓	
Senator Krebsbach			Senator O'Connell		
Senator Carlisle			Senator Robinson		
Senator Sorvaag					
Senator G. Lee					
Senator Kilzer	✓				
Senator Erbele	✓				
Senator Wanzek					

Total (Yes) 3 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-18-15
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2197

Senate Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☑ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Kilzer Seconded By Mathern

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		Senator Heckaman	✓	
Senator Bowman	✓		Senator Mathern	✓	
Senator Krebsbach	✓		Senator O'Connell	✓	
Senator Carlisle	✓		Senator Robinson	✓	
Senator Sorvaag	✓				
Senator G. Lee	✓				
Senator Kilzer	✓				
Senator Erbele	✓				
Senator Wanzek	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment ~~Mathern~~ Larson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2197, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2197 was placed on the Eleventh order on the calendar.

2015 HOUSE HUMAN SERVICES

SB 2197

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2197
3/11/2015
Job #24636

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Provide an appropriation to the State Health Dept. to expand a dental sealant program for elementary aged students.

Minutes: Testimonies 1-3

Chairman Weisz opened the hearing on SB 2197.

Sen. Brad Bekkadahl: From district 1 Williston introduced and testified in support of the bill. I am a practicing licensed dentist in ND and Minnesota. I've had a private practice in Williston for 31 years and have been a military dentist with Army National Guard for 20 years and served as a dentist at a tribal dental clinic in Fenton, ND for 10 years. I will be going into a reduced mode of practice. This bill is to expand a program we currently have which is a dental sealant program for school aged children that have low to moderate incomes. The sealant is a protective coating that prevents cavities from beginning. At one time we lost federal funding for this program which meant some children were not served. This appropriation for $150,000 would maintain the program and we serve about 2,000 children and with federal funding coming back on line, we could expand to serve another 2,000 children.

3:10
Chairman Weisz: Do you know how much the state is contributing now?

Sen. Bekkadahl: I'll defer that question.

Rep. Rich Becker: How long was the period not funded and how did it get refunded?

Sen. Bekkadahl: A year and a half.

Rep. Rich Becker: State or federal funding?

Sen. Bekkadahl: Federal. There has been no state funding prior to this for this specific sealant program. We are trying to establish a base of state funding so if the federal funding goes away again we can continue the program.

Rep. Mooney: You would use the federal funding first?

Sen. Bekkadahl: This would be added to the federal funding, but if the federal funding goes away we still have funding for the sealant program for 2,000 children.

6:30
Marsha Olson: Executive Director of Bridging the Dental Gap in Bismarck testified in support of the bill. (See Testimony #1)

12:49
Chairman Weisz: The 45% and 40% number you use for determining schools is that what you decided should be the...

Olson: We decided. Because of the oil funding status changing, some of the schools that use to be at 45% and 50%, there percentages have dropped. We are still serving the same kids and needs, but the data skewed things.

Chairman Weisz: At the school are 100% children eligible?

Olson: All children.

Rep. Fehr: Is there any way you can tell how much is saved by doing the sealants now?

Olson: Someone else is going to testify and can give that answer.

17:00
Cheryl Underhill: Executive Director of the ND Oral Health Coalition testified in support of the bill. (See Testimony #2)

NO OPPOSITION

Kim Mertz: Director of Family Health for the State Health Dept. gave some information. We are interested in the cost benefit and working with HERSA our grantee to find out what our cost benefit is. We have to have solid data and year to get those numbers.

Chairman Weisz closed the hearing.

Handed in Testimony
Dr. Brent L. Holman DDS: (See Testimony #3)

Chairman Weisz took up SB 2197.

Chairman Weisz: A $150,000. I don't know how well that is going to sell. If the committee wants it I will make a fight for it.

Rep. Mooney: Since the money would be used only if the federal funding went away.

Chairman Weisz: That is not what...

Rep. Mooney: That is not what he said?

Chairman Weisz: No. If they get this they will serve 4,000 children, but if the federal money goes away they could at least serve the 2,000 children they are doing now.

Rep. Hofstad: I move a Do Pass on engrossed Senate bill 2197 and re-referred to Appropriations.

Rep. D. Anderson. Second.

ROLL CALL VOTE: 11 y 1 n 1 absent

MOTION CARRIED

Bill Carrier: Rep. Hofstad

Date: 3-11-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2197

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Hofstad Seconded By Rep. D. Anderson

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz		✓	Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen	✓	
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	A				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert	✓				
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 11 No 1

Absent 1

Floor Assignment Rep. Hofstad

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2197, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (11 YEAS, 1 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2197 was rereferred to the **Appropriations Committee**.

2015 HOUSE APPROPRIATIONS

SB 2197

2015 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee - Human Resources Division
Sakakawea Room, State Capitol

SB 2197
3/23/2015
Job #25268

☐ Subcommittee
☐ Conference Committee

Kenneth M. Tarkh

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation to the state department of health to expand a dental sealant program for elementary aged students and for a dental case management pilot project.

Minutes: Attachments: Handout #1.

Chairman Pollert called the committee to order.

Rep. Robin Weisz, District 14, Chair of the Human Services Committee: Your committee did give this bill a unanimous Do Pass out of committee. A little background: There is a Federal program for sealants. The money was lost; I forget for how long, but they didn't have the funding. And so there was no program. Now that the Federal money is back, we do have a Federal, and they serve about 2,000 individuals. The bill in front of you would add $150,000 of state dollars, which in the testimony we received, would expand it to an additional 2,000 children that could be served with that $150,000. The other argument presented to us was that if we lose the Federal funding again, we would have the $150,000 to maintain the program, and so they aren't stuck in a position of laying off people or eliminating a position because there wasn't any Federal funding. The committee gave it a Do Pass based on the testimony we received during the hearing. I know there are some differing opinions based on the effectiveness, particularly of having public health do these, but this is the bill in front of you.

Chairman Pollert: I'll remind the audience on SB2197 and 2320, those are referred bills, so the Appropriations Committee does not take public testimony. If we have questions, though, we may bring people forward to talk about it. If you want to hand something out to us, that's fine. I will ask the committee, any questions of Rep. Weisz? Did you get a schedule from the Department of Health on what's being done as far as dental and dental sealants, and school visitations, and such as that?

Weisz: Yes. The program had grown to cover 52 schools, approximately 1950 students in 2012-2013. It was only able to service two schools and 92 children in 2013-2014 because they lost their funding. It says, without state funding, the sealant program became defunct

because there was no state funding at all. Last fall, HRS-HRSA(?) notified the program that funding had been reinstated. So they do have their funding back. They should be able to do the same number of children. For a little background, the criteria for a school to receive this was that they had to have at least 45% or greater of the students eligible for free lunch. This bill drops that, under their intention, to target schools that are 40 percent or greater free or reduced lunch. So, according to this, 89 schools now qualify. Again, part of the reason was to have this money so they should be able to expand to another 2000 students; and worst case scenario; if they lose the Federal funding, the original program stays intact and they are still able to do roughly 2,000 students.

Chairman Pollert: How many schools did you say?

Weisz: They were doing 52 schools and 1,950 students. Their goal is, at the 40 percent free and reduced lunch, 89 schools would qualify. They would be able to do approximately 4,000 students.

Chairman Pollert: Does the general funds of $150,000; do the Federal dollars, are they just there? Or do the general funds have to be there to get the match?

Weisz: The Federal funds are just there. The Federal program would run without this funding, as it did in the past. And I can't explain the reasons. I don't remember that it came up in committee why they lost the funding, or why it was pulled. But it was, and now they just received notice that it was back. So there is no requirement of any general fund match on this particular program.

Rep. Silbernagel: Is this population somewhat different from the Ronald McDonald effort or is it kind of the same population?

Weisz: It certainly can be the same population. Ronald McDonald goes to areas of low income, you know, and they serve, generally, the under-served, those that even they're Medicaid qualified, but for whatever reason they're not getting the service. Ronald McDonald sets their own criteria, and doesn't go to schools. I'm sure they're serving some of the same population. This is more expansive and this is strictly dental sealant. Ronald McDonald is doing the full spectrum of dental care in their mobile units.

Rep. Nelson: Is there any question about the value of the sealant program? Is there something that is better than the sealant program? Or is there questions about it?

Weisz: There have been conversations of those in the dental community that question the effectiveness when public health does it because it's very sensitive as far as its effectiveness; as far as the teeth, there can't be zero moisture of any kind. There was some questions that were raised to us about if it was being done properly. Also it is only effective on decay that's in the top part of the tooth. So you're not on the sides or in between the teeth. The sealant isn't effective. There were questions on whether the benefits were worth the additional cost, having to do with public health, if they're not trained properly. Some dentists say that they have problems, even, where they come back because a little bit of saliva or whatever, and it didn't take, and they have to come back in a couple weeks and re-do it. So that was some of the discussion.

Rep. Nelson: The option would be that each of the 4,000 potential students that would be served by this bill would be better served if they went to a dental practice and had it done, which is probably pie in the sky.

Weisz: I'm sure some in the dental community would prefer they go there so they can charge them. I just wanted the committee to be aware there was some discussion that, while they're effective, we shouldn't read too much into that; that it's a cure-all; that if we put the sealant on, they're not going to have cavities.

Rep. Nelson: How long does the sealant last?

Weisz: That's a good question. We never had that discussion. How long they last depends on how well they are applied. But I don't know how long they last.

Vice Chairman Bellew: You said that federal funding was reinstated this past fall.

Weisz: Yes.

Vice Chairman Bellew: How much was that?

Weisz: $150,000.

Vice Chairman Bellew: Was that per year or per biennium?

Weisz: I believe it's for the biennium. I don't believe we had specific testimony; merely that the program was in place again, and that they had been performing. I assume it had to be similar to the amount that we were funding because the discussion was that if we fund $150,000 for the biennium, they would be able to continue the program. So I assumed the Federal funding is very similar to that. Providing that amount of service, and then the one employee in the Health Department.

Chairman Pollert: When did you say those funds had tapered off? You talked about 52 schools; what year was that?

Weisz: In 2012-2013 they managed to do 52 schools and 1950 students. The next year it went to virtually nothing. They served two schools and 92 children. And then it said, without state funding, the program became defunct. They will be doing the sealant program. It's a matter of if we want to expand it, and do we want to insure that if Federal funding would leave again, you would still have the base program ongoing.

Chairman Pollert: I know during the Department of Health, we spent some time on the dental portion of it. Is there any questions? Do you need any further discussion on SB 2197? Or do you need any information?

Kim Mertz, Director, Division of Family Health, N.D. Dept. of Health: The oral health program is one program within the Division of Family Health, and there are oral health program health staff here, as well.

Chairman Pollert: We spent some time on the dental screenings portion of that, as well. With the dollar amount you brought forward at that time, was that dealing just with the $150,000 or was there more involved than that?

Kim Mertz: For clarification, our federal grant is currently $427,000. We use about $200,000 of that to pay for our school-based dental sealant and fluoride varnish program.

Chairman Pollert: Does the $427,000 include the $150,000 they're talking about?

Kim Mertz: The $150,000 the bill is asking for that for general funds.

Chairman Pollert: There is $150,000 Federal that they started back up again in 2014.

Kim Mertz: That was a little bit of confusion. The grant isn't $150,000; it was $427,000. We use $200,000 of that grant for the school-based dental sealant and fluoride varnish. The remaining $227,000 then, we have contracts with the Ronald McDonald Caremobile and also with the Family Healthcare Association to do a long-term care project, where we're focusing on dental care in the elderly. Now the contract we have with the Ronald McDonald Caremobile; as part of that grant, we work in collaboration with them, and Chairman Weisz did a wonderful job of talking about how the Caremobile provides much more inclusive services. So we really do the preventatives, the sealant. The one thing why it's so important that we collaborate with them is dental decay in children is a multi-prong approach. It's very complex and you have to use more than one mechanism to really address the issue. The Care Mobile does a wonderful job, but they currently only serve the western part of the state. And so there's a lot of kids in the eastern part of the state that need services as well.

Vice Chairman Bellew: What section of the budget is this in?

Kim Mertz: The $427,000 Federal grant is in the Community Health section.

Chairman Pollert: So you said, of the $427,000, $200,000 was for the school-based dental sealant and varnish. And then, was also the Ronald McDonald part of the $200,000? No, that's separate because that's general fund?

Kim Mertz: Of that $427,000, about $200,000 is for funding our public health hygienist to go into the schools to do sealants and varnish on kids teeth. The rest of that money, about $80,000 goes to the Ronald McDonald Caremobile to help them with operational costs for running the Caremobile. And then we have another $80,000-$90,000 that goes to the family health care association to do a long-term care project; and the rest of that money helps fund our staff. You're correct that in addition to those Federal funds, the state does put $100,000 per biennium into the Caremobile to help with operating costs. And that $100,000 of general fund money for the Caremobile is in the Dept. of Health general fund budget.

Chairman Pollert: But the $100,000 that's in the budget that we had the first half, that's not for $200,000; it's for $100,000 to continue that, right?

Kim: Yes, that $100,000 is a biennium. And, Rep. Bellew, you had asked; I think Chairman Weisz had indicated that he thought our grant was $150,000 per biennium. So we've got that cleared up: it's not $150,000 per biennium; it's $427,000 and that's per year; it's not per biennium. And that is a three-year grant. So that grant started last year, we're currently still in our first year. We'll have two more years of that funding, and then that Federal grant becomes competitive again. It started last September, and it will run through August 2017. So it will get us through three school years.

Rep. Silbernagel: Ronald McDonald would get $160,000 in a biennium?

Kim: Correct. It would be probably be more like about $180,000. The $80,000 is per year. So, from the Federal funds, it's about that, and only $50,000 from the general funds.

Chairman Pollert: So you're saying, for the adults it's like $140,000 of the $427,000?

Kim: Are you talking about the money we use for the elderly?

Chairman Pollert: Yes.

Kim: That's a grant for about $80,000-$90,000 per year, so it would be about $180,000 in a biennium for a long-term care project.

Rep. Nelson: As we mesh this bill into what we heard earlier, they talked about the fact that 4,000 students would have the ability to get service for the fluoride sealant aspect of this. What numbers are you utilizing from the Federal grant portion of this?

Kim: Currently with the federal funds we have, we are able to service about 2,000 students. If we got the general fund money, with another $150,000, we are anticipating that we would be able to add another 2,000 students. The question also came up as to why we lost the grant. We had the grant for three years, then it became competitive again. We wrote the competitive grant, we got a very high score, about 91 percent, and the grant was approved, but not funded, which means they just didn't have enough funds at the Federal level to fund us. Well, then, a year went by and they received more funds at the Federal level, and then our grant became reinstated. That's why now we have another three years of funding. But if that funding goes away, then so does our school-based program, and we are down to serving no students again. While this is not a Department of Health bill, it's an oral health coalition initiative, the general fund money would help keep the program going at a minimum if we lost Federal funds, and with the Federal funds, it would help enhance the program to serve more students.

Rep. Nelson: There was some question about the application of the sealant. From your experience, is this something that is being done appropriately from a public health standpoint? How much validity would you put into that statement that was asked earlier?

Kim: I'm really glad you asked me to clarify that. Sealants do have to be put on very well. It is a meticulous procedure. Our public health hygienists that are applying the sealants are very highly trained. First of all, they receive the training in school, so they come out of school very competent. But when we hire them to specifically work in this program, we

also have a retention. We go into the schools in the fall and put on the give them additional training to be able to apply dental sealants. So they really are very highly trained, and I have every confidence they are doing a great job. The other important thing to remember is, these dental hygienists, it's what they do every day. They're not like working in an office. They are working in our school-based system, and they are putting sealants on on a daily basis. They become very good at it. They're very proficient in it because it's what they do all the time. We also have a retention. So we go into the schools in the fall, put the sealants on and the fluoride varnish, and then we go back to the schools in the spring, and we do a retention check. So we check those same students to be sure that sealant is still there, and if the sealant isn't there, we re-apply it. Sealants last about two years after they are applied, sealants still have about an 81 percent effectiveness rate for reducing cavities in those molars, and sealants in general, if they're put on correctly and well, they'll last about 4 ½ years.

Chairman Pollert: Are these for anybody?

Kim: We do not discriminate. This is available to all students in all the schools that we serve.

Handout from Sen. Bekkedahl (Att. #1)

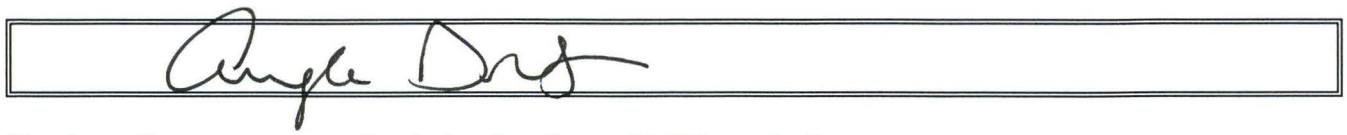
Chairman Pollert dismissed the committee.

2015 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee - Human Resources Division
Sakakawea Room, State Capitol

SB 2197
4/1/2015
"Click here to type recording job number"

☐ Subcommittee
☐ Conference Committee



Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation to the state department of health to expand a dental sealant program for elementary aged students and for a dental case management pilot project.

Minutes:

Chairman Pollert called the committee to order.

Vice Chairman Bellew: My understanding on why this was brought forward is because the federal funds were removed for this program. In my conversations with the Health Department, in this next biennium, they're going to have almost $200,000 for the dental sealant and varnish program in their budget. Based on that, I would move a Do Not Pass.

Rep. Kreidt: Second.

Rep. Nelson: My notes show that this bill would reduce the free and reduced lunch percentage from 45% to 40% to include more people. They're doing 52 schools currently, just short of 2,000 students. If this bill passed, it would be 89 schools and up to 4,000 students. I think it's an additional group and number of schools within the group. The Department of Health testified that they don't turn anyone away, whether they qualify for free or reduced lunch or not. This would be the funding for those kids that qualify under that area.

Vice Chairman Bellew: I did get this information from the Department of Health; for the next biennium that there will be roughly $200,000 in the dental sealant program. My Do Not Pass is based in part on what the Senator gave us for his testimony where it says the state funding requested would provide a backstop to the program allowing it to continue when and if federal funding is ever again compromised or removed. The federal funding is not removed so the program is not going to stop.

Rep. Holman: The notes I have on this are similar to Rep. Nelson. I have $427,000 federal, $200,000 state, $227,000 from Ronald McDonald and the state also puts money

into the Ronald McDonald. I'm not going to support the motion as it stands right now. It seems like this is a good program and it's not a major expansion but probably has a cost benefit ratio that actually cuts costs in the long run if you do this.

Rep. Nelson: My notes show that the Ronald McDonald Care Mobile, that $227,000, is care for elderly. I don't think that's even a part of this.

Chairman Pollert: I show $200,000 for school-based dental sealant and varnish and $80,000 to Ronald McDonald, and the rest is for adults, like $90,000.

Vice Chairman Bellew: The explanation I got in writing for the Department of Health says for the Ronald McDonald Care Mobile: It delivers urgently needed dental care to underserved children ages 0-21 in their own neighborhoods in the western half of ND.

A Roll Call Vote was taken. Yes: 4, No: 2, Absent: 0. Motion passed.

Chairman Pollert: Representative Bellew will carry the bill.

Chairman Pollert closed the hearing.

2015 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

SB 2197
4/6/2015
25845

☐ Subcommittee
☐ Conference Committee

Explanation or reason for introduction of bill/resolution:
To provide an appropriation to the state department of health to expand a dental sealant program for elementary aged students

Minutes:

Chairman Jeff Delzer opened the meeting.

Representative Bellew spoke on the bill.

Representative Bellew
Motioned for a do not pass

Representative Pollert: Seconded

Representative Bellew
Explained the bill; and that federal funds were available; that there is $200,000 available. It came out of Human Service committee with a Do Not Pass.

Chairman Jeff Delzer
Got information on the effectiveness of the program; was it as good as before? That's another reason as to why it may not be proper to go forward with it.

Representative Nelson
Sponsor of the bill is a dentist; and he feels it is the most cost effective measures for children's dental health. There has been a time when the federal money was not enough.

Representative Pollert
We had discussions on both sides; some dentists said it was questionable.

Motion for a Do Not Pass carries
15 Yes 6 No 2 Absent
Representative Bellew is the carrier.

Date: 4/1/2015
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2197

House Appropriations - Human Resources Division Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☒ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Vice Chairman Bellew Seconded By Rep. Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Rep. Holman		X
Vice Chairman Bellew	X				
Rep. Kreidt	X				
Rep. Nelson		X			
Rep. Silbernagel	X				

Total Yes 4 No 2

Absent 0

Floor Assignment Vice Chairman Bellew

If the vote is on an amendment, briefly indicate intent:

Date: 4/6/15

Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 2197

House: **Appropriations Committee**

☐ Subcommittee

Amendment LC# or Description:

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☑ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By: Bellew Seconded By: Pollert

Representatives	Yes	No	Absent
Chairman Jeff Delzer	✓		
Vice Chairman Keith Kempenich			AB
Representative Bellew	✓		
Representative Brandenburg	✓		
Representative Boehning	✓		
Representative Dosch	✓		
Representative Kreidt	✓		
Representative Martinson	✓		
Representative Monson	✓		
Representative Nelson		✓	
Representative Pollert	✓		
Representative Sanford	✓		
Representative Schmidt	✓		
Representative Silbernagel	✓		
Representative Skarphol	✓		
Representative Streyle			AB
Representative Thoreson	✓		
Representative Vigesaa	✓		
Representative Boe		✓	
Representative Glassheim		✓	
Representative Guggisberg		✓	
Representative Hogan		✓	
Representative Holman		✓	
TOTALS	15	6	2

Assignment: Bellew

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2197, as engrossed: Appropriations Committee (Rep. Delzer, Chairman) recommends **DO NOT PASS** (15 YEAS, 6 NAYS, 2 ABSENT AND NOT VOTING). Engrossed SB 2197 was placed on the Fourteenth order on the calendar.

2015 TESTIMONY

SB 2197

Attach #1
SB2197 01/20/15
J# 22182

Testimony SB2197

Human Services Committee

Tuesday, January 20, 2015

North Dakota Oral Health Coalition Cheryl Underhill, MSN, Mm

Good morning, Madam Chair and members of the Human Services Committee. My name is Cheryl Underhill and I am the Executive Director of the North Dakota Oral Health Coalition (NDOHC). I am here today to provide testimony on Senate Bill 2197.

The North Dakota Oral Health Coalition is a 501c3 organization with over 110 committed individual and organizational members representing many facets of oral health care from education and public health, to professional associations and community health centers. The coalition's mission is to "develop innovative strategies to achieve optimal oral health for all North Dakotans".

I joined the NDOHC last year as the first Executive Director of the coalition. I am a Registered Nurse and have worked over 30 years in private, public and community health care.

In 2014, members of the NDOHC discussed shared goals and priorities and agreed upon 4 priority areas, which are also identified in Health Services Committee Concurrent Resolution No. 4004, a resolution to study several aspects of dental services in ND. Two of the NDOHC priorities identified are:

- Expand the Seal!ND program through the State Department of Health oral health programs to target low income children in public schools.
- Funding for a Case Management outreach model supported through the State Department of Health and the North Dakota Dental Association.

The coalition priorities also align closely with the top five stakeholder priorities identified in the *2014 North Dakota Oral Health Report: Needs and Proposed Models,* a study conducted by the North Dakota Center for Rural Health, and funded by the PEW Foundation. The Center for Rural Health report findings are also documented in Concurrent Resolution 4004 and specifically include:

- Increased funding of the Seal!ND North Dakota program-to include using dental hygienists to provide care and incorporating case management and identification of a dental home.

The North Dakota Oral Health Coalition supports SB2197, to help prevent the pain and cost of tooth decay in high risk children, save tax payer dollars, increase access to dental care and connect children to a dental home. By studying and evaluating this process, valuable lessons and data will be obtained to aid in achieving cost effective continuity of oral care while building partnerships and positive oral health behaviors in high risk children early in life.

Thank you, the North Dakota Oral Health Coalition respectfully asks the committee for a 'Do Pass' on SB2197.

Attach # 2
SB2197 01/20/15
J # 22182

Testimony –Senate Bill 2197
Senate Human Services Committee
January 20, 2015
Bridging the Dental Gap and ND Oral Health Coalition

My name is Marcia Olson. I am the Executive Director of Bridging the Dental Gap in Bismarck. We are a non-profit dental clinic providing services to low income and Medicaid patients. I am also the current President of the ND Oral Health Coalition. I am here today to speak in favor of Senate Bill 2197.

This bill will provide funds to expand the Seal ND sealant program and set up a pilot dental case management project.

Sealants are placed on teeth to help prevent decay. They are especially effective in very vulnerable populations to help cut down on high incidences of decay. The Seal ND program provides sealants, fluoride varnish and oral health education. The Morbidity and Mortality Weekly Report (MMWR) that was released in September of 2014 reviewed the use of sealants in preventing decay in children and adolescents. The findings demonstrated that dental sealants prevented decay in permanent molars by 81% approximately 2 years after placement and continue to be effective up to 4 ½ years later. The American Dental Association recommends placing sealants on primary and permanent molars of children at the greatest risk of decay. Sealants as a preventative is an effective means of cutting down the costs of later fillings and extractions. The CDC and American Dental Association also recommend the use of fluoride varnish as effectively preventing caries or primary and permanent teeth.

The Oral Health program within the ND Department of Health has had a school based sealant project in place for a number of years. Sealants were provided to children in schools with 45% or greater free and reduced lunch. It took some time to build the program. Unfortunately a year and a half ago the funding from HRSA (Health Resources and Services Administration) was not renewed. This resulted in a drastic reduction in services and required all the public health hygienists to be laid off and a cut back in staffing in the Oral Health division. The program which had grown to cover 52 schools and approximately 1950 students in 2012-2013 was only able to service 2 schools and 92 children in 2013-2014. (The schools that

were chosen to be retained were St.John's and Warwick.) Without state funding, the sealant program became defunct.

Last fall, HRSA notified the ND Oral Health program that funding had been re-instated. Budgets were quickly rewritten, new data obtained and hiring process started to get new public health hygienists in place. By November 2014 the Seal ND project was back on its feet. Currently the targeted schools are 40% or greater free and reduced lunch. 89 schools now qualify. Using funds from the HRSA grant the state public health hygienists will provide services at some of the schools and a contract with the Ronald McDonald Caremobile will provide additional site coverage using additional hygienists attached to that program. This funding is in place until 2017. At present 17 schools have been visited but the actual numbers of students is not yet available.

The purpose of Senate Bill 2197 is to provide funds to expand care to approximately another 2000 children. In 2015 and 2016, the expansion would continue to cover these "extra" children. Ideally this expansion should continue to be funded thus assuring that at least the base number of students would always be covered even if the federal funds are lost again in the future.

The interim Health Services Committee chaired by Senator Lee heard repeated testimony and recommendations that the Seal ND! Program be expanded to provide greater access to oral health care. The UND Center for Rural Health Assessment study for Oral Health funded by PEW has as one of its priorities the expansion of the Seal ND program. (If you are interested in reviewing the study it is available online at http://ruralhealth.und.edu/projects/nd-oral-health-assessment/pdf/north-dakota-oral-health-report2014.pdf)

Another area that was rated as a high priority through the studies presented to the Health Services interim Committee was to create a case management project to help children access dental care. Not only is it a part of the UND Center for Rural Health Assessment but Senate Concurrent Resolution (SCR) 4004 also places a priority on this area by stating in part " the Legislative Management continue to study dental services in the state including the effectiveness of case management services…". There currently is not any case management services for oral health or dental care. This would be a new area and by funding at least a small pilot

project then Legislative Management may have more data to ascertain the efficacy of such a program.

Dr, Holman with the ND Dental Association is here today to expand on the case management portion of the bill and will provide the background and plan for implementing.

Are there any questions on the areas which I have presented?

Attach #3
SB 2197 01/20/15
J# 22182

Senate Human Services Committee

January 20, 2015

Testimony- Senate Bill No. 2197

North Dakota Dental Association **Brent L Holman DDS**

The North Dakota Dental Association supports Senate Bill 2197. Besides the sealant component already in place and that has been discussed, the bill also has a case management component that pilots a model for identifying children deemed to be high-risk for dental decay and linking them up with a case manager. A risk assessment tool is developed specific for the program that defines the child's risk for decay based on evidenced-based criteria developed by a technical assistance consultant. It is hoped that this tool would identify about 100 children that would benefit from referral and case management for comprehensive treatment. A case manager will be assigned to link these children to a dental home. A dental home is the most effective way to prevent dental disease and future treatment costs. Case management involves motivational interviewing, oral health literacy activities, education, linkage to other community resources, and help with transportation. Data will be accumulated to document treatment costs and help justify the benefits of prevention and Medicaid reimbursement for case management.

The appropriation for the case management part of the bill would be used for the technical assistance, training of the case managers and their services.

The management of the case management piece would be part of the overall program management currently provided by the Oral Health Program, State Department of Health. Also submitted with this testimony is information providing more detail about case management. Thanks for your consideration.

Attach #4
SB 2197
01/20/15
JH 22182

June 2013

Pediatric Oral Health
Research & Policy Center

The Use of Case Management to Improve Dental Health in High Risk Populations

Executive Summary

Untreated tooth decay affects more children than any other chronic infectious disease in the United States, leading to pain and suffering, and even death[1], despite being a largely preventable disease. Minority and socioeconomically disadvantaged children are especially hard-hit; they have higher rates of tooth decay and greater difficulty accessing dental care. The ravages of pediatric dental disease are especially disconcerting since there are resources available to prevent and treat dental diseases in this at-risk population. Informing caregivers of the existence of dental health resources is the crux of this public health crisis. Dental care case management, and establishment of a dental home, are the answers.

Dental care is readily available from dentists who accept Medicaid and CHIP; unfortunately low-income parents facing a pediatric dental crisis may be hobbled by health illiteracy, as well as limited funds for dental care and few personal resources to access care when it is available. Thus, only 38% of Medicaid eligible children received a dental service in 2008, well below the Healthy People 2010 goal.[2] Although over 70% of AAPD members accept public insurance[3], only 5.4% of general practitioners accept public insurance.[4] Dentists who desire to provide care to publically insured patients are discouraged by low reimbursement rates and administrative burdens. The combination of patient and provider barriers leads to low utilization of dental care options by publically insured pediatric patients, higher dental disease rates and treatment costs. Only by overcoming barriers to care will these children receive cost-effective preventive as well as therapeutic care.

Barriers to care can be breached by case management, which is a collaborative process of assessment, planning, facilitation, care coordination, valuation and advocacy for options[5] that has been shown to be a cost-effective tool to increase dental health in the publically insured population. Motivational interviewing (MI), a key component of case management, has proved to be effective in improving not only dental outcomes, but health outcomes in any population; when used in conjunction with other services (fluoride, Xylitol, and/or treatment of disease) MI has been found to reduce cavity prevalence by 62%.[6] The potential for such a radical reduction in cavity prevalence could result in substantial cost savings.

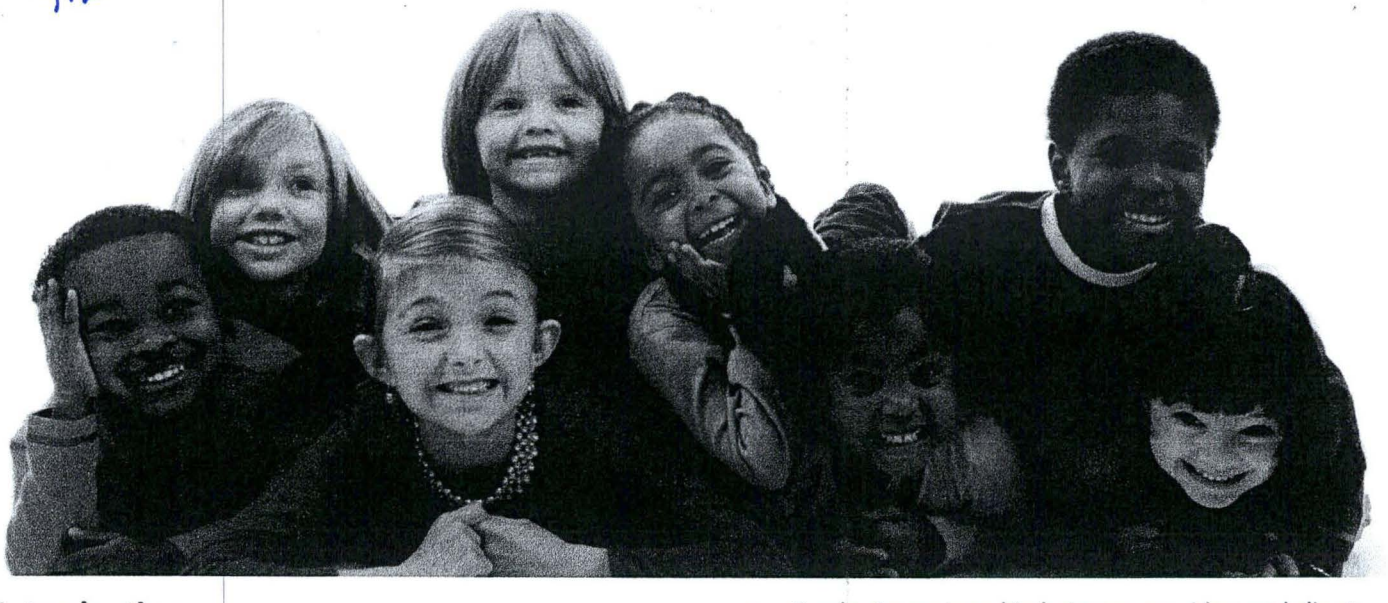
Individualized case management services allow for differences in physical, psychological and cultural makeup and addresses community-specific barriers to care. Case management is not only the customization of available resources to specific patient and provider needs, but the communication of, and explanation and support for, good oral health practices. Comprehensive case management has been found to increase publically insured beneficiaries' use of services and improve oral health literacy and treatment compliance. Ideally, use of case management leads to the patient adoption of a dental home. A dental home is a primary dental care provider that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. [7]

In sum, case management may be a cost-effective service that has the potential to reduce costs and improve oral health.

(Endnotes)

1 *Centers for Disease Control and Prevention. Health disparities experienced by racial/ethnic minority populations. MMWR 2004;53:755.*
2 *National Center for Health Statistics. Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD. 2012.*
3 *American Academy of Pediatric Dentistry. Member Needs Assessment, Winter, 2009.*
4 *American Dental Association. 2012 Survey of Dental Practice Pediatric Dentists in Private Practice Characteristics Report. 2012*
5 *Case Management Society of America. Standards of practice for case management, revised 2010.*
6 *Hirsch, G, Edelstein, B, Frosh, M, and Anselmo, T. A Simulation Model for Designing Effective Interventions in Early Childhood Caries. CDC - Preventing Chronic Disease: Volume 9, 2012: 11_0219.*
7 *American Academy of Pediatric Dentistry. Policy on the dental home. Pediatr Dennt 2012;34(6) (special issue): 24.*

4.2



Introduction

Poor oral health in children is a major public health problem in America. "Despite the considerable progress in pediatric oral health care achieved in recent years, tooth decay remains one of the most preventable common chronic diseases of childhood. Tooth decay causes significant pain, loss of school days and may lead to infections and even death."[1] Left untreated, dental caries can result in a broad range of functional impairments that have far-reaching implications for growth, development, school performance, and peer relationships. However, the public and even health care professionals remain, in large part, unaware of the basic risk factors and preventive approaches for many oral diseases, as well as the connection between good oral health and overall health and well-being.[2]

Children at higher risk of developing dental caries (tooth decay) include:

- Children with demonstrable caries, dental plaque, and enamel demineralization;
- Children of mothers with a high caries rate, especially with untreated caries;
- Children who sleep with a bottle containing anything other than water, or who breastfeed throughout the night (at-will nursing);
- Children in families with low socioeconomic status;
- Children with special health care needs.

Children at increased risk of developing caries often lack access to dental care and may not have good preventive home care practices. Additionally, these children may reside in families that may have few resources and face many barriers accessing oral health care and information. Case management can help these families utilize available dental providers and reduce caries risk-factors. Case management can also support the goals of health care and dental benefit providers (including state Medicaid and CHIP programs) through improving treatment plan compliance and reducing care costs. Case management services that are truly patient-driven:

- Emphasize partnership between providers and clients patients (and their families);
- Ensure the family is linked with appropriate community services;
- Improve the family's oral health knowledge and health literacy; and
- Utilize communication strategies that assist families in identifying and achieving their own goals.[3]

Oral Health Disparities

Significant disparities exist in oral health on the basis of socioeconomic status. Children from low-income families suffer twice as much dental caries as children from more affluent families.[2] In one study, approximately one half of those in lower income groups had dental caries compared to only one third of children from families with incomes ≧200 percent of the federal poverty level (FPL). [4] Utilization of dental services is also diminished among low income families.[5] Among 3-5-year-olds living in poverty, approximately one in four had untreated dental decay compared to 10.5 percent among those living above the poverty level.[6] Further, only 38 percent of children covered by Medicaid received a dental service in 2008, well below the Healthy People 2010 goal of 56 percent of children having a dental visit within a year.[6]

Racial and ethnic health disparities also exist. African-Americans, Hispanics, American Indians, Alaska Natives, and other racial and ethnic minority groups bear a disproportionate burden of disease and disability.[7] Among children aged 2–11 years during 1999–2004, Mexican-American children had higher caries levels (55.4 percent) than black (43.4 percent) or non-Hispanic white children (38.6 percent).[4]

These oral health disparities result in "lower life expectancy, decreased quality of life, loss of economic opportunities, and perceptions of injustice."[1] Children with poor oral health are more likely to experience dental pain, miss school and perform poorly in school. In fact, 17 percent of all missed school days are due to dental problems.[8] Dental problems have also been associated with indicators of emotional well-being, such as shyness, unhappiness, and feelings of worthlessness.[8]

Publically insured children face additional health disparities, which can potentially affect their ability to access dental care. These include obesity, developmental delay, learning disability, behavior problems, and anxiety problems.[9]

Barriers to Care

When it comes to achieving good oral health, many low-income and minority children face significant challenges. These factors include both internal family factors such as parental belief systems and health practices as well as external factors such as availability of providers and transportation. Barriers include:

- Internal family factors:
  - parental belief systems and practices;
  - child's temperament (e.g. resistance to tooth brushing);
  - low parental literacy and an inability to adequately understand current educational materials;[10]
  - lack of parental knowledge about optimal oral health, and uncertainty about prevention;[11]
  - financial difficulties which make it challenging to prioritize dental care;[12]
  - dental anxiety and phobias;[13]
  - perceived lack of access to affordable sources of care;
  - home oral care activities perceived as time consuming and low-priority when compared to other responsibilities.[11]
- External factors:
  - difficulty locating Medicaid and CHIP dental providers;
  - lack of health and dental insurance;
  - limited hours of dental office and clinic operations; and inability to schedule appointments that do not conflict with workplace demands and other parental responsibilities;
  - lack of transportation and geographic distance to dental providers;
  - having to miss school and/or taking time off of work for dental appointments;[14]
  - the complexity of navigating the health care system;[15] and
  - socioeconomic or cultural discrimination.

Many families at high risk of dental caries have a combination of barriers that not only interfere with care seeking, but also with treatment plan/home care compliance. According to Moore-Greene, "When the lack of environmental supports is coupled with limited education and the inability to negotiate a managed care system, noncompliance with treatment is the end result."[3]

Behavior plays a central role in maintenance of good oral health. In order to understand behaviors related to dental access and home care, one must distinguish between those families that are not motivated to adopt positive oral health behaviors and families that are motivated but need support in adopting new behaviors.[16]

Certain beliefs and attitudes mediate the impact of these barriers on access. Parents who do not obtain dental services for their children emphasize appearance, self-esteem, and treatment of pain as being more important reasons than health concerns for accessing dental care. These parents also view dental care in emergency rather than preventive terms. Parents who do obtain dental services for their children in spite of barriers, tend to perceive oral health as associated with overall health, identify professional preventive dental care as an activity that falls within normative caregiver responsibilities, and have a greater knowledge of preventive dental care.[17]

Given the multivariate causes of poor oral health, one specific approach is insufficient to overcome these barriers. Any intervention which seeks to improve the oral health of the population must incorporate numerous techniques in order to overcome specific barriers.

The Dental Home

According to the AAPD Policy Statement on Dental Home, "The dental home is inclusive of all aspects of oral health that result from the interaction of the patient, parents, non-dental professionals, and dental professionals."[18] A dental home:

- Is an ongoing relationship between the patient and the dentist or dental team that is coordinated/supervised by a dentist;
- Provides comprehensive, oral health care that is continuously accessible and family-centered;
- Is an approach that assures all children have access to preventative and restorative oral health care;[19]
- Should be initiated as early as early as 6 months of age, 6 months after the first tooth erupts, and no later than 12 months of age.

Ongoing periodic appointments provide time-critical opportunities to implement preventive health practices and reduce the child's risk of preventable dental/oral disease.[19] Early engagement in a dental home can significantly reduce the cost of care. Children who had a dental visit by the age of 1 year are more likely to receive more preventive services and require less treatment than those children who accessed dental services at an older age.[20]

4.4

Definition of Case Management

Case management activities address the reality that life is complex. Most communities are composed of a variety of health systems, providers and provider-types. Children's oral health is influenced by factors that include genetics, biology, social environment, physical environment, health-influencing behaviors, and medical and dental care. It is clear that those who suffer the most disease typically have a host of social issues that make consistent provision of established preventive services difficult.[21]

To affect oral health outcomes, a multi-level, multidimensional approach is required that addresses all these factors.

Case management is a collaborative process of assessment, planning, facilitation, and care coordination to meet an individual's and family's comprehensive health needs through communication and linkage to available resources. [22] It is important to note that non-judgmental, supportive communication is the cornerstone of successful case management. Such communication takes the form of active listening, encouraging self-sufficiency and collaborative problem-solving. It should:

- Enhance developmental, problem-solving and coping capacities of clients;[23]
- Link people with systems that provide them with resources, services and opportunities;[23]
- Support parents in their care-giving role;[23]
- Enable individuals to use their personal resources in meeting environmental challenges;[24] and
- Promote the use of evidence based care.[22]

Activities included in the role of case manager include:

1. Assessment of client's needs, strengths and resources;
2. Development of an individualized plan for achieving optimal health outcomes;
3. Linkage to appropriate community resources,
4. Facilitation of communication between the client and the health care team;
5. Education about treatment options, community resources, insurance benefits, etc.;
6. Active problem-solving with the client – allowing the client to develop her own plans and desired outcomes.

The Role of Case Management in Prevention of Dental Disease

Case management activities support the individual elements of a dental home and can assist families in overcoming barriers to engagement in a dental home through:

- Making the dental home more accessible to families by helping find transportation; completing Medicaid paperwork; scheduling appointments; and following-up with prevention, future appointments and after-care instructions. Community outreach and health literacy instruction can help address family motivation by correcting oral health misinformation and lack of knowledge.
- Ensuring that care is coordinated across providers and that families access available community support resources and helping families understand how the dental home fits within the medical care system and help them complete referrals to other providers.
- Providing services in the dental home that are family-centered and culturally appropriate. By assessing individual family strengths, needs and barriers, these activities are customized to support the individual family. The use of good communication tools, including interpreters when necessary, can assist families in identifying their own goals and developing the skills necessary to ensure optimal oral health for their children, while respecting family preferences and cultural beliefs.
- Utilizing effective and supportive communication techniques is key to achieving successful case management activities. When patients perceive their

Promotores Provide Specialized Case Management Activities.

According to the US Department of Health and Human Services, "Promotores de Salud/Community Health Workers (CHWs) are volunteer community members and paid frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. Promotores de Salud/Community Health Workers (CHWs) generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as a liaison, link, or intermediary between health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competence of service. Promotores/CHWs can enhance provider-patient communication; preventive care; adherence to treatment, follow-up, and referral; disease self-management; and navigation of the healthcare system. Additionally Promotores/CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities."*

**Adapted from the American Public Health Association, 2009, Community Health Workers National Workforce Study (HRSA) and the Patient Protection and Affordable Care Act of 2010*

Definition of Promotores de Salud available at http://minorityhealth.hhs.gov/templates/content.

dentist and the dental team as being dedicated, supportive and caring, they are more likely to take control of their own oral health.[11]

Since case management activities are based on individual family's needs, challenges and resources, they can be delivered efficiently without spending time and effort on unnecessary interventions. Listening to family beliefs and concerns, respecting the family's point of view and not blaming the family increases the likelihood that the family will comply with preventive recommendations.[11] Conversely, the perception of discrimination based on race and being on Medicaid seem to be common and lead to caregiver avoidance of the dental office, resulting in postponed or cancelled visits.[25]

Dental case management has been linked to positive oral health outcomes in the Medicaid population. One New York study that provided comprehensive case management services found an increase in oral health literacy and treatment compliance. The percentage of Medicaid covered children receiving dental care rose from 8.7 percent in 2000 to 41.2 percent in 2004.[26]

Similarly, Kids Get Care in the Seattle area found that, when dental clinics partnered with community organizations and provided case management they achieved an increase of 108 percent in the number of children age 0 to 2 who received a dental visit. In this model, community workers identified children with possible health problems; discussed their concerns with parents and assisted in making referrals to a case manager if the family did not have a regular physician or dentist. Case managers facilitated the first appointments, helped establish eligibility for public health coverage program, ensured follow-up, and helped troubleshoot other barriers to care with families.[27]

Effective Case Management Strategies

In dentistry, the following strategies are useful components of case management:

1. Motivational interviewing
2. Health literacy activities
3. Care coordination
4. Community outreach and education
5. Appointment reminder systems

Motivational interviewing (MI)

One successful communication tool is motivational interviewing (MI) which is a brief, patient centered, personalized counseling approach. Motivational interviewing is an essential component in a successful case management programs. The goal of MI is to assist the client in self-examination by: helping to raise their awareness of the problem; identifying their own oral health-related goals; and increasing their understanding of how current behavior may not be consistent with their goals. Reflective listening and the use of open-ended questioning are the basic components of MI. Motivational interviewing can be used to increase patient and family understanding or

The CARES program at SUNY School of Dental Medicine (SDM) provides an example of comprehensive case management services in the context of a dental school-school of social work collaborative effort. Patients presenting at the dental school receive a comprehensive assessment which identifies potential barriers to care. Case management services are developed based on this assessment and the patient's interest in receiving case management services. Eighty percent of patients who received case management services have been retained; many of these had barriers that may have prohibited them from completing treatment. Over the course of three years, the program developed four key functions. They are:

Education: providing behavioral education for dental students and retention of patients allowing dental students to achieve clinical competency, and providing a milieu for medical social work education for master's of social work students;

Clinical: providing cognitive behavioral treatment for orofacial pain and temporomandibular disorders patients;

Access to Care Assistance: providing linkage to community resources to assist with financial, transportation, health, mental health, living, family, caregiving, and legal situations that can make it difficult for patients to access needed dental care; and

Community Outreach: educating senior citizens about dental care needs, the types of dental care provided in the SDM, and how social workers can assist seniors in getting their dental care needs met.

Each of these functions is important in assisting families to overcome family-, community- and provider-related barriers to care.

the importance of oral health, their engagement in preventive behaviors, compliance with treatment plans, and utilization of community resources. It is a technique that can be utilized in patient education, care coordination and community education and outreach.

A recent meta-analysis of controlled clinical trials addressing MI found that methods similar to MI were equivalent to other active treatments and superior to no-treatment or placebo controls for problems involving alcohol, drugs, and diet and exercise.[28] A systematic review found MI to be the most effective method for altering health behaviors in a clinical setting.[29]

MI has been found to be effective in improving dental outcomes. Subjects receiving MI received more fluoride varnish treatments and had 46 percent fewer cavities than those that did not receive MI When used in conjunction with other services (fluoride, Xylitol, and/or treatment of disease), MI was found to reduce the prevalence of cavities by 62 percent. This reduction in caries can result in substantial cost savings.[30] When mothers received MI in addition to viewing a video and receiving a pamphlet, their children had lower incidence in carious lesions two years later (35 percent vs. 52 percent).[31]

4.6

Patient Education and Health Literacy

Health literacy is the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions. Healthcare systems often function as if all patients have a good understanding of the information provided. In practice, there is often a great discrepancy between what providers intend to convey, in both written and oral communication, and what patients understand.[32] Nearly one half of American adults have difficulty understanding and acting upon health information.[33]

Limited health literacy interferes with a person's ability to understand insurance options and plans features including provider networks, covered services, and specific terms such as cost sharing and managed care. This results in lower-quality communication with health professionals, increased costs, [33] negative health behaviors, poor preventive care and poor child health outcomes.[34] In terms of caries risk, Vann et al (2012) found that individuals with low health literacy were less likely to brush their child's teeth daily, more likely to put the child to bed with a bottle, and reported poorer oral health status. [35]

The U.S. Department of Health and Human Services has identified strategies to assist caregivers with low health literacy to access care and implement preventive strategies.[36] These include:

1. The use of motivational interviewing techniques to provide anticipatory guidance and parent education.
2. Using plain language to communicate concepts. Plain language elements include:
   a. Organizing information so that the most important concepts are presented first;
   b. Breaking complex information into smaller chunks;
   c. Using simple language and providing a definition for technical terms;
   d. Not using medical jargon.
3. Acknowledging different cultural beliefs, values, attitudes, traditions, and language preferences and adapting information and services to accommodate these differences. For providers not proficient in a patient or caregiver's primary language, use of an interpreter is a critical communication tool.

Care coordination

Care coordination facilitates communication:

- among members of one a health care team (receptionist, hygienist, assistant, dentist, etc.);
- between patient care teams, families and professional caregivers;[36]
- across health care settings (primary care, specialty care, inpatient, emergency department, etc.);
- between health care organizations;
- between patients and community services.

The Agency for Research and Quality (AHRQ) has outlined the benefits of care coordination to the patient and family, the health care provider and the system as a whole.

- Patient/Family Perspective. Care coordination helps ensure the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time.
- Health Care Professional(s) Perspective. Care coordination helps guide patients effectively and efficiently through the health care system, determining where to send the patient next, what information about the patient is necessary to transfer among health care entities, and how accountability and responsibility is managed among all health care professionals (doctors, nurses, social workers, care managers, supporting staff, etc.).
- System Representative(s) Perspective. Care coordination is the responsibility of any system of care (e.g., accountable care organization [ACO]) The goal of care coordination is to facilitate the appropriate and efficient delivery of health care services both within and across systems. [37]

Care coordination is an important component in case management. Caregivers who received education, assistance in finding a dentist if the child did not have one, and support in scheduling and keeping dental appointments from a dental care coordinator had significantly higher dental utilization rates (43 percent vs. 26 percent) than those children and caregivers who did not receive care coordination services.[17]

Community Outreach and Education

Community outreach and education addresses environmental issues, such as a general lack of information about the importance of oral health. Outreach activities engage families where they live, work and go to school. Outreach includes school-based oral health education and screening activities as well as services provided in other locations such as WIC clinics and Head Start programs. To alleviate health disparities, community programs must:

1. Ensure oral health is seen as a part of overall health at the level of the individual child, family, community, and society;
2. Promote health and wellness, not just the absence of disease;
3. Empower families and communities to improve children's health status; and
4. Take a multi-factorial approach to health to move beyond access to care to an overall improvement of health status. [38]

The Access to Baby and Child Dentistry (ABCD) program in Spokane County, Washington, illustrates the success of community outreach and education. In year one, 37 percent of the 4,144 ABCD children had at least one visit to the dentist compared to only 12 percent of non-ABCD Medicaid-enrolled children."[39]

4.7

Case Study

By: Barbara Greenberg

Tompkins County Dental Case Management (DCM) Program

The Dental Case Management Program was originally funded under an Innovative Oral Health Preventive Services Grant. The Tompkins County Health Department received $30,000 a year from the NYS Department of Health and contracted with the County Department of Social Services to support a full-time dental case manager within the Department of Social Services Medicaid Program.

Access to dental care had long been an issue for Tompkins County residents, especially in finding a dentist willing to take Medicaid. In 2000, only two dentists accepted new Medicaid patients.

THE CASE MANAGEMENT MODEL

DCM enhances access to dental care by linking patients to dental offices through a case manager.

The Case Manager:

- Recruits dentists for the Medicaid Program;
- Facilitates training and support of dental offices on electronic and paper billings;
- Helps resolve Medicaid billing issues;
- Conducts client intake appointments;
- Verifies client Medicaid eligibility;
- Educates clients about oral health and use of dental services;
- Matches clients to dental offices;
- Coordinates transportation;
- Reminds clients about appointments;
- Works with clients to minimize missed appointments.

THE RESULTS – AFTER THE FIRST 3 YEARS

- Dentists accepting new Medicaid patients increased from **two** to **28**;
- Clients averaged three dental visits a year; kept >98 percent of appointments;
- Percent of Medicaid clients getting dental care increased from **nine percent** to **41 percent**.

SHIFT TO MEDICAID MANAGED CARE

The county changed over to Mandatory Medicaid Managed Care on July 1, 2012. The case management staff worked with dentists in its dental case management provider network to get them to sign up as a dental provider with the managed care plans. They also worked with the plans and provided them with the names and contact information of all dentists who were participating in Medicaid fee-for-services. The focus was on getting the largest Medicaid fee-for-service dentists to enroll in the plans. Because of the excellent relationship that had already been established with the dental providers in the county, there were no problems with the transition to managed care.

With the shift to Medicaid Managed Care, there is less hands-on activities with respect to provider recruitment and helping clients to find a dentist.

The DCM Program continues to be highly valued by the dentists, clients, and county leaders.

PRIOR TO THE SHIFT TO MEDICAID MANAGED CARE

- 1,500 individuals were enrolled in dental case management;
- 46 dentists accepted Medicaid;
- No-shows were not a problem;
- Dentists were seeing children under 1 year old;
- Dentists would take anyone referred and educated by DSS.

An example of a multi-county model based upon the concept of care coordination is the Access to Baby and Child Dentistry (ABCD) program in Washington state. The program, which involves a combination of outreach and linkage, education for parents and dental professionals and delivery of services has been effective in reducing dental disease in Medicaid beneficiaries (10 percent of erupted teeth decayed or filled vs. 20 percent). In this model, program partners:

- Recruit and train dentists to provide preventive care and treatment to Medicaid-enrolled children from birth to six.
- Work closely with community organizations to help identify young Medicaid-eligible children and remove any barriers that prevent low-income families from receiving dental care for their young children.
- Engage trained primary care medical providers to deliver oral health preventive services during well-child checks.

Community outreach programs are financially feasible. A review of school-based screening and preventive services provided by hygienists with support staff and portable equipment found that services were financially feasible in states when Medicaid fees were at least 60.5 percent of mean national fees.[40]

Successful programs such as these have led the United States Department of Health and Human Services to emphasize community outreach and education through its Title VII, Section 747 Programs. In a recent report to Congress, recommendations for such programs state that they "should focus on providing skills to enable health care providers to deliver culturally effective care to diverse populations, enabling effective communication and outreach in community-based settings, including such non-traditional settings as schools, clubs, and houses of worship, and instilling the ability to interact effectively with local public health and policymaking bodies."[41]

One should keep in mind, however, that outreach is just one of a group of components necessary for a successful case management program. The dental literature suggests that without intensive follow-up, dental screenings in the school setting alone do not result in increased uptake of care at clinically meaningful levels.[39, 40, 42, 43] Thus one can deduce that screenings must be coupled with linkage to a dental home for successful uptake of care.

Appointment Reminder Systems

Failed appointments deter providers from participating in Medicaid due to lost revenue. In 2000, the American Dental Association (ADA) reported that one-third of Medicaid patients failed to keep their appointments. State Medicaid policies do not provide a mechanism for recouping the overhead costs of these missed appointments.[44] Most importantly, failed appointments mean that children may suffer persistent pain from untreated conditions. In fact, a history of failed appointments has been identified as a risk factor for ECC.[45]

Appointment reminders for patients can include face-to-face communication, postal messages, calls to landlines or mobile phones, and mobile phone voice and text messaging. Telephone, mail and text/short message service result in only a modest improvement in attendance.[46]

Conclusion

An increase in early prevention and oral hygiene instruction provided to children and parents/caregivers through early engagement as a result of community outreach and case management activities has the potential to substantially reduce the overall cost to the system that results from delayed treatment and lack of knowledge by vulnerable populations of good oral hygiene and other preventive practices.

Improving compliance with dental care and prevention need to be comprehensive in order to address the spectrum of challenges that families at high caries risk face. No one strategy alone is likely to be effective. A comprehensive approach to case management should encompass multiple strategies that can include proven modalities such as: motivational interviewing, health literacy activities, care coordination, community outreach and education and appointment reminder systems.

Policy Recommendations for Case Management in Pediatric Dentistry

1. Programs that provide care to low-income families, such as Medicaid and CHIP, can improve the oral health of children by reimbursing for case management activities including:
   a. Motivational interviewing;
   b. Patient education and improving health literacy;
   c. Care coordination; and
   d. Community outreach and education.
2. Case management and motivational interviewing should become a part of curricula for dentists and advanced training programs to aid in improving compliance with care and improving oral health.
3. A simple and provider-friendly mechanism for reimbursement for translation services must incorporated into dental benefit programs.

#1

Testimony –Senate Bill 2197
Senate Appropriations
January 27, 2015
Bridging the Dental Gap and ND Oral Health Coalition

My name is Marcia Olson. I am the Executive Director of Bridging the Dental Gap in Bismarck. We are a non-profit dental clinic providing services to low income and Medicaid patients. I am also the current President of the ND Oral Health Coalition. I am here today to speak in favor of Senate Bill 2197.

This bill will provide $150,000 in funds to expand the Seal ND sealant program.

Sealants are placed on teeth to help prevent decay. They are especially effective in very vulnerable populations to help cut down on high incidences of decay. The Seal ND program provides sealants, fluoride varnish and oral health education. The Morbidity and Mortality Weekly Report (MMWR) that was released in September of 2014 reviewed the use of sealants in preventing decay in children and adolescents. The findings demonstrated that dental sealants prevented decay in permanent molars by 81% approximately 2 years after placement and continue to be effective up to 4 ½ years later. The American Dental Association recommends placing sealants on primary and permanent molars of children at the greatest risk of decay. Sealants as a preventative is an effective means of cutting down the costs of later fillings and extractions. The CDC and American Dental Association also recommend the use of fluoride varnish as effectively preventing caries or primary and permanent teeth. There is also a handout attachment to this presentation demonstrating that information.

The Oral Health program within the ND Department of Health has had a school based sealant project in place for a number of years. Sealants were provided to children in schools with 45% or greater free and reduced lunch. It took some time to build the program. Unfortunately a year and a half ago the funding from HRSA (Health Resources and Services Administration) was not renewed. This resulted in a drastic reduction in services and required all the public health hygienists to be laid off and a cut back in staffing in the Oral Health division. The program which had grown to cover 52 schools and approximately 1950 students in 2012-2013 was only able to service 2 schools and 92 children in 2013-2014. (The schools that

were chosen to be retained were St.John's and Warwick.) Without state funding, the sealant program became defunct.

Last fall, HRSA notified the ND Oral Health program that funding had been re-instated. Budgets were quickly rewritten, new data obtained and hiring process started to get new public health hygienists in place. By November 2014 the Seal ND project was back on its feet. Currently the targeted schools are 40% or greater free and reduced lunch. 89 schools now qualify. Using funds from the HRSA grant the state public health hygienists will provide services at some of the schools and a contract with the Ronald McDonald Caremobile will provide additional site coverage using additional hygienists attached to that program. This funding is in place until 2017. At present 17 schools have been visited but the actual numbers of students is not yet available.

The purpose of Senate Bill 2197 is to provide funds to expand care to approximately another 2000 children. In 2015 and 2016, the expansion would continue to cover these "extra" children. Ideally this expansion should continue to be funded thus assuring that at least the base number of students would always be covered even if the federal funds are lost again in the future.

The interim Health Services Committee chaired by Senator Lee heard repeated testimony and recommendations that the Seal ND! Program be expanded to provide greater access to oral health care. The UND Center for Rural Health Assessment study for Oral Health funded by PEW has as one of its priorities the expansion of the Seal ND program. (If you are interested in reviewing the study it is available online at http://ruralhealth.und.edu/projects/nd-oral-health-assessment/pdf/north-dakota-oral-health-report2014.pdf)

Are there any questions on the areas which I have presented?

Preventing Dental Caries: School-Based Dental Sealant Delivery Programs

Task Force Finding and Rationale Statement

Definition

Dental (pit and fissure) sealants are clear or opaque plastic resinous materials applied to the chewing surfaces of the back teeth to prevent dental caries (tooth decay). School-based dental sealant delivery programs provide dental sealants to students either onsite at schools (using portable dental equipment) or offsite in dental clinics. These programs often target schools in low socioeconomic status (SES) neighborhoods, often identified based on the percentage of children eligible for the federal free or reduced-price meal programs. Some programs may target individuals within a school, based on their risk for caries.

Application demands meticulous technique, and licensed dental health professionals should consult manufacturer's instructions for specific sealant products.

Task Force Finding

The Community Preventive Services Task Force (/about/task-force-members.html) recommends (/about/categories.html) school-based sealant delivery programs based on strong evidence of effectiveness in preventing dental caries (tooth decay) among children. This recommendation is based on evidence that shows these programs increase the number of children who receive sealants at school, and that dental sealants result in a large reduction in tooth decay among school-aged children (5 to 16 years of age).

Rationale

Basis of Finding

The Task Force finding is based on four studies of sealant delivery programs in which sealants were applied within the school setting, and one high quality systematic review (Ahovuo-Saloranta et al. 2013, search period 1946-2012; 34 included studies) evaluating the efficacy of sealants in school-aged children. Based on this updated review, the previous Task Force finding of strong evidence of effectiveness for this intervention remains the same.

The systematic review included 34 trials, 12 of which compared sealants with no sealants for the prevention of caries in children. The four studies of school-based, onsite, sealant delivery programs reported on caries incidence (2 studies), sealant placement (2 studies), and health disparities (2 studies).

Evidence of efficacy of sealants and effectiveness of sealant delivery programs were addressed separately. Only studies with concurrent control groups were included. Table 1 summarizes review results by outcome.

Table 1: Summary Evidence Table

Outcome measures	Number of Studies	Results
Efficacy of sealants:		
Caries (percent caries reduction)	1 systematic review (12 relevant trials)	Median 81% (IQI: 74% to 88%) at 2 year follow-up[1]
Effectiveness of sealant delivery programs:		
Caries (percent caries reduction)	2	Median 50% (IQI: 38%, 61%) at 4 year follow-up
Caries (adjusted* percent caries reduction)	2	Median 40% (IQI: 30.5%, 48%)

[1] Sealing occlusal surfaces of permanent molars in school-aged children reduced caries up to 48 months after sealant placement when compared to no sealant. The quantity and quality of the evidence at longer follow-up is limited.
*Adjusted to allow for 20% non-consenters, assuming non-consenters have same caries level as children in control group.

Two studies assessed the number of children receiving sealants in schools with and without school-based sealant delivery programs. Results from both studies showed that implementing a sealant delivery program led to an absolute increase of approximately 26 percentage points in the number of children who received sealants. Both studies also presented data on prevalence of sealants by caries risk. The studies used different proxies for caries risk, including eligibility for free-or reduced-price school meals or a combination of this alongside other access-related indicators. Schools with sealant programs showed an increase in the number of children with sealants, for both lower and higher risk children, thereby reducing the disparity between risk groups.

Applicability and Generalizability

Included evidence comes from studies conducted in the U.S. and Europe. Most of the data for effectiveness of school-based sealant delivery programs are from areas of middle to low SES, and are therefore applicable to most school sealant programs in the U.S. There is no evidence on the impact of sealant delivery programs for reducing disparities in caries level by race/ethnicity, caries risk or SES. However, there was some evidence that disparities in the number of children who received sealants by caries risk or SES was reduced in schools with sealant delivery programs. These programs are an important way to reach children from low-income families who are at higher risk for caries and less likely to access clinical care.

The efficacy of sealants for preventing caries in children at high risk is well established. The evidence for the efficacy of sealants is predominantly based on trials with one-time sealant placement and no follow-up, indicating a benefit even when sealants cannot be maintained. In addition, most efficacy trials applied

1-3

sealants to sound occlusal surfaces of permanent first molars in children from 5 to 10 years of age. The degree to which sealants reduce caries in older children or in children at moderate to low risk of caries is unclear.

The included studies used a variety of licensed dental professionals (e.g., dentists, dental hygienists, dental therapists) to place dental sealants. There is no evidence to suggest there is variation in longevity of sealants applied by different dental health professionals.

All four studies evaluating sealant delivery programs assessed sealants applied within school settings, as opposed to off-site in dental clinics. More than 80 % of the trials assessing the efficacy of sealants also were conducted within school settings. There is strong evidence to support the effectiveness of programs applying sealants within school settings. However, further research is required to evaluate the effectiveness of programs that apply sealants off-site.

There is insufficient evidence to determine whether school-based programs are more effective at preventing caries when they are used as part of a multi-component approach (i.e., delivering sealants alongside other oral health promotion activities).

Data Quality Issues

In most of the included studies, regarding the effectiveness of school-based sealant delivery programs, the analyses focused only on children who consented to the sealant program, rather than those who were eligible to participate. It is possible that excluding those who did not consent excluded data from highest-risk children.

Other Benefits and Harms

School-based sealant delivery programs can increase the identification of caries in children who do not regularly visit a dentist and improve access to dental health services by referring children who need dental interventions. These programs also offer opportunities for additional preventive strategies and may lead to increases in self-esteem.

No adverse events associated with the school-based programs were identified in the included studies. However, the broader literature suggests possible stigmatization of children when individuals within a school are targeted (as compared with students whose entire schools are targeted). Also, any school-based program will compete for time and resources with other school-related activities.

Considerations for Implementation

Sealant application demands meticulous technique, and licensed dental health professionals should consult the manufacturer's instructions for use of specific sealant products in either school settings or offsite dental clinics.

Despite few studies focusing on the effectiveness of school-based sealant delivery programs, they demonstrate a large reduction in caries and the evidence is strong with regard to the efficacy of sealants placed in a school setting. The majority of this evidence comes from studies of children aged 5-10 years. Ideally, sealants should be applied as soon as possible after tooth eruption.

There is a general lack of evidence, in favor or against, school-based programs that apply sealants off-site in dental clinics. There is no evidence to suggest sealant efficacy would be reduced in programs that applied sealants off-site in dental clinics; however it is anticipated that participation rates may be affected.

Maintenance is encouraged, but a lack of resources or opportunities to maintain sealants should not be a reason not to apply them to high risk children.

Potential barriers to the implementation of school-based sealant delivery programs include the education of parents, children, and clinicians with regard to the value of pit and fissure sealants; socioeconomic issues including the proficiency and use of English language; and the availability of funding for public programs.

More research is needed to better understand the impact of school-based sealant delivery programs on disparities in caries levels by race/ethnicity. In addition, evaluation of the following would be helpful.

- The use of school-based sealant delivery programs as part of multicomponent vs. single component programs
- The age at which sealants should be placed
- The need and timing for sealant maintenance
- The effectiveness of dental sealant application onsite and off-site
- The benefit of programs for children at moderate to low risk

Future studies should clearly describe methods by which schools are recruited and programs are implemented. School-based programs are complex interventions. In order to determine what makes a program effective or not, full reporting of how the program is implemented is required. To understand why people do or do not choose to participate, more detailed descriptions are needed about the timing and quality of sealant information provided to schools and parents prior to consent and throughout the study. Details about the timing of parental consent (before allocation to group or after) may be important in determining the acceptability of sealants. In addition, accurate descriptions of those consenting and non-consenting (including non-responders), and any significant differences between them are needed to assess the generalizability of findings.

Review completed: April 2013

The data presented on this page are preliminary and are subject to change as the systematic review goes through the scientific peer review process.

References

Ahovuo-Saloranta A, Forss H, Walsh T, Hiiri A, Nordblad A, Mäkelä M, Worthington HV. (2013) *Sealants for preventing dental decay in the permanent teeth.* 'Cochrane Database of Systematic Reviews 2013', Issue 3. Art. No.: CD001830. DOI: 10.1002/14651858.CD001830.pub4.

1 — 4

The North Dakota Oral Health Coalition

SB2197

#2
SB2197
1-27-15

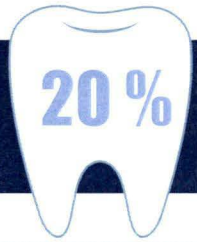
GOAL

To expand the number of children served by the Seal! ND program, thus reducing the preventable pain and cost of tooth decay.

WHY?

In 2009-2010, 20 percent of Head Start children and third graders had untreated dental decay.

Source: *Oral Health in North Dakota: Burden of Disease and Plan for the Future 2012-2017*



Dental Sealants

Sealants can help prevent the pain, infection and early tooth loss caused by decay.

In 2012, school-based sealant programs saved North Dakota taxpayers an estimated $62,500.

Nearly 1,800 North Dakota children will benefit from the expanded sealant program.

Sealants may help to prevent decay at one-third the expense of filling a cavity.

The Morbidity and Mortality Weekly Report (MMWR) states: Dental sealants prevent decay in permanent molars by 81 percent approximately two years after placement, and continue to be effective up to 4.5 years after being placed.

Children with dental pain are more likely to miss class, which reduces the chance of academic success. Decay can cause:

- **Failure to thrive**
- **Impaired speech development**
- **Absence from school**
- **Inability to concentrate**
- **Reduced self-esteem**

2.1

oralhealth
NORTH DAKOTA COALITION

#3

Senate Appropriations Committee

January 20, 2015

Testimony- Senate Bill No. 2197

North Dakota Dental Association Brent L Holman DDS

Chairperson Holmberg and members of the committee, I am Dr. Brent Holman, Executive Director of the North Dakota Dental Association. The North Dakota Dental Association supports Senate Bill 2197. This bill expands the SealND! Program that is currently managed through the State Oral Health Program, State Department of Health. The estimated additional 1800 children that would benefit from this expansion would be children that more likely do not have a dental home and would benefit from the documented preventive benefit of pit and fissure sealants. There is no debate in the scientific literature about the benefit of sealants in preventing decay and future treatment costs. Having the infrastructure in place through the current SealND! Program makes it very efficient to include more children in the program that will benefit.

Please vote DO PASS on SB 2197. Thanks.

#1

Testimony –Senate Bill 2197
House Human Services
March 11, 2015
Bridging the Dental Gap and ND Oral Health Coalition

My name is Marcia Olson. I am the Executive Director of Bridging the Dental Gap in Bismarck. We are a non-profit dental clinic providing services to low income and Medicaid patients. I am also the current President of the ND Oral Health Coalition. I am here today to speak in favor of Senate Bill 2197.

This bill as it stands will provide $150,000 in funds to expand the Seal ND sealant program.

Sealants are placed on teeth to help prevent decay. They are especially effective in very vulnerable populations to help cut down on high incidences of decay. The Seal ND program provides sealants, fluoride varnish and oral health education. The Morbidity and Mortality Weekly Report (MMWR) that was released in September of 2014 reviewed the use of sealants in preventing decay in children and adolescents. The findings demonstrated that dental sealants prevented decay in permanent molars by 81% approximately 2 years after placement and continue to be effective up to 4 ½ years later. The American Dental Association recommends placing sealants on primary and permanent molars of children at the greatest risk of decay. Sealants as a preventative is an effective means of cutting down the costs of later fillings and extractions. The CDC and American Dental Association also recommend the use of fluoride varnish as effectively preventing caries or primary and permanent teeth.

The Oral Health program within the ND Department of Health has had a school based sealant project in place for a number of years. Sealants were provided to children in schools with 45% or greater free and reduced lunch. It took some time to build the program. Unfortunately a year and a half ago the funding from HRSA (Health Resources and Services Administration) was not renewed. This resulted in a drastic reduction in services and required all the public health hygienists to be laid off and a cut back in staffing in the Oral Health division. The program which had grown to cover 52 schools and approximately 1950 students in 2012-2013 was only able to service 2 schools and 92 children in 2013-2014. (The schools that

were chosen to be retained were St.John's and Warwick.) Without state funding, the sealant program became defunct.

Last fall, HRSA notified the ND Oral Health program that funding had been re-instated. Budgets were quickly rewritten, new data obtained and hiring process started to get new public health hygienists in place. By November 2014 the Seal ND project was back on its feet. Currently the targeted schools are 40% or greater free and reduced lunch. 89 schools now qualify. Using funds from the HRSA grant the state public health hygienists will provide services at some of the schools and a contract with the Ronald McDonald Caremobile will provide additional site coverage using additional hygienists attached to that program. This funding is in place until 2017.

The purpose of Senate Bill 2197 is to provide funds to expand care to approximately another 2000 children. In 2015 and 2016, the expansion would continue to cover these "extra" children. Ideally this expansion should continue to be funded thus assuring that at least the base number of students would always be covered even if the federal funds are lost again in the future.

The interim Health Services Committee chaired by Senator Lee heard repeated testimony and recommendations that the Seal ND! Program be expanded to provide greater access to oral health care. The UND Center for Rural Health Assessment study for Oral Health funded by PEW has as one of its priorities the expansion of the Seal ND program. (If you are interested in reviewing the study it is available online at http://ruralhealth.und.edu/projects/nd-oral-health-assessment/pdf/north-dakota-oral-health-report2014.pdf)

Originally this bill also had a provision for a dental case management pilot project included. The cost for this project was $50,000 (in addition to the amount for the sealant program). This was a nominal cost and was to be used to do some basic case management on the existing students being seen under the sealant program. It seemed a simple way to determine the efficacy of such a program. This would cover some costs of training and travel and working with 100 or more students who are in need of additional dental services or other types of care or assistance for families to navigate the paperwork involved with health and dental insurance.

One of the areas of need that we have seen both through work on the Ronald McDonald Caremobile and the sealant project is that a large number of children who qualify for Medicaid or similar programs are not enrolled. Additionally they need help in surmounting some of the barriers to seeking dental care and dental homes. Case management would attempt to resolve some of these issues.

This area was rated as a high priority through the studies presented to the Health Services interim Committee especially as case management project related to help children access dental care. Not only is it a part of the UND Center for Rural Health Assessment but Senate Concurrent Resolution (SCR) 4004 also places a priority on this area by stating in part " the Legislative Management continue to study dental services in the state including the effectiveness of case management services...". There currently is not any case management services for oral health or dental care. This would be a new area and by funding at least a small pilot project then Legislative Management may have the data to ascertain the likelihood that a program of this type would resolve some of these issues.

I would urge your consideration to put this portion of the bill back into place along with the passage of the remaining sealant bill.

Dr, Holman with the ND Dental Association is testifying on another bill today in House Industry Business and Labor. He has asked that I provide his written testimony concerning the case management portion of the bill that provides the background and plan for implementing. He also supports the Sealant portion of this bill.

Are there any questions on the areas which I have presented?

#2

Testimony SB2197

Human Services Committee

Wednesday, March 11, 2015- 9:00 a.m.

North Dakota Oral Health Coalition Cheryl Underhill, MSN, Mm

Good morning, Chairperson and members of the Human Services Committee. My name is Cheryl Underhill and I am the Executive Director of the North Dakota Oral Health Coalition (NDOHC). I am here today to provide testimony on Senate Bill 2197.

The North Dakota Oral Health Coalition, established in 2005, is a 501c3 organization with over 110 committed individual and organizational members representing many facets of oral health care from education and public health, to professional associations and community health centers. The coalition's mission is to "develop innovative strategies to achieve optimal oral health for all North Dakotans."

In 2014, members of the NDOHC discussed shared goals and priorities and by consensus agreed upon 4 priority areas, which are also identified in Health Services Committee Concurrent Resolution No. 4004, a resolution to study dental services in ND. Two of the NDOHC priorities identified are:

- Expand the Seal!ND program through the State Department of Health oral health programs to target low income children in public schools.
- Funding for a Case Management outreach model supported through the State Department of Health and the North Dakota Dental Association.

These coalition priorities also align closely with the top stakeholder priorities identified in the *2014 North Dakota Oral Health Report: Needs and Proposed Models,* a study conducted by the North Dakota Center for Rural Health, and funded by the PEW Foundation. The Center for Rural Health report findings are also documented in Concurrent Resolution 4004 and specifically include:

- Increased funding of the Seal!ND North Dakota program-to include using dental hygienists to provide care and incorporating case management and identification of a dental home.

#3 Handed in

House Human Services Committee

Testimony- Senate Bill No. 2197

3-11-15

North Dakota Dental Association Brent L Holman DDS

Chairman Weisz and members of the committee, I am Dr. Brent Holman, Executive Director of the North Dakota Dental Association. The North Dakota Dental Association supports Senate Bill 2197. Besides the sealant component already in place and that has been passed by the Senate, the bill also had a case management component that pilots a model for identifying children deemed to be high-risk for dental decay and links them with a case manager. This case management component was taken out of the Senate bill. We support adding that back, given the importance of this activity in identifying high-risk children and linking them to dental homes. Like the sealant component, case management saves money by getting children into treatment early thereby preventing more expensive treatment.

A risk assessment tool is developed specific for the program that defines the child's risk for decay based on evidenced-based criteria developed by a technical assistance consultant. It is hoped that this tool would identify about 100 children that would benefit from referral and case management for comprehensive treatment. A case manager will be assigned to link these children to a dental home. A dental home is the most effective way to prevent dental disease and future treatment costs. Case management involves motivational interviewing, oral health literacy activities, education, linkage to other community resources, and help with transportation.

Data will be accumulated to document treatment costs and help justify the benefits of prevention and Medicaid reimbursement for case management.

The appropriation for the case management part of the bill would be used for technical assistance, training of the case managers, and for their services.

The management of the case management piece would be part of the overall program management currently provided by the Oral Health Program, State Department of Health. Thanks for your consideration.

SB 2197
3/23/2015
#1

SB 2197 **March 23, 2015**

House Appropriations Committee

Human Resources Division

Honorable Chet Pollert, Chairman

Chairman Pollert and Committee Members,

I am Brad Bekkedahl, Senator from District 1, which is the City of Williston. I am here this morning to introduce Senate Bill 2197, which is a bill to provide an appropriation of $150,000 to support and enhance preventive dental treatment, specifically the application of sealants to vulnerable teeth, to children in high risk school populations.

In its original version, this bill also had a $50,000 appropriation to the Department of Health for a Case Management pilot program to achieve early outreach through community-based oral health programs and targeting high-risk dental patients to get them connected to a dental home, which gives the at risk patients the greatest chance for continuous and comprehensive prevention and treatment. This provision of the bill and its appropriation was removed in the Senate, making the appropriation before you today $150,000.

In essence, the appropriation request is to provide State of North Dakota funding to an existing Federally funded program that in recent history, has been removed from the Federal budget and re-instated. This interruption in Federal funding has resulted in the program being eliminated, as well as Staff that provided the services being terminated. This interruption in the delivery system has meant the loss of key providers of the service and reducing the number of children served from approximately 2,000/year to less than 100. The State funding requested would provide a "backstop" to the program, allowing it to continue when and if Federal funding is ever again compromised or removed. When the Federal funding is in place, it means the program can serve nearly double the amount of children it would normally.

I am fortunate today to have representatives of the Oral Health Coalition, a Community based Dental clinic, and the Department of Health for further explanation of the funding request and how they would be used in the program.

Thank you for your attention and consideration. I am happy to stand for any questions at this time.